

## 2 Management of people with comorbidity of mental disorders and substance use

Mental disorders and substance use occur together very frequently and can interact negatively on one another.

Little evidence is available to allow advice about safe levels of substance use in people with mental disorders. Safe levels of consumption in the general population may cause severe adverse effects in people with mental disorders<sup>1,2</sup>. The assumption should be that any substance use has the potential to cause deleterious effects on the comorbid mental disorder.

The management of comorbid mental disorders and substance use requires a long-term perspective. Actual clinician interventions may be brief or extended over a period of time. A doctor-patient relationship based on honesty, trust and respect will form the basis for effective therapy. Active listening skills and a patient-centred clinical method should be used to establish rapport and develop a common understanding of the problems and an agreed management plan.

### 2.1 Detection

The most common questions include:

- How to identify the presence of possible problems.
- Which problem to focus on first.
- Whether/how to address both problems concurrently<sup>3</sup>.

Failure to detect all issues may contribute to poor treatment retention and outcomes<sup>3</sup>.

When a patient presents with either a substance-use<sup>1</sup> related problem or a mental disorder then the clinician should routinely enquire about the other.

Comorbidity should be assumed to be present when progress or response to therapy for either mental disorders or substance use appears to be ineffective or not progressing as planned. Comorbidity should be actively sought and needs to be excluded.

### 2.2 Assessment

A full assessment often takes several consultations. This assessment should include determination of:

- The patterns of substance use.
- The day-to-day problems associated with substance use.
- The reasons for substance use.
- The effect that it might be having on the mental disorder.
- The nature of the mental disorder itself, diagnosis, previous treatments and responses to treatment.

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1 Substance use: is intended to be a non-quantitative term for the consumption of a substance. The risk associated with the use may range from low to high. It does not necessarily imply dependent use.

2 Substance misuse: is a term for the consumption of a substance where the risk associated with the use is moderate or high, or where a substance is not being used for its intended therapeutic purpose, or use exceeds recommended therapeutic quantities.

3 Substance abuse is not a term favoured by the author but has been used in the context of information derived from publications using the DSM- IV diagnosis of substance abuse.

## 2.3 General management

Management should be based on the patient's readiness for change. This readiness for change might be different for the management of the substance use than for the mental disorder. For example, the patient may be ready to address their mental disorder and engage in treatment but not yet ready to alter their substance use, and vice versa.

Management should aim to increase the patient's awareness of the negative effect that the substance use and the mental disorder are having on each other.

Management should involve family or carers where appropriate.

## 2.4 Specific management

Detoxification should be offered as a first step to enable engagement in long-term approaches and decision making.

Specific management steps should include where appropriate:

- Provision of information.
- Structured problem solving.
- Motivational interviewing.
- Brief behavioural or cognitive approaches.

## 2.5 Pharmacological approaches

Clinicians should avoid using substances of dependence such as methadone unless these are used as part of a harm reduction plan.

Benzodiazepines should not be used for more than a few days. Generally, longer acting benzodiazepines are preferable.

Clinicians should consider whether the current medication for the mental disorder is adequate or causing side-effects as the patient may be self medicating with non-prescribed drugs to relieve symptoms or side effects.

The clinician should consider potential interactions between all substances used.

If there is drug-seeking behaviour, then engagement of the patient in a planned and limited prescribing program is required (e.g. Medicare Australia consent for all prescribing information to go to the one prescriber).

## 2.6 Referral

People with comorbid mental disorders and substance use frequently need care from several different disciplines. It is important that communication between all clinicians and service providers is coordinated. The use of a care plan in these instances is advisable.

Consider referral when:

- Self-harm risk or risk to others is present.
- Acute exacerbation of mental disorder occurs.
- Drug dependence with major associated problems (legal, health, social) is present.
- Complicated detoxification is anticipated.

It is important for GPs to develop links with local specialist mental health or AOD services (where they exist).