

Comorbidity

Definitions

In the National Comorbidity Project – Comorbidity of mental disorders and substance use in general practice - the term 'comorbidity' refers to the coexistence of a mental health problem with some form of substance use. This is a broader concept than the co-existence of severe mental disorders and diagnosable substance use disorders and is more relevant to primary health care than applies in tertiary care settings. (National Comorbidity Project, 2003) This threshold of recognition is more appropriate to achieving early and effective interventions.

A dual diagnosis client has been described by Bradley and Toohey (1999) as 'an individual who has a co-existing mental illness and substance abuse disorder without a determination of which disorder is causative or primary, or an individual with a mental illness and co-existing problematic substance use condition which seriously precipitates or exacerbates positive and negative symptoms of their mental illness.'

In this discussion paper the term comorbidity disorders is used as shorthand for co-occurring mental health and substance use disorders accepting that some latitude in 'diagnostic accuracy' is in the interests of more effective treatment, especially in the early stages of disorders. Other terms which are commonly used are dual diagnosis, comorbidity, co-existing mental health and substance use disorders/problems and mental illness and substance abuse.

Background

Recent literature and reports from alcohol and other drug (AOD) workers, indicate that people with comorbidity (co-occurring disorders/dual diagnosis) are perceived to be time consuming, difficult to manage and to adhere poorly to treatment regimens, (reference to NADA/MHCC material IWW), highly mobile (homelessness is common), lacking in social supports, emotionally labile and at high risk of having more severe psychiatric symptoms. They are believed to relapse more often and be readmitted to emergency departments and hospitals more frequently than either mental health or drug and alcohol problems alone. (Sitharthan et al: 1999)

There is a body of literature describing the optimal configuration of mental health and drug and alcohol services with carer and consumer input (Cupitt et al: 1999) and there is research to show the cost-effectiveness of treating the disorders concurrently. (Bradley and Toohey:1999). So far in Australia, there are relatively few examples of this level of integration. Those that do exist tend to be based on US models and have an abstinence-based approach.

The prevention of comorbidity and the provision of treatment and rehabilitation are major challenges for health and human service systems. This should be a high priority for government and for non-government agencies.

Epidemiology

Australian studies show the prevalence of people affected by a mental health disorder in the general population in a 12 month period is 18 per cent. The prevalence of those affected by anxiety, affective and substance use disorders is 2.8 per cent of the male population and 2.0 per cent of the female population in a 12 months period. Of people affected by low prevalence disorders such as schizophrenia and bipolar disorder 76 per cent had used nicotine in the 12 months period and the life-time diagnosis of alcohol disorder was 30 per cent and cannabis disorders 25 per cent. (Andrews et al., 1999)

There are similar patterns in other countries, for example, the Epidemiological Catchment Area Study in the US reported in 1990 that of the persons suffering from an alcohol disorder 37 per cent had another mental health disorder, those with a drug disorder 53% had another mental health disorder and of those with antisocial personality disorder, schizophrenia and affective or anxiety disorders the rates of alcohol disorder were respectively 74 per cent, 34 per cent, 22 per cent and 18 per cent. (Regier et al., 1990) Another study has shown the people with a life-time diagnosis of addiction disorder, 50 per cent have a mental illness and those with a life-time diagnosis of a mental disorder 50 per cent have a substance use disorder (not including alcohol use disorder). (Kessler R et al., 1996) In drug treatment services in the US 50 to 70 per cent are reported to have a mental disorder. (Sacks S et al., 2007) Other studies estimate the prevalence of comorbidity disorders ranging from 32%-87% which can be as 90% in males with schizophrenia. (Bradley and Toohy, 1999; Cupitt et al., 1999).

Alcohol and other drug workers in NSW estimate that between 30 and 90% of clients have a dual disorder (McKey: 1998) and research in psychiatric in-patients has estimated current or past substance use disorders at 64% (Bradley and Toohy: 1999). In detoxification centres up to 50% of patients can have a formal diagnosis of a mental illness. (Personal observation, 2008)

Thus Australian experience broadly indicates the prevalence of alcohol and substance use disorders is 30 to 80 per cent in mental health programs (depending on the substances) and in drug and alcohol programs the rates of mental disorders are of a similar magnitude, again depending on what is included.

These data point to the overlap in diagnostic classifications of mental illness and disorders and of addictions, dependence and problematic alcohol and substance use.

