Concurrent opioid dependence and mental health problems: a review of the issues for general practice

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Abstract

The literature is reviewed on the issue of concurrent opioid dependence and mental health problems within the general practice setting. People with such problems have poorer personal, clinical and social outcomes than people with either mental health or drug and alcohol (D&A) problems alone. Mental health and drug services operate from different policy systems and are generally not co-ordinated with each other, leaving the onus on the patient to move effectively through health systems. The common statement that GPs are ideal health professionals to manage concurrent problems is contrasted with the evident barriers in general practice such as lack of time, knowledge, skills and confidence. Models for managing concurrent problems tend towards shared care. However, these models either have received mixed evidence (eg. consultant-liaison psychiatry) or are amenable to development but remain untested (eg. co-ordinated care, community health centre programs). The Enhanced Primary Care items introduced in 1999/2000 may provide an incentive for GPs to participate in shared care arrangements with other health professionals. However, there is a need for mechanisms to increase the links between GPs and other health services.

Introduction

More than 80% of Australians will visit a GP each year (Health Insurance Commission 1998). Opioid dependent patients are high users of GP services (Bucknall, Robertson & Foster 1986). Moreover, opioid users report that they want assistance from their GP for drug use. For example, a survey conducted in the UK found that assistance with detoxification or management was the most commonly reported request from opioid dependent patients (Elander, Porter & Hodson 1994). These data imply that GPs are a frontline profession to treat patients with concurrent mental health problems and opioid dependence.

The aim of this paper is to examine the issues underpinning the management of concurrent mental health and drug and alcohol problems in the general practice setting. We initially review literature relating to the incidence and outcomes of concurrent mental health and drug and alcohol problems and then discuss literature that pertains to general practice. The underpinning objective of this process is to draw conclusions about the potential for general practice to assist individuals with concurrent problems. To this end, models of service delivery that are relevant to the Australian general practice setting are proposed and discussed.

Incidence and outcomes of concurrent problems

Despite methodological and population differences, studies have identified high rates of concurrent mental health problems in people with opioid dependence. The Epidemiologic Catchment Study, a large representative US population study, found that lifetime incidence rates of mental health problems may be as high as 65% in opioid users (Regier, Farmer, Rae et al 1990). Similar rates have been reported in Australian research on injecting drug users (Darke & Ross 1997). Three categories of mental health disorders are common among opioid users. They include depression, anxiety and antisocial personality disorders (Luthar, Cushing & Rounsaville 1996; Mattick & Hall 1993; Regier et al 1990). Alcohol problems are also common (ADCA 2000).

Five hypotheses for high prevalence rates of concurrent drug and alcohol (drug and alcohol) and mental health disorders are found in the literature:

- An increase in alcohol and other drug use particularly among young people (Ministerial Council on Drugs 1998);
- Social dislocation created by the trend towards the de-institutionalisation of people with mental health disorders (Gafoor & Rassool 1998);
- Attraction to the drug culture of people with mental health problems (Gafoor & Rassool 1998);
- Alleviation of emotional and affective symptoms by self-medication (Darke & Ross 1997; Khantzian 1985);
- Psychiatric sequelae caused by drug and alcohol dependence (Darke & Ross 1997).

The following personal, clinical and social outcomes are experienced more often by people with concurrent problems than by people with either mental health or drug and alcohol problems alone:

- increased hospitalisation (Haywood, Kravitz Grossman et al 1995); depression and suicide (Harris & Barraclough 1997); violence (Swanson, Holzer Ganju et al 1990); crime and incarceration (Abram & Teplin 1991); homelessness (Drake, Osher & Wallach 1991); human immunodeficiency virus (HIV) infection (Cournos, Empfield Horwath et al 1991); reduced ability to manage life needs (Drake & Wallach 1989); non-adherence to medication regimes (Alterman, Erdlen LaPorte et al 1982); increased family problems (Clarke 1994) and; higher service utilisation (Kessler, Nelson McGonagle et al 1996).

Moreover, it is reported that people with concurrent problems incur up to 60% higher treatment costs than people with either drug and alcohol or mental health problems alone and are less likely to complete treatment (Crome 1999).

