

The Difference is Research



National **comorbidity** guidelines: Guidelines on the management of **co-occurring** alcohol and other drug and mental health conditions in alcohol and other drug treatment settings

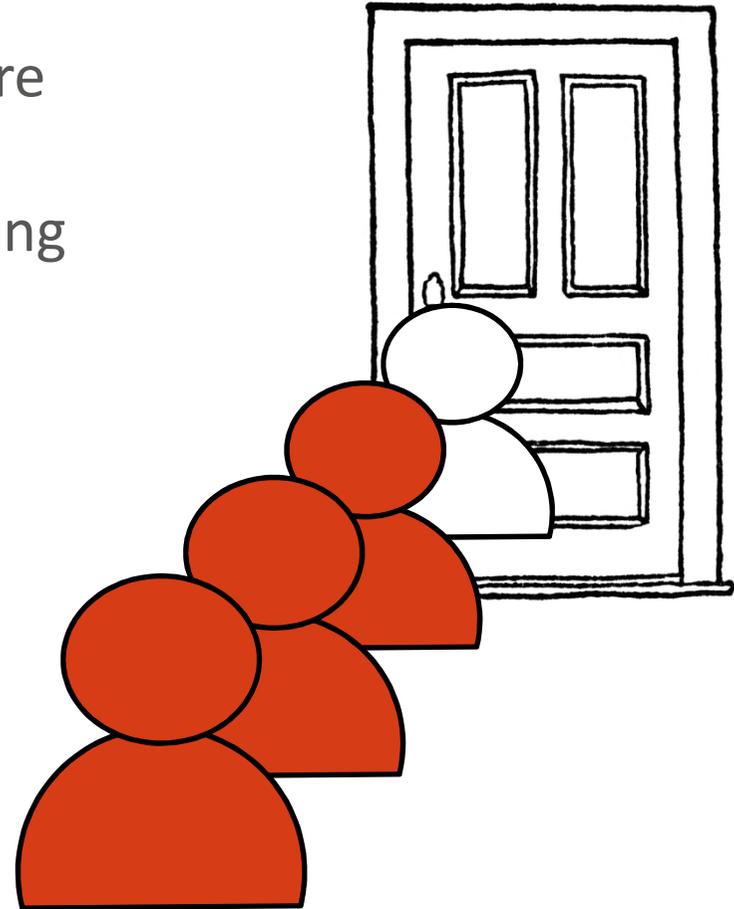
Medicine

National Drug and Alcohol Research Centre

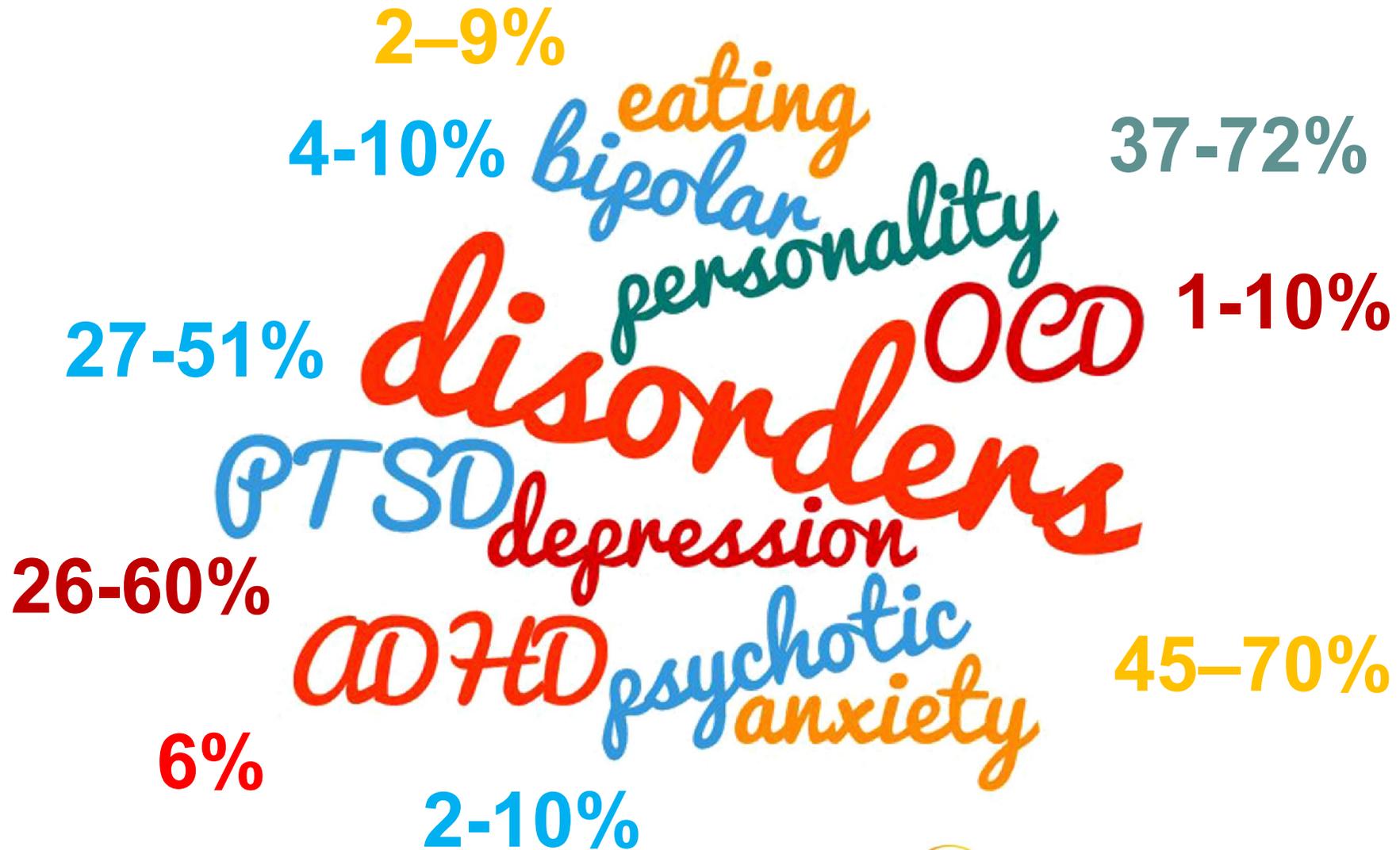
Dr Christina Marel, A/Prof Katherine Mills, Dr Rosemary Kingston, Prof Kevin Gournay, Dr Mark Deady, A/Prof Frances Kay-Lambkin, Prof Amanda Baker, Prof Maree Teesson & Mr Jack Wilson

