In Debate

Addiction Is a Mental Disorder, Best Managed in a (Public) Mental Health Setting—But Our System Is Failing Us

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For centuries, mental illness was viewed as an invasion by evil spirits that had to be exorcised. Later practices dictated sending the afflicted away to asylums, and eventually the custodial model gave way to a trend of deinstitutionalization. Despite its deficits, this translated into an increased potential for societal involvement and interaction that changed the mental health landscape. In the context of addiction, the last few decades have yielded a body of evidence confirming the formerly disavowed disease of addiction as a group of bona fide mental disorders. Although this disease concept is endorsed by most contemporary psychiatrists, many health care systems' models have not successfully escaped the "moral management archetype" holding addiction hostage. What does this mean, and how does this affect patient care? There are more questions than answers, and easy solutions are evasive, making the challenges at a systems level at least as intractable as the problem of addiction itself.

Addictionology, or the study of addictions, has emerged as a distinct and useful subspecialty,[1] and despite the multifaceted presentation of addictive disorders, it is described with remarkable similarity in major global mental health taxonomy systems.[2] Additionally, although the diagnoses in this category have achieved sufficient construct validity and internal consistency of criteria on a systems level, addiction is often not recognized as such and is neglected when public health policy and fiscal priorities are determined. Could patients be falling through the cracks as a result of our health care system's failure to adequately endorse addiction as a chronic, relapsing mental disorder? Is it possible that some policy-makers' views of addiction as a personal choice (or a social phenomenon responsible for undesirable behavior, crime, and immorality) have not been replaced by a more enlightened stance? The prevailing policies separating addiction from mainstream psychiatry certainly do not speak to the contrary. Addiction may, at last, be coming out of the shadows, but it is certainly not in from the cold.

Although addiction is a complex disease involving physiological, psychological, genetic, behavioural, and environmental factors, it is fundamentally a disease of the brain,[3–5] and like many other chronic mental disorders, it is amenable to treatment. In what amounts to a historical anomaly, the mental health community was (and in many jurisdictions still is) disenfranchised as the primary and rightful custodian for the treatment of this disease. Would it be considered a leap of faith to suggest that the treatment of this chronic mental disorder could be best directed by the discipline dedicated to the study and treatment of other chronic disorders of the brain?

Addiction is the most common psychiatric disorder and the most prevalent comorbid condition in individuals with other mental illnesses. It costs the Canadian economy an estimated $40 billion annually,[6] which is greater than the economic impact of all other mental illnesses combined. Further, for several plausible reasons, the prevalence and costs of addiction are increasing and have possibly not yet reached a plateau. Nevertheless, despite the devastating economic impact of addictions, a dire need for solutions, and the confusing panoply of available (but not necessarily effective) treatment options, most addicted individuals remain untreated. In treatment-seeking cases, the health care system often finds itself ill-equipped, yet compelled to deal with complications arising from addictions. In a system where there is no universal expectation to meet evidence-based standards, many addicted individuals seeking treatment fail to find an appropriately matched modality. In this diluted and fragmented system, so-called addicts may find themselves stigmatized, disenfranchised, homeless, impoverished, destitute, or drifting in and out of psychiatric facilities, the criminal justice system, emergency departments, and faith-based settings.

Current models have forced the premise that, unlike most other aspects of health care in Canada, addiction treatment is a

commodity that can be purchased, but only if you can afford it. It is often left up to mentally ill "addicts" to navigate a system designed for those suffering from, supposedly, one disorder at a time—only to find that they may remain ineligible for psychiatric treatment unless they are "clean and dry." This perpetuates the implicit message that addiction is a lifestyle choice, not a disease, and is essentially the consequence of bad choices. Case in point: Why are bupropion (for smoking cessation) and nicotine replacement therapy (both are safe, effective, and clinically more meaningful than many other psychiatric drugs that are routinely covered by insurance) almost universally excluded from drug coverage plans? What will it take for the mental health and public health systems to fully accept addiction as another mental disorder and lobby for appropriate treatment instead of focusing on drug use behaviour that is often labelled as volitional and voluntary?

For the minority of "addicts" with access to addiction treatment, such treatment is often exceedingly costly and representative of inequitable practices that may be fraudulent, unaccountable, or perhaps even dangerous. Programs are frequently delivered by individuals in addiction recovery themselves, with limited training except by virtue of their own experience. Compounding this, many addiction workers (without formal psychiatric training) remain distrustful of psychiatry because of the use of what they perceive to be mind-altering drugs, and some see psychopathology as merely a direct manifestation of drug use. The general lack of attention to minimum standards for education and training, credentialing, addiction-treatment expenditures, and outcome measurement are all symptomatic of the system's failure.

