Co-occurring Substance Use and Mental Health Conditions

Executive Summary

There are a range of terms which are commonly used to describe co-occurring substance use and mental health conditions in Australia. For the purposes of this paper, 'cooccurring conditions' will be used outside of direct quotes to avoid contributing to the stigma surrounding these issues.

PPEI strategies/programs can offer tangible benefits for avoiding or decreasing the harms to individuals and their families from cooccurring conditions.

Young people with a mental illness are more likely to use alcohol and other drugs. There is evidence that prevention programs targeting at-risk young people can reduce anxiety, depression and substance use.

There is compelling evidence for the use of integrated care systems for people with co-occurring substance use and mental health conditions.

In the ongoing investigation of complexity capable service systems, the Victorian Dual Diagnosis Initiative (VDDI) has articulated a comprehensive approach towards the provision of what they describe as 'a complexity-capable service system'.

The high prevalence of co-occurring substance use and mental health conditions means that Alcohol Tobacco and Other Drug (ATOD) workers are frequently faced with the need to manage complex issues, often outside their area of knowledge and understanding, and this may interfere with their ability to treat and support their clients.

Training workers in both the ATOD and the Mental Health sectors with understanding of co-occurring conditions will, at the very least, help to prevent compounding the severity of the situation.

Training identifies the need for service culture change, addresses stigma and discrimination and promotes a recovery-based approach: positive, non-blaming and optimistic. There is also a need for a plan which assists in transferring skills and knowledge into the workplace.

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1.0 Definition

Co-occurring Substance Use and Mental Health Conditions

A range of terms are commonly used to describe co-occurring substance use and mental health conditions in Australia, including co-morbidity, dual diagnosis, and co-occurring disorders. These terms have a strong association with a medical model view of disease and are at odds with the concept of the recovery model which encompasses a broader more holistic view of health. In addition, 'dual diagnosis' can be misleading as people can have a range of co-occurring conditions of varying severity. More recently the term 'Co-occurring disorders' is increasingly employed; however, for the purposes of this paper, 'co-occurring conditions' will be used outside of direct quotes to avoid contributing to the stigma surrounding these issues.

It should be noted that co-occurring conditions can also relate to the co-occurrence of substance use and/or mental health conditions and learning disabilities, cognitive impairment, chronic pain and other conditions. This paper specifically addresses the co-occurrence of substance use and mental health conditions.

Alcohol, Tobacco and Other Drugs (ATOD) Workforce

According to Australia's National Centre for Education and Training on Addiction (NCETA)[1] the ATOD workforce includes:

1. ATOD specialist workers - workers whose main work role is to deal with specific ATOD issues within a specific ATOD service. This includes workers employed in:
    - Specialist treatment agencies or organisations that provide other ATOD services such as education, prevention, or assessment and referral and the ATOD treatment service sector.
    - ATOD programs that are embedded within other (non-ATOD specialist) organisations (e.g. workers providing ATOD treatment, counselling or ATOD prevention and education within a hospital or community health organisation).
    - A diverse range of occupations which make up the ATOD workforce including:
        - ATOD workers
        - Psychologists
        - Counsellors
        - Social workers
        - Doctors
        - Allied health workers
        - Nurses
        - Pharmacists
        - Psychiatrists
        - Peer workers
        - Project workers
        - Education officers/trainers
        - Managers/admin officers
2. Mainstream non-ATOD Workers include those who are not employed in ATOD specialist agencies nor within ATOD programs embedded in non-ATOD specialist agencies, but who are often faced with ATOD issues as part of their main work role. Such workers generally have extensive contact with the wider community and are thereby well placed to implement ATOD prevention and intervention strategies.

    These workers may be employed in sectors such as health, welfare and community services, law enforcement, education and a wide range of other organisations and industries.

    Due to the breadth and diversity of the occupations and work roles that comprise ATOD work, data on mainstream generic workers are more difficult to collect and collate. However, examples of mainstream workers who may have an ATOD workforce role include:
    - Police
    - Ambulance officers
    - Community health workers
    - Occupational health & safety professionals
    - Teachers
    - Correctional service workers
    - Welfare workers
    - Social workers
    - Pharmacists
    - Paramedics
    - Nurses
    - Medical practitioners
    - Psychologists

1 National Centre for Education and Training on Addiction (Australia), 'Who Are the Alcohol and Other Drug Workforce?', NCETA, accessed 4 September 2020, http://nceta.flinders.edu.au/workforce/who-are-the-aod-workforce/.

- Mental health workers
- Youth workers
- Aboriginal and Torres Strait Islander Community Workforce

3. There are also many complementary services provided outside of the specialist alcohol and other drug treatment system to those experiencing alcohol and other drug problems. These services might address issues related to housing, education, financial disadvantage, other health conditions and unemployment, family and relationships, criminal justice and poverty.

