Thriving, not just surviving:

One person, diverse needs:
Living with a mental illness as well as the challenges from difficulties with alcohol and drug use

Lani, Queensland

I was diagnosed with bipolar 2 and ADHD in 2006. I was 24 then. After going through an extreme manic episode, I knew I needed help. And fast.

When I look back on the years preceding my diagnosis, there were big warning signs I wasn’t well. From the age of 16, my head suddenly began to operate independently of what I wanted it to do. I now understand that was bipolar. Back then I thought it was normal.

So I began to self-medicate. A treatment plan I devised myself; so dangerous to someone with mental health issues.

Over the next eight years, I struggled with alcohol and drug use. I couldn’t just drink a few drinks. I had to wipe myself out. For that was my intention always. I didn’t want to feel the hurt from depression and I wanted to numb the confusion and anxiety of hypomania.

The comedowns were horrific but that brief moment of escape made it seem worthwhile.

Until I kept going down, down, down. I’m now on an extensive treatment plan that includes medication, therapy, being mindful and working with my amazing husband, family and friends. I have two degrees, about to start my Masters, a great job and am leading a life I’m proud of.

I’ve found that doing the things I love helps greatly. For me that includes writing, reading, study, sport and music. I still have my down days, my up days and my all over the shop days. But doing the things I love regularly keeps me excited, engaged, and looking to the future.

I have to confront my mental illness by managing it every day. It doesn’t own me. I can own it. I no longer just want to survive. I want to thrive.

I choose happiness. I choose health. I choose life.

Watch Lani’s video at www.mentalhealthcommission.gov.au
Thriving, not just surviving

Introduction

The Commission recognises that the ability to live a contributing life is hindered for many people who live with the combination of drug and alcohol problems and mental illness.

The effects of experiencing both problems in tandem can be devastating for people, their families and supporters. People living with this mix of difficulties are discriminated against and are often judged and marginalised from services and the community.

They will have major challenges in their life and the social and health impacts of both problems are huge. People will most often start to use substances in adolescence, a time which is usually for forming identity, establishing relationships and completing education.

People with mental illness and substance use disorder will have their life expectancy reduced by up to 30 years and are twice as likely to smoke as the general population.

Although they have a high need for both physical and mental health support they will be reluctant to walk into a health service and ask for help.

People with this combination of problems will also be more likely to experience suicidal thoughts.

This is a tragedy.

The Commission wants to emphasise that substance use disorder is an illness – like cancer or heart disease. People with this illness should have the same human rights and should have the same access to appropriate health care and treatment as people who have physical health problems.

We have heard that this is not the case.

People with this mix of problems and their families and supporters will knock on many doors for help. They might ask for a safe place to sleep or help with money, for help with addiction or legal advice. It is essential that every door which is knocked on is a door which can lead to the right pathway to support, care and treatment.

We have heard that there is often nothing behind the door from people and their families.

In this chapter we will shine a light on the challenges faced by people who experience co-existing mental health and drug and alcohol use. We will look beyond policy and research, where much progress has already been made, towards the call for development of new models of care where much potential can be realised to change lives.

What we know

We know that in a year, almost 340,000 Australians will have both mental illness and a substance use disorder. Many will have their needs met from local supports whether it be a mental health or drug and alcohol service, or by their GP.

Here we focus on people living with a mental illness who are most significantly affected by substance use. We use the term ‘substance use disorder’ to describe their illness.

For many people, challenges at school, early exposure to drug use, difficult family relationships, a lack of community cohesion and poverty can lead to problems with drugs and alcohol.

We know that a large number of people who have a mental illness will use substances at some stage, and vice versa.

This may not be at a level that is problematic or needs a specialist alcohol and drug service. Many will have their needs met from local supports whether it be a mental health or drug and alcohol service, or by their GP.

We know that misuse of different drugs affects people in different ways and has variable health and social impacts. For example, 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 (refer Figure 1).

Figure 1: Percentage of people who have ever been homeless or in a correctional facility, by mental health status

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Our emergency services are heavily impacted by alcohol and drug misuse. Recent data from the Victorian Ambulance Service shows that of 5,993 callouts to people with depression between June 2012 and May 2013, alcohol was involved in 29 per cent, with drug use being present in 38 per cent.54

The range of effects of different drugs and the impacts on people and communities needs to be recognised and understood:

- People with a mental illness are twice as likely to smoke.69 Nicotine addiction is often overlooked when talking about co-existing mental illness and substance use disorder, but remains a major cause of death and illness in Australia, with people living with a mental illness smoking at higher rates compared to the general community.69

- For people with psychosis, their lives are more likely to be affected by problematic substance use across their lifetime in comparison to people without psychosis.65 Figure 2 shows the disproportionate use of alcohol, drugs and nicotine by people living with psychosis compared to the general population.

