

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

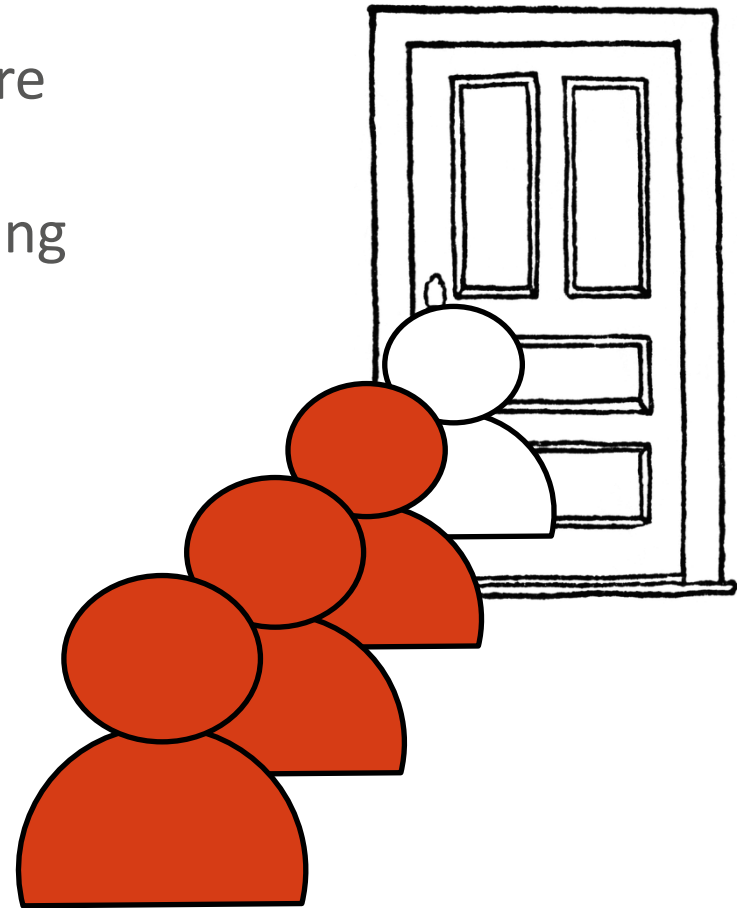
Medicine

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

# 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*?



# Why is *comorbidity* of concern?

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- 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
- Reduced life expectancy

# Why the need for comorbidity *guidelines*?

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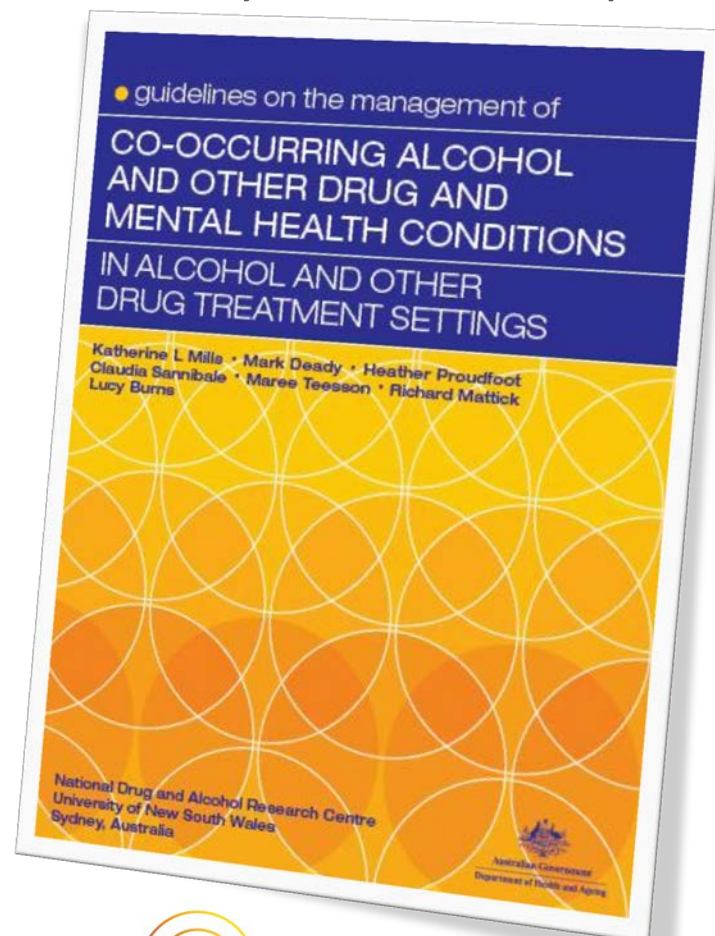
- Victorian review reported that AOD workers felt overwhelmed and fearful when treating people with comorbid mental health disorders, as their knowledge and the resources available to them were inadequate
- Need for AOD workers to have access to educational resources identified as priority by numerous 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

