2. Cohorts

Co-occurring disorders are not a single diagnostic category such as, for instance, 'Generalised *Anxiety Disorder*'. Rather the term refers to any of a wide range of mental health disorders that co-occur with any of a wide range of substance use disorders. Co-occurring disorders refers to a wide range of possible combinations of disorders. Considerable variation in the severity and impact of those disorders leads to substantial diversity in the individual treatment needs of the various people who experience co-occurring disorders.

Some of the cohorts of people with co-occurring disorders that treatment systems, researchers and the media have had a particular focus on include people with:

- Alcohol use disorders co-occurring with anxiety or depressive symptoms or disorders
- Cannabis use disorders co-occurring with psychosis
- Personality disorder co-occurring with opiate or polysubstance dependence
- Post-Traumatic Stress Disorder co-occurring with substance abuse
- Psychosis co-occurring with a range of substance use disorders
- Stimulant abuse or dependence co-occurring with psychosis

Spectrum of disorders

One possible –albeit broad - typology for mental health disorders is to sort the disorders by whether they are '*high prevalence- lower impact*' disorders (e.g. mild anxiety or depression) or '*low prevalence-higher impact*' disorders (e.g. psychosis). Similarly Substance Use Disorders, regardless of which substance/s are involved, can be placed on a spectrum from Mild to Moderate to Severe (DSM V) or from Harmful Use to Dependence (ICD 10).

Specialist mental health services, in the context of scarce resources, have tended to be oriented around the needs of people with '*low prevalence-high impact*' mental health disorders. Alcohol and Other Drug (AOD) treatment services principle treatment focus, perforce, has been on people with substance dependence rather than abuse – that is the groups to the far right of the spectrums in Diagram 1- *Mental health and substance use disorders spectrum*.

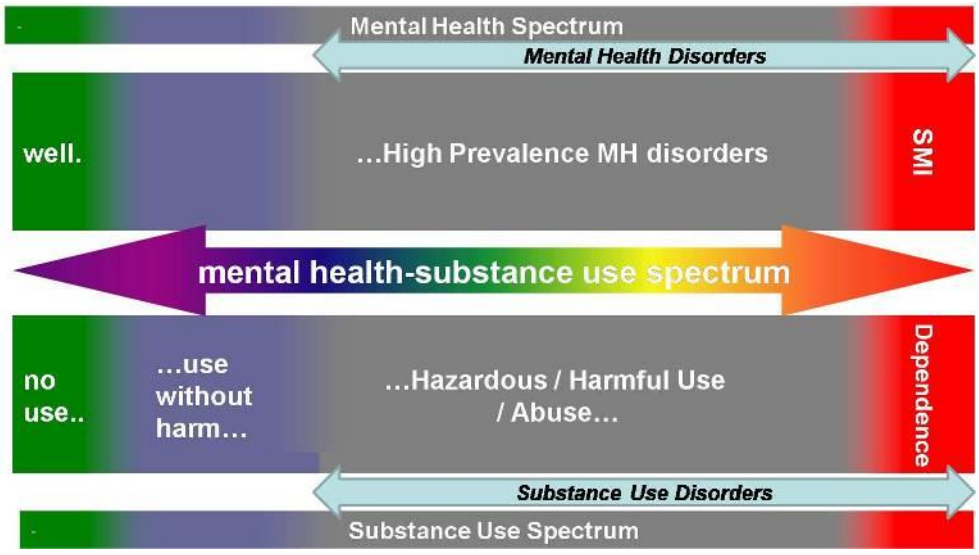

Diagram 1: Mental health and substance use disorders spectrum.

Notwithstanding these traditional orientations, when considering our systemic recognition of and response to people with co-occurring disorders, it should be borne in mind that:

- By reason of prevalence the **greatest costs and harms** associated with mental health disorders are for high prevalence –lower impact disorders (Diagram 2)
- Similarly, again due to prevalence, the **greatest costs and harms** associated with Substance Use Disorders are for the large group of people who are positive for Substance Abuse but not Dependence (Diagram 2)
- For both people with Severe Mental Illness (SMI) or Substance Dependence rather than Abuse **treatment tends to be high input and less effective** (Diagram 3)
- Whereas for both cohorts - people with high prevalence–lower impact mental health disorders and people with Substance Abuse rather than Dependence - **treatment tends to be lower input and effective** (Diagram 3)

