phn
CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

NHMRC CENTRE OF RESEARCH EXCELLENCE in MENTAL HEALTH and SUBSTANCE USE
CREMS

Managing and treating co-occurring mental and substance use disorders

Dr Christina Marel
A/Prof Katherine Mills

CESPHN-CREMS Webinar Series: Welcome!

Coming up...

Full details available at:
https://www.cesphn.org.au/events

http://comorbidity.edu.au/training/webinars

5 December 2017

Managing the physical health of people with co-occurring mental and substance use disorders

Join our mailing list to receive updates about other upcoming webinars

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

NHMRC CENTRE OF RESEARCH EXCELLENCE in MENTAL HEALTH and SUBSTANCE USE

Before we get started…

- Questions/comments “Q&A”
- Technical support:
  - Call 1800 768 027, extension 2, quote webinar ID 232-370-430 when prompted
  - Visit https://support.zoom.us/hc/en-us/categories/201146643-Meetings-Webinars and click on the help icon bottom right corner to chat online with support staff

- Access recording and handouts at conclusion of event: http://comorbidity.edu.au/training/webinars

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

UNSW SYDNEY

NDARC National Drug & Alcohol Research Centre
The Difference is Research

Managing and treating co-occurring mental and substance use disorders

Dr Christina Marel

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*
- Download: https://comorbidity.edu.au/cre-resources/guidelines-management-co-occurring-alcohol-and-other-drug-and-mental-health-0

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Learning outcomes

- Improved understanding of current approaches for managing and treating comorbidity, involving other services
- Understanding of the need to address lifestyle factors and work within a holistic health approach
- Improved understanding of referral pathways and techniques to facilitate referrals

Overview

- Brief background: What do we know about comorbidity?
- What to do once comorbidity is identified
  - Management
  - Treatment from a holistic health care approach
- Referral pathways

Case study: Michelle

- 18-year old female
- Presents to drop-in medical service after assaulted by her boyfriend – now staying with friends
- Extensive trauma history, heroin and cannabis use
- Very vulnerable

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

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 disorder or condition
- Often many other types of comorbidity
  - E.g., physical health, intellectual and learning difficulties, cognitive impairment, chronic pain

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 ¾ of entrants to AOD treatment have a co-occurring mental health condition

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

How common is comorbidity?

Source: Kingston, Marel, Mills (2016), A systematic review of the prevalence of comorbid mental health disorders in people presenting for substance use treatment in Australia, *Drug Alc Rev,* DOI: 10.1111/dar.12448

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

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

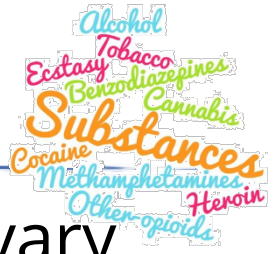
Mental health continuum

E.g., Mild depression responsive to medication

E.g., Severe depression needing hospital admission (suicidal delusional etc)

Move towards dimensional understanding of disorders in DSM-5

Variation between substances

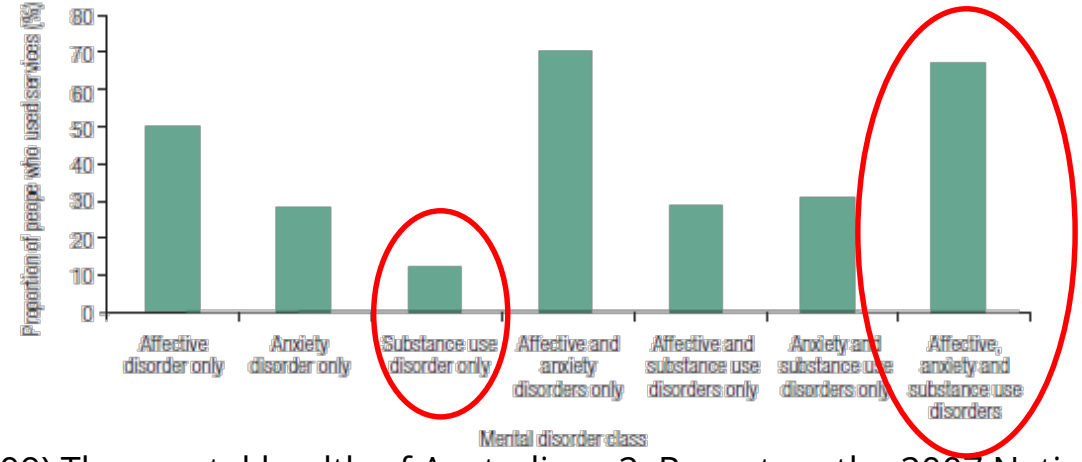


- Prevalence of mental health disorders may vary between substances
- Little research comparing the rates of mental health disorders across different types of AOD use disorders
- Substance use among those with mental health disorders mirrors general population trends in availability and fashion
  - Most commonly used are tobacco, alcohol, illicits (e.g., cannabis, methamphetamine, ecstasy)

Barriers to care

- Very few people with these conditions access treatment
- In part because they have difficulty accessing services and stigma

Figure 3-3: Service use by single and comorbid 12-month mental disorder classes



Source: Slade, et al (2009) The mental health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing. Department of Health and Ageing, Canberra.

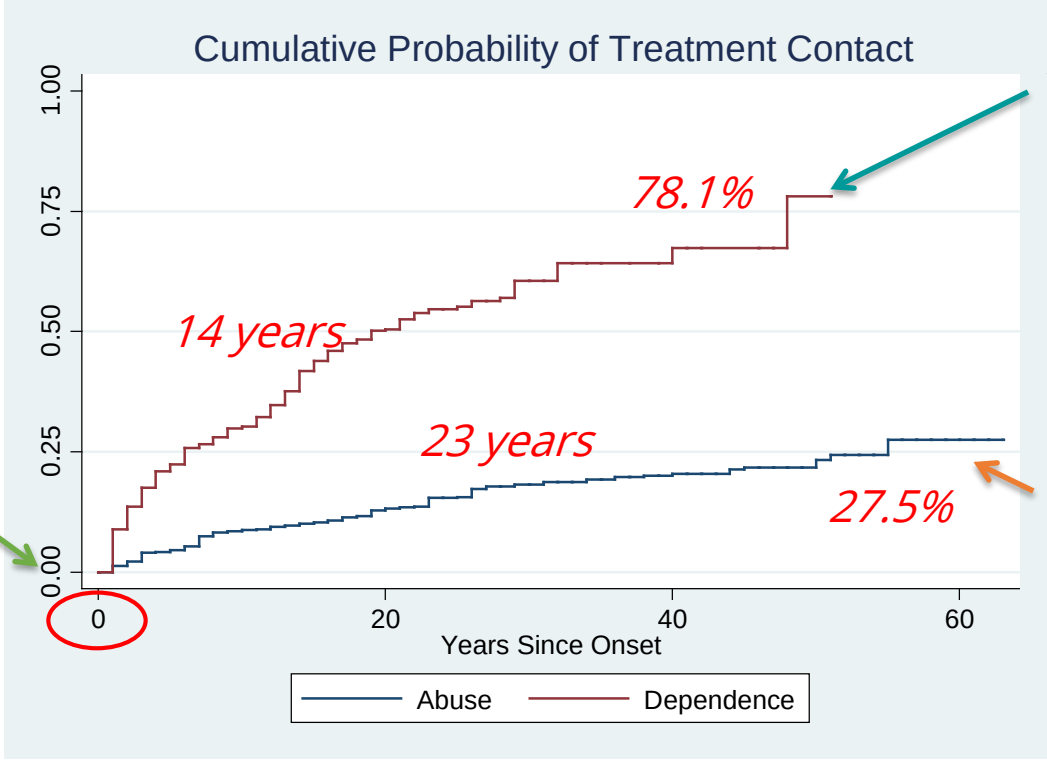
The delay to seek treatment is long…

The median delay among those with alcohol use disorders who eventually make treatment contact in Australia is… **18 years**