How common is *comorbidity*?

- Mental and substance use disorders are two of Australia's most common and burdensome health conditions, affecting 1 in 5 each year
- They frequently co-occur
- Estimated that up to $\frac{3}{4}$ of entrants to AOD treatment have a co-occurring mental health condition



How common is *comorbidity*?



How common is *comorbidity*?

- The number of potential combinations of disorders and symptoms is infinite
- There are a large number of people who present to AOD treatment who display *symptoms* of disorders while not meeting criteria for a *diagnosis* of a disorder
- Although may not meet full diagnostic criteria according to the classification systems their symptoms may nonetheless impact significantly on functioning and treatment outcomes



Why is *comorbidity* of concern?

- Complex trauma histories
- Poorer physical and mental health
- Poorer social, occupational and interpersonal functioning
- More severe and extensive drug use histories
- Increased risk of self-harm and suicide



People with mental or substance use disorders die an astonishing 20 - 30yrs earlier than the general population, and spend the last 10yrs of life living with disabling chronic illnesses



Why is *comorbidity* of concern?

- Once established, both disorders serve to maintain and exacerbate the other
- Complicating treatment and recovery



Why the need for comorbidity *guidelines*?

- Care fractured and disconnected
- Bounced between services with little continuity of coordination of care
- “Fall between the cracks” of our health system



Comorbidity is not an insurmountable barrier to treating people with AOD use disorders... research has shown that clients with comorbid mental health conditions can benefit just as much as those without comorbid conditions from usual AOD treatment



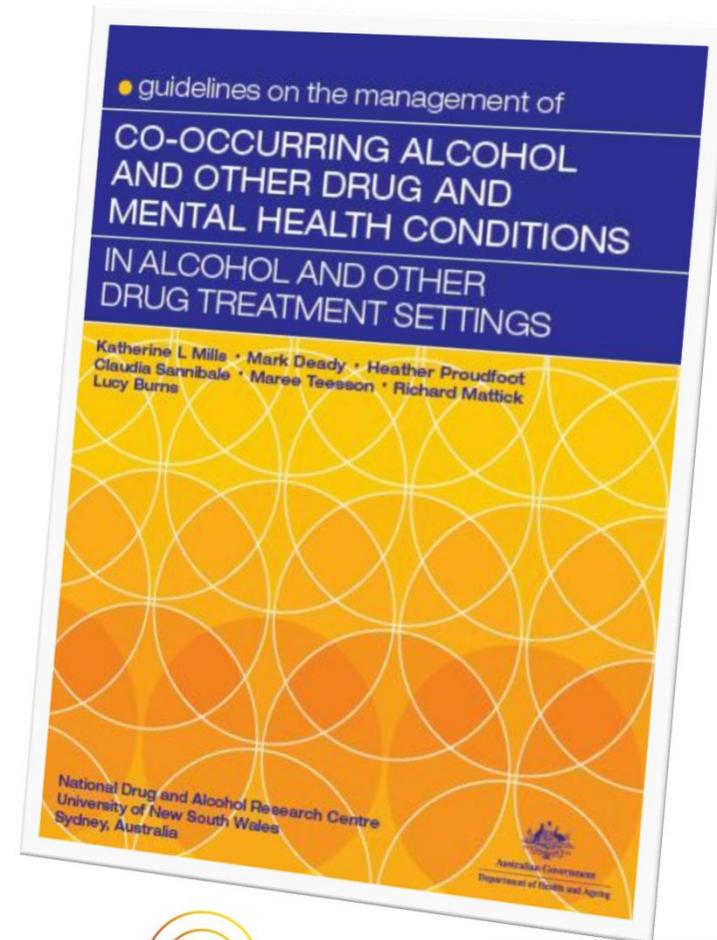
Why the need for comorbidity *guidelines*?

- Victorian review reported that AOD workers felt overwhelmed and fearful when treating people with comorbid mental health disorders, as their knowledge and the resources available to them were inadequate
- Need for AOD workers to have access to educational resources identified as priority by numerous reviews and policy documents, as well as by AOD workers themselves
- In terms of AOD workforce development, 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’

National Comorbidity Guidelines

- In 2007, the Australian Government Department of Health and Ageing funded development of the Comorbidity Guidelines as part of the Comorbidity Initiative:
 - Katherine Mills
 - Mark Deady
 - Heather Proudfoot
 - Claudia Sannibale
 - Maree Teesson
 - Richard Mattick
 - Lucy Burns
- Published 2009



Intended audience

- Developed primarily for AOD workers – all those who work in AOD treatment settings in a clinical capacity
- AOD treatment settings are those specialised services specifically designed for the treatment of AOD problems
- Services may be in the government or non-government sector



