THE MATILDA CENTRE WEBINAR SERIES

Welcome!

National comorbidity guidelines online training program: Evidence-based management of co-occurring mental health and substance use disorders

Presented by
Dr Christina Marel & Ms Erin Madden
Matilda Centre, the University of Sydney

Today’s webinar
Christina Marel
Erin Madden

Upcoming webinar

14th August @ 11:30am AEST
The cost-effectiveness of prevention for mental and substance use disorders: Building the evidence-base
Cathy Mihalopoulos, Long Le & Mary Lou Chatterton
The Matilda Centre brings together researchers working across siloed fields of expertise (mental health, substance use, suicide, exercise physiology, chronic disease) to share skills, synergise data, and harness new technologies to develop and trial innovative prevention, early intervention, translation and treatment programs.
OUR SPEAKERS FOR TODAY:

Dr Christina Marel  Ms Erin Madden

Welcome!
Building capacity in the AOD workforce

The National Comorbidity Guidelines

Presented by
Dr Christina Marel
Erin Madden

The Matilda Centre for Research in Mental Health and Substance Use
Sydney Medical School
University of Sydney
Overview

- Brief background: What do we know about comorbidity?
- Holistic health care approach
- Identifying comorbidity
- Managing and treating comorbidity:
  - What does the evidence say?
- Involving multiple services to deliver coordinated care
- Comorbidity Guidelines online training program demonstration
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.

- Growth in research relating to management and treatment of comorbidity.
  - In 2014, funded by Australian Government Department of Health to develop second edition to reflect the most recent evidence.

- In December 2018, moved to the Matilda Centre for Research in Mental Health and Substance Use, University of Sydney.
Development and aims

Development based on:

- Synthesis of best available evidence
- Feedback from expert panel (involving consumers, carers, academics, clinicians)
- Other interested stakeholders via an open call and discussion forum

Aims:

- Increase the knowledge and awareness of comorbid mental health conditions in AOD treatment settings
- Improve the confidence and skills of AOD workers
- Increase the uptake of evidence-based care
1. What do we know about comorbidity?
What is meant by ‘comorbidity’?

- Broad definition: the co-occurrence of two or more disorders in a person within a specified timeframe (e.g., lifetime, current)

- Our focus here: the co-occurrence of an AOD use disorder with one or more mental health disorders or conditions
What is meant by ‘comorbidity’?

– Other types of comorbid conditions:
  – Other AOD use disorders (including tobacco)
  – Physical health conditions (e.g., cirrhosis, hepatitis, heart disease, diabetes)
  – Intellectual and learning disabilities
  – Cognitive impairment
  – Chronic pain

– Often referred to as ‘dual diagnosis’ - misnomer
What do we know about 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?

- OCD: 37-72%
- Personality disorder: 1-10%
- Bipolar disorder: 4-10%
- Eating disorder: 2-9%
- Depression: 26-60%
- PTSD: 27-51%
- ADHD: 6%
- Psychotic disorder: 45-70%
- Anxiety: 2-10%
How common is comorbidity

- 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 a problem?

- 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
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.
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
2. Holistic health care approach
Holistic health care

HIGH RISK OF CVD

FOCUS ON WELLBEING

CLIENT-CENTRED APPROACH

REDUCE

IMPROVE

INCREASE

IMPROVE

IMPROVE
Strategies to help overcome barriers

- NRT
- Healthy sleep habits
- Dietary guidelines, food spending structure
- Food and activity diary, motivational tools
Healthcare worker’s role in holistic health care

- Holistic approaches focused on delivering the right services to the right person at the right time

- Involve multiple services in coordinated, client-centred approach

- Be prepared to address mental and physical health, as well as partner with other services to deliver complete individualised care
3. Identifying comorbidity
Identifying comorbidity

- Detection and treatment of comorbid conditions among AOD clients tends to be low
- Important for screening and assessment for comorbidity to be part of routine clinical care
- Identification of mental health problems can facilitate management during AOD treatment
- Diagnosis of mental health disorders requires assessment by mental health professionals (psychiatrists, clinical psychologists)
- Multiple assessments conducted throughout treatment, which can reflect symptom changes over time
Become familiar with classifications

– Become familiar with the DSM-5
  – Limitations and recommendations regarding differential diagnosis
  – Signs and symptoms of disorders

Signs of disorders

Symptoms of disorders
How is comorbidity identified?