Onset:

50% by age 20

75% by age 28



Alcohol dependence

Alcohol abuse

Lifetime treatment rate of AUDs is 34.6%

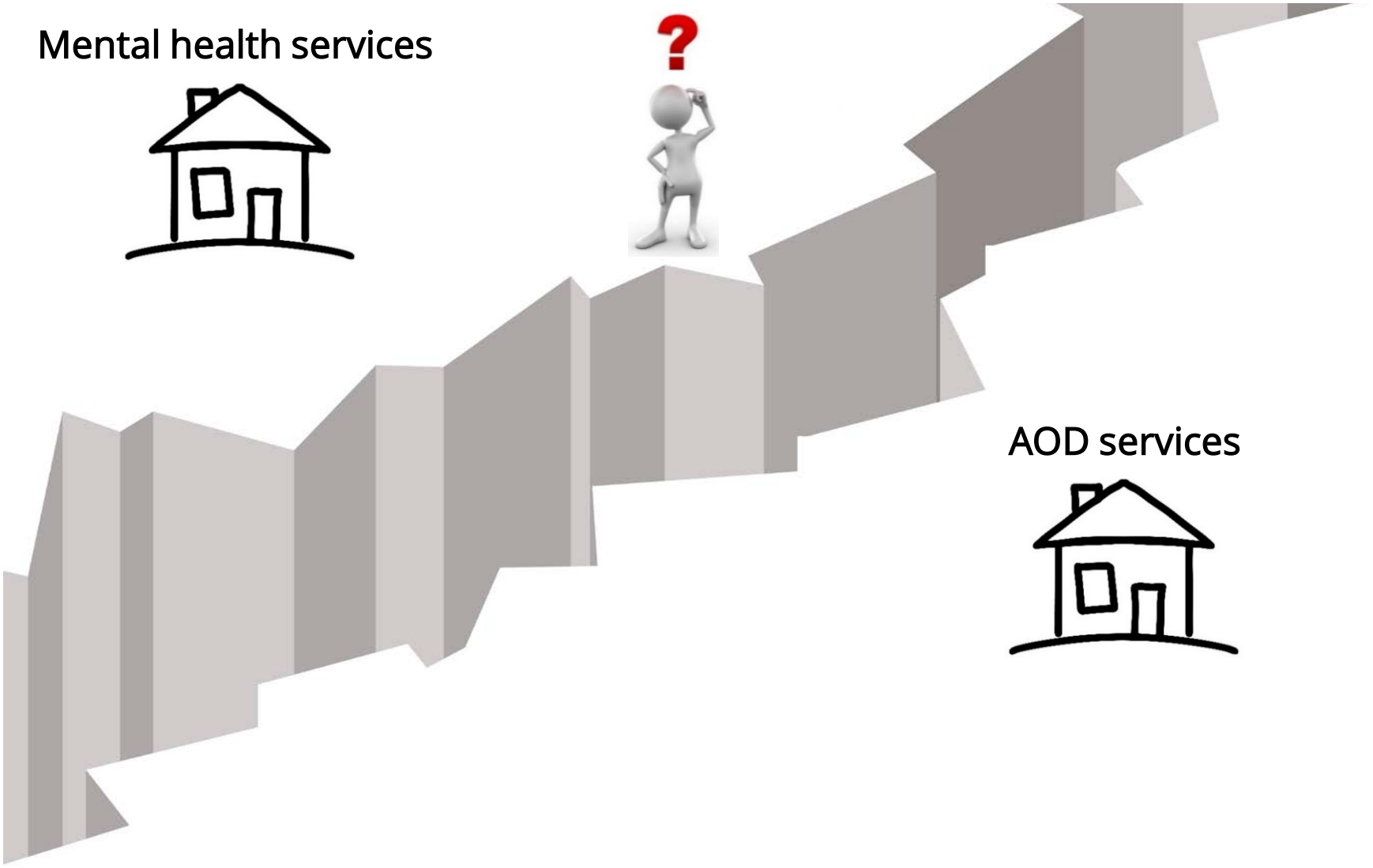
Source: Chapman C, Slade T, Hunt C, Teesson M (2015) Delay to first treatment contact for alcohol use disorder. Drug and Alcohol Dependence 147, 116-121

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Fragmented care

- “Siloed approach”
- “Fall through the gaps”

Fragmented care



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

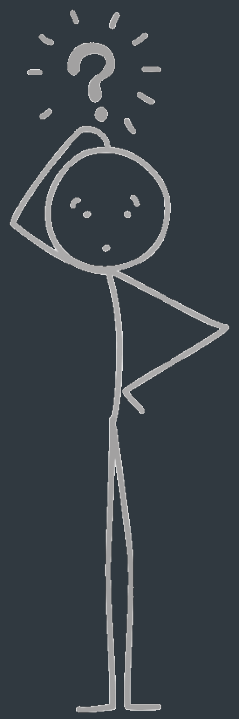
Key points

- Comorbidity is common
- Complicates treatment and recovery
- Relationship of mutual influence
- A number of barriers make it difficult for people with comorbidity to receive effective treatment

Overview

- Brief background: What do we know about comorbidity?
- What to do once comorbidity is identified
  - Management
  - Treatment from a holistic health care approach
- Referral pathways

What to do when comorbidity has been identified?



Once comorbidity has been identified

- Management of symptoms
- Treatment
  - Holistic health care approach

Managing comorbidity

Managing comorbidity

- The goal of management of mental health conditions is to allow treatment to continue with minimal disruption or drop-out
- Management strategies described in the Guidelines provide short term relief and control over symptoms
  - May not provide long-term relief from symptoms on their own - an interim measure during treatment until full treatment of co-existing problems is possible
- Guidelines provide “dos and don’ts” and practical strategies for managing common co-existing disorders

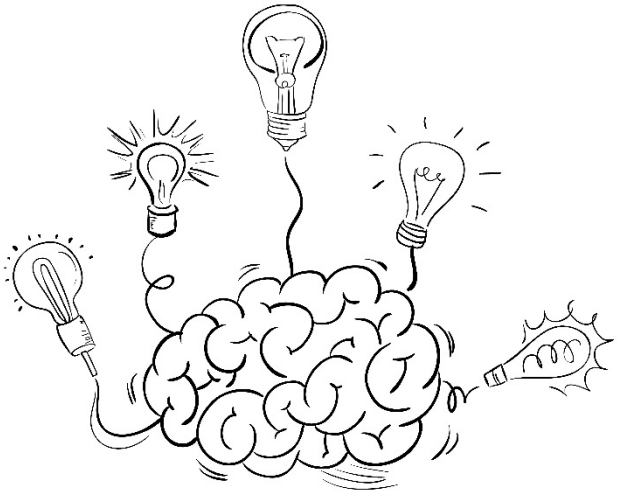
Managing comorbidity

- Various ways to effectively manage the symptoms of comorbid mental health conditions
- An advantage is that no diagnosis is required prior to their use
  - Symptoms are managed rather than disorders treated

