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Clinical Presentations: Substance Use In Psychiatry

Drug Science

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Drug Science was formed by a committee of scientists with a passionate belief that the pursuit of knowledge should remain free of all political and commercial interest.

Founded in 2010 by Professor David Nutt, following his removal from his post as Chair of the Advisory Council on the Misuse of Drugs, Drug Science is the only completely independent, science-led drugs charity, uniquely bringing together leading drugs experts from a wide range of specialisms to carry out ground-breaking research into drug harms and effects.

The Drug Science mission is to provide an evidence base free from political or commercial influence, creating the foundation for sensible and effective drug laws.

Equipping the public, media and policy makers with the knowledge and resources to enact positive change. Drug Science want to see a world where drug control is rational and evidence-based; where drug use is better informed and drug users are understood; where drugs are used to heal not harm.

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The mission of the Society is to broaden and promote the scientific understanding of addiction, and we particularly aim to help clinicians and policy makers get research evidence into practice.

We support education, training and development of individuals in the field. We disseminate research via our journals, conferences and by supporting third-parties' projects and conferences; also, via our website and social media.

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Learning Outcomes:

Co-occurring mental health and substance problems are very common

Working and training with professional groups is necessary to provide continuity of care as these conditions are often long term

Knowledge about screening and assessment for these complex disorders is a core part of undergraduate training

Interventions can be effective when implemented correctly

There are serious social, psychological and physical causes and complications resulting from combined mental health and substance problems

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Part 1: Introduction, presentations, barriers to treatment

Setting the scene: why is this important?

- Key facts and figures
- Characteristics of this patient group

Common presentations and risks in this patient group

- Special and distinctive features in this patient group
- Barriers to recognition and access of treatment
- Clinical presentations of common recreational drugs

Part 2: Assessment, treatment and referrals

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Assessment

- Screening and brief interventions
- Thorough assessments
- Importance of recognising comorbidity
- Important considerations
- Formulation of a case
- Patient interactions

Treatment

- Key elements of treatment
- Interventions
- Importance of reviews

Plus

- Referral/networks/services
- Vignettes (3 examples)
- References

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Part 1 - Setting the scene:
Why is this important?

Patients suffering from comorbid psychiatric illnesses as well as substance misuse are likely to show:

1. Poor compliance with treatment
2. Unplanned discharge from care
3. Relapse and rehospitalization
4. Death (from accidents, injuries, accidental overdose and suicide)
5. Pain
6. Infection
7. Injury
8. High risk of cancer

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Part 1 - Setting the scene:
Why is this important?

This group may also be characterised by:

- Homelessness
- Deprivation
- Unemployment
- Crime and violence
- Their early years are often disturbed (examples of adverse childhood experiences on the right)

This is therefore a very complex patient group

Examples of adverse childhood experiences (ACEs)

Abuse		Neglect	Household Dysfunction	
 Physical		 Physical	 Mental Illness	 Incarcerated Relative
 Emotional		 Emotional	 Mother treated violently	 Substance Abuse

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Part 1 - Setting the scene:
Why is this important?

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
- 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, so consequently, it is essential to have a low threshold of suspicion for substance misuse in any psychiatric assessment.

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Comorbity: Substance use and other mental disorders

Key facts and figures

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

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

&

85% of patients attending alcohol services

suffer from mental illness

about **40%** of patients patients attending mental health services have used drugs and alcohol

Further reading: Finding useful statistics [UK]

Source: NICE, 2015

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Comorbity: Substance use and other mental disorders

Key facts and figures

Alcohol and drug misuse in psychotic patients is reported in between

1/5 and 1/3

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

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

Further reading: Finding useful statistics [UK]

Source: NICE, 2015

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Key Point

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.

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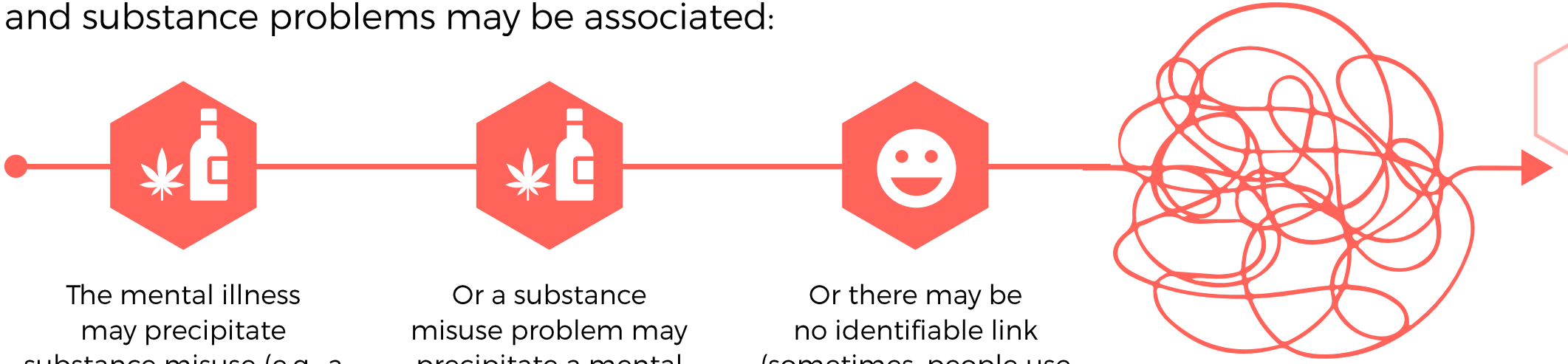
Common presentations and risks

