ALCOHOL CONCERN

Factsheet 17: Alcohol and mental health

Alcohol and mental health

Mental ill-health has been identified as a major health and social welfare issue in the United Kingdom today. It is estimated that 10-25% of the general population will seek help annually for mental health problems and of these 2-4% will have severe mental illness.[1] At the same time 27% of men and 15%[2] of women in the United Kingdom are drinking above recommended safe levels (3/4 units per day for men and 2/3 units per day for women[3] and are at risk of harming both their physical and mental health. Heavy drinking is closely linked with mental illness (psychiatric morbidity). This association is evident to practitioners in mental health services and in addiction services. Both mental illness and alcohol problems carry a powerful social stigma, and in more severe cases carry a potential risk of violence or suicide, a high relapse rate and can lead to serious personal and social problems, in particular criminal offending and homelessness:

- during a 12 month period there were 72,500 hospital admissions with a diagnosis of mental and behavioural disorders due to alcohol[4]
- In 1995 there were 5,905 suicides in the UK with a higher risk of suicide for people who misuse alcohol and/or drugs or who had made previous attempts[5]
- 65% of suicides are linked to excessive drinking[6]
- alcohol problems are a significant factor in male teenage suicides[7]
- 50% of the rough sleeper population are alcohol reliant[8]
- 35-38% of the homeless population in the UK have some form of mental health problem[9]
- Over half of male prisoners (58% remand and 63% sentenced) and over one third of female prisoners (36% remand and 39% sentenced) engaged in hazardous drinking in the year prior to going to prison. Of those who engaged in hazardous drinking, 71% of male remand prisoners and 59% male sentenced prisoners were assessed as having 2 or more mental health or behavioural disorders. Among female prisoners 87% of remand prisoners and 77% of sentenced had an additional 2 or more comorbid disorders.[10]

This article summarises research on the nature and scale of the problem of co-existent mental health and alcohol problems from the alcohol perspective.

Defining the problem

Extensive research into the relationship between mental health problems and substance misuse has been undertaken in the USA, however, the subject has also attracted a lot of interest in the UK over the last decade, particularly in the last 5 to 6 years. The introduction of community care in the early 1990s means that more people with severe mental health problems are now living in the community and have greater access to alcohol and/or illicit drugs. In addition many statutory and voluntary agencies are facing the effects of increased substance misuse in their areas including the consequent mental health problems experienced by their clients. So psychiatric services and substance misuse agencies have become very aware of the issue.

The term commonly used to describe people with mental health and alcohol and/or drug misuse problems is **dual diagnosis**. However, the term is hotly debated among researchers and practitioners. Many feel the term is inaccurate and implies that there are only 2 diagnoses involved when in fact it often encompasses a cluster of symptoms and disorders. Other terms in use include **comorbidity** to describe the co-existence of mental health and substance misuse problems. Terms such as **complex** or **multiple needs** are used as alternative terms to emphasise the point that people often have a range of needs including medical needs and social needs. This fact sheet will use **dual diagnosis** as the mostly widely used and recognized term. There are a large number of varying definitions of the term in existence. Two possible definitions include:

- **The coexistence of an alcohol and/or drug misuse or dependence problem and a range of mental health problems or behavioural disorders (a broad unrestricted definition)** or
- **the co-existence of an alcohol and/or drug misuse or dependence problem and a 'severe and enduring mental illness' (a restricted definition)**

A number of health authorities have usefully expanded on these definitions by outlining the various combinations of mental health and substance misuse problems included in dual diagnosis:

- those for whom mental illness or disorder precedes problem drug/alcohol use and may in some way precipitate it;

Figure 1 Mental health problems – definitions and indications of prevalence

Psychosis

The term 'psychosis' is used when a person's ability to distinguish between reality and imagination is affected such as in manic depression and schizophrenia. A survey of Great Britain suggested that 4 per 1000 of the adult population will experience a form of psychosis in the course of a year.[11]

- **Manic depression** is linked with severe and frequently recurring depression, and usually involves extreme mood swings from depression to elation and over-activity (mania). It is estimated that 1 in 100 adults will experience manic depression at some point in their life.[12]
- **Schizophrenia** can be characterized by 2 groups of symptoms including abnormal experiences such as hallucinations, delusions, feelings of loss of control and symptoms that indicate a loss in functioning such as lack of energy, lack of sleep and low motivation. It is estimated that between 3-4 per 1,000 of the population have schizophrenia at any one time.[13]

Neuroses

The most common forms of neurotic disorders included anxiety and depressive disorders.

