Concurrent Disorders: A Cat Chasing Its Tail

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Abstract

Dual disorders manifest as a social problem of high prevalence and great importance. The stigma associated with mental illness and substance use has been well documented and conceptually distinguished from physical disease. Those who suffer from mental health and substance use disorders recognize this sense of opprobrium, and their illness inevitably leads to social ostracism, self-deprecation, repeat or chronic self-harm experiences, the fear of being judged by authority figures, and the danger of suicide. Individuals with concurrent disorders often end up in acute care facilities, with inadequate follow-up, at great expense to the healthcare system. Despite the burden of concurrent substance use and mental illness, there is a lack of consensus on how to best identify and treat this pathology. These gaps in our knowledge base need to be addressed. It is mandatory that additional research be conducted to identify and engage the large number of individuals affected by both psychiatric and addictive disorders in a therapeutic manner. These realities highlight the need for the intelligent rationing of resources.

Patients suffering from co-occurring mental health and substance use problems, concurrent disorders, represent a heterogeneous and vulnerable population that faces unique challenges, including frequent relapse and rehospitalization as well as misdiagnosis and mistreatment.[1-5] Many of these individuals struggle to cope with deconditioning and insults to their overall well-being, most prominently including the risk of HIV and hepatitis C infection.[1,3,6] As a consequence, persons with concurrent disorders often experience higher rates of unemployment, incarceration, relationship difficulties, homelessness, and an increased risk of suicide, victimization, and social marginalization.[1,3,7] To further complicate matters, Canada's mental health and addiction systems primarily function independently of each other, and patients are often subject to a "one size fits all" treatment strategy that fails to appreciate their duality and does not address their diagnostic complexity.[1,5,8] Although the mental health and addiction systems in Ontario recognize individuals with concurrent disorders as a priority population, there is currently no standardized, province-wide system of evidence-based performance measurement for the mental health and addictions sector.[5,9] These therapeutic barriers prejudice this undertreated population and society as a whole. This apparent gap in the knowledge base of clinicians, the associated consequences for patients in terms of the implementation of policy and eligibility for services, and future directions will be reflected on in this paper.

There is no consensus among the various health service providers regarding the inclusion criteria for "concurrent disorders." The discrepancies in definition extend from process addictions, such as gambling, shopping, and sex, and go so far as to include tobacco use disorder.[5] In general terms, the working definition of the term "concurrent disorders" refers to patients experiencing a combination of mental or psychiatric illness coincident with the abuse of alcohol and/or other psychoactive drugs.[1] From a diagnostic perspective, this descriptive refers to any combination of mental health and substance use disorders, as outlined in the DSM-V.[2]

The causes of addictive behaviours are complex, involving both innate and social forces.[3] The bio-psychosocial-spiritual model suggests that people with a concurrent disorder are not a homogeneous population in terms of etiology but rather a group of heterogeneous subpopulations with vulnerability to disease.[1-4] That is to say, their pathologies stem from variable genetic loading, the biological impact of progressive physical illness, psychosocial disintegration, cultural disruption, and access to substances of abuse. From this perspective, one can more easily refer to a set of diverse "concurrent disorders" rather than a solitary disease entity.

From a diagnostic viewpoint, the relative proportion of the mental health as opposed to the substance-induced component of concurrent pathology is based on a "chicken and egg" chronology, with primary and secondary designations being determined by history.[1-3,10] In reality, the typical real-world clinical presentation of co-occurring disorders is more nuanced – and in need of diagnostic clarification over time. Healthcare professionals must investigate the relationship between the mental health and substance use problems and

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examine the intersection between these disease processes.[1-3,10] Failing clear evidence of causation, it is most useful to presume that an individual suffers from separate substance use and mental health problems that interact with each other and require personalized treatment.[3]

It follows that the prevalence of concurrent disorders varies depending on the substance of abuse and the particular mental health diagnosis in question.[5] Regier and colleagues noted that 37% of individuals diagnosed with an alcohol use disorder are likely to also suffer from a co-occurring mental health disorder during their lifetime, whereas the likelihood of co-morbidity for those using substances other than alcohol was approximately 53%.[11,12] On the other hand, it was found that 29% of people diagnosed with mental health disorders will also have a substance use disorder during their lifetime.[11,12] O'Campo and colleagues have suggested that 10 to 20% of the homeless population in North America have co-occurring mental health and substance use disorders, and other experts believe that the true prevalence of these maladies is much higher.[13] Despite the perverseness of this pathology, there is a lack of knowledge and training around how to best identify and treat concurrent substance use and mental illness.[1,3,5]

It is not surprising that this burden of pathology has an economic price and that mental illness in Canada is estimated to cost up to $51 billion per year.[14] Pan-Canadian data suggests that individuals diagnosed with concurrent mental health and substance use problems constituted approximately one third of psychiatric inpatients.[15] Individuals hospitalized with dual disorders were more likely to be readmitted within 30 days and one year of discharge (62% to 53.2% increased likelihood, respectively) as compared to individuals with the single diagnosis of schizophrenia or psychotic disorder.[15] During the year following discharge, those with co-morbid disorders were expected to remain in hospital 19% longer than those without either a mental health or substance use diagnosis.[15] It follows that targeted investment by the Canadian Federal and Provincial governments in the integration of hospital-based and outpatient services, particularly community and home care services, when combined with diagnostic acumen, has the potential to repurpose scarce economic and human resources with great social benefit.

