

## Substance use and mental illness co morbidity

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## Impact of SUD on mental illness, and vice versa

- More serious clinical problems
- More serious social problems
- Higher service utilisation
- Higher costs
- Worse outcomes

## Co morbidity associated with increased risk of

- Suicide
- Homelessness and unstable housing
- Violence
- Victimization
- Criminal activity
- Family problems
- Hospitalisation

## What's the problem?

- Complex poorly understood interactions
- Double stigma of co morbid substance and mental health disorders
- Loss of continuity of care
- People falling between services
- Social changes – substance use, families etc
- Co- morbidity the exception or the rule?

## % patients with a “primary SUD” who have a coexisting Mental illness

- 32% Affective disorder
- 24% Anxiety disorder
- 46% women Affective or anxiety disorder\*

ECA Regier et al JAMA 1990

\*National Survey of Mental Health and Well being 1997

## % patients with a “primary mental illness” who have a coexisting SUD

- Antisocial PD 84%
- Bipolar Disorder 61%
- Schizophrenia 47%

ECA Regier et al JAMA 1990

- 60% of male psychiatric inpatients and 40% of female psychiatric inpatients had hazardous / harmful alcohol consumption or dependence

(Hulse Get al 2000)

## Why is there an association?

- Substance use causes mental illness?
- Shared risk factors
- Self medication – symptoms or side effects
- Mental illness predisposes to positive reinforcing effects of substances
- Mental illness – hypersensitive to effects of substances?
- Social vulnerability of mental illness brings them into contact with substance abusing population
- Substance use facilitates social contact / coping

## Clinical issues

- Unstable illness
- Substances exacerbating mental illness
- Substances causing mental illness
- Unstable social circumstances
- Difficult engagement
- Poor compliance
- Interaction with medication / treatments
- May not be recognised / diagnosed

## Service issues

- Separate historical origin
- Separate organisational structure
- Separate training
- Separate geographical locations
- Different roles
- Limited skills in the other's area
- Who is responsible?
- Entrenched values and opposition to change

## Problems identified by families: FACT (families and carer training)

Families of patients with SUD most concerned about:

- Services for families (~ 70%)
- Access to mental health services (~ 60%)
- Patient unwilling to enter treatment (~ 60%)
- Access to treatment for patient (~ 60%)

## Problems identified by services

- Lack of dual diagnosis services adolescents
- After hours service, especially D&A
- Lack of specialist dual diagnosis services
  - Coordination of care across different services
  - Rehab – where do you get it?
  - Respite care
  - Accommodation
  - Services for families
  - Stigma and prejudice from mental health services

(Queensland) Kavanagh et al 2000

## Challenges with working with dual diagnosis clients

- Aftercare (maintaining stability, follow up)
- Treatment Compliance
- Medication management
  - Mental Health Act issues
  - Management plan development
  - Family management
  - Assessment of mental health problems

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## What treatments work?

- Relatively few studies
- What outcome measures?
- Assertive case management
- Brief interventions
- Psychotherapy
- Pharmacotherapy
- Treating the co morbid disorder
- Specialist dual diagnosis services

## Potential Solutions

- Sharing information
- Screening on intake
- Joint case conferences
- Intermingling of staff by various means

Kavanagh et al 2000

## Potential solutions

- Dedicated dual diagnosis service
- Specialist skilled dual diagnosis workers in each mental health team
- Up skilling all mental health staff
- Up skilling all AOD staff

## Current activity

- Mental health and substance use disorder: service delivery guidelines and discussion paper (current audit)
- Hunter Dual Diagnosis Project CD ROM
- Institute of Psychiatry manual of substance use disorders for mental health clinicians
- Engagement with Drugs program bureau
- NSW Health Alcohol summit
- National Co morbidity Taskforce
- Prevention and early intervention initiatives

## Local initiatives between MH and AOD services

- Regular Meetings
- Working groups
- Service agreements/ MOU
- Incident reviews
- Project officers
- Addiction psychiatrists and registrars
- Joint case management/ case conferences
- Shared assessment tools
- Outcome evaluation
- Specialist dual diagnosis services

## Service Issues

- Parallel, sequential or integrated
- Universal precautions vs. specialist services
- Role of GPs, Emergency departments, NGOs
- Pressure of demand
- Resources
- Sharing information

## What do MH and AOD services do?

- Case identification
- Engagement
- Assessment
- Diagnosis
- Treatment
- Follow up
- Relapse prevention

## What do MH and AOD services do?

- Standardised assessment tools
- Evidence based treatments:
  - Counselling
  - Psychotherapy
  - Pharmacotherapy
  - Inpatient, outpatient and residential
- Mix of primary, secondary and tertiary, and NGO
- Pretty much the same, or different?

## Integrated treatment

- Engagement
- Persuasion
- Active treatment
- Relapse prevention

Drake et al 1998

## What can AOD and MH services learn from each other?

- Importance of motivation
- Techniques of engagement
- Utility of individual and group therapy
- Use of client peer support
- Clearer understanding of role of mental state and underlying mental illness
- Role of medications
- Use of outcome measures and evidence based treatments
- Role of coercive treatment

## Training Issues: Needs

- Psychological interventions (eg Motivational interviewing, CBT)
- Diagnosis / classification / recognition
- General treatment management issues

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## Training Issues: Barriers

- Insufficient available quality training
- Excess workload
- Insufficient funding
- Not seen as a priority

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## Training Issues: Essential ingredients

- Multidisciplinary nature
- Regular
- Expert led
  
- Need to involve GPs

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## NGO issues

- Linkage with health and other services
- Referral pathways
- Admission criteria
- Program structure
- Outcome evaluation
- Funding sources
- Expanding roles

## Hard questions

- What does working together mean? Separate vs. Integrated vs. Assimilated services
- Who is responsible?
- Philosophical differences
  - Involuntary treatment
  - Harm reduction vs. abstinence
- What treatments WORK – clear what doesn't
- Why do people use substances dangerously

## Other issues

- Variety of qualifications and skills
- Acute vs. chronic problems
- Special populations: adolescents, NESB, indigenous
- Research
- Prevention
- Families and carers
- More, more types and more potent substances

## Summary

- Skills development
- Better coordination of health services: sequential, parallel, integrated or assimilated
- Better coordination with other services and NGOs
- Resource expansion
- Research
- Prevention