The nature of the problem

The predicament of a person who experiences comorbidity disorders is not readily captured by a diagnosis. Their situation goes beyond diagnostic descriptions of - disease, mental illness, impairment or disability (although disability comes closest to the situation). Not only are intrinsic characteristics important in these cases but account must be taken also of the social milieu and material circumstances. The diagnosis may be a small part of the person's situation. When continuing alcohol or other drug use is added the significance of a diagnosis can be even more problematic. Thus the complexities of comorbidity disorders do not allow for the tidiness sought in the usual processes of clinical diagnosis. On the contrary, specialised and reductionist approaches create their own problems as mental dysfunction is handed on to the psychiatrist,

alcohol and drug problems to the addiction specialist and the body symptoms to organ specialists.

Drugs and neurotransmitters

In the brain there are neural networks and transmitters in the mesolimbic system which monitors inputs from body systems to maintain homeostasis. These systems are concerned with subconscious processes of motivation, drives, emotion, anxiety, depression and sense of well-being and are linked to sensations of pain, pleasure, fear, heat, cold and hunger. These are the sites where psychoactive drugs, opioid analgesics and alcohol and other substances have their principal actions. These are the areas principally involved in mental illness and addiction. Thus there are not only overlaps in diagnosis and psychology but also in the basic mechanisms of neurobiology.

Mental illness, substance use disorders and physical illness

The users of mental health services who represent approximately eight per cent of the Western Australia population have high rates of physical illness. In a study reported in 2001 death rates in this group were 2.5 times higher than the general population and they accounted for half the state's suicides. The excess deaths were due mainly to heart disease. The suicide rate was increased twofold and there were higher rates of infectious disease. Hepatitis C and HIV and a range of other physical conditions were more common than in the general population. (Coglan et al., 2001)

Thus physical illness is common in people with mental illnesses and on their own demand greater commitment to prevention in mental illness, for example, of tobacco smoking, alcohol misuse, inactivity and overeating. It is incumbent, an obligation, on the welfare and health services to ensure that people with mental illnesses gain access to the health care they need.

Tobacco and alcohol are powerful biological agents which together and separately are major risk factors for chronic lung disease, hypertension, vascular diseases (cardiac, cerebral and peripheral), gastrointestinal and liver disease, cancers (nasopharyngeal, lung, oesophagus, stomach, bowel, pancreas, liver and breast), and neurological diseases. Together these two agents caused 22 290 of all deaths in 1998 (AIHW website). Other psychoactive substances affect physical health in other ways with the highest risks being from injecting drug use (and high risk sexual behaviours) of HIV, hepatitis C and B infections.

Thus when alcohol and other drug problems are added to mental health disorders the claims for prevention, early intervention and treatment are indeed pressing.

Barriers to effective management of dual diagnosis clients

A number of barriers to the provision of treatment for comorbidity disorders have been highlighted in reports from clinical staff and through research studies. These include:

- 1 a paucity of services;
- 2 poor integration of services;
- 3 difficulties in making an appropriate diagnosis;
- 4 competing professional and service paradigms;
- 5 a failure to involve consumers and families;
- 6 marginalization and stigmatization of clients and families;
- 7 lack of training, skills and commitment of staff; and,
- 8 an inability to recruit skilled staff.

Additionally services for people with mental health problems generally focus on those with most serious illness thus limiting the ability to reach people in the early stages of disorder(s). Also the heavy focus on pharmacological treatment for mental illness has the effect of limiting the deployment of other options (counselling, support, etc.) and frequently neglecting other important health problems (nutrition, physical illness, drug taking, etc.).

The problems in service delivery highlight the need for a concerted national approach for comorbidity disorders.

New approaches

Effort and funds need to be invested in prevention, primary health care, treatment, rehabilitation and recovery for co-occurring disorders. This cannot occur without substantial system reform. For example there are long-standing structural impediments in managing comorbidity:

1. low prioritisation of mental health, drug and alcohol services and of programs to integrate these services,
2. lack of knowledge, skills and confidence in front-line workers to manage people with co-occurring disorders; and
3. the perceived complexity of the problems.

Prevention

ADCA's policies on prevention, interventions in the workplace, and harm reduction are relevant to preventing the development of occurring disorders and are cited in the relevant sections in ADCA's policy statements. These emphasise the importance of primary prevention and early intervention programs in alcohol and other drug problems.

