

Shared care central to management of substance use disorder

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SUBSTANCE USE DISORDER (SUD) ENCOMPASSES THE USE OF DRUGS (ILLICIT AND

prescription) or alcohol in a way that may cause harm and is difficult to control. Diagnosis of SUD is based on clinical history and examination in accordance with ICD-11 criteria which categorise use as hazardous, harmful or dependent.¹

Although the pharmacological effects of abused drugs vary, the features of dependence are remarkably similar regardless of the specific substance used. Psychological craving is the key feature of the dependence syndrome which can exist without physiological withdrawal symptoms. Dependence forming drugs activate the mesolimbic dopamine system; dysregulation of this 'reward pathway' is believed to mediate the compulsive and pathological drug use central to the dependence state.

Dependence, however, is only the tip of the iceberg in SUD, with many harms related to use that falls short of a dependence diagnosis.

RISK FACTORS

Development of SUD involves the interplay of biological, environmental

and socioeconomic factors.² Early childhood adversity, poverty and deprivation are associated with substance use.³ Some drugs have a greater 'dependence liability' than others, however, not everyone who uses a particular substance becomes dependent.

Factors influencing alcohol dependence risk are most studied, with estimates that 50-60% of the liability is genetically determined.⁴ As well as influencing risk of development, socioeconomic factors also modulate the impact of SUD. Although alcohol consumption levels are similar in social class 1 and 5, cirrhosis rates are higher in the latter and strong correlations have been reported between poverty and drug-related harms.⁵

PRIMARY CARE ASSESSMENT

The GP has a pivotal role in the safe and effective delivery of care. The GP can identify problems, provide harm reduction support and brief interventions, manage complex comorbidities and provide drug treatment in shared care arrangements.⁶

People often see their GP for a medical problem arising from SUD without mentioning substance use.

How should patients be assessed?

Which patients should be referred?

What are the management approaches?

Good rapport and a non-stigmatising, empathetic attitude can facilitate disclosure.⁶ GPs should routinely ask about substance use if symptoms may suggest SUD e.g. chest pain in a young person, psychosis, mood disorders or sleep disorders.⁷

NICE suggests that screening for excessive alcohol consumption should be an 'integral part' of primary care practice, occurring at almost every opportunity. While possibly aspirational it should certainly occur in those at increased risk of harm from alcohol and with alcohol-related conditions.⁸

The severity of SUD will inform whether onward referral is indicated. Patients who misuse alcohol should be referred to specialist services when they show signs of moderate or severe dependence, have not benefited from brief advice or intervention, show signs of severe alcohol-related impairment or have related physical or mental comorbidities.⁸

Prophylactic oral thiamine should be prescribed to those who drink in harmful and dependent ways if they are malnourished, have decompensated liver disease, are in acute withdrawal, and before and after a planned alcohol detoxification.³¹ Other B vitamins can

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be considered e.g. vitamin B complex. Parenteral (followed by oral) thiamine is mandatory if Wernicke's encephalopathy is suspected, and this should be managed in the acute hospital setting, see further details on p18.

For those whose primary problem is drug use, shared care arrangements and referral guidelines will vary locally.

As patients may struggle to arrange or attend regular appointments, an opportunistic approach may be required for certain services such as cancer screening and treatment for blood borne virus (BBV) infections to be provided.

Table 1, below, sets out components of a general health check which should be considered and shared across teams and services.⁶

Table 1

General health check components

General lifestyle advice

- Healthy eating
- Exercise
- Smoking cessation advice, pharmacological interventions and support

Blood borne viruses (BBV)

- Testing for HIV, HBV, HCV
- Hepatitis B (and possibly hepatitis A) immunisation
- Harm reduction intervention and safe injecting advice
- Signposting to needle exchange programmes

Poor dentition or oral hygiene

- Offer information about local NHS dental services
- Direct referral to special care dental services if appropriate

Sexual and reproductive health

- Contraception review
- Pregnancy testing
- STI screening
- Cervical smears
- Safe sex advice
- Referral to sexual health clinic

Injection sites

- Inspection of sites and treatment of complications e.g. deep vein thrombosis and abscesses

Metabolic health and nutrition

- Weight monitoring
- Prescription of supplements
- Referral to dietitian

Liver function

- Blood tests to assess liver function

Review of other systems

- General enquiry re respiratory, cardiac, gastrointestinal and neurological health. Examination, investigation and onward referral where necessary

Mental health

Substance use is common in people with mental illness and vice versa. This is partially explained by shared risk factors; for example, both past trauma and certain genetic polymorphisms are associated with substance use and with the development of psychiatric illness.^{9,10,11} The Department of Health¹² regards dual diagnosis as the expectation rather than exception, emphasising that patients are seen as having complex difficulties rather than two distinct problems. Careful liaison between services is essential, ensuring a holistic approach that meets the individual patient's needs.

