Chapter 7

Comorbidity: why does it matter?
(A consumer perspective)

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Only about one in three people with a mental disorder or drug and alcohol problem are seen by a specialist service or general practitioner in any year (Andrews, Hall, Teesson, & Henderson, 1999). Mental disorders and drug and alcohol problems are highly stigmatised; there is a public perception that effective treatments are not available, service providers are often overworked and the health care system itself is under-funded.

When an individual has both a mental disorder and a drug and alcohol problem, the under-funded health system simply can’t respond. This chapter will firstly discuss how comorbidity affects the individual, and then how the mental health and drug and alcohol systems meet the challenge of comorbidity.

The two big drug and alcohol issues for consumers and carers in mental health are:
• the impact of cannabis; and
• the impact of alcohol.

The big mental health issues for consumers in drug and alcohol services are:
• depression; and
• anxiety

There is a small proportion of the population that has problems with heroin and amphetamines and other illicit drugs, but the ongoing and everyday problems are caused by the lack of understanding about the effects of the continued use of cannabis and alcohol on mental health and the impact of anxiety and depression in those with drug and alcohol problems.

The most important issue is how the services address this problem and how the users of the services and their carers perceive how well the services address it. Some services do okay, but there is a pervasive feeling in the area that no-one addresses the issue of comorbidity at all. Certainly proactive and assertive interventions are infrequent.

We would argue that the problems fall into four main areas:
1. Drug and alcohol services have a focus on providing treatments to individuals with problems with heroin.
2. There is a societal acceptance that people think it is a basic human right to get stoned and drunk.
3. Case managers in the mental health field are so overloaded with providing care for those with psychoses that they don’t feel they have time to do the drug and alcohol interventions or provide interventions for anxiety or depression.
4. Mental health services often do not have a good relationship with the drug and alcohol services.
Access to services for people with problems with alcohol and cannabis is becoming increasingly difficult. The Clients of treatment service agencies census findings (Shand & Mattick, 2001) demonstrated that drug and alcohol services were increasingly focusing on the treatment of individuals with heroin dependence and that treatment services for alcohol and cannabis were less available.

There are four options:

• The creation of treatment “Super Centres” for cannabis and mental health. There is little evidence such super centres are sustainable in the long term and effective in the short or long term (Hall & Farrell, 1997).

• Mental health services to identify drug and alcohol use as a problem and to work closely with researchers to develop interventions for such problems.

• Drug and alcohol services to provide treatment interventions for cannabis and alcohol comorbid with mental disorders.

• We do nothing.

However, we have a limited knowledge on how to intervene for cannabis and alcohol disorders comorbid with mental disorders (see Chapter 5). Even if the diligent case manager from drug and alcohol or mental health seeks the latest treatment then they still only have a limited chance of making a difference to the person’s cannabis use.

There is no easy solution to the complex challenge of comorbidity. However, some principles may help in developing the way forward.

Nothing about us without us — responses that don’t include consumers and carers will fail

If we identify comorbidity as a problem we need to involve carers and consumers in the solution. Crawford et al., (2002) conducted a review of the impact of involving consumers in the planning and development of health care. They found that the evidence supports the involvement of consumers with such involvement contributing to changes in the provision of services across a range of different settings. However, to date an evidence base for the effects on use of services, quality of care and satisfaction of health of consumers does not exist.

While little evidence exists on the involvement of consumers in the delivery and evaluation of mental health and drug and alcohol services, a number of trials have been conducted. These trials have found that consumers can be involved as employees, trainers or researchers without detrimental effects. Involving consumers with severe mental disorders is also feasible although to date little evidence exists on the effectiveness of such programs and more formal evaluations are needed. O’Donnell (1999) undertook a study of client focused case management and consumer advocacy in Sydney and found that family burden was lower for client focused case management as compared to standard case management, although there were no other differences in terms of satisfaction, quality of life, functioning or time in hospital.