The National Drug Strategy and programs run by State and Territory Governments aim to prevent the uptake of harmful alcohol and drug use and to intervene at all levels to prevent problematic alcohol and other drug use and disorders, lessen the harms caused and prevent the harmful consequences, for example, HIV/AIDS and hepatitis B and C transmission and infections. Effective prevention will in turn prevent the incidence of problematic comorbidity disorders.

There are strategies for prevention in mental health - the National Prevention and Promotion of Mental Health Strategy and Living is for Everyone (LIFE) the Strategic Framework for Suicide Prevention. These national initiatives and parallel programs in the states and territories set the agenda in mental health to prevent co-occurring disorders and outline the principal policy directions.

Universal interventions aim to lessen the exposure of the whole population, for example, to alcohol and other substances through controls on advertising and promotion; to reduce risks, for example through child abuse protection, school bullying; and, to promote resilience through school education, family support and welfare, community development and provision of basic services.

Where there is evidence of risk and harms in groups and communities, the aim in prevention is to promote self help and support, increase social cohesion and resilience and to focus preventive campaigns and service provision on the epidemiological risks of substance abuse, mental health and suicide in these communities.

The next level of prevention is closer to the individual to intervene directly in problems of mental health and substance use as they evolve. These actions concern primary health care - general practitioners – and other front-line workers and environments, such as schools, work places and some institutional settings. Here the aim is to identify individuals at risk or who need help and to act.

In treatment settings prevention aims to interrupt the development of the full picture of comorbidity disorders and to prevent complications, for example of liver disease and neurological damage.

Treatment

The bedrock principles for treatment are:

- 1 There are no 'rules' which precisely fit a particular case.
- 2 No person should be barred from treatment for reasons of having co-occurring conditions.
- 3 There are effective treatments for alcohol and other drug abuse and for mental illness and disorders which can be appropriately used in co-occurring disorders.
- 4 There should be ready access to general medical care.
- 5 The affected person is entitled to the same support and services as other citizens.

In managing comorbidity disorders the key therapeutic strategies are to:

- 1 identify the presence of a "second" disorder – all individuals presenting for treatment should as a minimum be screened for a co-occurring disorder,
- 2 assess mental health and substance use disorders, each in the context of the other,
- 3 intervene in psychological and neurobiological processes using evidence-based approaches,
- 4 treat concurrent diseases and impairments,
- 5 promote and reinforce a change in the person's view of themselves, their options and problems-solving,
- 6 support and assist the other needs of the person and their families – social, family and health.

Guiding principles

The origins and pathways in comorbidity disorders are nonspecific. Mental illnesses and disorders and the psychoactive substances are many, additionally there are many associated physical conditions and complications. Thus to build a comprehensive evidence base for all the possible permutations and combinations of comorbidity disorders is unlikely to be fruitful enterprise.

For some of the common comorbidity disorders it will be possible to define relatively specific guidelines - alcohol with depression or schizophrenia, cannabis and schizophrenia, methamphetamines and psychosis and/or benzodiazepines and anxiety. In general, however, it is the overall attitudes of acceptance and guiding principles which are most relevant to managing comorbidity disorders.

Clinical strategies

To be able to implement the above management strategies in practice demands a repertoire of approaches to be in place or readily available at the front-line of service delivery.

The key elements are set out below: -

Plans for managing crises (see appendix): The major crises in the presentations of co-occurring disorders need protocols for immediate implementation.

- 1 Psychosis, drug-induced or otherwise.
- 2 Intoxication.
- 3 Attempted suicide.
- 4 Injury and intercurrent disease.

Acceptance: It is important that the affected person is assisted to understand they will be treated with respect and dignity. This requires a careful and unhurried style of engagement.

Screening and integrated assessment: Screening aims to determine whether the person with a substance use (or mental health) disorder has signs suggesting the presence of a mental health (or substance use) disorder. The procedure aims to determine whether further assessment is needed. The objectives of integrated assessment are to (a) make a formal diagnosis, (b) evaluate functional capacity, (c) evaluate physical health and social needs, and, (d) develop the initial treatment plan.

An open door for primary care: Comorbidity disorders present most frequently in community settings - especially when families, the judicial system, schools and work places are involved. Therefore at this point of contact it is unreasonable to set eligibility criteria which focus on one disorder exclusively (mental health or drug and alcohol) and exclude persons with the other disorder.