- **Anxiety** is characterised by excessive worrying and agitation together with physical symptoms such as rapid breathing and heart beat rate. More than 1 in 10 people are likely to experience a 'disabling anxiety disorder' in the course of their life. These disorders include phobias and some forms of compulsive behaviour.[14]
- **Depression** is used to describe a range of moods of varying severity from feelings of low spirits to feelings of worthlessness, guilt and suicidal thoughts. It is estimated that 1 in 10 people will have some form of depression at any one time. An estimated 1 in 20 people will have serious or 'clinical' depression at any one time.[15]

Dementia

Dementia is the gradual decline in mental abilities including loss of memory, concentration and problem solving abilities usually associated with increasing age. Up to 670,000 people in the UK have some form of dementia and of these an estimated 17,000 below the age of 65 are affected[16]. Korsakoff's syndrome is a form of dementia due to the effect of excessive alcohol on the brain and is estimated to affect 2% of the general populations and 12.5% of dependent drinkers.[17] (See Alcohol Concern factsheet no. 6 for an overview of the subject)

Personality disorder

'Deeply ingrained and enduring behaviour patterns manifesting themselves as inflexible responses to a broad range of personal and social situations' [18]

- those for whom psychiatric symptoms are consequent to problem drug/alcohol use;
- those for whom psychiatric symptoms are independent of their problem drug/alcohol use.[19]

Note that the first definition is far more inclusive as it is not limited to 'severe and enduring' mental illnesses such as schizophrenia, but includes all forms of mental illness that could impair the daily functioning of a patient/client. In addition the inclusion of personality disorders in the first definition is of particular significance. In many hospital-based psychiatric services a personality disorder is not recognized as a mental illness and is viewed as clinically untreatable. However, in practice many such disorders are closely linked to alcohol and/or drug misuse.

This factsheet will focus as far as possible on comorbid conditions involving mental health problems and alcohol-related problems. Although many studies include findings for both drugs and alcohol the emphasis will necessarily be on those relating to alcohol.

Prevalence

Estimating the scale and nature of the problem in the general population is extremely difficult given the problems of establishing an agreed definition, difficulties with diagnosis and differences in time frames used to assess comorbidity prevalence, ie prevalence at the time of the study/survey or lifetime prevalence. The most comprehensive source of national data is a series of surveys into psychiatric morbidity carried out by the Office of Population Censuses and Surveys (OPCS) in 1995. Using a sample of 16,000 adults aged 16 to 65 years the surveys examined the prevalence of neurotic disorders, psychotic disorders and alcohol, cigarette and drug use and dependence. The main report dealt solely with adults living in private households with supplementary reports looking at people in institutions and the homeless.

OPCS psychiatric morbidity survey findings - main report

- **Drinking patterns of people with neurotic disorders** – Women with these problems were actually less likely to drink than other women. Among men, drinking patterns were similar to those in the general population except that men with a neurotic disorder were more likely than other men to be drinking over 50 units a week.
- **The extent of neurotic disorders among different levels of alcohol consumption** – The study revealed a complex pattern with both heavy drinkers (over 50/35 units per week) and abstainers more likely to suffer a neurotic disorder. However, among very heavy drinkers, the proportion rises - 30% of female heavy drinkers and 19% of male heavy drinkers have a neurotic disorder.
- **The prevalence of alcohol dependence among those with neurotic disorders** – The survey showed that 12% of regular drinkers with a neurotic disorder were classed as dependent, compared with 5% of those without such a disorder. People with more than one neurotic disorder were even more likely to be alcohol dependent.
- **The prevalence of neurotic disorders among those with alcohol dependence** – 30% of dependent drinkers had a neurotic disorder, compared with 14% of non-dependent drinkers.

- **Psychosis and drinking** – In this survey, people with psychotic disorder were less likely than others to be drinkers. However, the proportion of people with psychosis was very small and more studies were needed for a further analysis.
- **Alcohol dependence** – Overall rate of dependence in people aged 16 to 65 years of 4.7% including a rate of 7% for men and just under 3% for women.[20]

(See Alcohol Concern factsheet no.1 *Alcoholism or problem drinking* for an overview of problem drinking patterns)

Although this survey does not provide the data on the numbers of people with dual diagnosis within the general population, it does show the increased risk of dual diagnosis among heavy or dependent drinkers and those suffering with neurotic disorder. Results of a repeat OPCS (now ONS) survey due to taken place in 2000 should provide comparative data and indicate any trends in the prevalence of dual diagnosis in the general population.