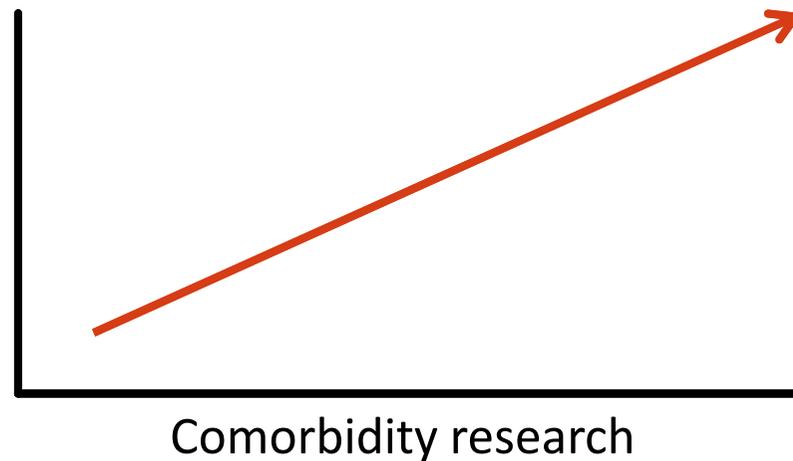
Comorbidity Guidelines: 1st edition

- >15,700 hard- and electronic copies disseminated across Australia
- Training rolled out nationally
- An evaluation found that the majority of clinicians perceived that the Guidelines were both useful and relevant in their clinical practice, and impacted on clinical decision making
- Recommended text for TAFE and university courses



Since 2009...

- Growth in research relating to management and treatment of comorbidity
- Australian Government Department of Health funded the revision to reflect the most recent evidence



Comorbidity Guidelines 2nd Edition

- Funded by the Australian Government Department of Health
 - Dr Christina Marel
 - A/Prof Katherine Mills
 - Dr Rosemary Kingston
 - Prof Kevin Gournay
 - Dr Mark Deady
 - A/Prof Frances Kay-Lambkin
 - Prof Amanda Baker
 - Prof Maree Teesson
- Based on:
 - Synthesis of the best available evidence
 - Feedback from expert panel (involving consumers, carers, academics and clinicians)
 - Other interested stakeholders via an open call and discussion forum



Revision process

Expert panel
meeting
September
2014



Expert Panel

- **Prof Steve Allsop**, National Drug Research Institute
- **A/Prof Michael Baigent**, Flinders Medical Centre and Flinders University
- **Ms Nicky Bath**, NSW Users and AIDS Association
- **Prof Tim Carey**, Centre for Remote Health
- **Mr Kelvin Chambers**, Drug and Alcohol Multicultural Education Centre
- **Dr Derek Chong**, Institute of Urban Indigenous Health
- **Dr Janette Curtis**, Drug and Alcohol Nurses Australasia
- **A/Prof Adrian Dunlop**, Hunter New England Health; University of Newcastle
- **Dr Suzie Hudson**, Network of Alcohol and other Drug Agencies
- **Mr Chris Gibbs**, Mental Health Professionals' Network
- **Mr Mark Goodhew**, Medically Supervised Injecting Centre
- **Ms Jennifer Holmes**, Drug and Alcohol Nurses Australasia; Medically Supervised Injecting Centre
- **A/Prof Nicole Lee**, National Centre for Education and Training on Addiction
- **Dr Steve Leicester**, Headspace
- **Ms Leonie Manns**, Consumer Advocate; Co-chair of Executive Advisory Board, NHMRC Centre of Research Excellence in Mental Health and Substance Use
- **Emeritus Prof Ian Webster**, University of NSW



