Alcohol and Other Drugs and Mental Health.

This mini bulletin provides an overview of the relationship between alcohol and other drugs and mental health problems, highlighting the need for integrated prevention, early intervention, treatment and management of these issues.

It is particularly relevant to health professionals including GPs, alcohol and other drug (AOD) workers, mental health clinicians, and community care workers. The intent is to support the need for a collaborative approach to mental health and alcohol and other drug comorbidity conditions which are prevalent and should be considered in tandem to support recovery.

The Relationship Between Alcohol and Other Drugs and Mental Health

The relationship between alcohol and other drug (AOD) use and mental health conditions can be mutual.[1]

Individuals may experience co-occurring mental health and substance use problems and may present to health professionals with one, or both, at any stage.

- At least 55 per cent of people experiencing an AOD use disorder have a co-occurring mental health condition.
- 60 per cent of people with a mental health disorder are also experiencing AOD dependence.[2]

Co-occurring AOD and mental health conditions – both medically diagnosed (known as a 'dual diagnosis') and non-diagnosed - can lead to poorer outcomes for that person.[1]

For some conditions, including alcohol dependence and depression, co-occurring mental health and drug disorders can be bi-directional, i.e.: alcohol dependence can arise from using alcohol as a coping mechanism for anxiety and depression; while, depression can be an outcome of alcohol dependence.[1]

The nature of this bi-directional relationship, and how it affects people, is different from person to person – and may change over the course of their life.

A person experiencing a dependence on alcohol may start to experience alcohol-related issues in their personal and work life.[3] The end of a relationship, or the loss of a job, may result in symptoms of anxiety and depression on top of the existing dependence on alcohol.[4]

A person's physical health can also be affected. For example, alcohol can disrupt sleep,[5] which may contribute to some symptoms increasing.[6] Nutrition and exercise could also be affected, contributing to poorer health.

People with both AOD and mental health issues also face higher rates of relapse and subsequent hospital visits, imprisonment, unemployment, and family difficulties.[1, 7]

They are also are more likely to be a victim of violence than the general community, particularly if their mental health condition is severe, and they are more likely to experience homelessness and discrimination.[8, 9]

Stigma is attached to both conditions and further marginalises people who may avoid seeking help, due to the real or perceived attitudes of others.[8]

Alcohol and other drugs and mental health challenges are not distributed equally throughout the population.

Many people are vulnerable due to genetic, environmental, social or biological factors over which they have little control: they may experience a severe difficulty or trauma in their life or face chronic personal, social, or economic problems.

Identifying Risk Factors

There is no single factor that will guarantee a person does, or does not, experience alcohol or other drug dependence as well as another mental health condition.

Rather, it is the result of a combination of highly personal and complex experiences that people with a dual diagnosis are more likely to be experiencing, such as unstable housing, experience of trauma, and poverty.[1, 10]

Common factors which may lead to a person experiencing an AOD use disorder and a mental health condition can include:

- genetic factors
- personality
- biology
- social and environmental characteristics.[1, 10]

Personal and family circumstances can impact a person's development[10], such as parental illness, unemployment, conflict or absence, and abuse or neglect.

As a person reaches adolescence and adulthood, other factors also contribute to health and wellbeing outcomes, such as:

- educational attainment
- the strength of the economy and opportunities for employment
- age and the experience of ageism
- the accessibility of family planning
- interpersonal relationships (such as experiencing family violence).[10]

The social determinants of health have a complex and dynamic relationship with the development of AOD and mental health needs.

For many, AOD use is a way of coping with 'psychosocial dislocation', which occurs when people live without a clear role or purpose in a stable, established community.

Psychosocial dislocation is a common experience of people who are subjected to dispossession, stigma, unemployment, physical or emotional abuse, neglect or mental illness.[11]

While people who grow up in, or who are exposed to, difficult circumstances are not destined to use substances or develop a dependency, some people are more vulnerable including:

- people who are emotionally distressed, disengaged and disconnected from society through lack of employment or mental health problems
- people who grow up with, or live with, drug use within their family or peer settings
- young people who are disengaged from the school system – children with learning difficulties, or from families experiencing trauma or disadvantage.