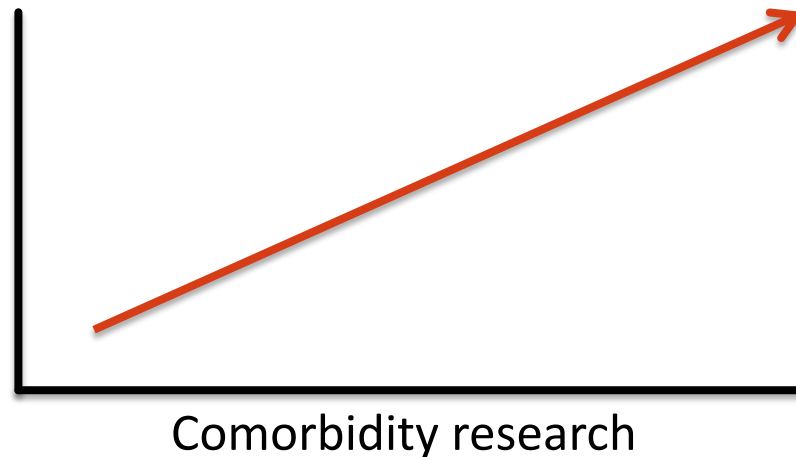
- In 2007, the Australian Government Department of Health and Ageing funded development of the Comorbidity Guidelines as part of the Comorbidity Initiative:
  - Katherine Mills
  - Mark Deady
  - Heather Proudfoot
  - Claudia Sannibale
  - Maree Teesson
  - Richard Mattick
  - Lucy Burns
- Published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



# Since 2009...

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- 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 2<sup>nd</sup> 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 at APSAD 2014





# Layout of the Guidelines

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- 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

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- **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

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- **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



## B2: Identifying comorbidity

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- 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 (using formal and informal assessments)
- 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

# 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 and 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

## B4: Coordinated care

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NEW

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



## B4: Coordinated care

NEW

- Linked to improved treatment outcome<sup>11</sup>
  - Prolonged client retention
  - Increased treatment satisfaction
  - Improved quality of life
  - Increased use of community-based services

<sup>11</sup>Vanderplasschen, et al., 2007



# B5: Approaches to comorbidity

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## 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

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- 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

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- Psychological approaches
- Pharmacological approaches
  - Little evidence regarding interventions for specific comorbidities
  - Recommended to use most effective treatment for each disorder
  - Pharmacotherapy should be accompanied by supportive psychological interventions
  - Possible interactions between medications and other substances
- E-health interventions
- Physical activity
- Complementary and alternative therapies
  - E.g., Yoga, dietary and nutritional supplements, herbal remedies
  - Some benefit, more research on *comorbid* disorders needed

NEW

# B6: Managing/treating comorbidity

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- 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

# B7: Worker self-care

NEW

- Rewarding...but challenging work
- Risk of burnout/secondary traumatic stress
- Ensure take time for self-care
- Clinical supervision and workplace support





# Part C



# Part C

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- **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