Services for concurrent problems

Historically, services for mental health and drug and alcohol problems in the western nations have operated independently with weak links between the two systems (El-Mallakh 1998). Specifically, services have been underpinned by disparate philosophies that have impeded collaboration and reduced their effectiveness for treating concurrent problems. According to Clenaghan, Rosen and Colechin (1996), the separation of services is problematic for three reasons:

- the burden of integrating two systems of treatment is invariably placed upon the client;
- each system tends to provide a standard form of treatment without the flexibility to modify approaches for special populations and;
- the potential for miscommunications, contradictory recommendations and non-compliance is maximised.

The result of this dual system approach for people with concurrent problems is usually a failure to fit the profile of either system and therefore a reduction in the potential for sustained recovery.

In response, models of integrated treatment that address both problems concurrently have been developed (Lehman, Myers & Corty 1993). These models combine assertive outreach and case management with techniques developed in the drug and alcohol field such as relapse prevention and motivational interviewing (Dixon, McNary & Lehman 1997). However, the conclusions drawn about the effectiveness of these treatment programs have been inconsistent across a number of studies (Drake, Mercer-McFadden, Mueser et al 1998). This inconsistency has been attributed to a lack of methodological rigour and a variation in program models (Drake, Mercer-McFadden, Mueser et al 1998; Ley, Jeffrey, McLaren et al 2000).

Pharmacotherapy treatment for concurrent opioid dependence and mental health problems

There is emerging evidence that the presence of concurrent mental health problems may predict less effective responses from pharmacotherapies. One Australian study reported that patients on methadone maintenance treatment had rates of mental health problems comparable with illicit opioid users who were not on pharmacotherapy maintenance treatment (Darke, Hall & Swift 1994). Moreover, other studies have considered the presence of concurrent mental health problems on the success of treatment (Krausz, Degkwitz, Kühne et al 1998).

A major Australian review suggested that relapse prevention could be improved with the use of both methadone and antidepressants amongst people with opioid dependence and clinical depression (Mattick & Hall 1993). Nonetheless, the benefits of concurrent pharmacotherapy treatment may be mitigated by factors such as polydrug use and poor treatment adherence that are common among opioid users. Use of prescribed drugs in combination with non-prescribed and/or illicit drugs may be a particular problem for opioid dependent people with a concurrent mental health problem. For example, Darke and Ross (2000) found that 93% of injecting drug users had used antidepressants in combination with other drugs such as heroin and benzodiazepines in the preceding six months that created a clear risk for overdose.

In sum, concurrent problems predict poorer success from pharmacotherapies. Simultaneously treating both mental health and drug dependence problems may significantly improve treatment outcomes, although management should be undertaken within established clinical guidelines.

Barriers in the treatment of opioid dependence and concurrent mental health problems in general practice

GPs frequently fail to detect drug and alcohol problems (Albery, Heuston & Durand 1996) or mental health problems (Tobin, Hickie & Urbanc 1997). According to a literature review, the potential for GPs to treat opioid dependent patients is under-utilised (Deehan, Taylor & Strang 1997). These missed opportunities may be related to a number of barriers related to the GP, general practice and the health system in Australia.

An Australian study found that GPs were less likely to ask patients about illicit drug use than about use of alcohol and other types of drugs (Jacka, Clode & Patterson et al 1999). There is evidence that GPs find patients with opioid dependence (Bell, Cohen & Cremorna 1990) and mental health problems (Lawrie et al 1998) difficult to treat and manage. Further, many GPs lack confidence in treating patients with opioid dependence (Roche, Parle, Stubbs et al 1995). This may be caused by issues such as fear of violence, confusion about the most appropriate treatment, lack of education and training and negative expectations about the success of treatment. Positive treatment outcomes are dependent upon accurate and specialised assessment of both the nature and severity of each problem. Research has identified a skill deficit in the ability of GPs to treat their opioid dependent (Abed & Neira-Munoz 1990) or mental health (Millar & Goldberg 1991) patients. Although GPs consider these diagnostic skills to be important (Phongsavan, Ward & Oldenburg 1995), existing instruments to assist the diagnosis of both drug use and mental health problems are generally under-utilised (Hall 1996).

