

CATEGORY I – CLINICAL PRESENTATIONS: SUBSTANCE MISUSE IN PSYCHIATRY

1.0 Introduction

Patients suffering from comorbid psychiatric illnesses as well as substance misuse are likely to demonstrate poor compliance with treatment, unplanned discharge from care, relapse and rehospitalisation, and death from accidents, injuries, accidental overdose and suicide. They may experience pain, infection, injury and cancer. This group may also be characterised by homelessness, deprivation, unemployment, crime and violence; their early years are often disturbed; these patients may present to any sector of the health care services as well as to social and welfare services such as education, housing, social work and the criminal justice system. Even though this group have multiple vulnerabilities, their substance problems are often missed. A very frequent reason that substances are misused is for their psychoactive effect. Consequently it is essential to have a low threshold of suspicion for substance misuse in any psychiatric assessment.

About 40% of people with psychosis misuse substances at some stage in their lifetime. This is at least double the rate seen in the general population. Those with co-existing mental health and substance misuse problems have a higher risk of relapse and hospitalisation (NICE, 2011).

LEARNING OUTCOMES

Medical students will recognise that:

- Co-occurring mental health and substance problems are very common in the health care setting; where one is present, the other often coexists.
- Knowledge about screening and assessment for these complex disorders is a core part of undergraduate training.
- There are serious social, psychological and physical causes and complications resulting from combined mental health and substance problems.
- Working and training with other professional groups in NHS and non-statutory agencies is necessary to provide continuity of care as these conditions are often long term.
- Interventions can be effective.

- The cost of caring for people with combined disorders is higher than for those with a single condition due to the multiple medical and social complications.
- People with multiple conditions often do not receive the full range of care they need because of the limited service provision, poorly coordinated care and stigma. Patients with substance misuse should not be excluded from any service because they are substance misusers. They deserve treatment for co-existing mental health problems such as psychosis, depression and anxiety and other psychiatric disorders from the appropriate service.

2.0 Context

- Co-existing mental illness and substance use problems (also classified as mental illnesses) may affect between 30-70% of patients presenting to mental health and social care settings.
- Approximately 75% of patients attending drug services, and 85% of patients attending alcohol services, suffer from mental illness.
- About 40% patients attending mental health services have used drugs and alcohol.
- Alcohol and drug misuse in psychotic patients is reported in between 1/5 and 1/3 of patients in mental health settings and in between 1/20 and 1/6 in addiction services.
- Anxiety and depression are the most common conditions associated with substance misuse

Vignette One

A 55 year old woman taken on for home based treatment presented with distressing tactile and auditory hallucinations. The woman and her husband were both habitual cannabis users. They consistently reported no change to their supply or the amount being used, but the couple were always vague about the actual amount used on a daily basis and this was never clarified.

Six weeks prior to the sudden onset of her psychotic symptoms, a new GP had significantly (and suddenly) reduced the woman's long standing diazepam prescription from 30mg daily to 5mg daily.

Possibilities as to the cause of her sudden onset of psychosis were – diazepam withdrawal, (understood to be uncommon and she had no other symptoms suggestive of this) or cannabis induced psychosis (common cause of psychosis, but why now in a very habitual and routine user?). The other possibility for a new presentation at this time of life was a new onset organic cause and nothing to do with her substance use or a switch to one of the newer forms of cannabis such as skunk, which has a much greater psychoactive effect.