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)

It's complex, and sometimes impossible to identify what came first

Clinical presentations of alcohol use

Reading Around... Drugs, Alcohol and Tobacco

Signs of intoxication	Signs of withdrawal
Disinhibition	Craving
Argumentativeness	Agitation
Aggression	Insomnia
Mood liability	Convulsions
Impaired judgement and attention	Malaise
Decreased level of consciousness	Visual, auditory or tactile hallucinations

WHO: The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic criteria for research

Clinical presentations of opiate use

Reading Around... Drugs, Alcohol and Tobacco

Signs of intoxication	Signs of withdrawal
Apathy	Restless sleep
Sedation and drowsiness	Craving
Impaired attention and judgement	Fearfulness and general discomfort due to unpleasant physical symptoms
Decreased level of consciousness	
Psychomotor retardation	

WHO: The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic criteria for research

Clinical presentations of cannabis use

Reading Around... Cannabis

Signs of intoxication	Signs of withdrawal
Euphoria and disinhibition	Anxiety
Anxiety and agitation	Irritability
Suspiciousness and paranoid ideation	Sweating
Impaired judgement and attention	
Hallucinations	
Depersonalisation and derealisation	

WHO: The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic criteria for research

Clinical presentations of nicotine use

Reading Around... Drugs, Alcohol and Tobacco

Signs of intoxication	Signs of withdrawal
Insomnia	Craving
Bizarre dreams	Malaise or weakness
Fluctuating mood	Anxiety, irritability or moodiness
Derealisation	Insomnia
Sweating	Increased appetite
	Difficulty in concentrating
	Palpitations

WHO: The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic criteria for research

Clinical presentations of stimulant use

Reading Around... Drugs, Alcohol and Tobacco

Signs of intoxication		Signs of withdrawal
Euphoria and increased energy	Abusiveness, argumentativeness and aggression	Lethargy
Hypervigilance	Auditory, tactile and visual hallucinations	Psychomotor agitation or retardation
Grandiose beliefs and actions	Agitation	Craving
Paranoid ideation	Sweats	Insomnia and hyper insomnia
Repetitive stereotyped behaviours	Convulsions Palpitations	Bizarre and unpleasant dreams

WHO: The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic criteria for research

Effects and risks of novel psychoactive substances

(Hohmann et al., 2014)

Synthetic cannabinoids		Synthetic cathinones	
Agitation	Headache	Agitation	Depression
Hallucinations	Irritability	Aggression	Anorexia
Anxiety/panic attacks Confusion	Loss of consciousness	Hallucinations	Panic attacks
Psychosis	Somnolence	Confusion	Suicidality
Aggressive behaviour	Convulsions	Anxiety	Psychosis
Delusions	Palpitations	Insomnia	
Anterograde amnesia		Anhedonia	

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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” so 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 impaired social functioning

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Barriers to detection, recognition and access

Patients may experience prejudice and stigmatisation, 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 contract 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

Learn more about how stigmatisation impacts people who use drugs health in this paper!

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Part 2: The difference between screening and assessments

Screening is an initial, simple enquiry about indications of problems results of which may lead to a fuller assessment and it takes place when an individual first presents to services

X

The assessment on the other hand determines the level of impact substance use has on an individual's physical, mental and social health

For more information on screening and assessment, click here

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Screening and brief interventions

Screening and brief interventions aim to identify current or potential problems with substance use and motivate those at risk to change their substance use behaviour	They can also be used to encourage those with more serious dependence to accept more intensive treatment within the primary care setting, or referral to a specialised alcohol and drug treatment agency
Brief interventions in primary care can range from 5 minutes of brief advice to 15-30 minutes of brief counselling	**The aim of the intervention is to help the patient understand that their substance use is putting them at risk and to encourage them to reduce or give up their substance use**
Generally, brief interventions are not intended to treat people with serious substance dependence, however, they are a valuable tool for treatment for problematic or risky substance use	Brief interventions should be personalised and **offered in a supportive, non judgemental manner**

Further reading: WHO: Brief Intervention For Substance Use: A Manual For Use in Primary Care

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Assessment

A thorough assessment is fundamental to achieving the best possible outcome for patients

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

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Assessment: history of drug use

History taking should cover the following:

✓ Substance use: legal, illegal, prescribed, over the counter	✓ Family/social history
✓ Treatment episodes	✓ Living arrangements – alone, with friends, carers, family..
✓ Medical history & presenting symptoms - substance related issues - complications: abscesses, venous thromboses, septicaemia, endocarditis, constipation	✓ Lifestyle – financial/ employed/ unemployed/retired
✓ Psychiatric history	✓ Personal history – education, criminal
✓ History of accidental/deliberate over-dose; risk factors	✓ Contact with other services – social services/ child protection….

