Substance misuse in patients with acute mental illness

Cherrie Ann Galletly and Darryl P Watson

To the Editor: There has been much public discussion recently about comorbidity between substance misuse and psychiatric disorders.[1,2] Drug and alcohol misuse can precipitate, exacerbate and prolong psychiatric disorders, and is often accompanied by a range of social problems. Here we report on the prevalence of substance misuse in an unselected group of patients admitted to the 20-bed acute psychiatric facility at Lyell McEwin Health Service, situated in an underprivileged region of northern Adelaide. The facility has five closed beds and 15 open beds.

In October 2005, 45 patients (23 men, 22 women; mean age, 39 years) were admitted to the unit, of whom 28 (62%) were detained involuntarily. Semi-structured interviews, clinical history taking and collateral information gathering revealed that 27 patients (60%) had a comorbid substance misuse disorder. The most common substance misused was cannabis (20 patients [44%]), followed by alcohol (16 patients [36%]), amphetamines (15 patients [33%]), opiates (6 patients [13%]) and benzodiazepines (5 patients [11%]). Misuse of more than one substance was common — for example, all 15 patients diagnosed with amphetamine misuse also misused cannabis. Patients who misused cannabis were younger (mean age, 33 years) than those who did not (mean age, 44 years) ($t_{43} = 0.23$; $P = 0.023$) and were more likely to be male (61% of male patients misused cannabis compared with 27% of female patients; $\chi^2 = 5.14$; $P = 0.036$). Of 19 patients with psychotic disorders, 11 misused cannabis.

These results indicate high rates of substance misuse in patients admitted to a psychiatric facility. Cannabis misuse by young men is a particular concern. It is apparent that more than half of inpatients with acute psychiatric conditions could benefit from interventions to address their substance misuse.

The extent of cooperation between drug and alcohol services and mental health services varies between different localities and between the private and public sectors. In states such as South Australia, where there is a historical separation between drug and alcohol services and mental health services, the treatment of these disorders is regarded as outside the role of mental health services. Patients considered to have a primary problem with substance misuse are treated by specialised drug and alcohol services. This service divide does not reflect clinical reality. Patients with comorbidity can "fall through the cracks", each service regarding them as someone else's responsibility.

Postgraduate training in psychiatry includes both academic input and the submission of case logs describing 10 patients with addiction disorders, but this aspect of training may need to be expanded in response to changes in the pattern of disorders in the patient population. Mental health clinicians, along with general practitioners and doctors working in settings such as emergency departments, will increasingly need to be highly skilled in diagnosing and managing comorbid drug and alcohol and psychiatric disorders.

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1 Godfrey K, Yung A, Killackey E, et al. Patterns of current comorbidity in young help-seekers: implications for service planning and delivery. *Australas Psychiatry* 2005; 13: 379-383.
2 Thirthalli J, Benegal V. Psychosis among substance users. *Curr Opin Psychiatry* 2006; 19: 239-245. ❑

A call for help. Australia needs a standard emergency phone number in all hospitals

Gerald F Williams

To the Editor: Much has been written to describe the best clinical protocols to improve patient outcome following a medical emergency in hospital.[1-4] However, one simple step in the process has not been clearly articulated: what is the hospital internal emergency number to ring to summon the medical emergency or "code blue" team?

Each hospital in Australia sets its own emergency phone number. Examples include 333, 444, 555, 666, 777 and 2333 — there are probably others. For the highly mobile workforce in our hospitals, it is often difficult to recall which number to ring when challenged by the immediacy of a situation.

All hospitals should upgrade their phone systems to have a single standard phone number for internal emergencies. This solution has been successfully applied in the broader community. In the Australian community an emergency call is 000, in the United States it is 911, and in the United Kingdom it is 999. It ought to be possible for all Australian hospitals to use a standard emergency telephone number to initiate an internal emergency response. I have only been able to find one health service internationally that has attempted this solution — the UK National Health Service advises trusts to use the number 2222.[5]

Technical advice on what number would be most suitable in Australia would be required. Telecommunications experts should advise on the technical aspects, cost and a reasonable time frame for all hospitals. State and federal health services would need to direct all hospitals to move to the new number, either as able or by a date to be determined.

I hope to raise the debate on what appears, at a superficial level, to be a very simple initiative that could save lives, or at least remove one more cause of error and delay in the internal emergency response of each hospital.[5] I have written to various authorities asking that this concept be explored. Those that have responded agree in principle, but have not taken responsibility for its progression. If this is a good idea, who should or could take control of it? It would be helpful to find an authority to back this proposal. This is a call for help.

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1 Henderson SO, Ballesteros D. Evaluation of a hospital-wide resuscitation team: does it increase survival for in-hospital cardiopulmonary arrest? *Resuscitation* 2001; 48: 111-116.
2 Bellomo R, Goldsmith D, Uchino S, et al. A prospective before-and-after trial of a medical emergency team. *Med J Aust* 2003; 179: 283-287.
3 Hillman K, Chen J, Cretikos M, et al; MERIT study investigators. Introduction of the medical emergency team (MET) system: a cluster-randomised controlled trial. *Lancet* 2000; 365: 2091-2097.
4 Australian Resuscitation Council. New changes to resuscitation guidelines. March 2006. Available at: http://www.resus.org.au/ (accessed May 2006).
5 National Patient Safety Agency. NHS. Crash call. Patient safety alert. 24 Feb 2004. Available at: http://www.npsa.nhs.uk/display?contentId=2400 (accessed May 2006). ❑

"Positive" family planning: another personal viewpoint

Jane M Andrews

To the Editor: I am not a regular correspondent, as, with three children and a career, I rarely have the time. But, having read the recent personal perspective on missed conception[1] and the accompanying commentary,[2] I felt compelled to offer my own personal