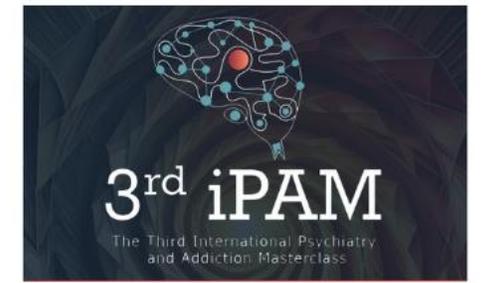
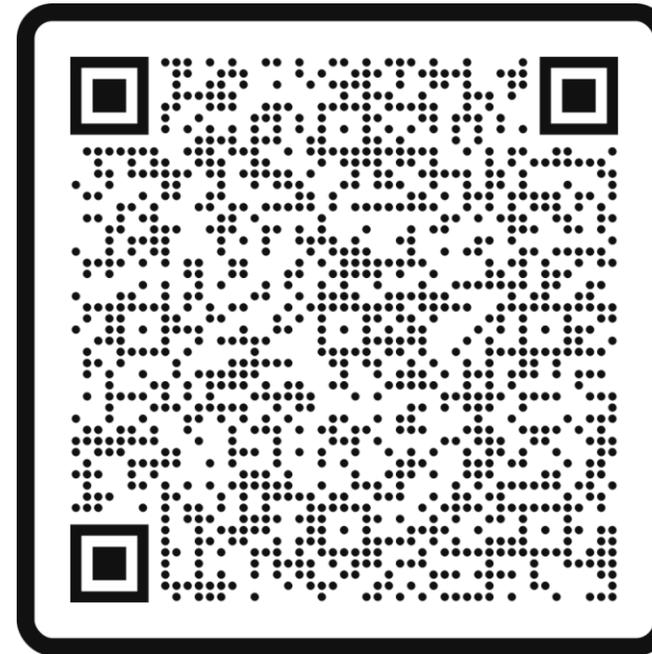


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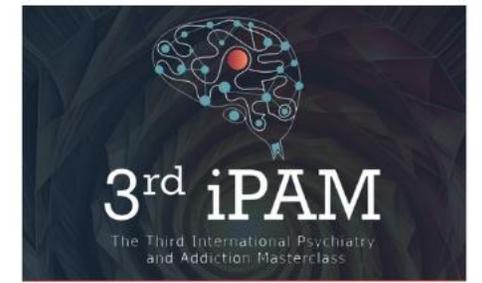


1st October 2025

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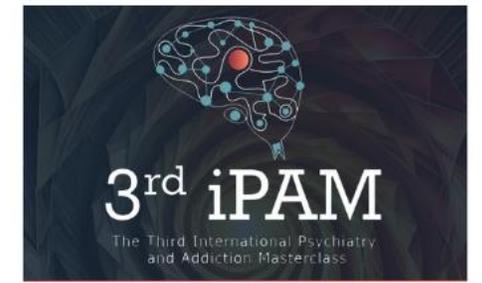


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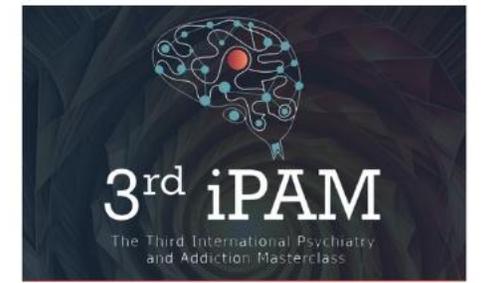
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Introducing the 3rd International Psychiatry & Addiction Masterclass



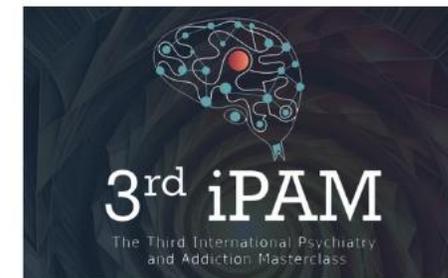
Prof Yasir Abbasi

CMO/MD at Ardens Medical Centre, Dubai-
UAE,

Consultant Psychiatrist, Via- UK,
Adjunct Professor at Liverpool John Moores
University, Liverpool- UK
Chair, PAIN Charity- UK



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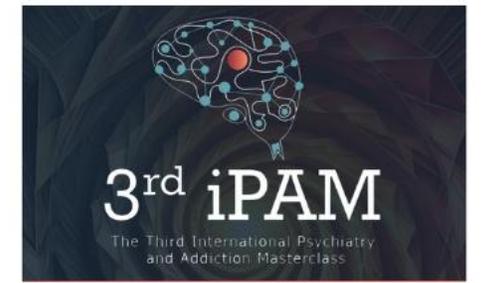


What is iPAM?

- The International Psychiatry and Addiction Masterclass (iPAM) is a conference-/masterclass-style event for healthcare professionals interested in psychiatry and addiction.
- To provide a forum for sharing *expert views*, latest research and evidence in the fields of psychiatry and addiction.
- To address emerging trends in psychiatry, the interface of mental health with physical health, psychological interventions, and addiction.
- To cover topics that are useful and relevant to delegates, evolving with what is currently needed in the field.



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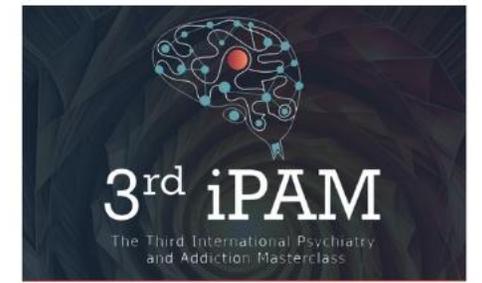


How it all started

- The **1st iPAM** (14–15 November 2020, virtual, Dubai) had “hundreds of registrations from across five continents.
- That first edition also included ~100 questions answered via Q&A, and “on an average 90% of the attendees rated the content, session and faculty from very good to excellent.
- The **2nd iPAM** (15 October 2021, hybrid, Dubai) was described as a “resounding success,” with speakers addressing themes of mental health, addiction, psychological interventions, co-morbidity between mental & physical health, and emerging trends in psychiatry.
- The **3rd iPAM** is being delivered today on 1 October 2025 in London (Prospero House, Borough High Street)



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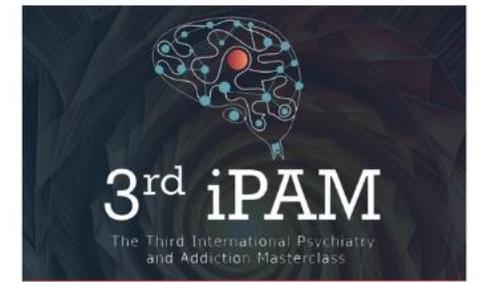


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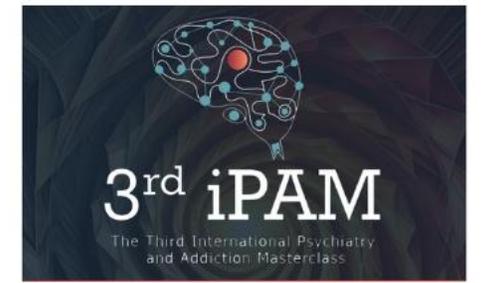


Chair

Dr Khansa Nabil



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Presentation

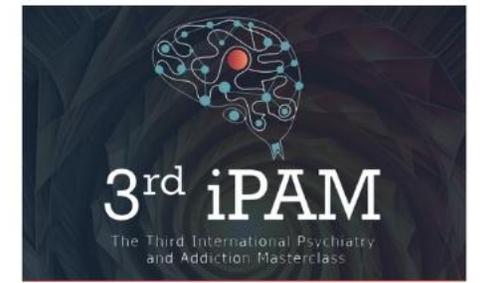


Dr Baxi Sinha

Consultant Psychiatrist & Lead, Ketamine Service
for TRD Deputy Medical Director (IR)
TEWV NHS Foundation Trust



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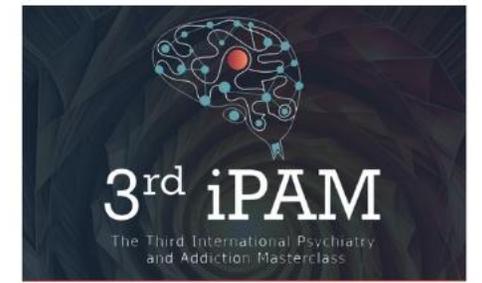


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Presentation



Dr Arun Dhandayudham
Executive Medical Director
VIA



Ketamine Addiction: Should we be concerned?

3rd IPAM

1st October 2025

Dr Arun Dhandayudham

Executive Medical Director Via

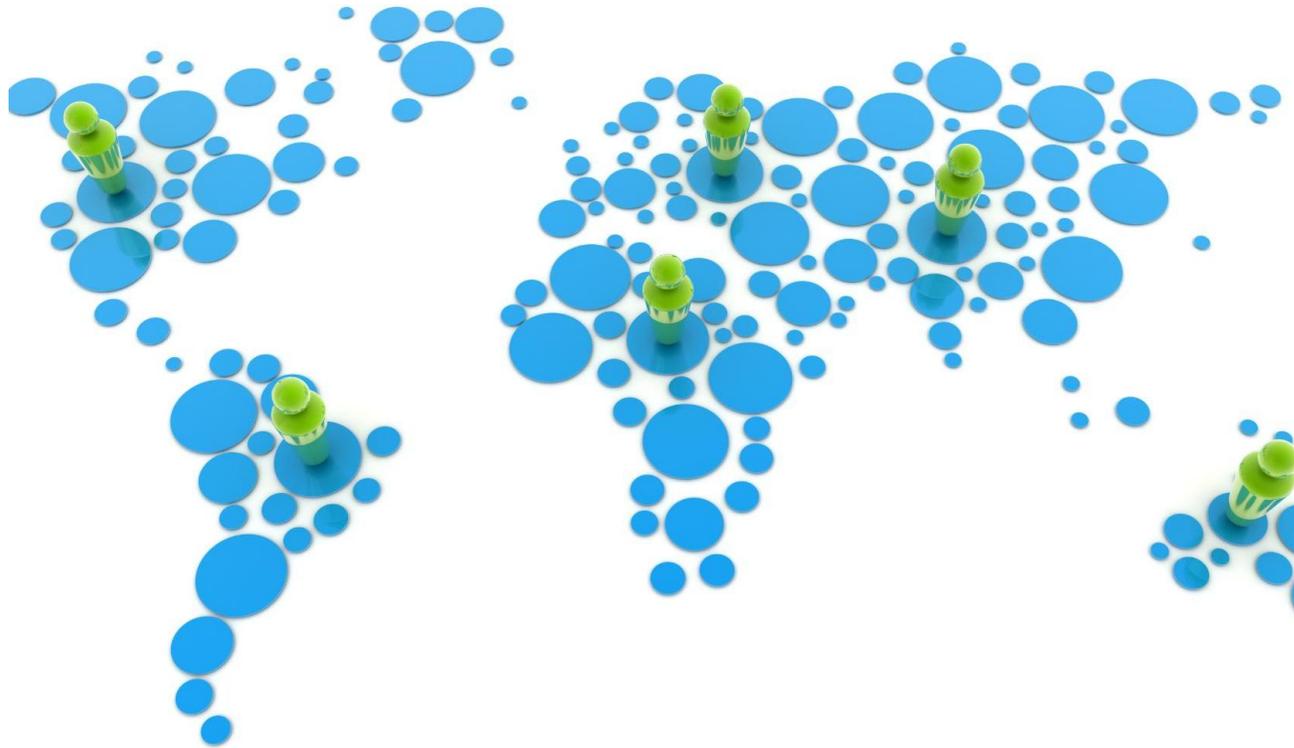
Today's Agenda

- The Ketamine story
- Prevalence and Demographic Trends
- Understanding Ketamine Addiction and Harms
- Via Strategies for Prevention and Treatment

3rd IPAM October 2025

Prevalence and Use of Ketamine worldwide:

Illicit Ketamine use across the world



THE UK PICTURE

THE EUROPEAN PICTURE

THE US PICTURE

INDIA

CHINA

SOUTH EAST ASIA

LATIN AMERICA



Forms of Ketamine and co-conspirators

Medically

Liquid IM and IV. Recently thin film, lozenges and nasal spray Spravato

Illicitly

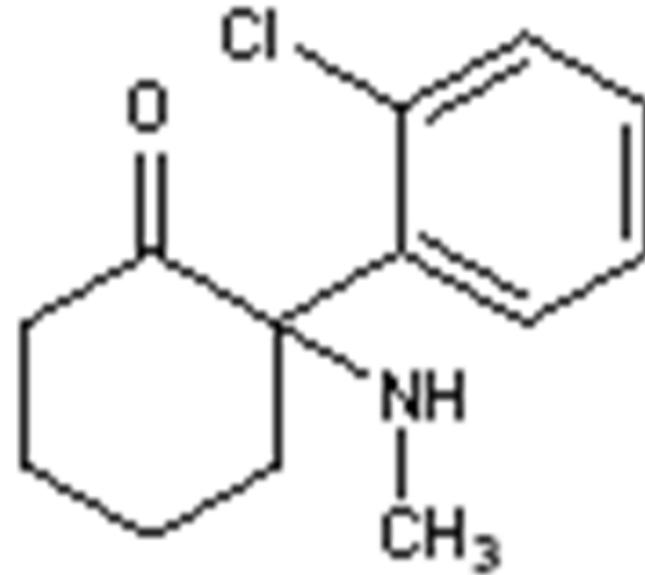
Can be snorted or taken orally or injected

Commonly Mixed With

MDMA, Cocaine, Alcohol, Cannabis, Benzos, 2-CB

The Ketamine Molecule and receptor interactions

Aryl-cyclo-hexylamine
Receptor Interactions



3rd iPAM October 2025

Ketamine Addiction from the Coalface



Why people like misusing it

Cheap and Available and big bangs for limited bucks. Great Dealer offers for bulk buys

The Experience

The problems with the experience



The Physical Effects

Deaths and Overdoses

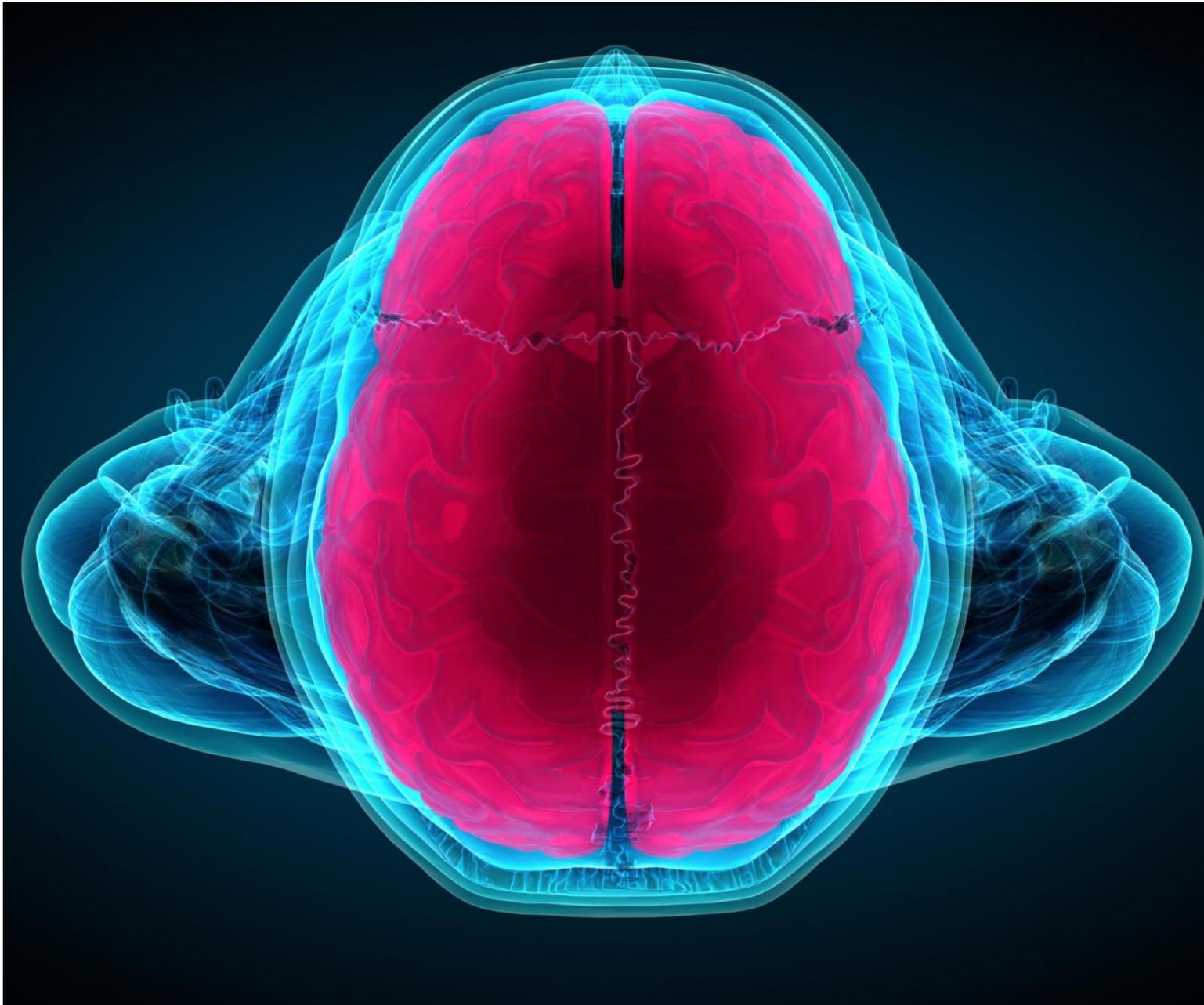
Accidents and date rape associations

Ketamine Bladder, Kidney and Pain

Ketamine Liver

Weight Loss

Brain Damage



The Mental Effects

Psychological Dependency and craving and relapse

Anxiety/Agitation/ Confusion/ Paranoia

Cognitive Changes???

Persistent Flashbacks and HPPD

What are we
doing in our
treatment
services?

Clinical Via approaches to Ketamine treatment



Is there a **Withdrawal syndrome**?

What **guidelines** are out there?

Counselling Support

Counselling offers emotional support and coping strategies to prevent relapse and promote well-being.

Behavioural Therapies

Behavioural therapies address the psychological aspects of addiction to support long-term recovery **Detoxification Process**

Detoxification

Detoxification helps safely manage withdrawal symptoms during the initial phase of addiction treatment.



Support resources and recovery programmes

Support Groups Importance

Support groups provide community and understanding, crucial for overcoming ketamine addiction.

Ongoing Care Benefits

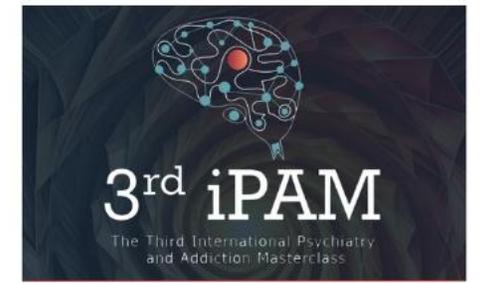
Continuous care ensures sustained recovery and prevents relapse after initial treatment.

VIA Staff and resources

3rd iPAM

Questions ???

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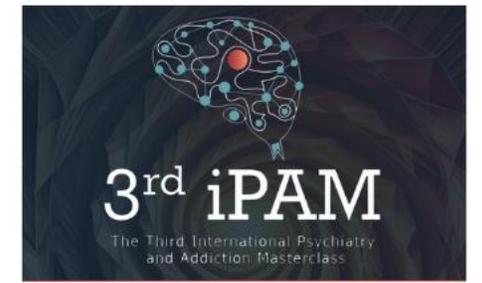


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Presentation



Dr Matthew Liveras
Consultant Psychiatrist
VIA



Introduction to Ketamine-Assisted Psychotherapy

Dr Matthew Liveras

Overview

Ketamine development and basic pharmacology

Ketamine in mental health

Ketamine use outside of the clinic

Ketamine with psychotherapy for SUD and AUD

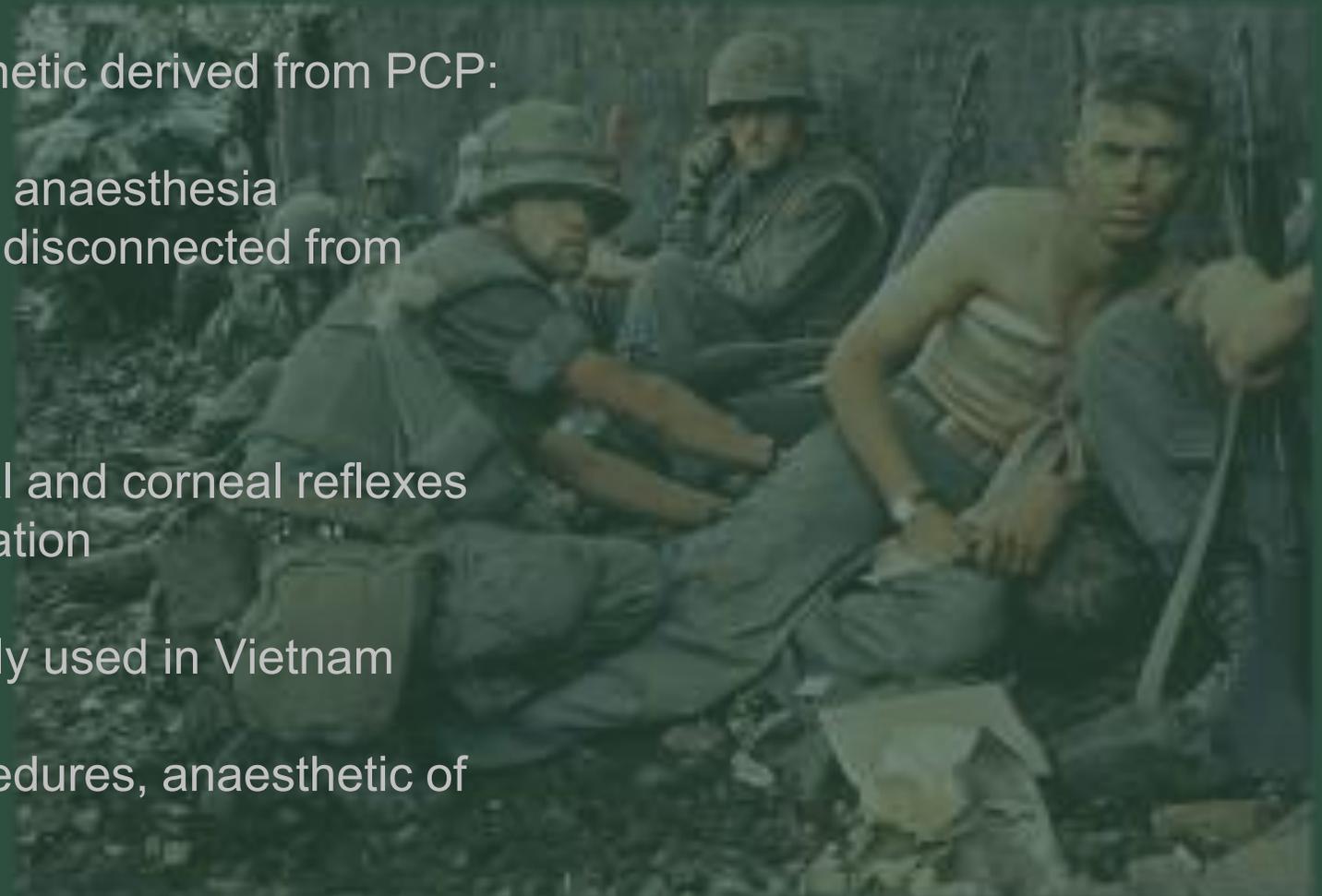
Ketamine : anaesthesia

Developed in early 1960s as an anaesthetic derived from PCP:

- Profound analgesia and short-lasting anaesthesia
- 'Dissociative' - altered state in which disconnected from environment
- Mild cardiovascular stimulation
- Little respiratory depression
- Preservation of laryngeal, pharyngeal and corneal reflexes
- Emergence phenomena of short duration

FDA approved in humans in 1970, widely used in Vietnam

Commonly used globally for minor procedures, anaesthetic of choice in low-resource settings

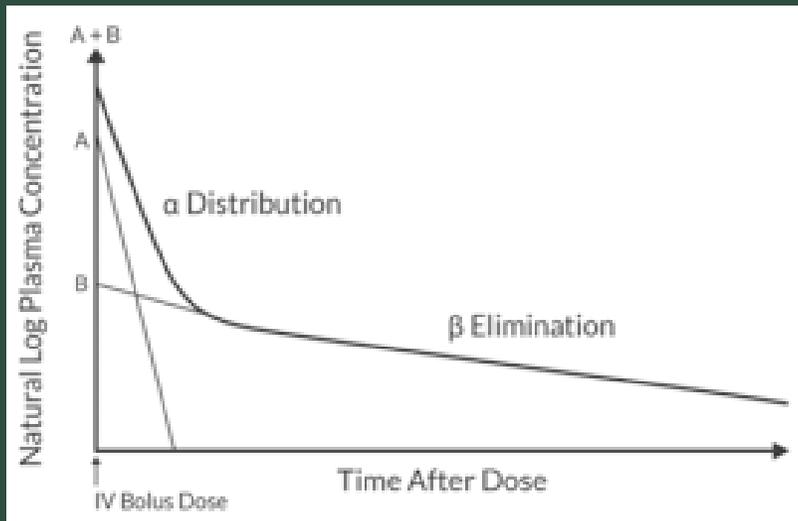


Ketamine : pharmacokinetics

Metabolised in the Liver

Extensive 1st pass metabolism: low oral bioavailability

Bioavailability : IM 93% ; Nasal 45%



Biphasic decline in plasma level after IV injection

Fast (alpha) phase $t_{1/2}$ 11 minutes - redistribution

Slow (beta) phase $t_{1/2}$ 2.5 hours - elimination by metabolism and excretion

Ketamine : antidepressant

Reports of use of sub-anaesthetic doses in mental health emerge soon after release as anaesthetic - e.g. Khoramzadeh and Lofty (1973, 1976)

Berman (2000). 1st RCT demonstrating effectiveness as antidepressant

Rapid, robust but **short-lived** antidepressant effect now well-established

Risks and side-effects

ACUTE and TRANSIENT:

Headache, dizziness, nausea, elevated blood pressure, blurred vision and anxiety.
Dissociation

Low mood / worsened symptoms

SERIOUS and LONGER TERM effects:

Drug dependence syndrome, cognitive deficits, severe urinary tract problems including ulcerative cystitis, Liver damage - cholangiopathy

Ketamine: Beyond the clinic (1)

Reports of non-medical use of ketamine date back to 1970s.

Lower doses: increased sociability, stimulation and euphoria

Higher doses: dissociation, hallucination, transcendental experience

UK 1980s dance and rave scene, move more into mainstream in mid 1990s – for reviews see Jansen (2000, 2004).

