Although the term ‘comorbidity’ can be applied to any co-occurring illnesses and can be considered as a lifetime or concurrent condition, the emphasis in this book has been on concurrent comorbid substance use and psychiatric disorders.

Those who have comorbid conditions see themselves as much more disabled than those with a single substance use or psychiatric disorder; hence their over-representation in health services. However, as the preceding chapters have illustrated, they are usually in treatment for a single disorder, and the services are not enabled to tackle comorbidity. A frequent message throughout has been that comorbidity is common, yet insufficient research and funding have been directed towards explicating and alleviating the serious problems associated with comorbidity. A telling figure is that presented in the introductory chapter, where it was highlighted that the percentage of the health dollar allocated to mental health services in Australia is currently 5% while the burden of disease due to the mental disorders is rated world-wide at 20%. Add to this the fact that this funding is allocated in general to treatment services for single disorders, with scant regard for individuals suffering comorbid conditions, then it is clear that such individuals tend to be seriously neglected within the present health system.

As highlighted by Andrews et al., (Chapter 3), comorbidity appears to be concentrated in certain individuals over their lifetime. This argues strongly for the implementation of early intervention or prevention programs which have been found to be efficacious in reducing later onset of single psychiatric disorders. Much of the evidence suggests that appropriately directed prevention strategies could reduce the overall incidence of single adult disorders and thus the levels of comorbidity. Similarly, implementation of best practice in treatment of single disorders, and fine-tuning for particular comorbidities, will have a significant impact on the lives of those people with comorbid disorders who are currently being poorly served in treatment.

Although less disabling alone, substance use disorders seem to exacerbate and prolong symptoms of comorbid psychiatric disorders. They also impede and complicate treatment for comorbid disorders. Studies have found that treating substance use can moderate symptoms of other psychiatric disorders. Hence treatment for substance disorders has an important part to play with comorbid individuals — even if those with a single disorder do not see themselves as in need of intervention.

Although the research is scant, we have managed to draw together what there is, to derive cautious conclusions regarding causality and best practice for interventions for comorbidity. Firstly, though, there is a need to address broad problems and limitations associated with the research.
Limitations and caveats

Broad conclusions cannot be drawn about the comorbidity of substance use disorders with other psychiatric disorders overall, largely due to the differing aetiology and presentation of the psychotic disorders and the more common mental disorders. There tends not to be one summary statement to encompass conclusions about comorbidity in the psychotic and non-psychotic disorders. Instead much of the discussion has tended to focus on these two types of disorder separately and conclusions have been drawn accordingly.

Within substance abuse, research on the more common drugs, especially alcohol, is far more extensive than that on the illicits. However, because tobacco smoking is not seen as debilitating in terms of mental health, interventions for comorbidities with this disorder are not given the consideration they probably deserve in the literature discussed throughout the book. An exception to this is Chapter 5, where the emphasis is on the management of psychotic disorders which show extraordinary comorbidities with nicotine addiction and where nicotine use interacts with pharmacological management of these disorders.

Although highly prevalent, comorbidity of personality disorders with substance use disorders does not feature in the reviews of available treatments nor in service delivery. This is because personality disorders are seen as highly intractable conditions, with currently few findings regarding effective interventions — let alone in research on their comorbidities. Although currently neglected, it is imperative that research on personality disorders is increased, as it features considerably in the prevalence data and contributes greatly to disability associated with drug and alcohol use.

In the introduction, three questions were posed:

How common is comorbidity? Which are the most common and most disabling comorbidities from both an individual and public health perspective using the epidemiological evidence?

Chapters 2 and 3 have outlined the extent of the research knowledge on prevalence and impact of comorbid substance use and psychiatric disorders. Epidemiological data has been particularly useful in elucidating types and prevalence of particular comorbidities within mental health and the various community surveys conducted around the world have shown relative agreement. Explanations of comorbidity on the other hand tend to be more elusive. Evidence from both epidemiology and twin studies suggests that at least some comorbidities are best explained by the sharing of common risk factors rather than simple causal relationships (i.e., one disorder preceding and therefore ‘causing’ the other — Chapter 2).