System and practice factors are also barriers to treating opioid dependence in the general practice setting. The fee-for-service remuneration system that places pressure on GPs to increase productivity rates by providing shorter consultations (General Practice Strategy Review Group 1999) often compromises their ability to treat complex conditions such as opioid dependence. Other economic disincentives may prevent GPs from treating opioid dependent patients. For example, according to MacQueen (1997), some GPs are concerned that opioid dependent patients may be a deterrent to other patients.

There is some indication that GPs, while unwilling to personally treat opioid dependent patients, would like to refer to specialist drug and alcohol services (Roche, Guray & Saunders 1991). In this respect the options for GPs are limited because demand often exceeds supply for existing services and there are limitations on entering and remaining on the programs (Duffy & Ask 2001). Service choice has now been expanded so that GPs can now be accredited to deliver pharmacotherapies. However, the number of GPs trained to provide this treatment is

disproportionately small compared with the demand. For example, in South Australia there are approximately 5000 people with opioid dependence and fewer than 30 GPs who are registered methadone prescribers (Duffy & Ask 2001).

Although evidence suggests that GP education and training improves both patient care and patient outcomes (Davis, Thomson, Oxman et al 1992), it is widely acknowledged that GPs do not receive adequate training to deal with problems associated with drug use (Roche, Guray, Saunders et al 1991). The importance of appropriately evaluated continuing medical education programs for GPs is emphasised in the literature (Farrell 1990) but not reflected in the uptake of training opportunities. A report noted that a significant increase in both development and uptake of mental health continuing medical education activities was not matched by a similar increase in activities for drug and alcohol problems (RACGP 1996).

Models for treatment of concurrent opioid and mental health problems in the general practice setting

In 1991 an identified need to strengthen links with the wider health care system underpinned a process of structural change to general practice. Based upon the recognition that effective health care cannot be limited to treating organic disease, *The Future of General Practice* (National Health Strategy 1992) called for general practice to integrate with the broader health system to effectively meet population needs. Subsequently, GPs were identified as the "most appropriate [people] to co-ordinate the various needs of an individual" (National Health Strategy 1992, p 104). This underpinned the development of a shared care approach to service provision for a range of population health needs. This model advocates the sharing of care between various health care professionals with the purpose of increasing quality of care for the patient while decreasing health care costs through reduced hospital admissions (O'Connell, Kristjanson & Orb 2000). A shared care approach may offer potential to provide the necessary level of comprehensive care to meet the multiple physical and mental health needs of people with concurrent opioid dependence and mental health problems. Three distinct models of shared care were evident in the literature.

The consultant-liaison model

Various models of mental health care based upon consultant-liaison links between psychiatric services and GPs have been implemented and evaluated in the United Kingdom (Meadows 1998). One report pointed to an improvement in detection rates but not in patient outcomes (Katon & Gonzales 1994), while another called for further evaluations in response to the lack of sustainability of many of these models (Gask, Sibbald & Creed 1997). Reports have produced inconclusive results on the effectiveness of this model in Australia. For example, the results of a pilot program initially concluded that it was applicable and effective to the general practice setting (Carr & Donovan 1992), but the former author later identified some significant problems with the model and the program failed to progress beyond the pilot phase (Carr & Reid 1996). More recently, a report on a project that built upon the relationships established through the consultant-liaison links with a model of shared care between psychiatrists, GPs and the mental health services concluded that it augmented the capacity of GPs to provide cost-effective continuity of care (Meadows 1998).

The community health centre model

Another model of shared care with potential to treat complex conditions which meets the current requirements of a cost-effective quality service has been examined in the literature. Copeman (1992) notes that there is evidence from both Australia and overseas that community health centres with a primary medical care component lead to a decrease in hospital costs without a concomitant increase in overall health care costs. The potential lies in their ability to provide access to a wide variety of primary health care services delivered by multidisciplinary teams of health professionals. In a study of the role of medical practice in community health centres in relation to women's health, the authors found that this model was preferable for individuals who have multiple social and physical problems (Baum, Kalucy, Lawless, et al, 1996). Another study found that longer consultations, counselling and follow-up visits presented clear advantages for addressing complex health

problems (Monalto, Dunt & Young 1994). Limitations of the community health centre model include long waiting lists and the limited availability of such programs (which require ongoing funding, training, development and evaluation). A further system limitation concerns the failure of the General Practice Reform Strategy to incorporate mechanisms to encourage co-ordination between GPs and the community health sector (Baum, Kalucy, Lawless et al 1996).