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Managing symptoms of…

- Depression
- Anxiety
- Bipolar disorder
- Trauma
- Grief and loss
- Psychosis
- Personality disorder
- Attention-deficit/hyperactivity disorder (ADHD)
- Obsessive compulsive disorder (OCD)
- Eating disorders



phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Managing symptoms of depression and/or anxiety

Depression and Anxiety

- Negative mood often a trigger for relapse
  - Important to address depressive symptoms as part of relapse prevention
- Many depressive/anxiety symptoms will subside after a period of abstinence and stabilisation
  - During and after this time, constant monitoring will allow the clinician to determine whether further treatment is needed
  - If independent disorder suspected, clients should be assessed for depressive/anxiety disorder and further treatment options considered

Strategies to manage symptoms of depression or anxiety

- Several simple cognitive behaviour therapy (CBT) strategies which can be useful:
  - Cognitive restructuring
  - Pleasure and mastery events scheduling
  - Goal setting
  - Problem solving

Pages 336-356:
https://comorbidity.edu.au/cre-resources/guidelines-management-co-occurring-alcohol-and-other-drug-and-mental-health-0

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

CBT for depression and anxiety

Cognitive restructuring

- Based on the premise that what causes feelings of depression/ anxiety is not the situation itself, but the interpretation of the situation

Activating Event

(a situation)

Beliefs

(your automatic thoughts/reactions)

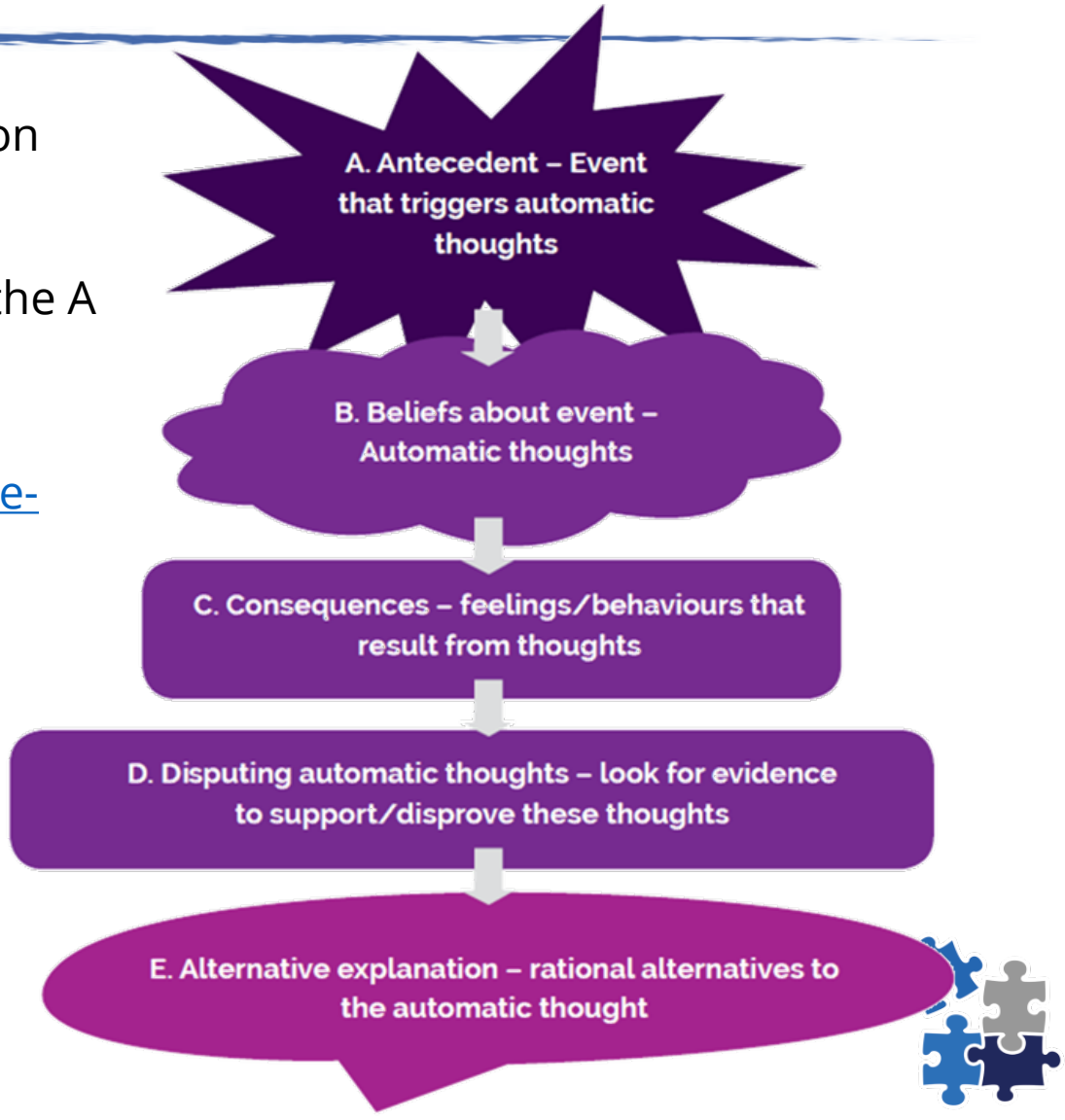
Consequences

(your feelings and behaviours)

- Rather than feeling hopeless about trying to control any situation which occurs (which is virtually impossible), a better approach is to learn how to control our **reaction** to those events - this will have a flow-on effect to our feelings and behaviours

Cognitive restructuring

- A simple process of recognition and modification of these thoughts and beliefs can be conducted with clients using the A – E model
- Page 255: https://comorbidity.edu.au/cre-resources/guidelines-management-co-occurring-alcohol-and-other-drug-and-mental-health-0



Cognitive restructuring: Managing thoughts

Overgeneralisation

Expectation that because something has failed once, it always will

'I tried to give up once before and relapsed. I will never be able to give up'

Catastrophising

Exaggerate the impact of events – imagine worst case scenario

'I had an argument with my friend, now they hate me and are never going to want to see me again'

Black/white, all or none

All or nothing, no balance

If gone wrong once, always will

'If I partly fail, it means I'm a complete failure'

Personalising

Blame self for anything bad that happens, take responsibility for others' feelings and behaviours

'It's my fault that my boyfriend is angry, I must have done something wrong'

Shoulds oughts musts

Can result in feelings of guilt, shame and failure

'I must always be on time'

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Cognitive restructuring worksheet

	A ⇨ B ⇨ C			Challenge negative thoughts		
	Activating event/trigger	Beliefs/ thoughts/ interpretations	Consequences: feelings/ behaviours			
Date	What happened?	What were you thinking?	What were you feeling? What did you do?	What is the evidence for and against your thoughts?	Is there any other way of looking at this situation?	What do you think now?

