Executive summary

Rapid Evidence Review: The relationship between alcohol and mental health problems

August 2019

Key findings

- There is a strong multi directional link between alcohol use disorders (AuDs) and mental health disorders which is reflected in the high level of complex needs experienced by the service user grouping.
- Rates of co-occurring substance use and mental health disorders range from 30-85%, according to the measures used and the sub group settings in which they are assessed.
- The variance in prevalence is also mirrored in the range of service delivery models which address the needs of those with co morbid conditions. However, three models are consistently referred to in the literature; serial, parallel and integrated.
- The literature also identifies inconsistencies in regional and UK policy and guidance for working with co morbid AuDs and mental health disorders with gaps in policy and guidance most evident for England and Northern Ireland.
- The development of a UK national policy framework for working with co morbid mental health and substance use disorders is overdue and should specifically address the issues of morbidities related to AuDs.
- A review of interventions indicated some level of success for cognitive behavioural interventions in the treatment of comorbid AuDs and mental health disorders.
- It was also clear that combinations of drug therapies for comorbid AuDs and mental health disorders showed successful outcomes, specifically those which incorporated Naltrexone and Disulfiram in the treatment arm of the studies. Conversely, there were less successful outcomes recorded for singular drug treatments such as Acamprosate.
- The majority of the studies in the review showed evidence of weak research design, including lack of detail as regards appropriate control groups, randomisation and concealment and a reliance on small sample sizes.
- Further methodologically rigorous research is needed to examine the effectiveness of pharmacological and psychosocial treatments for comorbid AuDs and mental health disorders.

Research team

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Background

The relationship between mental health disorders and alcohol misuse is complex, with the potential for multiple variations of diagnoses and mutually dependent problems (Baigent, 2012). There is a level of inconsistency in the definitions of comorbid mental health and co-occurring substance use disorders including Alcohol use Disorders (AuDs). In addition, there are multi-faceted and complex associations between AuDs and the various psychiatric disorders and these relationships are nuanced in terms of direction and symptomology. The term 'dual diagnosis' implies that there are only two clinical problem areas, when in fact there are usually several, all of which are specific to the individual are manifest in varying and multiple combinations. These may include a range of domains, including personal, familial and social, physical health, mental and emotional health, and involvement in the criminal justice system and accommodation. Therefore, it may be more useful to conceptualise this group as having 'complex needs' and subsequently reflect on working models and strategies which are flexible and tailored to the needs of the individual.

The high prevalence of coexisting mental health and substance use problems within mental health services is recorded in a number of studies in the United Kingdom (UK). The rates of co-occurring disorders recorded within UK mental health and addiction services vary between 30 and 85% (Schulte, 2008; Weaver et al., 2003; NICE, 2016) Evidence from a NICE review of prevalence of co-occurring conditions across secondary mental health settings indicated that the prevalence rate of co-occurring disorders was 34.3%, although due to heterogeneity of the sample it was stated that the result should be treated with caution (NICE, 2016). In order to respond to the myriad of problems engendered by comorbid AuDs and mental health disorders, a combination of service models have been developed in the UK and on an international basis. The majority of models of service delivery can be categorised as serial, parallel or integrated with the latter viewed as the most beneficial for service users and patients. Furthermore, interventions are also characterised by the many and varied range of pharmacological and psychosocial treatment modalities. Therefore, this review sought to provide an overview of policy, service delivery and treatment models to consider the context of treatment and the effectiveness of interventions relevant to individuals with comorbid conditions.

Aims

The Rapid Evidence Assessment (REA) considered two primary research aims:

1. To examine the effectiveness of psychosocial and pharmacological interventions for adults (18+) with comorbid alcohol use and mental health problems.
2. To identify the general policy framework for co-occurring substance use disorders and Alcohol Use Disorders (AuDs), assessment models, care plans and guidelines for practice within the UK. In addition, there was a specific focus on models of treatment delivery within the UK and international contexts.

Methods

A dualistic approach to the review was employed in accordance with the two primary aims of the review. First, a rapid review employing a systematic approach to searching, appraising and reviewing the results was used to identify the evidence base as regards interventions for comorbid alcohol use disorders and mental health disorders. Second, there was a broad literature review of UK policy frameworks and guidance documents which considered assessment and care planning and models of treatment service delivery in the UK. The section was augmented with international literature from the United States and European sources.

Findings

Findings suggest that there is a strong association between AuDs and mental health disorders including: depression, anxiety, bipolar disorder, personality disorder and schizophrenia. Across the UK, in the policy framework for substance use disorders and mental health comorbidity is inconsistent and is even more fragmented as regards alcohol-specific co-occurring disorders. In England, the last comprehensive guide to policy and practice was published by the Department of Health in 2002, whilst in Northern Ireland there has been a gap in specific policy guidance for comorbid substance use and mental health disorders since 2005. However, the Welsh government produced a recent comprehensive policy framework which addressed the specific needs of people with comorbid disorders in 2015. Similarly, Scotland may not have a recent specific policy framework document related to comorbidities but it does make a substantial reference to comorbid disorders in a number of mental health and alcohol policy frameworks (Scotland Mental Health Strategy 2017-2027, Scottish Government 2018, Alcohol framework, 2018).

