



Co-morbidity — drug use and mental disorders

An underestimated condition

Co-morbidity is often underestimated and underdiagnosed. Two main groups of co-morbid drug users are recognised, each with distinct profiles. One group is dominated by people with psychiatric illness and the second group is characterised by drug dependency. About 30–50 % of psychiatric patients in Europe today have a mental illness as well as a substance use disorder, mainly with alcohol, sedatives or cannabis. Among clients from drug treatment centres, co-morbidity mostly implies another profile, with heroin, amphetamine or cocaine use and one or several personality disorders as the dominant diagnostic features, followed by diagnoses of depression and anxiety and, to a lesser degree, by psychotic disorders. This distinction has consequences for the choice of optimal treatment interventions. Both groups often need combined but different pharmacological and psychosocial interventions over a prolonged time.

The co-occurrence of personality disorders and drug abuse was only recently described

in the general population. The US National Epidemiologic Survey on Alcohol and Related Conditions firmly established the relation between drug use disorder and personality disorder, with about half of drug users having at least one personality disorder.

In clinical prevalence samples of drug dependent patients, personality disorders (50–90 %) are the most prevalent form of co-morbidity, followed by affective disorders (20–60 %) and psychotic disorders (15–20 %). Anti-social personality disorder is 25 % in representative clinical samples. Recent research indicates that psychopathology usually precedes drug use. The prognosis of psychiatric problems worsens with early onset of drug use and long-term continued drug use. The syndromes mentioned interact and overlap, which means that a person might have more than one of these disorders in addition to drug-related disorders.

Available European data provide a diverse picture. In different clinical studies, personality disorders range from 14 % to

96 %, with the dominant types being anti-social and borderline disorders, depression ranges from 5 % to 72 %, and anxiety disorders from 4 % to 32 %. The large variation is probably due to differences in the focus of diagnostic assessment and the type of sample chosen, and underlines the lack of comparable data between EU Member States. The variation in diagnostic foci indicates a need for more structured studies with well-defined sample characteristics and assessment instruments across the EU.

‘When we see drug users, we tend to attribute their problems to their use of drugs. However, more often than not, drug users have co-morbid mental health disorders, which we often fail to recognise. We need to take account of co-morbidity when treating drug users.’

Marcel Reimen, Chairman
EMCDDA Management Board

Definition

Co-morbidity, sometimes called ‘dual diagnosis’, was defined by the World Health Organization (WHO) in 1995 as the ‘co-occurrence in the same individual of a psychoactive substance use disorder and another psychiatric disorder’.

Key issues at a glance

1. Problem drug users, more often than not, suffer from mental disorders. Both psychiatric teams and drug services regularly fail to identify patients with co-morbidity.
2. In the treatment of co-morbidity, there is no single psychosocial intervention for drug addiction that is superior to all others.
3. Co-morbid clients are often sent back and forth between psychiatric and drug services, not receiving proper assessment or treatment.
4. Treatment staff are often not trained to deal with co-morbid clients, since their training usually is specialised (medicine, psychology, social work, etc.).
5. Currently, treatment of co-morbidity is often not effectively organised and lacks quality management. This leads to inefficient treatment and high staff turnover.
6. Treatment of co-morbid patients involves different services over a long time.

1. Problem drug use and psychiatric disorders — a common combination

Systematic diagnostic studies indicate that around 80 % of patients with a drug dependency diagnosis also have co-morbid psychiatric disorders.

Co-morbidity is difficult to diagnose and both psychiatric teams and drug treatment services often fail to identify it in patients. The acute psychiatric syndromes of a co-morbid client seeking drug treatment can be mistaken for substance-induced symptoms or, conversely, withdrawal or intoxication phenomena may be misinterpreted as psychiatric illness. The routine assessment of psychiatric disorders among drug users at the start of treatment appears to be the exception rather than the rule. Consequently, many clients with co-morbidity commence drug treatment without receiving treatment for their mental health problems. Even when co-morbidity is diagnosed, often it is not considered in subsequent drug treatment interventions or, in the case of psychiatric services, results in no drug-related treatment. However, some psychiatric and drug services achieve good results with co-morbid patients, when they have expertise in both areas or work closely together.

Clients with co-morbidity often suffer from 'multi-morbidity', since there are severe somatic illnesses as well as social, housing and employment problems associated with co-morbidity. Drug use often implies a failure to comply with a pharmacological treatment schedule, thus increasing the problem of handling psychotic or depressive episodes. HIV infection and several types of hepatitis are common, as are a vast number of ailments; neglect of personal somatic health is the rule. An underrated problem is bad dental health, which increases the risk of primary and secondary infections and severely damages the self-image of the person. Social problems such as isolation and homelessness aggravate the situation for these persons.

