1 Co-morbidity

The concept of co-morbidity means that a substance use disorder and an additional psychiatric disorder exist at the same time. The simultaneous existence of different disorders caused by psychotropic substances does not fall under this concept. For this purpose terms like polyvalent or multiple drug use and dependency on multiple substances have been established. The presentation below follows this understanding.

Investigations at hand about the prevalence of co-morbid disorders lead to different results. The cause might be the practise of different diagnostic instruments or difficulties in setting a diagnosis, especially for laymen, as well as the time factor (e.g.: lifetime-prevalence, month-prevalence). Altogether data on co-morbidity in mental health and substance use are insufficient. From psychiatric experience and from different studies it is known, that a great deal of individuals who show psychiatric symptoms also use drugs and fulfil partly criteria for harmful use and dependency diagnosis respectively. Apart from this highly selective group of individuals data are available on a limited scale from treatment centres and surveys. In treatment centres normally social workers are not supposed to set up psychiatric diagnosis. Also interviews (face to face or in written form) have methodological limitations reducing the reliability of identifying disorders.

For the incidence of co-morbid mental disorders, different hypothesis are under discussion and partly complement each other.

- Drug use supports the incidence of mental disorders.
- Drug use is the attempt of self-medication in the presence of other psychotic disorders.
- Drug use is the attempt to reduce side effects of psychotropic drugs, especially of neuroleptic drugs.
- There is a common basis for the vulnerability of psychotic disorders and disorders in connection with drugs.

1.1 Main diagnoses and prevalence

1.1.1 The most common types of mental disorders diagnosed among drug users and prevalence

Different studies show that personality disorders (50-90%) are common co-morbid diagnoses in drug users. Affective disorders are in second place with a prevalence between 20 and 60%, psychotic disorders are to be found in 20%. Between 20 and 50% of the patients which have been examined show more than one co-morbid disorder (Uchtenhagen and Zieglgänsberger 2000). Altogether men are more often affected than women and young patients more often than elder ones.

On the basis of data from the Early Developmental Stages of Psychopathology (EDSP) study selected mental symptoms in ecstasy users were examined. The symptoms had not to fulfil

the criteria of misuse and dependency. Ecstasy users appeared already in this younger age group with a clearly increased risk for depressive symptoms and also for nearly all DSM-IV-anxiety disorders. The group was compared with coeval non-drug using individuals from the same sample. Effects of sex and socio-demographic characteristics were controlled (Lieb, Isensee 2002) (Table 29).

Table 1: Anxiety disorders and depressive symptoms in ecstasy users aged 14 and 24.

Diagnosis	Odds ratio	95% confidence interval
Depression		
Major Depression	2.7*	(1.8 – 4.0)
Dysthymie	2.6*	(1.2 – 5.6)
Anxiety disorders		
Panic disorder	5.6*	(2.1 – 14.3)
Agoraphobia	1.6	(0.7 – 3.6)
Specific phobia	1.8*	(1.2 – 2.7)
Social phobia	1.2*	(0.6 – 2.2)
Generalized anxiety disorder	4.3*	(1.8 – 10.4)
Posttraumatic stress disorder	4.3*	(1.8 – 10.4)
Obsessive compulsive disorder	2.4	(0.7 – 8.1)

Sample: adolescent and young adults aged between 14 and 24 years, (N = 211/ Ecstasy and related drugs; N=1329 / no drug)
*p<0.05

Kessler et al. (2001) analysed studies carried out with a standardised instrument (CIDI) in six countries. The sample covered 28.000 individuals and showed for participants with problem drug use an accumulation of anxiety disorders and affective disorders. Chronologically, the psychiatric disorder appeared in most cases primarily, hence the authors concluded that psychiatric disorders might influence the appearance of drug problems. Shedler & Block (1990) demonstrated the complexity of this subject by means of a follow-up study carried out accurately. The study investigated the correlation between mental health and drug use in youth. Individuals who didn't take drugs in youth and individuals who were consuming intensively drugs showed problems in mental health later. People who were consuming experimentally were rated best. The epidemiological interrelationship between schizophrenia and problematic use of cannabis is known and proved. The causality is still unknown (Andreasson 1989). For an in-depth discussion see e.g. Häfner et al. (2002).

1.1.2 Prevalence in different sub-populations

Opiate dependants in different treatment centres

Within the scope of a 5-years follow-up study 351 opiate dependants were investigated in respect of co-morbid disorders. They all were in contact with treatment centres in Hamburg. The life-time prevalence of mental disorders was assessed with the CIDI according ICD 10 and represented 55% of the 272 participants. Personality disorders were disregarded first. Diagnoses dominated with 43% in the group of stress and somatoform disorders. In 31% affective disorders were diagnosed. Split personality disorders were uncommon (5%). 5% of the opiate dependants suffered from eating disorders (table 30).