A number of studies undertaken since the OPCS survey indicate the prevalence of dual diagnosis among those with a diagnosed psychiatric illness:

- A study of people using an inner London mental health service with a diagnosis of psychosis found a one-year prevalence rate of 31.6% for alcohol misuse and dependence and 15.8% for drug use and dependence.[21]
- A survey of schizophrenia found a life-time prevalence for alcohol misuse of 22% for those with a diagnosis of schizophrenia.[22]
- A later study of dually diagnosed patients undertaken in a suburban area of London found a prevalence rate of 20% for alcohol misuse, 5% for drug misuse and 8% for misuse of both alcohol and drugs. (The idea behind this later study was to measure prevalence in a more 'demographically representative population' in comparison with inner-city London 'which is at an extreme on the national spectrum for ...overall social deprivation'.)[23]

Beyond these types of study of groups with existing psychiatric diagnoses, prevalence data on dual diagnosis in the UK is very fragmented. A 12-year study of clients in a hospital-based alcohol service reported that a consistent 30-40% received additional psychiatric diagnosis.[24] Using percentages from the influential US Epidemiological Catchment Area Study of comorbidity in the community (Regier et al 1990), Rorstad and Checinksi calculated that in a population of 500,000 (population size of a standard UK health authority) there will be nearly 6,000 problem drinkers with comorbid mental health problems. More recent figures are drawn from those service providers who come into contact with people with dual diagnosis. Figures vary widely. For example a survey of community drug/alcohol services report a prevalence of 10%-27%, probation services report c.10% prevalence and for housing agencies prevalence can be as high as 60% depending on the work they undertake with these clients. Note that these figures do not indicate prevalence across the whole community but reflect the level of contact these services have with people with comorbidity.[25] There is also a serious dearth of information regarding those clients with less severe comorbid problems that do not come into contact with social services. However, a recent census of alcohol service users indicated that 47% of clients were worried about their *'psychological well-being'* and this was by far the most common reason for seeking help.[26] Rorstad and Checnksi conclude that although there are *'no definitive answers about the extent of dual diagnosis in the UK… there is sufficient data to suggest that dual diagnosis is a real problem affecting a significant number of clients of mental health and substance misuse services'* [27]

Interaction between alcohol and mental health problems

The relationship between alcohol misuse and the different forms of mental illness is a complex one. Also the symptoms of alcohol-induced psychosis often mimic symptoms of psychiatric illnesses it can be difficult to make an accurate assessment of the problem. Alcohol has a role in a number of conditions:

- **Anxiety and depression**. Almost all drinkers seeking help report symptoms of anxiety and depression. Alcohol is a depressant drug. Prolonged drinking can lead to profound and long-lasting mood swings. Symptoms of alcohol-induced depression can be severe but subside during abstinence.
- While problem drinking may not cause clinical depression, its effect on personal circumstances (relationship break-ups, unemployment etc) together with the feelings of guilt and hopelessness may increase the likelihood of depressive illness.
- Research indicates that people do not tend to drink to relieve depression but depression may accelerate an already serious alcohol problem or lead to relapse after a long period of sobriety.
- Both depression and problem drinking are common problems so they can just coincide.
- In many cases anxiety is a consequence of heavy drinking rather than a cause. While low doses may appear to cheer people up, higher doses increase psychological distress so drinkers become progressively more depressed and anxious during chronic intoxication.
- Abstinence, particularly after physical dependence has developed, can trigger acute withdrawal symptoms including feelings of agitation, anxiety, mood swings that can last up to 6 weeks. In some cases it can be difficult to distinguish between these symptoms and clinically significant levels of anxiety and depression.
- **Alcohol and mental illness including psychosis**. Alcohol misuse may accelerate or uncover a predisposition to psychiatric disorder. Also some patterns of misuse can give rise to alcohol induced psychosis.

- Symptoms following from substance withdrawal often mimic those of psychotic illness.
- Alcohol may be used by some people as a form of self-medication to cope with the symptoms of mental health problems such as depression and anxiety as well as the symptoms of psychosis such as hearing voices and hallucinations.
- Using or misusing alcohol can enable people who feel isolated by their mental health problems to become part of a social group.