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Vignette Two

A 42 year old man was referred by his general practitioner to the community alcohol team for alcohol dependence and this was considered to be due to insomnia and pain. He suffered from hypertension. He lived on his own. His only brother had died recently. He had drunk heavily in his late teens, and following a period of controlled drinking in his 20s and early 30s his alcohol use had escalated when his wife was diagnosed with post-natal depression. His children had had to be taken into care for a period. He had had no periods of abstinence for 10 years. He found alcohol helped his insomnia. At times he felt depressed. He had previously also been under the care of psychiatric services and had been diagnosed with depression when he had been prescribed psychological therapy and antidepressant medication for about a year. His general practitioner had begun a course of antidepressant medication prior to referral to the community alcohol team. The community alcohol team engaged him in regular motivational interviewing sessions and he completed inpatient detoxification. His mood improved whilst he was an inpatient and he was discharged with a follow-up plan for relapse management and monitoring his mood disorder. He appeared to maintain abstinence initially, but in time destabilised and was discharged from services. After some time, his family encouraged him to attend outpatient appointments and would have liked him to undergo another detoxification. His general practitioner continued to be concerned about his alcohol dependence and depression as he thought he was at a high risk of suicide. He admitted that he wanted to continue to drink.

Vignette Three

A young woman who was 25 years old appeared in a distressed state at her general practitioner's surgery. She presented as being rather distracted, tearful, agitated and fearful. She was requesting tranquillisers to help her. She lived with her partner and worked for an advertising company. She had been feeling out of sorts for some months complaining of tension and nervousness. She was having difficulty concentrating and could not complete an assignment. She had been prescribed a short course of benzodiazepines but since this had ended she increasing found herself taking whatever she could get her hands on through friends, family, the chemist and internet. She was unclear as to exactly what and how much she had been taking. She had obtained some benzodiazepines she thought, as she had felt calmer once she took them. However, she thinks she might have had some antidepressant medication and even some 'legal' highs. She denied knowingly taking other illicit drugs such as cocaine or amphetamines or opioids. Occasionally she had drunk alcohol which helped her feel more relaxed. She was not confused but was tremulous and sweaty. The last time she had had anything was a few hours prior to the consultation.

- What further questions would you ask her?
- What further information do you need to obtain?
- What advice would you give her?

3.0 Common presentations and risks

Including special / distinctive features and barriers to detection, recognition and access.

There are several ways in which psychiatric disorder and substance problems may be associated: the mental illness may precipitate substance misuse (e.g. a depressed person wishing to alter their depressed mood by taking cannabis or alcohol); or a substance misuse problem may precipitate a mental illness (e.g. chronic alcohol dependence leading to depression; cannabis use leading to an episode of psychosis); or there may be no identifiable link (sometimes, people use drugs because they like them).

3.1 Special/distinctive features

- Patients can present with very complex problems, and are often highly vulnerable. For example they may present with suicidal ideation, victimisation, deprivation, poor physical self-care and suspiciousness of services. They may appear to be "difficult" or "hard to help". Simply managing to engage them in a meaningful conversation is a good place to start.
- Substance use (e.g. to the point of intoxication), misuse, harmful use and dependent use (e.g. withdrawal) may lead to or exacerbate a mental health problem, a physical health problem (e.g. pain), and social functioning.

3.2 Barriers

- Patients may experience prejudice and stigma and this may be a barrier to accessing services.
- There may be a lack of services skilled and equipped to manage patients with complex mental health and substance misuse problems.
- The mental health condition in itself is a barrier to access and patients may not engage easily with services, may not maintain contact and may drop out of contact, and find regularity of appointments and treatment a challenge.
- Non-adherence to prescribed medication may exacerbate illnesses and make health and social interventions less effective.
- Social isolation and exclusion, makes access more precarious.
- Some patients will try to conceal either one or both of their conditions.

4.0 Assessment

A thorough assessment is fundamental to achieving the best possible outcome for patients. Thus, the protocol outlined in the factsheet on Assessment should be followed. Mental state findings should be interpreted in the context of these possibilities too. Physical examination and collateral information should include sensitively seeking out further details about the extent of use/ complications of use. The use of investigations, such as urine drug screen and breathalyser, is an important part of assessment. Poly-substance misuse is the rule, rather than the exception, so always ask about other drugs and alcohol as well as prescribed drugs (and how they are obtained and taken) and medication bought in pharmacies and over the internet. Most

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patients, if they have a problem with one substance, will almost always have a problem with at least one other substance as well. Those who present for substance misuse treatment or those who present for treatment of another psychiatric illness are likely to have the other as a comorbidity. Thus the safest "start point" is to assume the presence of an additional disorder until you have excluded it: most patients with substance misuse disorders requiring treatment will have another mental illness; many patients with mental illness will have a substance misuse disorder.

