Comorbidity of mental disorders with substance misuse

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The title of this editorial evokes the image of a patient with a psychosis, usually schizophrenia, who abuses or is dependent upon alcohol or an illicit drug. The suffering of these individuals and their families is undeniable, as are the difficulties that mental health and addiction services face in helping them. None the less, this form of comorbidity has overshadowed more prevalent and remediable patterns of comorbidity between substance misuse and mental disorders (Hall, 1996).

PATTERNS OF COMORBIDITY

In the Epidemiologic Catchment Area (ECA) almost a third (29%) of persons who had a mental disorder (other than a substance use disorder), had experienced a substance use disorder at some point (22% an alcohol disorder, and 15% another drug disorder). Conversely, a third of persons with an alcohol disorder (37%) had experienced another mental disorder, and half of those with other drug use disorders had experienced another mental disorder (Regier *et al*, 1990).

The most prevalent comorbid mental disorders among persons with an alcohol disorder were: anxiety disorders (19%), antisocial personality disorders (14%), affective disorders (13%) and schizophrenia (4%). The most prevalent comorbid disorders among those with any other drug disorder were: anxiety disorders (28%), affective disorders (26%), antisocial personality disorders (18%), and schizophrenia (7%) (Regier *et al*, 1990). A third of persons with affective disorders (32%) also met criteria for a substance use disorder (22% for an alcohol disorder and 19% for another drug disorder) (Regier *et al*, 1990). The rates of comorbidity were lower among affective disorders than schizophrenia but since affective disorders are more prevalent in the community their contribution to the total prevalence of comorbidity is much larger.

The US National Comorbidity Survey (NCS) produced a higher prevalence of comorbidity than the ECA (79 *v.* 60%) (Kessler, 1995). There was, however, strong agreement in the patterns of comorbidity (Kessler, 1995).

The British Psychiatric Morbidity Survey found moderately higher rates of alcohol and drug dependence among persons with other mental disorders, and very high rates of heavy cigarette smoking (Meltzer *et al*, 1996). The survey of the homeless in night and day shelters (Gill *et al*, 1996) reported a 50% prevalence of alcohol and drug dependence, with high rates of comorbid mental disorders.

The ECA and the NCS surveys also indicated that rates of comorbidity among persons who are treated in specialist mental health services are even higher than those in the community (Regier *et al*, 1993). This is partly due to Berkson's bias (that persons with more than one disorder have an increased chance of being treated for either disorder) and in part to the fact that persons with substance use disorders and distressing symptoms of comorbid anxiety and affective disorders are more likely to seek treatment (Hall, 1996).

IMPROVING TREATMENT OF COMORBID DISORDERS

Comorbid mental and substance use disorders are often ignored in treatment systems where services specialise in treating either mental disorders or substance use disorders, as has occurred in the USA and Australia, for example. The failure to address comorbid mental disorders in persons with substance use disorders predicts a poorer outcome (McLelland *et al*, 1983; Helzer & Psyzbeck, 1988). Less is known about the impact of comorbid substance use disorders on the prognosis of affective and anxiety disorders.

The impact of comorbid disorders on the rate and duration of psychiatric hospitalisation is also critical to mental health service provision. There are increasing demands for specialist services to reduce their admission rates and the average duration of hospitalisation. Services for the homeless who have a high prevalence of morbidity, and in whom problems from many domains intersect, present a major challenge to specialist services that are required to change their patterns of service utilisation.

A PROPOSAL

Improving our treatment of persons who have comorbid mental and substance use disorders need not involve the creation of a psychiatric super-speciality to deal with dual diagnoses, as has been advocated in the USA (Lehman & Dixon, 1995). This is likely to be a very expensive approach that should be reserved for research centres until its effectiveness and, more importantly, its cost-effectiveness, have been demonstrated.

A more modest and achievable step would be to improve the ability of treatment staff in specialist mental health and addiction services to recognise and manage the most prevalent and remediable comorbid disorders among their patients. In mental health services and primary care settings more attention should be paid to persons who have anxiety and affective disorders, substantial minorities of whom will either have, or be at risk of developing, alcohol and other substance use disorders. Screen instruments for hazardous alcohol use (e.g. Conigrave *et al*, 1995) and regular enquiry about history of drug use could identify those who may benefit from brief interventions (Heather, 1989). Those with more established problems could be referred for specialist treatment, or they could be managed with support from specialist services which have developed good models for joint care of the long-term mentally ill with comorbid substance misuse.

Staff in addiction services should also be trained to identify anxiety and affective disorders in their clientele. Valid and reliable psychological tests, such as the GHQ (Goldberg & Williams, 1988) or the SCL-90-R (Derogatis, 1994), could be used to detect probable anxiety and depressive disorders among drug-dependent persons. Those with disorders could be referred for specialist treatment, or jointly managed with appropriate back-up advice and support.

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These steps, and the sharing of skills and support between addiction and mental health services, are essential if we are to improve the treatment of persons with comorbid mental and substance use disorders – a substantial minority, if not a majority, among those treated by both types of services.

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