Problem solving

- Depression/anxiety often the result of an inability (or perceived inability) to deal effectively with problems
- Steps to assisting the client:
  - Identify the problem (try to break it down) and define it
  - Step back from the problem and try to view it as an objective challenge
  - Brainstorm possible solutions (realistic and unrealistic)
  - Think about each solution in practical terms, and evaluate the pros and cons
  - Decide on best solution (and a second, 'back-up' solution)
  - Put solution into action
  - Evaluate how effective it was and whether it can be improved

Goal setting

- Allows the client to experience feelings of control and success, which may counter common feelings of hopelessness and worthlessness
- Increases motivation, helps clinician ascertain what client's central concerns are
- Goals should be:
  - Geared towards the client's level of motivation and concern
  - Negotiated between client and clinician
  - Specific and achievable - it is important that the client begins to gain a sense of mastery by achieving his or her goals
  - Based on process rather than outcome
  - Short term – break down overall goals into shorter-term ones in order to increase motivation and feelings of success
  - Described in positive rather than negative terms

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Pleasure and mastery events scheduling

- People with depressive symptoms often stop engaging in behaviours that give them a sense of pleasure and achievement
  - Can lead to a cycle in which they become very inactive, leading to more negative feelings and lower mood and energy, which then leads to even less engagement in activities, and so on
- Weekly timetable in which they can schedule particular activities
- Encouraged to think of just one activity they can do for achievement and one for pleasure each day

Page 352 https://comorbidity.edu.au/cre-resources/guidelines-management-co-occurring-alcohol-and-other-drug-and-mental-health-0

Anxiety management techniques

- CBT strategies
- Relaxation methods:
  - Progressive muscle relaxation
  - Controlled or abdominal breathing
  - Calming response
  - Visualisation and imagery
  - Grounding – focusing attention on the outside world rather than the internal distress
- Work best if practiced daily for 10-20 minutes
- Not every technique may be appropriate for every client – if unpleasant effects experienced discontinue use

Page 340 https://comorbidity.edu.au/cre-resources/guidelines-management-co-occurring-alcohol-and-other-drug-and-mental-health-0

Depression: Dos

DO

- ✔ Encourage and emphasise successes and positive steps (even just coming in for treatment).
- ✔ Take everything they say seriously.
- ✔ Maintain eye contact and sit in a relaxed position – positive body language will help you and the client feel more comfortable.
- ✔ Use open-ended questions such as 'So tell me about…?' which require more than a 'yes' or 'no' answer. This is often a good way to start a conversation.
- ✔ Constantly monitor suicidal thoughts and talk about these thoughts openly and calmly.
- ✔ Encourage the client to express their feelings.
- ✔ Be available, supportive and empathetic.
- ✔ Offer realistic hope (i.e., that treatment is available and effective).
- ✔ Provide contact details of counselling services and offer to make referrals if required (many depressed people struggle to do this alone).
- ✔ Encourage participation in healthy, pleasurable and achievement-based activities (e.g., exercise, hobbies, work).

Depression: Don’ts

DON’T

- ✗ Make unrealistic statements or give unrealistic hope, like ‘everything will be fine’.
- ✗ Invalidate the client’s feelings.
- ✗ Be harsh, angry, or judgemental. Remain calm and patient.
- ✗ Act shocked by what the client may reveal.

Anxiety: Dos and don’ts

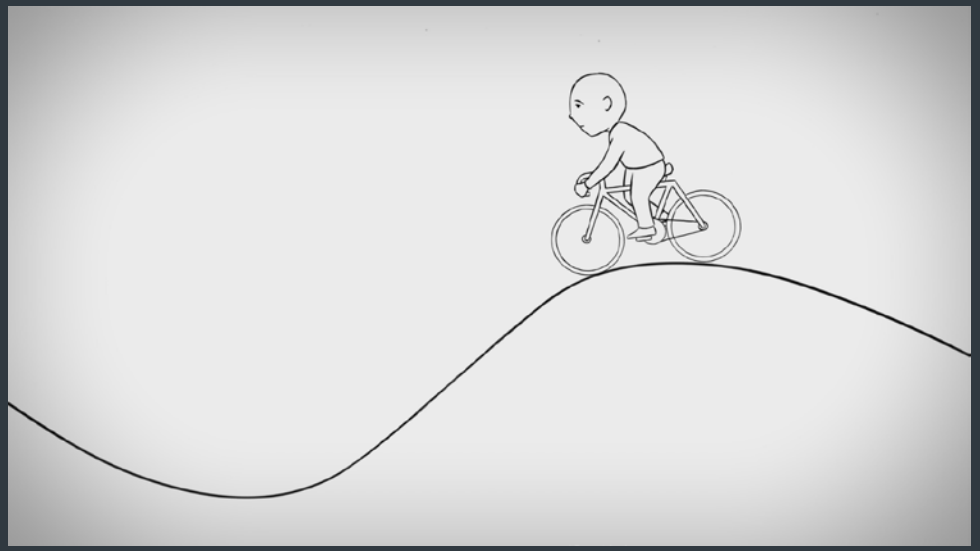
DO

- ✔ Approach the client in a calm, confident, and receptive way.
- ✔ Move and speak at an unhurried speed.
- ✔ Be patient in order to allow the client to feel comfortable to disclose information.
- ✔ Minimise the number of staff present and attending to the client.
- ✔ Minimise surrounding noise to reduce stimulation.
- ✔ Reassure the client frequently (e.g., ‘This won’t take much longer’).
- ✔ Explain the purpose of interventions.
- ✔ Remain with the client to calm them down.

DON’T

- ✘ Crowd or pressure the client.
- ✘ Get frustrated or impatient.
- ✘ Panic. The more relaxed you are the more relaxed the client is likely to feel.
- ✘ Act shocked by what the client may reveal.

Managing symptoms of bipolar disorder



Bipolar disorders

- Can be particularly challenging to treat due to the broad range of emotions experienced
  - Can impact on the relationship between the client and the therapist
- Clients can present with symptoms of depression or mania/hypomania
  - In between episodes, may appear completely well
- Predominantly present to services during the depressive phases of the disorder, rather than during periods of elation

Depressive episode

- If experiencing a depressive episode, may present with:
  - Low mood
  - Markedly diminished interest or pleasure in all, or most activities
  - Sleep disturbances
  - Appetite disturbances
  - Irritability
  - Fatigue
  - Psychomotor agitation or retardation
  - Poor concentration
  - Feelings of guilt, hopelessness, helplessness and worthlessness
  - Suicidal thoughts

Manic/hypomanic episode

- If experiencing a manic/hypomanic episode, may present with:
  - Persistent elevated mood
  - Symptoms of grandiosity
  - Flights of ideas
  - Hyperactivity
  - Decreased sleep
  - Psychomotor agitation
  - Talkativeness
  - Distractibility
- Can also lead to loss of insight, which can place the person at risk and impact negatively on medication compliance