Non-medical use on rise globally: 2.9% 16-24 year-olds responding to 2024 Crime Survey report use in last year (ONS 2024)

Winstock 2012 study (n= 3806) found 26.6% recent users reporting at least 1 urinary symptom and 17% reporting dependence



Early Psychedelic-assisted therapies – 1950s

Saskatchewan and New Westminster, Canada

Humphrey Osmond, AM Hubbard
(Chwelos *et al.* 1959)

- Single dose LSD in psychotherapy
- Attention to Set, Setting
- Therapist accepting, encouraging



Göttingen, Germany

Hanscarl Leuner: Low-dose LSD Guided Affective Imagery (Passie *et al* 2022)

Powick Hospital, Malvern UK

Ronald Sandison: LSD in psychotherapy : 'Psycholytic therapy' (Sandison 1954)

Ketamine Assisted Psychotherapy

Ketamine used to augment and facilitate a psychotherapeutic process through :

- Altered self-experience and perspective
- Effect on cognitive flexibility
- Insights
- Impact on mood
- ? Window of enhanced neuroplasticity

Psychedelic and Psycholytic approaches

Focus on Therapy as primary vehicle of sustainable change

Ketamine experience modulated through preparation and attention to setting

Ketamine Assisted Psychotherapy

PREPARATION

Introduce Therapy Model

Formulation and Goals

Begin therapy

Prepare for Ketamine Experience

Consent

DOSING

Safe, congenial setting

Agree Dose

Monitoring

Therapist available, non-intrusive, calm presence

Pre-discharge checks

INTEGRATION

1 - 2 days post-dose

Meaning-making

Therapy session

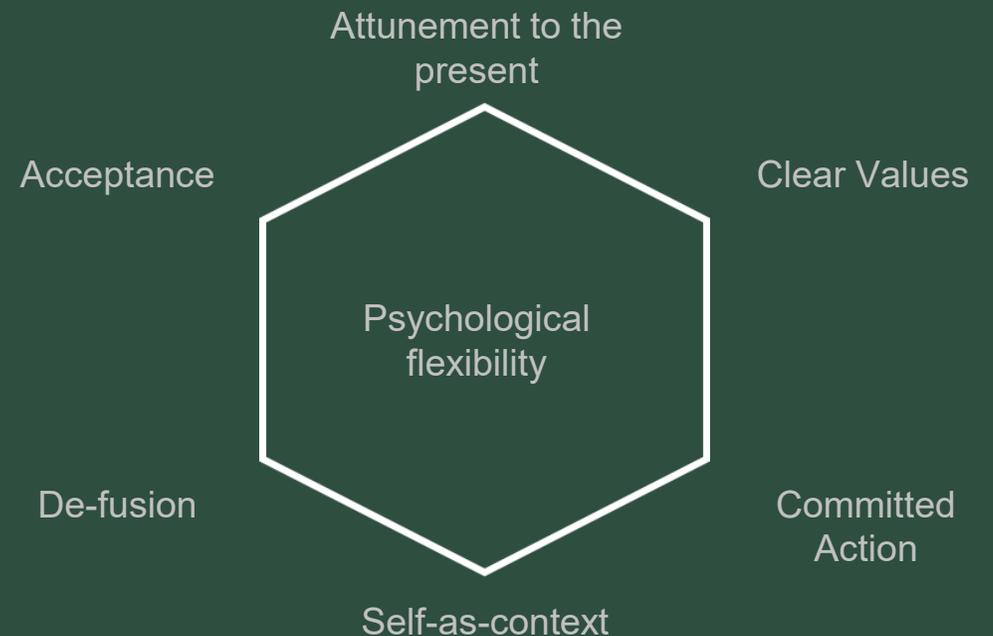
ACT – based Ketamine Assisted Psychotherapy

ACT gaining traction as a modality in psychedelic therapy

Concept of *psychological flexibility* operationalised across 6 domains

Psychedelic as opening window of enhanced flexibility and offering direct experience of changed perspective on self and problems that complements ACT therapy

Sloshower 2024, Watts and Luoma 2020



Ketamine Psychedelic Therapy: Evgeny Krupitsky

Over 1000 patients treated over 1980s - 90s – at first for AUD, then HUD and PTSD

Stage 1

Preliminary psychotherapy

Expectation primed – relief from dependence on alcohol to be achieved in an altered state of consciousness in which they will realise the negative effects of alcohol. They will have important insights in relation to their problems, their values and their sense of self

Close attention to personal motives and goals

Stage 2

2.5mg/kg IM ketamine with bemegride and aethimizol

Dialogue during experience emphasising negative impact of alcohol and positive of sobriety

Alcohol presented to client to smell to enhance negative

Stage 3

Group psychotherapy the day after KPT session

Ketamine Psychedelic Therapy for AUD: Evgeny Krupitsky

Non-randomised, controlled trial, $n=200$ (Krupitsky 1997)

One year f/u : 66% KPT group abstinent vs 24% control group

'In my whole body music starts playing in synchrony with the switched-on tape-recorder. I've got an irresistible feeling of being carried away.

I try to resist it with all my forces, but can't. It's as if a train disappears in the tunnel and you are flying after it into this black abyss and can't resist it.

The music is deafening; your whole body obeys it. It is as if your body is pulsating in unison with the music. And you are flying in pitch-darkness, and at the same time you are hearing the doctor's voice telling you about aversion to alcohol, about the sober life and so on. Then a flash of light.

You are always moving and feel as if you are a ball among other balls rolling along a corridor lined with similar balls'

Ketamine Psychedelic Therapy for HUD: Evgeny Krupitsky

Krupitsky (2002) Double-blind RCT high (2.0mg/kg im) vs low (0.2mg/kg im) dose KPT for HUD

70 recently detoxified patients randomised to high / low dose groups

3 stage KPT carried-out, with single dosing session

Significantly higher abstinence rate HD group from 1 month through to 24 months

At 1 year, 24% HD group remained abstinent

Krupitsky (2007) : Double-blind RCT of single vs multiple KPT for HUD

59 detoxified patients treated for HUD received one session of KPT. 6 relapsed within 1 month

53 Randomised to receive 2 further sessions KPT or psychotherapy alone

At 1 year 50% (13/26) mKPT abstinent vs 22% (6/27) in sKPT. ($p < 0.05$).

Ketamine with RP-based Therapy for AUD: Celia Morgan

Grabski *et al* (2022) Double-blind RCT phase 2 proof of concept clinical trial $n=96$

1. 3 weekly ketamine infusions 0.8mg/kg iv plus psychological therapy
2. 3 saline infusions plus psychological therapy
3. 3 ketamine infusions plus alcohol education
4. 3 saline infusions plus alcohol education

No significant difference in relapse rate but significantly greater number of days abstinent in ketamine vs saline group at 6 months with greatest difference between groups 1 and 4 (86% vs 69%)

Now recruiting to larger phase 3 multicentre trial to assess effectiveness of approach

Thank you!

References / Further reading (1)

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Chwelos *et al.* (1959) Use of d-lysergic acid diethylamide in the treatment of alcoholism. *Q J Stud. Alcohol* 20 : 577 – 90

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Khorramzadeh and Lotfy (1973) The Use of Ketamine in Psychiatry. *Psychosomatics* 14(6): 344 – 346

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Mollaahmetoglu *et al* (2021) “This Is Something That Changed My Life”: A Qualitative Study of Patients’ Experiences in a Clinical Trial of Ketamine Treatment for Alcohol Use Disorders *Front. Psychiatry* 12:695335. doi: 10.3389/fpsy.2021.695335

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Watts, R. & Luoma, J. (2020). The use of the psychological flexibility model to support psychedelic assisted therapy. *Journal of Contextual Behavioural Science*, 15, 92-102

Winstock *et al.* 2012 The prevalence and natural history of urinary symptoms among recreational ketamine users. *BJU Int*. 110: 1762–6

Ketamine vs ECT: antidepressant evidence (1)

Ekstrand et al. (2022) Racemic Ketamine as an Alternative to Electroconvulsive Therapy for Unipolar Depression: A Randomized, Open-Label, Non-Inferiority Trial (**KetECT**). *Int J Neuropsychopharmacol* 25 (5): 339-349

Severely depressed hospitalised patients

Remission rates ECT 63% KET 46%

Some had benefit after 6 treatments rather than rapid response

Safe and effective in patients with psychotic depression

At 1 year 30% of responders in KET group remained in remission vs 37% in ECT group

Ketamine vs ECT : antidepressant evidence (2)

Anand et al. (2023) Ketamine versus ECT for Nonpsychotic Treatment-Resistant Major Depression. NEJM 388 (25): 2315–2325 (**ELEKT-D**)

Outpatients referred for ECT at 5 community centres for major depression randomised to ECT or Ketamine. “Treatment resistant” to 2 antidepressant trials

Outcome was 50% reduction in Self-reported depressive symptoms on Inventory.

Response rate ECT 41.2%; KET 55.4.%

Lower remission rates on MADRS but KET higher than ECT (37.9% vs 21.8%)

Relapse at 6 months: ECT 56.3%; KET 34.5%

Ketamine: Unified model of action

Marguilho et al. (2023) A unified model of ketamine's dissociative and psychedelic properties. *Journal of Psychopharmacology*. 37 (1) pp14 - 32:

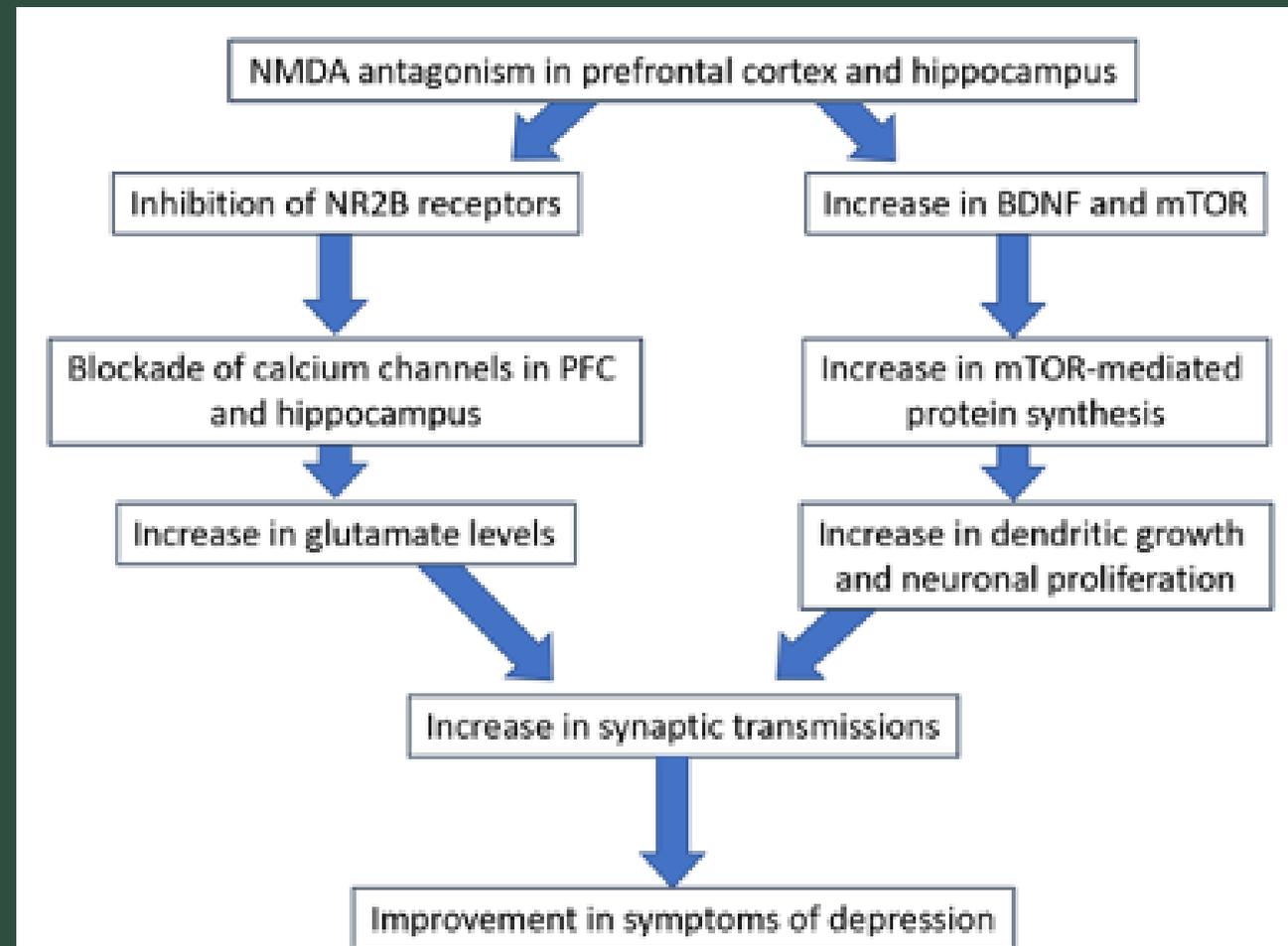
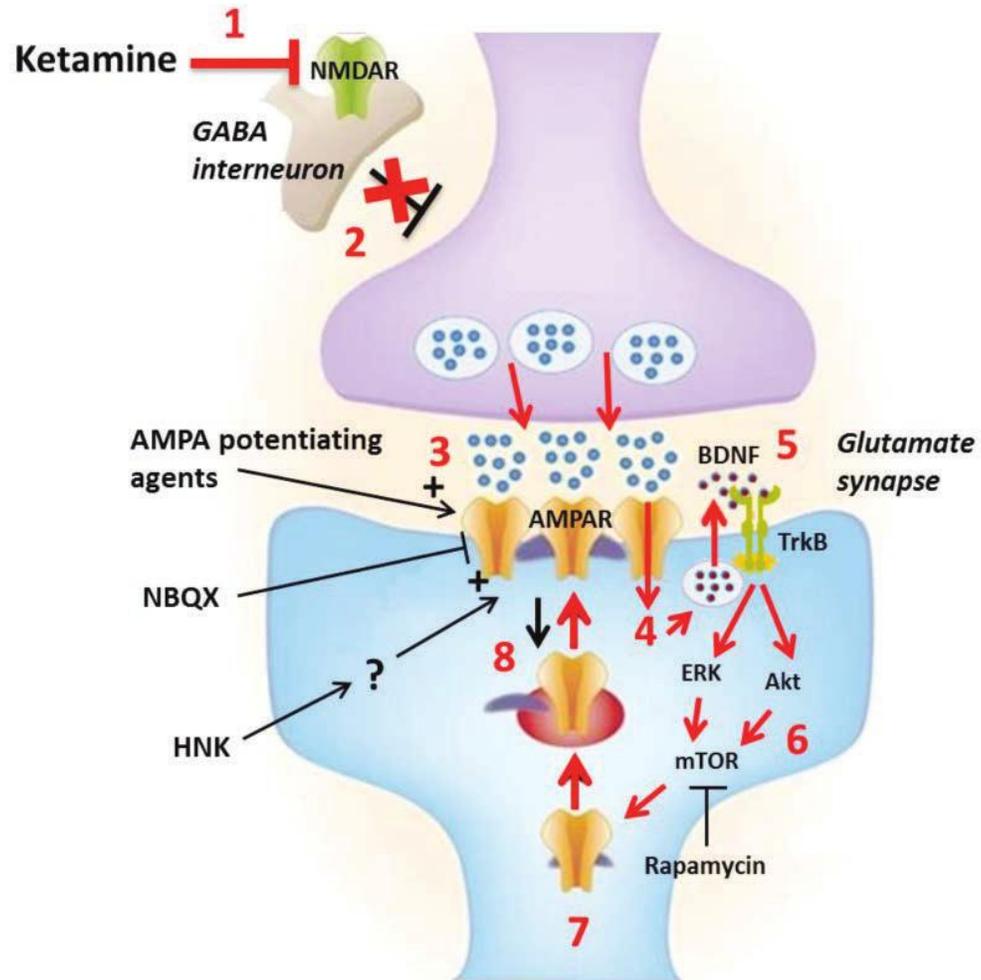
Immediate antidepressant effect maintained by increase in neuroplasticity.

Dissociative state: relaxation of 'bodily' self-representations encoded in salience network;

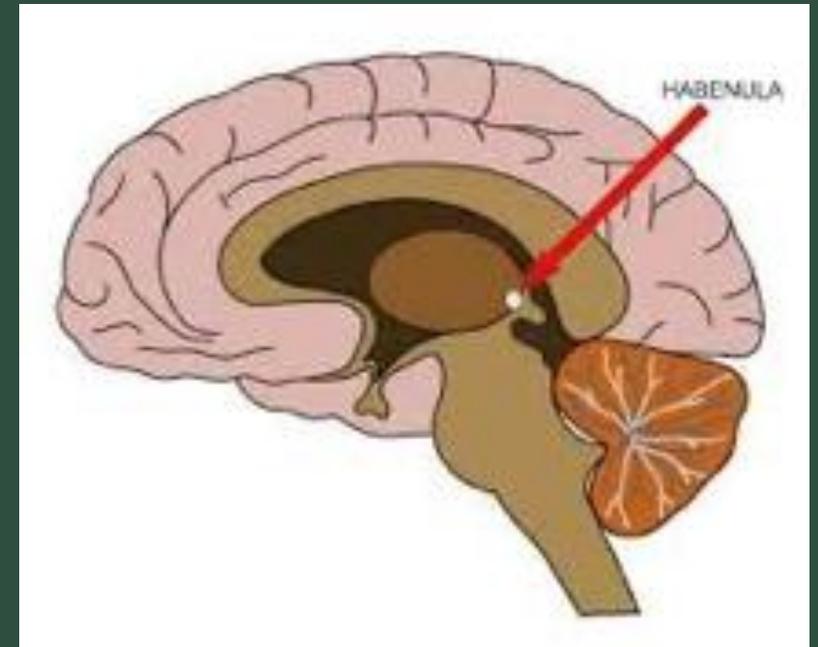
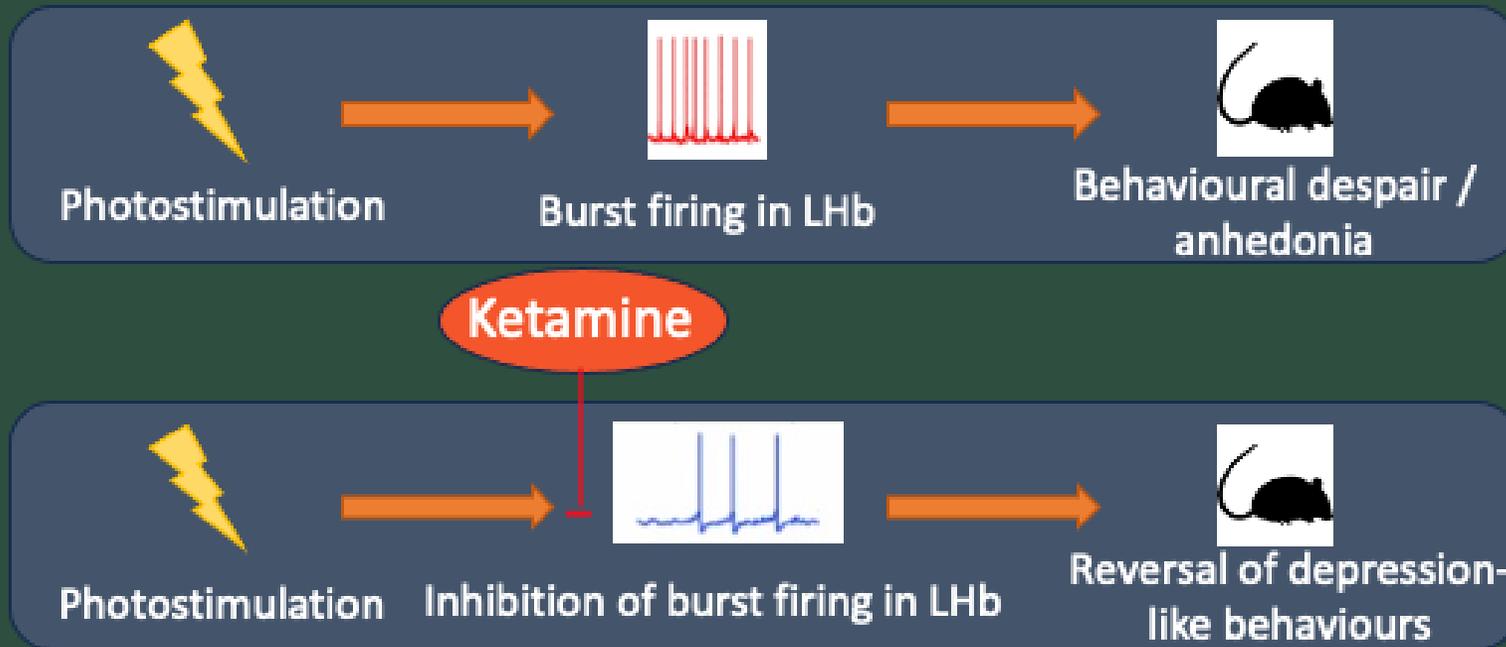
Psychedelic state: relaxation of 'narrative' self-representations encoded in default mode network.

Leads to a state of enhanced flexibility in which one can make sustained changes in self-representation, experience and behaviour

Ketamine : antidepressant mechanism of action - molecular

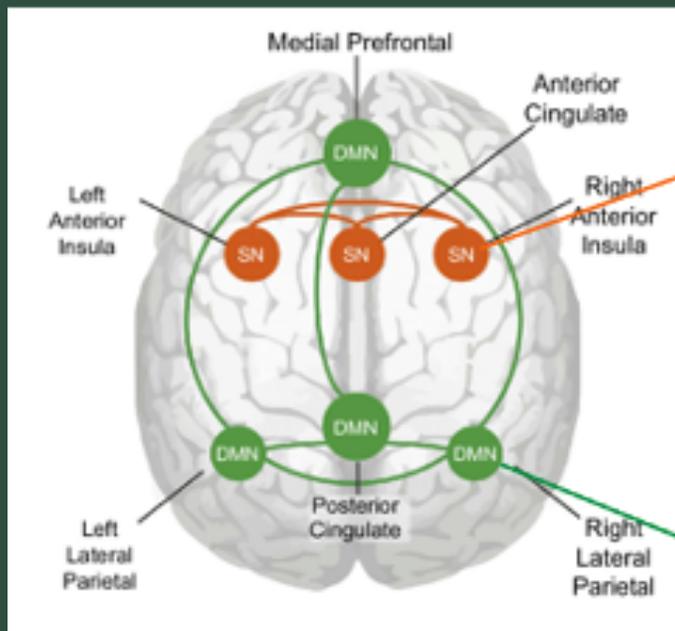


Ketamine : rapid antidepressant action at ‘anti-reward centre’



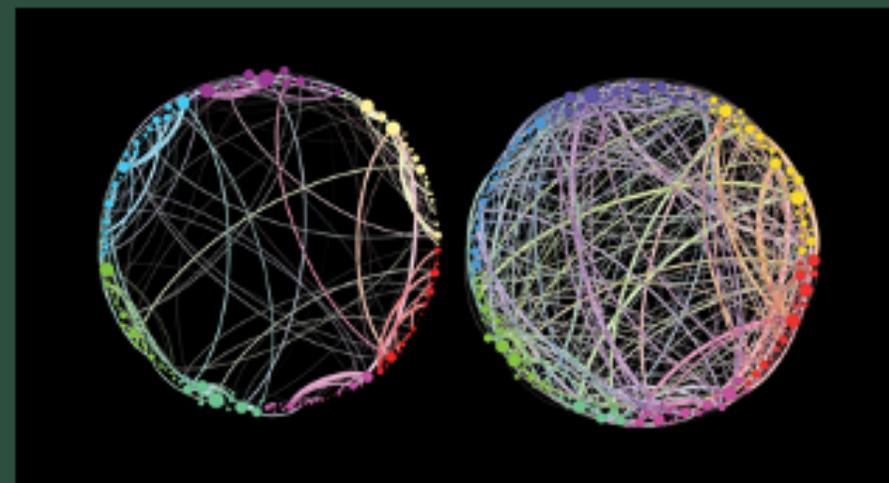
Yang *et al.* (2018) Ketamine blocks bursting in the lateral habenula to rapidly relieve depression. *Nature* 554:317 – 322.

Ketamine : action at brain networks



Representation of 'embodied self'; bodily sensations, boundaries, spatial location, personal relevance of emotions.

Introspection, autobiographical memory, daydreaming, imagining what others are thinking, envisioning the future. Narrative sense of self



↓ Within-network functional connectivity
↑ Between-network functional connectivity

Subjective experiences from a trial of KAP for AUD:

Set

And he advised me just to relax, he said, just chill out. Just have the confidence that you're gonna you're going to get out of this. And the whole situation will be more, will be better for you. And basically, yeah that's. I was prepared for it

“The process of getting back on the trial and having to fight for it meant that I was carrying some sort of negative feelings. And that's slightly obscured those positive aspects that I had before [during the first infusion] . . . I was nervous and that affected the experienced I had.

Subjective experiences from a trial of KAP for AUD:

Setting

I thought it was amazing how clinical it was and how organised it was and how safe I felt with it. That was brilliant

I just thought, right 'How extreme is this experience going to be? Is it going to be a ride from hell or something like that?' And it absolutely wasn't and that's down to the laboratory type conditions, the controlled environment

Subjective experiences from a trial of KAP for AUD: ketamine experiences and insights

we are all connected and there is this connection between all beings, people and things to again bring us out of this kind of prison of addiction. The transpersonal effects of the drug bring us out of ourselves and put the problems into perspective

Not only did I get a life changing and mind-altering experience, but then the therapist did plug some new thoughts to me that made me think differently... I feel that it is really important that when you are split open, you know, in such an intense and life changing way that you are given new thoughts and you know that someone gives you something to refill that, so you do change stuff

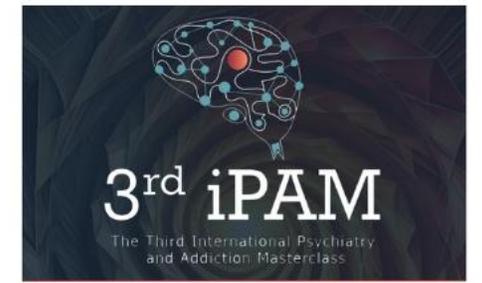
So, if trauma was like a ball so like you've got something about the size of a tennis ball that has a trauma experience. It's attached to your body. You can move it around in the body, but it's still attached to you. It's unpicking that fabric and weaving the fabric into your being. So, it doesn't cease to exist, but its power is gone

Subjective experiences from a trial of KAP for AUD: relationship with alcohol

"I still drink, but I'm quite capable of having 2, 3, 4, 5, 6, 7 days where I'm just not bothered about it, which is not something that happened in the past"

The sense of oneness that I felt and the sense of moving away from focusing on the worries and the small stuff is helpful in terms of improving my relationship with alcohol. Because I think I used alcohol as a self-medication and as a blocking and avoiding mechanism. And I think feeling that those issues are less prevalent or at least less important means I feel less motivated to drink

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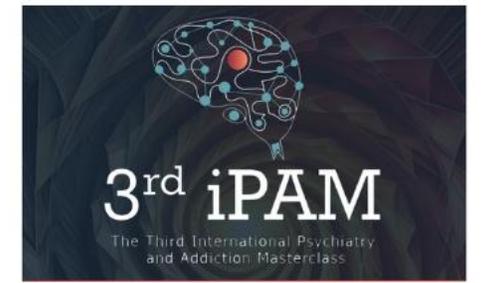


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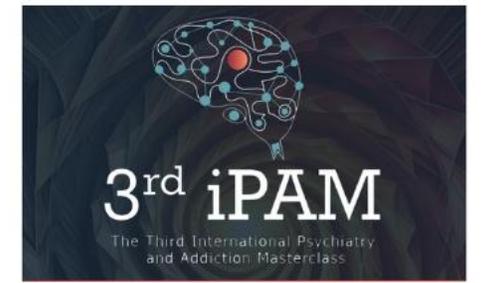
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Q&A



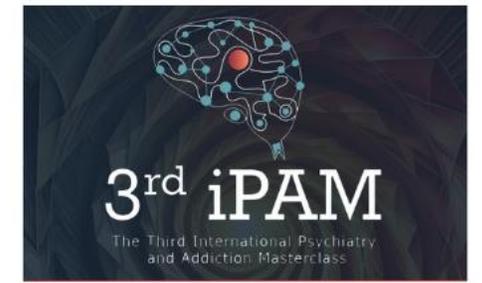
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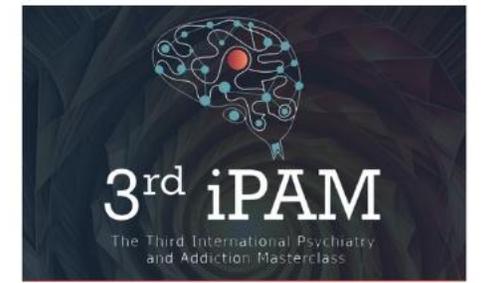
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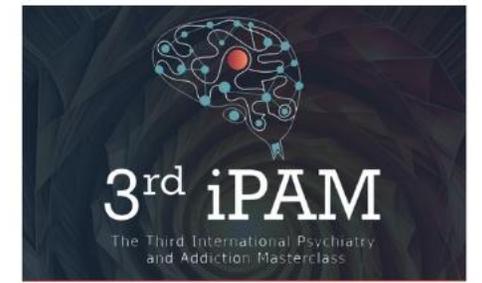
Chair Morning Reflection



Dr Louise Sell
Consultant Psychiatrist
Pennine Care NHS Foundation Trust



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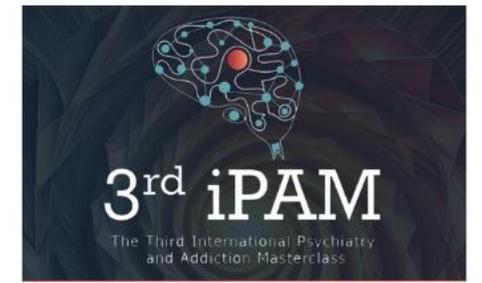


Dr Khurram Sadiq

Medical Lead Adult ADHD/ Clinical Care Lead Adult ADHD SE
London ICB/ Consultant Neurodevelopmental Psychiatrist
Oxleas NHS Foundation Trust



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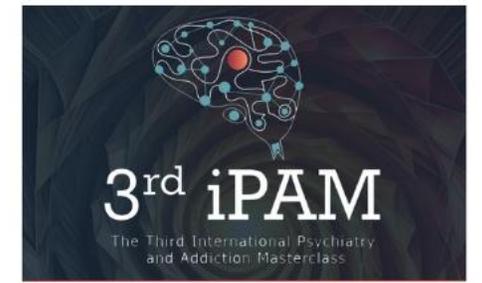


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Presentation



Dr Cyrus Abbasian
Consultant Psychiatrist
Private Digital Psychiatrist



Does Addiction Present Differently in People with Neurodiversity?