Populations that are at greatest risk of experiencing co-occurring mental health and alcohol or other drug issues include:

- young people[12]
- Aboriginal and Torres Strait Islander people[13]
- lesbian, gay, bisexual, queer, transgender and intersex people.[14]

Identifying and assessing the risk - and protective factors - that contribute to an AOD use disorder, mental health condition, or both, is fundamental to determine appropriate interventions and treatment.

Learn more about the social determinants of mental health: https://www.who.int/mental_health/publications/gulbenkian_paper_social_determinants_of_mental_health/en/

Other complex needs

Each person's experience of dual diagnosis is different. This can create a complex profile for treatment.[1]

People with a dual diagnosis or co-occurring disorders are more likely to:

- experience poorer overall physical health
- live in insecure housing
- experience homelessness
- be the victim of violence
- experience poverty or limited income
- have issues with debt
- be in contact with the criminal justice system
- experience family issues, including isolation from their family
- be at risk of self-harm, including suicide
- need social, financial or legal support.[1, 3, 7]

In recent years, increasing evidence of the impact of co-occurring poor health, has highlighted the role that the increasing risk of substance use and mental health plays in contributing to physical disability and poorer outcomes.[15-17]

People with AOD issues, mental health conditions, or a dual diagnosis have a higher risk of cardiovascular disease[17]and may also have heavier rates of:

- alcohol consumption[16]
- diabetes[18]
- poor diet[19]
- physical inactivity[20]
- obesity[19].

Tobacco use tends to be higher among people who have a mental health condition, people who use drugs including cannabis and alcohol, and people who are experiencing a dependence on alcohol or other drugs.[21]

Tobacco use is linked to a range of other illnesses, such as cancers and dental diseases, that can contribute to the cumulative harms a person may experience.[21] Tobacco use can also cost an individual several thousands of dollars a year, depending on how frequently they smoke.

The often complex profile of a person with dual diagnosis/comorbidity can be further compounded by stigma and its impact in reducing help seeking.[3, 8]

Additionally, the symptoms of a mental health condition itself can be a barrier to treatment.[3]

For example, if a person is experiencing depressive symptoms of persistently low mood, a lack of energy, and feelings of hopelessness, this can be a barrier to them seeking any kind of treatment.

Prevention and Early Intervention

The strong relationship between mental health and alcohol and other drugs has implications for how we prevent and address the burden these disorders place on individuals and on our community.

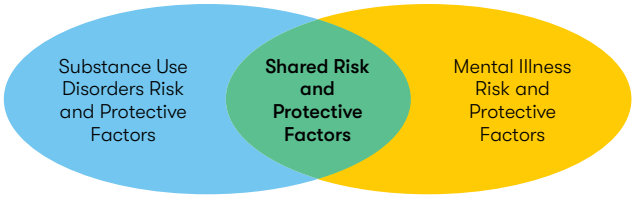
We can best do this by:

1. strengthening common protective factors to reduce the frequency of problems occurring with mental health or AOD use, working to prevent one to - in turn - prevent the other
2. providing appropriate treatment for people with dual diagnosis, including steps to ensure accurate diagnoses
3. improving capacity for services to deliver effective treatment for mental health and substance use problems, preventing individuals falling between the gaps[22]
4. reducing stigma to ensure people are seeking help when they need it and receiving appropriate and quality care[22].

Primary Prevention

Effective primary prevention acknowledges the prevalence and impacts caused by co-occurring disorders and focuses on reducing risk factors and strengthening the protective factors that are most closely related to the problem being addressed. This approach helps practitioners provide appropriate advice and treatment.

Because of the bi-directional nature of these conditions, efforts that prevent AOD use will reduce the prevalence of mental health conditions and vice versa.



Further information on risk factors and strengthening protective factors can be found here: adf.org.au/reducing-risk/community-approaches/prevention-strategies/

Primary prevention strategies aim to shift the focus 'upstream' by helping people to avoid, reduce or modify drug use; rather than reacting to a subsequent 'downstream' problem that requires acute treatment, and often an emergency response.

For example, encouraging people to avoid early or heavy alcohol and other drug use can help reduce personal and social dysfunction, mental and physical health problems and the need for complex interventions through the health, legal and justice systems.