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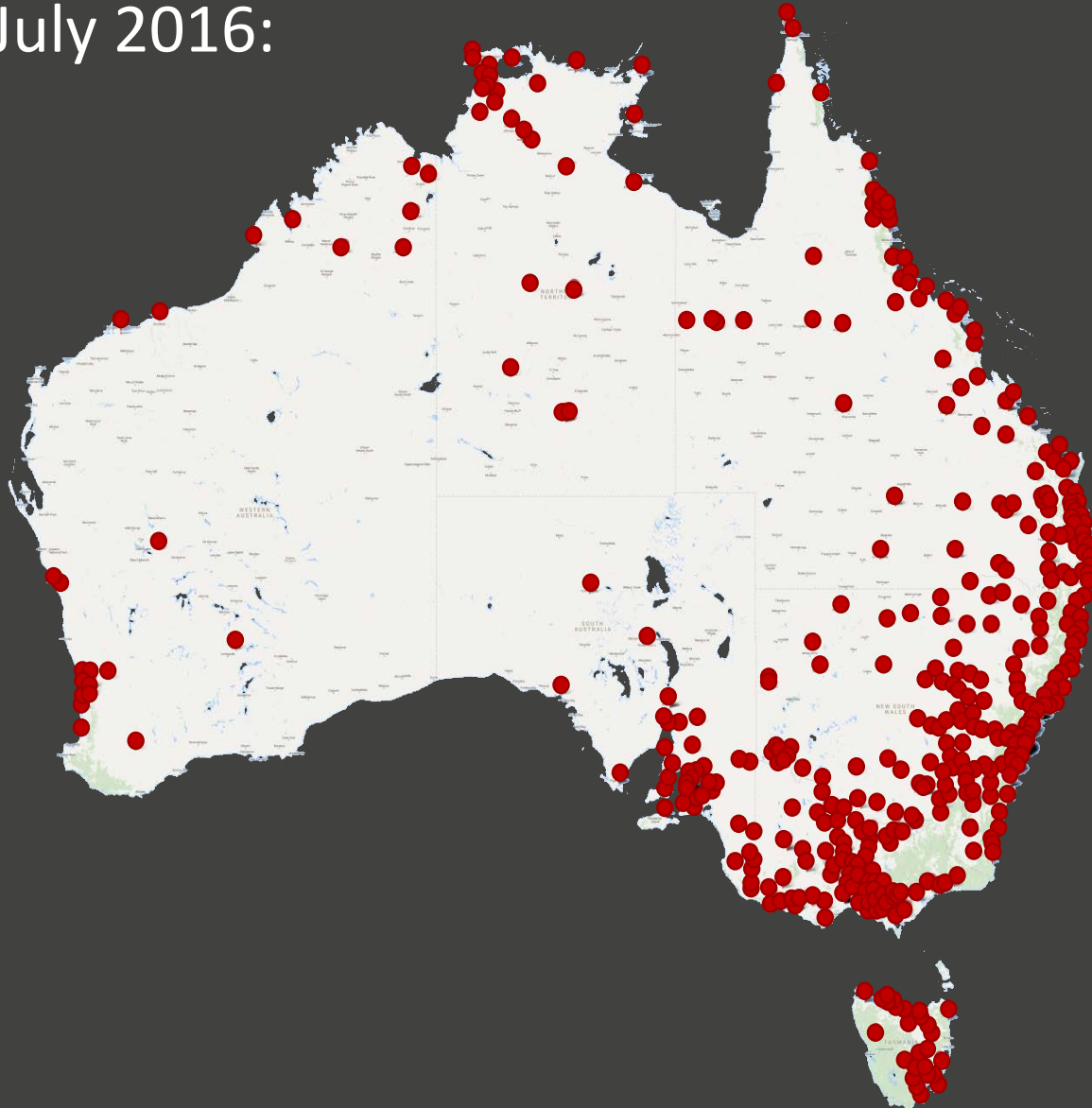
- AOD and other mental health disorders common
- Clients with comorbid MH conditions often have variety of other medical, family and social problems
  - Important to adopt holistic approach to management and treatment of comorbidity that is based on ***treating the person, not the illness***
- In addition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