The most serious and potentially life threatening complications of drug and alcohol use which can be part of the presentation should definitively considered and addressed – i.e. delirium tremens, Wernicke's encephalopathy, overdose, severe benzodiazepine withdrawal. Differentiating between delirium and abnormalities of the mental state due to psychiatric disorder or intoxication with one or more substances is not easy. It is very important to exclude delirium, which is – in patients with and without psychiatric illness of any sort – a medical emergency.

The assessment process may take several appointments to complete if the patient finds it difficult to concentrate. It is also important to obtain information from other agencies involved in care to build up an understanding of the patient's needs. If there is doubt about mental capacity, assessment of mental capacity should be made in relation to each decision. These principles should apply whether or not people are being detained or treated under the Mental Health Act (1983; amended 1995 and 2007). The Mental Health Act is currently undergoing review.

The use of brief screening tools such as AUDIT and DAST will be useful to identify the severity of drug and alcohol use.

It is important to consider:

- Assessment and re-assessment of the patient over time is needed as after time presentations can change depending on the quantity of substances used, access to substances of abuse, the development of withdrawal symptoms, and this should be communicated to other service providers.
- Whether the symptoms of intoxication and withdrawal may account for some of the problems. The substance being misused having a direct psychoactive effect which may be a prominent feature of the presentation in a psychiatric assessment. The psychoactive effects of the substances being used may be a consequence of:
- Acute intoxication (e.g. a toxic psychotic effect with paranoia in a prolonged binge of crack cocaine).
- Withdrawal from the substance e.g. delirium tremens in alcohol withdrawal; depressed mood with the cocaine "crash"
- Chronic effects of regular use e.g. relationship between alcohol use and memory dysfunction
- To what extent the presenting symptoms are caused by or consequent upon substance use or mental or physical

illness. It is not always straightforward to establish the direction of causality.

- That the assessment is part of engagement, which is the most important outcome, and without which no further intervention can be implemented.
- Assessment and re-assessment of the patient over time presentations can change depending on the quantity of substances used, access to substances of abuse, the development of withdrawal symptoms, and this should be communicated to other service providers.
- Assessment of risks attributable to drug and/or alcohol use and misuse and incorporate this into the management plan.
- Collaboration with other services, and corroboration of information with other sources including carers, family and other services. This will require negotiation regarding confidentiality and sharing of information between the patient and their family, carer or a significant other and other services.
- Physical examination of the patient

It is essential to formulate the case and attempt to understand the chronology of the combined disorders though at times it is very hard to obtain a neat cause-and-effect chronology, so that the important problems can be prioritised and resolved. Potentially life-threatening medical emergencies such as suicidal intent, delirium tremens, Wernicke's encephalopathy and chaotic life style using multiple medications, require urgent hospital admission.

Ensure that all psychiatric assessments include a systematic enquiry and consideration of any possible substance misuse. It is very easy for the role of psychoactive substances to be overlooked otherwise. The patient's response to screening questions (or anything else) that suggests drug or alcohol use should lead to a detailed drug and alcohol history. All questions should be asked in a non-judgemental, empathic and non-confrontational manner – this can help with developing a therapeutic relationship and facilitate disclosure. Actively look out for the possible interactions and patterns that can occur.

5.0 Treatment

Drug and alcohol use can lead to almost any psychiatric disorder. The most commonly associated are anxiety, depression, personality problems, psychosis and memory problems. Other disorders such as Post traumatic Stress Disorder (PTSD), eating disorders, and Attention Deficit Hyperactivity Disorder (ADHD), can be associated with substance problems. Thus, the key is to understand the relationship of the presenting mental state, and past history of mental illness and substance use, in order to determine what the co-occurring disorders might be. There may be more than one substance disorder and more than one psychiatric disorder. In addition, physical disorders should not be ignored. The first objective should be to engage the patients into the service in either a goal in reduction of abstinence in the treatment plan as this will reduce the psychiatric illness or psychological symptomatology (Crome, 2009).