2.0 PPEI: What works for people with Co-occurring Conditions?

Health Promotion, Prevention and Early Intervention (PPEI)

PPEI strategies/programs can offer tangible benefits for avoiding or decreasing the harms to individuals and their families from co-occurring conditions. Teeson et al. note that "*these disorders typically have their onset in late adolescence and early adulthood presenting unique opportunities for prevention.*"[2] The National Mental Health Commission also makes this point, "*Early intervention can change the life trajectories of many people with co-existing substance use and mental health conditions, particularly for young people and people from disadvantaged backgrounds. Evidence suggests that three quarters of adult substance use and mental health conditions begin by the time people are in their mid-twenties.*"[3] The Commission concludes that this suggests that practices involving a broad range of supports for young people – from schools, primary care providers and specialist services - all have a role to play in prevention of co-occurring substance use and mental health conditions. The onset of mental illness is known to occur, in a large number of cases, between the ages of 12 and 25, coinciding with exposure to alcohol and other drugs for many young people.

An Orygen policy paper notes that "*Young people with a mental illness are more likely to use alcohol and other drugs. The increased health risks of co-occurring conditions underlines the importance of treating both health issues. The longer-term health risks of alcohol/other drug use, in particular tobacco, makes early interventions for young people with a mental illness a policy priority.*" The same paper claims that evidenced-based programs for treating young people with a mental illness and alcohol and other drug, including those delivered on mobile phones, as computer programs and online, do exist and can be facilitated by the integration and co-location of services. However, "*while the importance of treating both mental illness and alcohol and other drug use is recognised and the ability to do so exists, policy momentum is missing. Gaps in the available data on comorbidity is a factor in this inertia.*" [4]

A key research strategy to improve the response to co-occurring substance use and mental health conditions is to determine whether interventions designed to prevent common mental disorders in adolescence reduce the prevalence of co-occurring harmful substance use in young adulthood. There is some evidence that prevention programs targeting at-risk young people can reduce anxiety, depression and substance use, however, none of these studies have attempted to investigate prevention or assess co-occurring conditions in a single program. Teesson et al. remind us that "*It is critical we build our knowledge in prevention and treatment and disseminate those interventions.*"[5]

A "Complexity Capable" system

Many experts and researchers have provided compelling evidence for the use of integrated care systems for people with co-occurring substance use and mental health conditions. Australian researcher Catherine Foley has found:

> *"An integrated care approach (coordinated treatment of both substance use and mental health conditions by clinicians or services working together) is recommended as best*

2 Maree Teesson et al., 'Mental Health and Substance Use: Opportunities for Innovative Prevention and Treatment' (National Health and Medical Research Council (NHMRC) Centre of Research Excellence in Mental Health and Substance Use, October 2014), https://nswmentalhealthcommission.com.au/sites/default/files/assets/File/NSW%20MHC%20Discussion%20document%20on%20comorbidity%20cover%20page.pdf.

3 National Mental Health Commission, 'A Contributing Life: The 2013 National Report Card on Mental Health and Suicide Prevention' (Sydney: National Mental Health Commission, 2013), https://www.mentalhealthcommission.gov.au/getmedia/62e98949-980b-4791-a90a-4ae92adbf2a3/Monitoring/2013-National-Report-Card-on-Mental-Health-and-Suicide-Prevention.pdf.

4 D. Baker and Frances Kay-Lambkin, 'Two at a Time: Alcohol and Other Drug Use by Young People with a Mental Illness' (Melbourne: Orygen: The National Centre of Excellence in Youth Mental Health, 2016), https://www.orygen.org.au/Policy/Policy-Reports/Alcohol-and-other-drug-use/alcohol_and_other_drug_policy_paper_2016?ext.

5 Maree Teeson et al. 2014

practice because it more consistently results in better outcomes than approaches that treat these conditions separately. Despite the benefits of integrated care, such as reduced symptom severity and fewer acute-care admissions for people who have co-occurring disorders, most MH and AoD services operate independently of each other. This is problematic given that neither recognition of the need for improved clinical services nor the identification of integrated care as the preferred treatment approach (in clinical guidelines in multiple countries), has been enough to achieve meaningful and sustained change in the delivery of integrated care. Reports estimate that less than 12% of people with co-occurring disorders receive treatment for both conditions." [6]

However, there is some interesting work in the investigation of complexity capable service systems which provide a deeper exploration of the notion of integrated systems. The Victorian Dual Diagnosis Initiative (VDDI) has articulated a comprehensive approach towards the provision of what they describe as 'a complexity-capable service system'. In their submission to the Royal Commission into Victoria's Mental Health System, VDDI researcher, Gary Croton refers to the work of Cline and Minkoff, architects of the Comprehensive Continuous System of Care (CCISC) model, who note:

"In real world behavioural health and health systems, individuals and families with multiple cooccurring needs are an expectation, not an exception. Individuals and families not only have substance use and mental health issues, they frequently have medical issues, legal issues, trauma issues, housing issues, parenting issues, educational issues, vocational issues and cognitive/learning issues. In addition, these individuals and families are culturally and linguistically diverse. In short, these are people and families who are characterized by 'complexity', and they tend to have poorer outcomes and higher costs of care." [7]

The challenge is to build systems that are designed to provide for and prioritise these individuals and families with complex issues. Croton suggests that CCISC recognises "*it is not adequate to fund a few 'special programs' to work around a fundamentally mis-designed system. We need to engage in a process of organizing everything we do, at every level, with every scarce resource we have, to be about all the complex needs of the people and families seeking help.*" [8]

Croton goes on to refer to Victoria as the Australian jurisdiction which "has *had the longest standing, most significant, investment in achieving better outcomes for people with co-occurring substance use and mental health concerns. Victoria has been active in developing systemic 'dual diagnosis capability' since 1998.*"[9] He refers to the cross-sector dual diagnosis policy developed in Victoria in 2007 "*offering all stakeholders an evidence-informed vision of how the AOD and mental health treatment sectors will look, feel, behave and interact when providing effective responses to the various cohorts of people with dual diagnosis.*"

The strategy included KPIs that service managers were obliged to report on. These provide a roadmap for an effective, integrated co-occurring disorders system and include:

- Universal screening
- Tiered 'dual diagnosis capability' of workers
- Mental health and ATOD services to establish partnerships and mechanisms to support integrated assessment and treatment
- Outcomes and service responsiveness for dual diagnosis clients to be monitored and regularly reviewed
- Consumer and carer involvement in the planning and evaluation of service responses.

The Victorian dual diagnosis policy was successful for a number of years in positively influencing practice across three sectors. The evidence informed vision that it offered provided a clear central focus around which all Victorian stakeholders – ATOD and mental health managers, workers, clinicians and VDDI workers – were able to unite and coordinate their efforts around.

6 Catherine Foley, 'Collaborating with Clinicians and Consumers to Improve the Uptake of Integrated Care in a Residential Mental Health Rehabilitation Unit: A Co-Design Approach', Drug and Alcohol Research Connections, December 2018, sec. Research Focus, http://connections.edu.au/researchfocus/collaborating-clinicians-and-consumers-improve-uptake-integrated-care-residential.

7 Gary Croton, 'Better Outcomes: Towards a Victorian Complexity-Capable Service System: A Submission to the Royal Commission into Victoria's Mental Health System', Government Submission (Victorian Dual Diagnosis Initiative, 5 July 2019), http://www.dualdiagnosis.org.au/home/images/VDDI/RCSubmissions/MHRC-Submission-Croton-DUAL_DIAGNOSIS-2.pdf.

8 Ibid.

9 Ibid.

VDDI's submission calls for "*refunding a VDDI Education and Training Unit with a remit to address AOD-MH workforce professional development, curriculum development and to influence the content of a range of undergraduate healthcare courses.*"[10] This is something that would benefit all jurisdictions in addressing the issues of co-occurring substance use and mental health conditions.

Training

The high prevalence of co-occurring substance use and mental health conditions means that ATOD workers are frequently faced with the need to manage complex issues, often outside their area of knowledge and understanding, and this may interfere with their ability to treat and support their clients. "*This lack of understanding can lead to a more complex and severe clinical profile, including poorer general physical and mental health, greater drug use severity, and poorer functioning.*"[11]

In terms of prevention, training workers in both the ATOD and the mental health sectors with understanding of co-occurring ATOD and mental health conditions will at the very least, help to prevent compounding the severity of the situation. We need to facilitate the application of knowledge to practice by addressing the gap in knowledge and workforce entry qualifications.

The Rethink Mental Health Long-term Plan for Mental Health in Tasmania states that there are two aspects to "*integration in this area: collaboration with the school education sector and partnerships with institutions such as UTAS to consider areas such as education and training of health professionals and research and conjoint appointments.*"[12] There may be a significant loss in the area of co-occurring conditions education, with the cessation of the dual Certificate IV in Alcohol, Other drugs and Mental Health in Tasmania. The Rethink plan stresses that the education sector is "*particularly important in the role of promotion, prevention and early intervention initiatives and the need to expand on work already occurring. Some schools already implement programs that aim to promote mental health and wellbeing and address risk factors such as bullying, body image and drug and alcohol use. There is a need to further support the expansion of these to ensure all schools are able to offer similar evidence-based approaches.*"

The Tasmanian Government has also reintroduced nurses to Tasmanian state schools with the Rethink Plan noting that "*School nurses will support school communities to create a physical and social environment that promotes lifelong health and wellbeing including mental health.*"[13] The addition of school nurses in all primary schools would be a welcome addition and would strengthen the work being done in secondary schools.