Managing symptoms of bipolar

- If client presents during a depressive episode, management should follow management of depressive symptoms
- Negative mood often a trigger for relapse
  - Important to address depressive symptoms as part of relapse prevention
- If client is experiencing a manic episode or symptoms of psychosis, consult with a medical practitioner
- Some clients may be aware that they are unwell and will voluntarily seek help, others may lack insight into their symptoms and refuse help
- In some cases, manic symptoms can put both the client and others at risk of harm and therefore mental health services should be contacted, whether the client wants such a referral to be made or not

Bipolar: Depressive symptoms: Dos

DO

- ✔ Encourage and emphasise successes and positive steps (even just coming in for treatment).
- ✔ Take everything they say seriously.
- ✔ Maintain eye contact and sit in a relaxed position – positive body language will help you and the client feel more comfortable.
- ✔ Use open-ended questions such as 'So tell me about…?' which require more than a 'yes' or 'no' answer. This is often a good way to start a conversation.
- ✔ Constantly monitor suicidal thoughts and talk about these thoughts openly and calmly.
- ✔ Encourage the client to express their feelings.
- ✔ Be available, supportive and empathetic.
- ✔ Offer realistic hope (i.e., that treatment is available and effective).
- ✔ Encourage regular sleep, exercise and eating patterns.
- ✔ Keep language clear, specific and simple.
- ✔ Assist the client to identify warning signs that they may become unwell.
- ✔ Provide contact details of counselling services and offer to make referrals if required (many depressed people struggle to do this alone).
- ✔ Encourage participation in healthy, pleasurable and achievement-based activities (e.g., exercise, hobbies, work).

Bipolar: Depressive symptoms: Don’ts

DON’T

- ✗ Make unrealistic statements or give unrealistic hope, like ‘everything will be fine’.
- ✗ Invalidate the client’s feelings.
- ✗ Be harsh, angry, or judgemental. Remain calm and patient.
- ✗ Lose hope or become frustrated.
- ✗ Act shocked by what the client may reveal.

Bipolar: Mania/hypomania symptoms: Dos

DO

- ✔ Ensure the safety of the client, yourself, and others.
- ✔ Assist the client identify warning signs that they may become unwell.
- ✔ Help to reduce triggers that aggravate the person's symptoms (e.g., reduce stimulation such as noise, clutter, caffeine, social gatherings).
- ✔ Speak clearly and calmly, asking only one question or giving only one direction at a time.
- ✔ Answer questions briefly, quietly, calmly and honestly.
- ✔ Use a consistently even tone of voice, even if the person becomes aggressive.
- ✔ Encourage regular sleep, exercise and eating patterns.
- ✔ Be cautious about becoming swept up by the person's elevated mood.
- ✔ Point out the consequences of the client's behaviour. Be specific.
- ✔ If the person is well enough, discuss precautions they can take to prevent risky activities and negative consequences (e.g., give their credit cards and/or car keys temporarily to a trusted family member or friend to prevent reckless spending and driving).
- ✔ If promiscuity or socially inappropriate behaviour is a problem encourage the person to avoid situations in which their behaviour may led to negative consequences.
- ✔ Encourage the person to postpone acting on a risky idea until their mood is stable.
- ✔ Ensure both you and the client can access exits – if there is only one exit, ensure that you are closest to the exit.
- ✔ Have emergency alarms/mobile phones, and have crisis teams/police on speed dial.
- ✔ If the person is placing themselves at risk, or they are experiencing severe symptoms of psychosis, arrange transfer to an emergency department for assessment and treatment by calling an ambulance on 000.

Bipolar: Mania/hypomania symptoms: Don’ts

DON’T

- ✗ Argue, criticise or behave in a threatening way towards them. Consider postponing or avoiding discussion of issues that aggravate the client for the time being. Try to talk about more neutral topics.
- ✗ Get visibly upset or angry with the client. Remain calm and patient.
- ✗ Confuse and increase the client’s level of stress by having too many workers attempting to communicate with them.
- ✗ Get drawn into long conversations or arguments with the person as these can be overstimulating and upsetting. People with elevated moods are vulnerable despite their apparent confidence, and they tend to take offence easily.
- ✗ Leave dangerous items around that could be used as a weapon or thrown.
- ✗ Laugh (or let others laugh) at the person.
- ✗ Act horrified, worried or panic.

Managing trauma-related symptoms

Trauma-related symptoms

- Following trauma exposure may experience:
  - Recurrent ‘re-experiencing’ of the traumatic event, through nightmares, ‘flashbacks’ and intrusive memories
  - Avoidance of thoughts, reminders or situations associated with the trauma, general numbing of emotional responsiveness
  - Symptoms of increased physiological arousal, including hypervigilance to cues, sleep difficulties, startle response, anger and poor concentration

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Trauma-related symptoms

- Common for the frequency/intensity of symptoms to increase when a person stops drinking or using drugs
- Avoidance symptoms associated with the perpetuation of trauma-related symptoms
- If a person does become upset due to these traumatic thoughts, they should not be encouraged to avoid or suppress these thoughts or feelings
- Telling a person not to think or talk about what happened may also intensify feelings of guilt and shame

Trauma: Dos

DO

- ✔ Display a comfortable attitude if the client chooses to describe their trauma experience.
- ✔ Give the client your undivided attention, empathy and unconditional positive regard.
- ✔ Normalise the client's response to the trauma and validate their feelings.
- ✔ Praise the client for their resilience in the face of adversity.
- ✔ Praise the client for having the courage to talk about what happened.
- ✔ Use relaxation and grounding techniques where necessary.
- ✔ Educate the client on what to expect if they undergo detoxification (e.g., a possible increase in trauma-related symptoms).
- ✔ Maximise opportunities for client choice and control over treatment processes.
- ✔ Monitor depressive and suicidal symptoms.

Trauma: Don’ts

DON’T

- ✗ Rush or force the client to reveal information about the trauma.
- ✗ Engage in an in-depth discussion of the client’s trauma unless you are trained in trauma responses.
- ✗ Judge the client in relation to the trauma or how they reacted to the trauma.
- ✗ Abruptly end the session.
- ✗ Encourage the client to suppress their thoughts or feelings.
- ✗ Engage in aggressive or confrontational therapeutic techniques.
- ✗ Be afraid to seek assistance.
- ✗ Use overly clinical language without clear explanations.

Grief and loss

- Sources of grief and loss:
  - traumatic experiences
  - lost partners, family members or friends as a result of AOD use
  - Giving up AOD use
- Normalise the process for clients
- Encourage and support the grieving process
- Different approaches work for different people

Grief or loss: Dos

DO

- ✔ Encourage the acceptance of the reality of the situation (e.g., discuss the loss, encourage client to attend gravesite), as well as the identification and experience of feelings (positive and negative) associated with loss.
- ✔ Help the client find a suitable way to remember, but also reinvest in life.
- ✔ Continually monitor levels of depression and suicidal thoughts and act accordingly; risk is increased during periods of grief (e.g., the first 12 months after a death, anniversaries, holidays).
- ✔ Be aware and understanding of feelings associated with grief, including anger.
- ✔ Give both practical and emotional support.
- ✔ Give the client your undivided attention and unconditional positive regard.
- ✔ Be aware that concentration may be affected, therefore repeat instructions, write down instructions and so on.
- ✔ Encourage healthy avenues for the expression of grief (e.g., physical activity, relaxation, artistic expression, talking, writing) rather than AOD use.
- ✔ Encourage the client to seek social support. This may include bereavement services.

