Co-occuring psychiatric & substance disorders

Współwystępowanie zaburzeń psychicznych i wywołanych substancjami psychoaktywnymi

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Kongres USA ogłosił ostatnią dekadę XX wieku Dekadą Mózgu. Od tego okresu wzrosła m.in. wiedza pozwalająca lepiej zrozumieć współwystępowanie zaburzeń psychicznych i wywołanych zażywaniem substancji psychoaktywnych, co – od strony głównie klinicznej – omówiono w niniejszym artykule.

Słowa kluczowe: *„Dekada Mózgu", współwystępujące zaburzenia psychiczne, substancje psychoaktywne*

The American congress declared the last decade of the 20th century as "The decade of the brain". Since then human knowledge on co-occurrence of psychic and psychoactive substance use disorders has significantly increased. The paper presents clinical aspects of the problem.

Key words: *"The decade of the brain", dual/concurrent psychic disorders, psychoactive substances*

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"The decade of the brain" significantly increased our knowledge related to understanding of human brain. Thanks to such a development we are able to better understand brain vulnerabilities and co-existence of both mental health and substance disorders. There have been however decades of separation between treatment of mental illness and substance use disorders. These periods of practice proved to have a number of areas of poor outcome. Those areas, among others, include problems with relapse, suicides, trauma vulnerability and re-hospitalizations.

Co-morbidity and co-existence of these disorders is highly prevalent in many systems of care such as mental health, substance abuse treatment, homelessness, criminal justice, family services and primary health care; to name a few [1]. Throughout the research-based treatment reviews of dual disorders it appears that the most significant predictor of therapeutic success is a continuous treatment relationship that provides integrated-care approach to those disorders [2].

The terms "concurrent disorders" [3] or "dual diagnosed disorders" [4] refer to the client/patient population that presents with both substance abuse and mental health disorders such as psychosis, severe personality disorders, affective or developmental disabilities [5]. It appears that much of research and literature on these important disorders has been contributed by studies in the United States. One of the first researchers to recognize and develop continuous study and concurrent treatment/programs of those disorders and coined the name Mentally Ill and Chemically Addicted (MICA) is Dr. K. Minkoff (2001) [5]. The interconnections and adverse interactions between those disorders have been known and documented for over 25 years by a few clinicians/researchers in North America and internationally. The population with co-occurring psychiatric and substance disorders represents a challenge in treatment and can be related to poorer outcomes and higher costs as well. It has been estimated that psychiatric disorders (trauma, anxiety, affective disorders, schizophrenia-spectrum disorders, personality disorders) are associated with an increase in concurrent substance disorders as compared to general population. It also appears that individuals with more severe psychiatric illnesses have the highest rates of co-occurring disorders [6, 7, 8].

As an example, the prevalence of lifetime alcohol or drugs use in general population is about 17%,

compared to 47% for people with schizophrenia, 56% for people with a bipolar disorder, and 30% for people with mood disorders. Data from different recent studies differ somewhat, nevertheless they all seem to be higher for people with dual diagnosis than for general population. For example, Health Canada quoted other data from the United States indicating the prevalence of substance use disorders in individuals with a concurrent disorder of 29% as compared to 16% in general population. Another more recent study in Canada (Health Canada, 2007) on alcohol use showed that 55% of those with lifetime alcohol use had a lifetime mental health illness diagnosis [9]. After reviewing a number of data, Dr. Mueser (2003) reported that rates of substance abuse disorders in individuals with severe mental illness expand from 20% to as high as 65% [10].