In its submission to the Rethink Mental Health project, the Alcohol Tobacco and Other Drug Council (ATDC) pointed out:

> *"The skill sets and qualifications for MH [mental Health] and AOD [Alcohol and Other Drugs] workers must be updated and refreshed on a regular basis via professional development. The benefits to the sectors and workers alike of participating in joint professional development opportunities would be immeasurable. AOD and MH workers have many unique skills. Despite the differences between the workers within each sector the benefits associated with developing particular skill sets when dealing with shared clients with co-existing AOD and MH issues would be significant."*[14]

Mills et al. argue:

> *"The need for improved training and support of AOD workers in responding to comorbid mental disorders has been identified as a priority by numerous reviews and policy documents, as well as by AOD workers themselves. Within the AOD workforce, the management of co-occurring mental health conditions has been described as 'the single most important issue... a matter akin to blood-borne viruses in the 1980s.'"* [15]

10 Gary Croton, 2019

11 Christina Marel et al., Guidelines on the Management of Co-Occurring Alcohol and Other Drug and Mental Health Conditions in Alcohol and Other Drug Treatment Settings, 2nd ed. (University of New South Wales: National Health and Medical Research Council (NHMRC) Centre of Research Excellence in Mental Health and Substance Use, 2016), https://comorbidityguidelines.org.au/pdf/comorbidity-guideline.pdf.

12 Department of Health and Human Services Mental Health, Alcohol and Drug Directorate, 'Rethink Mental Health: Better Mental Health and Wellbeing. A Long-Term Plan for Mental Health in Tasmania 2015-2025', Plan, 2015, https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0005/202496/DHHS_Rethink_Mental_Health_WEB.pdf.

13 Ibid.

14 Alcohol Tobacco and Other Drug Council (ATDC), 'Submission to the Tasmanian Government Rethink Mental Health Project Discussion Paper', February 2015, http://www.atdc.org.au/wp-content/uploads/2015/03/ATDC-Submission-Rethink-Mental-Health-Project-Discusion-Paper.pdf.

15 Katherine Mills et al., 'Lessening the Burden of Comorbid Substance Use and Mental Disorders Through Evidence-Based Care: The Case for a National Minimum Qualifications Strategy', Submission to Government (Sydney: University of Sydney, 2019), https://www.pc.gov.au/__data/assets/pdf_file/0003/240798/sub280-mental-health.pdf.

They describe the development of an online, interactive training program which the Matilda Centre for Research in Mental Health and Substance Use developed in November 2017. This program was developed in line with best practice e-learning principles in consultation with clinicians and consumers.[16] They describe the program as having been developed to assist ATOD workers with three key aims:

1. Increase their knowledge and awareness of co-occurring conditions.
2. Improve the confidence of those working with clients with co-occurring conditions.
3. Improve ATOD workers' ability to identify mental health conditions.[17]

It is clear that training has potential for improving outcomes beyond the clinical sector. The WA Mental Health, Alcohol and Other Drug Workforce Strategic Framework notes that:

> *"Whilst traditionally the specialist workforce is centred around clinical positions such as doctors, allied health (clinical psychologists, social worker, occupational therapists) and nurses, there is increasing recognition of the importance of other types of workers in effectively supporting people with mental health and AOD issues. Peer workers, who have a core role in the workforce are likely to continue to grow in the future and play a positive role within the mental health and AOD workforce."*[18]

Based on the evidence presented in the DEN discussion paper, 'Why Tasmania Needs an Alcohol and Other Drug Peer Workforce'[19], there are substantial benefits for developing a peer workforce in Tasmania. It is well documented that including Peers in the workforce is a positive prevention measure. To achieve an effective Peer Workforce, we need to provide training to potential peer workers and organisational readiness training to service provider organisational staff. Such training should also include information about co-occurring disorders and it would also be useful to train as Peer Workers some people with lived experience of both substance use and mental health conditions. In a first for Tasmania, a project which will begin its rollout in 2020 has been funded by the Tasmanian Community Fund, Primary Health Tasmania, and the Tasmanian Health Services South and run by a partnership of DEN, Holyoake Tasmania, the Salvation Army Tasmania and Youth, Family and Community Connections (YFCC). This project aims to inform the sector and produce a framework and resources to progress the development of an ATOD Peer workforce in Tasmania.