As diagnostic instrument for personality disorders in opiate dependants the Personality Disorder Questionnaire was used. This questionnaire is in line with the criteria of DSM-III-R (axis II). About one third of the participants had at least one personality disorder. Most opiate dependants had personality disorders like paranoid, antisocial and borderline disorders (Krausz 1999).

Table 2: Lifetime-Prevalence of mental disorders according ICD-10 in opiate dependants (multiple diagnoses, details in %, N=351)

disorder		men	women	total[a]
F 20	Schizophrenia	3	2	3
F 25	Schizoaffektive disorder	2	3	2
F 2	Schizoid and paranoid disorder	5	4	5
F 31	Bipolar affektive disorder	2	2	2
F 32	Depressive Episode	12	23	16**
F 33	Relapsing depressive disorder	7	16	10*
F 34	Persistent affektive disorder	11	20	14*
F 3	Affektive disorder	26	44	32**
F 40	Phobic disorder	28	43	32**
F 41	other anxiety disorders	10	22	14**
F 44	Dissoziative disorders	1	7	3**
F 45	Somatoform disorders	9	12	10
F 4	Neurotic, stress and somatoform disorders	38	55	43**
F 50	Eating disorders	2	11	5**
F 5	Conspicuity in behaviour with somatic disorder	2	11	5**
	No mental disorder	50	31	45*
	Average number of diagnoses	1.0	1.8	1.3**

a)χ^2 -Test:*p<0.05;**p<0.01, source: Krausz 1999

IDUs in substitution treatment

Table 31 shows co-morbid disorders in a group of 200 HIV-infected intravenous consuming drug users, who were in substitution treatment between 1996 and 2000. No comments were given on the kind of diagnostic instruments they used. Mainly narcissistic and borderline personality disorders were found in the context of psychiatric co-morbidity.

Table 3: Psychiatric co-morbidity in 200 HIV-infected intravenous drug users in a treatment centre in Berlin 1996-2000 (multiple response)

Diagnosis	Percentage	Number
No psychiatric disorder	10	20
Adolescent crisis	4	8
Anxiety neurosis	14	27
Dissocial personality disorder	8	15
Narcissistic personality disorder	31	62
Borderline personality disorder	24	48
Psychosis	10	20

Source: Gölz 2000

1.1.3 Studies about drug-related risk behaviour among mentally ill drug users

For this subject there are no studies available.

1.2 Impact of co-morbidity on services and staff

1.2.1 Research and practice reports

Clients with co-morbidity make special demands to the staff of therapeutic centres. Individuals with psychotic disorders have difficulties in being abstinent and need a different proceeding and different concepts as they are usually necessary in drug services. They often need a long-term medication for stabilising the psychiatric disorder. This fact has to be in line with the demand to do without psychotropic substances. Furthermore, a therapy concept of a piece has to be traced. A very important aspect in particular is the interaction in case of recurrences. The integrated treatment concept – see 16.3.4 - tries to provide a differentiated treatment offer.

In general there is always the danger with co-morbidity to blind out one disease. Especially with substance use disorders, where the affected people tend to deny the problem, also the physician has to take care not to overlook this fact. The staff reports often about excessive demands caused by clients. They experience supervisions as being helpful, where they discuss about problems coming up with clients and with colleagues. Employees also experience that prejudices with regard to mentally ill people, were transferred to them (Hofmann 1002).

1.2.2 Professional qualifications in mental health and training needs of staff

In Germany neither for therapists and physicians nor for nurses special professional qualifications are available. In line with a two years course in tandem with work, nurses have the chance to look into this subject. Furthermore, adequate institutions offer advanced trainings in an interdisciplinary setting.

1.3 Service-provisions

1.3.1 General problems in treatment

Clients with non-organic psychosis, personality disorders or affective disorders and drug dependency often show a strong dynamic between the substance misuse and the mental disorder, furthermore, there is high risk of a chronic proceeding. Moreover a frequent re-entry into inpatient treatment is recognised. The risk of sliding back into drug addiction is also high due to a reduced compliance with treatment. There is also an increased risk with regard to drug specific additional disorders and follow-up disorders, for example hepatitis or HIV-infections as well as increased mortality risk. Furthermore, professionals report from an increased risk of social disintegration and criminality within this group (Uchtenhagen und Zieglgänsberger 2000).

The expert literature discuss two fundamental questions (Mueser et al. 1997) regarding treatment of co-morbid psychiatric disorders in drug abusers:

- Should it be a parallel/sequential or an integrative treatment?
- Should it be a disorder specific or a comprehensive treatment ?