Revision process

Expert panel meeting
September
2014

Discussion
forum
November 2014



Discussion Forum

Melinda Beckwith

Rob Chase

Ruth Collins

Angela Corry

Gary Croton

Marie Coughlan

Neil Frazer

Deb Gleeson

Penny Glover

Sukalpa Goldflam

Rosemary Hambledon

Paul Harvey

Naomi Henderson

Bronwyn Hendry

Kate Hewett

Breanne Hobden

Kah-Seong Loke

Danny McCulloch

Jane Moreton

Hoa Nguyen

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Brendan Pont

Michael Quaass

Greg Robertson

Melanie Schofield

Jessica Smedley

Amanda Street

Elizabeth Stubbs

Michelle Taylor

Deb Tipper

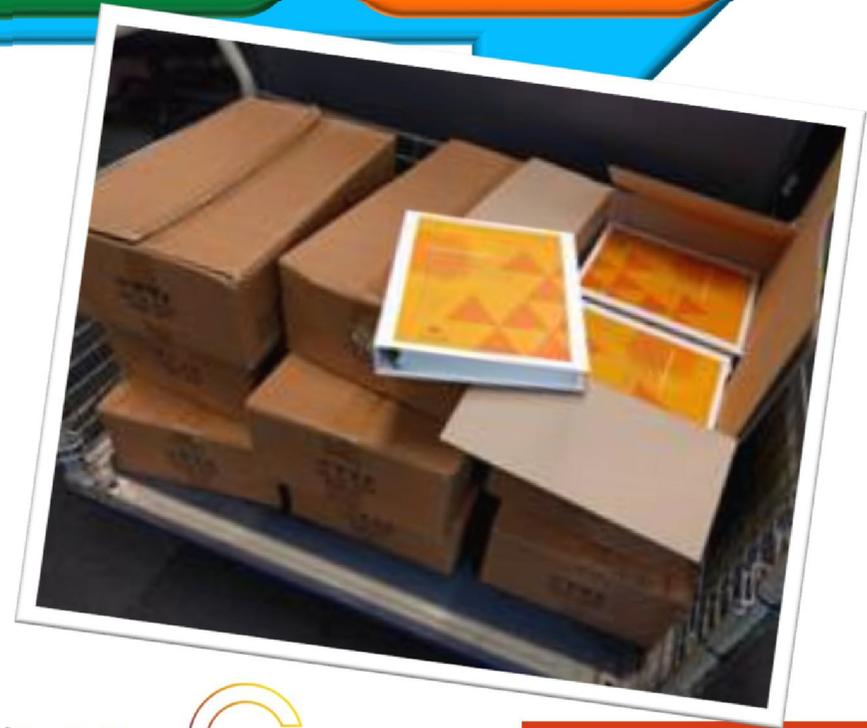
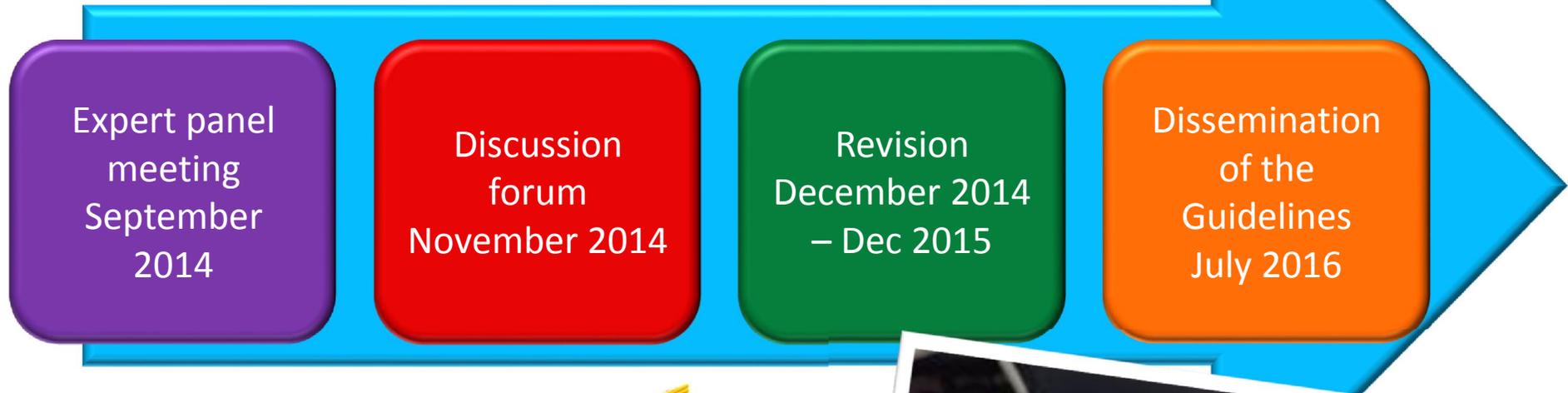
Gerard Tracey

Sharon Tuffin

Frankie Valvasori

Barry White

Revision process



Layout of the Guidelines

- Part A: What is comorbidity and why is it important?
- Part B: Responding to comorbidity
- Part C: Specific population groups
- Appendix: Resources, screening tools and assessments, CBT techniques, anxiety management techniques
- Worksheets



Part A



Part A

- **Part A: What is comorbidity and why is it important?**
 - A1: What is comorbidity?
 - A2: How common is comorbidity and why is it important?
 - A3: Guiding principles of working with clients with comorbidity
 - A4: Classification of disorders



Guiding principles

- Do no harm
- Work within your capacity
- Engage in ongoing professional development
- Recognise that the management of comorbidity is part of AOD workers' core role
- Provide equality of access to care
- Adopt a 'no wrong door' policy
- Recognise that comorbidity is common and that all clients should be routinely screened for comorbid conditions
- Conduct ongoing monitoring and assessment of client outcomes



Guiding principles

- Adopt a holistic approach
- Adopt a client-centred approach
- Emphasise the collaborative nature of treatment
- Have realistic expectations
- Express confidence in the effectiveness of the treatment program
- Adopt a non-judgmental attitude
- Adopt a non-confrontational approach to treatment
- Involve families and carers in treatment – where appropriate
- Consult and collaborate with other health care providers
- Ensure continuity of care



Part A

- **Part A: What is comorbidity and why is it important?**
 - A1: What is comorbidity?
 - A2: How common is comorbidity and why is it important?
 - A3: Guiding principles of working with clients with comorbidity
 - **A4: Classification of disorders**



Part B



Layout of the Guidelines

- **Part B: Responding to comorbidity**
 - B1: Holistic health care
 - B2: Identifying comorbidity
 - B3: Risk assessments
 - B4: Care coordination
 - B5: Approaches to comorbidity
 - B6: Managing and treating specific disorders
 - B7: Worker self-care



Layout of the Guidelines

- **Part B: Responding to comorbidity**
 - **B1: Holistic health care**
 - B2: Identifying comorbidity
 - **B3: Risk assessments**
 - **B4: Care coordination**
 - B5: Approaches to comorbidity
 - B6: Managing and treating specific disorders
 - **B7: Worker self-care**