Substance use may trigger a first episode of a mental health condition in a susceptible individual or exacerbate an existing disorder, e.g. cannabis use and schizophrenia.¹³ However, substance use alone is rarely the sole cause of a severe and enduring mental illness.¹⁰

For patients with psychosis or bipolar affective disorder in whom alcohol or substance use is suspected or confirmed, NICE recommends referral to secondary care services.^{14,15} Although a putative drug-induced psychosis would be expected to resolve on cessation of substance use, treatment of an acute psychosis is the same regardless of aetiology. Urgent involvement of psychiatric services is mandatory.

Low mood and anxiety are sometimes secondary to substance use and often resolve with abstinence or stabilisation. This has been shown to be the case in the majority of patients presenting to alcohol treatment services.^{16,17}

For patients who misuse alcohol and have concurrent depression or anxiety, NICE guidelines recommend treating the alcohol use first to see if symptoms improve. If symptoms continue after 3-4 weeks of abstinence, assessment of the depression or anxiety should be undertaken and referral and treatment in line with the relevant NICE guideline.⁸

A meta-analysis found that antidepressants exert only a modest benefit in comorbid depressive and substance use disorders.¹⁸

If antidepressant therapy is continued, citalopram and sertraline are the safest choices in patients who continue to drink¹⁹ and tricyclics should be avoided. Cognitive behaviour therapy (CBT) is an effective non-pharmacological intervention.

Physical health

SUD is associated with premature mortality, reducing life expectancy by

9-17 years.²⁰ This is mainly due to the effects of cigarette smoking, emphasising the importance of routinely offering assistance with smoking cessation.

Physical health can be affected by the substance itself or route of administration. Injecting drug use carries a risk of infection, either local (abscesses) or systemic (blood borne viruses, endocarditis), and vascular injury. Rates of HIV and hepatitis B in the drug-injecting population have fallen but rates of hepatitis C are the highest in a decade.²¹ Smoking any drug can cause pulmonary morbidity and increase susceptibility to respiratory infections.

The effects of alcohol on the gastrointestinal, cardiovascular and central nervous systems are well documented. Alcohol-related brain damage is an increasingly recognised consequence of chronic heavy drinking and is thought to be present in up to 30% of alcohol-dependent individuals.²² Liver disease is the fifth most common cause of death in the UK and 70% of cirrhotic liver disease is alcohol related. Abstinence significantly improves survival in cirrhosis; there is even evidence synthetic function can normalise.²³

MANAGEMENT

Psychosocial interventions

All patients with SUD should be offered psychosocial interventions^{7,8} whether they opt to pursue abstinence, medication assisted treatment, a harm reduction approach or no treatment. These range from formal psychological therapies to key working by a third sector support worker. They are the mainstay of treatment for cannabis, stimulant and hallucinogen use.

Patients should be routinely offered information on self-help groups and peer-support models such as SMART Recovery and those based on the 12-step principles e.g. Alcoholics Anonymous, Narcotics Anonymous.^{6,7} Third sector organisations also play an important role in supporting individuals in recovery, many offering a self-referral pathway.

Alcohol-based brief interventions in primary care are clinically useful and cost effective²⁴ and although less studied, this is likely true for brief interventions for substance use too. Brief interventions involve screening e.g. using the Alcohol Use Disorders Identification Test (AUDIT), detection of a problem and then fostering motivation to address problematic use.

Just asking about consumption can be beneficial, reflected in the fact that studies of brief interventions find

reduced use in both treatment and control groups.²⁵ This effect can be increased with the motivational interviewing techniques that are core to brief interventions. The aim is essentially to shift people into taking action on substance use; a non-judgemental style of questioning which avoids confrontation and lecturing but helps the individual to make their own arguments for change is central (see table 2, below). While abstinence will be the goal in those with a history of dependence or who have developed physical complications, any reduction in use is beneficial. Brief interventions have been shown to have an NNT of 8 in shifting people from hazardous to non-hazardous drinking.²⁶

Evidence-based formal psychological therapies recommended by NICE for drug use include contingency management, behavioural couples

therapy and CBT.⁷ For those with harmful drinking and mild alcohol dependence, CBT, behavioural couples therapy, social network and environment-based therapies are recommended.⁸

Opiate dependence

It is important to establish a diagnosis of opiate dependence through history taking, physical examination and where possible a corroborative history from others.