As the WA Mental Health Commission also notes, "*There is also a need for an increased involvement of community members, consumers, families and carers in service planning and delivery, and a growing number of people who contribute their time to assist in policy development, planning and service delivery.*"[20]

PPEI in conclusion

To promote a holistic, recovery-oriented, human rights-based approach to working with and supporting people with co-occurring substance use and mental health conditions it is important that:

- Co-occurring conditions are treated within a holistic approach and that prevention interventions recognise people with mental ill-health and people with ATOD issues as at-risk populations.
- Core co-occurring competencies are promoted for inclusion in tertiary courses for medical, nursing, allied health, promotion and support workers.
- The feasibility of implementing an exchange program is investigated, whereby staff from the mental health and the ATOD sectors have the opportunity to undertake worker exchanges with clear measurable objectives.
- Organisational capacity and workforce training and development are developed across both sectors.
- There is collaboration between government, private sector and non-government services to maximise training opportunities for staff. Training promotes the importance of leadership in the field of co-occurring conditions and integration and collaboration between mental health, alcohol and other drug and primary care service providers.

16 'Comorbidity Guidelines Online Training Program Landing Page', Comorbidity Guidelines, accessed 8 September 2020, https://comorbidityguidelines.org.au/training-modules.

17 Ibid.

18 Mental Health Commission, 'Mental Health, Alcohol and Other Drug Workforce Strategic Framework: 2018 - 2025: A Guide for the Planning and Development of the Mental Health and Alcohol and Other Drug Workforce - Consultation Draft', 2018, https://www.mhc.wa.gov.au/media/2447/workforce-strategy-draft-version-4-consultation-draft-10-07-18.pdf.

19 Drug Education Network Inc., 'Alcohol and Other Drug Peer Workers Discussion Paper', April 2020, http://interactive.den.org.au/toolbox/DEN_DiscussionPaper_AlcoholAndOtherDrugPeerWorkers_2020_Ver1.0.pdf.

20 Mental Health Commission, 2018

- Training identifies the need for service culture change, addresses stigma and discrimination and promotes a recovery-based approach – positive, non-blaming and optimistic and a plan is developed for transferring skills and knowledge into the workplace.
- Workers are provided with the confidence, role legitimacy and skills to effectively work with people with co-occurring substance use and mental health conditions.
- The impact of co-occurring mental health and substance use issues is understood across the community services and public health sectors. It is essential to consider the whole person, taking into account psychological, physical, and sociodemographic perspectives.
- The presence of co-occurring substance use and mental health conditions can place a great strain on the families and carers, both emotionally and financially, of those seeking help. At least some of this stress is due to lack of knowledge and understanding and can be helped with the provision of targeted, evidence-based information.

3.0 Background

Research shows that the co-occurrence of substance use and mental health issues have a high prevalence in Australia.

> *"According to the Australian Institute of Health and Welfare (AIHW), about one in four people with anxiety, affective or substance use disorder also had at least one other mental illness. People with mental illness experience drug problems at far higher rates than the general community with studies suggesting that around 50 per cent of people with mental illness also have a drug or alcohol problem. Data from the 2007 National Survey of Mental Health and Wellbeing also indicated that 38.6 per cent of males and 48.5 per cent of females with a substance use disorder had at least one co-occurring affective or anxiety disorder."*[21]

It is evident that people with co-occurring substance use and mental health conditions have poorer outcomes than those who have a single disorder. They have poorer physical health, poorer social, occupational and interpersonal functioning, increased risk of self-harm and suicide and reduced life expectancy. All these factors complicate prevention measures, treatment and recovery outcomes. Researchers Teeson et al have concluded that co-occurring substance use and mental health conditions "*remain a major cause of disability among young people and, in the longer-term, are associated with poor quality of life and early mortality at the end of life.*"[22]

Teeson et al. have also noted that co-occurring substance use and mental health conditions "*are one of health's most significant challenges. The prevention and treatment evidence base is weak, limited by traditional single disorder models and treatment silos. It is critical that we break down the single disorder silos, generate significant new research, ensure effective transfer of knowledge and mentor future leaders in this area of significant need.*" [23]

Given the high prevalence of people with co-occurring substance use and mental health conditions and significant concern expressed regarding this situation, there are some areas that warrant improvement and examples of responses that could support an improved response to co-occurring substance use and mental health conditions. This paper aims to review the issues related to the gaps and barriers to providing effective prevention and early intervention for people with co-occurring substance use and mental health conditions and what can be done to address these.