Grief or loss: Dos

DON'T

- ✗ Avoid the reality of the situation or the feelings associated with it (e.g., use the name of deceased).
- ✗ Judge or be surprised at how the client reacts – every person is different.
- ✗ Time-limit the client when discussing grief, it can be a slow process.
- ✗ Be afraid to seek assistance.

Managing symptoms of psychosis

Acute psychosis

- Represents one of the most severe and complex presentations
- During an episode a person's behaviour is likely to be disruptive and/or peculiar
- Psychotic symptoms include:
  - Delusions
  - Hallucinations
  - Disorganised speech
  - Disorganised thought
  - Catatonic behaviour
  - Rapid or extreme mood swings

Psychotic symptoms

- Clients in AOD settings can present with sub-acute psychosis, as a result of methamphetamine and other stimulant use
- Display a range of low-grade psychotic symptoms:
  - Increased agitation, severe sleep disturbance
  - Mood swings
  - A distorted sense of self, others or the world
  - Suspiciousness, guardedness, fear or paranoia
  - Odd or overvalued ideas
  - Illusions/fleeting, low-level hallucinations
  - Erratic behaviour

Psychosis: Dos

DO

- ✔ Ensure the environment is well lit to prevent perceptual ambiguities.
- ✔ Ensure discussions take place in settings where privacy, confidentiality, and dignity can be maintained.
- ✔ Try to reduce noise, human traffic, or other stimulation within the person's immediate environment (e.g., reduce clutter).
- ✔ Ensure the safety of the client, yourself, and others.
- ✔ Allow the person as much personal space as possible.
- ✔ Be aware of your body language – keep your arms by your sides, visible to the client.
- ✔ Ignore strange or embarrassing behaviour if you can, especially if it is not serious.
- ✔ Listen attentively and respectfully.
- ✔ Appear confident, even if you are anxious inside – this will increase the client's confidence in your ability to manage the situation.
- ✔ Speak clearly and calmly, asking only one question or giving only one direction at a time.
- ✔ Use a consistently even tone of voice, even if the person becomes aggressive.
- ✔ Limit eye contact as this can imply a personal challenge and might prompt a hostile, protective response.
- ✔ Point out the consequences of the client's behaviour. Be specific.
- ✔ Ensure both you and the client can access exits – if there is only one exit, ensure that you are closest to the exit.
- ✔ Have emergency alarms/mobile phones, and have crisis teams/police on speed dial.
- ✔ If psychosis is severe, arrange transfer to an emergency department for assessment and treatment by calling an ambulance on 000.

Psychosis: Don’ts

DON’T

- Get visibly upset or angry with the client.
- Confuse and increase the client’s level of stress by having too many workers attempting to communicate with them.
- Argue with the client’s unusual beliefs or agree with or support unusual beliefs – it is better to simply say ‘I can see you are afraid, how can I help you?’
- Use ‘no’ language, as it may provoke hostility and aggression. Statements like ‘I’m sorry, we’re not allowed to do ____ but I *can* offer you other help, assessment, referral…’ may help to calm the client whilst retaining communication.
- Use overly clinical language without clear explanations.
- Crowd the client or make any sudden movements.
- Leave dangerous items around that could be used as a weapon or thrown.

Managing symptoms of psychosis

- Some clients may be aware that they are unwell and will voluntarily seek help
- Others may lack insight into their symptoms and refuse help.
- Active phase psychosis can put both the client and others at risk of harm and therefore mental health services should be contacted, whether the client wants such a referral to be made or not.
- Consider stigma and discrimination associated with both psychotic spectrum disorders and AOD
  - Frightened of being imprisoned, forcibly medicated, having children removed
  - Engage the client, develop respectful, non-judgmental relationship, with hope and optimism

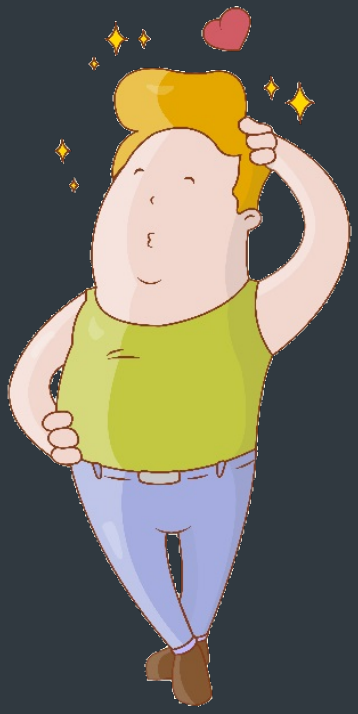
Symptoms of psychosis

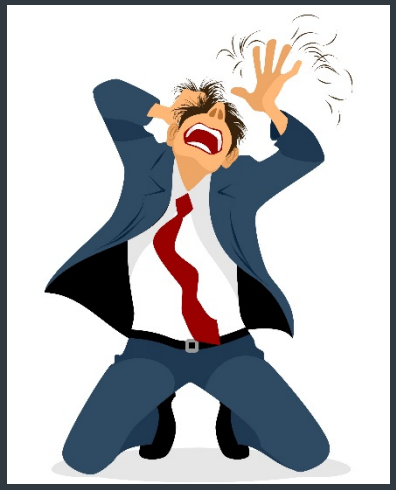
- Some clients with psychotic disorders may present to treatment when stable on antipsychotic medication and may not be displaying any active symptoms
- Encouraged to take any medication as prescribed
- Ensure they receive an adequate diet, relaxation and sleep - stress can trigger some psychotic symptoms

Psychosis and continued AOD use

- Despite the risk of further psychotic episodes, some people choose to keep using substances that may induce psychosis. In such cases the following strategies may be helpful:
  - Educate the client about 'reverse tolerance' (i.e., increased sensitivity to a drug after a period of abstinence) and the increased chance of future psychotic episodes
  - Encourage the client to avoid high doses of drugs and riskier administration methods (e.g., injecting in the case of methamphetamine)
  - Encourage the client to take regular breaks from using and to avoid using multiple drugs
  - Teach the client to recognise early warning signs that psychotic symptoms might be returning (e.g., feeling more anxious, stressed or fearful, hearing things, seeing things, feeling 'strange'), encourage them to immediately stop AOD use and seek help to reduce risk of full-blown episode
  - Inform the client that AOD use can make prescribed medications for psychosis ineffective

Managing symptoms of personality disorders





Personality disorders

- Clients with personality disorders have frequent and enduring problems in coping and interpersonal interaction. Symptoms can include:
  - Manipulative behaviour
  - Impulsivity
  - Social impairments
  - Emotional detachment
  - Suspiciousness
  - Difficulty accepting responsibility or accommodating others
  - Emotional instability and hypersensitivity
  - Pervasive and persistent anger/aggression
  - Being overly self-involved
  - Excessive dependence on others
  - Inflexible, maladaptive responses to situations