According to the evidence, all levels of assessment and care planning in working with comorbid disorders must be tailored to the complex individual needs of the service user (and carers where appropriate), be developed in full partnership with the service user (where possible) and founded on a non-judgemental, empathic and person-centred approach. In addition, shunting of service users between mental health and substance disorder services is often apparent with a lack of clarity about case management responsibility. NICE (2016) guidance also recommends that initial goals for alcohol and mental health comorbidities may be agreed on the basis of a harm reduction approach but that the ultimate goal for this specific service user grouping should be abstinence.

Three models of service delivery were identified from the literature: serial, parallel and integrated. Whilst the integrated service model demonstrates more efficacious treatment outcomes (Mangrum et al., 2005; Muser et al., 2003; McCoy et al., 2003), it is not entirely clear how many treatment providers in the UK currently provide an integrated service for concomitant AuDs and mental health disorders. However, there is the suggestion that the majority of treatment models in the UK and the United States tend to work within the parameters of the serial and parallel models. In Europe there is substantial heterogeneity in the range of treatment models offered for co-existing disorders, although it is noted that the wide range of options may also act as barrier to treatment provision as some providers may lack the skills and expertise to address the needs incurred by both AuDs and mental health disorders.

Results from the current rapid structured review of interventions for alcohol use problems/disorders and comorbid mental health conditions showed mixed results for both pharmacological and psychosocial intervention studies. Naltrexone was the most commonly administered pharmacological intervention, and was most beneficial when combined with other drugs (for example Sertraline and Disulfiram) than when used alone. The combination was successful at treating alcohol use and psychiatric symptoms compared to placebo (Petrakis et al., 2005, Pettinati et al., 2011). Similar to Naltrexone, when Sertraline was used alone it was less successful at treating comorbid conditions (Gual et al., 2003). In addition, combinations of lorazepam and Dilsulfiram demonstrated promising outcomes with reductions in alcohol use and psychiatric symptoms. Conversely, single application of Acamprosate was reported to be the least effective in the treatment of comorbid conditions (Tolliver et al., 2012; Ralevski et al., 2011). Whilst the majority of the studies were randomised controlled trials, there was some evidence of methodological design flaws, including lack of appropriate control groups, small sample sizes and high attrition rates.

Cognitive behavioural therapy (CBT) was reported as an effective psychosocial intervention in treating at least one aspect of comorbid problematic alcohol use and psychiatric conditions (Toneatto & Calderwood, 2015; Morely et al., 2016; Brown et al., 2011). Moreover, computer-based CBT outcomes were similar, if not more effective than therapist-based CBT for a reduction in depressive symptoms and alcohol use (Agyapong et al., 2013; Deady et al., 2016; Kay-Lambkin et al., 2008) and a non-significant reduction in alcohol-related problems only (Geisner et al., 2016). On the other hand, outcomes from a motivational interviewing based intervention were not significantly different when compared to a ‘brief advice’ intervention. However, both groups experienced improvements in comorbid conditions. Only one study reported a specific integrated intervention administrating a pharmacological agent and psychosocial support. Although it reported a small sample and no control or comparison group, Lamotrigine and an individual relapse prevention programme demonstrated a significant reduction in problematic alcohol use and psychiatric symptoms.

Conclusion

Results from both the policy/guidance and interventions components of the review indicate the complex issues and the problems faced by vulnerable individuals who have comorbid AuDs and mental health disorders. It is clear that the multi-faceted problems reach far beyond the dual diagnosis label to include many and varied combinations of mental and physical health problems. National and regional UK Governments have tried to address some of the complex and multi-layered issues via a number of policy framework and guidance documents. The somewhat sporadic UK Government documentation on co-occurring disorders has been usefully supplemented by published material from expert commentators, practitioners and community-based or voluntary sector mental health and substance use disorder organisations. From the policy review it is clear that the development of a UK national policy framework for working with comorbid mental health and substance use disorders is overdue and should specifically address the issues of morbidities related to AuDs. In addition, whilst the interventions review indicated some level of success for CBT, and other psychosocial and mixed modality drug interventions as treatment options for comorbid AuDs and mental health disorders, it is apparent that the majority of studies are marred by weak research design. It is also clear that studies with high-quality design and rigorous methodological approaches should be developed to examine the efficacy of pharmacological, psychosocial and integrated treatments for comorbid disorders.

This report was funded by **Alcohol Change UK**. Alcohol Change UK works to significantly reduce serious alcohol harm in the UK. We create evidence-driven change by working towards five key changes: improved knowledge, better policies and regulation, shifted cultural norms, improved drinking behaviours, and more and better support and treatment.

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