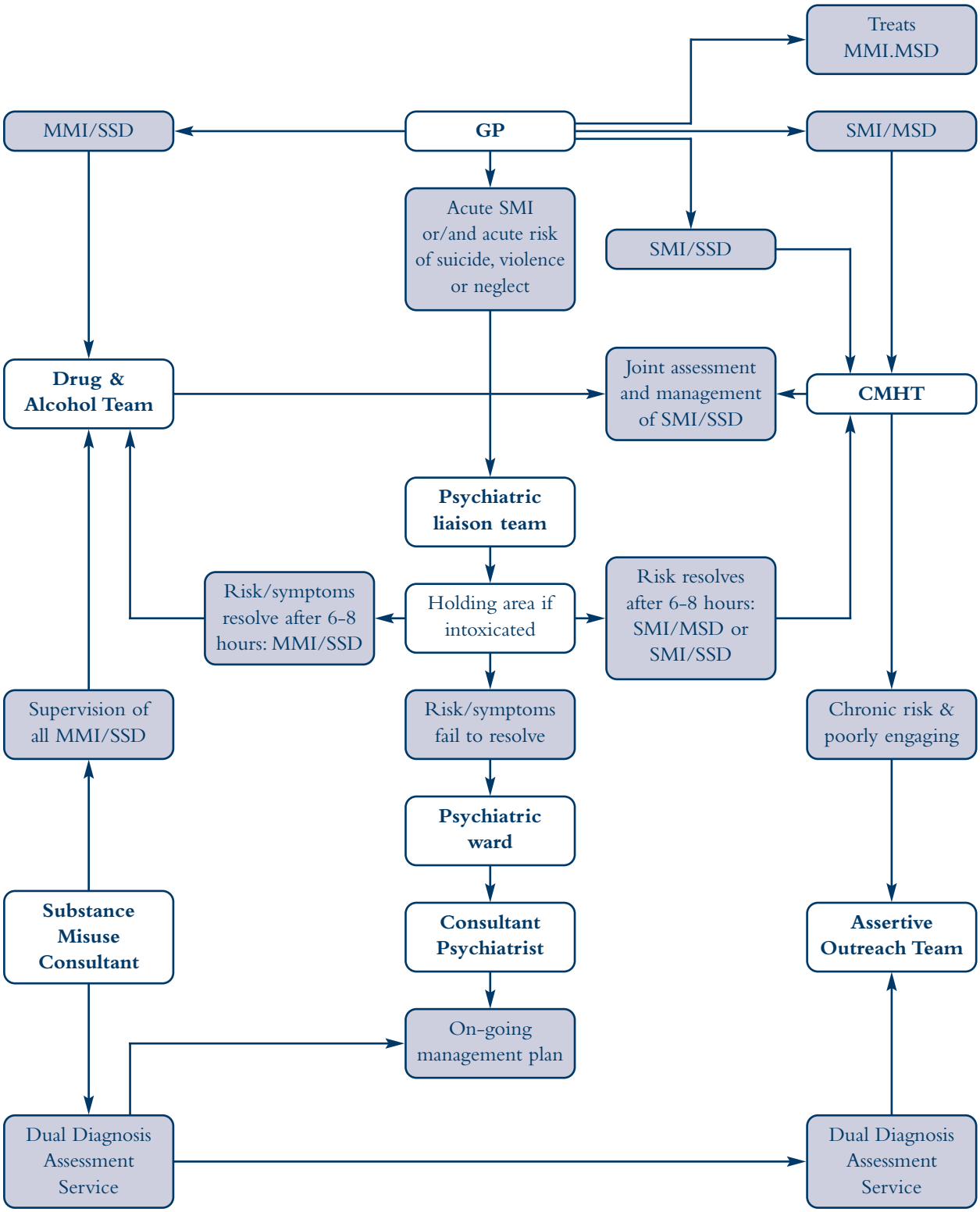
MENTAL DISORDER AND SUBSTANCE MISUSE DISORDER

The diagram below represents a model for allocation of responsibility and referral for patients with a dual diagnosis.