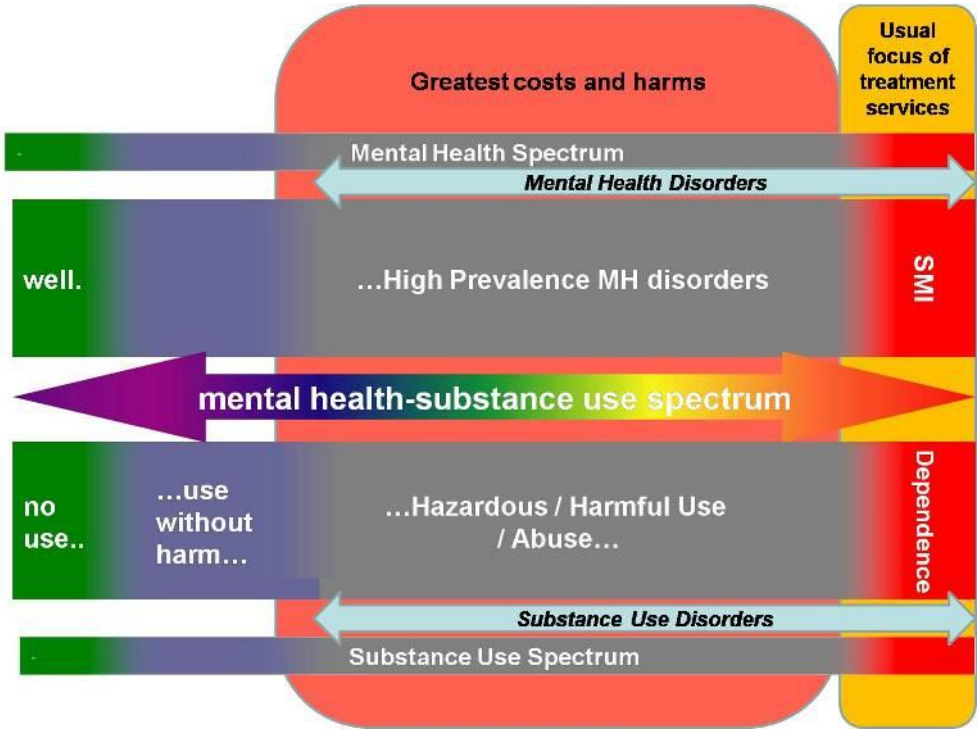

Diagram 2: Costs and harms / focus of treatment services

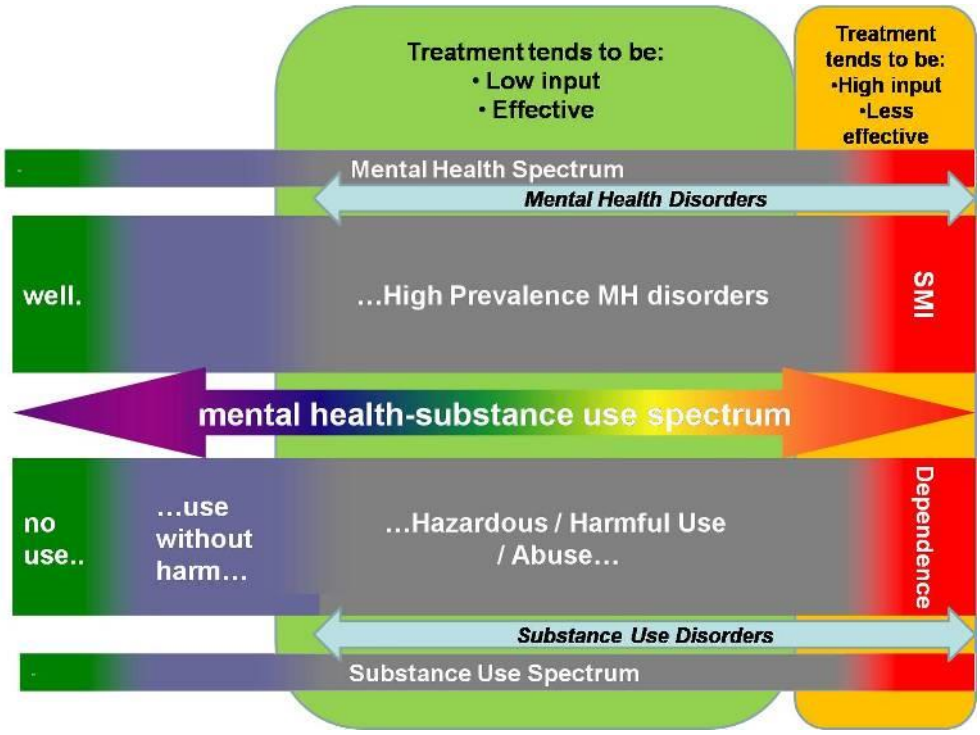

Diagram 3: Treatment inputs and effectiveness

An implication of the above is the need to have a broad and inclusive definition of co-occurring mental health and substance use disorders – one that embraces cohorts of people with (often less visible, less easily detected) Substance Abuse and/or high prevalence mental health disorders. Of course, in a socially just society, investing in providing the most effective possible responses to the cohorts with Severe Mental Illness and/or substance dependence has to be of the highest priority.

At the same time it is strategic to recognise that the greatest potential gains and savings associated with co-occurring disorders are to be found in developing our recognition of and effective responses to those cohorts of people whose co-occurring disorders includes either Substance Abuse or high prevalence mental health disorders.