The demographics, personality characteristics and family history of substance abuse-prone individuals are compatible with individuals with severe mental illness in general population. It has been noticed that lower level of education, younger age, male gender with single marital status are related to higher vulnerability to substance abuse. At the same time one cannot neglect the fact that a significant numbers of women experience problems related to substance abuse as well. Family substance abuse is also related to this disorder in individuals with severe mental illness. Also, history of conduct disorder and antisocial personality disorder is related to substance use disorders. It seems that populations of urban or rural regions do not differ in rates of substance use disorders. However, individuals who are homeless, incarcerated or with severe mental illness in acute care treatment have higher rates of substance abuse. With regard to race it was found to be mostly related to the type of substances used and appears to reflect their availability, rather than preferences. Similarly, there is evidence that prevalence of specific substances use is not related to any of specific psychiatric disorder and is rather governed by the availability of those substances. There are two specific clinical correlates, according to Dr. Mueser (2003) [10], that relate to substance abuse and mental disorder and those are antisocial personality disorder (ASPD) and non-adherence treatment. APSD seems to be a very important correlate and often starts with a conduct disorder at a young age. Those two disorders seem to be important predictors of substance abuse in general population and in individuals with severe mental illness. The other correlate, non-adherence, seem to be actually a common problem in individuals with concurrent disorders. This specific problem contributes substantially to re-hospitalizations and relapses. An important role for providers would be to engage those individuals in treatment again [11, 12, 13, 14].

All aspects considered, it appears clear that concurrent disorders are rather an expectation and not an exception. Therefore a comprehensive, continuous and integrated system of care is required that permits to address these problems in an organized manner, based on best practice guidelines. It appears that Dr. Minkoff's group (2001, 2004, 2005) [5, 6, 7, 8] presented A Comprehensive Continuous Integrated System of Care (CCISC) as practice guidelines. The general organizational concept of this approach seemed to be accepted in the United States, Health Canada, and Center for Addiction and Mental Health (2008) in Ontario [8, 15, 16].

Substance abuse and anxiety have been recognized as the most common combination in co-occurring disorders as well as substance abuse and mood disorders. There have been developed general principles and clinical practice guidelines by a number of clinicians/researchers Dr. Minkoff (2004, 2005) [6, 7, 8], Dr. Drake (2007) [2], Curie, MA (2005) and recognized by some centers such as AADAC (2005) [3], Centre for Addiction and Mental Health (2008) [15], accepted in treatment of co-occurring disorders and promoted as a best practice approach in the USA and Canada.

This model and similar models propose several general principles of best practice:

1. Dual diagnosis is an expectation, not an exception. This requires the providers' understanding and acceptance that assessed individuals may very well manifest psychiatric and substance disorders at the same time. Also, routinely accepted consultations due to usually complex clinical issues would be beneficial.
2. The success of treatment to be based on hope, empathy and continuity of relationships. We are certainly aware that this field and psychopharmacology is not an absolute science yet. Therefore, it is recommended that all treatment is performed in the context of the above mentioned factors together with mental health and substance use.
3. Treatment needs to be individualized utilizing guidance from the following structured approach. There has been a widely accepted "four quadrant" model for diagnostic and therapeutic categorizing of assessed individuals with co-occurring disorder in order to organize treatment.
   The combination of mental illness (MI) and substance use disorder (SUD):
   - Both High Severity
   - MI High Severity, SUD Low Severity
   - MI Low Severity, SUD High Severity
   - Both Low Severity

Individuals with high severity mental illness represent serious and persistent mental illness and have a high engagement in psychopharmacological treatment. Individuals with high severity of substance use disorders are those with addiction and in this instance the psychopharmacologic approach may vary depending on their mutual severities.

4. Provided clinical care and case management need to be appropriately balanced including empowerment and choice, contracting, empathic detachment and contingent learning. Medication treatment needs to balance continuity of care, negotiations of duration and type of treatment, and this process may require several attempts before achieving a success. All plans seem to be most effective within well developed therapeutic alliance.
5. In a case when substance abuse and mental illness co-exist, then each disorder is "primary" and requires specific diagnostic and treatment approach.
   Psychopharmacologic treatment is designed for both disorders with an intention to improve the outcome of each of them. Thus, for a mental illness a utilization of the most effective medication for a given disorder is considered, with the caution of certain psychotropics that have addictive potential. In turn, for a substance disorder specific psychopharmacologic medications are utilized to support recovery. Medications considered are such as naltrexone or disulfiram.
6. One has to emphasize that both disorders are primary biopsychosocial disorders and can be treated in the context of a discussed model. In addition, treatment must be matched to the phase of recovery. Psychopharmacological treatment may be utilized accordingly depending whether acute treatment, rehabilitation, prolonged stabilization or relapse prevention is needed.
7. It is apparent that there no single correct approach in treatment of individuals with co-occurring disorders. Clinical interventions need specific individual approach which in principle provides the main framework for treatment.

