Risking our sanity

Both mental health services and drug services are reluctant to grasp the nettle of 'the mentally ill problem drug user'. But – as Tom Waller argued in the last Druglink – unless we learn from other disciplines, we all run the risk of failure. And failure here can mean wrongly sectioning a drug user or prescribing a lethal cocktail of drugs to a mentally ill patient. The key to success is correct diagnosis

by
Ira Unell
Leicestershire Community Alcohol and Drug Team

SUMMARY

Mentally ill drug users are among the worst-serviced groups in the community, with both mental health and drug services often refusing to acknowledge their existence. This creates a huge scope for misdiagnosis. Unless services can recognise and respond appropriately to all their clients, they effectively exclude them. And this response requires a re-examination of the suitability of harm reduction tactics when dealing with mentally ill drug users.

THE DRUG FIELD HAS SPENT the last 20 years arguing that drug use has little or nothing to do with mental illness. This is, of course, a highly laudable aim which has met with a degree of success, but a by-product of severing the stigma of mental illness from drug users has been a reluctance on the part of drug services to be associated with mental health services.

Likewise, mental health services tend to be (like most other health services) unfavourably disposed to problem drug users. On a more practical level, workers in both disciplines often feel ill-equipped and under-trained when faced with a client who they feel may be better served by a worker from the other discipline.[1]

The upshot of all this is that mentally ill drug users are among the worst-serviced (and least cared-for) groups in the community, and the reasons for this go far beyond those of resourcing and the inevitable boundary disputes between services.

The problem of diagnosis

There is one very good reason why mental health services should be more exercised about the possibility of illicit drug use: diagnosis. Some forms of mental health problems present symptoms that are virtually indistinguishable from the effects of intoxication or withdrawal from certain drugs, and without relevant training or links with drug services, a mental health worker could flounder in the conflicting evidence.[2]

Standard urine screens only provide qualitative information – they simply demonstrate whether a drug is or is not present in the sample. They do not give information on how much is in the sample or when it was taken and, crucially, they do not test for all drugs. Cyclizine, for example, which may mimic symptoms of schizophrenia, is rarely part of a standard urine screen.

Another confounding issue is time-related. Traces of drugs such as cannabis can be detected in urine samples for up to six weeks, long after they cease to have an effect on the user's mental state. But an unqualified mental health worker could cling to a test result and ascribe a mental health problem to drug use.

At the other end of the scale, some conditions, like amphetamine psychosis (caused by an acute episode of heavy use with symptoms similar to schizophrenia), may linger for many weeks, long after traces of the original drug have disappeared from a urine test.[3]

So, while urine screens can give valuable information they are rarely definitive in differentiating between mental health problems and drug problems. Interviews with someone suffering from delusions and paranoia are never straight forward at the best of times. Taking a drug history from someone suffering from paranoia may increase their paranoia and, not surprisingly, yield less than reliable results.

Urine testing is, however, more often honoured in the breach. Many admissions to hospital for psychiatric treatment are precipitated by an acute episode of violent or aggressive behaviour. If the person presenting with the problem is not known to the service, there is no time to take a urine sample – a decision needs to be made on the spot.

The drug service case

Mental health services are not alone when it comes to running the risk of misdiagnosis. Unless drug services are able to recognise and respond appropriately to all their clients, they effectively exclude them. Most drug services do try to provide for a range of needs but often mental health needs are badly articulated and so drown in the sea of competing priorities.

Few assessment forms which I have seen include questions about mental health. This means that when assessing problem drug users, many drug workers fail to ask about mental health problems. Drug workers, for instance,

may not recognise serious depression by assuming that a low mood, lethargy, suicidal ideas and sleep problems are solely the result of stimulant withdrawal and will soon fade away.

Many clients attending drug services do probably suffer from depression, anxiety, phobias and other mental health problems, but these should not automatically be ascribed to their drug use. Researchers in Canada have concluded that 17 per cent of substance misuse patients suffer from major depression, 16 per cent from generalised anxiety and 26 per cent from phobias.[4] Other researchers have found that

> Problem opiate users are seven times as likely as the rest of us to suffer from a psychiatric disorder

problem opiate users are almost seven times as likely as the general population to suffer from a psychiatric disorder, five times as likely to suffer from a depressive disorder and almost three times as likely to suffer from an anxiety disorder in their lifetime.[5]

Such evidence may come as a surprise to many drug workers. Failure to recognise mental health problems can of course arise for any number of reasons, but chief among these is an ideology which attempts to 'normalise' drug use. This is not to suggest that we return to previous disease models, but it should act as a reminder that many drug service clients may well be vulnerable to mental health problems.

