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PTSD and addiction in the military: Treating the military member with a dual diagnostic process to effectively treat the illnesses

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Treating the military with addiction issues has mostly been treated as a separate issue to the other diagnosis. Often times the addiction is treated as the only issue with which the member of the United States Military is living. The standard of treatment is typically associated with the treatment of preparing the individual for upcoming work requirements and less about long term effective treatment of the co-morbidity of mental health illnesses such as, but not limited to, PTSD. Through my experience and research I propose that military organizations begin to adopt a treatment plan that treats all mental health issues, not just addiction, resulting in long term, effective treatment of the member. Addiction affects an astounding 39% of the United States Military according to a study conducted by the *American Journal of Public Health,* active duty military and veterans prone to substance abuse, depression and suicide. Many of these individuals will, unfortunately, only be treated minimally and for the substance abuse and/or the addiction while, depression, PTSD, anxiety and so on will go untreated resulting in the member returning to civilian life without the supervision needed to assist in sobriety to a life of addiction, essentially self medicating the undiagnosed and or untreated mental illness.

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Psychiatric co-morbidity among patients on methadone maintenance therapy

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Objective: Although methadone maintenance therapy has benefited individuals with opioid dependence, a substantial proportion of patients still experience psychiatric symptoms which may affect treatment outcome. As the methadone maintenance therapy reaches its first decade in Malaysia since its implementation in 2005, this study aims to examine the association between psychiatric co-morbidity and quality of life.

Method: A total of 225 male patients who were on methadone maintenance therapy completed the study underwent the Mini International Neuropsychiatric Interview, Opiate Treatment Index, and World Health Organization Quality of Life-BREF Scale. The association between different variables and quality of life scores was tested using t-test for categorical variables and Pearson's correlation for continuous variables. Multiple regression analysis was then performed for the significant variables.

Results: 14.2% and 15.6% of patients on methadone maintenance therapy had a current and lifetime non-substance use Axis I psychiatric disorder respectively, with major depressive disorder being the most prevalent Axis I disorder. The analysis showed that patients with a non-substance use Axis I psychiatric disorder were significantly more likely to use psychiatric medications (OR=11.92, 95% CI 3.42-41.51, p<0.001), have an antisocial personality disorder (OR=5.07, 95% CI 1.83-14.10, p=0.002) and had higher scores for physical health on OTI, indicating poorer physical health (OR=1.41, 95% CI 1.02-1.96, p=0.041). In multiple linear regression analysis, having a non-substance Axis I disorder was the only factor which significantly predicted the quality of life in all 4 domains and in the combined quality of life and general health.

Conclusions: Patients on methadone maintenance therapy with a non-substance use Axis I co-morbidity have a poorer quality of life in all domains than those without the co-morbidity. The impact of psychiatric co-morbidity on quality of life calls for attention to detect psychiatric co-morbidity and provide adequate treatment to patients on methadone maintenance therapy to improve their quality of life.

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