Key elements of treatment include

- Providing practical support to respond to basic social and physical health care needs.
- Engagement into the service and building up trust and rapport.
- Pharmacological interventions to treat the substance use disorder (where indicated) and the mental health disorder.
- Psychosocial interventions to support pharmacological approaches (motivational interviewing, cognitive behavioural approaches, contingency management).
- Relapse prevention and recovery planning to reduce / avoid returning to using substances again.

Before starting treatment for adults and young people with psychosis and co-existing substance misuse, review:

- The diagnosis of psychosis and of the coexisting substance misuse, especially if either diagnosis has been made during a crisis or emergency presentation and the effectiveness of previous and current treatments and their acceptability to the person. Discontinue ineffective treatments. (NICE, 2011)

The pharmacological and psychological treatment interventions should follow that for each diagnosis e.g. substance use disorder, mental health problems and physical disorder.

There are a range of interventions that can be implemented with the family such as motivational interviewing, group or individual cognitive behavioural work and contingency management.

The set of NICE guidelines (<http://www.nice.org.uk/Guidance/Health-protection/Drug-misuse>) on the treatment of drug and alcohol misuse, and substance misuse and psychosis, and the British Association of Psychopharmacology guidelines, provide detailed guidance. (Linford-Hughes *et al*, 2012)

In general, it is advisable that patients be detoxified or stabilised in the first instance. Once their substance use has decreased or ceased, the patient can be assessed after 4-6 weeks for symptoms of mental illness. Many of the signs and symptoms of mental illness overlap with those of intoxication and withdrawal. Where a patient is suicidal, clinical judgment will have to determine whether the treatment has to be initiated as a matter of urgency by admission to a psychiatric inpatient unit.

There are some pointers to consider:

- The treatment plan may need to be implemented over a lengthy period.
- Crisis should be managed or pre-empted if possible and allowance should be made for the often chaotic life styles of these patients.
- Particular groups have special needs e.g. older, younger, pregnant, homeless users, prisoners, refugees and asylum seekers
- Availability and accessibility of local services is a necessary component for coordination of treatment.
- Comprehensive facilities are likely to reduce relapse and rehospitalisation, by improving treatment adherence and recovery.

- Regular review, proactive engagement with carers, training and supervision of staff are all features of services which can minimise risks.
- In dependent users, alcohol or benzodiazepine withdrawal may well require substitute prescribing and controlled withdrawal.
- Attempting to address cigarette smoking in those who have a comorbid mental illness is worthwhile as those with mental illness are just as able as those without to make use of smoking cessation activities.

6.0 Referral/networks/services

Patients and carers require social and healthcare support. A coordinated approach to addressing comorbid psychiatric and substance use disorders is advised. Co-treatment of the co-occurring disorders is necessary. Treating one in isolation from the other is unlikely to be successful.

Referral for specialist advice and input needs to be considered, particularly when the risk assessment highlights concerns about problematic substance use, when the patient is pregnant, and /or dependence is evident.