1. Screening
2. Assessment
3. Case formulation
Step 1: Screening

- Process of identifying possible cases of co-occurring mental health conditions
- Not diagnostic – cannot establish whether a disorder exists
  - Identifies symptoms typical of a disorder
  - Highlights need for further assessment
- Ideally occur after 2-4 week stabilisation period
  - NB: “False positives” during intoxication and/or withdrawal
  - Screening best conducted after completion of acute AOD withdrawal
  - Not practicable, conduct multiple assessments over time
Useful screening instruments

- Camberwell Assessment of Need Short Appraisal Schedule (CANSAS)
- Kessler Psychological Distress Scale (K10)
- Depression Anxiety Stress Scale (DASS)
- Deady review of screening tools for use in AOD settings (2009):
  - Comprehensive review of all available screeners and assessment tools, including where to access, costs, validity and reliability
  - Report available for free download via NADA’s website
Step 2: Assessment

- Detailed investigation of a person’s mental health

- Ongoing process rather than a one-off event — involves the ongoing monitoring of clients’ mental health symptoms and AOD use

- Ongoing assessment important because clients’ mental health symptoms and AOD use may change throughout treatment
Presenting issues

Medical history

AOD use history

Psychiatric history

Risk assessment

Trauma history

Mental state

Strengths and weaknesses

Personal history

Current situation

Criminal history

Family history

Source of referral

Readiness to change

Assessment

Readiness to change
Step 3: Case formulation

- Involves:
  - Gathering information regarding factors that may be relevant to treatment planning
  - Formulating a hypothesis as to how these factors fit together to form the current presentation of the client’s symptoms

- Should be aware of:
  - What problems exist? How did they develop? How are they maintained?
  - All aspects of the client’s presentation, current situation, and the interaction between different factors/problems

- **Person-centred, NOT service-centred**
Consider:

- trauma-history
- suicidal-thoughts
- family-history
- physical-condition
- spirituality
- criminal-history
- cognitive-abilities
- socioeconomic-status
- age
- ethnicity
- mental-state
- present-illness
- psychiatric-history
- sexual-orientation
- aod-use
- readiness-to-change
- cultural-issues
- medical-condition
- social-issues
- violent-thoughts
Differentiating substance-induced disorders

- Symptoms of mood, anxiety and psychotic disorders may all be induced as a result of AOD use or withdrawal:
  - Alcohol use and withdrawal can induce symptoms of depression or anxiety
  - Manic symptoms can be induced by intoxication with stimulants, steroids, or hallucinogens
  - Psychotic symptoms can be induced by withdrawal from alcohol, or intoxication with amphetamines, cocaine, cannabis or LSD
Differentiating substance-induced disorders

- Does the client have:
  - Any current mental health symptoms (e.g., depression, anxiety, psychosis)?
  - Experienced these in the past?
  - Ever been diagnosed with a mental health disorder?
If the client **has** mental health symptoms

- When did symptoms start (prior to AOD use)?
- Is there a family history of the particular mental health condition?
- Do they only occur when person is intoxicated or withdrawing?
- Do symptoms change when client stops using AOD (better, worse, stay same)?
- Have symptoms continued even after period of abstinence (approx. 1 mth)?
Substance-induced disorders

- Occur as a direct consequence of AOD intoxication or withdrawal
- Symptoms only present during intoxication or withdrawal
- Symptoms displayed in the absence of intoxication or withdrawal suggestive of an independent mental health disorder

Likely substance-induced

Possible independent disorder

Symptoms occurred in context of intoxication or withdrawal

Symptoms experienced when not intoxicated or withdrawing

Symptoms improved after period of abstinence

Family history
Substance-induced psychosis

– Difficult to distinguish substance-induced psychosis from other psychotic disorders

– Factors that may help differentiate:

  – Substance-induced symptoms:

    • Tend to appear quickly

    • Last a shorter time (hours to days), until the effects of the drug wear off (can persist for days, weeks, months or longer)

    • Visual hallucinations more common in substance withdrawal and intoxication than in primary psychotic disorders
Common symptoms of low-level methamphetamine-related psychosis

- Suspiciousness, guardedness, hypervigilance
- Overvalued ideas
- Illusions or misreading the environment
- Erratic behaviour
Substance-induced psychosis

- Stimulant psychosis
  - More commonly associated with tactile hallucinations (“ice bugs”)
  - More agitated, energetic and physically strong, more challenging to contain in a safe environment, and
  - More difficult to calm with sedating or psychiatric medication than people with psychosis unrelated to the use of stimulants
So far...