The clinical practice guidelines suggested by the same group propose the sequence of clinical activities:

1. **Welcoming** with empathy and engagement into an integrated treatment.
2. **Access** that means no sobriety required to start evaluation and treatment, provided the client is able to carry a reasonable conversation.
3. **Safety** which is the first priority in the evaluation process.
4. **Integrated assessment**. This involves chronological description of both disorders. It is important to pay attention to periods of sobriety and presence of psychiatric symptoms at that time. This assessment process may prove difficult since those disorders symptoms overlap. Diagnostic decisions regarding psychiatric disorder can be best made when the co-morbid substance use is stabilized. However, it is strongly recommended to immediately start psychotropic medication as well, even though some individuals may still be actively using substances. The process requires continuing integrated assessment in order to appropriately monitor and regulate treatment of both disorders.
5. **Continuity** of psychotropic medication needs to be maintained regardless of substance use. In more complicated cases one needs to monitor treatment even closer and not to discontinue treatment.
6. **Consultations** with experts/peers to assist with decisions regarding the best treatment.

There are a number of psychiatric disorders that co-occur relatively often in concert with substance use disorders. Those disorders have been indicated by a number of clinicians as well as by organizations such as Health Canada or AADAC. Such clinicians and leading authors on dual diagnosis and treatment as Dr. Minkoff (2005), Drs. Mueser, Noordsy, Drake, and Fox, MA (2003) indicate borderline personality disorder, antisocial personality disorder, depressive disorder, bipolar disorder, generalized anxiety and panic disorder, PTSD, OCD, schizoaffective disorder, schizophrenia as often co-occurring with substance disorders. There are specific guidelines with regard to diagnosis and treatment of those disorders separately and in co-existing situations. Also, all the authors focus on the importance of the family role and stress in the process of developing vulnerability to these disorders as well to a process of recovery.

The Assessment process has to be an ongoing one throughout the treatment period involving both disorders. Dr. Mueser (2003) and others propose five steps assessment that includes goals, instruments, and strategies:

1. **Detection** – identifying individuals experiencing problems; DALI
2. **Classification** – determining possible DSM-IV diagnoses; AUS-R, DUS-R
3. **Functional Assessment** – information regarding individual's adjustment and pattern of substance use; Functional Assessment Interview, Drug/Alcohol Time-Line Follow-Back Calendar (TLFBC)
4. **Functional Analysis** – identifying factors maintaining substance use, or posing a risk of relapse; Payoff Matrix, Functional Analysis Summary

5. **Treatment Planning** – developing an integrated plan addressing substance use and mental disorder; Substance Abuse Treatment Scale-Revised (SATS-R), Individual Dual-Disorder Treatment Plan, Individual Treatment Review

There are additional instruments with the well recognized reliability and validity such as: The addiction Severity Index (ASI), SATS that places an individual along "stages of change", the Person-in-Environment System (PIE), Global Assessment Functioning Scale (GAF), CAGE-AID, Michigan Alcoholism Screening Test (MAST) or its shorter version SMAST, Substance Abuse and Dependence Scale: SADS, the Alcohol Use Disorders Identification Test (AUDIT).

These instruments and approach to concurrent disorders have been recommended as a standard practice by the above mentioned authors, Health Canada and AADAC as valid and reliable tests. It seems one can definitely follow those guidelines of best practice as recognized at present and accordingly choose appropriate screening/testing instruments depending on the individual needs during the assessment and treatment.