Evidence-based treatment: The prime objective is to intervene as early as possible in the course of an illness/disorder. As the condition(s) progresses there is a need for more intense psychological and medical treatment as well as group and residential therapeutic community programs. Each of these intervention methods has research evidence of effectiveness.

However a key factor influencing outcomes is whether or not the affected person remains involved in the program to allow time for change to occur. Thus there is a body of evidence on the effectiveness for treatment and rehabilitation in mental health and alcohol and drug problems separately, but the data for comorbidity disorders are still limited.

Pharmacotherapy: Some 'psychiatric' medications are useful in addiction, for example, during withdrawal and for psychotic symptoms, depression and anxiety disorders. On the other hand pharmacological treatment of mental disorders can lessen the use of substances and moderate the course of addiction and its outcomes. But during periods of intoxication and acute withdrawal skill and care are needed to use these medications and in general they should only be used under medical professional supervision. The pharmacotherapies for alcohol, opiate, psychostimulant and nicotine addiction can be used following careful assessment and follow-up and attention to drug interactions in the presence of a co-occurring mental disorder. There is extensive clinical research currently being undertaken to assess the role of pharmacotherapy in some of the common patterns of co-occurring disorders, for example, alcohol dependence and depression.

Non-medical treatments: Psychological interventions - psychotherapy, cognitive behavioural therapy, dialectical behaviour therapy, therapeutic group programs and residential therapeutic communities have been evaluated separately for mental health and substance use disorders. They contribute in different ways and represent significant elements of the armamentarium for treating comorbidity disorders; but more research is needed to strengthen and guide best practice.

Recovery: The processes of recovery from mental health and substance use disorders have much in common. Thus the "recovery movements", with thoughtful modification and implementation, have much to contribute in the process of 'recovery' from comorbidity disorders.

Non-government organisations have a long history of initiating treatment programs for these problems. Their approach is often centred on particular paradigms of treatment based on views of the causes and nature of the underlying problems. It is important, therefore, that non-government organisations be encouraged to accept people experiencing comorbidity disorders as many have developed exclusive selection criteria centred on mental illness or addiction.

Realistic expectations: The client needs to be assisted to understand what the health professional can do, what others can do, and, what they themselves can and need to do.

Organising time and anticipatory care: When addiction and mental health disorders occur together more time is needed for change and improvement. It takes time to undo long-term patterns of living. Also treatment becomes more complex and lengthy. Time is a precious asset which needs to be managed carefully. Thus arranging frequent but shorter visits and sharing time with other members of the treatment team can be a useful approach.

People affected by comorbidity disorders experience difficulties in problem-solving and planning. Thus follow-up visits scheduled at defined intervals can lessen the number of crisis presentations and provide anticipatory care.

A system of linked care: In chronic and relapsing conditions an acute presentation is one episode in a long trajectory. This is especially true with emergency department presentations, mental health crises and on discharge from treatment or rehabilitation facilities or other places such as prison. The management of the presenting episode or crisis is critical to achieving long-term outcomes but improvement will depend ultimately on continuity and follow-through. Each link in the chain of care is only as effective as the strength of its link to the next stage in the process. These links in care are most important when the person's needs are compounded by multiple problems.

Community care: People with comorbidity disorders have the desire to live normally in the community and wish to be supported to do this. Thus general practitioners, community health and other community-based services are the key front-line agencies for community care of comorbidity disorders. When mental health is the main problem, access to mental health treatment is imperative; similarly access to specialist drug and alcohol services is needed when that issue predominates. Thus these services should function so as to integrate their responses to people experiencing comorbidity disorders.

People who suffer most from comorbidity disorders are often the most marginalised and stigmatised group in our society. There is a high risk of homelessness. One of their greatest needs is a place to live, an environment of safety, personal space, support and access to health services. Much of this provision depends on the good-will of non-government organisations which are poorly funded to perform this role. In a number of states supported public housing is being made available for people with mental illnesses and for some with comorbidity disorders; ADCA strongly endorses these initiatives. But there is a wide gap between the needs and the response.

Organisational change

For services to have the capacity to manage comorbidity disorders there are some necessary elements: -

1. Formal screening protocols to answer the question, "Is there a possible mental (or substance use) disorder in the person presenting with a substance use (or mental) disorder?"
2. Protocols for integrated assessment to (a) make a formal diagnosis, (b) evaluate functional capacity, (c) evaluate physical health and social needs, and, (d) make initial treatment plans.
3. Arrangements for continuing treatment and re-evaluation of service outcomes.
4. Implementation of evidence and consensus-based practice.