- Comorbidity is common
- Complicates treatment and recovery
- Relationship of mutual influence
- Conduct routine screening and assessment for these comorbidity as part of case formulation
- Consider a range of factors, not only AOD and mental health issues, in case formulation
- Full assessment should ideally occur after a period of abstinence, or at least when client is not withdrawing or intoxicated
- Conduct multiple assessments throughout treatment, as symptoms may change over time
- Provide assessment feedback in a positive, easily understood way
4. Managing and treating comorbidity
## Models of care

<table>
<thead>
<tr>
<th>Sequential treatment</th>
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<tbody>
<tr>
<td>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).</td>
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<tr>
<th>Parallel treatment</th>
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<tbody>
<tr>
<td>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.</td>
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<tr>
<th>Integrated treatment</th>
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<tbody>
<tr>
<td>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.</td>
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</table>

<table>
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<tr>
<th>Stepped care</th>
</tr>
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<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>
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
Managing comorbidity

- The goal of management of mental health conditions is to allow AOD treatment to continue with minimal disruption or drop-out.

- Management strategies described in the Guidelines provide short term relief and control over symptoms; an interim measure during AOD treatment until full treatment of cooccurring conditions is possible.

- Guidelines provide “dos and don'ts” and practical strategies for managing commonly cooccurring conditions.
Managing and treating comorbidity

- 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
Managing/treating comorbidity

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

Management techniques:

- Anxiety, panic and agitation
- Trauma-related symptoms
- Confusion or disorientation
- Cognitive impairment
- Grief and loss
- Aggressive, angry and violent behaviour
5. Coordinated care
Coordinated care
Coordinated care: the “comorbidity roundabout”
Coordinated care

- Increases the likelihood that clients will received specialised care
- Linked to improved treatment outcomes such as:
  - Prolonged client retention
  - Increased treatment satisfaction
  - Improved quality of life
  - Increased use of community-based services
AOD workers’ role in coordinated care

- AOD workers coordinate and manage, not deliver, appropriate services
- Challenge is managing active engagement of multiple services across professional and non-professional sector
- Primary positions to coordinate care, incorporate services that reflect their clients’ individual needs, delivering the best quality of care possible.
Comorbidity Guidelines Online Training Program: Demonstration

www.comorbidityguidelines.org.au
Online training program

- Based on the Comorbidity Guidelines content
- The online training program is free and takes approximately 10 hours to complete
- The online training program aims to:
  - Increase the knowledge and awareness of co-occurring mental health conditions among the AOD workforce;
  - Improve the confidence and skills of AOD workers to manage co-occurring mental health conditions;
  - Increase the uptake of evidence-based care;
  - Improve outcomes for people with co-occurring AOD and mental health conditions.
Benefits of online training

- Sustainable
- Provides consistent training
- Convenient
- More feasible
- Can reach more people
- Update information
- Reduce information overload
- Reduces delivery cycle time (time between learning content and implementing into practice)
Best practice e-learning

- E-learning principles
- Interactive
- Rationale-based
- Job-relevant course content
- Multimedia approach
- Relevant information
- Includes assessment
Managing Co-occurring Alcohol and Other Drug and Mental Health Conditions

This website provides evidence-based information, training, and resources to assist with the management of co-occurring alcohol and other drug and mental health conditions. The content is based on the second edition of the "Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition). Sydney, Australia: Centre of Research Excellence in Mental Health and Substance Use with funding from the Australian Government Department of Health.


Please note that the Comorbidity Guidelines website and online training program moved from the University of New South Wales to the University of Sydney on 10th December 2018, and is now located at The Matilda Centre for Research in Mental Health and Substance Use.

For participants taking part in the evaluation of the online training program: This will have no impact on the study or your participation. However, please be advised that the study is now being conducted under the auspices of the University of Sydney and your data will be stored at the University of Sydney, under the same conditions that it was stored at UNSW. If you have concerns, questions, or wish to discuss this change please contact Dr Christina Marel.