Comorbidity of psychotic disorders with substance abuse is high, but so too is comorbidity arising from anxiety and depression. And given the much higher prevalence of these disorders, their contribution to burden of disease is considerable.

Drawing on data from the Australian NSMHWB, Andrews et al., (Chapter 3) have illustrated just how serious a burden comorbidity is, associated with the more common disorders. They have argued strongly for greater attention to be paid to the ‘quieter’ disorders of anxiety and depression. They have also pointed to the inequity
in spending in our health budget where mental disorders are under-funded and
where within the mental disorders the common disorders tend to be overlooked in
favour of the more confronting psychotic and substance abuse disorders.

**How would you prevent and treat comorbidity?** What is the research evidence on the
prevention and treatment of the most common and most disabling comorbidities?

We have argued that if the prevalence of mental disorders can be reduced by early
intervention, then there would be a concomitant decrease in comorbidity of these
disorders in adulthood. Furthermore, where particular disorders can be shown to be
risk factors for other disorders, then intervening for these prior disorders will result
in decreased incidence of the later ones and decreased comorbidity in adulthood.
Dadds and Atkinson in Chapter 4 highlight the lack of positive findings regarding
psychoeducation and resistance training to reduce drug and alcohol abuse and
present cogent arguments for addressing risk factors in young people in order to
reduce or prevent comorbidities in adulthood. There is considerable evidence that
treating childhood risk factors such as conduct disorders and childhood anxiety and
depression can lead to the reduction of associated disorders in adulthood. There is
still a need for more definitive longitudinal studies to confirm the link between
effective intervention for the childhood disorders and later substance abuse, but
evidence to date is certainly suggestive that this is the case.

The chapters on service delivery and intervention agree that the available literature
supports screening and assessment, training of staff in comorbidity and, to a lesser
degree, integrated treatments for severe mental disorders comorbid with substance
abuse. Screening needs to be carried out carefully, from the perspective that it is a
first step in establishing the therapeutic alliance of client and caseworker. Care
should be taken not to screen whilst the individual is in an acute state of distress due
to either disorder. It may be an extended process carried out over a week or so in
order to ascertain which symptoms are likely due to which of the multiple disorders
that the client has. In all of this, standard screeners and careful training of specialist
staff and general practitioners is essential. The impact of comorbidity on the course
of treatment is far too significant to be left undiagnosed and unattended.

Many of the traditional, confrontational styles of treatment for drug and alcohol
disorders have been shown to be ineffective in individuals with a single disorder. So,
it is unlikely that treatments that are ineffective for one disorder will be effective for
that disorder comorbid with another. Much of the earlier research on interventions
for comorbidity, however, incorporated these interventions with poor outcomes.
Hence it is important to attend to the recent research which specifically addresses
comorbidity and uses effective treatments for substance abuse. In particular,
psychosocial interventions have an important role to play and these should be
implemented using evidence-based principles. Both motivational interviewing and
CBT have shown promise as has community-based support such as housing, family
support and assistance with medication management for those with the more severe
psychiatric illnesses.

Lastly, GPs have an important role to play in prevention and treatment of comorbid
disorders. In prevention, it is important that they are able to identify and refer as
appropriate, mental disorders in childhood. The use of standardised screeners with
both children and adults should be encouraged. As discussed in Chapter 6, this may
not prove to be the increased workload they anticipate. Referring and/or treating the common mental disorders such as conduct, anxiety and depressive disorders, may in fact lighten their workload in the long run. In the short term they should be assisted to become more mental health friendly with training and support from mental health specialists.

*What are the implications of comorbidity for service delivery?* How do we improve our response to comorbidity and what is current good practice in treatment and service system models?

Current best practice in prevention and intervention has been dealt with in detail in Chapters 4, 5 and 6. Clearly the issue of service provision is the most difficult one to answer. Not enough research has preceded this to allow definitive answers as to how best to set up the services to take full account of comorbidity. However, enough research has been carried out to nudge us in the direction most likely to produce best outcomes. It starts with community screening and treatment for disorders in childhood and proceeds to well-trained service providers at both general practice and specialist levels, screening, referring and/or implementing evidence-based treatments.