Particular attention should be paid to the prison population. Psychiatric illness and drug use are both much more prevalent in prisons than among the general population

and so is the combination of both. Relapse rates are high among drug users who have served long sentences and there is a growing recognition that incarceration can worsen mental health problems and that drug use often continues within the prison.

Among the psychological and psychiatric problems, various studies have identified suicide attempts in about 50 % of co-morbid patients, often reflecting problems in the family, at school and in peer relations. Many female drug users have experienced sexual abuse and trauma during their upbringing. Early onset of drug use is a negative prognostic factor since the problem worsens with time more for this group than for other drug users. Investing in intensive and targeted measures to prevent drug use and mental health problems is very worthwhile.

2. Treatment options for co-morbidity

For opiate abuse, the pharmacological intervention of choice has been substitution treatment with methadone, and in more recent years buprenorphine. Pharmacological agents that block the effects of morphine and heroin, for example naltrexone, are rarely used. Strong empirical evidence supports the use of these pharmacological substances, but there is no pharmacological treatment for cocaine, amphetamine, hallucinogenic drugs or cannabis at present.

Studies support the treatment of opiate dependence by methadone maintenance in combination with manualised (a treatment following a manual) behavioural approaches targeting the drug problem, including cognitive behavioural treatment, relapse-prevention, contingency training, as well as more elaborated short-term psychotherapies like family therapy, behavioural therapy and psychodynamic therapy. For cocaine dependence, only the manualised behavioural interventions targeting the drug problem have a proven, although low, effect. For cannabis abuse, family therapy has an effect on the abuse in teenagers with an intact family network.

Only more elaborated psychotherapeutic interventions had a medium positive effect on retention in drug treatment. For all drugs, well-defined, manualised treatment

interventions are the most effective. The essential characteristics of effective interventions are that they provide (a) a stringent structure, (b) a clear target on the drug problem and (c) a minimum treatment period of between three and six months.

For patients with co-morbid patterns of mental illness and drug use, case-management, structured protected accommodation and use of multi-professional teams may all contribute to a successful intervention.

3. Coordinating treatment for co-morbid drug users

Diagnosis and treatment of co-morbidity is hampered by the fact that drug treatment staff generally know little about psychiatry, and psychiatric staff generally know little about drug treatment. This, combined with the contrasting mindsets of the two disciplines, often prevents the development of a global, integrated perception of co-morbidity.

Further difficulties experienced by co-morbid patients arise from the manner in which they are viewed by the drug or psychiatric services. In some countries, drug services do not admit drug users with psychiatric disorders. On the other hand, psychiatric services may view drug users with apprehension, even to the extent of refusing admission to users who are stable on substitution treatment.

Treating clients with co-morbidity requires cooperation and coordination between services that are involved in their treatment, especially psychiatric and drug services, but also health and social services. For the treatment of problem drug users with co-morbidity in prison, the authorities must also be involved. Where residential treatment or prison is part of the intervention, in order to secure a stable and continuous treatment package, it is important to organise the treatment as a chain with few disruptions in the links between various agencies.

Case management is a working method to assist and coordinate clients' way through the treatment system and enable individualised care. It is acknowledged as a particularly effective method with co-morbid patients, who have great difficulties in coping with a complex reality. Case

management needs investing in human and organisational resources but is in the end cost-effective.

4. Training treatment staff to deal with co-morbidity

Dealing with co-morbid clients presents staff with many problems. Disruptive and aggressive behaviour of clients, particularly of those with the more 'dramatic' types of personality disorders, along with their emotional instability often makes them difficult to manage.

A multi-disciplinary comprehension of how to deal with patients with different patterns of co-morbidity is vital for all levels of treatment staff. Often, however, staff are specialised and feel competent only within the limits of their profession. The patients' difficulties in regulating self-esteem, consequently manifested by acting-out, inability to postpone impulses and handle drug craving often make staff members feel frustrated and unappreciated.

For the well-being of both patient and the staff members and for the overall quality of treatment, it is vital to enhance the ability of all staff to understand specific and differing problems of handling patients with personality disorders in contrast to those with psychotic disorders.

Burnout problems are common in staff members working with drug users with co-

morbidity. Integration of different services and professions, case supervision, as well as practical training and theoretical education might be the most powerful antidote.

Training in specific interventions to reduce drug use and/or to develop specific skills are among the more promising methods. If training includes the whole staff, manualised interventions are effective in increasing the general level of therapeutic competence. Several of the cognitive-behavioural methods have been implemented and found to be effective.

5. Effective organisation is the key to maintaining the quality of treatment

An effective treatment organisation is essential to maintain the quality in the clinical management of patients. A consolidated and integrated structure may decrease the negative impact of the personality disorders on the treatment climate. The quality of the leadership, work satisfaction, security and development among staff are all factors conveyed to the patients more or less subliminally.