Dr Cyrus Abbasian

Consultant Adult/Addiction Psychiatrist, London, U.K.

@abbasian @cyrus_abbasian [linkedin.com/in/abbasian](https://www.linkedin.com/in/abbasian)

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**Primary care, Mental Health & Long-Term
Care**

09:00 am
01 Oct, 2025
etc.venues, Prospero House, 241 Borough High St, London SE1 1GA

Abstract

- As clinicians, we are increasingly recognising and developing competencies in identifying and managing neurodiversity-related conditions, particularly adult ADHD and autism. Individuals with a dual diagnosis—neurodiversity co-occurring with other mental health conditions such as addictions—pose a distinct set of clinical challenges. Their addictive behaviours, whether substance-related or behavioural (e.g. problem gambling, gaming, internet use, social media, or smartphone overuse), may present atypically and often prove more resistant to conventional treatment approaches. This presentation explores the complexities of such dual diagnosis cases, with a focus on both substance misuse and the growing recognition of behavioural addictions. It underscores the need for mental health services to adapt and provide responsive, neurodiversity-informed care pathways.

1. Dual diagnosis cases with neurodiversity often present atypically and show resistance to standard treatments.
2. Behavioural addictions—including gambling, gaming, internet use, social media, and smartphone overuse—are increasingly recognised in neurodiverse individuals.
3. Mental health services must adapt to deliver more flexible, neurodiversity-informed care.

Conflict of interest...

- Shareholder with Psychiatry-UK.com
- Private work at Harley Street, London.
- I am an adult ADHD and adult autism assessor!

Outline...

- Why ask about addictions.
- Addiction and neurodiversity prevalence.
- Extra questions to ask.
- Stimulation.
- Healthier stimulation.
- Management issues.
- Case examples..



Why ask about addictions

1. DD and triple diagnosis
2. Risk management
3. Correct diagnosis (treatment resistance)
4. Rx stimulant risks
5. Treatment hierarchy

Addiction Model	
Hallucinogens (trip) <ul style="list-style-type: none">• LSD• Psilocybin	Depressants (downer) <ul style="list-style-type: none">• Alcohol• Benzodiazepines
Stimulants (upper) <ul style="list-style-type: none">• Cocaine• Amphetamines	Behavioural Addictions <ul style="list-style-type: none">• Gambling• Gaming



Submit a Manuscript: <https://www.f6publishing.com>

World J Psychiatry 2023 March 19; 13(3): 84-112

DOI: [10.5498/wjp.v13.i3.84](https://doi.org/10.5498/wjp.v13.i3.84)

ISSN 2220-3206 (online)

EXPERT CONSENSUS

Identification and treatment of individuals with attention-deficit/hyperactivity disorder and substance use disorder: An expert consensus statement

Susan Young, Cyrus Abbasian, Zainab Al-Attar, Polly Branney, Bill Colley, Samuele Cortese, Sally Cubbin, Quinton Deeley, Gisli Hannes Gudjonsson, Peter Hill, Jack Hollingdale, Steve Jenden, Joe Johnson, Deborah Judge, Alexandra Lewis, Peter Mason, Raja Mukherjee, David Nutt, Jane Roberts, Fiona Robinson, Emma Woodhouse, Kelly Cocallis

Prevalence (clinically relevant)

	Adult ADHD	Adult Autism
Alcohol	↑↑↑ (4/10)	↑↑? episodic (2.5/10)
Opiates	↑↑? (1/10)	↑? (<1/10)
Cocaine	↑↑↑ (1/4 user, 1/10 addiction)	↑? (<1/10 user)
Amphetamines	↑↑ (1/10)	↑? (<1/20)
Hallucinogens	↑ (X 2-3)	Low ↓
Nicotine	↑↑↑ (throughout day)	Low ↓ (variable)
Caffeine	↑↑↑ (throughout day)	Low ↓ (variable)
Gambling	↑↑↑ (1/5)	↑↑ (1/10)
Gaming/Internet	↑↑↑ (1/3)	↑↑↑ (<1/3)
Social Media	↑↑ (1/4)	↑↑ (1/4)
Pornography/Sex	↑ (>1/10)	↑ (<1/10)

Online Behavioural Addictions (Problems)

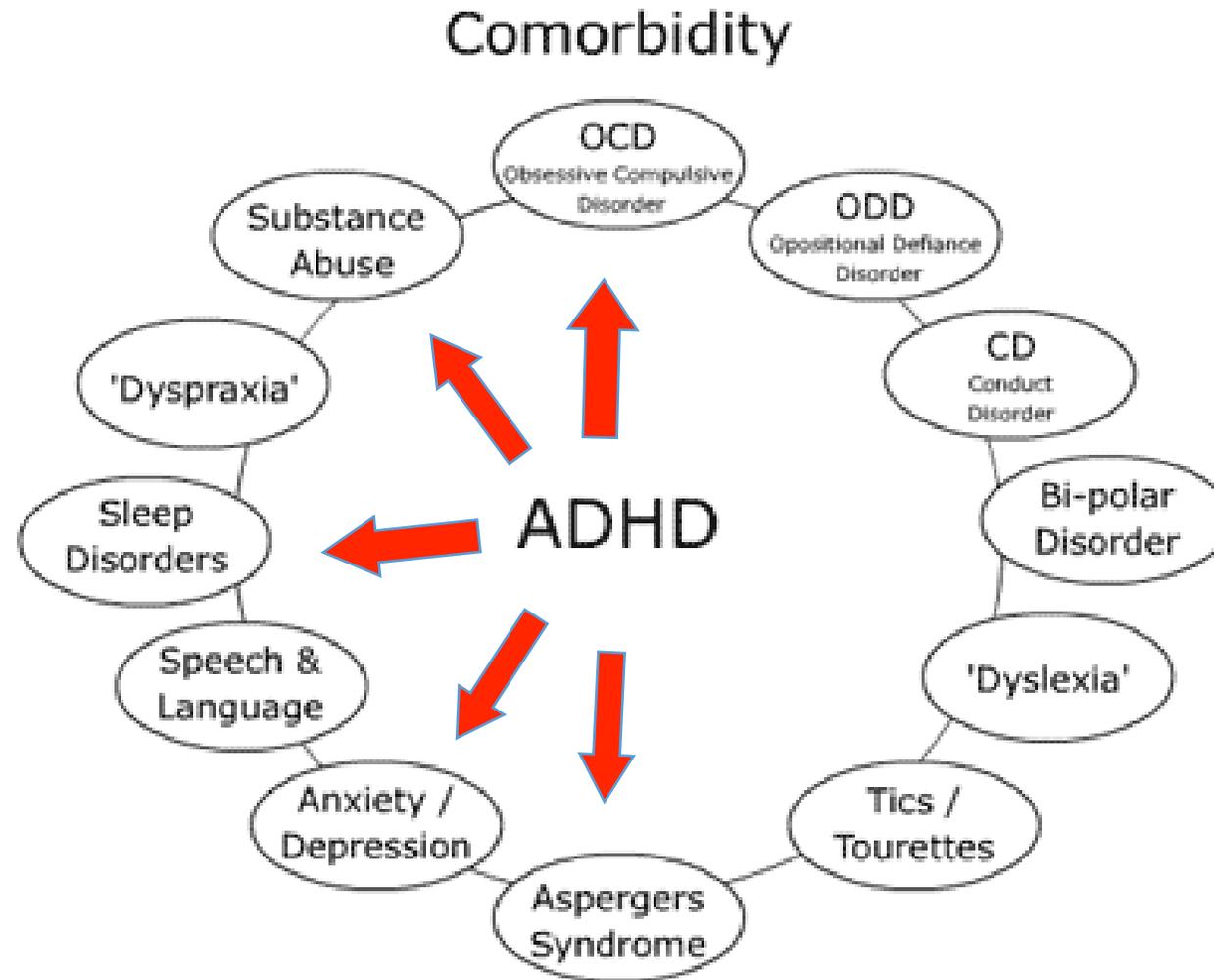
- **Up to 1/3 for ADHD & ASD**
- Gaming (ADHD first person vs ASD role-playing)
- Gambling (ADHD slots > ASD cards/games)
- Internet use (ADHD doom-scrawl vs ASD restricted/repetitive interest)
- Social media (ADHD validation-seeking vs ASD substitution)
- Pornography (ADHD 'extreme' > ASD 'normal')
- Dark Net! (forensic and safeguarding)

Other Dopamine Seeking Behaviours

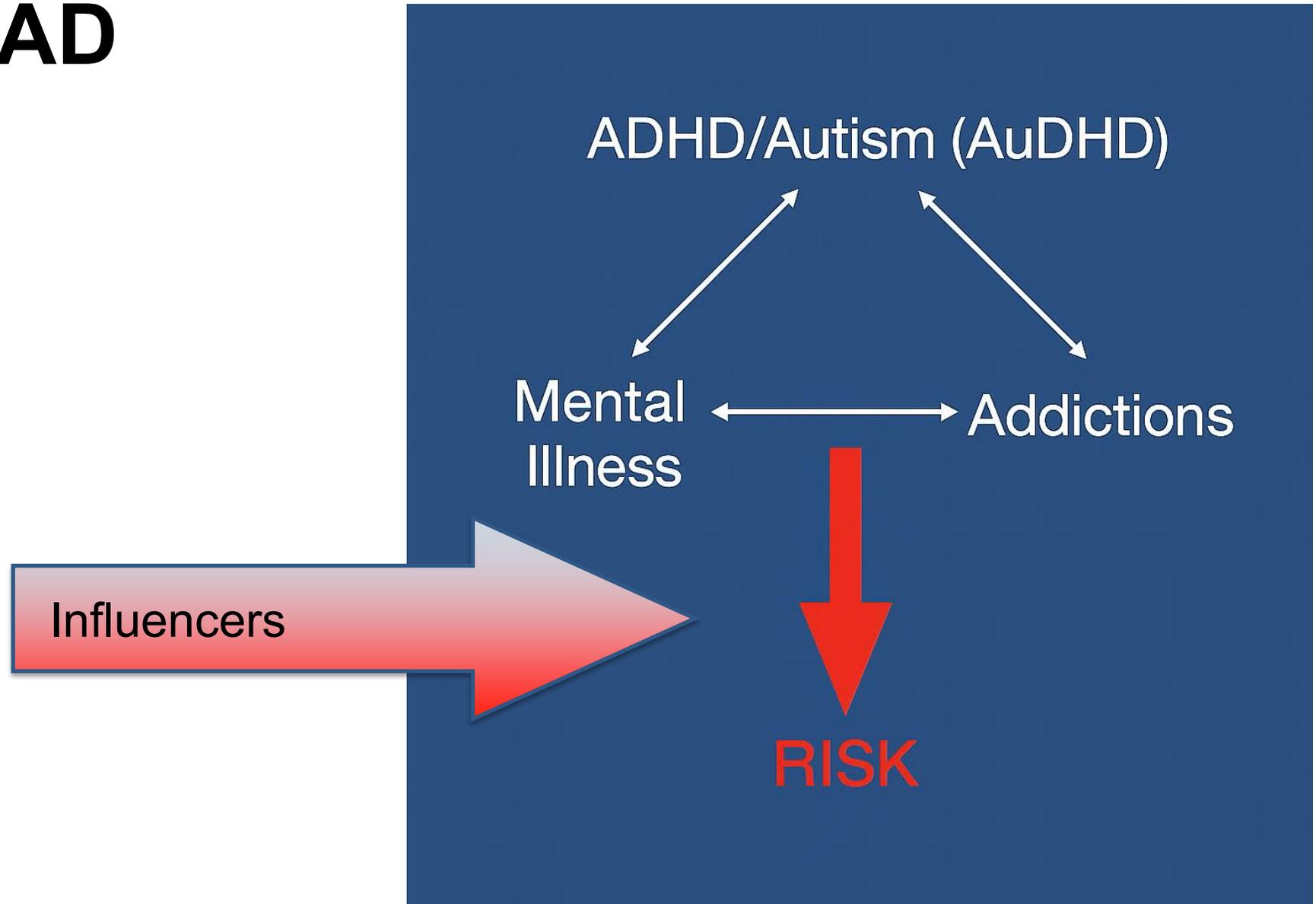
- Sugar & fat binging/addiction (ADHD>ASD (ARFID))
- Sex & porn
 - ADHD - multiple-orgasms, sex crime victims/perpetrators.
 - ASD - sexual fetishes (gender identity).
- Excess exercise (ADHD (high intensity) >ASD (restricted repetitive))

(DSH (ADHD>ASD) & excess tattoos/piercings (ADHD) - *high endorphin, high serotonin, low cortisol.*)

Dual Diagnosis



RISK TRIAD



ND Risk Symptoms

- Seeking thrill/novelty & intensity (Stimulation).
- Impulsivity with hyper-focus.
- Instant reward-seeking.
- Impulse control.
- Social anxiety.
- Restricted-repetitive fixed interest.
- Craving for Structure.
- Poor decision making.



Extra questions to ask...

- First effect after abusing stimulant?
- Bedtime routine?
- Effect of (over)exercise?
- Caffeine & nicotine use? How?
- Eating Disorder? (BED? BN?)
- Debt?
- Online activity? (Illegal?)





Guidance

Channel and Prevent Multi-Agency Panel (PMAP) guidance

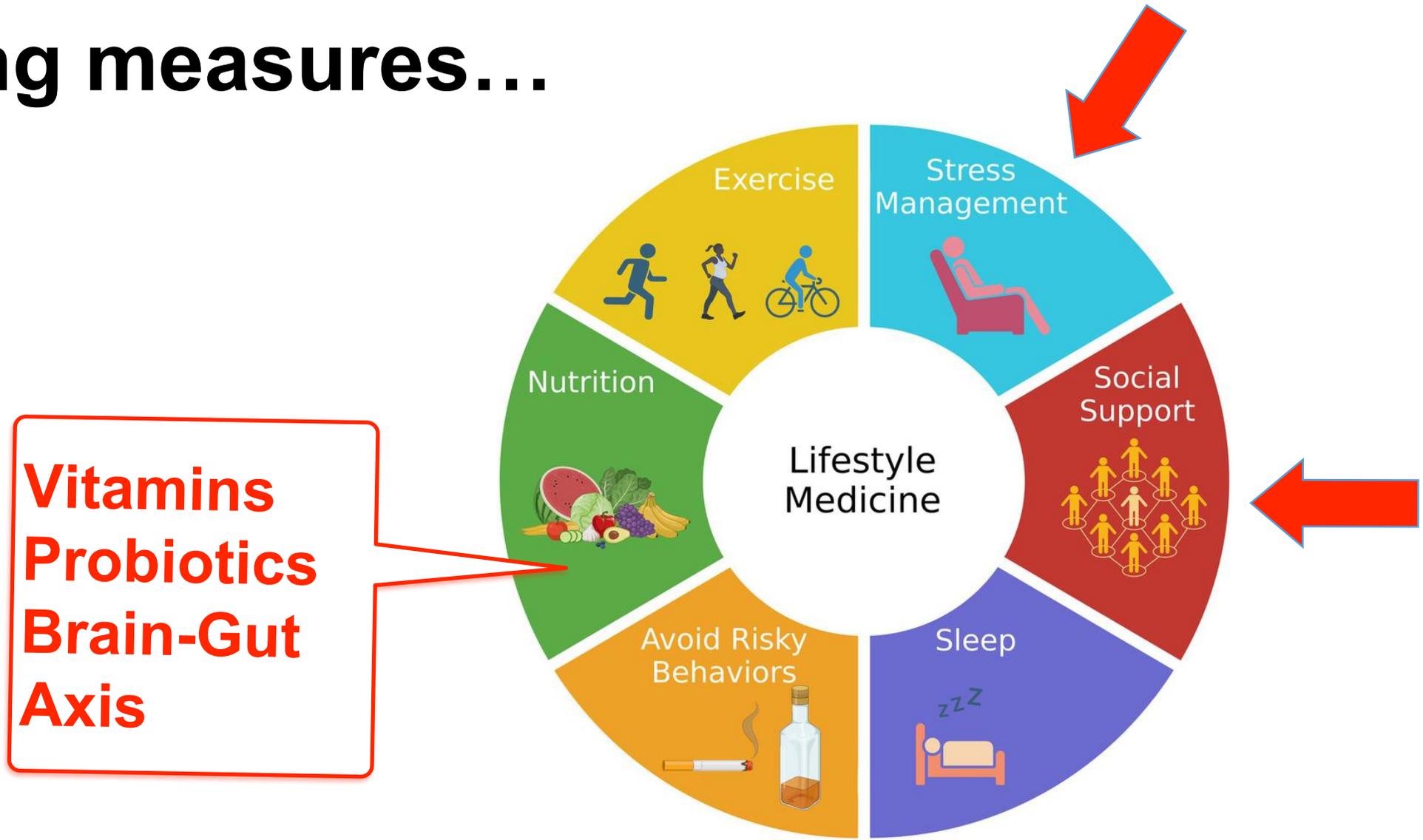
Channel and PMAP are part of the Prevent strategy. The process is a multi-agency approach to identify and support individuals at risk of being drawn into terrorism.

From: [Home Office](#)

Published 22 February 2021

Last updated 7 April 2025 — [See all updates](#)

Wellbeing measures...



Healthier Stimulation

- **Harm minimisation/reduction principles.**
- Vaping (short-term).
- Coffee/tea use.
- Lifestyle medicine (BSLM).
- Brisk walking or swimming. (Rhythmic exercise)
- Task chunking & creative flow.
- Cold exposure (outdoor swim) & mindful breath work.
- ADHD apps - gamification (?)
- Sensible adventures!
- Diet - high protein/fat (ketogenic) & Omega-3 fatty acids.
- Lightbox.

Management principles

- **Coaching**
- Modified CBT.
- Reasonable adjustments.
- Debt restructuring/write-off.
- Nokia phone!
- Gambling & credit card self-exclusion.
- Limited access to internet and money (digital detox).
- Go slow titration. Consider non-stimulants.
- MDT approach if complex.



Debt and Mental Health Evidence Form (Version 4)

Only a health or social-care professional should fill in this form

This form has been given to you because the person named opposite:

- is in debt to one or more creditors; and
- has said they have a mental health problem that affects their ability to repay or communicate with their creditor.

You have been identified by this person as:

- a health or social-care professional who knows the person's health situation.
- a professional who could provide evidence about the person's health situation.

They have given their consent for you to fill in this form

Your evidence could really help the person's health and

- It will help creditors to take relevant mental health issues into account.
- This could improve the person's financial situation and

Person's full name

Date of birth

Address

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GAMSTOP helps you control your online gambling.

Once registered you will be prevented from using gambling websites and apps run by companies licensed in Great Britain, for a period of your choosing.

REGISTER TODAY

It only takes a few minutes to sign up with GAMSTOP. Just tell us a few details about yourself and let us confirm your identity.

[GET STARTED](#)

UPDATE DETAILS

It's important to keep your details up to date. Sign in to your account to update your information.

[SIGN IN](#)

It's very easy to self-exclude yourself from EVERY casino in Great Britain by simply enrolling yourself onto SENSE.

You can enrol online from home via your phone, tablet or PC by visiting our website and following a link to the simple enrolment process.

Alternatively, please speak to a manager who will help you enrol in person at the casino.

HOW DOES SENSE SELF-EXCLUSION WORK?

SENSE is the national self-exclusion scheme for the entire British casino industry. SENSE enrolment therefore applies to ALL casinos.

The minimum SENSE self-exclusion period is SIX MONTHS, but you can extend that period for up to one year if you wish. You can do this either at the time of enrolment or at any point up to six months after your minimum requested period has elapsed.

For details of how to renew / extend your exclusion, visit our website: www.senseselfexclusion.com or email info@sensescheme.com

By joining SENSE, you agree to your photo and personal data being shared with all participating casinos so that they can then use their best endeavours to stop you from gambling on their premises.

Please ensure that you have read our full Terms and Conditions and Privacy Policy before you enrol. These can be found on our website, which also gives further details on how the SENSE scheme works.

Within the Terms and Conditions of the scheme, if you DO manage to gain entry whilst self-excluded (in breach of your SENSE agreement), you will not be paid any outstanding winnings or refunded any losses.

You can only remove yourself from SENSE during the six-month period AFTER your minimum or extended period has elapsed. You will need to speak to a casino manager in person to remove yourself during this period. You cannot be removed during your minimum period of six-months (or extended period of one year) under ANY circumstances.

If you have not removed or extended / renewed your exclusion six-months after your minimum requested period has elapsed, it will then expire, and you will be automatically removed.

If you need to speak to someone in confidence about a gambling problem, GAMCARE offers free confidential help and support 24/7. You can contact them by phone on: **0808 80 20 133** or via online chat at: www.gamcare.org.uk

We recommend that you self-exclude yourself from all other forms of gambling, in addition to SENSE. Contact details for other sector schemes (online, bingo, betting shops and slot machine arcades) can be found on the SENSE website.



senseselfexclusion.com

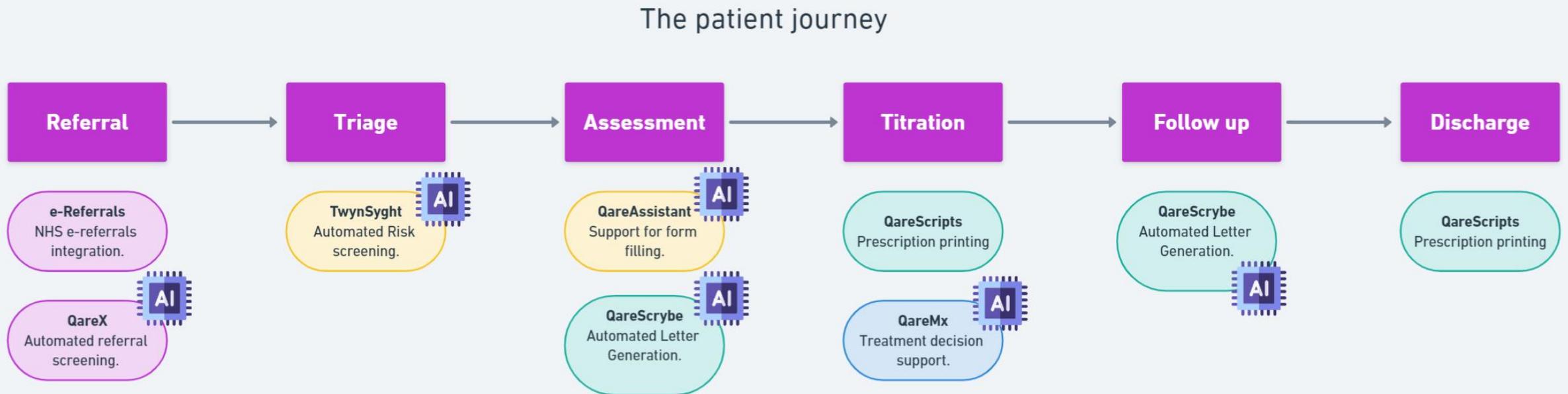
- A handful of studies on gaming disorder in autism and ADHD.
- 20–50% of gaming disorder clinic patients are neurodiverse.
- GD services do not diagnose ADHD/autism.
- Comorbid psychiatric conditions - primary and secondary.
- Co-creation in game design (Ninja Theory) for healthier games.
- Gaming industry influence; self-regulation is ineffective.
- Government should regulate for low-risk, therapeutic, and educational game design.
- Taskification (structured tasks in games) may reduce harms, build empathy, reduce bullying, and promote physical activity in games.



CASE Examples...

- EUPD female, atypical effect of cocaine
- AuDHD young male with porn addiction
- Female professional has sex after argument
- 'Gaming Disorder' teenager with ASD
- Binge eating disorder (BED) ADHD female
- *Coffee to sleep, cake before midnight...*
- *Amazon blues!* Problem shopping.
- “Power-hour” man, outdoor swimmer 365

AI - the good



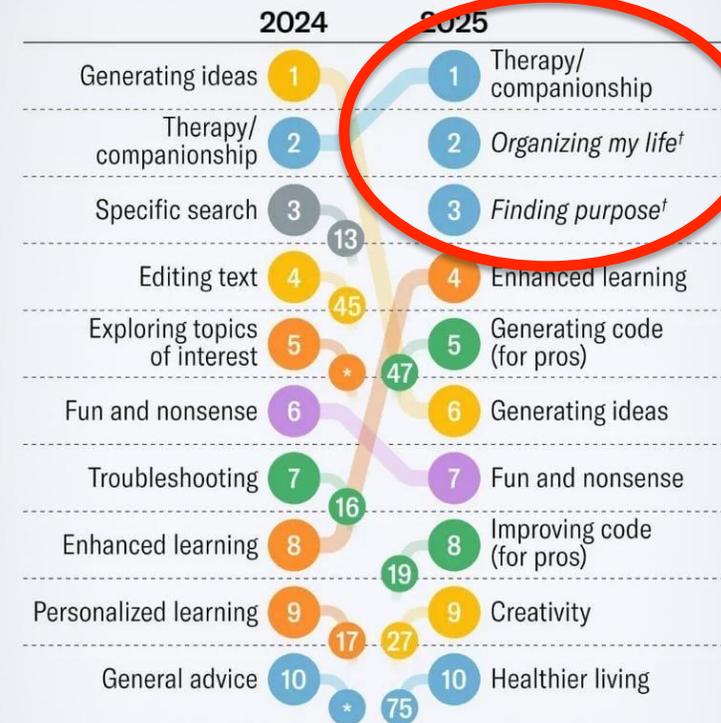
Q - How can AI make my work more efficient and safer??

AI - the bad & ugly!