The Matilda Centre for Research in Mental Health and Substance Use refers to findings from the most recent Australian National Survey of Mental Health and Wellbeing (NSMHWB) which "*show that these disorders frequently co-occur with 35% of individuals with a substance use disorder (31% of men and 44% of women) also meeting diagnostic criteria for at least one co-occurring mood or anxiety disorder. Prevalence is even higher among individuals entering alcohol and other drug (AOD) treatment programs, with estimates indicating between 50–76% of Australian clients of AOD treatment services meet diagnostic criteria for at least one comorbid mental disorder.*" [24]

This finding is reinforced by the Victorian Dual Diagnosis Initiative, referring to a Victorian DHHS report in 2017 which stated that "*up to 75% of people with substance abuse problems may also have a mental health issue.*"[25] The Dual Diagnosis

21 Department of Health and Human Services Mental Health, Alcohol and Drug Directorate, 2015

22 Maree Teeson et al. 2014

23 Ibid.

24 Katherine Mills et al. 2019

25 Victorian Dual Diagnosis Initiative (VDDI), 'Victorian Dual Diagnosis Initiative Submission to the Royal Commission into Vicortia's Mental Health System' (Victoria, 2019), https://www.svhm.org.au/ArticleDocuments/3105/MHRC-VDDI.pdf.aspx?embed=y.

Initiative also noted that DHHS has suggested that a typical person with a co-occurring mental health and substance use disorder "*is likely to be alienated and lack support from family and friends, and have difficulty engaging with siloed single issued focused health care providers.*" [26] The National Mental Health Commission has noted that, "*people who have mental health issues and a substance use disorder are twice as likely to be homeless as those who had one of these problems, and twice as likely to have been in prison or a correction facility.*" [27] The Australian Institute of Health and Welfare (AIHW) confirms that there are cohorts that have greater percentages of co-occurring substance use and mental health conditions, including the homeless and people in prison who have co-occurring disorders up to 2.5 times higher than the general population. [28]

However, there is also the issue of people who do not present for treatment. The Black Dog Institute references the Australian Institute of Health and Welfare (AIHW) to conclude that "*54% of people with mental illness do not access any treatment... This is worsened by delayed treatment due to serious problems in detection and accurate diagnosis. The proportion of people with mental illness accessing treatment is half that of people with physical disorders.*"[29]

Turning Point stresses that stigma is a major barrier, particularly with regards to people with co-occurring substance use and mental health conditions:

> *Research shows that stigma can lead to substantial delays in help-seeking (up to two decades for alcohol and other drug use disorders), as well as treatment noncompliance, reduced self-esteem, social exclusion, discrimination, and relapse... Individuals with alcohol and other drug use disorder and/or co-occurring mental illness face considerable stigma and a range of structural barriers to accessing treatment... Protracted delays in treatment-seeking directly contribute to poor clinical outcomes, including recurrent relapses and multiple complications (e.g. poor physical and mental health, fractured relationships and social instability). This highlights the importance of creating an accessible and effective treatment system for people who need treatment for their alcohol and other drug use, as well as earlier intervention for this group once problems manifest.* [30]

It is important to note that tobacco use is a common and often neglected form of co-occurring substance use in all mental health conditions. It is especially common among persons with serious mental disorders and, given the extremely adverse impact of smoking on the health of individual smokers, it is an issue of major public health concern. With regards to the prevalence of smoking among people with mental health problems, Greenhalgh, Stillman and Ford have noted:

> *"Data from the National Drug Strategy Household Survey show that in Australia in 2016, daily smokers were more than twice as likely to have high/very high levels of psychological distress compared with people who had never smoked (22% compared with 10%, respectively) and were more than twice as likely to have been diagnosed or treated for a mental health condition (29% compared with 12%). Smoking prevalence tends to increase alongside the severity of the psychiatric disorder. For example, two Australian studies conducted 10 years apart both found that among people living with psychotic disorders, about 70% of men and 60% of women are smokers."* [31]

A SANE factsheet notes that:

> *"Around 32% of people with mental illness smoke cigarettes, compared to just 18% of the general population. The rate is far higher among people with schizophrenia.*
>
> *It is estimated that nearly 40% of all smokers have a mental illness. Like all smokers, they use tobacco because it can be a way of dealing with feelings such as boredom or stress, and they become physically addicted to nicotine.*

26 Ibid.

27 National Mental Health Commission 2013

28 Australian Institute of Health and Welfare, 'The Mental Health of Prison Entrants in Asutralia', June 2010, https://www.aihw.gov.au/getmedia/54a2e44e-dab7-4e88-a2db-268cda9c5888/13607.pdf.aspx?inline=true.

29 Black Dog Institute, 'Facts & Figures about Mental Health', accessed 4 September 2020, https://www.blackdoginstitute.org.au/wp-content/uploads/2020/04/1-facts_figures.pdf?sfvrsn=8.

30 Turning Point, 'Submission: Royal Commission into Victoria's Mental Health System', July 2019, https://www.easternhealth.org.au/images/Turning_Point_Submission_to_the_Victorian_Royal_Commission_into_MH_July_2019.pdf.

31 EM. Greenhalgh et al., '7.12 Smoking and Mental Health', in Tobacco in Australia: Facts & Issues (Tobacco in Australia, 2020), https://www.tobaccoinaustralia.org.au/chapter-7-cessation/7-12-smoking-and-mental-health.