Examples of questions

Substance Use

How much, how often, route of use, length of use, pattern of use, triggers to relapse

Treatment

Contact with services – how long, interventions, reason for discontinuing

Family history/ affects

Is there history of substance use, history of psychiatric problems, how does it affect life, work, family?

Does the patient they think they have a problem

Do they want help?

Medical history

Any chronic conditions, medications, any screening for BBV

Further reading: Screening and Assessment Factsheet
https://www.addiction-ssa.org/knowledge-hub/reading-around-screening-and-assessment/

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Assessment

- 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 patients, if they have a problem with one substance, will almost always have a problem with at least one other substance as well

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
- And 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

Assessment

- 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 people are being detained or treated under the Mental Health Act (1983; amended 1995 and 2007)

n.b. The Mental Health Act is currently undergoing review

Further reading:
Substance Use Screening & Assessment Instruments Database
http://lib.adai.washington.edu/instruments/

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

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Important to consider during assessment

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

Important to consider during assessment

- 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

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Formulation of a case - beware

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

Ensure that all psychiatric assessments include a systematic enquiry and consideration of any possible substance misuse

Potentially life-threatening medical emergencies such as suicidal intent, delirium tremens, Wernicke's encephalopathy and chaotic lifestyle using multiple medications, require urgent hospital admission

It is very easy for the role of psychoactive substances to be overlooked otherwise – if the patient's response to screening questions (or anything else) suggests drug or alcohol use, this should lead to a detailed drug and alcohol history

Patient interactions

- 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
- Look out for the patterns in patients behaviour.

Good examples of how to ask these questions can be found here

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Treatment

- Drug and alcohol use may be associated with many psychiatric disorders – these may include:
  - Anxiety
  - Depression
  - Personality problems
  - Psychosis
  - Memory problems
  - Post traumatic Stress Disorder (PTSD)
  - Eating Disorders
  - Attention Deficit Hyperactivity Disorder (ADHD)
- Therefore, it is essential to understand the relationship of the presenting mental state, and 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
- Equally, any signs of 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

Read more about this here: The Orange Clinical Guidelines and Recovery

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Before starting treatment for adults and young people with psychosis and co-existing substance misuse, you should 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)

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Types of interventions

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
- Contingency management

The set of NICE guidelines on the treatment of drug and alcohol misuse, and substance misuse and psychosis, and the British Association of Psychopharmacology guidelines, provide detailed guidance (Lingford-Hughes)

Click images to be directed to both guidelines

NICE National Institute for Health and Care Excellence

BAP British Association for Psychopharmacology

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Treatment evaluation

In general, it is advisable that patients be detoxified or stabilised in the first instance

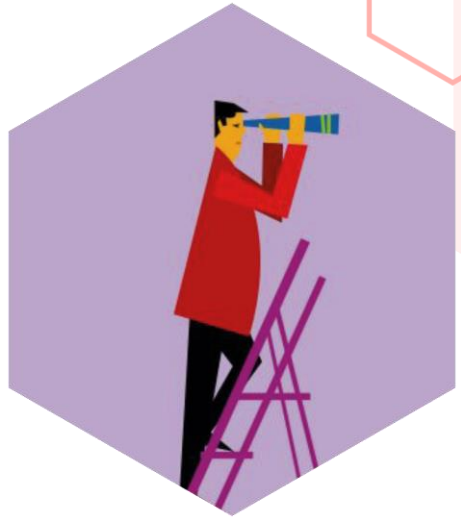
Once their substance use has decreased or ceased, the patient can be assessed after 4-6 weeks for symptoms of mental illness

Many of the signs and symptoms of mental illness overlap with those of intoxication and withdrawal

Where a patient is suicidal, clinical judgement will have to determine whether the treatment must be initiated as a matter of urgency by admission to a psychiatric inpatient unit

Key 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 lifestyles of these patients
Specific 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



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 as 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

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Vignette 1

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 daily 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.

1. What further questions would you ask her?
2. What further information do you need to obtain?
3. What advice would you give her?

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Vignette 2

A 42-year-old man was referred by his general practitioner to the community alcohol team for alcohol dependence and this was thought 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.

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1. What further questions would you ask him?
2. What further information do you need to obtain?
3. What advice would you give him?

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Vignette 3

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

1. What further questions would you ask her?
2. What further information do you need to obtain?
3. What advice would you give her?

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For more information about Addiction Assessment and Screening, **please click here**

Or visit https://www.addiction-ssa.org/hot-topic/reading-around/

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