Answer To The Ultimate Question - The Hitchhiker's Guide To The Galaxy - BBC

Top Gen AI Use Cases



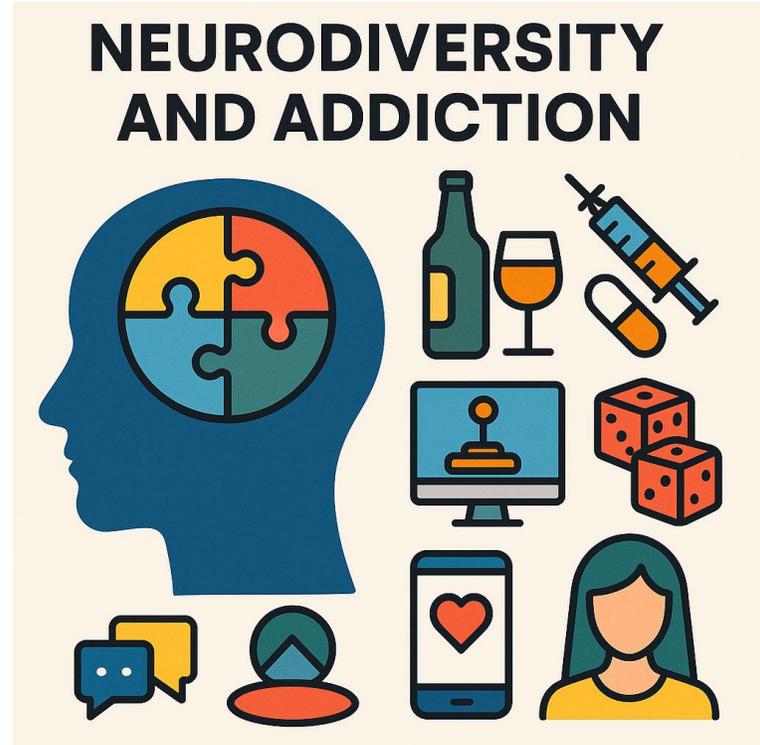
*Did not make list of top 100 in 2025 †New use case
Source: Filtered.com



@harvard_business_review

Conclusion

1. Dual diagnosis cases with neurodiversity often present atypically and show resistance to standard treatments.
2. Behavioural addictions—including gambling, gaming, internet use, social media, and smartphone overuse—are increasingly recognised in neurodiverse individuals.
3. Mental health services must adapt to deliver more flexible, neurodiversity-informed care.



Questions...

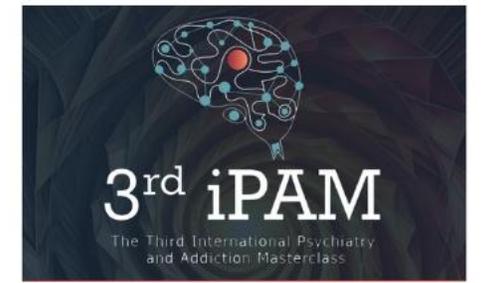
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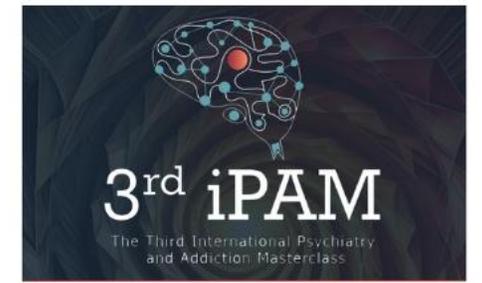


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Presentation



Dr Hasanen Al-Taiar

Consultant Forensic Psychiatrist Forensic TPD. Medical
Member HM Tribunal Service
The Oxford Clinic, Littlemore Mental Health Centre



*Forensic Aspects of Addiction Psychiatry:
Risk, Responsibility, and Rehabilitation*

Dr Hasanen Al-Taiar FRCPsych
Consultant Forensic Psychiatrist, Forensic TPD
Medical Member, HM Tribunal Service
The Oxford Clinic, Littlemore MHC
2025



Introduction

- Addiction psychiatry in forensic settings examines how substance misuse intersects with risk, responsibility, and rehabilitation. This presentation will:
 - - Explore culpability and criminal responsibility in addicted offenders
 - - Examine links between addiction, risk, and recidivism
 - - Discuss rehabilitation and medico-legal challenges
- Duration: 20 minutes

Culpability & Criminal Responsibility

- • Substance misuse disorders impact *mens rea* (criminal intent)
- • Legal frameworks: diminished responsibility, insanity, automatism
- • Key considerations:
 - - Was the act voluntary?
 - - Role of intoxication vs. underlying disorder
- • Case law examples highlight role of psychiatric evidence

Addiction, Risk, and Recidivism

- • Addiction contributes to violence, acquisitive crime, sexual offending
- • Risk assessment in addicted offenders:
 - - HCR-20 (Historical-Clinical-Risk)
 - - RSVP (Risk for Sexual Violence Protocol)
 - - Substance misuse screening tools
- • Comorbidity with mental illness increases risk complexity

Murder

- of sound mind and discretion (sane)
- unlawfully kills (not self-defence or other justified killing)
- any reasonable creature (a human being)
- in being (born alive and breathing through its own lungs)
- under the King's Peace (not in wartime)
- with intent to kill or cause grievous bodily harm (in contrast to the offence of attempted murder, where only intent to kill will suffice)

Manslaughter

- Killing with the intent for murder but where a partial defence applies, namely loss of control, diminished responsibility or killing pursuant to a suicide pact.
- Conduct that was grossly negligent given the risk of death, and did kill ("gross negligence manslaughter"); and
- Conduct taking the form of an unlawful act involving a danger of some harm that resulted in death ("unlawful and dangerous act manslaughter").

Diminished Responsibility

- suffering from an abnormality of mental functioning
- recognised medical condition
- substantially impaired the defendant's ability either to understand the nature of their conduct or to form a rational judgment or to exercise self-control (or any combination)
- if so, whether it provided an explanation for their conduct:

Loss of Control

- Loss of control (the first component);
- A qualifying trigger (the second component); and
- An objective test (the third component): A person of D's sex and age, with a normal degree of tolerance and self-restraint and in the circumstances of D, might have reacted in the same or in a similar way to D.

R v Reynolds (2014)

- The Court reaffirmed that psychiatric factors (mental illness, developmental disorders, vulnerabilities) must be considered, even in very serious offences.
- ADHD can impair impulse control, judgment, and emotional regulation, which are central to sentencing considerations under diminished responsibility and mitigation.

C PTSD, ADHD

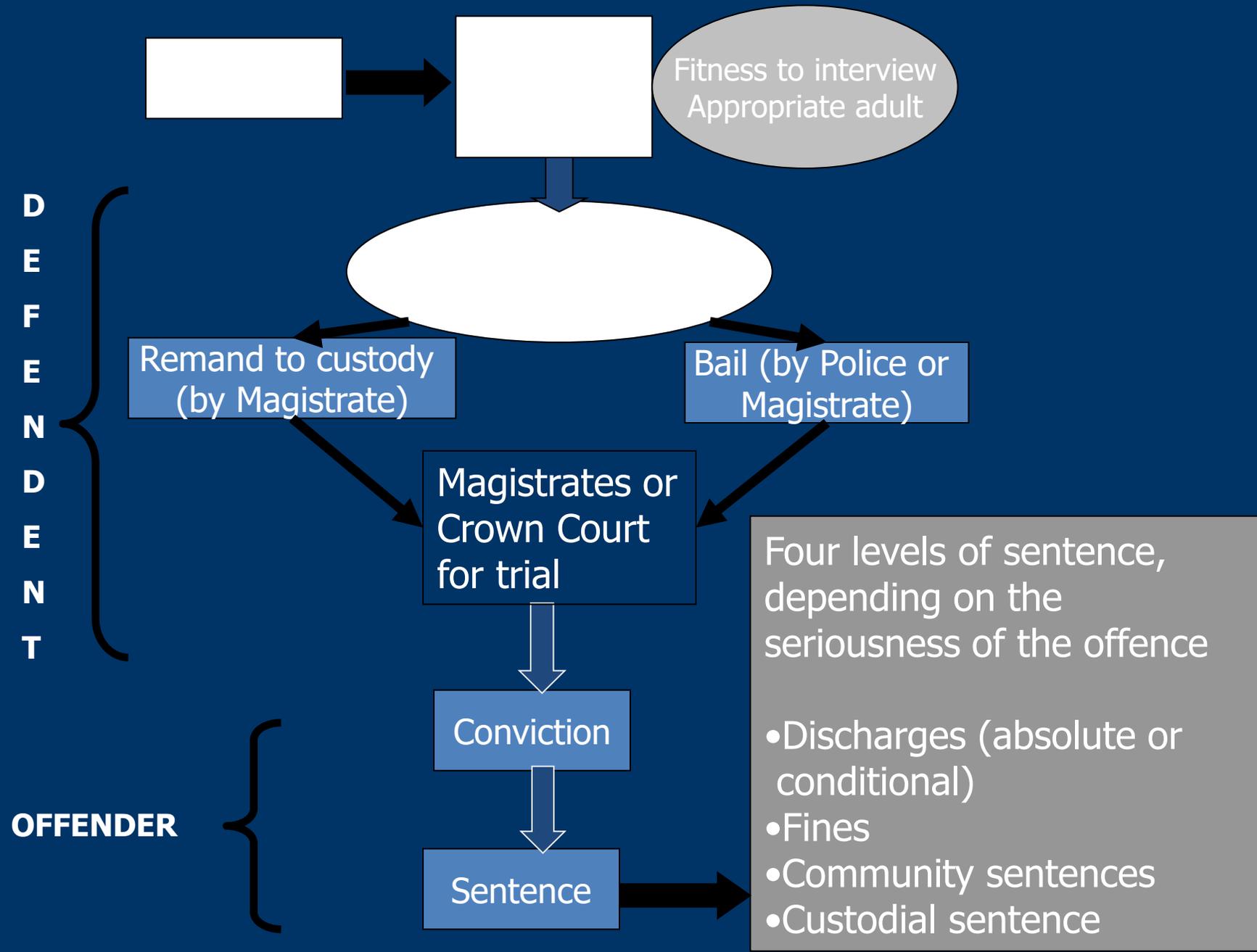


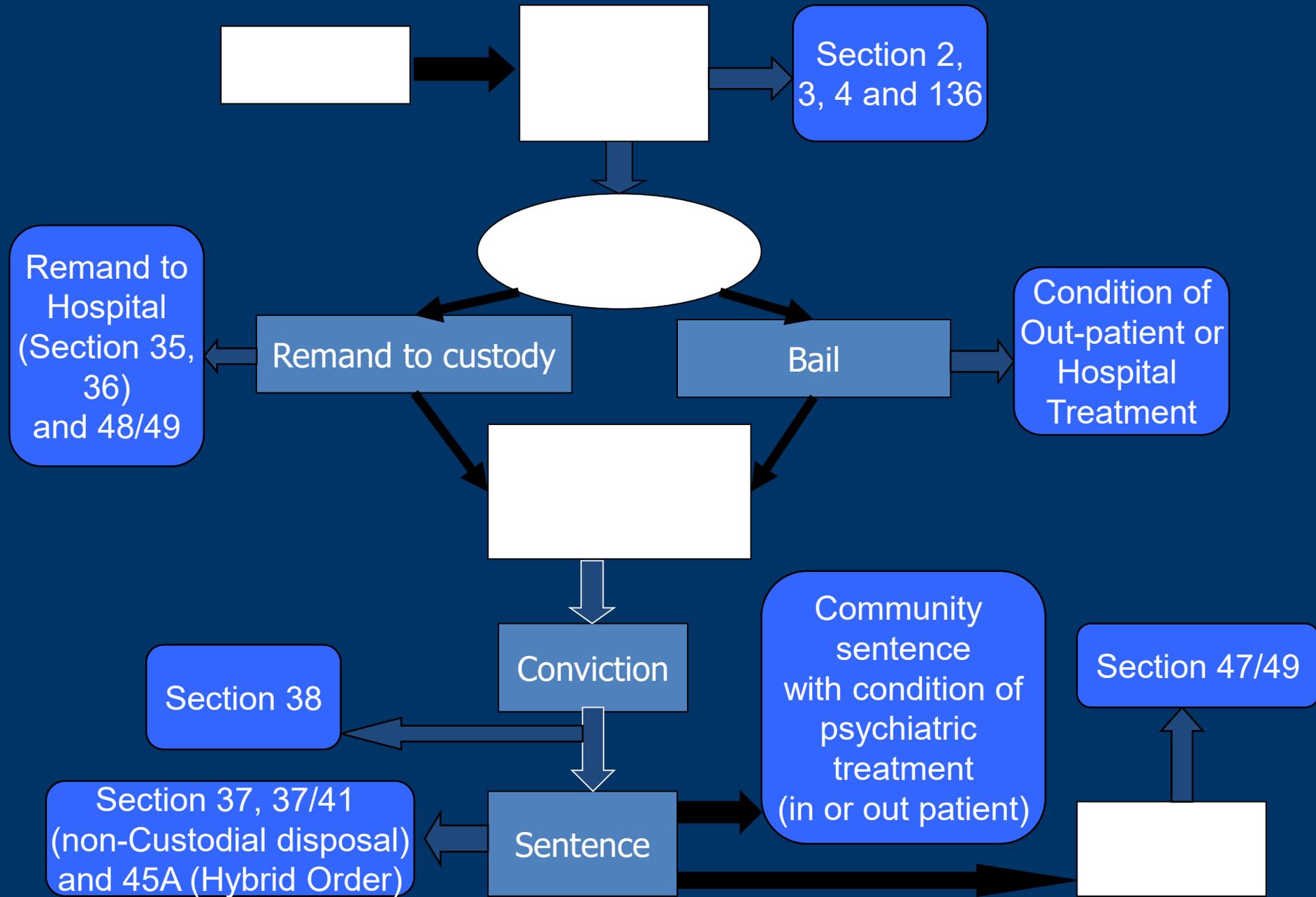
80 y homicide

- *I agree with Dr Al-Taiar that any delusions you had were relatively encapsulated or ring-fenced. They did not take over your entire life. On the day of the killing you were not acting oddly as you went to the pub, drank a few pints, and completed the crossword, nor as you walked steadily home from Sainsburys with your normal bag of shopping. Your delusions, whatever they were, did not upset you or impact on your self-control as you went about your daily business. Your mood was not elevated or manic or outwardly angry. You were able to operate well within yourself.*

Practical Implications

- Successful DR → reduces conviction from murder to manslaughter
- Sentencing options broaden:
 - - Hospital order (s.37/41 MHA 1983)
 - - Custody with psychiatric treatment
- Balancing accountability and clinical vulnerability





Rehabilitation & Risk Management

- • Evidence-based models:
 - - Dual diagnosis pathways
 - - Trauma-informed care
 - - Therapeutic jurisprudence
- • Secure hospitals and prison-based interventions
- • Medico-legal challenges:
 - - Consent and capacity in treatment
 - - Balancing autonomy with risk
 - - Long-term relapse prevention

Case Examples

- Case 1: Violent offence under cocaine intoxication – role of intoxication vs. disorder
- Case 2: Repeat acquisitive offending in heroin dependence – risk assessment & relapse cycle
- Case 3: Sexual offending linked to disinhibition under alcohol misuse

Medico-Legal Challenges

- • Distinguishing intoxication from mental disorder
- • Expert bias in court: addiction as choice vs. illness
- • Limited treatment access in prisons
- • Human rights considerations (Article 3 ECHR)
- • Importance of integrated risk management

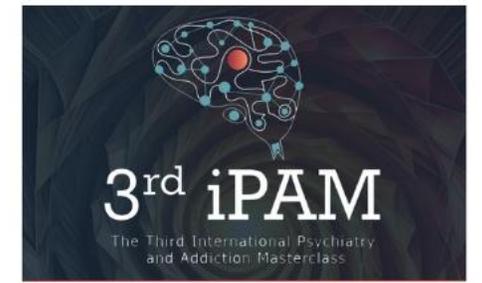
Key Takeaways

- • Addiction complicates culpability, risk, and rehabilitation
- • Expert psychiatric input is vital for courts
- • Risk assessment tools must be adapted for comorbid addiction
- • Rehabilitation requires dual focus: public safety & patient recovery

Thank You

- Dr Hasanen Al-Taiar
- Email: Hasanen.al-taiar@oxfordhealth.nhs.uk
- 2025

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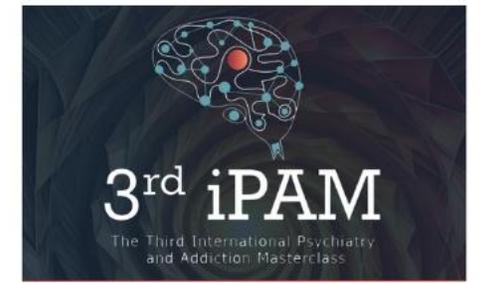


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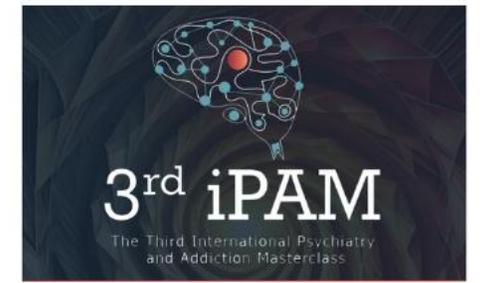
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Q&A



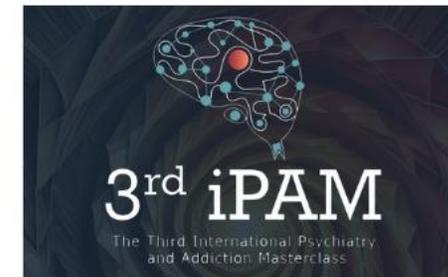
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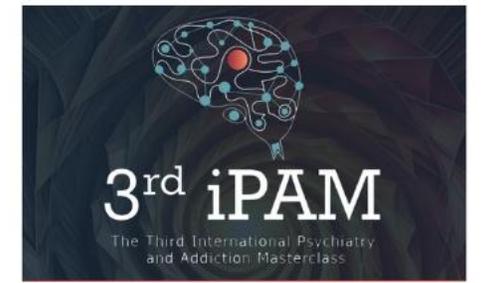
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Chair Afternoon Reflection

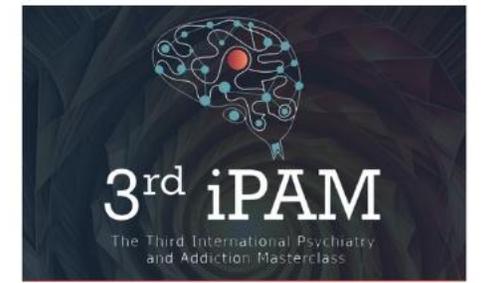


Dr Emily Finch

Addictions Clinical Director
South London and Maudsley NHS
Trust



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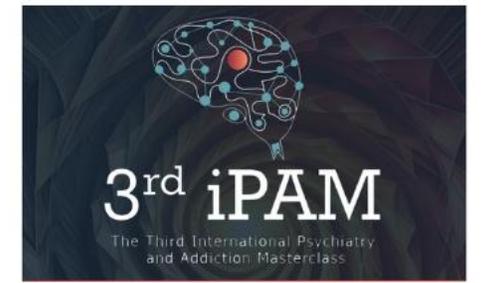
Presentation



Prof Henrietta Bowden-Jones OBE DL
National Advisor on Gambling Harms
NHSE



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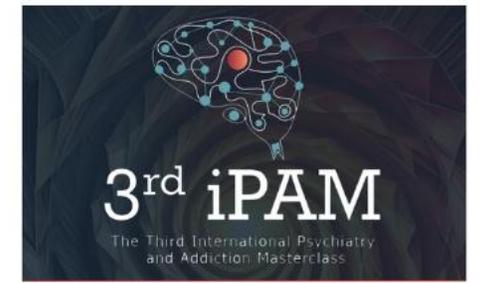


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Presentation



Professor Subodh Dave

Dean for RCPsych | Consultant Liaison Psychiatrist & Deputy Director of Undergraduate Medical Education, Derbyshire Healthcare Foundation Trust
Professor of Psychiatry, University of Bolton | Board Member, Centre for Research Equity, University of Oxford



Developing Addictions Training and Workforce

Subodh Dave

Dean, Royal College of Psychiatrists



Conflicts

- None to declare



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WORKFORCE

Increased spend on Mental Health

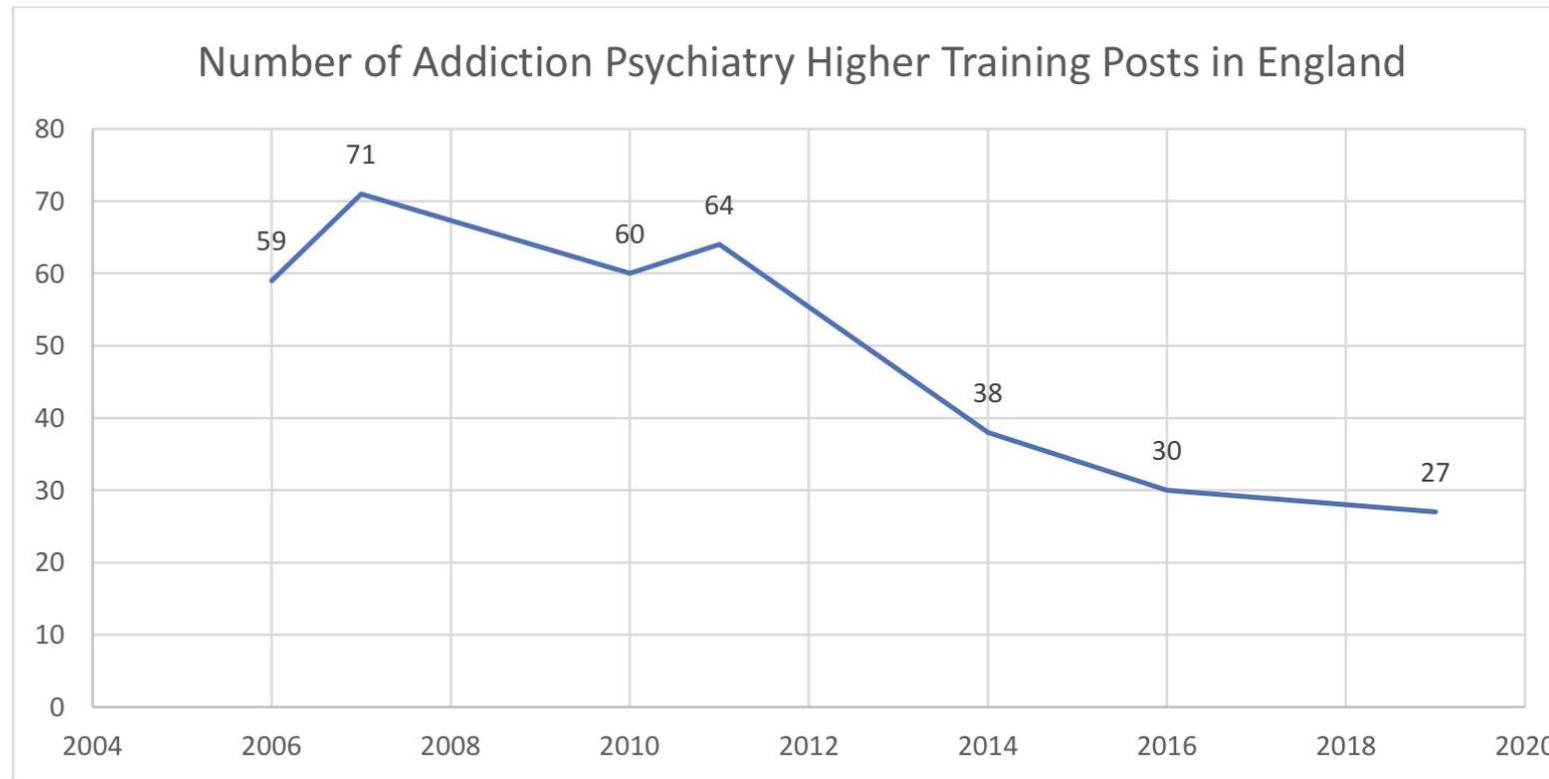
- Spending across mental health services (Specialised Commissioning and ICB combined, including learning disability, autism and dementia) has increased significantly

2018/19 £12.51bn

2023/24 £16.81bn

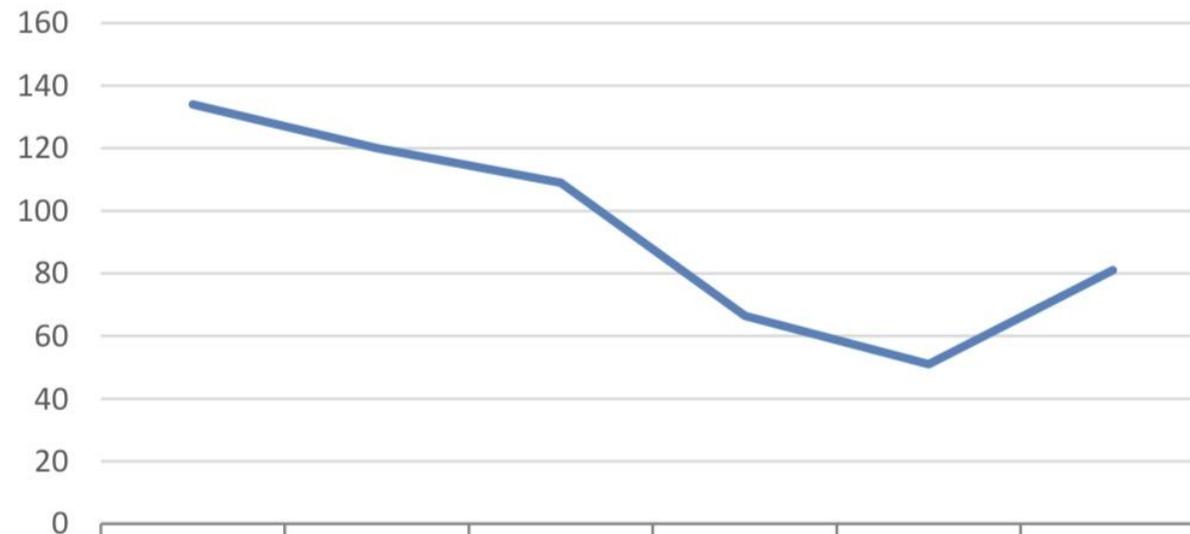
2024/25 £18.22bn

Decline in Addictions Workforce



Decline in Addictions Workforce

Substantive Whole Time Consultant Posts



	2007	2009	2011	2013	2015	2017
— No. of substantive Whole Time Posts	134	120	109	66.5	51	81

Addictions Workforce in UK

- Voluntary sector dominance – 74% of staff from voluntary sector
- 12% of treatment provider workforce were unpaid volunteers
- Significant vacancies especially for medical staff at senior Consultant level

MH Plans

- Five Year Forward View – 2016
- Mental Health Implementation Plan – 2019
- NHS Long Term Plan for England 2019
- From Harm to Hope: A 10 Year Drugs Plan To Cut Crime And Save Lives - 2022
- Long Term Workforce Plan – 2023
- Ten Year Health Plan – 2025

- Key Summary of Plans
 - Increased Mental Health Spend (mainly in workforce to enable catch up with Physical Health) with increased workforce numbers in addictions

RCPsych Recommendations

- Mandatory Workplace Based Assessments (WBAs) in addictions psychiatry in order to progress through training
- Develop and provide training courses for higher trainees and consultants who had no addictions experience during training, and for SAS (staff grade, associate specialist, speciality) doctors with addictions experience
- Engage with and support SAS doctors to gain access to the specialist register via the Certificate of Eligibility for Specialist Registration (CESR)
- Support the GMC credentialing of addiction psychiatry

< [Back to Blog](#)

My special interest in addictions and substance misuse

Careers in psychiatry, Choose Psychiatry

24 November, 2023



This blog post by Dr Deepak Moyal is part of the 2023 [Choose Psychiatry campaign](#).

My name is Deepak and I am a Higher Trainee ST5 with Forward Leeds, which is Substance Misuse Psychiatry service in Leeds.

When I first learned about Special Interest Days

I came to know about Special Interest Day in the life of a Higher Trainee when I started my Higher Training in ST4.

I have always thought that a Special Interest Day gives you a taster about a particular service or sub speciality of psychiatry.

It is up to the higher trainee to see whether they want to pursue a career or do they just want to have some experience about that particular area.

However I have come to feel over time that this day can have long lasting learning implications as well, as the trainee is able to gain some really interesting competences.

Addictions psychiatry learning resources

These learning resources are for medical students as well as resident doctors.

These resources have been collated to support students and resident doctors, and will be developed over time. If you have any suggestions or would like to contribute to the resources yourself please contact the Addictions Faculty via Stephanie Whitehead at stephanie.whitehead@rcpsych.ac.uk.