Nicotine and other chemicals in cigarettes may temporarily affect the positive and negative symptoms of schizophrenia.

As a consequence, smokers generally need higher doses of antipsychotic medication, which can lead to increased side-effects." [32]

What comes first: Substance use or mental health issues?

People are different when it comes to their experience with substance use and mental illness. There has been considerable investigation of the causality of co-occurring disorders and some of the evidence has found that:

- There are individuals who begin to experience mental health issues during childhood or adolescence and experiment with drugs and alcohol soon after, developing both a substance use problem and a serious mental illness virtually at the same time.
- Others may seek out drugs and alcohol to 'self-medicate' a mental health issue that develops in early adulthood or that develops out of an injury or trauma later in life.
- There are also those who may first develop a substance use problem that grows so severe that it causes mental health issues or triggers the onset of symptoms that may otherwise have remained dormant. [33]

It may not always be clear what comes first, however, it is known that people with mental health disorders have an increased risk for ATOD disorders, and people with ATOD disorders have an increased risk for mental health disorders. Also:

- ATOD use can cause mental ill-health symptoms and mimic mental health syndromes.
- ATOD use can initiate or exacerbate a mental health disorder.
- ATOD use can mask symptoms associated with mental health disorders.
- ATOD withdrawal can cause symptoms associated with mental health disorders.
- The behaviours of people with mental health disorders can mimic ATOD use problems.
- Substance use and mental health conditions may share common causes or risk factors, particularly trauma history.
- The symptoms of a co-occurring mental health issue may be misinterpreted as poor or incomplete 'recovery' from ATOD use. For example, many people who are affected by harmful substance use present with depressive and anxiety symptoms that can be attributed to due over-use and withdrawal from drugs and alcohol. Further probing is necessary once the possibility of a particular diagnosis is identified through screening.

It is important to note that understanding the reasons for co-occurring substance use and mental health conditions is vital for appropriately supporting vulnerable individuals and their families. Understanding why different disorders co-occur may also provide important opportunities for prevention. For example, if as some studies find, anxiety and affective disorders commonly co-occur with alcohol use, if we can identify people with early symptoms of these disorders then we could intervene to reduce self-medication with alcohol and other drugs.

Irrespective of order of onset, a number of barriers make it difficult for people with co-occurring disorders to receive effective prevention programs and treatment.

4.0 Barriers to Treatment

A significant barrier to treatment and the prevention of further harm from co-occurring disorders is that, although they are recognised as a significant challenge facing the Australian health system, effective models for prevention and treatment are rare. According to Deady et al.,

"Despite a great deal of work in this area in the past 10 years, single disorder treatment models remain dominant. The silo structure of the healthcare system has historically treated clients in sequence of disorder (based on which is considered primary), or in parallel by different treatment providers. Recent evidence suggests that integration of treatment is ideal for optimal client outcomes and to avoid clients falling through the gaps."[34]

32 SANE Australia, 'Smoking & Mental Illness', SANE Australia, 11 August 2015, https://www.sane.org/information-stories/facts-and-guides/smoking-and-mental-illness.

33 American Addiction Centre, 'Co-Occurring Disorder (Dual Diagnosis) Treatment & Substance Abuse', American Addiction Centers, 15 May 2020, https://americanaddictioncenters.org/co-occurring-disorders.

34 Mark Deady et al., 'Evidence Check: Comorbid Mental Illness and Illicit Substance Use' (Sax Institute, December 2014), https://www.saxinstitute.org.au/wp-content/uploads/Comorbid-mental-illness-and-illicit-substance-use.pdf.

This is also the case for prevention strategies which must be holistic and tailored to individual difference to be truly effective. Other barriers include:

- In an environment of already limited access to treatment, care and referral programs, there is often confusion and lack of knowledge about where to go to receive treatment or support. Prevention of further complicating and worsening a person's situation relies on timely screening and referral. In a submission to the Royal Commission into Victoria's Mental Health System, it is noted that "there is strong evidence of poor access to treatment for either mental health and substance use concerns. Access is further compromised when a person has both disorders. A long-standing, often identified, issue occurs when a person assessed by mental health services receives feedback that before receiving any mental health service they first need to address their substance use - only then to be told by AOD services that [they] first need to address their mental health concerns… thus falling through the gaps receiving no treatment from either service." [35]
- There is evidence of inconsistent clinical and support practices across both the public and the community services sector with low numbers of practitioners skilled in co-occurring disorders. Back in 2006, a Commonwealth Senate report declared that "*A national commitment to build skills among service providers in both mental health and ATOD services is vital if 'services silos' are to be broken down. This would involve investment in widespread upgrading of the skills base, with a focus on cross-skilling of health professionals to support service integration. Specialist staff and services could be developed within this framework, but should not dominate in a third service tier.*" [36] It appears that progress has been slow in this regard and that many jurisdictions, including Tasmania have not yet attained this goal.
- A fear of being committed to a psychiatric hospital or being forced to take medications.
- Fear of being stigmatised. One study[37] found that concerns about views of other people were a more significant barrier to substance use conditions than mental health treatments.
- The concern that the use of ATOD services may be more stigmatising. Negative views regarding ATOD services have traditionally been among the major reasons for not using these services. Integration of ATOD services in mental health or physical health services may help to overcome this barrier. [38]

