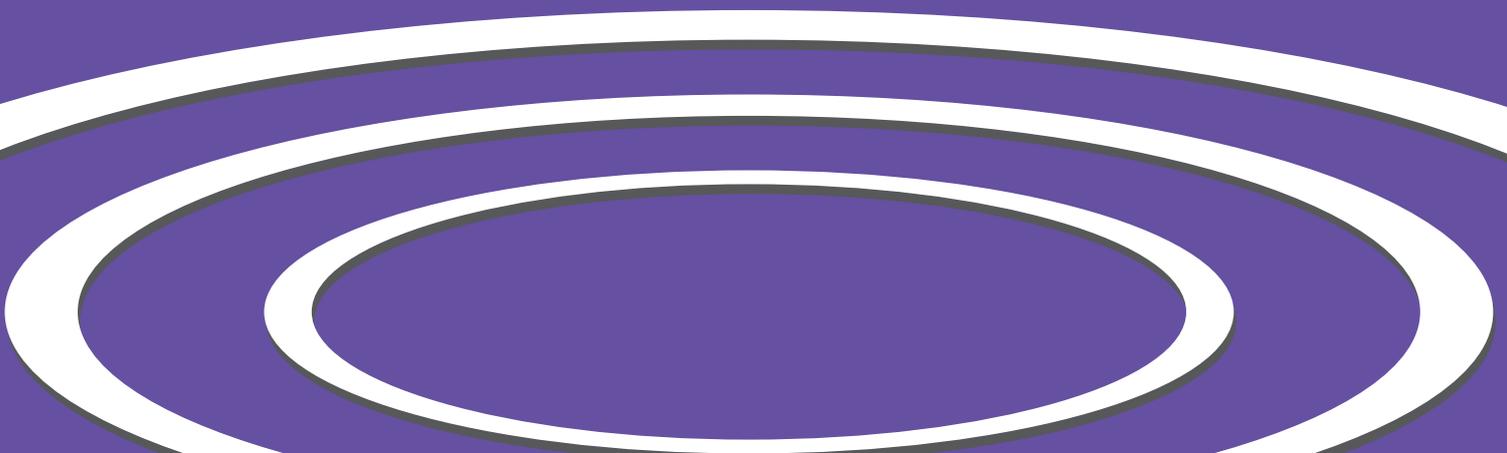




Executive Summary

A national epidemiological study of comorbid substance abuse and psychiatric illness in primary care between 1993-1998 using the General Practice Research Database

Report prepared by:
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Disclaimer

This study was funded through the UK Department of Health, Drug Misuse Research Initiative (project grant 1217199). All views expressed are those of the authors and not necessarily of the Department of Health.

Background

Data from 1.4 million patients in 230 practices in England and Wales were used to determine the nature and extent of comorbidity (psychiatric and substance abuse) in primary care in England and Wales from 1993-1998. These practices contribute to the General Practice Research Database (GPRD).

Comorbidity was defined by the co-occurrence of substance abuse and psychiatric disorders as recorded by a general practitioner. Most patients identified as comorbid cases within the database had the two conditions recorded within a one year period.

Findings

During the study period 1993-1998 we estimate that there were at least 195,000 comorbid patients and 3.5 million GP consultations involving comorbid patients in England and Wales. An unanticipated finding was that 80-90% of patients consulting for both substance abuse and mental illness in any one year are doing so for the first time, and about 50% of comorbid cases continue to receive treatment for substance abuse or psychiatric illness.

We addressed concerns that substance abuse and psychiatric illness might not be recorded in general practice records. A concurrent validation study indicated that over 90% of patients treated for substance abuse or psychiatric illness in secondary care settings are known to their general practitioner.

Our figures paint a picture of a significant problem in terms of primary care workload. The numbers of individuals newly developing comorbidity in primary care is increasing year-on-year. It is clear from our data that the impact on health services is far in excess of that for mono-morbid patients; comorbid individuals have an extra consultation frequency for all problems, estimated as an excess of 1,115,751 consultations in England and Wales from 1993-1998. Compared to age/sex matched controls, the number of excess consultations is 2,285,922

Despite the reluctance of many primary care physicians to accept responsibility for the care of substance abusers, it is difficult for primary care as a whole to avoid the implication that comorbidity is placing high demands on the profession. Our data indicate that the active early recognition of comorbidity may lead to better outcomes. Comorbid patients who had contact with secondary care psychiatric services had fewer A &

E visits. This at least suggests the potential of active engagement to reduce the need for crisis care.