- Long-term cannabis use is common in people experiencing mental illness, in particular for those with psychosis.66 Prolonged use has been associated with psychotic symptoms.56

- There is a strong association between methamphetamine ("ice" or "crystal meth") use and psychosis, with some studies showing that the prevalence of psychosis in methamphetamine users is 11 times higher than in the general population.67

- There is an association between completed suicide and alcohol consumption58.

- We know that excessive alcohol consumption is associated with physical health problems such as cardiovascular disease, liver disease and diabetes. We know advances have been made in research about treatment approaches for co-existing conditions and we recognise that many services promote a principle of shared care or ‘no wrong door approach’.

But we hear this has made little difference to the lives of people and their families. Of great concern, is that despite the high health needs of these people, we know that use of health care services is no greater by people with co-existing disorders than those who live with a mental illness alone. Despite isolated examples of good practice, estimates show that only seven per cent of people with a co-existing mental illness and substance use disorder will receive treatment for both problems.60

We know that delay and reluctance to seek treatment places great stress on families and support people – as does the reliance on them to navigate a fragmented system. As a result, families and support people often experience financial hardship, compromised emotional and physical health, risks to personal safety and family conflict.61

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Good practice means an end to leaving it to people and their supporters to take responsibility for co-ordinating different elements of care. It means meeting peoples’ needs in the first instance and stopping the revolving door.

A number of therapeutic communities, such as We Help Ourselves, Odyssey House and Ted Noffs’ PALM program, although set up and funded primarily to assist people with drug and alcohol addiction, do not discriminate against those with co-existing difficulties and will arrange concurrent treatment as part of the person’s care. Lyndon Community in Orange, New South Wales shows promising practice and the integration of physical and mental health wellbeing programs, drug and alcohol treatment and principles of mental health recovery in the one place. We know that there are other organisations providing flexible and integrated care to improve access to treatment for people with co-existing conditions, and it is more of these approaches that are needed.

Clinical treatment guidelines have also been developed, including those on the management of co-existing alcohol and other drug and mental health conditions.

Despite the advances in research, there is comparatively little evidence of true integration of care occurring at the coal face. We know that the problems that people face with co-existing mental illness and substance use disorder are far reaching. There is often no quick fix. For this reason, the most promising practices are those which address a person’s whole-of-life needs concurrently, rather than addressing one at a time.

This means working with the person; meeting them where they are, for example, providing assertive outreach to people who are homeless, or addressing their needs within the service where they first seek help. When a person arrives at a service, a thorough assessment of the substance use should precede any treatment. This should look at the impact of the substance use on the person’s relationships, work, leisure, accommodation, physical health and harm. Consideration should be given to the person’s motivation and preference for what they think should be the next step in their recovery journey.

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‘I would make it so that people don’t have to all fit into a box (in terms of their mental illness). As I think there are a lot of areas in between that aren’t catered for.’

Good practice gets a tick from the Commission.

What the evidence shows is good practice

The National Co-morbidity Project has made great strides in identifying good practice.
Some potential models are:

• Nominating a liaison person to work between drug and alcohol services and mental health services to develop clear pathways in local areas. This can nurture improved communications, referral protocols and joint approaches.

• Augmenting mental health teams with a specialist drug and alcohol worker who is still able to access professional support in their original discipline and is able to retain their skills and expertise, and vice versa. It is important that this worker does not become a case manager, but is used for up-skilling colleagues and for specialist interventions.

• Creating a specialist integrated team with professionals and leadership across both disciplines.

A recent study looked at 17 Australian ‘co-morbidity services’ considered to represent good practice. This found that whichever model is used, it is vital that there is flexibility in the way support is provided to each person because of the complexity of this set of needs.

Supporting a brother

For people living with co-existing mental illness and substance use disorder, navigating daily life is challenging enough without having to put up with encountering support services which don’t communicate with each other.

This means people have to repeat their story again and again and only one aspect of their illnesses are dealt with. They face different eligibility criteria, referral systems and paperwork.