By strengthening and supporting personal and social protective factors the likelihood that people, particularly young people, will engage in problematic AOD use is reduced, thus promoting mental and physical health and improving their life chances.[11]

Protective factors for young people include:

- maintaining positive relations with parents and other family members
- enjoying school
- completing school or leaving to take up employment pathways
- having a firm attachment to adult role models outside the home (such as teachers, sporting coaches and/or youth leaders)
- developing future-oriented recreational pursuits
- living in communities with lower levels of drug use.

Secondary and Tertiary Prevention

Health practitioners play an important role in reducing the harms associated with dual diagnosis and comorbidity through effective secondary and tertiary prevention.

Secondary prevention seeks to identify risk factors and early warning signs through screening for early detection and treatment, resulting in a decrease in the number of cases of a disorder or illness.[23]

Tertiary prevention focusses on effectively treating conditions and preventing their reoccurrence, as well as addressing the reciprocal and compounding effect of self-medication or under-treatment.[24]

'No Wrong Door' Approach

Another key priority for specialist AOD and mental health practitioners and services is to take a 'no wrong door' approach.

This ensures that individuals who present for support or treatment to one specialist can also be treated for their dual diagnosis condition by another specialist, or multiple specialists, sometimes across a number of organisations.

Services that adopt a 'no wrong door' approach are committed to ensuring any door into the health care system will lead a person to the treatment that is appropriate for them.

This helps prevent people with a dual diagnosis and other complex needs from falling through the cracks.

Learn more about working together with other services to adopt a 'no wrong door' approach: https://nowrongdoor.org.au/

Treatment Approaches and Outcomes

People with a co-occurring AOD and mental health problem may have worse impairment, a more trying course of illness and are more difficult to treat than people with a singular problem.[12]

Research shows people with a dual diagnosis may also have poorer treatment outcomes.[25]

However, emerging evidence has clearly demonstrated that individuals with dual diagnosis benefit equally from treatment as those without comorbid conditions,[25]

both in terms of their physical and mental health and AOD use, including those with severe mental health disorders.[26]

This highlights the importance of treating both conditions simultaneously.[25] AOD workers and service providers should deliver sound treatment for AOD issues, despite the clinical complexity.

While the conditions of both groups improve with treatment, people with a dual diagnosis may be at higher risk of continuing to use AOD and having poorer levels of functioning following treatment compared to people without a dual diagnosis.[26]

However, people with dual diagnosis do benefit from treatment, which can result in reductions in AOD use and improvements in overall health, including the symptoms of a mental health condition.[1]

Screening

A key focus for practitioners should be supporting prevention efforts through holistic screening and early intervention.

Effective screening to assist dual diagnosis is critical.

The high prevalence of mental health disorders of between 47-95 per cent (particularly mood and anxiety disorders) in substance use treatment settings highlights the need for clinicians to effectively screen and assess for these disorders as part of standard clinical care.[27]

While clinical tools for screening, assessing and responding to presentations for mental health conditions and AOD use disorder are already available,[12] the high prevalence rate reinforces the need for clinicians and health practitioners to be familiar with evidence-based management and treatment strategies.[27]

Single Condition Treatment

Co-morbid patients and clients usually have their health problems dealt with singly. This often results in one condition going untreated, which can - in turn - jeopardise their recovery from the treated condition.

When one co-occurring condition is not identified, the resultant misdiagnosis will confuse and frustrate clinician and patient alike.

For example, the treatment of psychosis is often overlooked because the onset of psychosis and the onset of drug use typically occurs during adolescence and early adulthood.[28]

Conversely, the psychomimetic qualities of many drugs can result in a person being wrongly diagnosed for a drug-induced psychosis when they present for the first time.[24]

Misdiagnosis delays proper treatment with adverse consequences for the eventual outcome.[24]

Concurrent Treatment

The current evidence-based guidelines in Australia suggest that the integrated treatment of mental health and AOD use disorders is best practice.[29]

Concurrent treatment of anxiety and substance use problems is difficult, and some experts advise it may be efficacious to treat the AOD use disorder first, as anxiety symptoms often cease or reduce markedly when problematic drug use is discontinued.[28]

This, however, presents a challenge for clinical staff as some patients in psychiatric services prefer their anxiety and depression be treated, without addressing their AOD use.[28]

Staff involved in treating AOD dependence need to include treatment of psychiatric disorders for co-morbid clients. Psychiatric staff similarly need the capacity to introduce AOD treatments into mental health service programs.[28]

Treatment of people with co-occurring problems will require the training of general practitioners and staff in alcohol and other drug services and in mental health services.