The nature and severity of dependence need to be ascertained, including the frequency and route of administration, as well as effects on other aspects of health, relationships, social functioning, and forensic record. Urine/oral toxicology screens can confirm recent opiate use and support a diagnosis of dependence, as can the presence of withdrawal symptoms on examination.⁶

Methadone and buprenorphine are first-line agents for opiate replacement therapy (ORT).²⁸ They can sometimes be initiated in primary care by GPs with higher level training in the management of drug and alcohol problems (e.g. the RCGP certificate for the management of drug misuse parts 1 and 2) or as part of a shared care arrangement. In practice, most patients will be started on a substitute prescription by substance use services and then referred to their GP for shared care once stable.^{28,29} RCGP guidance is that patients stable on ORT should be reviewed at least three monthly, asked about changes to their health or wellbeing, and whether there is any drug or alcohol use on top of their prescription.²⁹ Toxicology screening should be regular at the start of treatment and random thereafter.⁶

Prolonged-release injectable buprenorphine was approved by NICE in 2019³⁰ and is now available across the UK. NICE suggests a designated place for this treatment in particular when patients prefer not to attend daily for medication due to work or education commitments, and may prefer a weekly or monthly medication regimen, and in cases where there is high risk of medication diversion e.g. prisons. At the time of writing, prolonged release buprenorphine is restricted to specialist use only although there is a groundswell of support for this to be extended to primary care.

Alcohol withdrawal

Acute withdrawal from alcohol can be fatal and careful management is required for patients with severe alcohol dependence. Assisted alcohol withdrawal is advised for patients drinking more than 15 units per day or who score more than 20 on the AUDIT. It can be carried out in the community (generally by specialist alcohol services) unless criteria for inpatient detoxification are met (see table 3, left).^{8,31}

The management of unplanned acute alcohol withdrawal and complications, including delirium tremens and withdrawal-related seizures, is described in NICE guideline CG100.³¹ Delirium tremens has a high risk of mortality and hospital admission to a medical ward is necessary for life saving treatment.

Alcohol withdrawal can also precipitate Wernicke's encephalopathy in the malnourished. Consider elective admission for detoxification of those at risk to enable treatment with parenteral thiamine; symptoms suggestive of the condition are a medical emergency necessitating immediate treatment to

Table 2

Questioning patients about substance use²⁷

Suggested approach

- Ask open ended questions e.g. 'I understand you have concerns about your drinking. Can you tell me about them?'
- Use reflections/rephrasing the patient's statements to help them see associations and capture implicit meanings e.g. 'So you used to drink after you had a stressful day at work, to unwind, but now you have stopped working and are drinking most days yet feeling more stressed.'
- Make affirmations to build rapport and support the patient e.g. 'It must have taken a lot of courage to come and discuss your drinking with me today.'
- Foster change talk. This may be through asking about the disadvantages of the status quo or advantages of change e.g. 'What worries you about your blood test results?', 'What might be the advantages of reducing drinking?'

The following approaches should be avoided

- Asking dead end questions e.g. 'Do you have a problem with drinking?'
- Confrontation or moralising e.g. 'You have a serious drinking problem that you are denying'
- Threatening e.g. 'If you don't stop drinking there is no point in arranging follow-up'
- Imposing labels e.g. 'The problem is that you are an alcoholic'

Table 3

NICE criteria for inpatient or residential assisted alcohol detoxification^{8,31}

Criteria for inpatient or residential assisted detoxification

- Drinking > 30 units alcohol per day
- Severity of Alcohol Dependence Questionnaire (SADQ) score > 30
- Epilepsy or seizures or delirium tremens during previous assisted detoxifications
- Need concurrent withdrawal from alcohol and benzodiazepines
- Regularly drink 15-30 units per day AND significant psychiatric or physical comorbidities OR a significant learning disability OR cognitive impairment

Groups that may benefit from a lower threshold for inpatient detoxification

- Frailty ● Multiple comorbidities ● Lack of social support ● Learning difficulties
- Aged 16 or 17 ● Cognitive impairment

key points

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Substance use disorder (SUD) encompasses the use of drugs (illicit and prescription) or alcohol in a way that may cause harm and is difficult to control. Diagnosis is based on clinical history and examination in accordance with ICD-11 criteria which categorise use as hazardous, harmful or dependent. People often see their GP for a medical problem arising from SUD without mentioning substance use. Good rapport and a non-stigmatising, empathetic attitude can facilitate disclosure. GPs should routinely ask about substance use if symptoms may suggest SUD e.g. chest pain in a young person, psychosis, mood disorders or sleep disorders. NICE suggests screening for excessive alcohol intake should be an 'integral part' of primary care practice, occurring at almost every opportunity.

Substance use is common in people with mental illness and vice versa. Part of the reason for this co-occurrence is shared risk factors; for example, both past trauma and certain genetic polymorphisms are associated with substance use and with the development of psychiatric illness. The Department of Health regards dual diagnosis as the expectation rather than exception, urging that patients are seen as having complex difficulties rather than two distinct problems. Careful liaison between services is required ensuring a holistic approach.

