

Substance Use Disorder, Serious Mental Illness, and Violence

Diagnostic Criteria for Substance Use Disorder

The diagnosis of substance use disorder (SUD) is determined by the presence of a problematic pattern of substance use that leads to clinically significant impairment or distress, as manifested by at least two of the following 11 criteria occurring within a 12-month period.

The severity is determined by the number of criteria met:

● 2-3 criteria = mild

● 4-5 criteria = moderate

● ≥6 criteria = severe

Criterion Category	Specific Criteria
Impaired Control	<ol style="list-style-type: none"> 1. Substance taken in larger amounts or over longer period than intended 2. Persistent desire or unsuccessful efforts to cut down or control use 3. Great deal of time spent obtaining, using, or recovering from substance 4. Craving or strong desire/urge to use the substance
Social Impairment	<ol style="list-style-type: none"> 5. Recurrent use resulting in failure to fulfill major role obligations at work, school, or home 6. Continued use despite persistent/recurrent social or interpersonal problems 7. Important social, occupational, or recreational activities given up or reduced
Risky Use	<ol style="list-style-type: none"> 8. Recurrent use in physically hazardous situations 9. Continued use despite knowledge of persistent/recurrent physical or psychological problems caused or exacerbated by substance
Pharmacological Criteria	<ol style="list-style-type: none"> 10. Recurrent use in physically hazardous situations 11. Continued use despite knowledge of persistent/recurrent physical or psychological problems caused or exacerbated by substance

Dual Diagnosis and Violence Risk

The presence of co-occurring SUD significantly magnifies the risk associated with symptoms of serious mental illness (SMI).

- Substance use can exacerbate psychotic symptoms (paranoia, delusions).
- Substance withdrawal can increase irritability and impulsive aggression.
- SUD often leads to social instability, poverty, and criminal involvement, all of which are independent risk factors for violence.
- Substance use alone can increase impulsive aggression and psychotic symptoms associated with violence.
 - 8-fold increase in risk with substance use alone.
 - 3x increase in risk when SMI is combined with SUD.
- Risk is especially elevated with alcohol, though also highly noticeable with methamphetamine and cannabis.

Behavioral Manifestations by Substance Class

Substance	Intoxication Features	Withdrawal Features	Physical Signs of Intoxication *Below signs are not meant to be diagnostic but meant as a guide
Alcohol	Inappropriate sexual/aggressive behavior, mood lability, impaired judgment, talkativeness; amnesia (“blackouts”); depression/social withdrawal (during prolonged intoxication)	Autonomic hyperactivity, hand tremor, insomnia, nausea/vomiting, anxiety, psychomotor agitation, transient hallucinations, seizures	Slurred speech, incoordination, unsteady gait, nystagmus, impaired attention/memory, stupor/coma at high levels
Cannabis	Euphoria with inappropriate laughter, grandiosity, sedation, impaired short-term memory, difficulty with complex mental processes, distorted sensory perceptions, sensation of time passing slowly, anxiety (occasionally severe)	Irritability, anger/aggression, nervousness/anxiety, sleep difficulty, decreased appetite, restlessness, depressed mood	Conjunctival injection (“red eye”), increased appetite, dry mouth, tachycardia, impaired motor coordination
Opioids (heroin, prescription opioids, fentanyl)	Initial euphoria followed by apathy, dysphoria, drowsiness (“on the nod”), psychomotor agitation/retardation, impaired judgment, inattention to environment	Dysphoria, irritability, anxiety, insomnia, craving, muscle/bone pain, abdominal cramping, nausea, vomiting, diarrhea	Pupillary constriction (intoxication), pupillary dilation (withdrawal), slurred speech, lacrimation, rhinorrhea, piloerection, diaphoresis, tachycardia, hypertension
Stimulants (amphetamines, cocaine)	Euphoria, enhanced vigor, hyperactivity, grandiosity, talkativeness, anxiety, paranoid ideation, auditory hallucinations, impaired judgment	Depression, suicidal ideation, irritability, anhedonia, fatigue, social withdrawal, increased appetite, hypersomnia	Tachycardia or bradycardia, pupillary dilation, hypertension or hypotension, perspiration/chills, psychomotor agitation/retardation, weight loss

Assessing Potential for Violence (SMI & SUD)

Risk Factor Category	Examples of Relevant Factors
Comorbidity/Substance Use	Active substance use (especially during periods of non-adherence to psychiatric medication), recent or severe intoxication, drug of choice associated with risk of violence (i.e. alcohol, meth, and +/- cannabis, and PCP use), violence used to obtain drugs/money.
Historical (Static)	Prior history of violence or aggression (the single strongest predictor), history of childhood abuse/maltreatment, early onset of antisocial behavior or conduct disorder, family history of violence/antisocial behavior.
Clinical/SMI-Related	Medication non-adherence, poor insight into illness/treatment need, active psychotic symptoms (e.g., persecutory delusions, command hallucinations instructing violence, grandiosity/mania), impulsivity, elevated anger/irritability.
Contextual/Socio-Demographic	Unemployment, homelessness/unstable housing, low socioeconomic status, lack of social support, recent stressful life events (e.g., job loss, relationship break-up), living in a high-crime neighborhood.