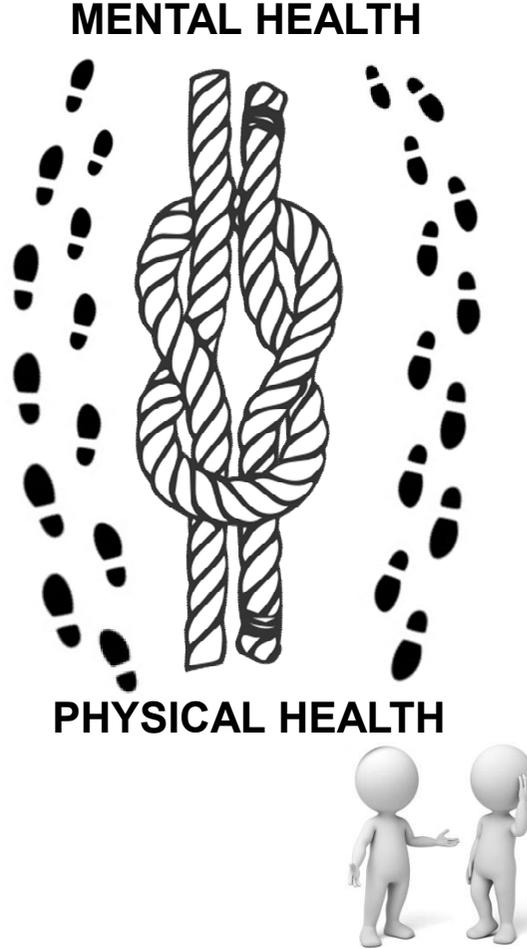


Responding to comorbidity: Pathway through care model



B1: Holistic health care

NEW

HIGH RISK OF CVD	FOCUS ON WELLBEING	CLIENT-CENTRED APPROACH
	<p>Reduce smoking</p> <p>Improve diet</p> <p>Increase physical activity</p> <p>Improve sleep patterns</p>	<p>MENTAL HEALTH</p>  <p>PHYSICAL HEALTH</p>

B2: Identifying comorbidity

- Not unusual for comorbid conditions to go unnoticed - not routinely looked for
- All clients should be screened and assessed for comorbidity as part of routine clinical care
- Become familiar with symptoms associated with different disorders
- Once symptoms identified more specialised assessment may be required by mental health professionals
- Multiple assessments should be conducted throughout treatment, which can reflect symptom changes over time

B2: Identifying comorbidity

- Assess needs
- Case formulation
- Informal assessment
 - Mental state examination
 - Presenting issues
 - AOD use history
 - Personal, medical and family history
 - Trauma history
 - Readiness for change
- Standardised assessment
- Feedback



Case formulation

- Organises information to address:
 - What problems exist?
 - How did they develop?
 - How are they maintained?
- Generates a hypothesis of how these factors fit together to form the current presentation
- Informs treatment planning

- Consider:



B3: Risk assessments

NEW

- Clients with comorbid mental health conditions are at high-risk of suicide, domestic or family violence
- Important that suicide risk assessments are an ongoing process, with AOD workers:
 - Trained to detect direct and indirect warning signs of suicide
 - Trained in the assessment and management of suicidality
 - Utilise clinical skill and expertise when incorporating screeners and assessments into their practice

B3: Risk assessments

NEW

- Risk of domestic and family violence needs to be incorporated into assessment practices:
 - AOD workers be familiar with organisational policies and procedures for responding to family violence
 - The response requires a broad, comprehensive, coordinated approach involving multiple services