From a therapeutic perspective, psychiatric disorders are negatively associated with the outcome of substance use treatment and particularly with the ability of patients to withdraw from opioids, benzodiazepines, cocaine, and even alcohol.[1,16-18] Concurrent mental health and substance use disorders increase the probability that patients will relapse, manifest noncompliance, and prematurely abandon treatment.[1,19-21] These individuals often have difficulty establishing a therapeutic alliance and have been reported to experience intense transference and counter-transference reactions limiting their therapy.[1,3,10,22] For this reason, it has been suggested that "retention and treatment" is the best predictor of therapeutic success. The doctor-patient relationship must thus be nurtured by means of a nonjudgmental "don't ask, don't tell" stance that is intended to reduce harm while directing the patient toward more definitive treatment.[23]

The definition of harm reduction remains a matter of ongoing debate, but most experts accept as its core principal "any policy or program designed to reduce drug-related harm without requiring the cessation of drug use."[23] This concept of harm reduction has been endorsed as a pragmatic set of practices within a continuum of care geared to the stabilization of psychiatric or acute substance use symptoms. However, prior to making a psychiatric diagnosis and developing a long-term treatment strategy, the clinician must observe the patient substance free for a minimum of three to six weeks, and sometimes for much longer periods, particularly given the protracted withdrawal syndromes that patients can experience with opioids, benzodiazepines, and even stimulant drugs.[1,3,4] Inpatient treatment pending stability is the ideal, with care provided by means of a single most responsible physician, within a single program. The effective treatment of both concurrent conditions, sequentially or in tandem, is the key, or neither will improve.[1,3,4] At the same time, although relapse to substance use has usually been considered a treatment failure when managing single disorders, this approach has not been the case in the therapy of duly disordered patients.[1,3,4]

Instead of one unified system of care, there are currently two fiefdoms in the form of a mental health system and a substance abuse system, each having its own set of stakeholders and power structure.[1,5,24] Patients have reported being forced to comply with the divergent rules of psychiatric and addiction facilities and with therapeutic discharge to the street rather than to an alternative level of safety.[1,5,24,25] A 2017 Health Quality Ontario (HQO) report highlighted this disparity in access to treatment.[25] In fact, first contact visits to emergency, hospital readmissions, and follow-up visits with primary care doctors or psychiatrists for this cohort varied significantly between Ontario's Local Health Integration Network (LHIN) regions in 2015.[25] HQO examined more than 1,000 organizations in Ontario, but a failure to focus on the mental health and addictions sector has limited the ability of regulatory authorities to accurately evaluate quality of care.[9,25]

The ensuing lack of therapeutic direction in Ontario resulted in a fragmentation of services and in the paradoxical belief that we are saving money in primary and secondary healthcare sectors while actually losing it within our tertiary system. The Concurrent Disorders Ontario Network (CDON) administered through the Centre for Addiction and Mental Health in Toronto was active from 2005 until 2010 and was intended to promote system coordination and integration, with the goal of developing a seamless continuum of services to patients with concurrent disorders.[5] Today, "Open-Minds, Healthy Minds – Ontario's Comprehensive Mental Health and Addiction Strategy", conceived in 2011, is intended to support mental health throughout life, from childhood to old age, and to provide integrated services directed at dual disorders.[9] The implementation of a mental health and addictions data and quality strategy, including the formulation of performance measures, will enable the standardization of care across hospitals and community-based mental health and addiction organizations for the benefit of this patient population.[9]

It is clear that strong linkages across mental health and substance use agencies are a necessary prerequisite in the treatment of dual disorders. Human oversight is the tie that binds treatment and outcome. A truly patient-centred system will require a care facilitator, who, like the conductor of an orchestra, will act as an interface between the patient and treatment team.[3,26] Care facilitators can be non-clinicians or healthcare professionals who provide a central point of contact in this therapeutic process, with a view to monitoring compliance and promoting treatment retention. This arrangement mandates further training, which will allow for a focused multidisciplinary team that addresses the needs of a complex patient population whilst avoiding splitting.[1,3,5,26] A parallel redistribution of disability supports addressing issues such as childcare, housing, transportation, and education, along with outreach and intervention, will convince patients that the cost-benefit of recovery is worth their time and effort.[1,24,27] Health Canada has now acknowledged that new funding sources will be required in order to accommodate the multiple mergers across provinces that are necessary to implement this new model of unitary care for concurrent disorders.[1,5] Some provinces and territories have already begun the process of amalgamating their mental health and substance use systems based upon this understanding of a difficult problem. The process of integration should continue because the associated cost of turnstile admissions to psychiatric emergency departments or detoxification facilities is prohibitive, but also because it is the right and humane thing to do.[5,25]

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