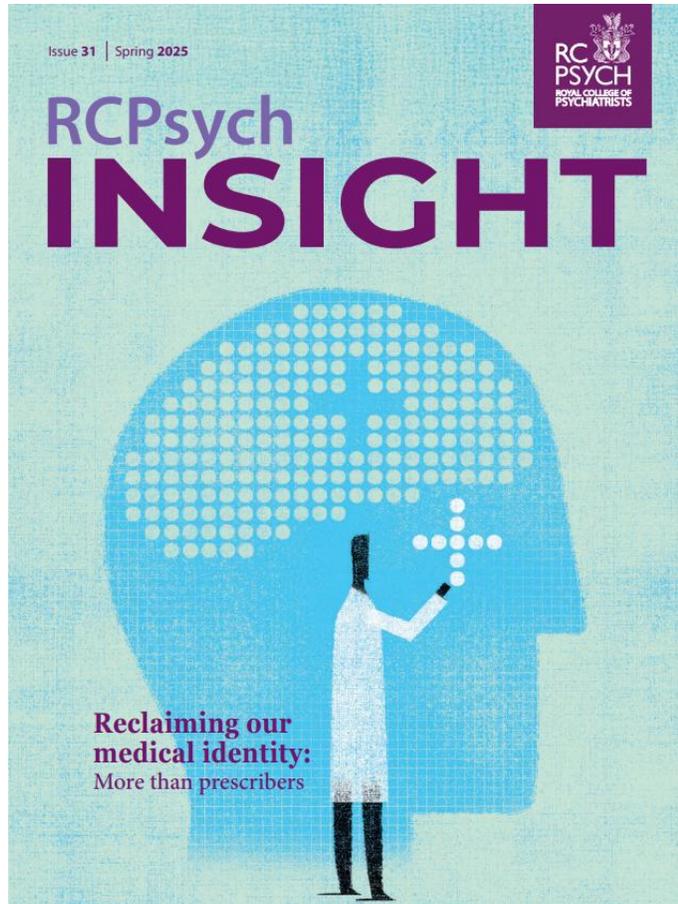
Please note, although we have selected useful resources, where links direct to external websites, the Faculty/RCPsych cannot be responsible for content.

+ **General addictions
resources**

+ **Recovery resources**

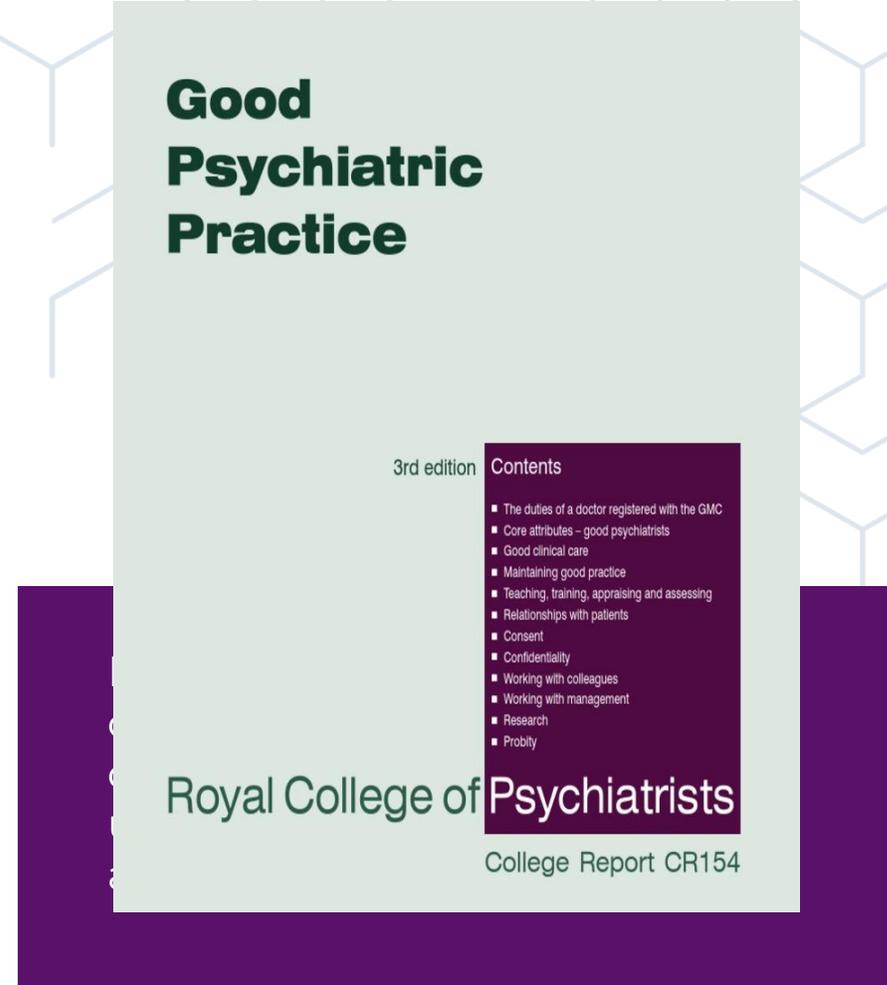
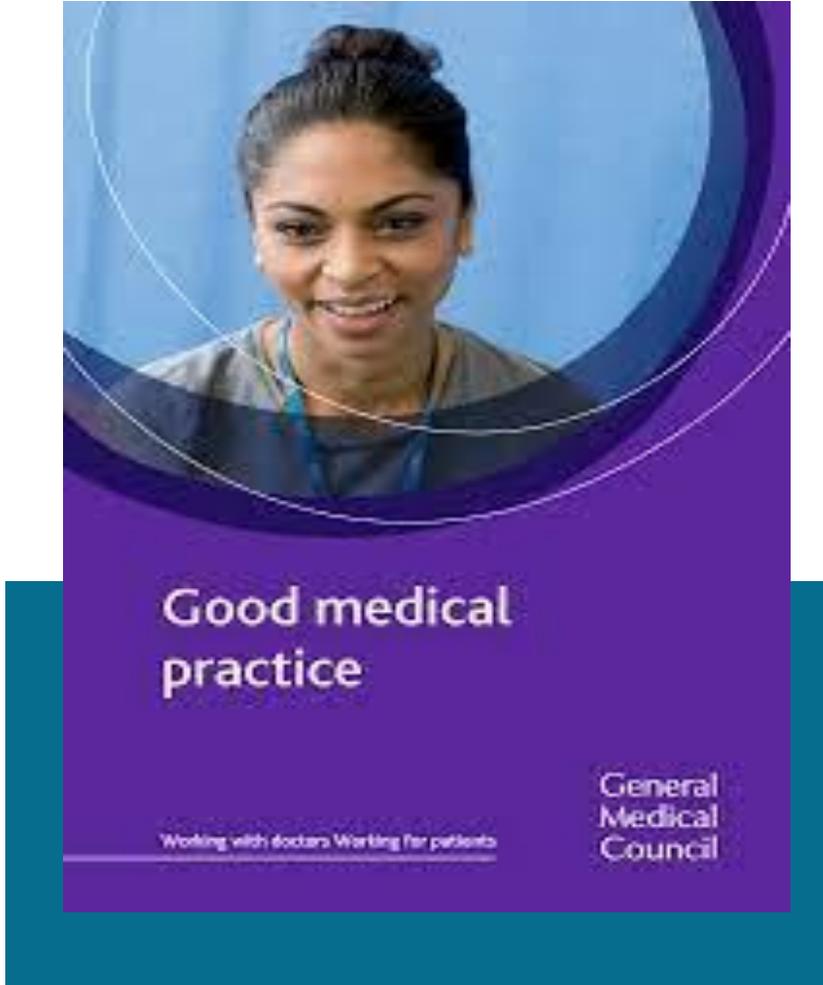
+ **Opioids**

Professional Identity



- Psychobiosocial Formulation Skills
- Core Medical and Neuroscience Skills
- Compassionate and Relational Skills
- Clinical Leadership Skills
- Joy at Work

Doctor-Patient v Doctor-Community



Managing Rising Demand



Public Mental Health

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Person-centred care

Public Mental Health Leadership Certification Course



The Public Mental Health Leadership Certification course is a new type of hybrid eLearning and webinar course developed by the [Public Mental Health Implementation Centre \(PMHIC\)](#), [eLearning Hub](#) and the Centre for Advanced Learning and Conferences (CALC).

"I am pleased to endorse these excellent resources from the Royal College of Psychiatrists on leadership in public mental health.

A public health approach to mental health means focusing on mental wellbeing promotion, mental illness prevention, and addressing the wider social determinants of health.

There is an active leadership role for Psychiatrists in working with communities to co-produce approaches that reflect their needs and values and improve mental health and wellbeing at population-level.

These resources are a guide for Psychiatrists looking to expand their public health leadership and we look forward to working together to support better mental health for all."

Professor Kevin Fenton (President: Faculty of Public Health)



[Frequently Asked Questions \(FAQs\)](#)

[Contact us](#)

[Register your interest in this course](#)

Overview of the course eLearning modules



Public Mental
Health Leadership
CERTIFICATION COURSE



1) An introduction to public mental health

- Definition of 'public mental health' (PMH), its structure and organisation in the UK
- Role of psychiatrists and other health professionals in PMH
- Global impact of mental health conditions
- Why **prevention** of mental health conditions is a key goal

2) Determinants of mental health and mental health conditions

- Determinants of mental health
- Frameworks in PMH (including Dahlgren & Whitehead rainbow model)
- Life course approach to PMH

3) Health inequalities

- Overview of health inequalities (definitions, history and need)
- Definitions and differences between 'equality' and 'equity' approaches
- The role of intersectionality, social justice and a rights-based approach
- Effects of stigma, discrimination, racism on mental health
- Working with marginalised people

4) Public mental health interventions

- Mental disorder *prevention* (primary to tertiary)
- Mental well-being promotion
- Resilience promotion
- Case studies including smoking cessation

5) Bridging the mental health–public health gap

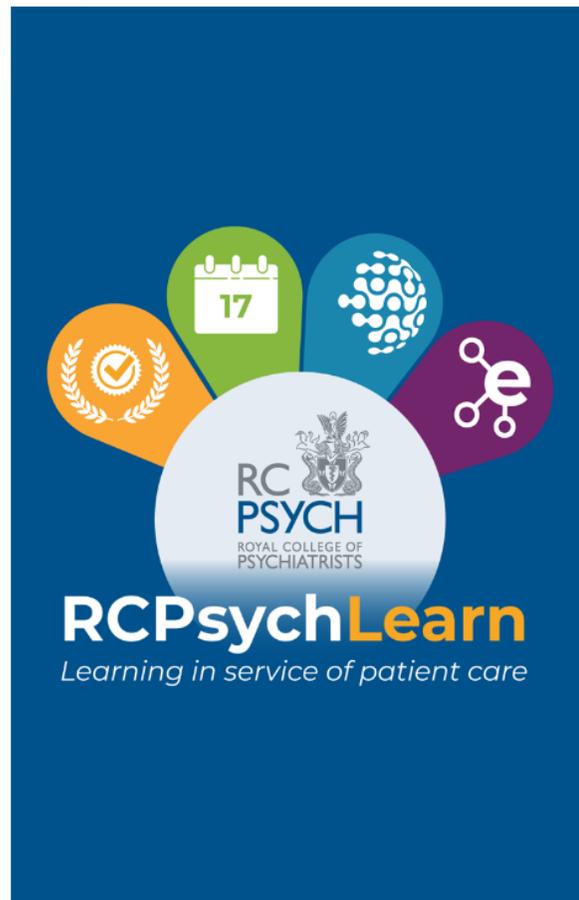
- Overview of the gap
- Causes of the gap
- Opportunities to address the gap
- Health-in-All policies

6) Future leadership in public mental health

- Leadership and advocacy
- Collaborations and networks
- On-the-ground implementation of cultural changes
- Sustaining *PMHL* course attendees' leadership community in the mid- to longer-term

Make Training Meaningful

– RCPsych Learn



RCPsych Learn brings together many of the College's learning activities under one roof – Advanced Learning courses, events, International Congress and the eLearning Hub.

We have been working hard behind the scenes to reform the committee structure and create brand new learning opportunities and products. The new RCPsych Learn Oversight Board will be responsible for all College educational products that are overseen by the Dean of the College.

By having one oversight board, the College will create conferences and training events that are aligned to its strategic objectives, and will identify ways it can support and upskill the mental health workforce to best meet the needs of their patients.

As well as continuing to deliver an excellent International Congress, RCPsych Learn will create new blended learning courses to sit alongside our sell out Public Mental Health Leadership Certification Course and our International Diploma, and will grow the ever popular Dean's Grand Rounds and resources available on the eLearning Hub.

Making Training Meaningful



Masterclasses: ICD-11, ADHD, AI and Psychiatry



Certificate Courses: Public Mental Health Leadership; National Autism Training Programme



Diploma Courses: 1st ever College Diploma Old Age Psychiatry



Credentials : Eating Disorders, Military Psychiatry

Dean's Grand Rounds

Dean's Grand Rounds



- **Dean's Grand Rounds (Narrowing the Gap b/w Evidence and Practice)**
- Lived Experience- Individual/Community
- Academic evidence
- Data – contextual/benchmarking
- Quality Improvement action points



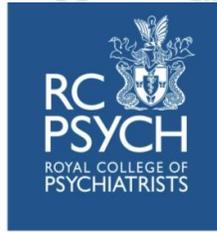
[Home](#) › [Improving care](#) › [College Centre for Quality Improvement \(CCQI\)](#) › [Quality Networks and Accreditation](#)
Alcohol Care Team Innovation and Optimisation Network (ACTION)

Alcohol Care Team Innovation and Optimisation Network (ACTION)

The Alcohol Care Team Innovation and Optimisation Network (ACTION) is a network of alcohol care teams.

We facilitate quality improvement and development in alcohol care teams through a supportive peer-review model and enabling communication and the sharing of best practice between services.

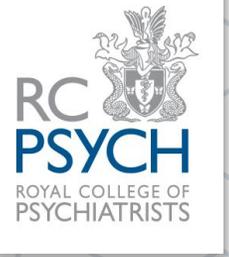
ACTION is open to all alcohol care teams in the United Kingdom.



CR243

Co-occurring substance use and mental health disorders (CoSUM)

May 2025



21 Recommendations

Several relate to training

- Addiction Tutor in every hospital provider
- Mental health training for substance use workers and assessment and brief intervention /harm reduction training for mental health workers
- In-patient staff training in detoxification
- Commissioners of care pathways to have training in COSUM and trauma informed care

Table 1: Appropriate treatment services for CoSUM disorders by severity

Mental illness	Substance use	Example case	Appropriate treatment services for:	
			Mental illness	Substance use
Severe	Mild/ Moderate	Weekly binge-drinking and schizophrenia	Specialist mental health services	Primary care or shared care with substance use services
Severe	Severe	Daily dependent cannabis use and schizophrenia	Specialist mental health services	Substance use services
			Collaborative working between both services is essential to coordinate care	
Mild/ Moderate	Mild/ Moderate	Weekly binge-drinking and moderate anxiety	Primary care; talking therapies	Primary care or shared care with substance use services
Mild/ Moderate	Severe	Daily dependent heroin use and moderate depression	Primary care; talking therapies and substance use services	Substance use services

Get in touch

#IdeasToAction

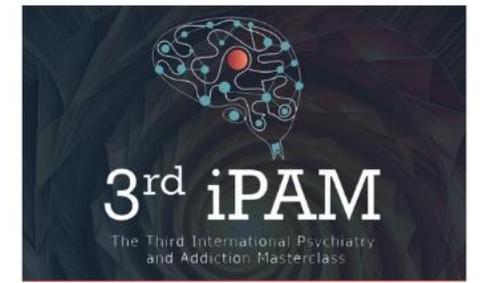
#CanDoWillDo

@subodhdave1

dean@rcpsych.ac.uk



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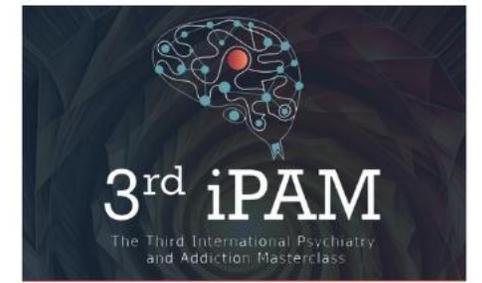


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Presentation



Professor Cathy Montgomery
Professor of Psychopharmacology & Health
Inequalities; Head of Institute for Health Research
Liverpool John Moores University



Devon De Silva
Innovation and Research Unit Manager
VIA



Cross-sectional comparison of long-acting injectable buprenorphine and oral medication for opioid use disorder

Professor Cathy Montgomery, Professor of Psychopharmacology & Health Inequalities, Liverpool John Moores University

Devon De Silva, Innovation & Research Unit (IRU) Manager, Via



[@LJMU_IHR](#)

[@ViaOrg](#)

- This work was funded by a research grant from Camurus to Via (Yasir Abbasi) and LJMU (Cathy Montgomery).
- Yasir Abbasi has received honorarium and accommodation funding from Camurus, Ethypharm and Newbridge Pharmaceuticals.
- Cathy Montgomery is also funded by CSL Seqirus.

Pilot

In 2019, Via (formerly WDP), piloted the use of LAIB within the London Borough of Redbridge.

Via were the first state-funded substance misuse treatment provider to pilot LAIB within England and Wales.

Between 2019-2023, 31 service users were offered LAIB. 25 (81%) service users commenced and continued using LAIB.



Pilot evaluation findings

In 2021, Via conducted a survey with service users (n16), Via staff (n6) and pharmacy staff (x1 pharmacy) involved in the pilot.

Key findings included:

- 12/13 service users rated LAIB as somewhat or significantly better than oral medication.
- 13/13 service users would recommend LAIB to others: *'Go for it. It is great. Better than all these others'*
- Advantages of LAIB reported: convenience, freedom, reduces using on top, and fewer symptoms of craving/withdrawal.
- Staff reported high abstinence rates: *'haven't observed such high rates particularly for completely stopping in my 35 years of practice'*
- Disadvantages of LAIB: fear of being triggered by injection, pain from the injection.
- Staff expressed some concerns about service users not engaging in psychosocial support / wanting to reduce.

Predictors (*Lofwall & Fanucchi, 2021*)

LAIB may be useful for individuals:

- Who do not wish to take daily oral doses
- Who live in rural areas
- Who live in places where safe storage is problematic
- At increased risk of overdose

Outcomes

LAIB is associated with:

- Reductions in fatal and non-fatal overdoses (Laroche et al, 2018, Sordo et al 2017)
- Increased abstinence relative to placebo plus counselling alone (Wakeman et al, 2020)
- Similar retention rates to buprenorphine and methadone (Farrell et al, 2022)

Outcomes

Real world evaluation in the US found that 65% of individuals experienced no precipitated withdrawal or ongoing opioid use (Peckham et al, 2021)

Another US study found that LAIB appealed for more than half of individuals surveyed (Kenney et al, 2018)

US study found significant improvements in self-reported quality of life, increased employment, and reduced healthcare (Ling et al, 2019)

Lived experience

Benefits of LAIB:

- Improved choice
- Reduced travel
- Requirements to attend clinic /pharmacy
- Reduced stigma

Concerns included:

- Loss of control of medication
- Bodily autonomy
- Isolation
- Potential adverse effects (Clay et al, 2023, Saunders et al, 2020, Tompkins et al, 2019)

Is LAIB associated with improved outcomes?



Who is prescribed LAIB in Via?



Are gender, age, primary substance, social deprivation (IMD decile) and other relevant sociodemographic factors predictive of receiving LAI Buprenorphine vs. other MOUD?



Do outcomes differ for those that receive LAIB vs. other MOUD treatments?

Cross-sectional analysis of electronic health records from 15/8/22 – 15/8/23.

Data from 6 Via services was included.

Sociodemographic information, prescribing data, opioid and IV drug use, and physical and mental health assessments (Treatment Outcome Profiles – TOP).

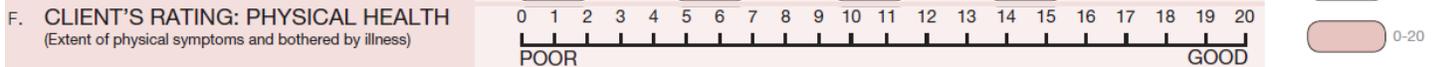
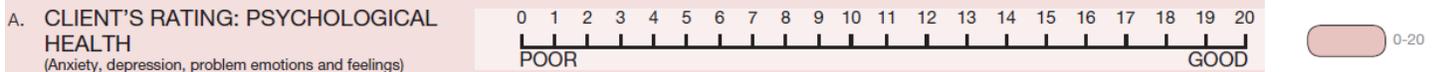
People receiving LAIB (N = 235) were compared to a selected group of people receiving other Medications for Opioid Use Disorder (MOUD) (N = 266).

2 INJECTING RISK BEHAVIOUR

Record the number of days the client injected non-prescribed drugs during the past four weeks



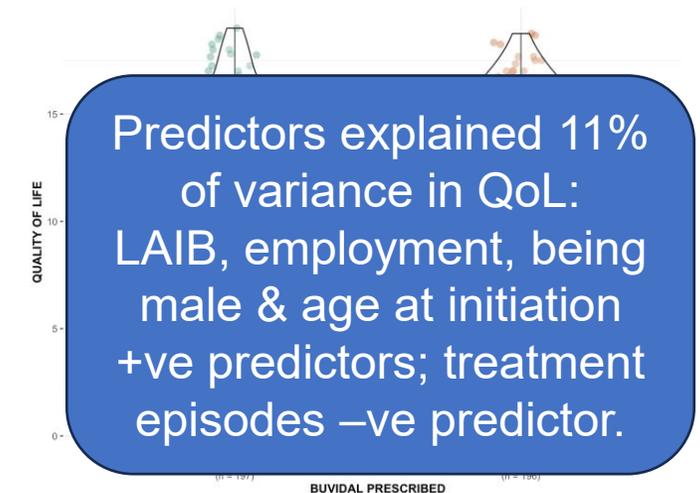
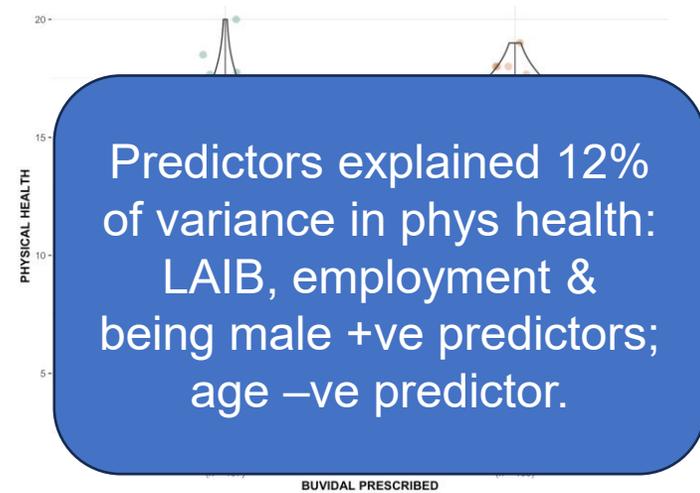
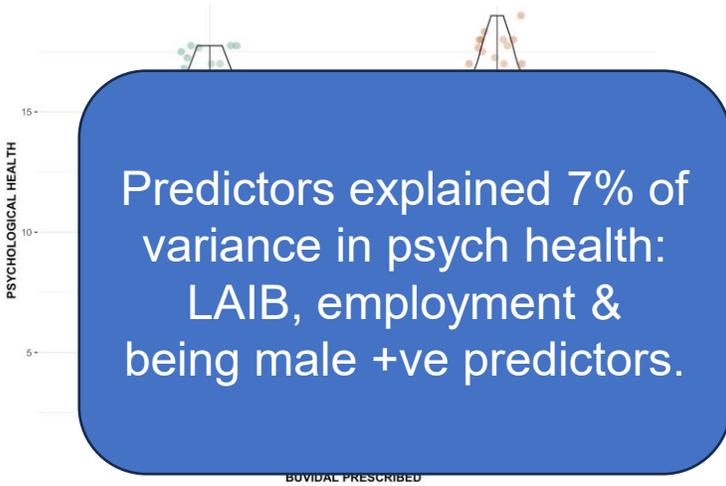
4 HEALTH & SOCIAL FUNCTIONING



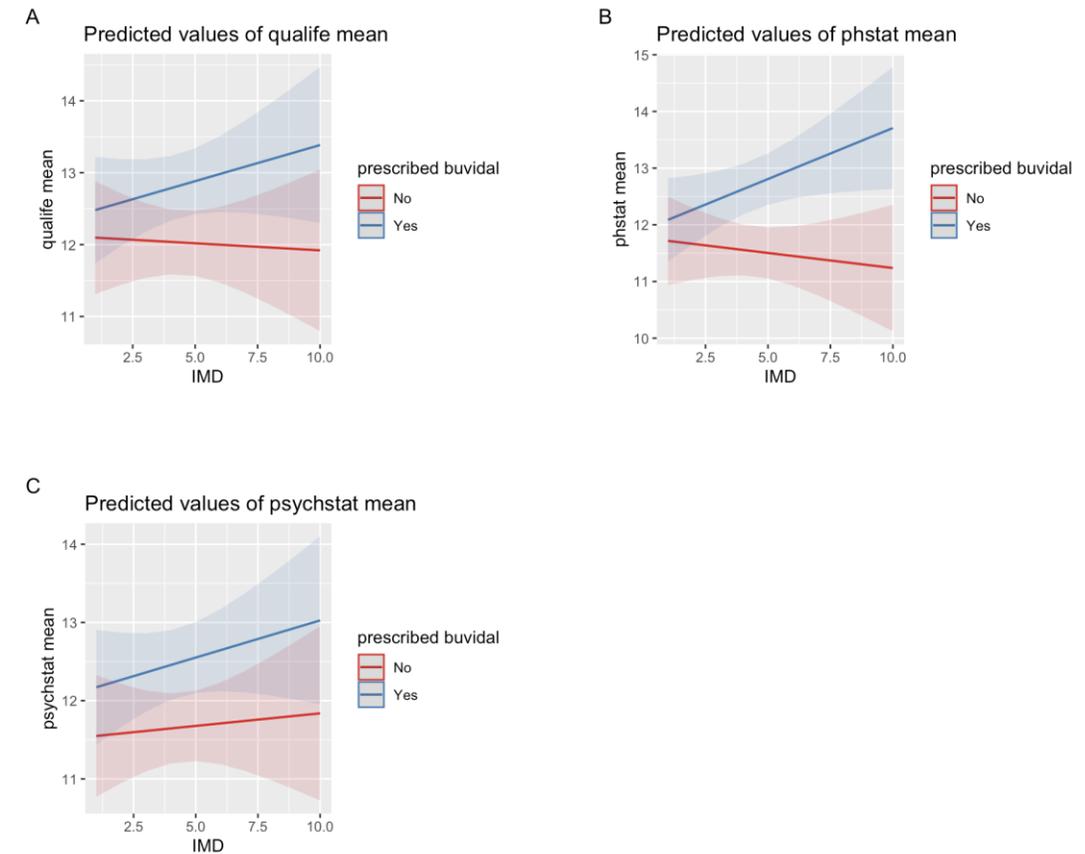
	Buvidal	Other
	<i>Mean (SD)</i>	<i>Mean (SD)</i>
Current Age	43.17 (9.00)	47.23 (9.89)
Age of first substance	22.44 (6.93)	23.36 (9.10)
Number of episodes	1.86 (1.21)	1.52 (1.04)
IMD	4.43 (2.53)	4.54 (2.35)
	<i>N (%)</i>	<i>N (%)</i>
<i>Ethnicity</i>		
White British	169 (71.9%)	187 (70.3%)
Other	66 (28.1%)	79 (29.7%)
<i>Employment</i>		
Regular Employment	55 (23.4%)	38 (14.3%)
Other	180 (76.6%)	228 (85.7%)
<i>Gender/Sex</i>		
Female	60 (25.5%)	67 (25.2%)
Male	175 (74.5%)	199 (74.8%)
<i>Primary Substance</i>		
Illicit Heroin	186 (79.1%)	220 (82.7%)
Other	49 (20.9%)	46 (17.3%)

- Clients in both groups were predominantly:
 - White British
 - Male
 - Around 23 years at age of initiation
 - Using heroin as primary substance
- LAIB clients:
 - Were significantly younger
 - Had significantly more treatment episodes
 - Had higher employment

- TOP difference scores (final assessment – first assessment): no significant differences between LAIB vs. other in physical health or psychological health. LAIB clients reported significantly higher QoL.
- TOP summary scores (average of all TOP assessments): Significantly greater psychological and physical health and quality of life reported by LAIB group.



