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Health improvements needed in persons with mental disorders and substance use disorders

PERSPECTIVES

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People with severe mental disorders and substance use disorders have poorer health and a shorter life expectancy than the general population. We can change this.

People with severe mental disorders and severe substance abuse disorders have poorer health and at least a 15–20 years shorter life expectancy than the general population (1, 2). Mortality increases significantly in those with a concurrent severe mental disorder and severe substance use disorder (1, 3).

The cause of death is sometimes specifically related to the nature of the disorders, such as suicide in severe mental disorders and overdose in substance use disorders. Most deaths, however, especially with increasing age, are due to acute and chronic somatic disorders (4, 5). These disorders often start at a significantly younger age than in the general population. This phenomenon is linked to poverty and social marginalisation, as well as lifestyle factors and inadequate prevention, treatment and follow-up of these illnesses. We can change this. It will require closer cooperation between various parts of the health service, and general practitioners (GPs) should play a key role in these efforts.

The causes are complex and multifaceted

Two important documents, the Norwegian Medical Association's report on improving the health and life expectancy of people with severe mental disorders or substance use disorders (*Bedre helse og lengre liv for personer med alvorlig psykisk lidelse eller rusmiddel- og avhengighetslidelse* – in Norwegian only) and Report no. 23 to the Storting (2022–2023) on the escalation plan for mental health 2023–2033 (*Opptrappingsplan for psykisk helse 2023–2033* – in Norwegian only), have recently been presented. Both documents emphasise the need for the health service to prioritise the reduction of morbidity and mortality in these groups in the years ahead.

However, we have actually been aware of this problem for a long time, and in recent years, the evidence has become overwhelming. But why is it so difficult to do something about it? The reasons are many and complex.

Severe mental disorders and substance use disorders are complex phenomena. They can be considered 'bio-psycho-social syndromes' where biological, psychological and social factors are intertwined and mutually impact on each other within a broader societal context. This includes government policies on substance use and health, which govern the prioritisation of preventive measures and healthcare services for these groups. The organisation of healthcare services for these vulnerable groups and general attitudes in society and the health care system are also crucial. All these elements are intertwined and mutually impact on each other. This makes the situation very complex, and there are no quick, easy solutions for such problems. I believe this is the basis of why it is 'so difficult to do something about it'.

Challenging, but not impossible

But it is not impossible. There are interventions that are effective, and the Norwegian Medical Association's report gives many good examples of these. However, when a case history is complex, the interventions need to be versatile and involve various parts of the social services and health care services. Cooperation is required on many levels, between patients and the treatment providers, between different occupational groups in the health and social services, between primary care and the specialist health service, and between the specialist services in substance use treatment, psychiatry and somatic care.

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Perhaps it has gone unnoticed that the excess mortality is primarily due to somatic diseases. These are easily overshadowed and deprioritised in favour of addressing more dramatic problems related to substance use, substance dependence and mental disorders. Due to the multifaceted health problems

faced by these groups and the complexity of the situation regarding their treatment, practitioners have settled for an approach to the treatment of somatic disorders that may not be optimal ('negative pragmatism') (Anne Høye, professor at UiT The Arctic University of Norway, first introduced the term in a lecture on somatic morbidity and mortality among people with severe mental disorders at a national conference organised by Faglig Forum in Trondheim on 23 January 2017). Based on what we know today, this has to change.

Healthcare provision tailored to the target group

The health service must be organised in a way that facilitates the prioritisation of prevention, investigation, treatment and follow-up of somatic diseases in these patient groups. This requires closer cooperation between the different services, and a strong emphasis on tailoring services to the needs of individual patients. Society invests considerable resources in treating these groups. For example, around 70 % of people with severe substance use disorders in Norway are receiving some form of treatment, which is high in an international context. When highlighting somatic health problems, better organisation of the services is therefore just as important as increasing resources.

What does tailoring the services to the needs of these groups entail? Many of them are able to navigate and engage with the health service in the same way as others, and for them, the problem may primarily be getting the health service to recognise their somatic needs. Others struggle to navigate the complex support system, and can easily fall through the cracks. Attending treatment appointments, taking prescribed medication, digital communication and paying for services become a challenge: not out of ill will but due to the nature of their disorders and social circumstances, such as poverty. In such cases, they can easily lose out on treatment opportunities that others receive.

Modern health services are, and must remain, specialised. It is therefore necessary to create pathways into and through treatment systems that are tailored for these patients, ensuring they receive as much help as they need. In Norway, everyone, with some exceptions, has the same right to health care. However, the health service has to realise that it is their responsibility, not the patient's, to tailor the treatment to reach the target groups. Health care must not take the form 'one size fits all'. Cooperation must therefore be tailored to the patient's needs and be sufficiently flexible to reach the intended recipients.