Pharmacologic Management of Acute Agitation in Patients with SMI and/or SUD

The table below provides first-line pharmacologic recommendations for managing acute agitation in patients with SMI and/or SUD.

Etiology	First-Line Agents (Route)	Mechanism/Rationale	Key Considerations for SMI/SUD
Psychosis/Mania (Schizophrenia, Bipolar)	Second-Generation Antipsychotics (SGAs): olanzapine (IM/ODT/PO), ziprasidone (IM), aripiprazole (PO) Use caution when prescribing a benzo given abuse potential. (e.g., seroquel, benzos, olanzapine)	Directly addresses the underlying <i>psychotic symptoms</i> and agitation without relying solely on sedation. Lower risk of Extrapyrimal Symptoms (EPS).	Olanzapine (IM) should NEVER be given with IM lorazepam due to the risk of severe respiratory depression (at least 1 hour between administration of these agents). SGA choice is preferred if the aggression is clearly psychosis-driven.
Uncertain/Mixed Etiology (Psychosis + SUD/ Intoxication)	SGA + benzodiazepine (BZD) Combo: e.g., olanzapine (PO/ODT) or haloperidol (IM) + lorazepam (IM/PO) Use caution when prescribing a benzo given abuse potential.	The SGA targets psychosis, while the BZD addresses anxiety, agitation, and the potential SUD/withdrawal component.	IM haloperidol is less effective than SGAs alone, but its combination with IM lorazepam is a standard effective regimen (must monitor for EPS).
Suspected Withdrawal (Alcohol, Benzodiazepine)	Benzodiazepines (BZD): lorazepam (IM/IV/PO), diazepam (PO).	BZDs are the treatment of choice for withdrawal-related agitation as they prevent progression to seizures and delirium. Lorazepam is preferred due to its shorter half-life.	Avoid antipsychotics as monotherapy: They can lower the seizure threshold, especially during alcohol or sedative withdrawal. Use only BZDs or BZD + antipsychotic combination.
Stimulant/PCP/Cocaine Intoxication	Clonidine; hydroxyzine In emergencies consider using Benzodiazepines (BZD): lorazepam (IM/IV/PO)	Calms the severe agitation and motor excitement associated with stimulant intoxication.	Use antipsychotics (e.g., aripiprazole, quetiapine, olanzapine, risperidone, haloperidol) to manage psychotic symptoms, as shown effective in trials. Avoid chlorpromazine and clozapine in stimulant-induced psychosis due to increased seizure risk.

References

- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). American Psychiatric Publishing.
- American Society of Addiction Medicine & American Academy of Addiction Psychiatry. (2024). *The ASAM/AAAP clinical practice guideline on the management of stimulant use disorder*. *Journal of Addiction Medicine*, 18(1S, Suppl. 1), 1–56. <https://doi.org/10.1097/ADM.0000000000001299>
- Department of Veterans Affairs & Department of Defense. (2021). *VA/DoD clinical practice guideline for the management of substance use disorders*. https://www.healthquality.va.gov/guidelines/MH/sud/VA-DoD-SUD-CPG_Final_for-508_v3.pdf
- Englander, H., Thakrar, A. P., Bagley, S. M., Rolley, T., Dong, K., & Hyshka, E. (2024). Caring for hospitalized adults with opioid use disorder in the era of fentanyl: A review. *JAMA Internal Medicine*, 184(6), 691–701. <https://doi.org/10.1001/jamainternmed.2023.7282>
- Gonin, P., Beysard, N., Yersin, B., & Carron, P. N. (2018). Excited delirium: A systematic review. *Academic Emergency Medicine*, 25(5), 552–565. <https://doi.org/10.1111/acem.13330>
- Kim, H. K., Leonard, J. B., Corwell, B. N., & Connors, N. J. (2021). Safety and efficacy of pharmacologic agents used for rapid tranquilization of emergency department patients with acute agitation or excited delirium. *Expert Opinion on Drug Safety*, 20(2), 123–138. <https://doi.org/10.1080/14740338.2021.1865911>
- Nazarian, D. J., Broder, J. S., Thiessen, M. E. W., et al. (2017). Clinical policy: Critical issues in the diagnosis and management of the adult psychiatric patient in the emergency department. *Annals of Emergency Medicine*, 69(4), 480–498. <https://doi.org/10.1016/j.annemergmed.2017.01.036>

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