MMI: Minor Mental Illness, **MSD:** Minor Substance Disorder,
SMI: Severe Mental Illness, **SSD:** Severe Substance Disorder

TREATMENT PRINCIPLES

Most psychiatric symptomatology occurring in substance misusing individuals is causally related to the use of substances. Whilst in the longer-term treatment of the substance misuse disorder holds the most promise for the prevention of further episodes of psychiatric symptomatology, in the immediate term psychiatric symptoms may still be amenable to treatment with the usual psychotropic medications and other management techniques used in the treatment of primary mental illness. Acute psychiatric symptomatology should thus always be assessed for its treatability and treatment commenced when appropriate. This is especially the case for psychotic symptoms and suicidality. Substance-induced mental illness may be precipitated by intoxication with a substance, withdrawal from a substance, or due to delayed effects of the substance working through a mechanism of neuroadaptation.

- Formulate a working differential diagnosis.
- Treat acute symptoms which are threatening to the patient and/or others.
- If symptoms have resolved and the patient is discharged to the community from the holding area, refer to the Community Drug and Alcohol Team for assessment.
- If symptoms did not resolve during the holding period and the patient has been admitted to a general psychiatric ward, refer to the Community Drug and Alcohol Team for an opinion.
- Use indicated psychotropic medications if symptoms persist and impair function or recovery.
- Following resolution of disabling psychiatric symptoms, discontinue psychotropic medication and observe the patient's response in an illicit drug-free environment.
- Refine the diagnosis.
- Formulate the long-term management plan based on definitive diagnosis where possible.

STAGE 1

Formulate a working differential diagnosis.

In the acute presentation, it will usually be impossible to accurately differentiate between a primary psychiatric illness, a substance-induced mental disorder, or mere psychiatric symptoms occurring as a result of acute intoxication or withdrawal. These three possibilites should form the major part of a working differential diagnosis in the first instance.

STAGE 2

Treat acute symptoms which are threatening to the patient and/or others.

The existence of addiction does not diminish the dangerousness of psychotic symptoms or suicidality. Symptomatic treatment should be provided as in any other case where addiction is not a component. The one significant difference in evaluating the acute drug-involved patient is the use of a **safe holding area** as opposed to formal admission to a ward, as acute symptoms may resolve rapidly (hours) if they are solely intoxication-induced. Most substances frequently associated with intoxication-induced psychiatric symptoms have relatively short durations of action (alcohol, stimulants). It should thus be possible to routinely use the holding area for no longer than 6 to 8 hours before excluding intoxication as the cause of persisting symptoms and admitting to the ward, either on a formal or informal basis.

STAGE 3A

If symptoms have resolved and the patient is discharged to the community from the holding area, refer to the Community Drug and Alcohol Team for assessment.

STAGE 3B

If symptoms did not resolve during the holding period and the patient has been admitted to a general psychiatric ward, refer to the Community Drug and Alcohol Team for an opinion.

STAGE 4

Use indicated psychotropic medications if symptoms persist and impair function or recovery.

Affective, psychotic and anxiety symptoms should be treated as for patients with primary psychiatric disorders. The major exception to this rule is the prescribing of sedative-hypnotics for the management of anxiety and agitation, which should be avoided if possible in patients with addiction problems (such drugs can however be used for detoxification). Behavioural disturbance and psychosis are usually more appropriately treated with a **high-potency neuroleptic** (e.g. haloperidol) to avoid complications caused by additive (illicit drug and neuroleptic) anticholinergic effects. A list of illicit drug/alcohol-medication interactions can be found in *appendix 9,* page 129.

STAGE 5

Following resolution of disabling psychiatric symptoms, discontinue psychotropic medication and observe the patient's response in an illicit drug-free environment. (i.e. observe the patient during a medication-free period of verifiable abstinence).