- Compared data for reports of opioid use (N = 252) with not (N = 151):
 - No significant association with LAIB
 - Treatment episodes was significant positive predictor.
- We plotted interactions between IMD and LAIB vs. other for TOP:
 - No main effects once IMD included in analyses.
 - Trend to interaction with physical health – LAIB and higher IMD = better physical health.



Predictors: Number of episodes, age & employment

*'Key workers identify clients who are **struggling with engagement** or that are **high risk**.'*



Dr Sue

'Young and middle-aged people are more likely [to use LAIB], those who are older are less so, 'maybe because they're used to methadone'



Dr Maya

*'I'd had enough, I was at the mercy, whatever could help. I couldn't get to grips, **desperate last chance**. I'd disappear for weeks, spending thousands at a time'*

Shane now owns his own construction business
'8 months clean and learning how to live'

'It's been amazing... I have my own business, a construction company. I have handymen and carpenters and I'm making a profit... Because I'm able to focus, am clean and can concentrate on my life'



Shane

Increase in quality of life: substance use & OST

I convinced myself I needed drugs to live... the idea of taking drugs now turns my stomach, makes me feel sick'

When going back to the service for his injection, Shane explained 'I'd forgotten the fact I'd had a drug addiction'



'No sweating, no withdrawal... all pains and worries gone. I used to use pills to take the edge off before, but not needed now... I did stumble and smoked a bit but it did nothing for me'



Service users 'feel very safe having something that stops them using drugs, a sense of immunity and sense of power'



'When we're reducing people slowly, they kind of stock up just in case. They come off and then take a lot more than they were on. Whereas with this, they know they can come off and don't feel it as much, because they've got used to going about normal business. They just forget about it'



Increase in quality of life: relationships & wellbeing

'With heroin you wake up needing a fix but now we can lie in bed and have a tea... we can engage in our relationship.'



Hanah explained that as an Asian woman, she felt **stigmatised** when attending the pharmacy; *'having to go to the pharmacy all the time... [they] looked down their noses at you and treated you like you're nothing'*.

LAIB has *'made me normal again'*



'Heroin affected my sleep... I'm now running on my own energy. Buzzing on life'

'10 years ago I was sleeping in my car, now I've got my own business, my own house, my partner'



'I've got a young man with mental health and his mum is his carer. LAIB gives them one less thing to worry about, him and his mum. It's not improved his mental health...but it's one less worry.'



Challenges & considerations

'Hoping to get a home office licence...[currently we have to] order the day before we're due to see someone and predict the dosage required. Challenge is you can't be responsive'

*It 'takes nursing time.. [we're] looking at ways to cut **admin** hours'*

*'We've got the drug, we've got the people but it's the workforce really... the **nursing numbers** hasn't gone up'*

'I would love not to have restrictions to offer [it] to more people'



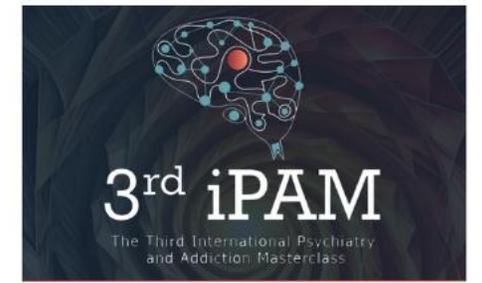
'Street workers would absolutely benefit but they don't want to be touched or injected'

Future research

Key themes from the retrospective evaluation and qualitative interviews have suggested further research is required to understand:

- patient and staff experience and acceptance of LAIB
- the costs vs benefit of prescribing LAIB and how it can be made more widely available
- what the optimal dosage of LAIB is and whether this differs among different groups: anecdotally Dr Sue explained that with LAIB the required dose seems to be higher and that this is particularly noticeable in women
- how to effectively reduce service users off LAIB;
- how to effectively reduce service users' use of other substances such as crack cocaine and/or alcohol whilst they are being prescribed

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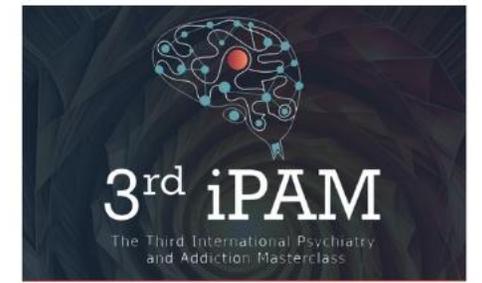


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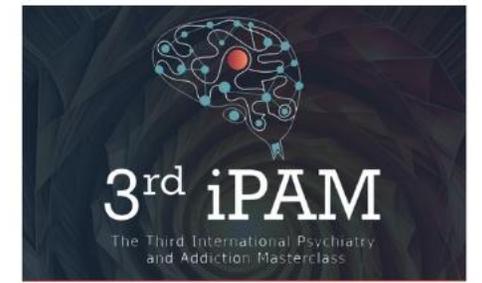
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Q&A



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Presentation



David Nutt FMedSci

Psychiatrist and Professor of Neuropsychopharmacology
Imperial College London



Psychedelics for addiction

London 2025

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CRO Solvonis

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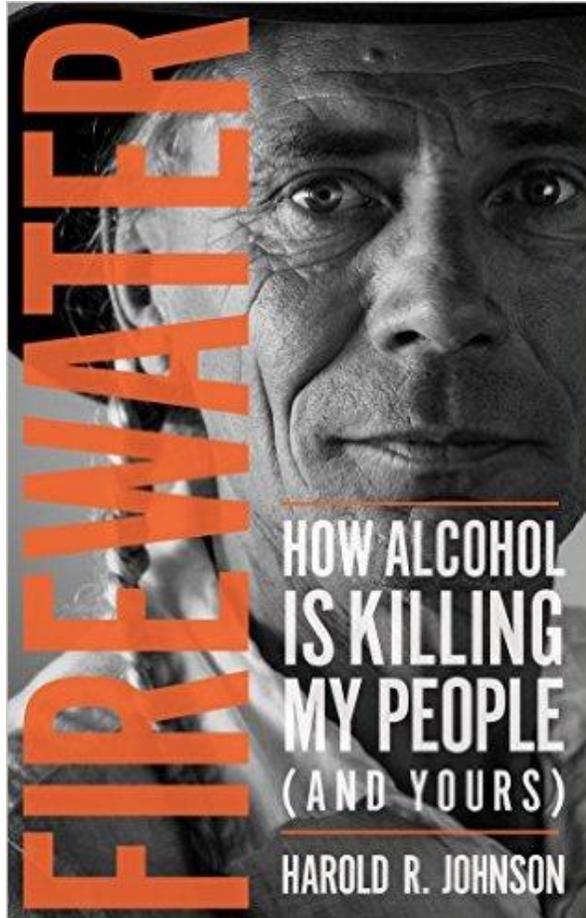
[profdavidnutt@bluesky.com](https://bsky.app/profile/profdavidnutt)

Podcasts on www.drugscience.org.uk

Declaration of interests – 2019-2023

- Advisor - British National Formulary
- Past President - British Neuroscience Association - European Brain Council
- Past President - European College of Neuropsychopharmacology
- **Chair – DrugScience [UK] - & PAREA Europe (Psychedelic Access and Research European Alliance)**
- Member International Centre for Science in Drug Policy
- Editor of the journal Drug Science Policy and Law
- CRO Solvonis therapeutics
- Advisory Boards - **Psyched Wellness, Neural Therapeutics**
- Speaking honoraria (in addition to above) Lundbeck, BMS/Otsuka, Janssen, Takeda
- Grants or clinical trial payments: Wellcome Trust, MRC
- Share options – P1vital, Psyched Wellness Director Equasy Enterprises and Alcarelle
- Expert witness in a number of legal cases relating to psychotropic drugs
- Edited/written >40 books - some purchased by pharma companies

Why we need new treatments for addiction



>400 million people with addiction in the world

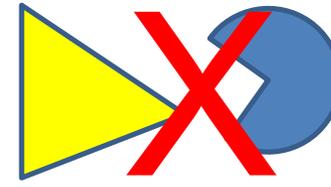
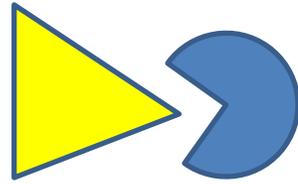
>90% do not get treatment

And treatment success rates < 30%

Alcohol responsible for over half of all crime and health problems in some Canadian First Nation peoples

Addiction - current medicines target the receptors drugs act on

drug → receptor



Medicine

Block the drug getting to its binding site

- Antagonists – e.g. naltrexone for heroin (low compliance)

Block elements of drugs effects

- Opioid antagonists nalmefene/ naltrexone for alcohol

Substitution therapy – give less harmful drug/stop craving

- Methadone, buprenorphine for heroin
- Sodium oxybate, baclofen for alcohol
- Varenicline for tobacco

**Limited efficacy -
especially for
behavioural
addictions**

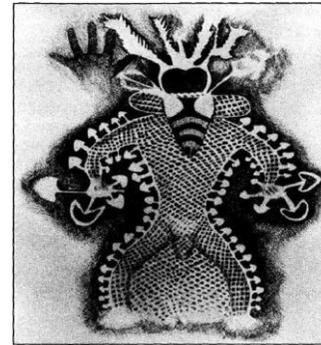
Psychedelics – the first psychoactive drugs were serotonergics

Peyote /San Pedro cacti
mescaline



Native American churches
USA

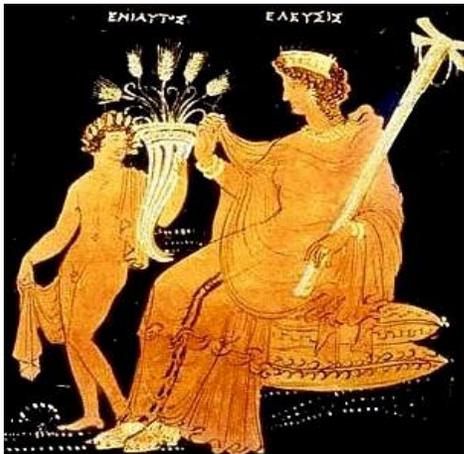
Magic mushrooms/ Mushroom man
Algeria 5000 BCE
psilocybin



Ayahuasca = DMT drink



Serpent and jaguar
indigenous gods
Now used in several
“Christian” churches



Ancient Greeks
Kykeon drink = wine +
ergot (lysergamides)



Hinduism

Soma =
Cannabis +
magic
mushrooms
+ephedra

5-MEO-DMT



Bufo Alvarius toad

So why not go back to the future? – the founding of AA in 1933 by Bill Wilson

During his 'belladonna' treatment for alcohol withdrawal Bill had a psychedelic experience

*“Suddenly the room lit up with a great white light. I was caught up in an ecstasy which there are no words to describe. It seemed to me in my mind's eye, that I was on a mountain and that a wind not of air but of spirit was blowing. **And then it burst upon me that I was a free man.**”*



Years after this psychedelic-induced sobriety conversion Bill Wilson experienced LSD with Aldous Huxley and came to believe that it could help “cynical alcoholics” achieve spiritual awakening more later

Aldous Huxley and mescaline



Peyote cactus



“ the brain is an instrument for focusing the mind”

“a reducing valve”



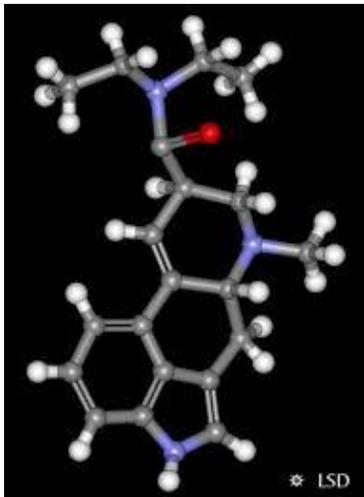
***If the doors of perception were cleansed every
Thing would appear to man as it is, infinite.
For man has closed himself up, till he sees all
Things thro' narrow chinks of his cavern.***

William Blake, 1793

LSD – the big breakthrough

LSD

- synthetic and more potent psychedelic
- wide medical and research use



Albert Hofmann – the discoverer of the chemistry of LSD and psilocybin - at 100



Early Psychiatric Uses for LSD and psilocybin

1. Psychotomimetic

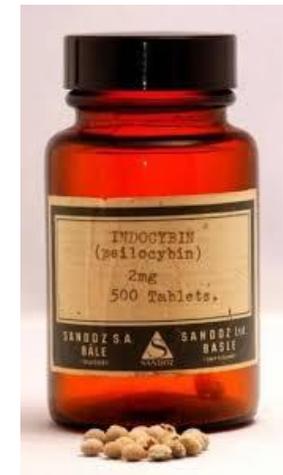
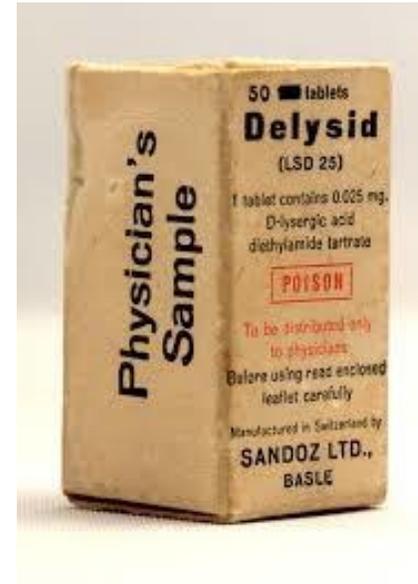
2. Self-experimentation by mental health professionals

3. Psychedelic Psychotherapy

- High dose single drug session
- Mystical / Peak experience
- Favoured in the US

4. Psycholytic Psychotherapy

- Low doses
- Frequent, regular sessions
- Favoured in the UK



Clinical Interest in LSD in the 1950s and 1960s

- Hundreds of psychiatrists worldwide
- 140 NIH grants
- 1000 clinical papers
- 40,000 patients
- 40 books
- 6 International conferences

**Results were overwhelmingly positive, describing
safe and effective treatments**

(Masters and Houston, 1971)

Pooled analyses in the 1960s

- **44 psychiatrists, 5000 subjects and 25,000 drug sessions:**

Rate of psychosis: 0.2%

Rate

(Cohen S

- **700**

One c

(Chandle

- **350**

One c

(Ling TM,

"Treatment with LSD is not without acute adverse reactions, but given adequate psychiatric supervision and proper conditions for its administration, the incidence of such reactions is not great,"

- **Review of 20 years of psychedelic therapy in the UK, 4000 patients and 50,000 psychedelic drug-assisted sessions.**

Two completed suicides

Thirty-seven patients with a prolonged psychosis

(Malleon, N. (1971) 'Acute Adverse Reactions to LSD in clinical and experimental use in the UK.' Br J Psychiatry. 18(543): 229-30)

Schlag AK, Aday J, Salam I, Neill JC, Nutt DJ et al., 2022, Adverse effects of psychedelics: From anecdotes and misinformation to systematic science, *JOURNAL OF PSYCHOPHARMACOLOGY*, Vol: 36, Pages: 258-272, ISSN: 0269-8811

6 LSD trials in alcoholism

1970

problems and treatment intentions

quiet room

group therapy

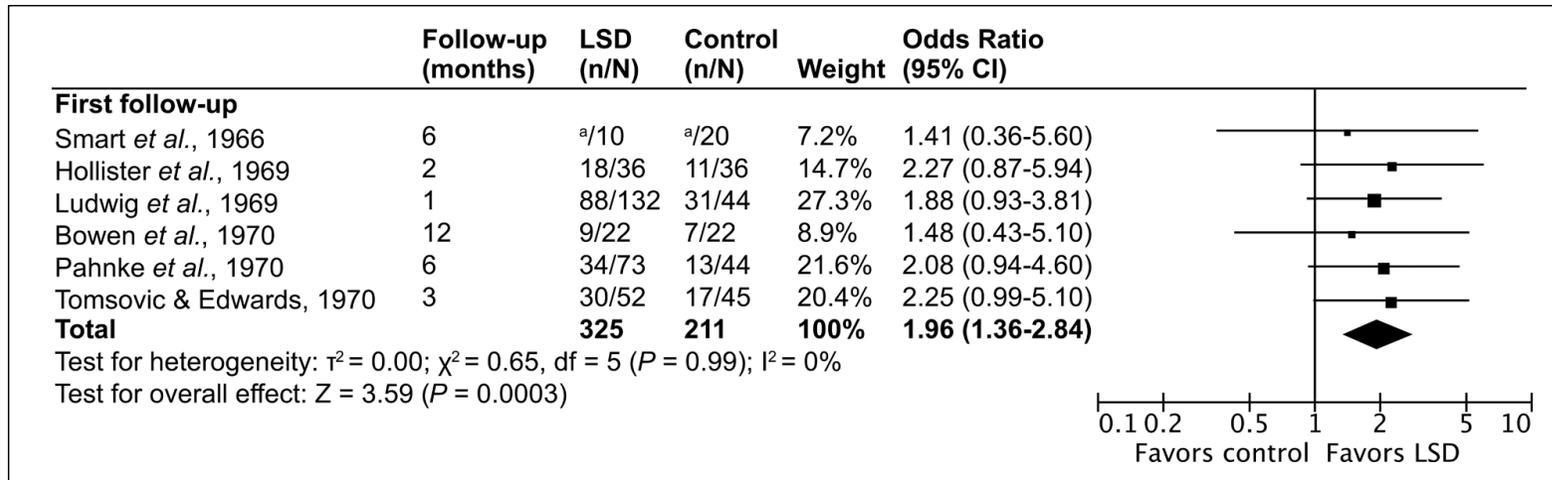


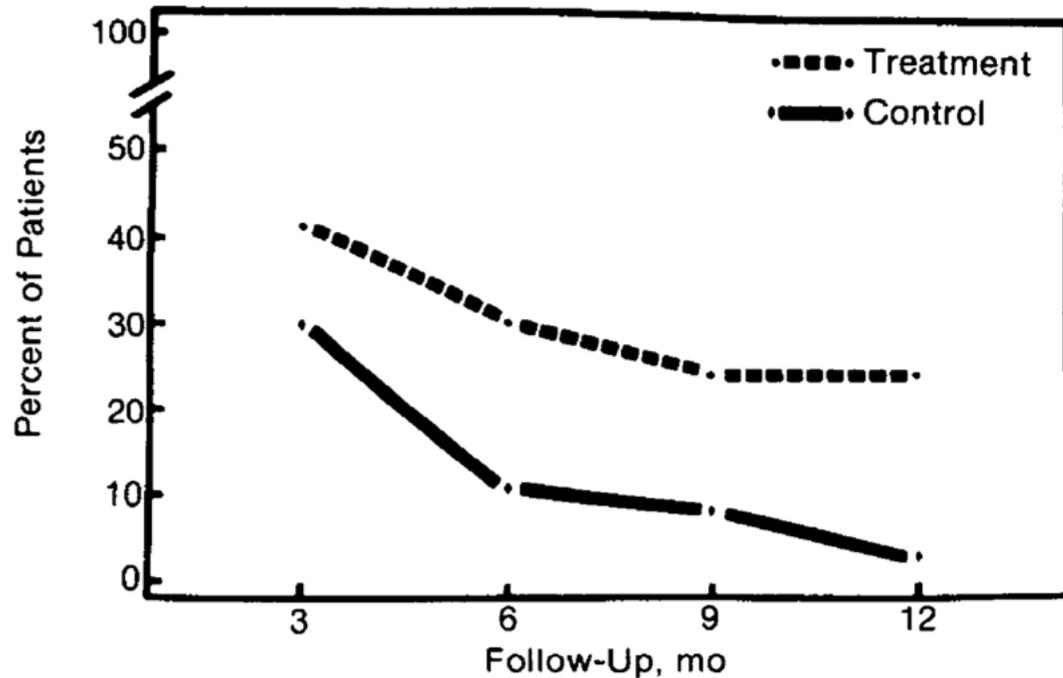
Figure 2. Improvement on alcohol misuse at the first available follow-up after LSD versus control treatments.

^aContinuous outcome data.

Effect size \geq all current therapies

LSD for heroin addiction

Fig 1.—Percent of patients maintaining total abstinence at 3-, 6-, 9-, and 12-month follow-up.



Leonard N

The two experiences of heroin and LSD are like night and day. Heroin is night, a time to sleep and with sleep nothing comes. But with LSD it is like dawn, a new awakening, it expands your mind, it give you a brand-new outlook on life.

Residential Psychedelic (LSD) Therapy for the Narcotic Addict

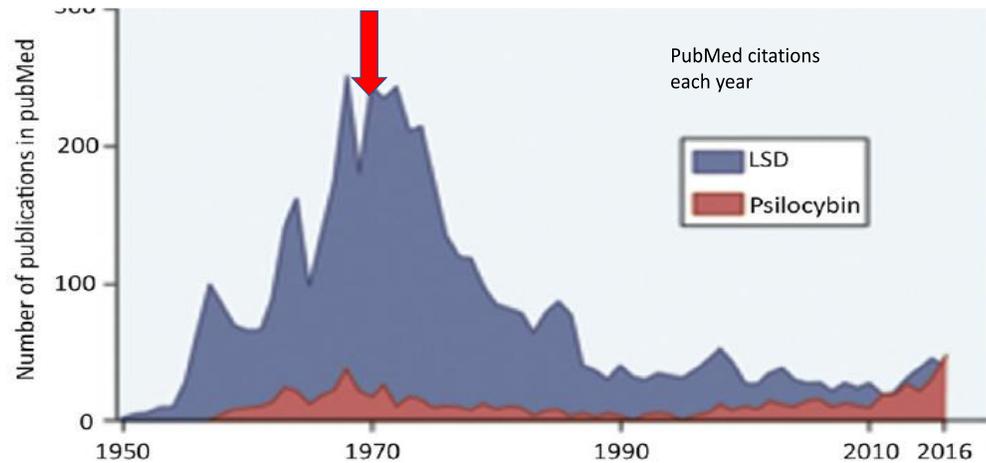
A Controlled Study

Charles Savage, MD, O. Lee McCabe, PhD, Baltimore

Arch Gen Psych 1973

How the 1967 US ban and the 1971 UN Conventions destroyed psychedelic research

Impact of the 1971 UN Psychotropics Convention on psychedelic research



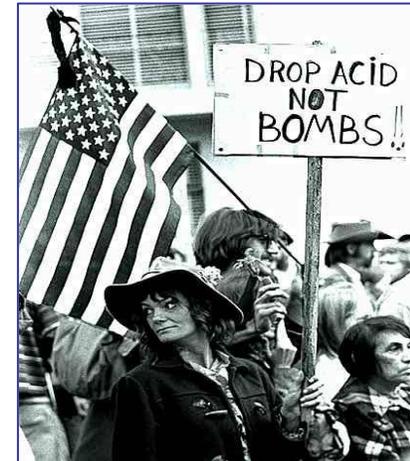
Kyzar et al 2017 TIPS

Put into Schedule 1 – “highly dangerous and no medical use”

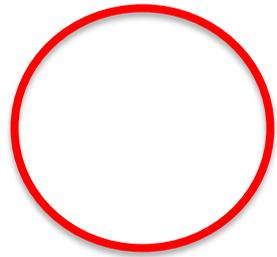
→ the worst censorship of ANY research in the history of the world



Psychedelics banned as they were changing art, music and culture and were associated with the anti-Vietnam war movement



For over 50 years the ban has persisted based on the myth of serious harms despite overwhelming evidence to the contrary



**Psychedelics and
MDMA**

UK experts

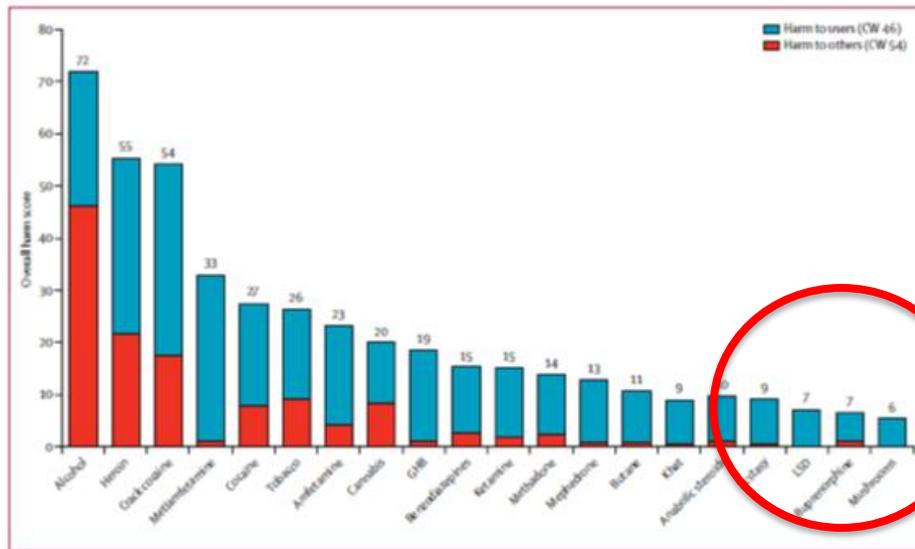
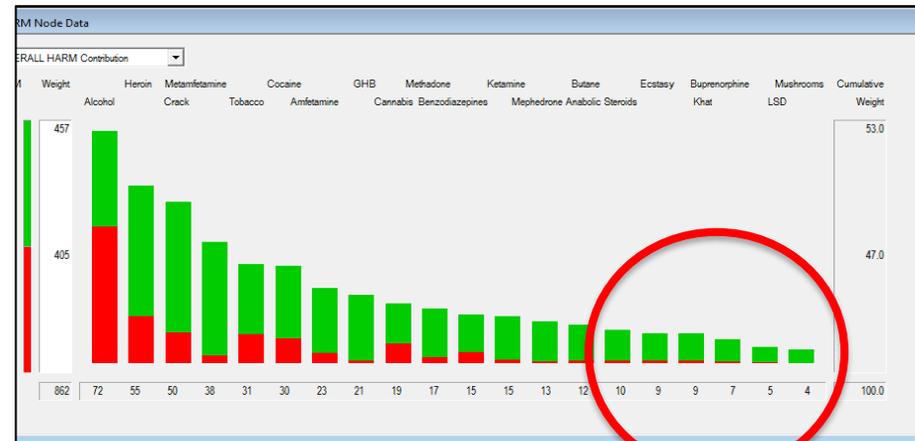
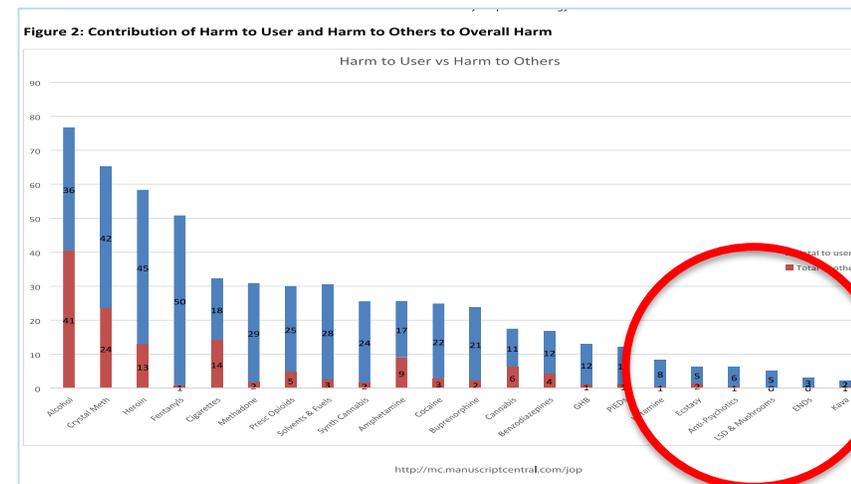


Figure 2: Drugs ordered by their overall harm scores, showing the separate contributions to the overall scores of harms to users and harm to others. The weights after normalisation (0-100) are shown in the key (cumulative in the sense of the sum of all the normalised weights for all the criteria to users, 46; and for all the criteria to others, 54). CW=cumulative weight. GHB=γ hydroxybutyric acid. LSD=lysergic acid diethylamide.