B4: Coordinated care

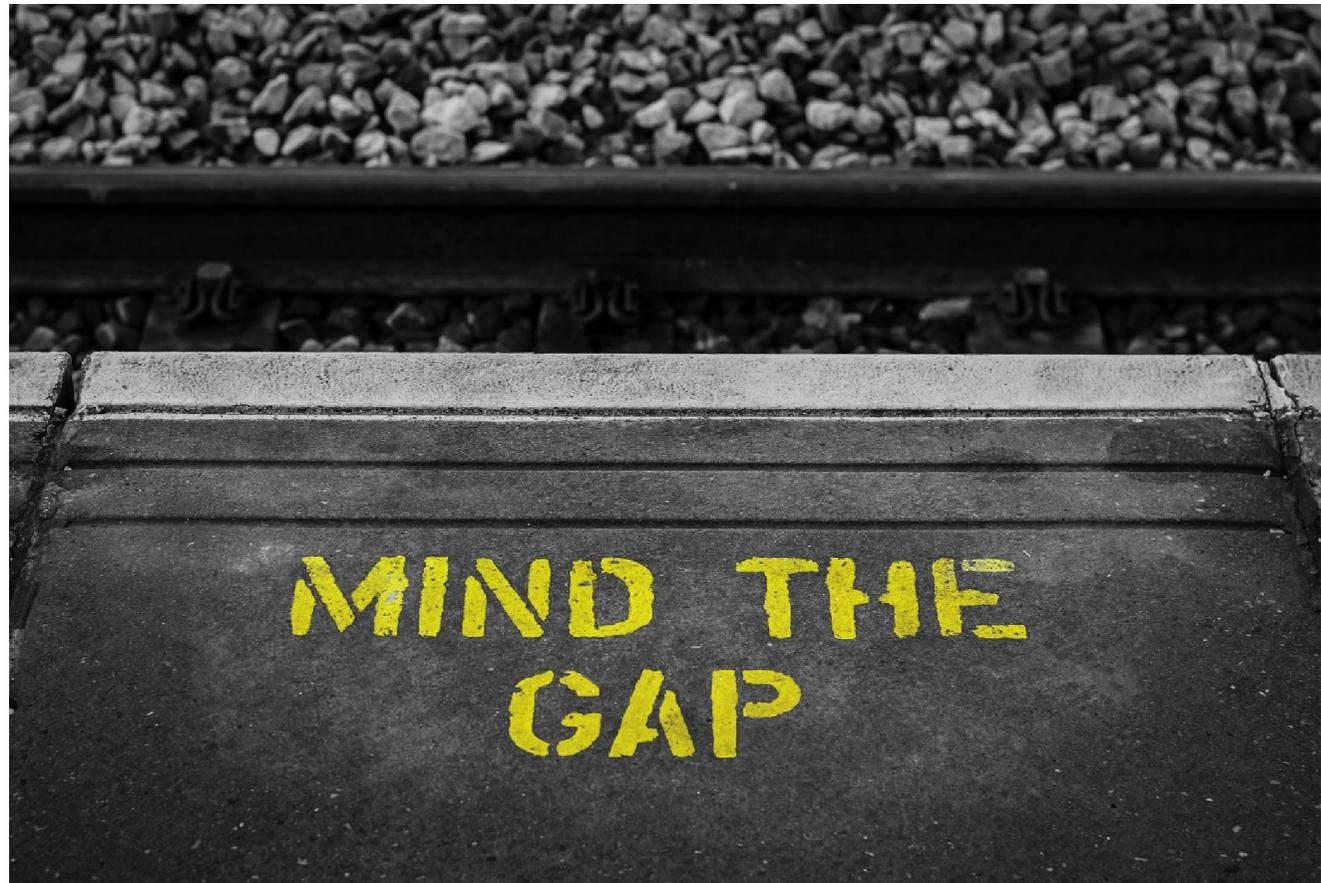
NEW



B4: Coordinated care

NEW

- Risk of clients disappearing from treatment
 - Difficulty navigating available services



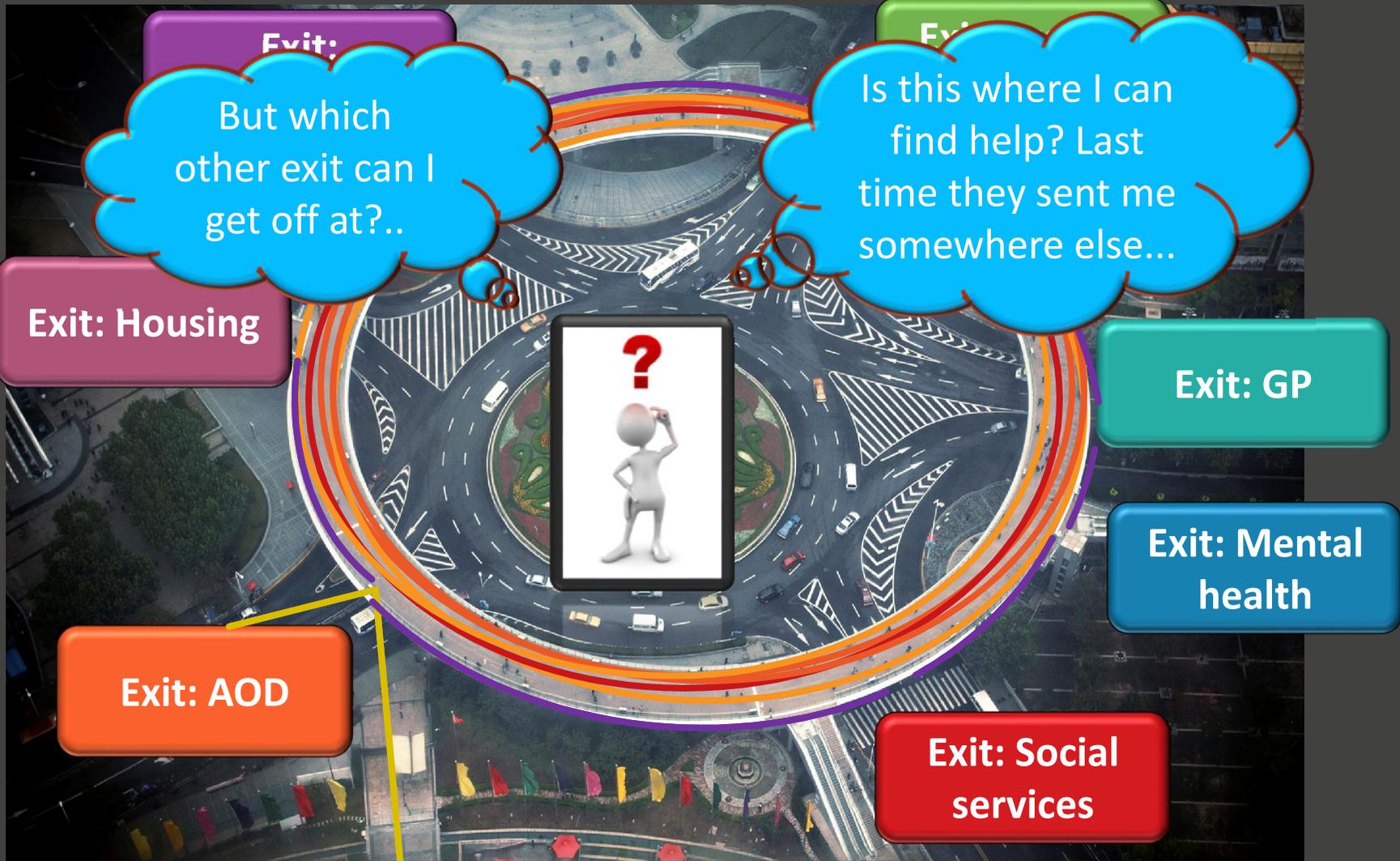
B4: Coordinated care

NEW

- Risk of clients disappearing from treatment
 - Difficulty navigating available services



Comorbidity roundabout



B4: Coordinated care

NEW

- Linked to improved treatment outcome¹¹
 - Prolonged client retention
 - Increased treatment satisfaction
 - Improved quality of life
 - Increased use of community-based services
- Principles adopted into referrals and discharge practices, emphasis placed on:
 - Communication
 - Consultation
 - Interagency support

¹¹Vanderplasschen, et al., 2007



B5: Approaches to comorbidity

Sequential treatment

The client is treated for one condition first which is followed by treatment for the other condition. With this model, the AOD use is typically addressed first then the mental health problem, but in some cases it may be whichever disorder is considered to be primary (i.e., which came first).