Health Canada (2007) recommends a two-level screening approach utilizing all listed instruments as reliable and valid. Within the Level I there is a first contact utilizing some more brief screening and a few questions related to DSM-IV classification. Level II screening requires some more time and utilizes additional tests, however all of them are relatively brief instruments. There are recommended best specific practice approaches that include:

- Level I : using an index of suspicion, asking a few questions, using a brief screening instrument, using case manager judgment
- Level II : Dartmouth Assessment of Lifestyle Instrument (DALI), Short Michigan Alcoholism Screening Test (SMAST), Drug Abuse Screening Test (DAST), Alcohol Use Disorders Identification Test (AIDIT)

These Assessments can take place anywhere, depending on where an individual is and during the engagement stage this process may start in the community at the location convenient to a particular individual.

There is a number of screening and assessment instruments recommended by Dr. Mueser (2003) in order to evaluate stage of change, treatment motivation as well as mental and substance use disorders. These instruments are the same or similar to those recommended by Health Canada. Mental disorders themselves are diagnosed with a clinical interview, however there are also psychological tests regarding assessment of psychopathology that at times may be utilized as well.

Screening for mental disorders can be helped by utilizing Brief Symptom Inventory, a short form of the SCL-90-R which is a reliable screen of psychopathology. Further reliable instruments such as Minnesota Multiphasic Personality Inventory (MMPI-2) or Millon Clinical Multiaxial Inventory could be used if warranted after screening procedures. There is also a number of short and reliable clinical assessments relevant to depression, anxiety or suicidal intentions that can be utilized routinely during the assessment interview.

Treatment of dual disorders has become a concern in North America and other countries, therefore the guidelines of best practice were developed by a number of organizations such as the American Psychiatric Association, the American Society of Addiction Medicine, Health Canada and various groups that actually conclude fairly similar approaches promoted by such researchers as Drs. Minkoff, Mueser and Drake with collaborating colleagues a number of years ago.

Health Canada recommended five categories within co-occurring disorders to be used as the best practice guidelines.

They are:

1. Co-occurring substance disorders and mood and anxiety disorders
2. Co-occurring substance disorders and severe and persistent mental disorders
3. Co-occurring substance disorders and personality disorders
4. Co-occurring substance disorders and eating disorders
5. Co-occurring substance disorders and mental health disorders

This approach to group individuals with complex problems of concurrent disorders was developed in order to help with directing people for appropriate treatment depending on access of services in a given region. However helpful, it seems somewhat restricting because there are many individuals who experience combinations of disorders or strong features of the above that generate distress and difficulties in a number of areas of their lives and therefore of their functioning.

Dr. Mueser and colleagues (2003) promote treatment approach related closely to stages of recovery that are proposed to be engagement, persuasion, active treatment, and relapse prevention. It has been observed that people progress from one stage to another, at times move back and forth between stages. It was proposed that specific goals are developed for specific stages. They also proposed some principles of treatment and strategies that seem to be clinically relevant. The principles include medication adherence, decreased stress, treatment of both disorders, individualized treatment, collaboration.

Treatment strategies include groups, increased structure, rehabilitation, self-help groups, motivational strategies, hope, family support and problem solving. It was also pointed out that "many different treatments can help people with a dual diagnosis" which seems to be of ultimate importance in order to avoid the lack of flexibility in treatment approach. It can also be appreciated that individual clinician's professional and personal experience and skills as well as personal abilities may very well be a major factor in treatment success as well.

There are guidelines of management and interventions for co-occurring disorders recommended by a number of clinicians leading in the field, such as Drs. Drake, Mueser, and Brunette (2007). On the basis of extensive research review they recognize two major interventions, psychosocial and pharmacological. These authors see as effective psychosocial interventions through peer-oriented groups, long-term residential interventions, and developing contingency management. There are other promising interventions that have not been a focus of research and they may include family psycho-education, intensive outpatient programs or jail diversion and release programs.