An important step forward in quality of documentation is the introduction of the Addiction Severity Index (ASI), a multifunctional instrument that can be used in diagnostics, treatment, follow-up and

research. For more extensive treatment planning, more refined psychiatric assessments including SCID, CIDI, MINI and various psychological tests must be applied. The impact of toxic substances on the clinical picture must be determined, since many drugs may induce alterations in perception and judgment similar to those caused by a mental disorder.

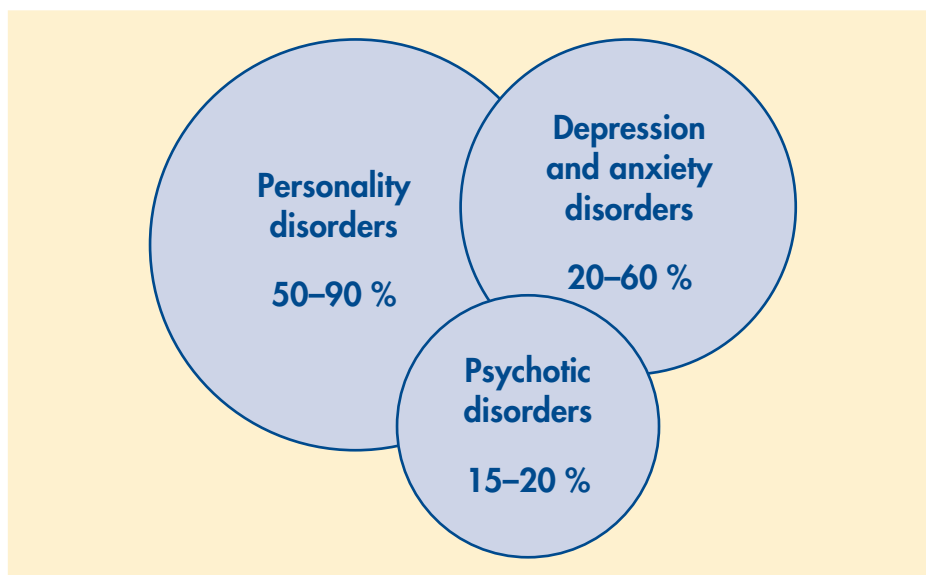
The introduction of assessment instruments like ASI and quality management systems is also important for feedback and for correcting misconceptions. Studies have found that the staff severely underestimate the prognosis of the patients, since patients with repeated and unsuccessful treatment admissions ('revolving-door patients'), while not representing a valid picture of treatment outcome, might induce a pessimistic attitude. Documentation and systematic follow-ups are often the only way to correct such prejudices.

Organisational interventions to decrease staff turnover easily go hand in hand with efforts directed at increasing competence and fostering a realistic and positive attitude to possible improvement in the staff and in the patients. This, by itself, will reduce costs.

6. Co-morbid drug users need long-term treatment

In some cases, psychiatric disorders are chronic diseases that need long-term treatment or care. Integration of treatment services, multi-professional teams and sheltered living are some of the interventions that have been shown to be effective. In addition, patients with mainly personality disorders benefit from long-term social reintegration interventions. The social networks of these people are always very weak and they have a general lack of ordinary life skills, like relating to other persons, keeping routines and appointments, seeking and keeping jobs, social skills, daily life skills, housekeeping and managing money. A coordination of community services and continuity in the treatment chain, combined with a case-management approach, increases effectiveness and is more cost-efficient than disparate and uncoordinated treatment efforts.

Overlap of the three dominating diagnostic syndromes in patients with co-morbid drug-use disorders



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Rua da Cruz de Santa Apolónia, 23–25, 1149-045 Lisbon, Portugal
Tel. (351) 218 11 30 00 • Fax (351) 218 13 17 11
info@emcdda.eu.int • <http://www.emcdda.eu.int>

Conclusions

Co-morbidity – drug use and mental disorders: policy considerations

1. Co-morbid patients often have many mental, physical and social problems, which have to be identified and diagnosed.
2. Treatment is effective if delivered according to evidence-based practice, planned and managed individually.
3. Co-morbid patients need carefully coordinated and integrated services in order for treatment to be successful. Case management is a particularly effective approach for these patients.
4. Training at all levels of each involved organisation is necessary to enhance staff capacity to deal with co-morbidity patients in a holistic way and increase treatment success.
5. Coordinated, integrated and flexible treatment services based on scientific evidence and with regular monitoring will reduce staff turnover and be cost-efficient.
6. Aftercare and social reintegration efforts are important in order to avoid relapse and renewed need for cost-intensive care.

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