Parallel treatment

Both the client's AOD use and mental health condition are treated simultaneously but the treatments are provided independent of each other. Treatment for AOD use is provided by one treatment provider or service, while the mental health condition is treated by another provider or service.

Integrated treatment

Both the client's AOD use and mental health condition are treated simultaneously by the same treatment provider or service. This approach allows for the exploration of the relationship between the person's AOD use and his/her mental health condition.

Stepped care

Stepped care means the flexible matching of treatment intensity with case severity. The least intensive and expensive treatment is initially used and a more intensive or different form of treatment is offered only when the less intensive form has been insufficient.

Models of care

- Integrated treatment has considerable intuitive appeal, and has a number of advantages over other treatment approaches:
 - Single point of contact
 - Common objectives
 - Treatment is internally consistent
 - Relationship between AOD and MH conditions can be explored
 - Communication problems between services do not interfere with treatment

B5: Approaches to comorbidity

- Psychological approaches
 - Motivational interviewing
 - CBT
 - DBT
 - Relapse prevention
 - Mindfulness
 - Contingency management
 - Psychosocial group therapy
- Pharmacological approaches
- Self-help groups
 - E.g., AA, NA
- E-health interventions
- Physical activity
- Complementary and alternative therapies
 - E.g., Yoga, dietary and nutritional supplements, herbal remedies

NEW



B6: Managing comorbidity

- Various ways to effectively manage the symptoms of comorbid mental health conditions:
 - Motivational enhancement
 - CBT strategies
 - Relaxation and grounding techniques
- Distinction between management and treatment

B6: Managing/treating comorbidity

- ADHD **NEW**
- Psychosis
- Bipolar
- Depression
- Anxiety (GAD, PD, SAD)
- OCD
- PTSD
- Eating disorders **NEW**
- Personality disorders

Management techniques:

- Anxiety, panic and agitation
- Trauma-related symptoms
- Confusion or disorientation
- Cognitive impairment
- Grief and loss
- Aggressive, angry and violent behaviour

B6: Treating comorbidity

- People with AOD use commonly excluded from psychotherapy and pharmacotherapy trials for MH disorders
- Little evidence regarding interventions for specific comorbidities
- Recommended to use most effective treatment for each disorder
- Pharmacotherapy should be accompanied by supportive psychological interventions
- Be aware of possible interactions between medications and other substances



B6: Treating comorbidity

NEW

- E-health interventions
- Exercise and physical health interventions
- Complementary and alternative therapies



B7: Worker self-care

NEW

- Rewarding...but challenging work
- Risk of burnout/secondary traumatic stress
- Common stresses:
 - Workload and time pressures
 - Conflict
 - Lack of supervision/support
 - Job uncertainty
- Ensure take time for self-care
- Clinical supervision and workplace support



Part C



Part C

- **Part C: Specific population groups**
 - Indigenous Australians
 - Culturally and linguistically diverse groups
 - Gay, lesbian, transgendered and intersex people
 - Rural/remote communities
 - Homeless people
 - Women
 - Men
 - Young people
 - Older people

Summary

- AOD and other mental health disorders common
- Clients with comorbid MH conditions often have variety of other medical, family and social problems
 - Important to adopt holistic approach to management and treatment of comorbidity that is based on ***treating the person, not the illness***