It seems that all researchers/clinicians agree on the importance of pharmacological treatment of individuals with co-occurring disorders. The conclusion of treatment review was that medication such as disulfuram and naltrexone are effective in treatment of alcohol disorders, however there is not enough research with regard to dually diagnosed individuals. Also, it has been recognized that psychopharmacological treatment of a concurrent mental disorder reduces the severity of substance abuse. Antidepressant medication, for example, reduces not only depressive symptoms but also alcohol use. Mood stabilizing medication has a positive effect on bipolar disorder and alcohol use. However, a typical antipsychotic medication does not have a positive effect on substance use. The newer antipsychotic medications are improving psychotic symptoms and reducing cravings. As an example, Clozapine appears to be a potent effective medication in substance use disorders. It is apparent that extensive clinical research studies are needed to further develop the knowledge of therapeutic interactions, effectiveness and potential side-effects in treatment of concurrent disorders.

Center for Addiction and Mental Health in Toronto (2008) recognizes as best practice four psychosocial treatments: psycho-education, psychotherapy, family therapy, and peer support. It has been recognized that knowledge is indeed helpful for individuals and families as well. Psycho-education deals with many problems, make plans to prevent them, create plans supporting recovery. Psychotherapy, in turn, deals with thinking, acting and interacting with other people. There are some strongly supported therapies such as cognitive-behavioral (CBT), dialectical behavior (DBT), psychodynamic, interpersonal, group and support therapy, and family therapy.

The above group recognizes three types of medication helping substance use: aversive, reducing cravings, and substitution medication. An example of aversive medication is disulfiram (Antabuse), for craving reduction – naltrexone (alcohol, opioids), buproprion (nicotine). Substitution medication can reduce withdrawal and cravings and an example is Methadone used for opioids.

They also recognize special situations during treatment and recommendations for practice approach. Those arising issues may include withdrawal management, crisis, relapse prevention, and hospitalization. Specific guidelines criteria have been elaborated in order to provide the best standard of care. It also appears that each province and jurisdiction operates within its own guidelines related to involuntary admissions and request, as examination can be ordered by a justice of the peace. Laws protect people's rights and "rights advisor" will be involved as well.

Some authors, Drs. Drake, Mueser, Brunette (2007) indicate the importance of special programs such as peer-oriented groups and "housing first". They also recognize long-term residential treatment as the only established intervention for individuals who did not respond to outpatient integrated program.

Further, with regard to assessment and treatment, it has been strongly suggested that the best practice is to recognize and follow stages of change and matching stages of treatment.

Recognized stages of change include:

1. Pre-contemplation – there is no intention to change the behavior
2. Contemplation – an individual is aware of the problem and did not make the commitment to take action
3. Preparation – there is intention to take action within the next month
4. Action – an individual modifies his/her behavior or environment to overcome problems
5. Maintenance – working toward relapse prevention

Further, the concept of stages of change is closely related to stages of treatment.

Stages of treatment are recognized as:

1. Engagement – an individual does not have regular contact with a clinician; this stage matches pre-contemplation stage of change

2. Persuasion – an individual has a regular contact with a clinician, but does not want to work on a substance use reduction; this stage matches contemplation and preparation stage of change
3. Active treatment – an individual is motivated to reduce substance use, reduction for less than 6 months; this stage matches action stage of change
4. Relapse prevention – an individual is abstinent for at least 6 months; this stage matches maintenance stage of change

Detoxification and treatment

Most of abused substances, while stopped, can produce withdrawal symptoms that are usually very unpleasant and hard to bear. Also, discontinuation of those substances can be very dangerous and life-threatening at times (Current Medical Diagnosis & Treatment, 2009). Therefore it is of ultimate importance to monitor withdrawing individuals and consider appropriate withdrawal medication as prescribed by an attending physician. In addition, the supervision of this process needs to be conducted by professional and qualified staff.

