Addiction psychiatry

Psychiatry has a long history of having to justify its place, as a discipline, in mainstream medicine. As the focus becomes more biological and knowledge more scientific, it would be expected that stigma towards those suffering from mental illness would decrease. However, this is not the case. While there seems to be increasing acceptance of depression, for example, as an illness rather than a personal weakness, addiction, unfortunately, has not made the transition and has remained in the domain of social welfare agencies. This has resulted in substance use disorders often being managed from a moral rather than clinical / scientific standpoint. The result is the entrenchment of stigma and poor access to health services for addicts. With the scientific progression to the medicalization of addictions, opposition from many non-scientific quarters has been strong. For instance, a substance abuse ward at Mathari Hospital - the National Psychiatric Hospital located in Nairobi, Kenya - initially met with overwhelming resistance when it was opened, from those opposed to regarding addiction as a mental illness as well as prejudice against addicted patients themselves.

Work from as early as the 1980's demonstrated that consumption of psychoactive substances affects almost all of the known neurotransmitter systems with resultant detrimental pathology.[1,2] The genetic predisposition to substance misuse is also beyond dispute.[3] Despite this, addicts are subjected to harsh, punitive and judgmental attitudes from the community and non-scientific practitioners that has a negative impact on their management and recovery. Current rehabilitation centres tend to focus on social management and isolation as the sole intervention for people with a biological illness. This equates to quarantine to protect patients from environmental factors that impact on the disease rather than managing the underlying pathology.

Nowhere are the deficiencies in addiction treatment more evident than in the management of dual diagnosis disorders. The high rate of co-morbidity between addiction and psychiatric pathology is related to common contributing factors and brain neurobiology.[4] Taking cannabis as an example, in a US population study the prevalence of abuse was 29,2% among patients with psychosis, compared to 4% of the general population.[5] Prospective studies have shown a major increase in the risk of developing schizophrenia in cannabis users.[6] There is also data to suggest that cannabis users have more severe psychotic symptoms than non-users.[7] If cannabis use ceases, there is significant reduction in psychotic and depressive symptoms.[8] The impact of substance use on all areas of functioning and community integration of people with serious mental illness is also significant. These negative consequences are not only in terms of worsening pathology but also social complications that affect the broader community. Problems such as crime, HIV infection, family disruption, school drop-outs, homelessness and the special needs of the children of addicts, require expensive and labour intensive interventions. Substance abuse tends to persist over long periods of time in patients with severe mental illness.[9] Obviously this dramatically increases the cost of treatment, particularly as a result of regular hospitalization.[10]

There are very strong grounds for integrated interventions for individuals with serious mental illness and substance use disorders. Often, these patients are treated in parallel, but separate, mental health and substance abuse programmes.[11] Both are chronic illnesses and require long-term specialized care by a team of clinicians able to provide a rational and coherent approach to treatment. In order to achieve this, the psychiatrist is the obvious choice to drive the process for a number of reasons. Firstly, management of the psychiatric pathology is of paramount importance, not only in terms of reducing the burden of the disease itself, but also because response to neuroleptic medication may be critical in recovery from the substance abuse.[12] Secondly, the use of pharmacological treatments for substance abuse (maintenance treatments) are vital adjuncts in the management of dual diagnosis patients. Prescription of such drugs, based on individual patient factors, needs to remain in the hands of experts in neuropsycopharmacology particularly when used in conjunction with other psychotropic drugs. This is beyond the scope of a social programme. Similarly, detoxification is a medical process that can, if not managed by a trained professional, result in severe morbidity and even mortality. The physical consequences of addiction are often managed by other medical disciplines, for example surgeons treat the pancreatitis that may occur due to alcohol abuse. Liaison with these disciplines is essential for a patient being managed for a chronic, relapsing disorder. By placing addiction firmly in the area of a medical disorder, interaction between medical specialists occurs more easily and provides an opportunity to share knowledge and allows greater understanding and acceptance of the roles of different disciplines. Additionally, research is vital in driving knowledge of the disorder. An integrated treatment facility allows monitoring, measuring and evaluating outcomes to better plan for the future. Public-private partnerships may help fund various therapeutic programmes and play a role in directing future management strategies. Research conducted in the field of dual diagnosis shows a bidirectional relationship between substance use and psychiatric pathology and this has implications for future behavioural and biological treatment interventions.[13] An addiction sub-specialty network can bring together the ideas of not only specific units within an academic institution but also across disciplines, other centres nationally and build relationships with experts from abroad.

Recognizing the enormous role substance abuse played in the pathology experienced by both in- and out-patients at the psychiatric unit at Chris Hani Baragwanath Hospital (located in Soweto, South Africa), a dual-diagnosis unit was

set up in 2008. An attempt was made to establish integrated dual disorders programmes similar to those used internationally that have been able to attract and retain patients in the services and reduce the use of psychoactive substances in these patients.[14] Located within the psychiatric unit of a large general hospital, existing resources in terms of professionals and facilities have been utilized which has reduced financial cost and allowed integration within the acute psychiatric service as well as consultation with other medical professionals. It is an out-patient unit but in-patient detoxification is supervised by the team. Other services supplied by this ''one-stop-shop'' include assessment by a psychiatrist for dual pathology, a consulting physician taking specific referrals, support groups from Alcoholics and Narcotics anonymous, occupational life-skills groups, parent support groups and individual psychotherapy. Additionally, registrars in psychiatry gain experience in the field by working in the unit. In the future, the daily, observed administration of maintenance anti-addiction pharmacological agents may become part of the service provided. The unit is an addiction sub-speciality facility which evolved out of the dire need for such a service despite addiction psychiatry not being recognized as a sub-speciality in South Africa at the time.

The specialist addiction psychiatrist is central to the management of the substance abuser, but this does not mean that activities related to the management of such patients require that degree of expertise in all areas and all phases of the condition. Caring for addicts is a long-term process of building relationships, but different types of services and individuals can meet some of these requirements. Referrals to appropriately trained nurses, general practitioners, counselors and organizations such as SANCA, AA and NA allows greater access to qualified professionals by the community despite the lack of specialists in developing areas. In addition, these individuals can drive outreach and advocacy in their communities which is a vital component of an integrated substance abuse programme. The addiction psychiatrist can be a leader and developer of services while acting inclusively with other health care practitioners in defined roles.

Addiction psychiatry has certain unique challenges and goals. Specialized academic training in this discipline is essential to ensure that clinicians have a thorough theoretical background on which to base clinical care. To this end, and within South Africa, the Western Cape has introduced a post-graduate training programme in addiction care with an MPhil degree in Addiction Psychiatry at the University of Cape Town. Recently a similar programme has been introduced at Stellenbosch University. While having experience in these areas makes one a better general psychiatrist, patients with dual disorders are entitled to expertise that can best be provided by sub-specialists in addiction psychiatry.

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