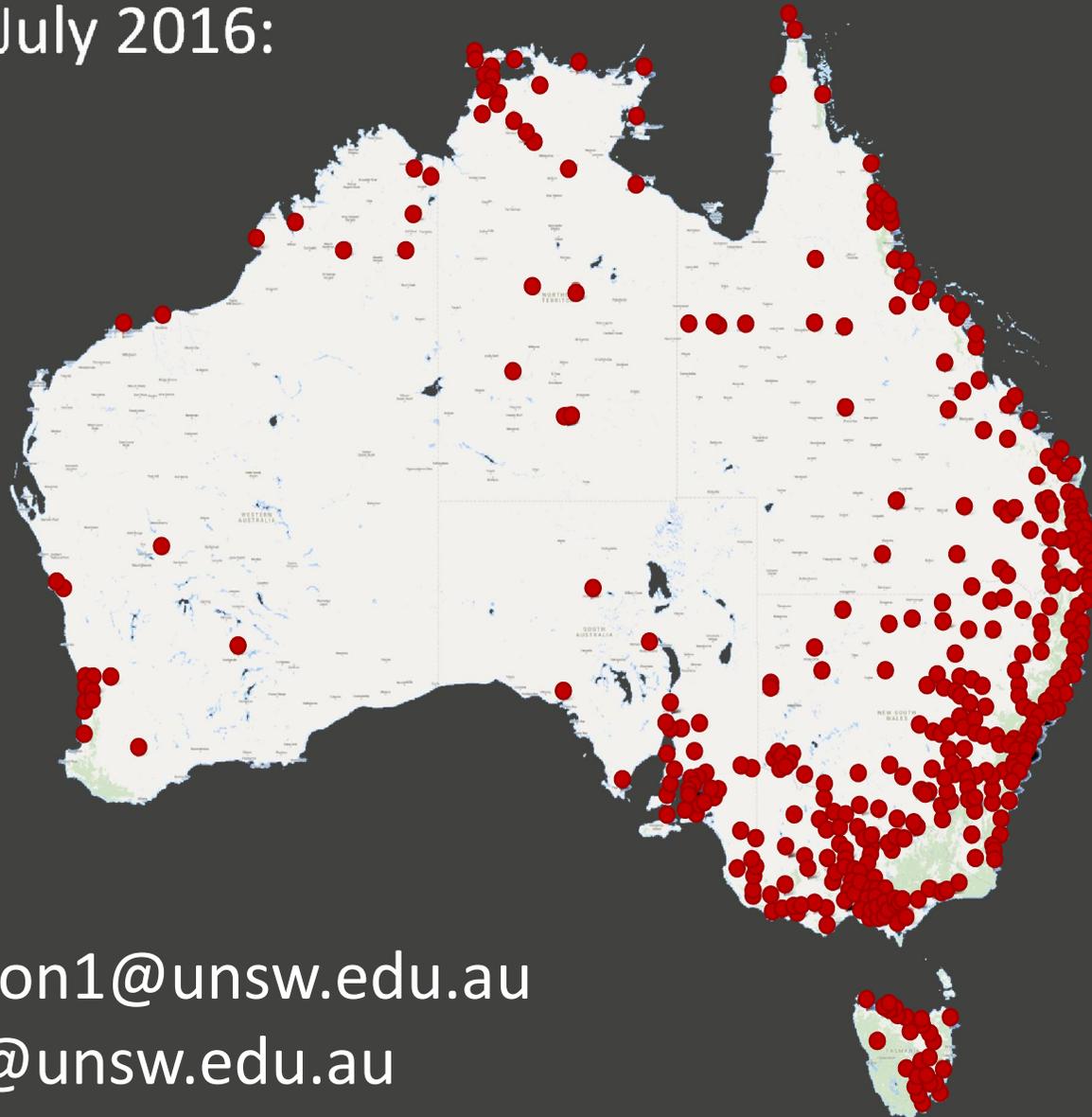
Summary

- Important that comorbid AOD and mental health conditions be identified so that may be managed and treated appropriately
- In addition to mental health services, AOD workers may need to engage with range of other services
- Develop strong links with range of local services



Distribution 2nd edition

Since 15 July 2016:



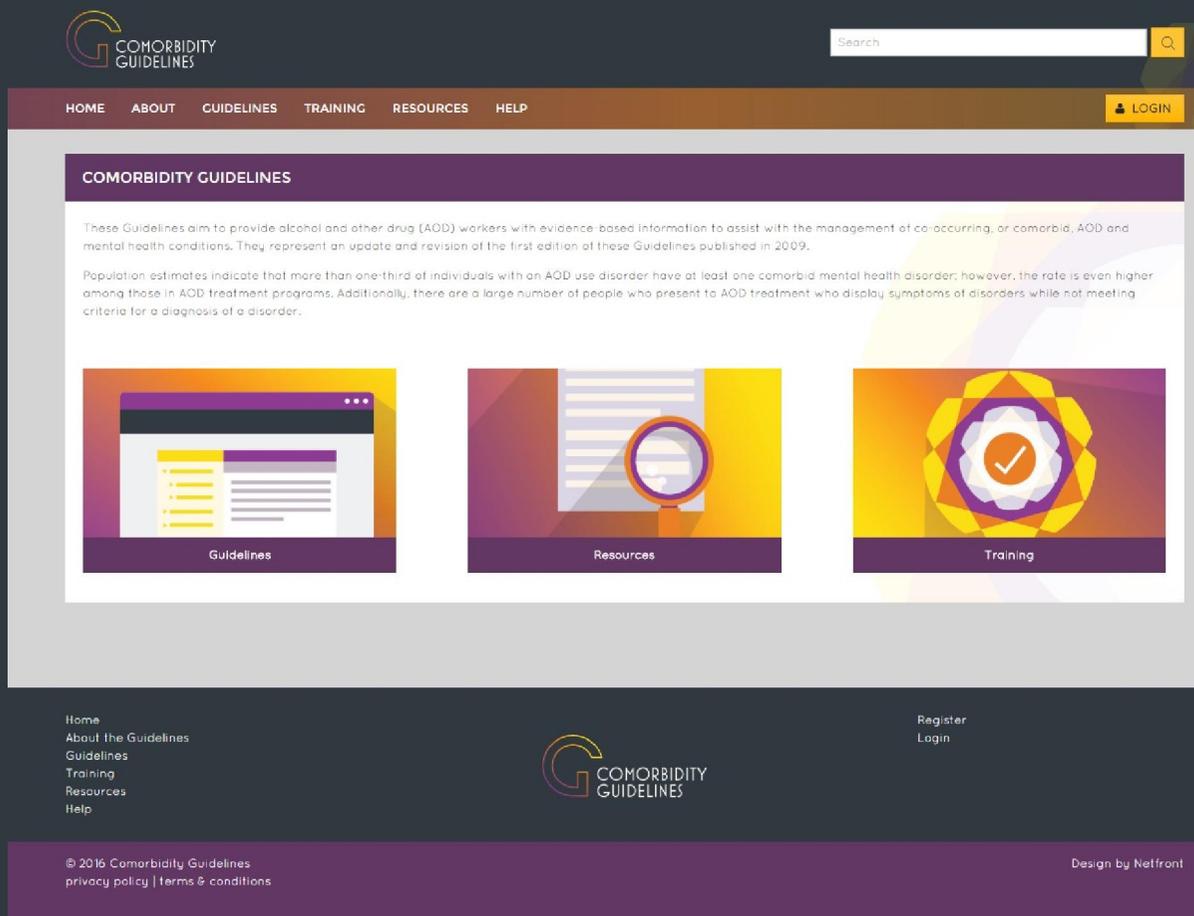
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Coming soon: Training website



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Questions?