Clients with mental health problems may require more regular appointments, active follow-up if they fail to attend an appointment, more supportive accommodation, better liaison with mental health services, and closer work with significant others. In other words, as a group they require more time, effort, and skill than clients without mental health problems.

The no-option option

Drug services (rightly) work on the assumption that the client is a rational and responsible adult who has every right to make the decision about what kind of help or treatment, if any, they accept. But what about those clients, who because of their mental health, are not as able to exercise that right?

Prescribing can become problematic if the drug prescribed by the drug agency interferes with other drugs prescribed by mental health services. Many residential services do not accept someone with a label of 'schizophrenia' attached. They may have a completely 'drug free' policy which would exclude clients using prescribed drugs for their mental health problems. A whole range of treatment options may be limited because of mental health problems. Group therapy, for instance, may simply be inappropriate for someone experiencing a very different reality from most people. Ultimately, you have to ask whether even harm reduction models of intervention can realistically be used when the client is experiencing a very different reality from the drug worker. While the answer may be "yes" in most cases, when does the worker decide to say "no"?

Finally, as the BMA has recently recognised,[6] the issue of confidentiality needs to be addressed. Drug workers all too often offer blanket promises of client confidentiality. But while most people who suffer from mental health problems present no danger to others, self harm and suicide attempts are not uncommon. Few agencies have clear policies about when confidentiality needs to be breached, but breached it sometimes has to be.

Who carries the can?

Few health or local authorities have formal agreements to settle the question of responsibility for drug users with mental health problems. This is not to say that there is always a need for such agreements. If informal arrangements are able to do the job well, than perhaps services should be left to continue their existing practice. However, those suffering from mental health and drug problems are often treated inadequately and inappropriately or not helped at all.

There is no easy answer as to who should bear the lead responsibility. The answer will depend on several factors which include the nature of the mental health problem, the nature of the drug problem, the training and experience of staff in both agencies, and finally client preference. In practice, each case will probably be negotiated between the two teams, though a 'shared care' approach will not suit all clients.

> Can harm reduction realistically be used when the client experiences a very different reality?

Some agencies are better placed to offer help to drug users with mental health problems than others. Many drug workers (such as community psychiatric nurses, psychiatrists and approved social workers) are already experienced and qualified in mental health. But their expertise is not always utilised to the full.

Perhaps the best way forward is for purchasers to require both mental health services and drug services to monitor the situation and gather information. They might also insist that working agreements be instituted if informal arrangements prove inadequate. Joint training schemes could benefit both services and hopefully reduce prejudice on both sides. But even if such power- and information-sharing arrangements do come about, the problems of misdiagnosis will not disappear overnight, nor will we be much nearer to the holy grail of accurate dual diagnosis.

THE 1983 MENTAL HEALTH ACT

The Mental Health Act specifically excludes "dependence on alcohol or drugs" and mere intoxication as sufficient grounds for being detained or treated under the provisions of the Act. Drug dependence or addiction are not regarded as 'mental illness', 'mental impairment', 'severe mental impairment' or 'psychopathic disorder', which are the only categories of mental disorder for which compulsory admission for assessment or treatment is allowed under the Act. In other words, a patient cannot be compulsory treated for dependence upon drugs or intoxication by drugs.

There are, however, circumstances when drug users can be compulsorily admitted to hospital for assessment. These are when their behaviour constitutes a danger to themselves or others, they show signs or symptoms of 'mental illness' – whether or not caused by drugs – and "informal admission" is not appropriate (often meaning that the patient refuses to accept admission).

1. Rorstad P. and Checinski K. *Dual Diagnosis: Facing the Challenge.* Wynne Howard Publishing, 1996.
2. Ghodse H. *Drugs and Addictive Behaviour: a Guide to Treatment.* Blackwell Science, 1995.
3. Ellinwood I. and Petrie W. "Psychiatric syndromes produced by nonmedical use of drugs", in: Gibbins R. *et al. Research Advances in Alcohol and Drug Problems.* John Wiley and Sons, 1976.
4. Ross H. *et al* "Sex differences in the prevalence of psychiatric disorders in alcohol and drug patients." *British Journal of Addiction*: 1988, *83*, p.1179-92.
5. Regier D. *et al* "Comorbidity of mental disorders with alcohol and other drug abuse: results from the Epidemiological Catchment Area (ECA) study." *Journal of the American Medical Association*: 1990, *264*, p.2511-18.
6. Mars S. "The English patient. Doctors and drug users in Britain today." *Druglink*: 1997, *12*(4), p.10-11.