Nutt King & Phillips Lancet Nov 2010



van Amsterdam et al J Psychopharmacology 2014



Bonomo et al J Psychopharmacology 2018

**EU
experts**

**Australian
experts**

The modern era starts

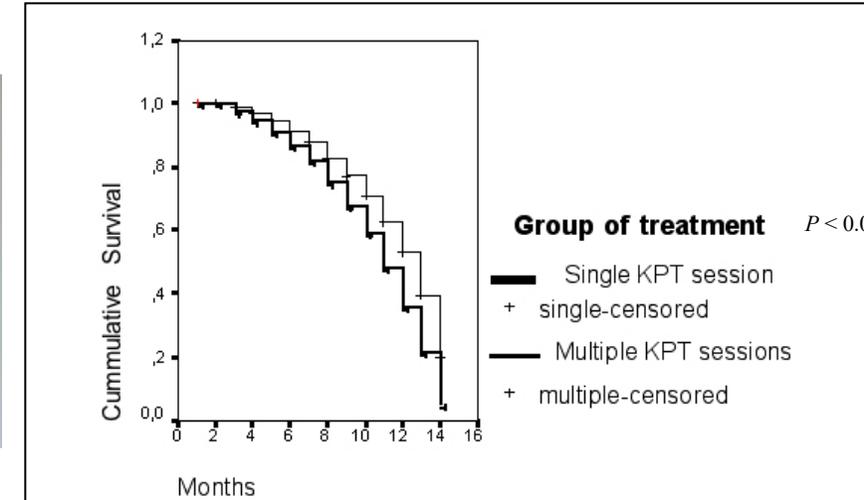
Evgeny Krupitsky pioneers ketamine treatment for addiction

Ketamine Psychedelic Therapy (KPT): A Review of the Results of Ten Years of Research

E.M. Krupitsky, M.D., Ph.D.* & A.Y. Grinenko, M.D., Ph.D.*

Abstract—Ketamine is a prescription drug used for general anesthesia. In subanesthetic doses, it induces profound psychedelic experiences and hallucinations. The subanesthetic effect of ketamine was the hypothesized therapeutic mechanism in the authors' use of ketamine-assisted psychotherapy for alcoholism. The results of a controlled clinical trial demonstrated a considerable increase in efficacy of the authors' standard alcoholism treatment when supplemented by ketamine psychedelic therapy (KPT). Total abstinence for more than one year was observed in 73 out of 111 (65.8%) alcoholic patients in the KPT group, compared to 24% (24 out of 100 patients) of the conventional treatment control group ($p < 0.01$). The authors' studies of the underlying psychological mechanisms of KPT have indicated that ketamine-assisted psychedelic therapy of alcoholic patients induces a harmonization of the Minnesota Multiphasic Personality Inventory (MMPI) personality profile, positive transformation of nonverbalized (mostly unconscious) self-concept and emotional attitudes to various aspects of self and other people, positive changes in life values and purposes, important insights into the meaning of life and an increase in the level of spiritual development. Most importantly, these psychological changes were shown to favor a sober lifestyle. The data from biochemical investigations showed that the pharmacological action of KPT affects both monoaminergic and opioidergic neurotransmitter metabolism, i.e., those neurochemical systems which are involved in the pathogenesis of alcohol dependence. The data from EEG computer-assisted analysis demonstrated that ketamine increases theta activity in cerebrocortical regions of alcoholic patients. This is evidence of the reinforcement of limbic cortex interaction during the KPT session.

Keywords—alcoholism, hallucinogen, ketamine, psychedelics, psychotherapy, Russia



Positive results in heroin and alcohol addiction

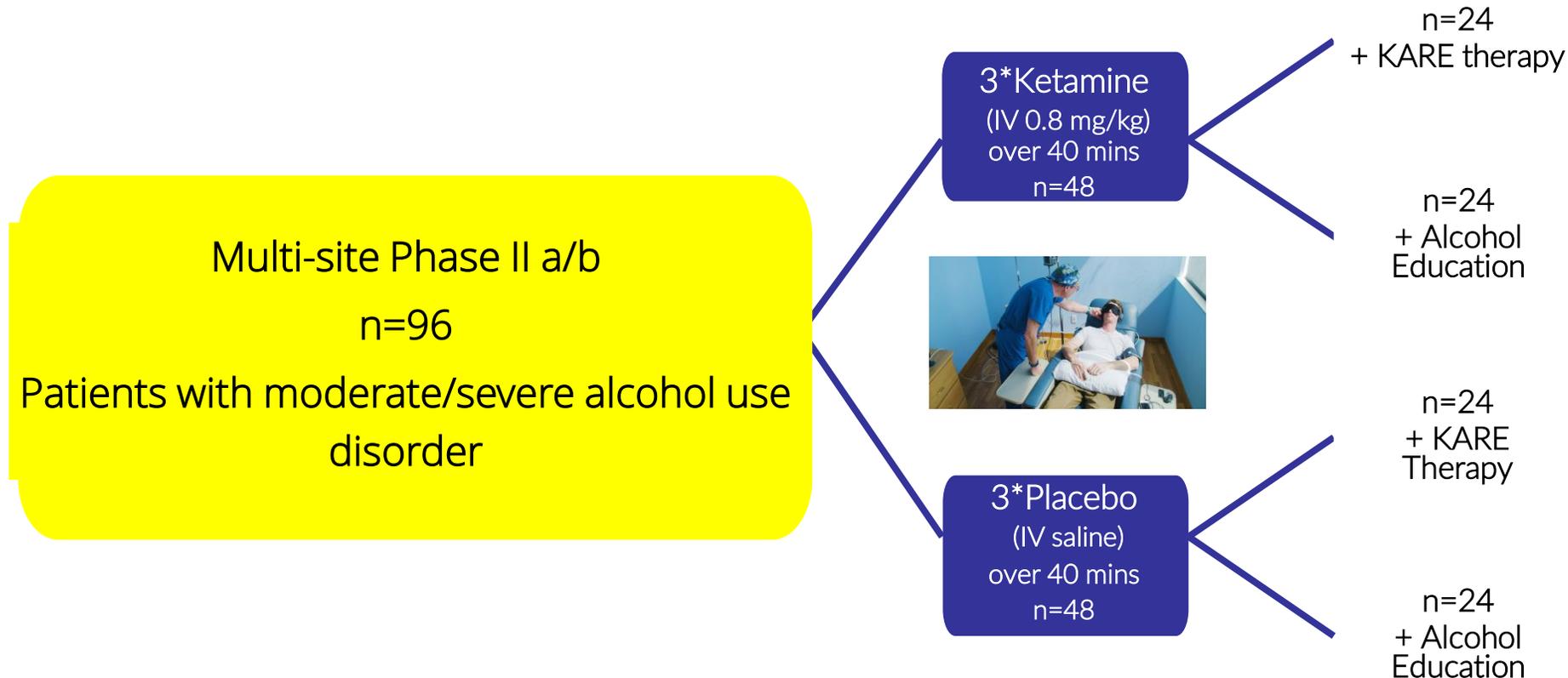
Nutt et al 2025 A long strange trip: the history of ketamine in psychiatry *Journal of Psychopharmacology* in press



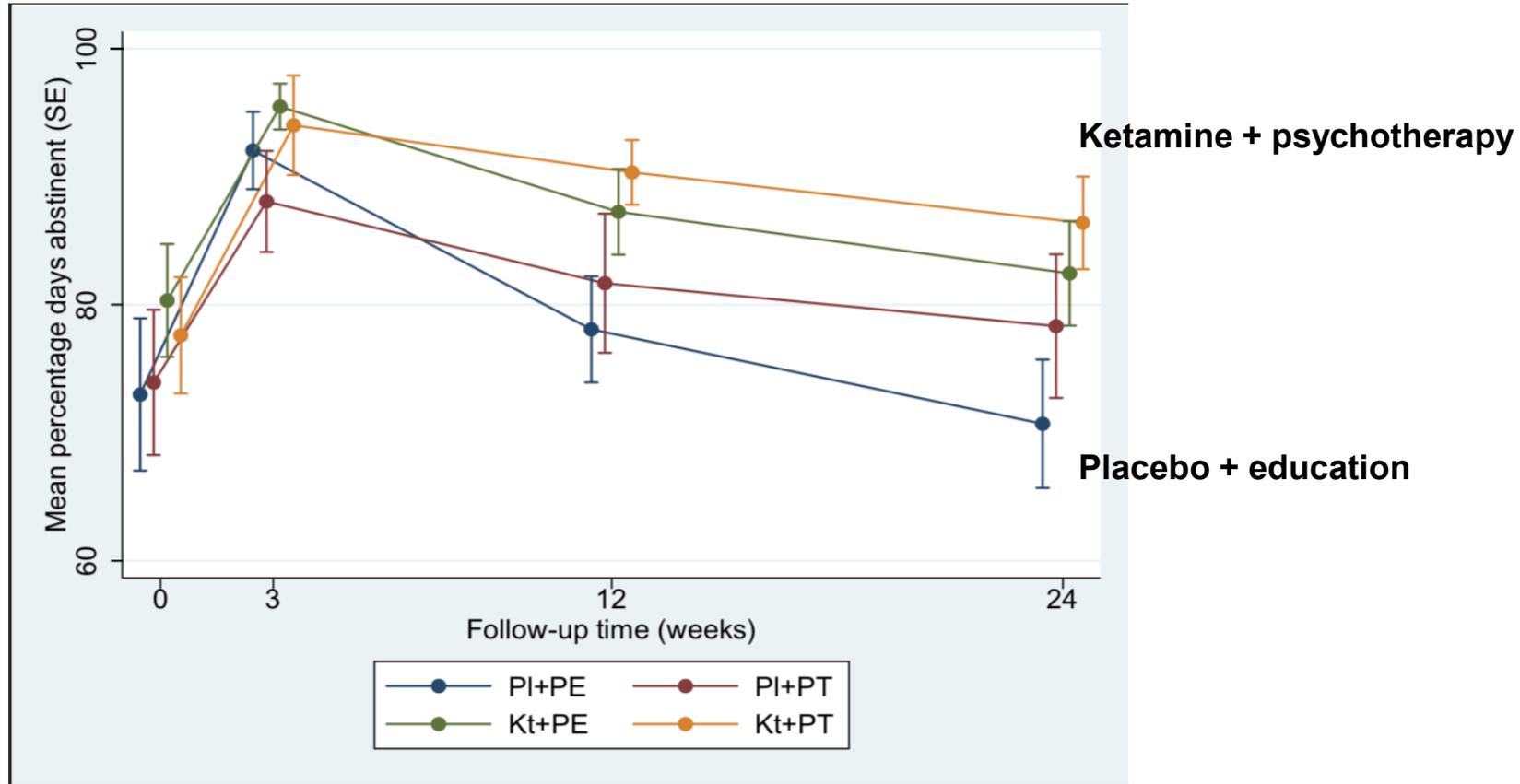
The first UK trial



KARE Trial Design

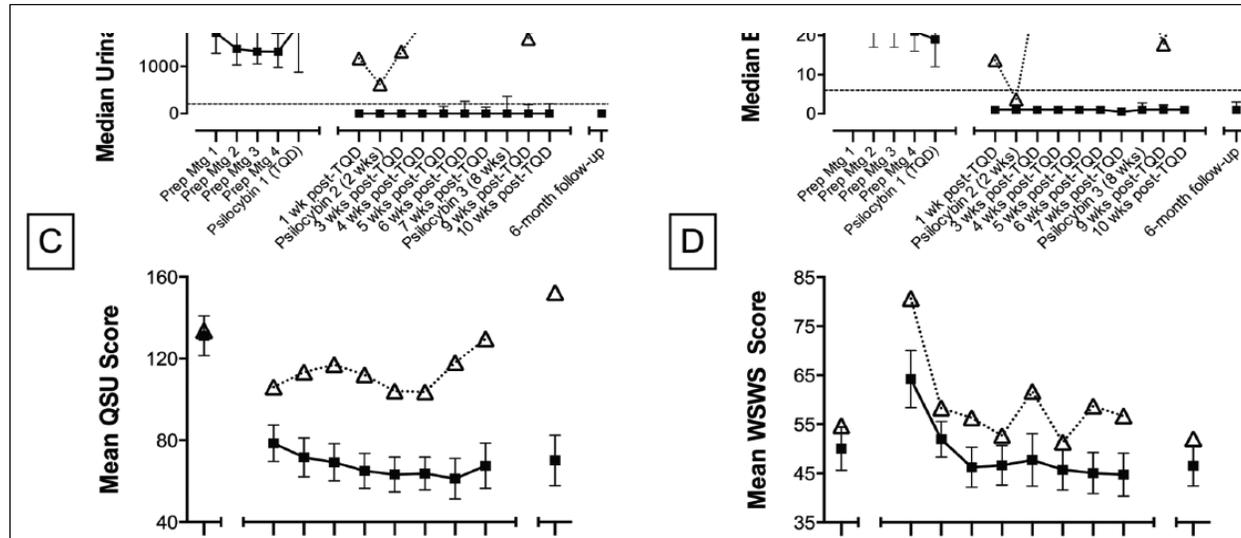


Main results: Drinking Outcomes



Psilocybin for tobacco quitting

Tobacco quitting – Johnson 2014 – J of Psychopharmacology



Johnson – unpublished data on 100 treatment-resistant smokers
1 dose psilocybin -v- nicotine patch
59% psilocybin – abstinent -v- 28 patch
Stops mood symptoms of nicotine withdrawal – no effect on physical ones
Improved cognition in oddball task = less cognitive interference = less automaticity

US National Institute for Drug Abuse now funding a new larger quitting study

Psilocybin for alcohol dependence

Percentage of Heavy Drinking Days Following Psilocybin-Assisted Psychotherapy vs Placebo in the Treatment of Adult Patients With Alcohol Use Disorder A Randomized Clinical Trial

Michael P. Bogenschutz, MD; Stephen Ross, MD; Snehal Bhatt, MD; Tara Baron, MA; Alyssa A. Forchimes, PhD; Eugene Laska, PhD; Sarah E. Mennenga, PhD; Kelley O'Donnell, MD, PhD; Lindsey T. Owens, MA; Samantha Podrebarac, MA; John Rotrosen, MD; J. Scott Tonigan, PhD; Lindsay Worth, MA

Bogenschutz et al.

295

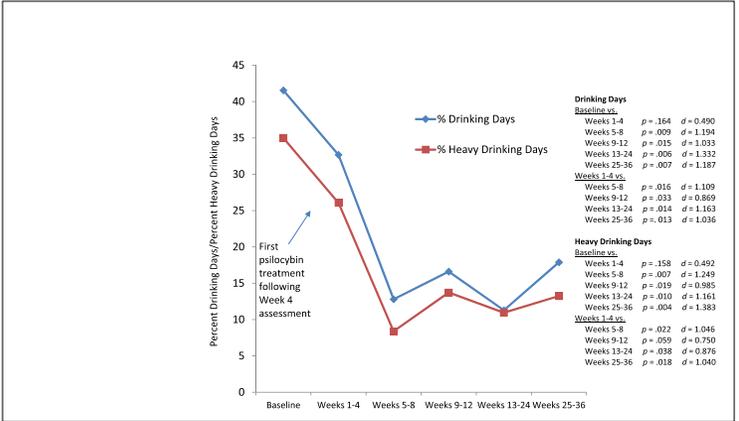
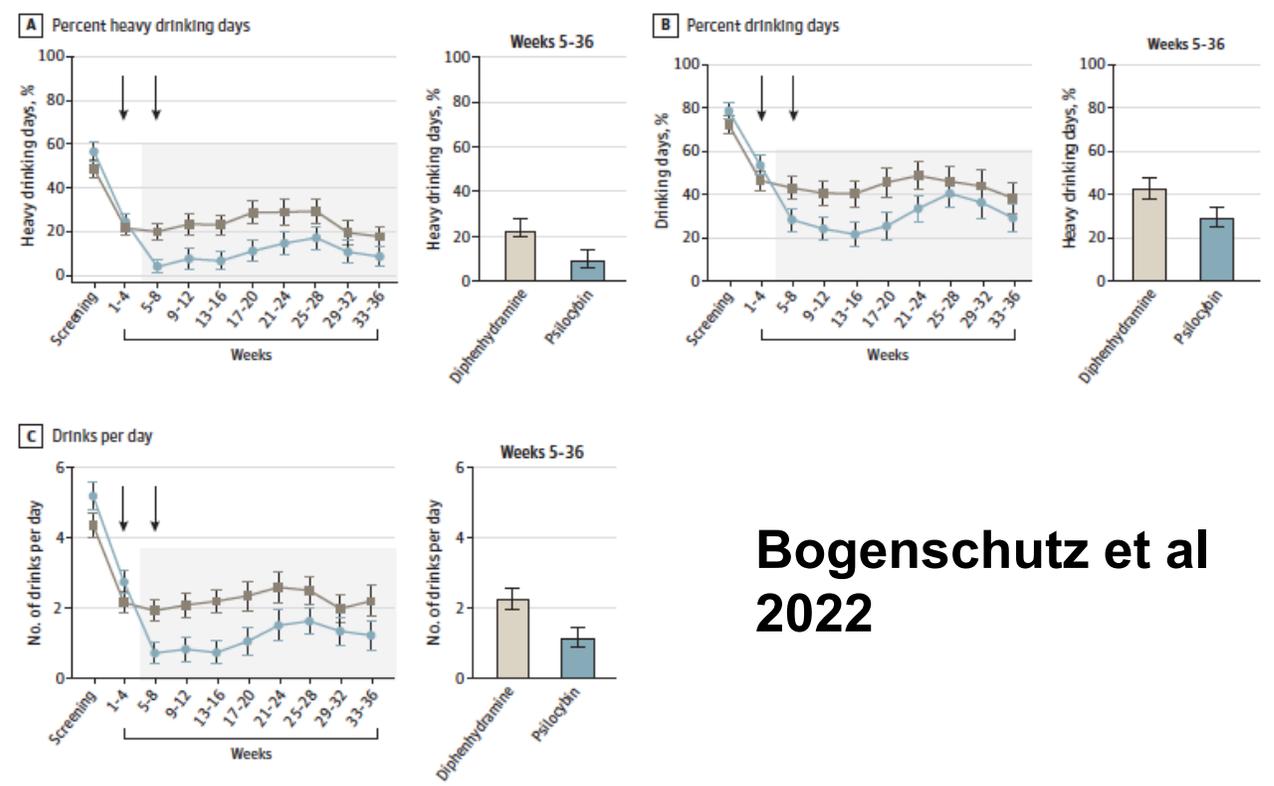


Figure 3. Drinking outcomes and effect sizes. Means shown are for all available data ($n = 10$ at baseline, $n = 9$ at all other time points). p -values are from paired t -tests ($df = 8$). Cohen's d is shown for the contrast between baseline or weeks 1-4 and each follow-up time point.

Psilocybin-Assisted Psychotherapy vs Placebo in the Treatment of Adult Patients With Alcohol Use Disorder

Original Investigation Research

Figure 2. Effects of Treatment on Continuous Drinking Outcomes



Mean (SE) estimates for screening (84 days prior to screening), weeks 1-4 (28 days prior to first double-blind medication session; covariate in the model), and eight 28-day bins following the first double-blind medication session (shaded area: weeks 5-8, 9-12, 13-16, 17-20, 21-24, 25-28, 29-32, and 33-36). Arrows represent double-blind medication sessions 1 and 2.

Bogenschutz et al
J of Psychopharmacology 2015

**Bogenschutz et al
2022**

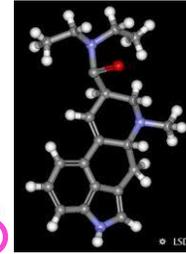
All serotonergic psychedelics are 5-HT2A receptor agonists

Affinity for the 5-HT2A receptor

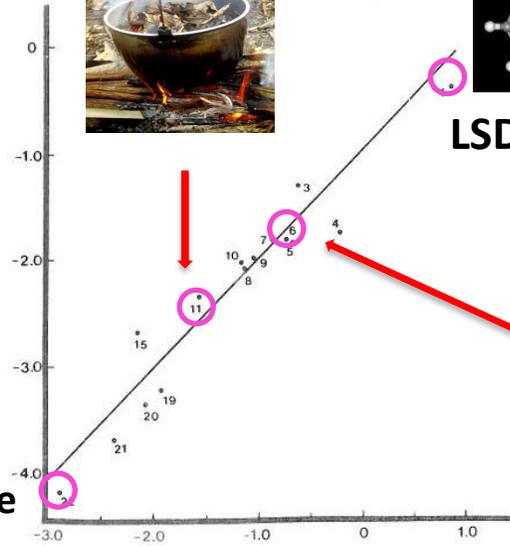


Mescaline

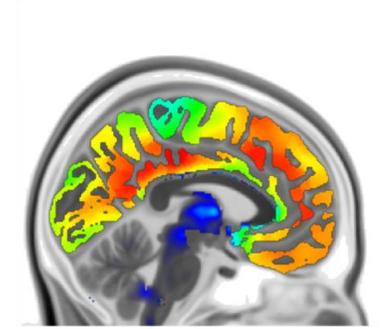
Ayahuasca/DMT



LSD



Potency in humans

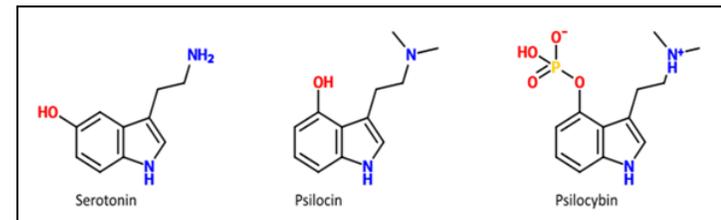


5-HT2A receptors in human brain

Psilocybin – magic mushrooms – note active ingredient is psilocin

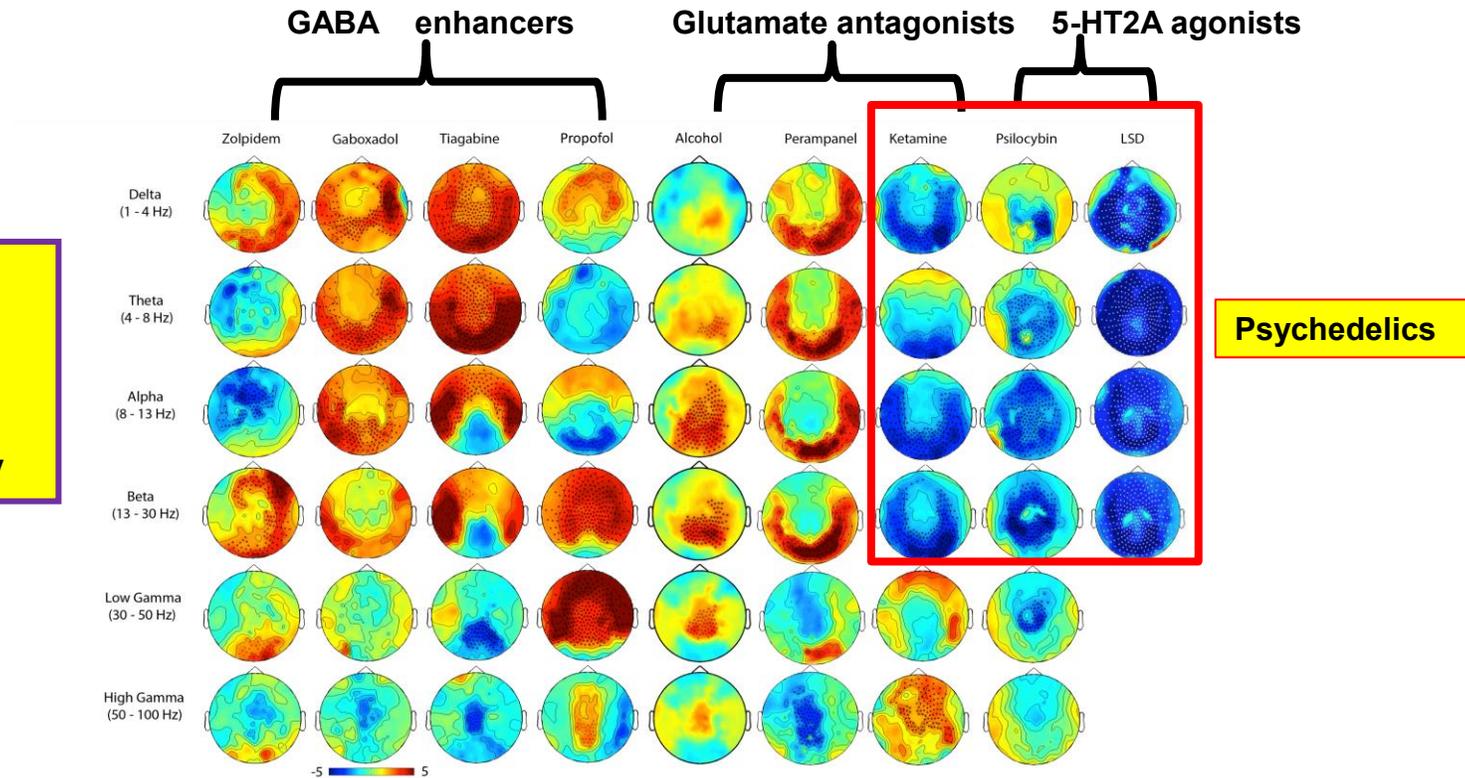


Glennon et al. 1984. Human dose data from Shulgin 1978



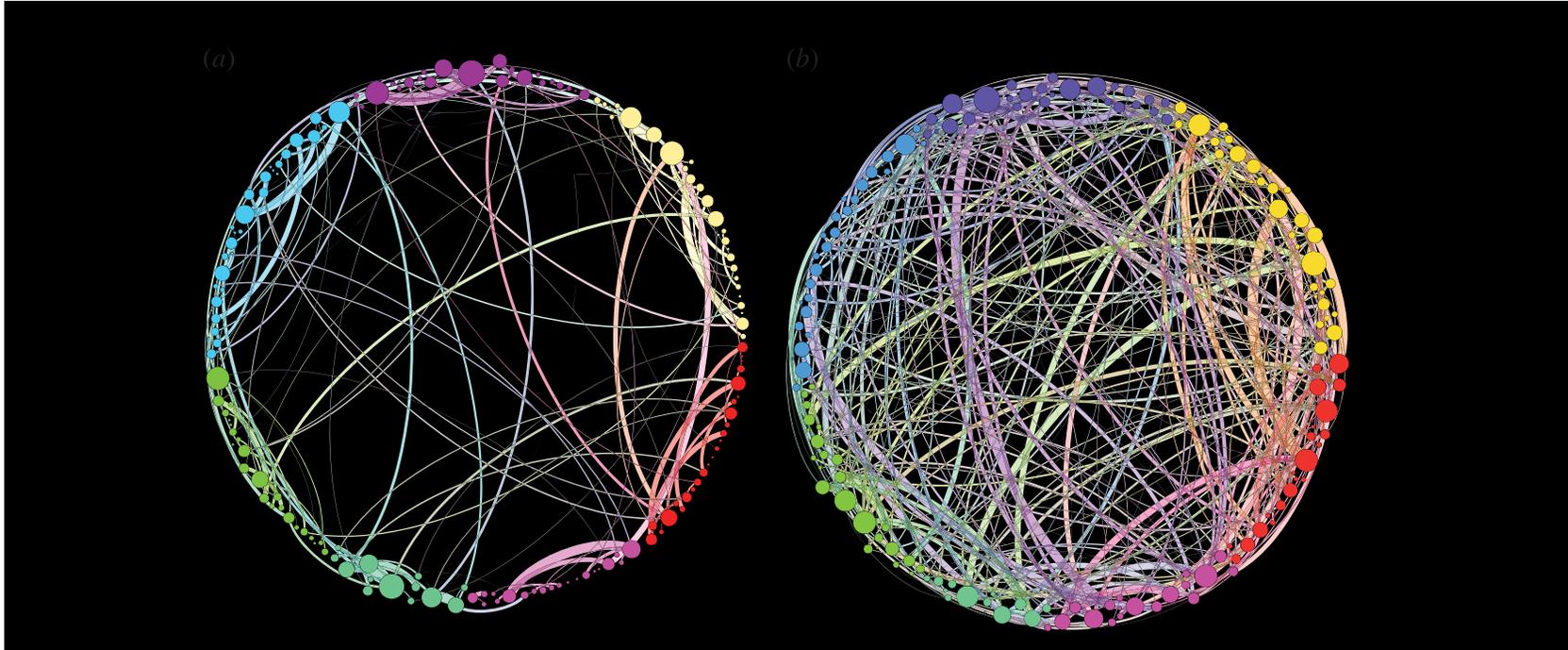
Both serotonin psychedelics and ketamine increase cortical entropy - MEG brain prints

Spectral power changes
Hot = more power = less entropy
Cold = less power = more entropy



Ketamine and serotonin psychedelics induce profound disruption of cortical rhythms

Psilocybin increases brain connectivity → new solutions to old problems?