There are good examples of such cooperation in Norway, two of which are opioid agonist treatment (OAT) and Flexible Assertive Community Treatment (FACT) teams. In OAT, treatment groups are established for each patient, and the patient, the GP, a designated representative from primary health care and social services, and a representative from the OAT team in the specialist health service work together on the long-term treatment and rehabilitation of the patient. FACT teams are multidisciplinary and aim to provide structured, comprehensive treatment to a group of patients with mental disorders, often combined with substance use problems. The teams consist of health and social care personnel from both primary care and the specialist health service. They

must also include personnel with service user experience, peer-support workers and a psychologist or psychiatrist. Somatic health is often followed up by the GP in collaboration with the FACT team.

In these models, comprehensive and holistic treatment is provided over a long period, often spanning many years. The treatment addresses the underlying substance use and/or mental disorder, as well as somatic health problems and general follow-up and rehabilitation. What distinguishes these models from others is that each team possesses expertise in both psychiatric and addiction medicine, while the general medical treatment is overseen by the team's doctors or GPs within a binding collaboration model that includes both the specialist health service and primary care.

Who should do what?

There is no 'turf war' raging between different parts of the health service in the somatic follow-up of these groups. On the contrary, vulnerable groups fall through the cracks and their somatic health is not addressed. Thus, the principle should instead be 'those in a position to do so, should act'. This entails psychiatrists and addiction specialists in the specialist health service also having a focus on somatic issues, especially in a longer-term perspective. They should carry out somatic examinations and initiate and follow up on treatment, potentially in collaboration with somatic specialists and especially with GPs. This will require a competence boost in somatic medicine for some healthcare personnel. After discharge, GPs should have primary responsibility for further follow-up. There is also a need for specific targeted low-threshold healthcare provision aimed at persons with a substance use disorder in cities. These services should be closely linked to GPs, particularly where they do not have their own doctors.

The GPs' role

Although other parts of the health service also bear responsibility for somatic follow-up, the long-term and fundamental responsibility will largely lie with GPs. This is also in line with the best and leading traditions in general practice in Norway, 'giving the most to those with the greatest needs' (6). Patients with mental disorders and substance use disorders are included in those with 'the greatest needs'; needs that are not properly met. Under the Norwegian GP system, everyone has a right to have a GP, and many GPs have put extensive and long-term efforts into these patient groups. The GP has been the most important 'healthcare person' in many people's lives for a long, long time.

Not always easy being a GP

The GP system is under pressure. High workloads, new duties, recruitment challenges, patients without GPs and extensive use of locums can make it difficult to find time for closer follow-up of these groups. When planning measures to improve the GP system, it is therefore crucial to facilitate intensified efforts aimed at narrowing the health gap. However, it is not only problems with the system that can hinder doctors' good work in this field.

Most GPs have had challenging encounters with patients with severe mental or substance use disorders. This can involve threatening, manipulative or, at worst, violent behaviour. Such experiences can be very unpleasant and burdensome, making some GPs reluctant to have further contact with these patients. It is therefore important that such experiences are discussed and worked through with colleagues and in a supportive setting.

It is important to recognise that all behaviour is guided by a kind of 'inner logic', and if this logic is not understood, such patient behaviour can appear incomprehensible and chaotic. However, if the behaviour is understood as an expression of the patient's suffering, it is often the first step towards relating to the behaviour and turning it into a fruitful doctor-patient relationship.

Doctors can also be at risk of interpreting acute and chronic somatic complaints as expressions of mental illness or drug dependence. Since severe somatic illness occurs more frequently and at a younger age in these groups, information about mental and/or substance use disorders should heighten, rather than diminish, vigilance for severe somatic illness. The doctor's assessment must account for the possibility that intoxication or symptoms of mental illness can occur simultaneously with somatic illness and that they can 'mask' the underlying illness. The doctor should never, therefore, settle for the 'preconception' that 'it's probably intoxication or a mental health issue' before sufficient investigation.

> ***«Patients with substance use disorders or mental disorders are no different from anyone else when it comes to seeking medical assistance for somatic issues or having concerns about serious illness»***

It is also important to emphasise that patients with substance use disorders or mental disorders are no different from anyone else when it comes to seeking medical assistance for somatic issues or having concerns about serious illness. They, along with the doctor, want clarity on the situation and to receive the necessary treatment. Consequently, the doctor can generally trust what the patient says.

Conclusion

Modern general practice is now more office-based than before. However, for these patient groups, who can be difficult to reach and challenging to follow up, it is often necessary to adopt a more proactive approach to facilitating treatment. Patients may struggle to adhere to scheduled appointments, and they may consider waiting rooms to be threatening. Collaboration with others in the support system often becomes necessary. By adapting to these challenges and addressing the considerable healthcare needs of these patients, GPs can play a key role in narrowing the health gap between these vulnerable groups and the general population.

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