Managing symptoms of personality disorders

- Symptoms often present in varying degrees in many clients, do not necessarily indicate a personality disorder
- Can make the therapeutic process more difficult
- Some of these characteristics (impulsivity in particular) place clients at extremely high-risk for suicide – monitor risk of suicide and self-harm
- Assist clients to develop skills (e.g., breathing retraining, meditation, cognitive restructuring) to manage negative emotions

Clients with personality disorders

- Difficulty forming a genuinely positive thera alliance
- Frame reality in terms of their own needs and perceptions and not to understand those of others
- Limited in their ability to receive, accept or benefit from corrective feedback
- Progress is likely to be slow and uneven

Engaging clients with personality disorders

- Engagement and rapport building very important - may require more time and attention.
- Clients may have trouble engaging in treatment:
  - history of poor relationships with health professionals
  - bias towards suspiciousness or paranoid interpretation of relationships
  - chaotic lifestyle making appointment scheduling and engaging in structured work more difficult
- Structure and firm boundaries important

Personality: Dos

DO

- ✔ Place strong emphasis on engagement to develop a good client–worker relationship and build strong rapport.
- ✔ Set clear boundaries and expectations regarding the client's role and behaviour. Some clients may seek to test these boundaries.
- ✔ Establish and maintain a consistent approach to clients and reinforce boundaries.
- ✔ Anticipate compliance problems and remain patient and persistent.
- ✔ Plan clear and mutual goals and stick to them; give clear and specific instructions.
- ✔ Help with the current problems the client presents with rather than trying to establish causes or exploring past problems.
- ✔ Assist the client to develop skills to manage negative emotions (e.g., breathing retraining, progressive muscle relaxation, cognitive restructuring).
- ✔ Take careful notes and monitor the risk of suicide and self-harm.
- ✔ Avoid judgement and seek assistance for personal reactions (including frustration, anger, dislike) and poor attitudes towards the client.
- ✔ Listen to and evaluate the client's concerns.
- ✔ Accept but do not confirm the client's beliefs.

Personality: Don’ts

DON’T

- ✗ Reward inappropriate behaviour (such as demanding, aggressive, suicidal, chaotic or seductive behaviour).
- ✗ Get frustrated and angry with the client. Remain firm, calm and in control.
- ✗ Assume a difficult client has a personality disorder; many do not, and many clients with these disorders are not difficult.

Managing symptoms of attention deficit/hyperactivity disorder (ADHD)

Attention-deficit/hyperactivity disorder (ADHD)

- Pattern of inattention, hyperactivity, and/or impulsivity
- Attentional difficulties are more likely to persist into adulthood, whilst impulsivity and hyperactivity tend to diminish over time
- Adult symptoms present differently to those displayed in children, and may include:
  - Difficulties with time management
  - Disorganisation, procrastination
  - Lack of motivation
  - Difficulties sleeping
  - Irritability, frustration, or anger
  - Fatigue

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Managing ADHD symptoms

- Adult symptoms of ADHD (cont.):
  - Difficulties concentrating or studying
  - Occupational or workplace difficulties
  - Problems forming and maintaining relationships
  - Difficulty obtaining and/or maintaining stable employment
  - History of imprisonment or frequent contact with police
- People diagnosed with ADHD in adulthood may require additional psychosocial support to assist them to come to terms with their diagnosis, and reframe their past

ADHD: Dos and Don’ts

DO

- ✔ Assist the client plan activities and organise prompts or reminders (e.g., using a smartphone).
- ✔ Encourage stress-reduction methods, such as progressive muscle relaxation.
- ✔ Encourage physical exercise.
- ✔ Monitor closely during times of stress – these may lead to fluctuations in symptoms and may necessitate the adjustment of medication.
- ✔ Involve family members and friends – educating them about the condition and treatment will provide long-term benefits.
- ✔ Offer to help the client engage with education courses or training, which can assist with attention training.

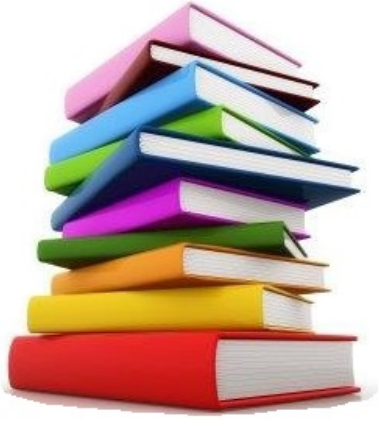
DON’T

- ✘ Get visibly upset or angry with the client.
- ✘ Confuse the client by conducting unstructured, unfocused sessions.

Managing symptoms of obsessive compulsive disorder (OCD)

Obsessive compulsive disorder (OCD)

- Symptoms can cause significant distress, and impair functioning
- Plagued with persistent thoughts or impulses that are intrusive and unwanted (obsessions) and may feel compelled to perform repetitive, ritualistic actions that are excessive and time consuming (compulsions)
- Symptoms of obsessions may include:
  - Fear of germs, dirt, or poisons
  - Harm from illness or injury to self or others
  - Intrusive thoughts about sex or sexual acts
  - Excessive concerns with symmetry or orderliness
  - Needing to know or remember things
  - Hoarding or saving and collecting things



phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Symptoms of OCD

- A person may feel annoyed, discomforted, distressed, or panic about their obsessions, and feel driven to perform repetitive mental or physical acts in response
- Symptoms of compulsions may include:
  - Excessive hand washing, showering, tooth brushing
  - Excessively checking locks, appliances, other safety items
  - Repeating activities or routines (e.g., opening a door, switching a light on and off)
  - Applying rules to the placement of objects
  - Inability to throw out excessive collections of items (e.g., newspapers, clothes)

Managing OCD

- May go under-detected among people with AOD conditions
- Many people may have mild symptoms that are associated with stressful life events or situations
  - Often improve without the need for specific treatments
- Those who experience the severity, distress and impairment associated with more chronic and enduring OCD may benefit from some form of treatment

OCD: Dos

DO

- ✔ Ignore strange or embarrassing behaviour if you can, especially if it is not serious.
- ✔ Approach the client in a calm, confident and receptive way.
- ✔ Move and speak at an unhurried speed.
- ✔ Be patient in order to allow the client to feel comfortable to disclose information.
- ✔ Minimise the number of staff present and attending to the client.
- ✔ Minimise surrounding noise to reduce stimulation.
- ✔ Reassure the client frequently (e.g., 'This won't take much longer').
- ✔ Explain the purpose of interventions.
- ✔ Remain with the client to calm them down.

OCD: Don’ts

DON’T

- Crowd or pressure the client.
- Become frustrated or impatient.
- Laugh (or let others laugh) at the person.
- Act horrified, worried or panic.
- Confuse and increase the client’s level of stress by having too many workers attempting to communicate with them.
- Argue with the client’s unusual beliefs or agree with or support unusual beliefs – it is better to simply say ‘I can see you are anxious, how can I help you?’
- Use ‘no’ language, as it may provoke hostility and aggression. Statements like ‘I’m sorry, we’re not allowed to do ____ but I *can* offer you other help, assessment, referral…’ may help to calm the client whilst retaining communication.
- Use overly clinical language without clear explanations.