Normal (small world brain)

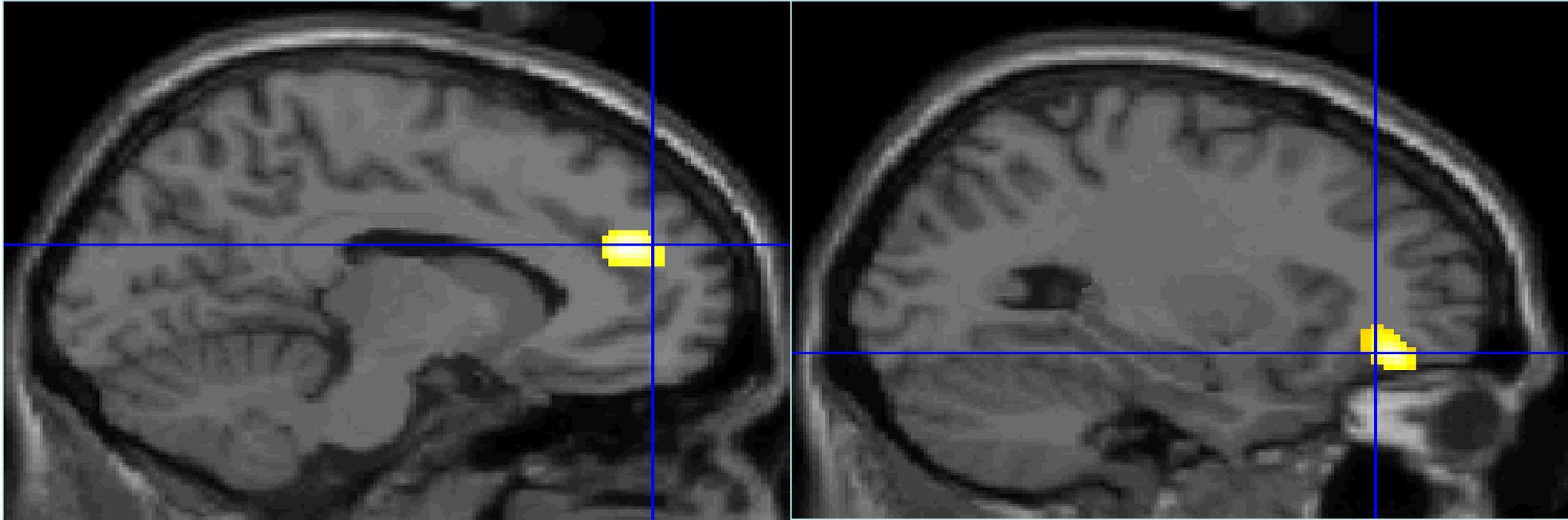
Psilocybin (open brain)

So how do these drugs work clinically?

**Theory → disrupt the brain processes
of addiction (and depression)**

**- rather than block or replicate single
neurotransmitter effects**

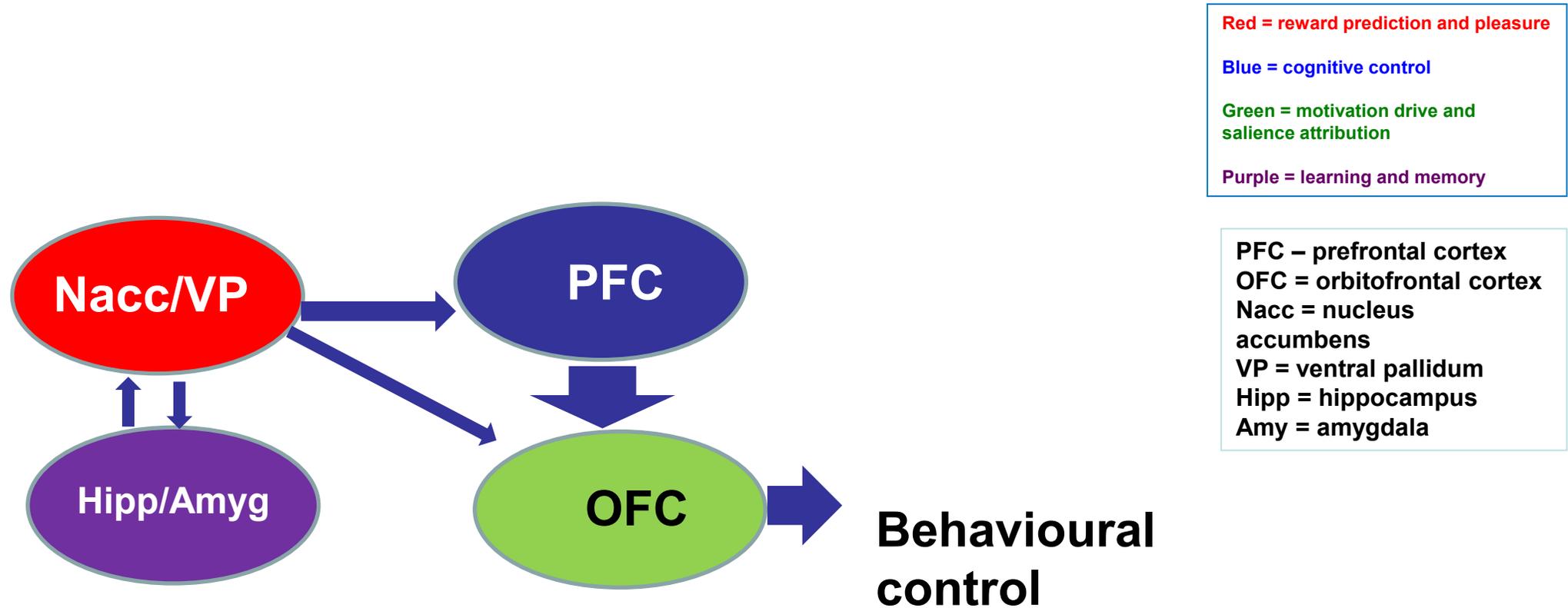
Would a focus on brain circuits do better?
All addictions share a common brain circuit



Remembering use

Urge to use

Balanced brain state – no addiction



PFC controls final decision making

Addicted brain

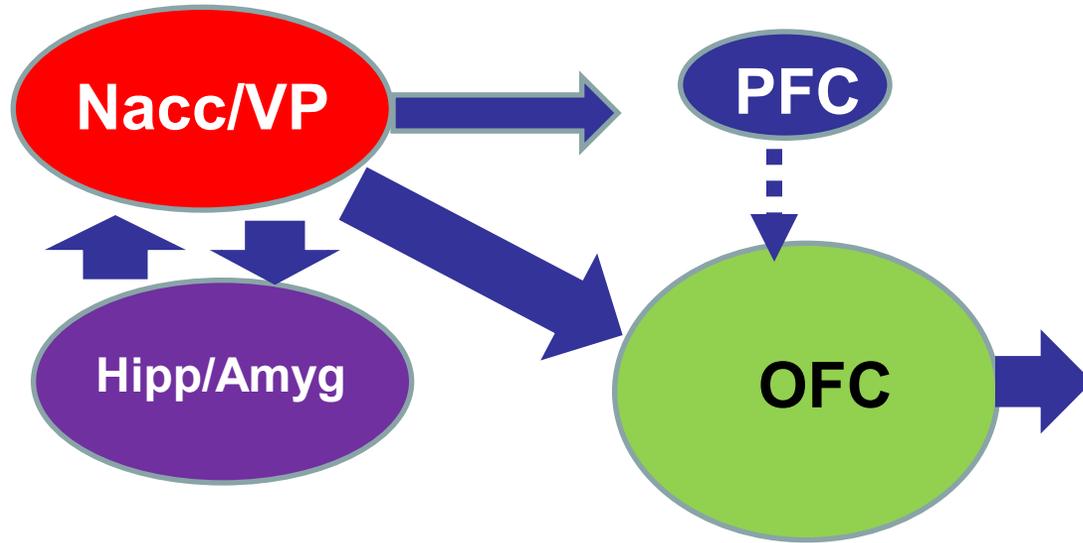
Red = reward prediction and pleasure

Blue = cognitive control

Green = motivation drive and salience attribution

Purple = learning and memory

PFC – prefrontal cortex
OFC = orbitofrontal cortex
Nacc = nucleus accumbens
VP = ventral pallidum
Hipp = hippocampus
Amy = amygdala



Go → drugs and other addictive behaviours

Excessive drives from memory and reward circuits depress PFC and enhance OFC functioning so PFC no longer controls behaviour

Enhanced connectivity between amygdala and dopamine nuclei in alcohol use disorder → excess urge → loss of control?

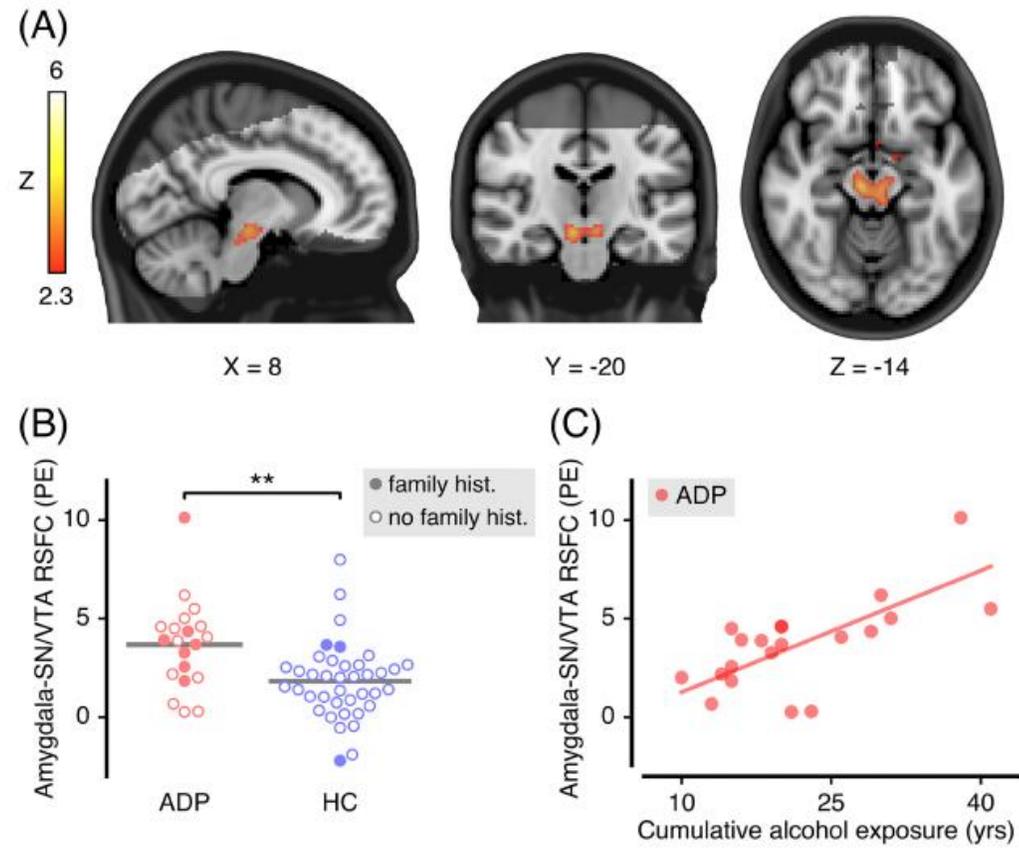
Received: 21 July 2019 | Revised: 31 July 2020 | Accepted: 5 October 2020

DOI: 10.1111/adb.12980

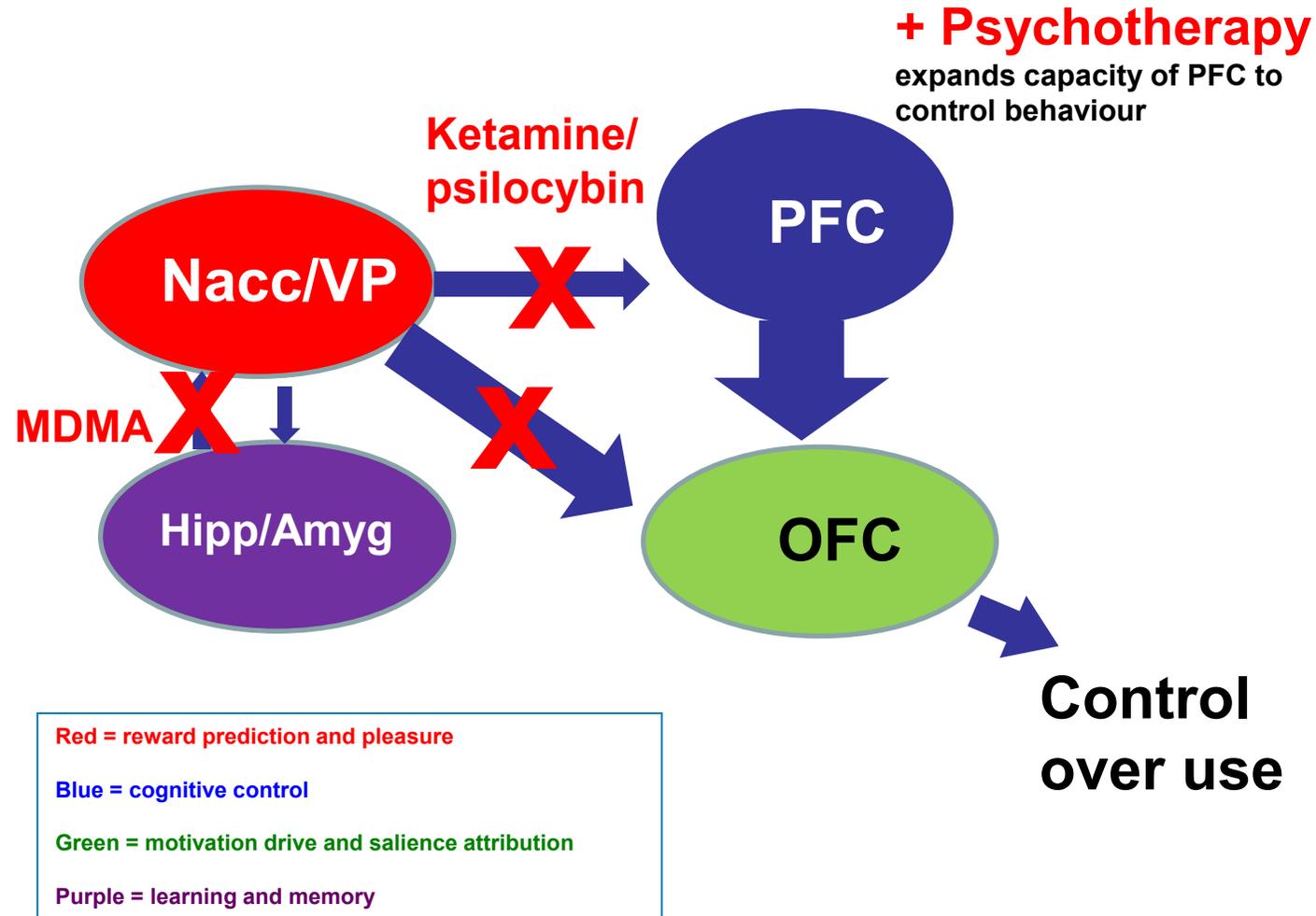
ORIGINAL ARTICLE

Chronic alcohol exposure differentially modulates structural and functional properties of amygdala: A cross-sectional study

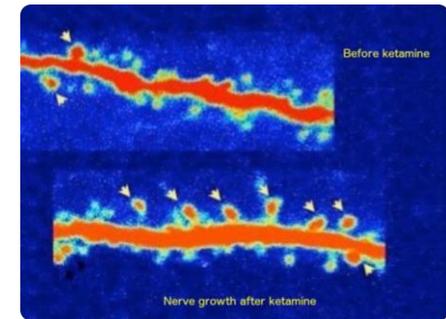
Csaba Orban^{1,2,3} | John McGonigle¹ | Remy S.A. Flechais¹ |
Louise M. Paterson¹ | Rebecca Elliott⁴ | David Erritzoe¹ | Karen D. Ersche^{5,6} |
Anna Murphy⁴ | Liam J. Nestor^{1,6} | Filippo Passetti^{1,5,6} | Laurence J. Reed¹ |
Andre S. Ribeiro¹ | Dana G. Smith^{5,7} | John Suckling^{5,6,8} | Eleanor M. Taylor⁴ |
Adam D. Waldman⁹ | Victoria C. Wing¹ | J.F. William Deakin⁴ |
Trevor W. Robbins^{5,7} | David J. Nutt¹ | Anne R. Lingford-Hughes¹ | ICCAM Platform*



Disrupting these overactive addiction circuits can restore balance in the brain



+ neuroplasticity
may facilitate new learnings



Increased synaptic spines
after ketamine

Neuroscience explains how psychedelics work in depression and addiction



The brain reconstructs the image to what it expects - or wants - to see



But always with limitations
"Man sees thro' the chinks of his cavern" William Blake 1793



Addiction

Depression

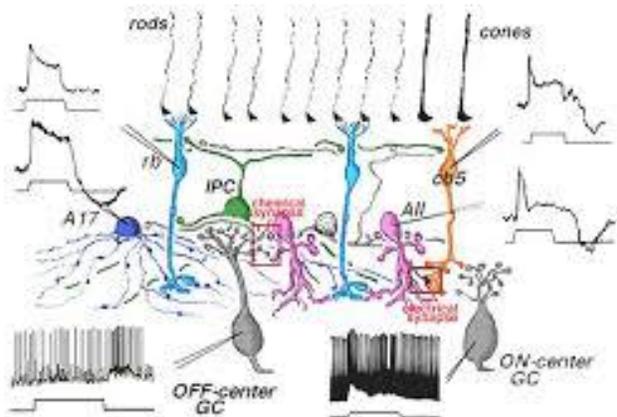
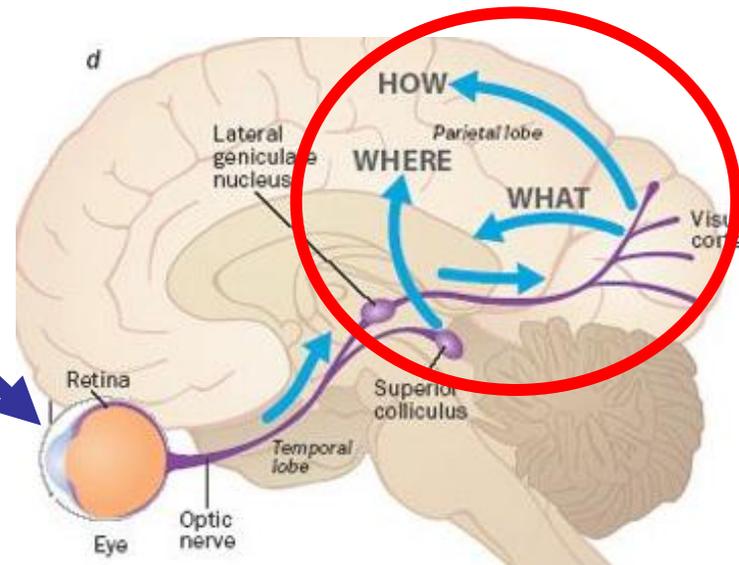
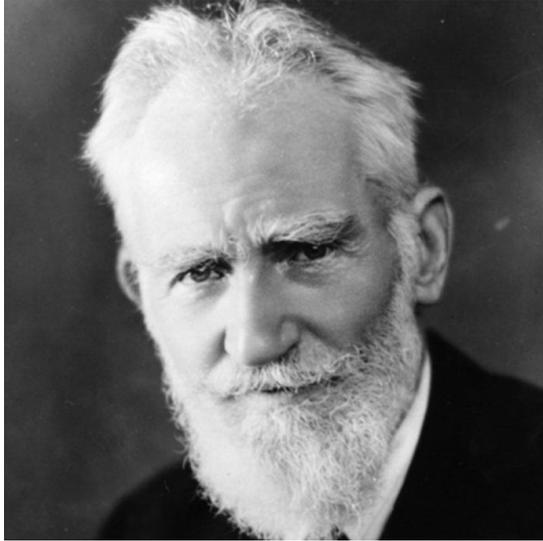


Fig. 20. Summary diagram of the rod pathway neurons and their responses. Amacrine cells intervene between rod bipolar and ON and OFF-center ganglion cells.

Humans make "mind-forged manacles" also William Blake

A psychedelic experience can break these.....like they did for Bill Wilson

“Those who cannot change their minds cannot change anything”



George Bernard Shaw
(1856-1950)

The Scales of Justice being built

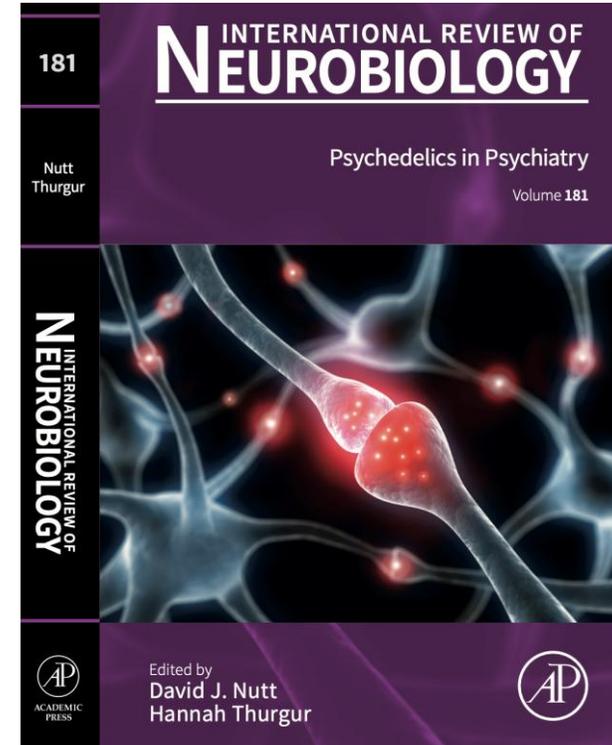
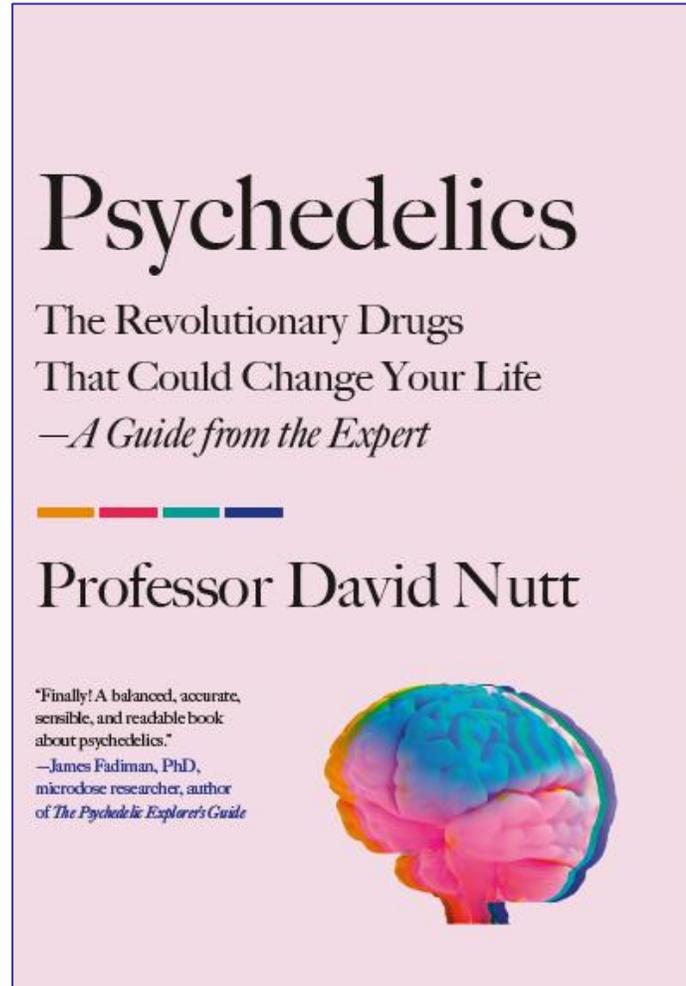
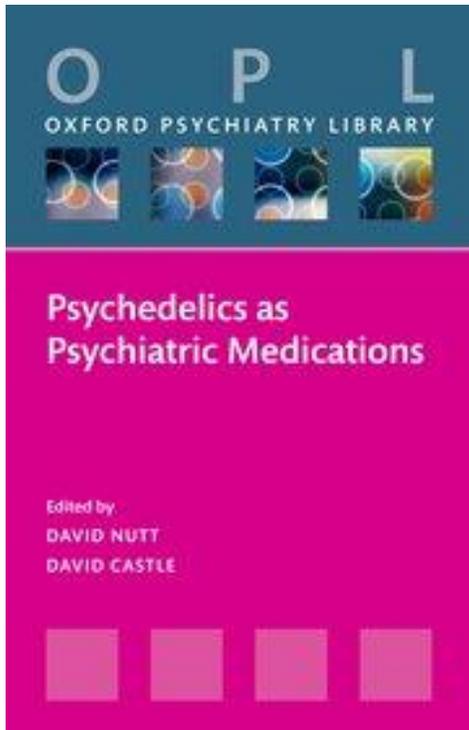


**Time now to apply too
psychedelics!**

**Treatment with psychedelics such as ketamine and psilocybin has changed the minds of our patients
→ through changing their brains**

**We hope that this research can now change the public and politicians' minds and bring those still
controlled under the UN Conventions back into medical practice**

If you want to change (or confirm) your mind?



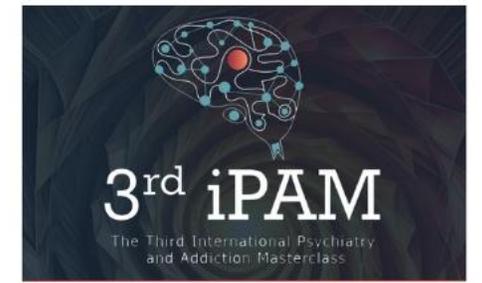
Acknowledgements and questions



**Alexander Mosley
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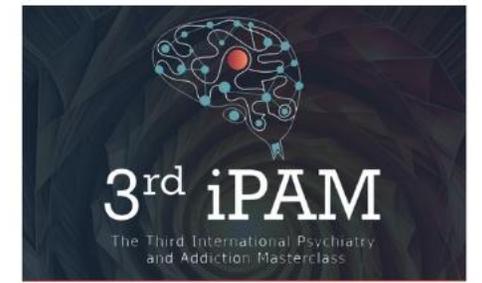


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Closing Remarks



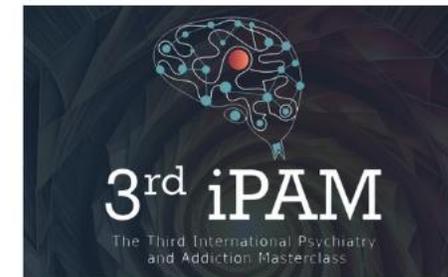
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University, Liverpool- UK
Chair, PAIN Charity- UK



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