A critical issue is the extent to which the increase in comorbidity can be attributed to substance abuse. During the six year study period the annual comorbidity rate increased by 62% but rates of comorbid schizophrenia, paranoia and psychoses increased by 128%, 144% and 147% respectively. These data indicate that substance abuse may be precipitating more serious forms of comorbidity although it is by no means clear that this is the case. For example, nearly all diagnoses of comorbid schizophrenia precede substance abuse. Further work is required to test this hypothesis.

The Government's Mental Health Czar has recently expressed concerns over continuing benzodiazepine dependence and how it can be monitored. In this study the rate of comorbid licit dependence increased from 1993-1995 by 65% but from 1995-1998 fell by 66% to 1993 levels. Although benzodiazepine dependence is decreasing it remains the most prevalent form of substance abuse among people aged 55+.

In comparison to drug misuse and treated mental illness, comorbidity displays more widespread social and regional variation. In the Northern & Yorkshire region the rate was more than 300% higher than the rate in the West Midlands. The comorbidity rate in practices in the most deprived areas was also more than 300% higher than in practices in affluent areas. However there are indications that comorbidity is spreading to relatively 'immune populations' as comorbidity is increasing more rapidly in affluent areas and regions such as South Thames and Trent where the rate was previously low.

The level of comorbidity is increasing at a higher rate among younger patients which indicates that comorbidity may increase, perhaps at a faster rate than observed in the study period, in future years.

The findings on transition from mono to comorbidity have major implications for understanding and preventing comorbidity. They suggest that individuals with comorbidity may be qualitatively different in the form of their mono-morbidity than those who remain mono-morbid. Early development of comorbidity suggests that there may be characteristics already present at the mono-morbid stage, which may predict the likelihood of developing comorbidity. Identifying such characteristics in future research might contribute to the early management or prevention of comorbidity in primary care.

Issues arising from the study

We cannot ascertain whether the increase in comorbidity reported here represents an actual increase in the prevalence of comorbid conditions or reflects the medicalisation of social, economic or personal problems. The latter are issues that are outwith the scope of an epidemiologically focused study although they may be informed by epidemiological analyses.

The report provides prevalence data on the basic forms of comorbidity but there is a need to further examine health care utilisation pathways in relation to distinct forms of comorbidity. We also need to examine paths between what might be classed as mild and severe forms of comorbidity. For example, does comorbid neurosis predict comorbid psychosis.

The database affords the opportunity for longer term follow up. Specific questions that might be addressed include: Is treatment effective for comorbid patients? If so are some types more effective than others? What is the role of medication in comorbidity? How important is contact with secondary care services? Is methadone being prescribed in adequate dosages?

On current trends, GPs will see ever increasing numbers of comorbid patients - probably reaching one million GP consultations in England and Wales per year by 2003. This figure is a minimum estimate as every year 80-90% of comorbid patients are newly diagnosed and about 50% of existing comorbid cases are still be treated.

Implications

The recognition of the scale of comorbidity and its impact should lead to the following:

- *More training in the management of comorbid patients in both primary and secondary care.*
- *More studies on the likely impact of early recognition and care on improving outcome; more studies on different interventions in primary and secondary care.*
- *Experiments with increased resources and new models of care in selected general practices in order to improve the early detection and management of comorbid patients.*
- *Longer-term follow-up of individuals identified in primary care as having comorbidity in order to determine the impact and outcome of chronic comorbidity and their use of medication and health services.*
- *Regular monitoring of the incidence and prevalence*

of comorbidity and also exploitation of the extensive information on comorbidity available on the full national General Practice Research Database (such as the variable which links household members).

- *A series of focused GPRD studies on a) benzodiazepine dependence, b) methadone prescribing, c) transition from mild to severe comorbidity and d) the impact of secondary care contact. ■*