7.0 References and useful resources

- Crome I. *et al* (2009) SCIE Research briefing 30: The relationship between dual diagnosis: substance misuse and dealing with mental health issues. Social Care Institute for Excellence, London
<http://www.scie.org.uk/publications/briefings/briefing30/>
- Department of Health 2017 Drug Misuse and Dependence Guidelines on Clinical Management <https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management>
- Findings (2014) Authoritative review reveals limitations of medicating dependence
http://findings.org.uk/count/downloads/download.php?file=Lingford_Hughes_AR_2.txt
- Hayes R, C. *et al* (2011) Associations between substance use disorder sub-groups, life expectancy and all-cause mortality in a large specialist mental healthcare service. *Drug and Alcohol Dependence* 118(1): pp 6-61. doi: 10.1016/j.drugalcdep.2011.02.021.
- Hohmann N M., Mikus, G. and Czock, D (2014) Effects and risks associated with novel psychoactive substances. *Dtsch Arztebl Int* 111 pp139-47
<https://www.ncbi.nlm.nih.gov/pubmed/24661585>
- Lingford-Hughes, *et al* (2012). BAP updated guidelines: evidence based guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity: recommendations from BAP *Journal of Psychopharmacology* 1-54
http://www.bap.org.uk/pdfs/BAPaddictionEBG_2012.pdf
- Marta Di Forti M, *et al* (2015) Proportion of patients in south London with first-episode psychosis attributable to use of high potency cannabis: a case-control study. *The Lancet Psychiatry*, Vol. 2, No. 3, p233-238
- NICE - Drug Misuse - all NICE guidance, pathways and quality (16 items) Standards <https://www.nice.org.uk/Guidance/Health-protection/Drug-misuse>
- PHE (2017) Guidance - People with co-occurring conditions: commission and provide services <https://www.gov.uk/government/publications/people-with-co-occurring-conditions-commission-and-provide-services>
- NICE (2011) Psychosis with coexisting substance misuse, Assessment and management in adults and young people. NICE clinical guideline 120
<https://www.nice.org.uk/guidance/cg120>
- Royal College of Psychiatrists (2002) Co-existing problems of Mental disorder and substance misuse (dual diagnosis)
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- Schifano *et al* (2015) Novel Psychoactive Substances of interest for Psychoactive Substances of interest for psychiatry *World Psychiatry*; 14: p15-26.

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SUBSTANCE	INTOXICATION	WITHDRAWAL
Alcohol	<ul style="list-style-type: none"> Disinhibition Argumentativeness Aggression Mood lability Impaired judgement and attention Decreased level of consciousness 	<ul style="list-style-type: none"> Craving Agitation Insomnia Convulsions Malaise Visual, auditory or tactile hallucinations Craving
Opiates	<ul style="list-style-type: none"> Apathy Sedation and drowsiness Impaired attention and judgement Decreased level of consciousness Psychomotor retardation 	<ul style="list-style-type: none"> Restless sleep Craving Fearfulness and general discomfort due to unpleasant physical symptoms
Cannabis	<ul style="list-style-type: none"> Euphoria and disinhibition Anxiety and agitation Suspiciousness and paranoid ideation Impaired judgement and attention Hallucinations Depersonalisation and derealisation 	<ul style="list-style-type: none"> Anxiety Irritability Sweating
Nicotine	<ul style="list-style-type: none"> Insomnia Bizarre dreams Fluctuating mood Derealisation Sweating 	<ul style="list-style-type: none"> Craving Malaise or weakness Anxiety, irritability or moodiness Insomnia Increased appetite Difficulty in concentrating Palpitations
Stimulants	<ul style="list-style-type: none"> Euphoria and increased energy Hypervigilance Grandiose beliefs and actions Paranoid ideation Repetitive stereotyped behaviours Abusiveness, argumentativeness and aggression Auditory, tactile and visual hallucinations Agitation Sweats Convulsions Palpitations 	<ul style="list-style-type: none"> Lethargy Psychomotor agitation or retardation Craving Insomnia and hyperinsomnia Bizarre and unpleasant dreams

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Effects and risks associated with novel psychoactive substances (Hohmann et al 2014)	
Synthetic cannabinoids	Agitation Hallucinations Anxiety/panic attacks Confusion Psychosis Aggressive behaviour Delusions Anterograde amnesia Headache Irritability Loss of consciousness Somnolence Convulsions Palpitations
Synthetic cathinones	Agitation Aggression Hallucinations Confusion Anxiety Insomnia Anhedonia Depression Anorexia Panic attacks Suicidality Psychosis