In addition the Mental Health Foundation also identifies 4 risk factors associated with dual diagnosis:

- homelessness and poverty
- more than one period of detention under the Mental Health Act (1983)
- a history of violence or offending
- failure to respond to mental health services/treatment[28]

Treatment and barriers to treatment

People with co-existent mental health problems and substance misuse problems have traditionally been viewed as hard to treat. Yet they are also recognised as some of the most vulnerable and needy members of society who make a disproportionate use of services such as A&E departments, acute admission wards, housing services and the criminal justice system. Studies also suggest that people with combined mental health and substance misuse problems experience greater medical, emotional and social problems as those with a sole diagnosis of mental illness. For example dually diagnosed people are likely to spend twice as long in hospital than those with a single psychiatric diagnosis as they often take longer to recover from a psychotic episode complicated by substance misuse and may be at risk of homelessness.[29]

Despite this high level of need, dual diagnosis clients often fail to access appropriate treatment and support. There are a number of reasons for this relating to the nature of the condition itself, structure of the available services and approaches taken to treatment.

- *'Dual diagnosis is made difficult by the fact that substance misuse complicates and confounds psychiatric diagnosis and assessment'*[30]
- There is a separation of services into alcohol and/or drug teams and mental health teams and clear demarcation of specialists and resources on each side. Professionals tend to train as addiction specialists or mental health specialists with little cross-over between the two areas.
- In relation to treatment approaches mental health services tend to classify people in terms of having either a *primary mental illness* and *secondary substance misuse problems* or a *primary substance misuse problem* and a *secondary mental illness*. The two disorders are tackled in sequence. In many cases the presence of a second disorder, particularly alcohol misuse, debars the client from treatment for the mental health problem as many services will only assess and treat patients who are abstinent before and during treatment.
- Too narrow a definition of the term mental illness will exclude many clients with milder forms of illness, particularly those with behavioural disorders.
- Dual diagnosis clients are difficult to reach. They often have chaotic lifestyles, do not seek treatment and find it difficult to engage in longer courses of treatment.
- People with a dual diagnosis are likely to experience social problems, such as housing which fall outside the remit of specialist mental health or alcohol and drug agencies.

These barriers result in many cases falling through gaps in service provision. However, experience has prompted a belief that dual diagnosis should be viewed as a combined problem; requiring a planned holistic approach to the dual or multiply diagnosed problems.

Studies in the USA suggest that there are a number of combined or integrated treatment approaches that are effective with clients/patients with dual diagnosis. Key elements of these treatment approaches include:

- **Integrated treatment** with the same team or teams of clinicians working in one setting to provide appropriate mental health and substance misuse interventions in a coordinated approach.
- **Staged interventions** to motivate the client to control his/her illness and pursue agreed recovery goals though not necessarily in a linear development.
- **Assertive outreach** involving intensive case management in the home of the client or, in the case of those at risk of homelessness, helping with accommodation. This type of support enables the client to access services and maintain long-term contact with treatment agencies.
- **Long-term perspective**. Effective programmes need to take a long term community- based perspective that includes rehabilitation and allows for relapses.
- **Comprehensiveness**. Attention to substance misuse problems needs to be incorporated at every stage of the mental health service system including inpatient hospitalisation, assessment, crisis intervention, medication and rehabilitation.
- **Cultural sensitivity** when working with different groups (including ethnic groups, the homeless, young people etc) is needed to ensure that individuals from these groups engage with services.

These treatment models have yet to be introduced on a large scale in the USA.

At present 'there has been no UK-based evidence to suggest which types of interventions, and in which setting, work best with clients'[31]. However a number of projects have looked at service provision and treatment for this client group. Two such projects include the Department of Health funding of 8 mapping exercises involving statutory and voluntary agencies 'designed to promote the development of joint working protocols between local agencies concerned with this client group'. The projects examined issues such as:

- establishing working definitions of dual diagnosis for agencies working with clients with concurrent alcohol and/or drug problems and mental health problems
- developing better systems of data collection to provide more accurate estimates of prevalence
- identifying gaps in services
- mapping service routes for clients
- identifying obstacles in the system
- drawing up joint protocols for joint working between agencies
- developing training plans

Alcohol Concern has produced a report of these 8 mapping projects carried out between 1998 and 1999.

Another significant DoH project provided funding for 4 voluntary sector agencies across England to develop services to this client group[32]. The main questions being asked in this project were:

- How does the dual diagnosis service engage clients?
- what means are used to identify dual diagnosis?
- What types of interventions are used?
- How do service users perceive the service they receive?
- what impact does the service have on those that come into contact with it (eg other service providers)?
- What are the staff characteristics, skills and burnout levels?