What is the goal of detoxification? Individuals with substance dependency have to be detoxified which means to be helped through the withdrawal process in order to protect health/life and provide maximum psychological comfort for those participating (The Harvard Mental Health Letter, 2000).

The goal of detox itself can be seen in three steps: managing symptoms of withdrawal; preventing serious medical events such as seizures, delirium, or death; referring patients to treatment for long-term recovery (J.R. Volpicelli, M.S.Gold, H.N.Sokol, 2009).

As indicated, detoxification can be conducted on an inpatient or outpatient basis, however it has been recognized that some centers prefer inpatient detox for some specific substances due to a high level of relapse. Some other centers conduct inpatient detox for individuals who are dependent on more than one drug, who are psychotic or depressed, or those who plan to enter halfway house (Manual of Psychiatric Therapeutics, Third Edition, 2003). There are also clear assessment recommendations that include: the context of patient's admission, the events leading to admission, the availability of social support, the purpose for which the patient used the substance, past history of detoxification, the patient's expectations of difficulties without the substance, the patient's motivation.

It has been also recognized that in some circumstances inpatient detoxification would be the recommended choice of approach. These criteria would include: dangerousness, inability of self-care, recent development of homelessness, inadequate social support, untreated serious medical conditions (Manual of Psychiatric Emergencies, 1994).

Detoxification is a most likely necessary process and it seems appropriate in the active stage of treatment.

This process usually utilizes medication with the addictive potential. Detoxification can be performed on the outpatient (ambulatory) or inpatient basis and in the case of outpatient basis requires an active case management monitoring. It also appears that this process requires some specialized medical attention due to the dramatic physiological and metabolic changes most individuals undergo. The frequency of monitoring itself is individually evaluated and may happen from a few times a week to a few times a day.

In more complex or severe cases with substance-induced symptoms such as psychosis or mania they need to be treated pharmacologically immediately. Dr. Hillard (2004) summarizes the general management to follow, regarding more intensive approach in treatment of substance use disorders and withdrawals. He clarifies the disposition choice as follows: from least restrictive to most restrictive and it may be managed from outpatient setting through intensive outpatient, partial hospitalization, residential, and inpatient hospitalization.

The choice of treatment setting can therefore depend on the evaluation of the individual:

- **Outpatient** setting seems appropriate for motivated individuals in a stable clinical condition and social support for participation in the program
- **Partial hospitalization** – particularly for individuals who display signs of potential relapse (poor motivation, psychiatric co-morbidity, history of relapse, etc.), those who have poor social support and live in high-risk environment, and those who failed in outpatient care
- **Residential** – for those individuals whose lives revolve around substance use; who lack psychosocial support, social and vocational skills. Longer term residential treatment of more than 3 months is associated with better long-term outcome
- **Hospital** is the most restrictive setting. The reasons for such approach are as follow: history of poor outpatient response, multiple treatment failures, history of detoxifications and other life-threatening withdrawals, history of co-morbid GMC if individuals continue to drink, history of co-morbid mental disorder, imminent risk of self-harm or harm to others.

It has been stressed however that treatment should proceed in the least restrictive setting that provides safety and effectiveness.

During the detoxification period there is a high risk of mental disorder such as depression, anxiety or agitation relapse and a full episode of mental illness may follow.

In addition, during that time there is also a high risk of side-effects of psychotropic medication such as sedation or respiratory depression. At the same time the threshold of seizures is decreased due to the use of these medications. Particularly, there is a risk of seizures during withdrawal from alcohol and sedatives and appropriate medication is required when needed, particularly with the history of previous seizures.

Therefore, utilization of medication during detoxification needs to be closely monitored, based on signs of withdrawal according to a standardized scale such as the Revised Clinical Institute Withdrawal Assessment for Alcohol Scale. Also, individuals with the higher potential risk for the above complications of detoxification should be rather referred to a hospital.

During the detoxification period the metabolic status must be assessed and monitored since some individuals may be prone to medical complications development due to pre-existing conditions such as poor nutrition or developed polydypsia.