Standardised and manualised treatment packages for the range of co-occurring AOD and mental health conditions in primary care and specialised service settings would expedite those developments.[28]

Unfortunately, as little research has been conducted into treating co-morbid conditions there is a lack of evidence about effective treatment interventions.[28]

The idea of combining treatment for multiple disorders has considerable appeal and presents a number of advantages over sequential or parallel approaches.[30] Further research and evaluation is necessary to confirm that these approaches lead to significantly better outcomes for individuals and their families.[30]

Where possible, integrated treatment by a single service assists in ensuring consistent, focussed treatment, enabling the complex relationship between conditions to be understood by treating practitioners.[30]

This single point of engagement:

- lessens the burden on the individual
- mitigates potential communication problems and conflicting approaches to treatment
- reduces the chance of people falling between the gaps when it comes to treatment.[22]

Where this single service approach is not possible, individuals need to access different services to have their respective needs meet.

When this is the case, there is a need for specialist health services to improve their collaboration and coordination between each other, ensuring that the most appropriate communication, treatment and supports are available to individuals seeking help, in a timely, safe and effective way.[26]

While each individual's experiences and needs will be different, most people will be likely to require support from a number of different services which may have varying levels of interconnection with each other.

This need underscores the importance of services adopting a 'no wrong door' policy to ensure that people always receive appropriate treatment and support – especially when multiple organisations are involved.

Defining Success in Treatment

There is no single definition of success for either AOD treatment, or for the treatment of a mental health condition.

Each individual is the expert on their own goals.

Care should be taken to not oversimplify the diversity of people with mental health conditions, or their goals in seeking treatment or support.[31]

Determining what recovery means to the individual can help ensure treatment is appropriately tailored.[31]

For some people who use alcohol or drugs, abstinence from AOD is neither achievable or desirable – they may seek instead to reduce, or feel in control of, their use. If this is the case, health practitioners can provide evidence-based advice and resources to help individuals engage in low risk substance use and information on the associated harms and support.

Stigma

For individuals experiencing substance use disorders or dual diagnosis, the evident lack of treatment is partly due to stigmatisation, because a person's experience of dependence is often regarded as 'personal choice or moral failure'.[8, 32]

Stigma is a mark of disgrace that sets members of the stigmatised group apart, marking them as less valuable than other members of society.

A person who is stigmatised is not seen as a full and complex human being – they are judged first and foremost based on their stigmatised traits.

People experiencing an AOD dependence or a mental health condition are often stereotyped as being dangerous and unpredictable and may be considered 'to blame' for experiencing a dependence.[8]

When a person starts to believe these things about themselves, they can experience shame, low self-esteem, and feel unable to succeed or accomplish goals.[8]

Stigma stops people asking for help.[8]

The stigma associated with both AOD use and mental health can lead to people denying their symptoms or feeling as if they cannot seek treatment.[3]

In this way, stigma can contribute to worse health outcomes amongst people who are stigmatised.[8]

Being afraid to seek treatment or unwilling to tell health care practitioners about either mental health symptoms or the use of alcohol and other drugs can mean that people aren't getting the care and support they need.

Health care practitioners have a key role to play in reducing the stigmas associated with alcohol and other drug use and mental health conditions.

Health professionals can help reduce stigma by using person-first language. Learn more about the 'Power of Words' around AOD here: https://adf.org.au/resources/power-words/

Resources for Patients, Clients, People with Dual Diagnosis

SUMITT Fact Sheets

The Substance Use and Mental Illness Treatment Team (SUMITT) have developed a series of harm reduction factsheets. They include information on how they can affect mental health, how to reduce harm, and where to get help. Download the factsheet PDFs here: http://www.dualdiagnosis.org.au/home/index.php/publications/fact-sheets

DirectLine

This 24/7 service provides confidential support around AOD issues to Victorians, including phone counselling, counselling online, and referrals.