Access to online version of the Guidelines

More info / register for online training

Additional resources and links
Compulsory introduction module

Progress shown here

Key learning outcomes

11 modules, can be completed in any order
TRAINING
- Start training
- Edit profile details

TRAINING PROGRESS
- INTRODUCTION: Complete
- MODULE 1: WHAT IS COMORBIDITY: Incomplete
- MODULE 2: GUIDING PRINCIPLES: Incomplete
- MODULE 3: CLASSIFICATION OF DISORDERS: Incomplete
- MODULE 4: HOLISTIC HEALTH CARE: Incomplete
- MODULE 5: IDENTIFYING COMORBIDITY: Incomplete
- MODULE 6: RISK ASSESSMENTS: Incomplete
- MODULE 7: CARE COORDINATION: Incomplete
- MODULE 8: APPROACHES TO COMORBIDITY: Incomplete
- MODULE 9: MANAGING AND TREATING SPECIFIC DISORDERS: Incomplete
- MODULE 10: WORKER SELF-CARE: Incomplete
- MODULE 11: SPECIFIC POPULATION GROUPS: Incomplete

CONTINUE MODULE 1 WHAT IS COMORBIDITY
KEY LEARNING OUTCOMES

LOGOUT
This module (approx 13 mins) provides an introduction to comorbidity and an overview of how and why it occurs.

The material in this module is based on Chapters A1 and A2 of the Comorbidity Guidelines.
Key learning outcomes for comorbidity

By the end of this module, you will be able to:

- Define comorbidity
- Understand the difference between a mental health condition and a mental health disorder
- Understand how and why comorbidity occurs
- Understand the potential impact of comorbidity on treatment outcomes
- Explain some of the harms associated with comorbidity

Define comorbidity

Understand the difference between a mental health condition and a mental health disorder

Understand how and why comorbidity occurs

Understand the potential impact of comorbidity on treatment outcomes

Explain some of the harms associated with comorbidity
In this training program, the term 'comorbidity' refers to the co-occurrence of one or more alcohol or other drug (AOD) use disorders, with one or more mental health conditions.

This phenomenon is often referred to as 'dual diagnosis', but this term is misleading, as many clients present with a range of co-occurring conditions of varying severity.

There are of course, other examples, for example, a person may have a mental health condition and an alcohol use disorder, which refers to more than one AOD use disorder. Other conditions that often co-occur with AOD use disorders are physical health conditions (e.g., cirrhosis, hepatitis, heart disease, diabetes), intellectual and learning disabilities, cognitive impairment, and chronic pain.

While there are a number of different types of comorbidity, this training focuses on the co-occurrence of AOD use disorders and mental health conditions.
Use of multimedia, such as animations
Cognitive behavioural therapy (CBT)

CBT emphasises the important role of thinking in how we feel and how we behave.

There is considerable evidence supporting the use of CBT for the treatment of depressive, anxiety, and AOD use disorders.

A number of CBT techniques that may be used in the management and treatment of AOD use and mental health problems are discussed in more detail in Module 5: Motivational interviewing.

The video on the right shows a brief example of a motivational interview.

Source: Merry and Gold 2009, developed with funding from the Flight Attendant Medical Research Institute (#63504)
Is causality important?

Conditions may occur in any order, or they may develop at the same time.

Evidence regarding the typical order of onset of disorders is not consistent, and differs between males and females.

Although establishing the order of onset between conditions can be useful for understanding the relationship between them, it is important to note that once comorbid conditions have been established, it is most likely that the relationship between them is one of mutual influence rather than there being a clear causal pathway.
Defining terms
- Although other types exist, in this training, ‘comorbidity’ refers to co-occurring AOD use and any other mental health condition
- Mental health ‘disorder’ refers to those who have a diagnosable mental health disorder, as defined by the DSM-5
- Mental health ‘condition’ refers to those with a diagnosable disorder as well as those who display symptoms of disorders while not meeting criteria for a diagnosis of a disorder

Explaining comorbidity
- Although there are a number of possible explanations as to why two or more disorders may co-occur, it is most likely that the relationship between conditions is one of mutual influence

Prevalence
- The most common comorbid mental health disorders are anxiety, depression, PTSD, and personality disorders