The project found significant differences in the characteristics of the client groups attending each service which were largely attributable to the nature of the client population and the way each service operated. However, the project evaluators from the Sainsbury Centre for Mental Health, were able to make recommendations for service development that applied across the board including the need for specialist training to work with this particular group and the need for greater involvement by the statutory section in this area. Evaluation projects such as this provide valuable pointers for the future. Ongoing work on different types of interventions, such the Sainsbury Centre's project on assertive outreach services in London, are of great help but clearly more work and pooling of ideas/experience across the UK is required to provide a strong evidence base for appropriate interventions.

Government initiatives

Reform of the Mental Health Act (1983)

An extensive review of the Mental Health Act (1983) was undertaken by an expert committee lead by Professor Genevra Richardson. The draft report was released for consultation and a final report published in November 1999. The government published its proposals for reform of the Act, drawing from the report in the same month in the green paper 'Reform of the Mental Health 1983: Proposals for Consultation'. The act primarily deals with the compulsory detention of people with mental health problems for their own safety of the safety of the community. The main issues in relation to alcohol misuse as covered within the proposals are as follows:

- Whether people who misuse alcohol and develop a mental health problem solely related to their alcohol misuse, have or do not have, access to the provisions within the Act.
- Prejudice towards people with alcohol problems means that those with mental health problems related or unrelated to their alcohol misuse are often denied access to health services. This, and the difficulties of diagnosis that requires access to assessment, could exclude a wider group of people with alcohol and mental health difficulties including people with Korsakov's syndrome.
- Exclusion or inclusion of alcohol misusers may have implications for the way alcohol problems are viewed in future which is a matter for concern within the alcohol field.

Following this consultation, a briefing outlining the Government's White Paper on the reform of the Act was published in December 2000. No final decisions have been taken on how the provisions of the new Act will tackle issue of alcohol-related mental illness but the act does not explicitly exclude people on the basis of having an alcohol problem.

Mental Health National Service Framework (NSF)

The NSF was published in September 1999 and sets out the agenda for change in the provision of mental health services and provides standards of service provision.

People with alcohol and drug problems are mentioned as one of a number of higher risk groups for mental illness. Also rough sleepers, people suffering domestic violence and prisoners are mentioned in the NSF as being at higher risk of mental illness and here alcohol misuse is a factor. The prevention of suicide is a major theme running through the NSF. To ensure that alcohol is taken seriously, training plans should be developed for (continued overleaf)

Government initiatives (continued)

the wide range of staff expected to be competent to assess risk of suicide and account of the role played by alcohol misuse. A milestone towards the implementation of the NSF will be local suicide audits. Alcohol Concern has pressed for the audits to assess the role alcohol played in incidents of suicide.

Dual diagnosis is covered by the NSF under the standards on people with 'severe' mental illness which cover 'away from home' care and people on the Care Programme Approach.

In order to implement the NSF, health authorities are expected to work with stakeholders to incorporate the NSF within joint commissioning plans and Health Improvement Plans (HImPs). Although full implementation of the NSF will take 5 to 10 years, it was intended that strategic local plans were to be in place by April 2000. Alcohol Concern is working to help local areas incorporate means to reduce alcohol-related harm and promote proper interventions in order to implement the National Service Framework.

Mental Health Czar

The Department of Health established a new post of National Director of Mental Health. Professor Louis Appleby was appointed Mental Health Czar in April 2000 with the task of overseeing the complete modernization of mental health services and producing quality services for patients.

Department of Health (DoH) Dual Diagnosis Steering Group

In 1998 the DoH established a steering group to ensure that people with mental health problems and either an alcohol problem or drug problem receive an integrated, effective and efficient service. The group's remit includes:

1 The Group aims to produce a framework for the care and treatment of people with dual diagnosis which includes

- a working definition of dual diagnosis
- prevalence
- data collection
- an evidence based service model/specifications
- identification of potential obstacles and ways to overcome these and examples of good practice

2 Identify the key issues and ensure these are fed into the National alcohol and drug strategies.

3 Identify training and education issues and ensure these are fed into the work of the Mental Health Care Group Workforce Team

Dual Diagnosis Information Project

The DoH has commissioned the Royal College of Physicians to identify the best information and training materials on psychiatric comorbidity (dual diagnosis) and to disseminate this to all relevant professional groups in the UK. One key product of the first phase on the project is an information review to identify relevant information, key organisations and individuals with expertise in this area.