Learn more about DirectLine: https://www.directline.org.au/

Learn more about Counselling Online: https://www.counsellingonline.org.au/

Mental health care plan

Working out a mental health care plan can help a person and their doctor agree on shared goals and how to work towards them, as well as helping with the cost of accessing mental health support.

Learn more about mental health care plans: https://www.healthdirect.gov.au/mental-health-care-plan

Resources for Professionals

Using the Australian Comorbidity Guidelines

The Australian 'Comorbidity Guidelines' have been developed for AOD workers and other health professionals. The Guidelines provide comprehensive information about recognising and treating people with a dual diagnosis.

A range of resources are attached to the Guidelines, including access to free training, screening and assessment tools, information on motivational interviewing, and worksheets that health professionals can use to help support their clients.

Learn more about the Guidelines and access the training and other resources: https://comorbidityguidelines.org.au/

Dual Diagnosis Australia and New Zealand

Provides information and tools for health care practitioners, including clinical guidance and self-assessment checklists for workers and agencies to assess their current capability to support people with a dual diagnosis, and then identify gaps in training or other needs.

Visit their website: http://www.dualdiagnosis.org.au/

The Victorian Dual Diagnosis Initiative (VDDI)

Learn more about this cross-sector initiative to support health care practitioners, including contact details: http://www.dualdiagnosis.org.au/home/images/VDDI/Vicn_Dual_Diagnosis_Services-Profile-Contacts_Jan-2019.pdf

Access the presentations delivered at the VDDI 2019 forum: https://www.svhm.org.au/our-services/departments-and-services/n/nexus/resources/vddi-forum-2019

Help reduce stigma

Use person-first language

Person-first language recognises that the order of the words, not just the words we choose, affects the way we imagine the person or group being described. Putting the person first emphasises that someone is a person, before they are anything else.

Learn more about the power of language around alcohol and other drugs: https://adf.org.au/resources/power-words/

Watch for stigma in the media

SANE Australia operates Stigma Watch, where anyone can report stigmatising media coverage of mental health: https://www.sane.org/information-stories/facts-and-guides/reducing-stigma#what-can-i-do-about-stigma

Mindframe provides guidelines for best-practice reporting on mental health, including self-harm, and alcohol and other drug topics: https://mindframe.org.au/

References

1. Marel C, Mills K, Kingston R, Gournay K, Deady M, Kay-Lambkin F, et al. Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings. Sydney: Centre of Research Excellence in Mental Health and Substance Use, Centre NDaAR; 2016.
2. Jaffe A, Jiang D, Huang D. Drug-abusing offenders with co-morbid disorders: Problem severity, treatment participation, and recidivism. Journal of Substance Abuse Treatment. 2012;43:244-50.
3. Holt M, Treloar C, McMillan K, Schultz L, Schultz M, Bath N. Barriers and incentives to treatment for illicit drug users with mental health comorbidities and complex vulnerabilities. Canberra; 2007.
4. Keyes KM, Hatzenbuehler ML, Hasin DS. Stressful life experiences, alcohol consumption, and alcohol use disorders: the epidemiologic evidence for four main types of stressors. Psychopharmacology. 2011;218(1):1-17.
5. Thakkar MM, Sharma R, Sahota P. Alcohol disrupts sleep homeostasis. Alcohol. 2015;49(4):299-310.
6. Nutt D, Wilson S, Paterson L. Sleep disorders as core symptoms of depression. Dialogues Clin Neurosci. 2008;10(3):329-36.
7. Victorian Government Department of Human Services. Dual diagnosis: key directions and priorities for service development. Melbourne: Government of Victoria; 2007.
8. National Academies of Sciences E, and Medicine,. Ending discrimination against people with mental and substance use disorders: The evidence for stigma change. Washington (DC): National Academies Press; 2016.
9. Latalova K, Kamaradova D, Prasko J. Violent victimization of adult patients with severe mental illness: a systematic review. Neuropsychiatric Disease and Treatment. 2014;10:1925-39.
10. World Health Organization and Calouste Gulbenkian Foundation. Social determinants of mental health. Geneva: World Health Organisation; 2014.
11. Hawkins D. Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention. Psychological Bulletin. 1992.
12. Hall W, Degenhardt L, Teesson M. Reprint of "Understanding comorbidity between substance use, anxiety and affective disorders: Broadening the research base". Addictive Behaviors. 2009;34(10):795-9.
13. Trewin D, Madden R. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples. Canberra, Australian Bureau of Statistics. 2005.
14. Demant D, Hides L, Kavanagh DJ, White KM, Winstock AR, Ferris J. Differences in substance use between sexual orientations in a multi-country sample: Findings from the Global Drug Survey 2015. Journal of Public Health. 2017;39(3):532-41.
15. Baker A, Baker A, Ivers RG, Baker A, Ivers RG, Bowman J, et al. Where there's smoke, there's fire: high prevalence of smoking among some sub-populations and recommendations for intervention. Drug and alcohol review. 2006;25(1):85-96.
16. Irving HM, Samokhvalov AV, Rehm J. Alcohol as a risk factor for pancreatitis. A systematic review and meta-analysis. Jop. 2009;10(4):387.
17. Stenbacka M, Leifman A, ROMELSJÖ A. Mortality and cause of death among 1705 illicit drug users: a 37 year follow up. Drug and alcohol review. 2010;29(1):21-7.