Low mood and anxiety are sometimes secondary to substance use and often resolve with abstinence or stabilisation. This has been shown to be the case in most patients presenting to alcohol treatment services. For patients who misuse alcohol and have concurrent depression or anxiety, NICE recommends treating the alcohol use first to see if symptoms improve. If symptoms continue after 3-4 weeks of abstinence, assessment of the depression or anxiety should be undertaken and referral and treatment in line with the relevant NICE guideline.

Alcohol-based brief interventions in primary care are clinically useful and cost effective. Brief interventions involve screening e.g. using the AUDIT tool, identification of a problem and then fostering motivation to address problematic use. Just asking about consumption can be beneficial; studies of brief interventions have found reduced use in both treatment and control groups. This effect can be increased with the motivational interviewing techniques that are core to brief interventions.

A diagnosis of opiate dependence needs to be established through history taking, physical examination and where possible a corroborative history from others. The nature and severity of dependence should be determined including the frequency and route of administration, as well as effects on other aspects of health, relationships, and social functioning. Urine/oral toxicology screens can confirm recent opiate use and support a diagnosis of dependence, as can the presence of withdrawal symptoms on examination.

reduce the risk of (potentially irreversible) Korsakoff's syndrome.³² Clinical features and risk factors for Wernicke's encephalopathy are listed below.³²

Clinical features

- Acute confusion
- Ophthalmoplegia
- Decreased consciousness level
- Nystagmus
- Memory disturbance
- Unexplained hypotension with hypothermia
- Ataxia/unsteadiness

Patients with clinical features of

Wernicke's encephalopathy should be treated with 2 pairs (4 ampoules) IV thiamine TDS for 3 days, then OD 2-3 days, then oral thiamine 100 mg TDS.

Risk factors

- Intercurrent illness
- Peripheral neuropathy
- Delirium tremens or treatment for it
- Drinking > 20 units daily
- Alcohol related seizures
- Recent diarrhoea/vomiting
- IV glucose infusion
- Signs of malnutrition
- Significant weight loss

Table 4

Drugs used to maintain abstinence from alcohol in adults aged 18 and over

Acamprosate

Indication

Maintenance of abstinence; can reduce cravings for alcohol

Only licensed for patients aged 18-65

Initiation

As soon as possible after detoxification. Usually prescribed for up to 6 months, or longer if there is a benefit and patient preference

Major contraindications

Serum creatinine > 120 micromol/L; pregnancy (unless benefits outweigh risks); breastfeeding

Naltrexone

Indication

Relapse prevention

Supervision improves outcomes

Initiation

After detoxification. Usually prescribed for up to 6 months, or longer if there is a benefit and patient preference

Major contraindications

Patients dependent on opioids; severe or acute hepatic impairment, hepatic failure, acute hepatitis; pregnancy (unless benefits outweigh risks); breastfeeding; severe renal impairment

Disulfiram

Indication

Disulfiram is an alternative for patients in whom acamprosate and naltrexone are not suitable, or if the patient prefers disulfiram and understands the risks of taking the drug.

Maintenance of abstinence; ensure patient understands risks of drinking while on this medication (induces disulfiram-ethanol reaction); and also knows to avoid certain toiletries and hand sanitisers that contain alcohol.

Supervision improves outcomes

Initiation

At least 24 hours after the last alcoholic drink

Major contraindications

Significant cognitive impairment (which would preclude understanding/recall of risks of concurrent alcohol use); cardiac failure; coronary artery disease; history of stroke; hypertension; psychosis; risk of suicide; severe personality disorder; first trimester of pregnancy; breastfeeding

● Poor diet/nil by mouth

Patients with risk factors for Wernicke's encephalopathy should be treated with 1 pair (2 ampoules) IV thiamine OD for 3 days, then oral thiamine 100 mg TDS.

Relapse prevention

Before considering elective alcohol detoxification, interventions to maintain abstinence should have been discussed. For those patients who are unwilling to consider abstinence, harm reduction interventions should be offered. Various pharmacological agents are available to help maintain abstinence from alcohol (see table 4, p18). Prior to commencing these medications, baseline urea and electrolytes and liver function tests are required.⁸

Nalmefene, when used with psychosocial interventions, can reduce alcohol consumption in patients who are not alcohol dependent but who exhibit 'high drinking level risk'.³³

Naltrexone can also be considered in opioid dependence following detoxification. Medications are most effective when offered in conjunction with psychosocial interventions.⁸

Competing interests: None

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Useful information

For patients

Alcoholics Anonymous

Freephone 0800 917 7650

www.alcoholics-anonymous.org.uk

Narcotics Anonymous

Helpline 0300 999 1212

www.ukna.org

SMART Recovery

www.smartrecovery.org.uk

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