For further information contact the DDIP team at: 6th Floor, 83 Victoria Street, London, SW1H 0HW. Tel: 020 7227 0828 e-mail:sena.quaye@virgin.net

Please note that the DoH is also currently funding a number of studies looking at prevalence and interventions but it has not been possible to reference these studies in space available but further queries can be directed to the Information Service at Alcohol Concern.

Conclusion

The coincidence of mental illness and alcohol and/or drug misuse, and the resulting problems are recognised as a major challenge by those working in the alcohol field and mental health services. Recent studies indicate the gravity of the problem with regard to patients with a diagnosed mental illness. However, given the prevalence of mental health problems and alcohol problems (see fig. 1), it's probable that many people could potentially be dually diagnosed to varying degrees of severity. There is increasing concern around the issue of how these people can be supported to enable them to function in the community. Often people with combined mental health and substance misuse problems are vulnerable difficult clients and while they may make heavy use of emergency health services, many are excluded from the mainstream services that could help them. There is a pressing need for joint working between services, including addiction services, mental health specialists and the general support services, so that their combined expertise can be coordinated to the benefit of this disadvantaged group.

Vulnerable groups

Young people

Research suggests that alcohol misuse among adolescents is a major contributary factor in the development of mental health problems in the young. One US study of psychiatric comorbidity among school children aged 14 to 18 years showed that 80% of adolescents with alcohol problems had a psychiatric disorder. Studies suggest worrying trends in the early onset of alcohol and drug use and mental illness:

- The early onset of substance misuse among adolescents is linked with higher rates of major depressive disorder and a shorter time lapse between misuse and dependency.[33]
- Depressive disorder rates are significantly related to levels of use of alcohol, tobacco, marijuana and other drugs.[34]
- Early onset young males with alcohol dependency have been found to have more anti-social characteristics than late onset males with alcohol dependency.[35]
- Early substance misuse among young males may 'bring forward' the age of onset of schizophrenia.[36]
- There is an association between eating disorders and alcohol among young men and women, with eating disorders being present in 30% of those with alcohol problems and alcohol problems present in 27% of those with eating disorders.[37]
- Suicides account for 20% of all deaths by young people[38]. Alcohol is an important factor precipitating deliberate self-harm and suicide[39]. It is estimated that one third of young suicides are intoxicated at the time of death[40].

In addition the Mental Health Foundation identifies various risk factors for mental health in young people. Family background plays a major part but social deprivation including poverty, unemployment and involvement in crime also impact on young people's mental health.

Homeless people and rough sleepers.

There is evidence that mental health problems are associated with social deprivation and various forms of deprivation such as homelessness can aggravate existing problems.

Although it is difficult to estimate the prevalence of dual diagnosis among the homeless, studies indicate a high level of substance misuse and mental health problems with a significant overlap between them:

- One recent study from a homeless project in Oxford suggested that 52% of clients had a comorbid mental health and substance misuse problem including 24% with alcohol and mental health problems, 24% with drugs and mental health problems and 4% with a combined drug/alcohol and mental health problem.[41]
- Research suggests that the number of homeless people in UK cities has increased over the past decade in parallel with a rise in mental health problems and substance misuse.[42]
- With a 75% reduction in the number of direct access hostels (1981-1991) there is a need for residential alternatives for people with complex needs including coexistent mental health and substance misuse problems.[43]
- A Mental Health Foundation survey of homeless young people showed that many had experienced domestic problems, neglect and abuse in childhood and that homeless young people are almost 3 times as likely to suffer mental health problems.[44]

Comorbidity among offenders

A 1997 survey by the Office for National Statistics showed that there is a high prevalence of comorbid substance misuse and mental illness among offenders in prison. The survey looked at the prevalence of five main disorders – personality disorder, psychosis, neurosis, drug dependence and alcohol dependence:

- Of those who engaged in hazardous drinking, 71% of male remand prisoners and 59% male sentenced prisoners were assessed as having 2 or more mental health or behavioural disorders. Among female prisoners 87% of remand prisoners and 77% of sentenced had an additional 2 or more comorbid disorders.[45]
- Both mental illness and substance misuse play a major role in youth offending with 10-20% of young people involved in criminal activity thought to have a psychiatric disorder.[46] Also 25% of young people who offend report that they were intoxicated at the time of the crime.[47]
- Research suggests that the combination of alcohol and/or drug misuse with low adherence to medication may lead to a higher risk of violence among people with severe mental illness.[48]
- Around a third of perpetrators of homicide had a diagnosis of mental disorder, most commonly alcohol or drug dependence and personality disorder.[49]

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