Treatment outcomes
- Although people with comorbid mental health conditions may have more complex profiles, they have been found to benefit as much from traditional AOD treatment methods as those without comorbid mental health conditions
1. In this training program, what does the term comorbidity refer to?
   - Meeting the criteria for one mental health disorder
   - The co-occurrence of one or more mental or other drug (AOD) use disorders with one or more mental health conditions
   - The co-occurrence of anxiety and depression
   - A continuum ranging from mild to severe mental health disorders

2. The direct causal hypothesis refers to when:
   - One condition affects a biological factor, increasing the likelihood of another condition developing
   - Factors common to the AOD and mental health conditions may increase the likelihood they will co-occur
   - The AOD use disorder may be a consequence of a mental health disorder, or vice versa

3. The strategies used to manage co-occurring conditions depend on the order of onset:
   - True
   - False

4. Once comorbidity is established, the relationship between disorders is likely one of mutual influence:
   - True
   - False

5. A mental health condition refers to:
   - Those who have a diagnosable mental disorder, as identified by the DSM
   - Those who have a diagnosable disorder, as well as those who display symptoms of disorders

6. Up to ______ of Australian clients accessing AOD treatment services meet diagnostic criteria for at least one comorbid mental disorder.

7. Those with comorbidity and those without follow a similar course in terms of their treatment outcomes:
   - True
   - False

8. Some of the harms associated with comorbidity include (select all that apply):
   - Poorer general physical and mental health
   - Greater drug use severity
   - Improved relationships with family and friends
   - Increased risk of violence
   - Increased homelessness
   - Increased risk of suicide and self-harm
   - Increased social and occupational functioning

9. According to the 2007 National Survey of Mental Health and Wellbeing, the leading mental health disorder among adults with substance use disorders is:
   - Post-traumatic stress disorder (PTSD)
   - Social phobia
   - Generalised anxiety disorder (GAD)
   - Major depressive disorder
   - Bipolar disorder
   - Major depressive disorder

10. Those with comorbid mental health and AOD use disorders generally have poorer physical and mental health compared to those without comorbidity:
    - True
    - False
4. Once comorbidity is established, the relationship between disorders is likely one of mutual influence

- True
- False

5. A mental health condition refers to

- Those who have a diagnosable mental disorder, as identified by the DSM
- Those who have a diagnosable disorder, as well as those who display symptoms of disorders

6. Up to _____ of Australian clients accessing AOD treatment services meet diagnostic criteria for at least one comorbid mental disorder

7. Those with comorbidity and those without follow a similar course in terms of their treatment outcomes

- True
- False

8. Some of the harms associated with comorbidity include (select all that apply)

- Poorer general physical and mental health
- Greater drug use severity
- Improved relationships with family and friends
- Increased risk of violence
- Increased homelessness
- Increased risk of suicide and self-harm
- Increased social and occupational functioning
Wrong questions link to relevant Guidelines section for more information.

A mental health condition refers to

Unfortunately this response is incorrect. Please review the following resources to assist you in finding the correct response.

Q: What is comorbidity?

Up to No response selected of Australian clients accessing NEL treatment services meet diagnostic criteria for at least one comorbid mental disorder.

Those with comorbidity and those without follow a similar course in terms of their treatment outcomes.

Some of the harms associated with comorbidity include (select all that apply)

- Partially correct

Unfortunately this response is incorrect. Please review the following resources to assist you in finding the correct response.

Q: What are the harms associated with comorbidity?
Certificate upon completion
Summary

- AOD and MH disorders are 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**
- Important that comorbidity is identified so that it can be managed and treated appropriately
- In addition to mental health services, AOD workers may need to engage and develop strong links with range of other services
Stay tuned!
Face-to-face training program coming soon.

TO BE NOTIFIED WHEN TRAINING IS AVAILABLE

enquiries@comorbidityguidelines.org.au
Thanks for being part of the Matilda Centre Webinar Series!

Video recording and handouts of this webinar, and our past webinars, are available at:
https://vimeo.com/channels/comorbiditywebinars

Click this link to join our mailing list for updates about upcoming webinars

Join us again on 14th August @ 11:30am AEST
“The cost-effectiveness of prevention for mental and substance use disorders: Building the evidence-base.”
Presented by Cathy Mihalopoulos, Long Le & Mary Lou Chatterton

We’d love to hear you feedback! Please complete our survey at the end of the session.