A ‘no wrong door’ approach underpins Australian health policy for services supporting those with co-existing problems. In practice, this means that every door in the public support service system should be the right door with a range of services being accessible to everyone from multiple points of entry. This commits all services to respond to the individual’s needs through either providing direct services for both their mental health and drug and alcohol problems or linkage and case co-ordination, rather than sending a person from one agency to another.

However, we continue to hear about separate systems, with workers not having sufficient time or resources to do further work beyond only the assessment of co-existing mental illness and substance use disorder. Nonetheless, it is widely recognised that working with people with co-existing disorders is core business of both drug and alcohol and mental health services, and this should be the expectation rather than the exception.

We are not talking about small numbers. One in ten people with a mental health disorder have a co-existing substance use disorder. It is incomprehensible that services and supports may operate without this dual perspective.

There are a number of options that embody the ‘no wrong door’ ethos and have the potential to change outcomes. Integrated care does not necessarily mean integrated funding or a specialist service.

Some potential models are:

• Nominating a liaison person to work between drug and alcohol services and mental health services to develop clear pathways in local areas. This can nurture improved communications, referral protocols and joint approaches.

“Reduce the form-filling and referral run-around. Reduce the emails and phone calls. Reduce the red tape. Reduce the intrusive questions from the next professional and the next professional, when you have done it all before over and over again.”

Spotlight issue

‘No wrong door – or is there nothing behind it?’
Supporting a brother

What it means for Kristine, New South Wales

My brother was a son, a husband, a father, a grandfather, and a pastor. This story is about how his life ended tragically after many, many years of service providers passing the buck and not assisting him for both his mental illness and his alcohol use.

There were numerous occasions when he was admitted to hospital with physical injuries. Each time he was admitted we tried to get help for his mental health as well, but he was discharged on his word. He presented with the smell of alcohol on his clothes and was labelled a ‘drunk’.

One day he attended court to answer a drink driving charge. He was drunk. The judge said he did not know what to do with him and decided to send him to prison. After prison he went to rehab to treat his alcohol abuse.

He passed out at the Rehab Centre and by the time the ambulance arrived he had recovered consciousness. The rehab would not allow him back if he was put on medication for his mental health.

When he arrived at the hospital the staff assessed him and asked him if he was a threat to himself. He said ‘no’ so they waited for a doctor.

He wanted to call his wife, using their phone because he had not brought any money with him from rehab, but they refused.

My brother had issues with alcohol his whole life and because of this he was denied services which could have helped him with his mental illness. He took his own life while at the hospital because he couldn’t get the help he needed.

I believe service providers need to treat mental illness, physical health and drug and alcohol use together. Not separately.

Watch Kristine’s video at www.mentalhealthcommission.gov.au
What we don’t know

Where we need more evidence and to shine a light

It is clear that there is a close and often complex relationship between mental illness and substance misuse. The nature of the relationship and the pathways to mental illness from drug use is not clearly understood; however, Australia has made advances in this area of research. Some common theories are as follows:

The first theory is that mental health problems contribute to problems with alcohol and other drugs. For example, alcohol can be used to relieve feelings of anxiety prior to a social occasion. Over time, the alcohol becomes relied upon and problems can develop.

The relationship may also work in the other direction. An accumulation of loss, exposure to trauma and difficult circumstances due to prolonged alcohol and drug use may contribute to the development of depression and Post Traumatic Stress Disorder (PTSD) in particular. Research has shown that acute alcohol use is associated with suicide. More studies are needed to develop treatments for specific combinations of different disorders. The approach for co-existing schizophrenia and cannabis use will differ from that for co-existing PTSD and alcohol use disorder. In most treatment studies, people with multiple disorders tend to be excluded as it is recognised that poor outcomes are more likely where disorders co-exist. Integrated treatments for PTSD and substance use disorders have been developed and trialled with a number of concurrent treatment approaches showing promise.

Alcohol dependence has also been shown to be associated with suicidal behaviour.

The third explanation is that both mental illness and substance use problems arise from the same environmental factors and from genetic sources. Studies examining the relative influence of these three theories tend to support the third explanation most strongly. It may well be that the role of different pathways is variable between people and between specific combinations of disorders.

Progress in research into co-existing mental illness and substance use disorder are yet to flow in to practice. Many misconceptions still persist, such as that the treatment of the primary disorder may resolve the secondary disorder; there can be a reluctance of professionals to treat both issues at the same time.

We need more evidence as to what types of services and interventions could best meet the needs of this group of Australians and at what point a person with both problems would require help from a specialist service.

