

Meeting the challenge in care of co-occurring disorders

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Support for addiction medicine is the key

Over the past decade or so, care of people affected by comorbidities of substance use disorder and mental health problems has been a focus of Australian state, territory and national campaigns. Despite these efforts, true coordinated treatment models remain the exception rather than the rule.

Patients with “dual diagnosis” (a term that must now be close to its use-by date) present substantial challenges to existing treatment models. Various mechanisms conspire against these patients getting better: addictive substances exacerbate psychiatric symptoms; patients with mental illness may continue to use psychoactive drugs in an effort to attenuate symptoms; and substances of misuse in themselves can induce psychiatric disorders.¹ Active use of substances often substantially interferes with psychiatric pharmacotherapies. For example, standard antidepressant treatment may not provide the expected benefits in patients with mood disorder and comorbid untreated addiction.²

The field of addiction medicine struggles to recruit doctors, while the level of complexity of patients and the expectations of the community for evidence-supported care across all health fields have increased. Workforce challenges are fed by the perception of clinical complexity, such as that associated with DSM-IV Axis II disorders and substance use (*page S16*).³ These “heart-sink” patients are often referred to alcohol and drug treatment services, where staff expertise in managing behaviours that interfere with treatment delivery may vary.

In Australia, patients with substance use and high-prevalence mental health disorders tend to be treated by alcohol and other drug agencies, while those with low-prevalence disorders, many of whom have significant associated drug problems, are core clinical business for public mental health services. The heterogeneous nature of these services and the complexity of much of this patient group make it hard to know how well either sector performs this clinical work.

The mantra is that we must deliver “integrated care” for optimal patient outcomes. Supporting this is the review by Smith and colleagues, which concludes that an approach that addresses psychiatric and substance use problems is likely to benefit outcomes in problem gamblers (*page S56*).⁴

Alcohol and nicotine are our most popular drugs and carry a corresponding burden of disease that dwarfs illicit substance use. Industries backing these drugs are powerful and tenacious, as seen by the response to recent moves to change tobacco packaging and introduce volumetric taxing of alcoholic beverages. Tobacco and cannabis use is associated with high levels of anxiety and depressive disorders, as evidenced in the 1997 and 2007 National Survey of Mental Health and Wellbeing (*page S12*).⁵ Nevertheless, in some inpatient psychiatric and alcohol and other drug treatment settings, smoking is not assertively addressed, sometimes based on the myth that cessation will exacerbate mental illness or interfere with recovery

from other drug use. Such an idea is unsupported by the study of smokers by Segan and colleagues, which found that smoking cessation was not associated with an exacerbation of depression (*page S7*).⁶

Programs with enhanced approaches to co-occurring disorders often focus on screening and assessment mechanisms. Effective (and clinician-accepted) screening and assessment tools enable clinicians to identify comorbidity in patients and plan comprehensive management. Identification of comorbidities by both alcohol and other drug and mental health services is a good start, but does assume that integrated care is accessible. The availability of services, particularly those that are able to support mental health care in management of people with identified comorbid addictive disorders, remains a substantial challenge for Australia.

Although medical care is yet to be delivered by robots, technologies using online social networks, handheld devices, phone, text, internet and global positioning system functions, videoconferencing and software-assisted care have a huge scope in mitigating workforce issues. Computer-assisted treatments offer promise by addressing issues of access (given that care for comorbidity is often not reaching patients in need) and potentially ensuring structure and consistency in approach (*page S44*).⁷ Pleasingly, treatment approaches using new technologies are now seen as important enough to warrant Medicare telehealth items.

Developing a workforce capable of providing good medical care of comorbid disorders requires a foundation of specialist support from psychiatry and addiction medicine. Given the burden of addictive diseases on the community, including those co-occurring with mental illness, the specialty of addiction medicine is embarrassingly poor in trainee and consultant positions, a balanced mixed public and private specialist sector, and a critical mass of clinical leadership. Over the past decade, Australia, like North America, has experienced increasing harm from prescription medication, with an exponential growth in numbers of patients with the trio of opioid addiction, mental illness and chronic pain (rendering the term “dual” diagnosis obsolete).

Publicly funded health care, including mental health care, has always struggled to deliver services due to ever-tightening health budgets. If we want to grow the capacity of Australian health care to manage co-occurring disorders, we must recognise all the medical crafts that provide expertise and leadership in this area, and particularly in the field of addiction medicine.

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