# Distribution 2<sup>nd</sup> edition

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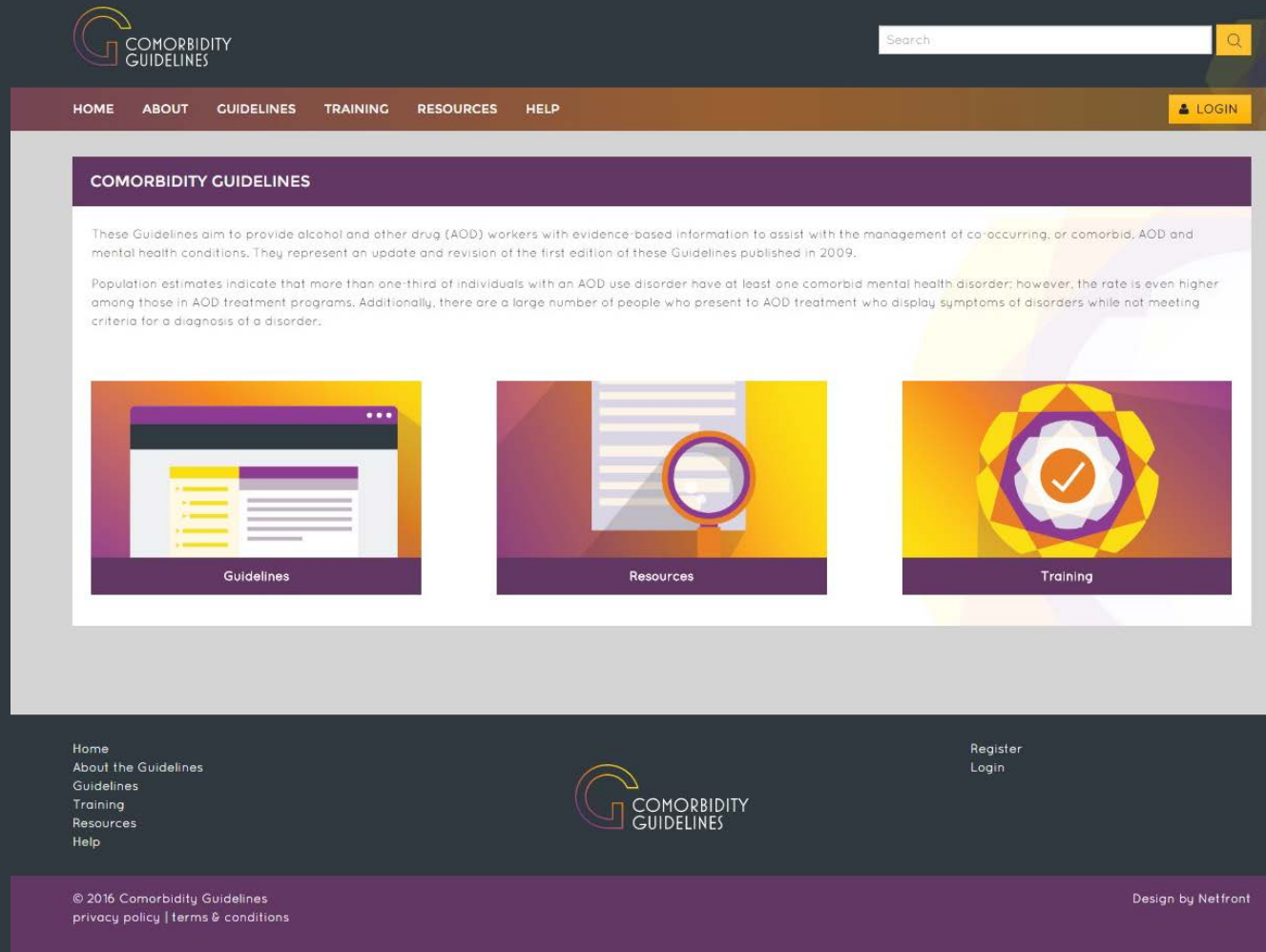
Since 15 July 2016:



# Coming soon: Training website



Subscribe at [www.comorbidityguidelines.org.au](http://www.comorbidityguidelines.org.au)



# Thank you!!

Email: [c.marel@unsw.edu.au](mailto:c.marel@unsw.edu.au)