The status quo creates unrealistic expectations for the health care system to deliver curative interventions instead of prevention (for example, costly lung transplant procedures without adequate prevention of tobacco use in the population). Where is the wisdom of an ounce in prevention being worth a pound of cure? This apparent disregard of the preventable determinants inflicts immeasurable human suffering, incurs massive costs to the economy, and leaves us with a sense of therapeutic nihilism. Existing resources and scientific evidence are not optimally deployed when addiction care is forcibly divided into de facto parallel or sequential systems of care in which multiple legitimate treatment providers may be involved but in which nobody is willing (or mandated or accountable) to lead the integration of addiction into health care.

Despite a body of scientific evidence in favour of it, the suggested integration of addiction care into mental and public health care has remained elusive and dependent on the political appetite of the day. In general, addiction-treatment policy does not appear to be driven by an interest in the health of individuals but, instead, to be motivated by politics, ideology, and money. The largest policy deficit is evident in the failure to apply existing scientific knowledge to stimulate organizational adaptation and policy reform. What can be done now? First, the Kirby Report's[7] recommendations should be implemented to lay the foundation for mental health care that includes addiction issues in public mental health planning. Second, we have to rely on mental health (and public health) leaders' political skills to lobby for adequate funding of integrated and evidence-based service systems that incorporate cultural sensitivity and take the needs of minority and gender groups into account. Third, to optimize outcomes, it is imperative for opinion leaders to place a stronger focus on prevention. Guided by jurisdictions wherein it has already occurred, this focus on prevention should be prioritized as the benchmark for all mental health systems in Canada, with program accreditation being contingent upon it.

Mental health care is at a crossroads. There is a dire need for the partnering of psychiatry and the public health system to universally embrace addiction care with the same vigour that goes into treating other chronic illnesses and public health threats. Is it not time for addiction care standards to be granted parity with other standards of prevention, care, funding, and research in the respective disciplines? The challenge lies not with individual service providers' endorsement of addiction as a chronic disease but with the mental and public health systems' appreciation and acceptance of the addiction portfolio. We have to rely on visionary leaders to transform the addiction landscape and bridge the gap between what we know about the science and what individuals suffering from addiction and mental illness actually need; further, policy makers should be accountable for ensuring that this takes place. Perhaps the first step to make this agenda operational is a move toward a focused organizational hybrid of the psychiatric and public health disciplines—public mental health—to create a suitable vehicle for addiction prevention and care.

The (sweetest) low-hanging fruit can be harvested by targeting tobacco, the historically anomalous yet universally dangerous drug. The mentally ill population, which is disproportionately affected by addictions, is falling through the cracks while the disease vector (the tobacco industry) is reaping billions in profits from their illness. For how long can we overlook the fact that almost 50% of tobacco is consumed by the mentally ill, that it affects 50% of those suffering from mental illness, or that it kills more than 45 000 Canadians annually? Tobacco is a drug which could never be legal if introduced to the market today. Standard protocol dictates that, when a pharmaceutical drug directly causes death, it is immediately removed from the market. This means that tobacco (containing over 4000 chemicals) would have been pulled off the Canadian market at least 45 000 times last year. This regulatory inconsistency is nothing less than a systemic

failure. However, there is a glimmer of hope: leading the way are the Canadian Mental Health Association and the Schizophrenia Society of Canada, which recently reformed their policies and now refuse money from the tobacco industry. Would it be unreasonable to expect the same standard from medical (and public health) schools—which exist to research new life-saving innovations and best practices for treatment as well as to train new practitioners—to stop providing legitimacy for the tobacco industry by accepting its funding?

For now, addiction remains a unique disease: it is prevalent and lethal, and despite its treatable status, most addicted individuals are left untreated. To meet our targets for health care, addiction needs to be taken out of isolation and integrated into mental health services. Bureaucratic obstacles are responsible for the excess fiscal burden on the health care system that is caused by addictions, and a truly long-term and integrated strategy is needed to treat addiction as a chronic, relapsing mental disorder. Considering its status as the leading preventable cause of death, disease, and disability in Canada, addiction could perhaps be viewed as the most important disease of our time.

The most vexing question remains: Who assumes the primary mandate, responsibility, and accountability for the prevention and care of addiction? Whoever assumes this mandate will have to ensure that service system integration is achieved to accurately focus undivided attention where it is most needed. Perhaps it should be a hybrid of the mental health and public health sectors, where legitimately allied providers' roles are recognized and valued. The ideal of an available, accessible, universal, portable, affordable, and nonstigmatizing health care system will remain an elusive goal until addiction is granted its rightful place by policy-makers and opinion leaders at the organizational level. It is time to challenge conventional wisdom and practice by challenging the current expectations and benchmarks so that addicted individuals can be accommodated (or rather, welcomed) in the public mental health system.

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