It must be noted that the psychological, social and physical contexts of substance use and mental health conditions are quite different for women as opposed to men. Women need help to overcome personal barriers to treatment such as shame and motivation.[39] The increased stigma associated with female substance use (particularly among those who are pregnant or have children) is likely to result in greater guilt and shame. This stigma may lead some women to delay seeking help, so that their substance use problem may become quite severe and mental health issues may progress before they can access help.

5.0 Conclusion

There is a precedent for implementing a complexity capable system for supporting people with co-occurring disorders. DEN suggests that there is an opportunity for the ATOD and community sectors to work collaboratively with government to improve the systems that underpin this important work.

Key areas where DEN can contribute to this work include: developing and delivering training, continuing to educate and resource the ATOD and community sectors in current evidence based PPEI approaches and providing Brief Intervention training that helps providers screen for co-occurring disorders.

The consultation undertaken by Primary Health Tasmania to inform its commissioning intentions for ATOD treatment services resulted in key issues and themes being identified, including "*The need for service coordination for clients with co-occurring alcohol and other drug issues and mental health problems.*" [40]

35 Gary Croton, 2019

36 Canberra corporateName=Commonwealth Parliament; address=Parliament House, 'Chapter 14 - Dual Diagnosis 'The Expectation Not the Exception', Mental Health (2006), https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/report/c14.

37 Ramin Mojtabai et al., 'Comparing Barriers to Mental Health Treatment and Substance Use Disorder Treatment among Individuals with Comorbid Major Depression and Substance Use Disorders', Journal of Substance Abuse Treatment 46, no. 2 (February 2014): 268–73, https://doi.org/10.1016/j.jsat.2013.07.012.

38 Ibid.

39 Shelly F. Greenfield et al., 'Substance Abuse in Women', Psychiatric Clinics of North America, Women's Mental Health, 33, no. 2 (1 June 2010): 339–55, https://doi.org/10.1016/j.psc.2010.01.004.

40 Primary Health Tasmania, 'Alcohol and Other Drug Treatment Services: For the Tasmanian Community Including Aboriginal and Torres Strait Islander Peoples - Commissioning Intentions Document Version 1.0', 2018, https://www.primaryhealthtas.com.au/wp-content/uploads/2018/09/Alcohol-and-other-Drug-Treatment-Services-Commissioning-Intentions.pdf.

It is not uncommon for the issue to be described as the responsibility of service providers.

> *"Meeting the requirements of people with co-occurring problems continues to be a challenge for some mental health and AOD services. It is essential that staff work together across primary care, community and hospital-based services and across the health and human service sectors in an integrated, coordinated way to improve consumer, family and carer service experience and outcomes."*[41]

Integrating services requires that professionals from multiple fields learn to work together and in general, interprofessional dynamics play an important role in the process.

In its National 2013 Report Card on Mental Health and Suicide Prevention, the Australian National Mental Health Commission highlighted the importance of integrating care for this population. Specifically, it is stated that individuals with co-occurring substance use and mental health conditions "*must be responded to in a comprehensive, integrated way wherever they present*" (recommendation 11). The report acknowledged that "*workers are often not supported to work in this way*" because of "*siloed structures, inadequate funding, or constraints on professional development and supervision*".[42]

In conclusion, the Commission calls for mechanisms to test compliance with 'no wrong door' practices, innovative and non-discriminatory responses encouraging the integration of services, and for funding and policy to facilitate these actions.

To achieve such a system, it is critical to increase the capacity and capability of the generalist health workforce to respond appropriately to individuals with co-occurring substance use and mental health conditions and their families and carers. It is also important that training is funded to equip workers who have a particular mental health or ATOD focus - the staff in mental health and ATOD services – with the co-competent knowledge and skills necessary to identify and respond appropriately to clients with co-occurring conditions and their families and carers. It is not only important for this workforce to be competent in responding to co-occurring conditions but to also have an ability to effectively work with priority groups, such as youth, the ageing population, and Aboriginal and Torres Strait Islander peoples and communities. This training should also take into account the requirements of staff in different service settings across the prevention and treatment continuum (community, residential, acute inpatient/ withdrawal).

41 Mental Health Commission 2018

42 National Mental Health Commission 2013

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