In case of sequential and parallel treatment of a person with co-morbidity the treatment will take place with two therapists or therapy teams whether simultaneous or successive. In case of integrative treatment both disorders will be handled by one therapist or by one therapy team. For the client this form of treatment has the advantage that he is not confronted with twofold messages. Drake and Mueser (2000) argue clearly for the integrative treatment since otherwise clients with serious personality disorders are in danger to fail therapy due to defence mechanisms such as splittings.

The second problem field affects the choice between a disorder specific treatment and a comprehensive treatment. A disorder specific treatment concentrates predominantly on the needs of a specific group of clients. One effect of this kind of treatment is the exclusion of different groups of clients. In addition each treatment is a disorder specific treatment as far as each adequate psycho-pharmacological treatment is adjusted to the disorder.

1.3.2 Legal provisions for treatment of mentally disturbed drug users

There are no specific legal rules for this group of clients.

1.3.3 Policy of referral of clients

Drug counselling centres and in-patient drug treatment centres normally try to refer clients with co-morbidity to specialized drug services. Due to the small number of available treatment spots this is often not possible.

1.3.4 Co-operation between treatment services

In principle specialized drug services and mental health services are intended to co-operate with each other. Although different professions, agencies and modes of financing make co-operation difficult. Local working groups in the field of drug addiction and similar bodies are often an important medium of exchange.

In order to fulfil the needs of these clients psychiatric competences are requested as well as psychological-therapeutic competences. General practitioners are often swamped with clients with co-morbidity. The multidisciplinary co-operation of these competences is not sufficiently developed in the out-patient sector nor in the in-patient sector.

Clients with co-morbidity are mostly treated in general psychiatric institutions or in drug services. Networking between the two systems is still not developed sufficiently. Yet in traditional therapeutic settings clients are in danger to become losers. Therefore co-operation with both disciplines is requested urgently.

1.3.5 Availability and access to treatment

In Germany drug services and services for people with mental disorders are traditionally divided into two different systems standing relatively isolated side by side. The two systems are also made up of different professions. The main focus of therapy is already given with the choice of the institution – psychiatric hospital or drug service. Although in recent years some specialized departments were opened for this kind of clients, treatment offers for co-morbidity are rare.

Normally the general practitioner, the medical specialist, the polyclinic or the day hospital refer clients to the adequate institution.

1.4 „Examples of best practice“ and recommendations for future policy

Meanwhile there is an agreement that each comprehensive supply system for co-morbid clients has to allow an integrated treatment. This means that drug therapy and psychiatric therapy have to be available at the same time. First initiatives started about 20 years ago. Since then, specialized complementary facilities have been provided increasingly. Institutional experience show that the integrative approach has established in treatment (Landschaftsverband Rheinland 2001). The advantage of this approach is that substance use is recognised in all therapy aspects and also in further help. Concerning the decrease of psycho-pathologic symptoms (Schönell und Closset 2002) the integrative method does not create expectances that are to high.

As shown before treatment supply for co-morbid clients is still rare. Therefore it is not possible to make already general conclusions about the effects.

1.4.1 Current discussions with regard to co-morbidity

Professionals request for a better integration of co-morbid clients in psychiatry and drug services. The involved staff who is responsible for treatment has to take the special situation of co-morbidity into consideration and the divided medical care systems (the professional and financial splitting) which exists in this form since decades, has to be improved by co-operation. In order to create adequate treatment services, professionals demand on distinct and individual supply. One important area which should be improved is diagnostic skills, e.g. the clinical inventory of general practitioners.

1.4.2 Recommendations for improving future treatment supply

The improvement of the treatment of co-morbidity still need action. Existing services are not enough. They are also not based sufficiently on evaluated and operationalised concepts for treatment and aid. The Laender program in North-Rhine-Westphalia against addiction has looked into these problems and recommends the following:

- Drug services should be placed at regional level and inside or close to communities to make it possible to integrate clients - also difficult clients - in the long run.
- In small regions drug aid supposed to be integrated into exisiting supply for drug services and psychiatric services.
- Specialized institutions should be placed in crowded areas due to financial aspects.
- Development of low-threshold supply especially for co-morbid clients.

Acting on these general statements a set of measures is recommended.

The first recommendation underlines that the provision of qualified drug-therapeutic and psychiatric treatment in out-patient centres should be sufficient. Further on, a higher qualification of general practitioners and psychotherapists is necessary due to the needs of co-morbid clients. Moreover, the responsible bodies of out-patient drug services and out-patient psychiatric services should take co-morbid clients more serious. They should see them as a target group and should adapt supply accordingly. Rehabilitation of co-morbid clients is important and has to be improved. In most cases these are serious disease patterns with a high risk of a chronic proceeding. Therefore a qualified medical rehabilitation is very necessary. Especially with regard to the living situation one has to bear in mind that for co-morbid clients it is often difficult to stay abstinent. This problem should not drop them out from drug services.