18. Brown S, Birtwistle J, Roe L, Thompson C. The unhealthy lifestyle of people with schizophrenia. Psychological medicine. 1999;29(3):697-701.
19. Taylor D, McAskill R. Atypical antipsychotics and weightgain—a systematic review. Acta Psychiatrica Scandinavica. 2000;101(6):416-32.
20. Beebe LH, Tian L, Morris N, Goodwin A, Allen SS, Kuldau J. Effects of exercise on mental and physical health parameters of persons with schizophrenia. Issues in mental health nursing. 2005;26(6):661-76.
21. Greenhalgh E, Scollo M, Winstanley M. Tobacco in Australia: Facts and issues. Melbourne: Cancer Council Victoria; 2020.
22. Kenny A, Kidd S, Tuena J, Jarvis M, Roberston A. Falling through the cracks: Supporting young people with dual diagnosis in rural and regional Victoria. Australian Journal of Primary Health. 2006;12(3):12-9.
23. Mortlock KS, Deane FP, Crowe TP. Screening for mental disorder comorbidity in Australian alcohol and other drug residential treatment settings. Journal of Substance Abuse Treatment. 2011;40(4):397-404.
24. Hinton M, Edwards J, Elkins K, Wade D. Problematic drug use in young people with first episode psychosis. Drug Use and Mental Health. 2009:165-78.
25. Siegfried N. A review of comorbidity: major mental illness and problematic substance use. Australian and New Zealand Journal of Psychiatry. 1998;32(5):707-17.
26. Kay-Lambkin F, Baker A, Lewin T. The'co-morbidity roundabout': a framework to guide assessment and intervention strategies and engineer change among people with co-morbid problems. Drug and Alcohol Review. 2004;23(4):407-23.
27. Kingston R, Marel C, Mills K. A systematic review of the prevalence of comorbid mental health disorders in people presenting for substance use treatment in Australia. Drug and Alcohol review. 2016;36(4):527-39.
28. Proudfoot H, Teesson M. Challenges posed by co-occurring disorders in the clinical and service systems. Drug Use and Mental Health: Effective Responses to Co-Occurring Drug and Mental Health Problems Melbourne: IP Communications. 2008:65-77.
29. Kavanagh D. Treatment of comorbidity. In: Teesson M, Burns L, editors. National Comorbidity Project. Canberra: Commonwealth Department of Health and Ageing; 2001.
30. Deady M, Barrett E, Mills K, Kay-Lambkin F, Haber P, Shand F, et al. Effective models of care for comorbid mental illness and illicit substance use: An Evidence Check review brokered by the Sax Institute for the NSW Mental Health and Drug and Alcohol Office. 2014.
31. De Ruysscher C, Vandevelde S, Vandersplasschen W, De Maeyer J, Vanheule S. The concept of recovery as experienced by persons with dual diagnosis: a systematic review of qualitative research from a first-person perspective. Journal of Dual Diagnosis. 2017;13(4).
32. Adlaf EM, Hamilton HA, Wu F, Noh S. Adolescent stigma towards drug addiction: Effects of age and drug use behaviour. Addictive behaviors. 2009;34(4):360-4.