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Comorbidity must be treated in substance use disorders

KOMMENTAR OG DEBATT

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Patients with substance use disorders very often have comorbid psychiatric disorders. Many also have somatic diseases. Provision for this patient group is still inadequate and fragmented.

We must assume that around 90 % of patients treated for substance use disorders in the specialist health service have comorbid psychiatric disorders (1, 2). Most of these are independent of the substance use and must therefore be considered for treatment in their own right. These disorders require expert management. Psychiatric disorders often give rise to such issues as difficulty in concentrating, lack of energy, loss of motivation, avoidance, relationship difficulties and behavioural problems. Comorbid psychiatric disorders thus lead to a reduced ability to sustain motivation for change, adopt new coping strategies or make use of general assistance. Provision for these patients should not therefore be limited to treatment of their substance dependency.

Patients' needs

All patients undergoing treatment for substance use disorders in the specialist health service should be offered expert diagnosis of psychiatric disorders. Professionals or teams that work in this field must have expert knowledge of

substance use disorders, psychiatric symptom disorders and personality disorders. They must also be able to judge whether a given symptom is an indication of intoxication, withdrawal, somatic disease, or of a substance-induced or substance-independent psychiatric disorder (3).

On the basis of recent research, integrated treatment (treatment of both disorders simultaneously in the same place by the same team, generally by the same therapist) is recommended for comorbid psychiatric and substance use disorders (4). For the most part, treatment of substance use disorders is effective with respect to dependency, while treatment of psychiatric disorders has an effect specifically on psychiatric symptoms. Leaving one disorder untreated will predispose to a relapse of the treated disorder. Up until now, the vast majority of these patients have not received the healthcare to which they are entitled for their multiple disorders. This is despite the fact that there are several psychotherapeutic methods that can be effective for both substance use disorders and psychiatric disorders, and which can be integrated to produce therapy that feels coherent for the patient. In addition, all patients should be evaluated for pharmaceutical treatment for their various disorders.

Spotlight on professional quality

The provision of treatment for substance use disorders in Norway has evolved from being based on care homes, via social care institutions, to become part of the specialist health service (5). In all other parts of the specialist health service, specialty doctors are obligatory members of multidisciplinary teams. Within this field, units have been approved as part of the specialist health service without the necessary specialist positions. «Clinical adult psychology» and «psychological therapy for substance- and addiction disorders» are specialties for psychologists. An «addiction medicine» specialty is now being established for doctors. If patients are to have access to the integrated services they need, then both types of specialist psychologist as well as specialists in addiction medicine and psychiatry should be included in multidisciplinary teams. A neuropsychologist is also needed, as a number of patients will have a history of organic brain dysfunction or have developed cognitive impairments as a result of substance use or ensuing complications. The number of specialist doctor and psychologist positions must be scaled up in proportion to a unit's size. Often, only a single position is established for one specialist who must meet the needs of large institutions. Such positions, in which there is no possibility of fulfilling all specialist duties and with a lack of colleagues in the same profession, may be unattractive.

Despite the fact that the need for integrated services for these patients is highlighted in the national professional guidelines (6), the tradition of organising treatment of substance use disorders and psychiatric disorders in separate units continues. Patients with both types of disorder are to be found in large numbers in both types of department. It is costly to build up the same dual expertise in parallel units and leads to competition for the same professionals. In addition, a number of institutions are in isolated locations. This creates challenges with regard to recruitment of specialists, and it hampers

ongoing collaboration with practitioners in psychiatry, somatic medicine and frontline services. Coordination cannot compensate for the disadvantages of fragmentation and geographical distance.

Conclusion

If patients with comorbid disorders are to receive the specialist healthcare provision they are entitled to, current provision must be strengthened significantly in terms of professional quality. There must be emphasis on building solid professional communities with the necessary multidisciplinary specialist expertise and access to expertise in somatic medicine. There must be more emphasis on research in this field, both to develop better treatments and to stimulate professional development within clinical environments. A fragmented, functionally distributed and geographically dispersed specialist health service is impractical when it comes to long-lasting and complex disorders. It is worrying that the government is more concerned with purchasing beds in private institutions than with ensuring that these patients receive specialist health service provision of the same high quality as others.

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