The co-ordinated care model

A final shared care approach that has received scant attention thus far is co-ordinated care. The first round of Co-ordinated Care Trials in Australia was conducted from June 1997 to December 1999 on patients with chronic and complex medical conditions. The underlying principle of the trials was that the management of chronic conditions might be improved by better co-ordination between service providers and by a different system of payment outside of the Medicare fee-for-service arrangements. The idea was to establish a funding pool based on an estimate of what would otherwise have been spent on services used by trial participants (patients with chronic conditions). Each participant's 'care co-ordinator' (usually their GP) would then use the money from that funding pool to buy the full range of services set out in a prospective plan of care, established according to best practice.

A number of co-ordinated care models were trailed during the first round. The most effective in terms of patient health outcomes was SA HealthPlus – the largest trial in Australia (McDonald & McGowan 1999). SA HealthPlus was designed to reduce service fragmentation for consumers by employing a Service Co-ordinator (usually a registered nurse) who worked in liaison with a GP (care co-ordinator) who was principally responsible for the patient's care. The role of the Service Co-ordinator is to assist the GP with health assessments, prospective care planning, arranging health services, improving self-management capacity, and providing ongoing patient support. A system change that has resulted from the first round of the Co-ordinated Care Trials is the Enhanced Primary Care package introduced by the Department of Health and Aged Care in 1999. Although untested as yet, the applicability of this type of model for patients with concurrent problems is apparent and is amenable to development in the second round of trials. An advantage of the co-ordinated care model is that it can provide linkages to other shared care models (e.g. CHC) and requires limited system change.

The capacity of the shared care model in the Australian general practice setting has been increased by the Enhanced Primary Care package for complex and chronic conditions. The Medicare items that emanate from this package provide remuneration for care plans. These plans consist of a comprehensive program of treatment and maintenance for all aspects of chronic conditions and are implemented during consultations that can last for up to 45 minutes. They also allow case conferences that review the progress of a patient with a chronic condition(s). This model has major advantages for treating concurrent opioid and mental health problems. The provision of payment for GPs can address the barrier of time and, moreover, the utilisation of other health professionals (either within or outside of the general practice setting) can provide expert advice to the GP on the non-medical issues of opioid dependence and mental health problems.

Summary

This review has identified a need to address concurrent opioid and mental health problems, in order to reduce individual and community harms. General practice is considered to be an appropriate and effective setting for the treatment of complex health conditions - including concurrent problems - because of its potential to provide accessible cost-effective care to patients. However, barriers related to the GP, the practice and the health system compromise the potential for GPs to treat concurrent problems. The effectiveness of models of shared care that link the GP with other health professionals has been examined in the literature. Although evaluations of these models for mental health problems have produced varying results, in Scotland, shared care between drug specialists and GPs has resulted in 70% of GPs managing opioid dependent patients and has led to a significant reduction in the harms associated with injecting drug use (Greenwood 1996). To date there has been little research on the effectiveness of a shared care model for opioid dependence in Australia.

Given the wide range of mental health and social problems experienced by people with opioid dependence, the potential of a shared care model to provide effective treatment is dependent upon the development and

implementation of mechanisms to improve linkages between GPs and community services and address the barriers that impede the delivery of comprehensive and integrated ongoing care. Specifically, these could include the organisation of primary care teams that contain a range of health professionals (such as GPs), as well as resources that assist these teams to address concurrent opioid dependence and mental health problems in the community setting. Given the evidence that suggests the treatment needs of opioid users are not being met and that concurrent problems affect treatment outcomes, a new approach that utilises existing services and resources holds potential to fill the current gap in service delivery.

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