Many people who require help with substance misuse can experience symptoms of depression or anxiety. They may not need specialist support for both issues. Integrating services therefore requires further research and a clear definition of who would be eligible for and in need of such services.

More work is needed on how different professions work together in an integrated team, while respecting the others’ specialist experience, and ensuring adequate access to professional development and supervision.

We know that a few integrated models internationally exist to provide services to people with co-existing mental illness and substance use disorder, yet their long-term effectiveness and appropriateness for use in Australia has not been tested.

We do not know if current programs are meeting the needs of Aboriginal and Torres Strait Islander peoples, CALD populations and LGBTI communities or whether integration on its own would respond to the needs of these diverse populations. Further exploration of mental health literacy in diverse populations is needed to ensure culturally appropriate service planning.

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Helping people with drug and alcohol problems to thrive

What it means for Rod, New South Wales

I work at The Lyndon Community where we provide alcohol and other drug treatment in both residential and non-residential programs. We’ve been doing this for over 30 years and have a range of services, including withdrawal, rehabilitation and outreach.

We see a lot of people with co-existing mental health and drug and alcohol problems. Sometimes it’s difficult to work out the root cause of a person’s suffering.

People are complicated. There is no rule that says they can have just one problem. Labels do not help people unless they are correct and the person themselves sees the benefit in being diagnosed.

It’s also vital that they have an effective management plan that will help them achieve positive outcomes for the future.

As an Addiction Medical Specialist at The Lyndon Community for the past 12 years, I’ve come to believe that professionals really need to work in a holistic manner to ensure service delivery is not fragmented for those in need.

I’ve seen many positive changes in the mental health sector over the years. Evidence-based practice has improved significantly along with better staff education, enhanced liaison with professionals including social workers and psychologists, and improved staff education at all levels starting from those on the ground.

Better integration of mental health concerns into the drug and alcohol services has made a huge difference too. There’s also more awareness of latest research into how drugs and alcohol can potentially affect clients dealing with mental health issues.

Working at The Lyndon Community gives me hope for the future. I believe there is a real positive in up-skilling our staff in current research and education, which leads to improved help for our clients. I also believe the flexibility we have as an NGO is excellent. It places us in a unique position to be able to work with individuals on a needs basis. This has seen us engage with smaller populations of people who don’t access mainstream services.

Watch Rod’s video at www.mentalhealthcommission.gov.au
**Where the Commission is looking for continuous improvement**

We have basic information about the prevalence of co-existing mental illness and substance use disorder in Australia.

Part of the problem is that in research, people are often asked if they experience any mental health, alcohol and/or drug use problems in a single question. This makes it impossible to identify people with co-existing mental illness and substance misuse. The Commission calls for development of such data as a basic requirement for service development and improved integration.

We know that primary care is often the first point of contact for many people with co-existing mental health difficulties and substance misuse problems, with estimates showing that around two people per day in an average General Practice are presenting with co-existing mental illness and drug use. This is a significant opportunity, and improvements could be made to better support GPs to identify issues early and deliver or refer people to supports.

Good case management, appropriate clinical supervision and access to expertise in dealing with both mental health difficulties and substance misuse problems can help support services to identify and meet the needs of those affected. The Commission looks for advancement in this area as well as the testing of new support models and innovative practices to provide integrated care.

We need greater recognition of co-existing mental illness and substance use problems experienced by people in contact with the criminal justice system. More insight is being gained into the mental health and wellbeing of prisoners with the National Prisoner Health Surveys. Unfortunately, the data collection tool does not as yet allow for identification of co-existing conditions.

An integrated treatment approach while in prison and subsequent co-ordinated health and social services on release from prison could not only reduce the impact of their illnesses on the person but also has the potential to reduce re-offending. Diversion of people to programs such as the New South Wales Drug Court, have been effective in reducing recidivism. The Commission welcomes more innovation and development in this area.

People with mental illness and co-existing substance use problems are heavy users of a number of public services such as housing, Centrelink and primary health care. Using multiple support services requires repeated form-filling to provide the same information to every service. We would welcome solutions to these burdens for people who are often living in chaos.

Although research has advanced and a number of services in Australia show promising practice, it is relatively hard to find truly integrated care models that consider the whole person and their full range of needs. Further exploration and implementation of flexible models to suit the demands of specific communities is vital.

The Commission looks for urgent and rapid improvement in this area, given the unacceptably poor health and social outcomes for people who experience mental illness and substance use disorder, and their families.