Outcome is not just about a reduction in symptoms

“People with mental disorders have symptoms and behaviours which can impair their ability to work and love, and that can impair access to physical health care, income maintenance, education, housing, transport, legal advice, and leisure opportunities. While each citizen, mentally ill or not, has the right to have these
commodities, citizens with mental disorders will often find access reduced, specifically because the symptoms and behaviours associated with the mental disorder impair their ability to compete for access.” (Andrews, Peters, & Teesson, 1994).

Any health system must encompass interventions which not only change the symptoms of the disorders but also impact on the disabilities in the above areas. Change in disability is often termed rehabilitation or recovery. The terms are confusing and the language is often clumsy but overall it is about going the next step after aggressive treatment interventions to ensure that consumers get better or at least that their lives improve sufficiently for them to move more easily back into community life.

There is however growing agreement that the interventions that are used need to be meaningful and have some measurable outcomes. There is also agreement that the steps towards recovery are systematic and program based. A four step program may look like this:

1. **Skills Training:** This needs to be very basic and should involve development or improvement of cognitive skills — such as clearer thinking, improved concentration and motor skill development.

2. **Peer Support:** This may include coffee meetings, support groups, social outings, work crews and advocacy development. They need to focus on the concept of ‘normalisation’ and empowerment of consumers with severe and persistent symptoms of mental illness.

3. **Vocational Services:** Involves supported employment and education, transitional employment, consumer run job clubs and specific training. It is imperative that consumers set their vocational goals as this is the strongest motivation towards recovery.

4. **Consumer Resource Development:** This includes direct services such as education, advocacy services, speakers’ bureaux, drop-in centres and consumer-run businesses. The important concept here is that there is very little input from professionals and it is important because it creates an infrastructure of community support.

**Equity in access to care**

“…people with mental health problems or mental health disorders should have access to services and opportunities available in Australian society for people of a similar age with equity and justice” (Commonwealth Government of Australia, 1992).

People with drug and alcohol and mental health problems are vulnerable. People with mental illness alone are already vulnerable, and because of this they are at a greater risk of having comorbid disorders. This is often due to the perceived efficacy of alcohol and other substances as a form of medication; referred to as self-medication.

The pathway to treatment and recovery is further compromised because of the confusion around service delivery. This is not necessarily due to a lack of will to recover; people want to behave appropriately but are confused and unclear about the way to proceed.

The vulnerabilities often faced by people with comorbid disorders also differ. As Andrews et al., point out in Chapter 3, psychosis comorbidities nearly always result
in a crisis and chaos in the person’s life. On the other hand the “quieter problems”
of drug and alcohol abuse in those people with anxiety and depression don’t usually
result in a full blown emergency or crisis. The need to respond has therefore not
been seen as so important. If we are to respond to the individual and community
burden resulting from comorbid drug and alcohol and mental disorders then it is
important for services to not discount the disability of those with anxiety and
depression. The system or service solutions to these problems will not necessarily
be the same, but must be met.

Thinking innovatively about prevention

Drug and alcohol use disorders are a substantial health and community problem
and traditional prevention strategies about the dangers of drug and alcohol misuse
have to date, been unsuccessful (see Chapter 4).

The mental health and drug and alcohol field have been slow to take up prevention
opportunities. Firstly, traditional strategies in prevention don’t work and secondly,
the mental health field has very effective medicine-based interventions so there has
been less of a desire to develop other interventions which would potentially be more
effective on a broader societal level. There is too big a comfort zone around the
medications and we have to break out of the traditional mould.

Conclusions

There are many barriers to effective change; the first step is to identify them. More
research on identifying the needs of people with comorbid substance use and mental
disorders is essential. Treatment at the crisis level is not efficient; true recovery
involves both psychological and social wellbeing. The involvement of consumers and
carers in our response to comorbidity is both feasible and crucial to the achievement
of good outcomes.

References

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