Concurrent Disorder

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Concurrent disorder refers to a diverse set of combinations of substance use disorders and mental disorders simultaneously in need of treatment. Concurrent disorders are underdiagnosed, undertreated, and more complex to manage, practicing the best recommendations can support better outcomes. The purpose of this work is to systematically assess the quality of the current concurrent disorders' clinical recommendation management guidelines. Literature searches were performed by two independent authors in electronic databases, web, and gray literature. The inclusion criteria were English language clinical management guidelines for adult concurrent disorders between 2000 and 2020. The initial search resulted in 8841 hits. A total of 24 guidelines were identified and assessed with the standardized guidelines assessment tool: AGREE II (Appraisal of Guidelines for Research and Evaluation). Most guidelines had acceptable standards, however, only the NICE guidelines had all detailed information on all AGREE II Domains. Guidelines generally supported combinations of treatments for individual disorders with a very small evidence base for concurrent disorders, and they provided little recommendation for further structuring of the field, such as level of complexity or staging, or evaluating dierent models of treatment integration.

Concurrent Disorder Guideline Mental Health

Concurrent disorder (also called dual diagnosis, co-occurring disorder, comorbidity) refers to a specific form of multimorbidity within the area of mental health, where at least one substance use disorder and at least one non-substance-bound mental disorder is simultaneously in need of treatment. The World Health Organization (WHO) defined dual diagnosis as the co-occurrence of a psychoactive substance use disorder and another psychiatric disorder in the same individual[1]. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) defined comorbidity/dual diagnosis as the temporal coexistence of two or more psychiatric disorders as defined by the International Classification of Diseases, one of which is problematic substance use. To describe the co-occurring mental health and substance use disorders, other terms have been used as well. The Canadian accepted term is "concurrent disorder"[2]. The US-American accepted term is "co-occurring disorders"[3]. The term "comorbidity" is used in Australia; however, recently more descriptive terms have been used: "coexisting mental health and substance use disorders" or "coinciding mental illness and substance abuse". The term "coexisting problems" is used in New Zealand. "Chemically affected Mental Illness" (CAMI), "Mental Illness Chemically Affected" (MICA), "Substance Affected Mentally Ill" (SAMI), "Mental Illness Substance Affected" (MISA), "Mental Illness Substance Use Disorder" (MISUD), and "Individuals with Co-Occurring Psychiatric and Substance Use Disorders" (ICOPSD) are other terms used to describe the same condition[4]. The term "dual diagnosis" is frequently used in the United Kingdom, Australia, Spain, and Spanish speaking countries. Adding to the confusion, the term "dual diagnosis" is applied for concurrent intellectual or developmental disorders with mental health

disorders in Canada. For the purpose of this work the intellectual and developmental disabilities with mental health concerns that are considered as a “dual diagnosis” or “concurrent disorder”, will not be considered or discussed.

1. Introduction

In mental health, the focus of research and guidelines has been on individual disorders, despite concurrent disorders being common and seemingly increasing[5]. Substance use disorders and non-substance-related mental disorders are frequently chronic, requiring long-term care. Greater severity of a single psychiatric disorder increases the risk of developing concurrent disorders. This also means that in general the frequency of comorbidity increases from population-based studies, to outpatient studies, to inpatient studies. In population-based studies, approximately one-fourth of people with anxiety or major depressive disorders are expected to have an overlapping substance use disorder in their lifetime[6][7]. Similarly, half of the people with bipolar disorder or schizophrenia will experience a substance use disorder[8]. Studies generally exclude tobacco dependence, otherwise the numbers would be substantially higher.

People with concurrent disorders tend to be underdiagnosed and undertreated, whilst experiencing a high burden of morbidity and mortality. There are big gaps between the need for substance use disorders, mental disorders treatment, and delivered services. Unmet need for treatment is more for substance use disorders. Psychiatrists are often uninvolved with the management of substance use disorders, and general or addiction physicians treating substance use disorders do not necessarily diagnose psychiatric disorders. The treatment of psychiatric disorders and substance use disorders is separated in many countries, with different treatment traditions, separate organizations within the healthcare system, separate treatment providers, and separate funding. Individuals with concurrent disorders are not only more complex to diagnose and treat, but they are also at higher risk of additional multimorbidity, becoming socially marginalized, entangled with the legal system, and subject to stigma[9]. Both mortality and morbidity are increased in those with concurrent disorders. The main causes are premature drug-related death[10] and increased risk of suicide[11][12]. Increased utilization of healthcare services has been demonstrated, despite the demonstrated treatment gap. For example, in a Canadian cohort study, individuals with concurrent disorders had significantly higher odds of Emergency Department use (Adjusted odds ratio [AOR] D 1.71; 95% confidence interval [CI]), 1.4–2.11, hospitalization (AOR D 1.45; 95% CI, 1.16–1.81), and primary care visits (AOR D 1.34; 95% CI, 1.05–1.71) than those with either substance use disorder or non-substance-related mental disorders[13].

The mechanisms of development of concurrent disorders are complex, however, frequently both conditions share neurological pathways, overlapping underlying genetic risk factors, as well as common “environmental” risk factors. People with concurrent disorders are frequently part of a highly vulnerable population—with multiple biological, psychological, and social risk factors; as a consequence, the course of both types of conditions can be more severe and complicated due to multiple persistent risk factors[14][15][16]. Additionally, the impact of substance use disorders and non-substance-use mental disorders interact, affecting the course and prognosis of both[15][17]. As a result, the management of concurrent disorders is quite complex.

The traditional approach in healthcare systems has been, and still is to address each issue separately, with limited or no standards to simultaneously address both components of concurrent disorder within the same care team. Traditional treatment methods of sequential or uncoordinated parallel care are nowadays considered obsolete. Despite new coordinated and integrated treatment approaches constituting the current standard, the majority of healthcare systems have yet to adapt.

There are still many barriers to the management and delivery of services for concurrent disorder[18][19][20][21][22]. In Canada for example, models for service delivery evolved unevenly, coordination and integration of care were limited by challenges related to the implementation of collaborative care and the need for local networks to foster service coordination and policy accountability[23][24].

The last 20 years have seen some developments, with the creation of new journals (e.g., the Journal of Dual Diagnosis) and new societies (e.g., the World Association of Dual Diagnosis). While the need for improved care for concurrent disorders is clear, the process of adapting the healthcare system to efficiently care for these individuals seems to have been slow. Clinical management guidelines are an important tool, developed to help facilitate evidence-based treatment practice.

2. Management

Overall, specific evidence for the management of concurrent disorders continues to be rare, making it necessary for guidelines to often rely on combining evidence for individual disorders. Some studies in concurrent disorder patients indicate that certain approaches working in individual disorders are less or not effective in concurrent disorders, such as SSRIs in alcohol-dependent individuals with major depressive disorder. There is also some evidence that some medication may work better, such as clozapine for individuals suffering from schizophrenia and substance use disorder.

As current evidence suggests that better outcomes of concurrent disorder management can be achieved with integrated management approaches, broader application appears warranted. However, integrated approaches in current medical systems are rare. Furthermore, it seems that higher functionality in patients appears to allow for less integration of treatment for different disorders. Guidelines rarely allow for graded approaches and generally lack any recommendations regarding grading or staging.

Based on available evidence of this review of current guidelines quality, some of the subsections in practically all guidelines can be improved. Furthermore, certain important aspects that are essential for treatment planning are not addressed by any guideline, including the specifics of a concurrent disorder framework, the “matching” of treatment needs, and the evaluation or “staging” of the severity.

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