The ability to effect these changes will require -

1. Competent and committed staff.
2. Clinical databases which are capable of sharing information.

3. Integrated systems of management.
4. Leadership in managing change.
5. Integrated budget allocations and management.

As the community comes to recognise that comorbidity disorders are common in populations with mental illness and substance use problems new administrative arrangements are being set in place to integrate mental health and drug and alcohol services. Governments and non-government organisations must facilitate and fund these changes in health and welfare systems

Summary and recommendations

There is a widely held view among front-line workers, other service providers and advocate organisations that comorbidity disorders¹ are significant problems which are not managed optimally. The Australian and international literature supports this view. The available research indicates that the most effective programs are those developed locally and which involve input from those affected and their carers.

There is a clear need for a national approach to this ubiquitous problem given the evidence of unmet needs and the inconsistent approaches operating in different jurisdictions.

In addressing this social and public health problem, policy makers and funding bodies should adequately fund research, education and training and new models of management. Initiatives which promote close cooperation between mental health and alcohol and other drug sectors should be given the highest priority. But support and training of general practitioners and other front-line practitioners must be the first line of attack.

- ADCA supports the Federal Government's initiatives in the National Comorbidity Project and the funding of co-occurring mental health with illicit drug disorders through the Council of Australian Governments (COAG) Mental Health Agreements. ADCA acknowledges that the Australian states and territories are beginning to implement more appropriate responses to comorbidity disorders. Initiatives which reach out to community-based organisations are especially welcome, for example, the NSW Government's funding of the Network of Alcohol and Drug Agencies and Mental Health Coordinating Council for research partnerships in comorbidity. Such initiatives strengthen the community's capacity to respond and increase the knowledge and skills for effective community programs.
- ADCA acknowledges there are many organisations in the drug and alcohol and mental health fields which have strong track records in treating people with comorbidity disorders. The evolving partnerships are strongly supported by ADCA especially projects sponsored by the Alcohol Education and Rehabilitation Foundation, the Mental Health Council of Australia, Suicide Prevention Australia, Lifeline, Turning Point, SANE, the Schizophrenia Fellowship and the state and territory peak drug and alcohol and mental health organisations. Governments too are increasingly supporting new collaborations and partnerships. The

¹ See the section on definitions and the use of the term co-occurring disorders.

- experience and evaluation of these projects will provide the evidence for wider implementation.
- Research from the National Drug and Alcohol Research Centre, National Drug Research Institute, ORYGEN and academic centres in psychiatry, psychology and social sciences is advancing our understanding of the prevention and treatment of comorbidity disorders. ADCA advocates that all governments support this area of research.
 - Successful interventions in comorbidity disorders will depend on the interest and commitment of the community as well as on the preparedness of institutional services to accept the desirability of integration. ADCA recommends that government and non-government organisations aim to integrate mental health and alcohol and other drug services as a high priority.
 - The most significant changes, however, will be at the point of engagement with affected individuals, their families and with the communities at risk. This level of engagement will require a strong commitment to primary care as the lynch pin to appropriate services. If we can engender interest, indeed excitement, in this important issue in front-line mental health and drug and alcohol workers, in all health and human service system staff much of what is seen as problematic will be vitiated. ADCA recommends that governments re-focus their health and related budgets on primary health and community care rather than on tertiary services which have minimal impact on the outcomes in comorbidity disorders and related conditions.
 - While governments can fund new directions much more is needed if the standard of care for people with comorbidity disorders is to match that of more 'acceptable' conditions such as diabetes, cancer or indeed mental illnesses in their own right. ADCA recommends that the principles of care and management outlined in this policy statement be adopted by all health and welfare agencies dealing with people affected by comorbidity disorders.
 - ADCA recommends there should be a stock take of the tasks of the health professions and services and of social service professions. The statuses of specialities within the professions, their working environments and the disparate financing arrangements demonstrate that the intangible phenomena of behaviour, cognition, emotion and motivations and interactions with the law are viewed negatively within the professions further marginalising the people with comorbidity disorders.
 - The specialities in medicine and other disciplines through their limited clinical focus frequently trivialise comorbidity disorders. There are many examples: in the training of specialist physicians the use of laboratory investigations, organ imaging and other procedures are emphasised but there is no training in psychology or psychiatric issues. This is remarkable when at the very least there could be acknowledgement that physical illness often leads depression and depression is a risk factor for some physical illnesses. Clinical epidemiological data demonstrate the ubiquity of mental health and substance use problems in general medicine and surgery.
 - ADCA believes there must be professional leadership and reform. Reforms that de-emphasise procedures and techniques and reward the skill and time required to assess and plan treatment in the context of complexity. With good leadership these tasks can be shown to be interesting and challenging and that managing people with comorbidity disorders can be professionally fulfilling.
 - Undergraduate teaching in medicine, nursing, allied health professions, social work must give greater emphasis to social and behavioural medicine, problem-solving in complexity, chronic pain syndromes, pharmacotherapy and behavioural interventions and the pharmacology and public health aspects of

