

Chapter 24

Management of Chronic Mental Illnesses and Substance Use Disorders

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ABSTRACT

There is vast literature available about prevalence and pattern of substance use in patients with Chronic mental illness such as Schizophrenia. Many of these studies have also investigated the issues related to the impact of substance use on the course and prognosis of the mental illness and vice versa. The factors affecting the use and its impact on treatment have also been studied to some extent in the Western countries. Estimates of the prevalence of substance abuse in schizophrenia and major affective disorder vary as a function of settings (e.g., community, hospital-in-patient vs. out-patient), demographic characteristics of the sample and assessment methods, with most prevalence rates ranging between 15% to 65%. Patients with Chronic Mental illnesses and Substance use disorders are difficult to treat and many models for their management have been proposed. This chapter will deal with some of these issues.

INTRODUCTION

During the period following deinstitutionalization in 1950's, psychiatrists started focusing on patients with chronic mental disorders who left institutions and were in the process of getting rehabilitated in the community. By the late 1980s, mental health professionals began to attend to this new younger population of persons with severe mental illness leading to the emergence of the concept of co-occurring disorders

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or dual diagnosis (Ridgely et al., 1987). As a consequence of deinstitutionalization along with other risk factors like poverty, poor education, poor social skills, lack of vocational skills and opportunities, and residence in drug-infested neighborhoods, such patients experienced a high rate of regular exposure to psychoactive substances and of social pressures to use them. Exposure of these patients with severe mental illness to the drug culture in the community led to the development of another entity of patients having co-morbid substance abuse with psychiatric disorders. Such individuals were discussed under the rubric of dual diagnosis but were also called mentally ill chemical abusers or substance-abusing mentally ill persons (Drake & Wallach, 2000).

There is no single form of dual diagnosis. There are numerous types of psychiatric illness along with different patterns of alcohol or drug abuse. Most of these patients would fall within the following four categories:

1. Those who are severely disabled by comorbid mental health and substance use disorders and will require a coordinated and integrated approach by both mental health and drug and alcohol services,
2. Those who are severely disabled by mental health disorders and adversely affected by problematic substance use disorders
3. Those who are disabled by substance use disorders and adversely affected by mental health problems
4. Those who are mildly disabled by mental health disorders and substance use disorders and who will be treated primarily by a general practitioner but may also require access to either mental health or substance abuse services at various times (Burnam & Watkins, 2006; Drake et al., 2001; Todd et al., 2004).

It is therefore necessary to be clear that dual diagnosis is not a diagnosis in itself. Instead it simply implies that a person has both psychiatric and substance use issues. Among dual-diagnosis patients, substance-use disorders range from single drug abuse to a cocktails of substances, whereas mental health problems can include a wide array of disorders, from those defined as “high-prevalence and low- impact therapeutic”, such as anxiety and depression, to those defined as “low prevalence, high-impact therapeutic”, such as psychosis and major mood disorders (Canaway & Merkes, 2010). Although the “low impact” group is the most represented among dual-diagnosis patients, the “high impact” group, even if smaller, requires more intensive and expensive treatment programs.

Despite being perceived as a difficult to manage group, and perhaps untreatable, those with dual diagnosis are a disadvantaged and vulnerable group. Accumulating evidence suggests that co-occurring substance abuse leads to relapse and hospitalization, disruptive behavior and violence, familial problems, homelessness, decreased functional status, HIV infection, and medication noncompliance (Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998). Substance abuse along with medication non-compliance has been found to be predictors of violent behaviour in patients with mental illness (Torrey, 1994). Homelessness is a major issue for patients with dual diagnosis. Mentally ill persons with substance abuse tend to congregate in urban areas where availability of drugs are higher but housing options are few. The McKinney Research Demonstration Programs for homeless mentally ill adults showed that alcohol or other drug abuse was the reason that patients were unable to find or retain housing and not because of their mental illness per se (Making a Difference, 1995). Studies have also shown that problems related to substance use tend to persist over the long term amongst patients with severe mental illness (Kozaric-Kovacic, Folnegovic-Smalc, Folnegovic, & Maruic, 1995; Morse, Calsyn, Allen, Tempelhoff., & Smith, 1992). The economic burden of dual diagnosis has also become evident. Research has shown

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