Detoxification may be guided by CAMH (2008) approach recognizing three basic types of withdrawal management:

– Community management at home where there is health professionals' support
– An individual stays in a centre with more intensive care and supervision
– Medical management when needed for severe withdrawal symptoms, such as seizures or hallucinations. In this case a physician or a nurse supervises the process and a person may stay in a hospital and receive medication to help symptoms as required by his/her medical condition.

Detoxifying individuals means weaning them from physical dependence on substances. This process depends on a person to be able to abstain or there is the risk of medical complications.

There are guidelines for Detoxification of individuals with Dual Disorders provided by Dr. Mueser and others (2003) as follows:

– Evaluation if detoxification is necessary on the basis of signs of physical dependence
– During the process an individual needs to be closely monitored with regard to a possible relapse of the mental disorder and then early signs must be treated
– Monitoring interactions between different medications and a given substance withdrawal, having in mind the risk of side effects: respiratory depression and sedation with high doses of benzodiazepines, lower seizure threshold with antipsychotics and bupropion
– Lower seizure threshold in acute withdrawal from alcohol or sedative/hypnotic medication
– Monitoring metabolic status and appropriate treatment if necessary.

Again, the spectrum of manifestations of withdrawal varies depending on the substance that has been used (Current Medical Diagnosis & Treatment, 2009). Alcohol withdrawal symptoms can range from anxiety, hyper-reactivity, decreased cognition, generalized seizures to delirium tremens. The onset of symptoms is 8-12 hours and the peak of symptoms is 48-72 hours. There is also evidence that these symptoms may persists for a longer term up to 12 months, finally becoming chronic. Therefore the complications may include not only medical, but also economic and psychosocial problems, and they are apparently staggering.

Opioids withdrawal may cause only moderate morbidity symptoms, similar to those of "flu". This withdrawal can be graded from 0 to 4 and treatment can start at the grade 2 (tremors, anorexia, mydriasis, hot and cold flushes and general aching). Pharmacological treatment would then include methadone.

Psychodelics have psychoactive properties producing feelings of tension, emotional release (crying, laughing), perceptual distortions (hallucinations), mood liability, sense of time change, and other terrifying experiences. The main important focus is to protect a patient from possible erratic behaviors that could lead to serious injuries.

Phencyclidine can produce, among others, disorientation, combativeness, increased blood pressure, respiratory arrest, or convulsions.

Marijuana during withdrawal produces insomnia, irritability, nausea and myalgia.

Stimulants withdrawal is characterized by depression, hyperphagia, and hypersomnia. Acute intoxication causes a number of symptoms such as sweating, elevated blood pressure, and acute brain syndrome. Withdrawal from cocaine produces severe depression with often suicidal ideations as well many other symptoms.

Many other substances can produce symptoms during intoxication or withdrawal that are potentially dangerous or lethal.

In conclusion, it appears that recognition of concurrent disorders in everyday practice is a must in order to provide a high standard care following recommended best practice approaches, as proven by at least 25 years of clinical observations and research of treating mental and substance use disorders.

Also, psychological treatment plays an important role in treating mental disorders as well as in the management of individuals with dual disorders. The treatment must be based on a sound diagnostic assessment and monitoring. Psycho-educational effort for individuals with dual disorders may be an important factor leading to shared decisions with regard to treatment. In addition, an appropriate education and training of all professionals involved in the process of assessment and treatment of individuals with co-occurring disorders seems to be of paramount importance. It is also important to provide appropriate medical attention during treatment to treat or prevent a number of metabolic and other possible illnesses. It is also important to recognize that individuals inflicted with those disorders are much more vulnerable and may present with a complex health problems in addition to substance use and mental disorder. There are also important social, economical and family implications as a result of those complex disorders.

It is important to recognize that each patient must be considered as an individual, and therefore an integrated approach with a continuity of care allows more accurate diagnosis and treatment.

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