- psychoactive substances.
- ADCA strongly endorses the establishment and role of the Chapter of Addiction Medicine in the Royal Australasian College of Physicians and the role of the Section on Addiction Medicine in the Royal Australian and New Zealand College of Psychiatrists. Further, ADCA recommends that these colleges work collectively to provide leadership in medicine and health as advocates for this area of health and prevention.
 - ADCA welcomes the Commonwealth Government's - Better Outcomes for Mental Health program which has provided additional funding to support general practitioner involvement in mental health and the extension of Medicare payments for patients referred to psychologists by general practitioners. The high take up of these initiatives demonstrates the extent to which Medicare and other government funding has been biased towards physical care to the neglect of mental health and related areas. These areas of funding are now being extended to include comorbidity disorders. ADCA strongly supports a greater commitment by the Commonwealth Government to fund general practitioner and specialist treatment of substance abuse disorders and further that funds be allocated through the Commonwealth and States shared health agreements.
 - While not normally discussed in the context of co-occurring mental health and substance use disorders, the problem of chronic and unremitting pain needs to be considered as well; this condition is commonly associated with depression and suicide and commonly requires opioid analgesic medications and other potent pharmaceutical agents. The support measures directed particularly to general practitioners need also to be extended to physicians and other specialists who engage in these complex areas of health care. ADCA so recommends.
 - The dominant health problems in modern western societies are behavioural, attitudinal and secondary to the patterns of living associated with affluence and inequality. Thus both mental health and alcohol and substance use problems should be placed at the top of the public health agenda. In the past two decades we have seen higher priorities accorded to mental health which incorporate the National Mental Health Plan, National Mental Health Prevention and Promotion Strategy and the National Suicide Strategy. Since 1985 there has been the National Drug Strategy which incorporates all drugs – alcohol, tobacco, other licit substances and illicit drugs. ADCA strongly endorses these initiatives and proposes that all Australian governments place mental health, alcohol and substance use at the top of the list for action in population health.
 - In some states supported public housing is being made available for people with mental illnesses and for some with comorbidity disorders; ADCA strongly endorses these initiatives and commends those non-government organisations which are attempting to support and serve the needs of those with comorbidity disorders who are at risk of homelessness or indeed are homeless.
 - ADCA, as the peak non-government national organisation in the drug and alcohol sector resolves to work collaboratively with governments and other peak NGOs such as the Mental Health Council of Australia to further the national response to comorbidity disorders.

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Appendix:

Psychotic presentations

In today's climate the greatest concern is with drug-induced psychosis. There is a view that drug induced psychosis is more difficult to manage than psychosis due to mental illness. But we should not feel powerless in the face of these episodes as they are not unknown.

The principles of management are: -

- 1 safety of the person,
- 2 safety of others, and,
- 3 calm reassuring approach.

Sedation and antipsychotic medications may be needed.

Intoxication

Intoxication can have many manifestations and management will depend upon the

- 1 substance,
- 2 depth of intoxication,
- 3 level of consciousness, and,
- 4 vital signs.

There are medications which can be used such as diazepam for alcohol intoxication/withdrawal and naloxone in severe opiate overdoses; but the main approach is careful observation, maintenance of vital body functions and allowing *time* to take its course.

Attempted suicide

Attempted suicide involves the same general principles. But for some toxic overdoses antidotes or special intensive care measures may be necessary.

Alcohol and suicide: Alcohol is frequently linked to attempted suicide. Therefore in EDs suicidal threats by alcoholic patients should be taken seriously - full risk assessment and of mental state and treatment plan is needed. Above all treatment should not be refused because the person is intoxicated or has been drinking.

Injury and intercurrent disease

And injury and intercurrent disease also need to be treated.