There are two factors here which are likely to impede the effective implementation of the management plan.

1. Achieving a drug-free environment.

- Patients discharged to the community can never be safely assumed to have remained abstinent from substances, unless they are tested for substance misuse on a daily basis.

- Psychiatric wards often experience problems with substance misuse occurring on the ward, and ward policies should be rigorously implemented to minimise this as far as possible. Urinary drugs of abuse screening (or breathalysing in the case of alcohol) should take place on a daily basis for in-patients with substance misuse problems.

- In some instances transfer to a residential rehabilitation unit (for substance misusers) may be appropriate. Such transfers should be affected direct from hospital wherever possible. The unit chosen should have expertise in treating dual diagnosis cases, and provide an on-going psychiatric assessment service. Transfer to such units can enable the evaluation period to continue, whilst providing clinically appropriate interventions simultaneously.

2. Assessing the length of time by which symptoms related to drug-induced disorder should have resolved.

- In general drug-induced psychotic syndromes will resolve in days or weeks, and affective symptoms over a similar period. Anxiety, agitation, insomnia may all persist over a period of months. Changes in personality may only occur after years of abstinence. If patients are discharged to the community or other non-drug-free environment before the relevant time period has elapsed, then any future recurrence of symptoms will not be helpful in confirming the diagnosis.

The vital component of the assessment plan is to achieve a period of verifiable abstinence from substance misuse having ceased to prescribe psychotropic medication.

STAGE 6

Refine the diagnosis.

The following indicate a likely substance-induced disorder:

- Symptoms of mental illness resolve in a manner that is temporarily related to the cessation of substance misuse (psychotic symptoms within days to weeks; affective symptoms within weeks; anxiety and sleep disorder within months).

- Symptoms of mental illness recur after a period of abstinence and their onset is temporarily related to a verifiable relapse to substance misuse.

- The presence of features that are atypical for the primary mental illness (e.g. atypical age of onset or course).

The following indicate a likely co-existant primary mental disorder:

- Symptoms of mental illness persist past the duration that it typical for the particular symptom and substance.
- Symptoms of mental illness recur when on-going abstinence can be safely assumed.
- The intensity of symptoms is substantially in excess of what would be expected given the type, amount or duration of substance misuse.

STAGE 7.

Formulate the long-term management plan based on definitive diagnosis where possible.

- On-going management of the substance misuse disorder will always be required.
- Where a primary mental disorder has been diagnosed as concurrent with the substance misuse disorder, then this should be managed according to standard practice for that disorder.
- Where a substance-induced mental disorder has been diagnosed, then the management plan should focus on the on-going management of the substance misuse disorder. The patient should however continue to be observed for signs of recurrent psychiatric symptomatology.
- Where the diagnosis has not been clarified due to failure to achieve a period of medication-free abstinence clinicians should a) continue to manage the substance misuse disorder, b) continue to treat psychiatric symptoms on a symptomatic basis, c) continue to plan for a period of medication-free abstinence.
- If the diagnosis has not been clarified by the time of discharge and recurrence occurs at some point in the future, the above algorithm should be re-instituted.

USE OF THE MENTAL HEALTH ACT

Patients who are markedly intoxicated cannot be assessed for admission to hospital under the Mental Health Act. Intoxication with the large majority of substances will have subsided sufficiently after a period of 6 to 8 hours. During this period, patients being considered for admission under The Act should be observed in a holding area. Patients refusing to comply with this should usually be held under common law if they are felt to pose an immediate risk to themselves or others. Following resolution of acute intoxication, patients who remain at acute risk to themselves or others should be formally assessed. Patients may be assessed as meeting the criteria for a formal admission to hospital under The Act, whether their mental disorder is considered to be a result of substance misuse or not. Apart from in the case of acute intoxication, the underlying cause of the mental disorder is largely irrelevant as far as use of The Act is concerned.