Managing symptoms of eating disorders

Eating disorders

- Anorexia nervosa, bulimia nervosa, binge eating disorder frequently co-occur with AOD use
- Particularly complex and challenging in terms of assessment and treatment, associated physical health complications, potential negative cognitive impacts
  - Can be made more challenging by tendency of people with eating disorders to minimise or deny symptoms => genuine lack of insight or deliberate deception

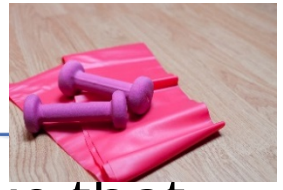
Managing eating disorders

- Identification of comorbid eating disorders and AOD use is critical – consequences are severe and can include:
  - medical complications
  - additional, severe psychiatric comorbidities
  - suicidal ideation and attempts
  - mortality

- Vital that health workers can recognise clinical and subthreshold signs of eating disorders, and have so understanding of simple management strategies

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Symptoms of eating disorders



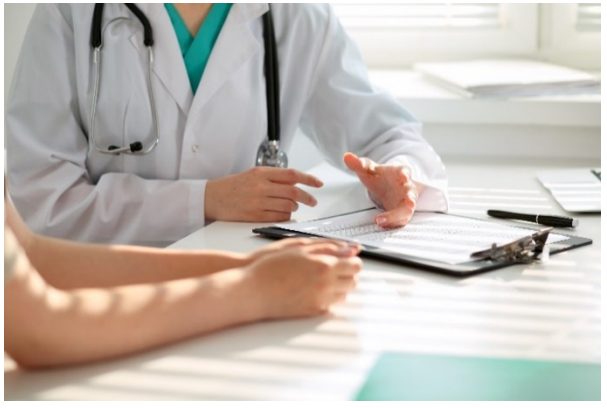
- Disturbances in eating behaviours and food intake that impair psychosocial functioning and/or physical health. This may involve:
  - Food restriction (e.g., limiting the amount of food eaten each day by reducing portion size, eliminating food types such as fats or carbohydrates, or not eating at all)
  - Vomiting and purging
  - Overexercising
  - Binge eating (i.e., consuming an objectively large amount of food in a short period of time, accompanied by a sense of feeling out of control)

Symptoms of eating disorders

- Physical symptoms related to starvation, bingeing, purging, overexercising
  - May show few outward signs of disorder
  - Any signs may be complicated by AOD use (e.g., AOD use can influence weight, appetite, food restriction)
- Level of care dependent on illness severity, medical complications, dangerousness of behaviours, psychiatric comorbidities (depression/anxiety)
- May be AOD use related to eating disorder (e.g., use of tobacco, stimulants, diet pills, laxatives, diuretics, caffeine to control or suppress appetite)
- Assessment should include focus on AOD use as weight loss mechanism and role in emotion regulation

Managing eating disorders

- General principles of managing (and treating) eating disorders include
  - Establish trusting, collaborative, therapeutic relationship
  - Avoid any potential power struggles



Eating disorders: Dos

DO

- ✔ Encourage and emphasise successes and positive steps (even just coming in for treatment).
- ✔ Take everything they say seriously.
- ✔ Approach the client in a calm, confident and receptive way.
- ✔ Be direct and clear in your approach.
- ✔ Use open-ended questions such as ‘So tell me about…?’ which require more than a ‘yes’ or ‘no’ answer. This is often a good way to start a conversation.
- ✔ Constantly monitor suicidal thoughts and talk about these thoughts openly and calmly.
- ✔ Encourage the client to express their feelings.
- ✔ Focus on feelings and relationships, not on weight and food.
- ✔ Be available, supportive and empathetic.
- ✔ Encourage participation in healthy, pleasurable and achievement-based activities (e.g., exercise, hobbies, or work).
- ✔ Encourage, but do not force, healthy eating patterns.
- ✔ Assist the client to set realistic goals.
- ✔ Involve family or friends in management or treatment strategies.
- ✔ Be patient in order to allow the client to feel comfortable to disclose information.
- ✔ Explain the purpose of interventions.

Eating disorders: Don’ts

DON’T

- ✗ Act shocked by what the client may reveal.
- ✗ Be harsh, angry, or judgemental. Remain calm and patient.
- ✗ Use statements that label, blame or shame the client.
- ✗ Invalidate the client’s feelings.
- ✗ Make comments (either positive or negative) about body weight, appearance or food – these will only reinforce their obsession.
- ✗ Express any size prejudice, or reinforce the desire to be thin.
- ✗ Engage in power struggles about eating.
- ✗ Criticise their eating habits.
- ✗ Trick or force the person to eat.
- ✗ Get frustrated or impatient.

Managing Michelle's symptoms

- Decided to see a counsellor at the clinic
- Identified depression, anxiety and trauma-related symptoms (in addition to AOD use problems)

- Counsellor provided several techniques to help Michelle manage her symptoms on a day-to-day basis
  - Controlled breathing
  - Grounding
- Also tried to do something nice for herself each day

Key points

- Comorbid mental health symptoms can be managed and controlled whilst the client undergoes treatment
- Monitor suicide risk throughout treatment
- Motivational enhancement, simple CBT-based strategies, relaxation and grounding techniques can be useful in managing AOD use as well as mental health conditions

Overview

- Brief background: What do we know about comorbidity?
- What to do once comorbidity is identified
  - Management
  - Treatment from a holistic health care approach
- Referral pathways

Treating comorbidity

Treatment

- Much more research is needed before definitive practices can be prescribed
  - People with AOD use disorders are commonly excluded from trials of psychotherapies and pharmacotherapies for mental health disorders
  - Recommendations are based largely on expert opinion rather than evidence from research
- It can be generally concluded that treatments that work for a single disorder will lead to some improvements in comorbid clients, if not in both disorders
- Some interventions have been designed for the treatment of specific comorbidities; however, these interventions generally have not been well researched
- In the absence of specific research on comorbid disorders, it is generally recommended that best practice is to use the most effective treatments for each disorder

Treatment of AOD use

- Abstinence is favoured - particularly for:
  - Those whose mental health conditions are exacerbated by AOD use
  - Those with more severe mental disorders (or cognitive impairment) - even low-level AOD use may be problematic for these individuals
  - Those taking medications for mental health conditions (e.g., antipsychotics, antidepressants) - interaction effects

BUT many will prefer goal of moderation


Lapse
≠
Relapse

Mindful of ‘whole person’

treat the person, not the illness

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Models of care

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

Approaches

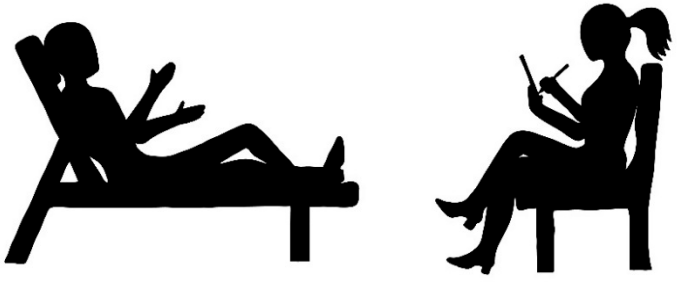
- For most comorbidities, both psychological and pharmacological interventions have been found to have some benefit
- Recommended that when pharmacotherapy is used, should be accompanied by supportive psychosocial interventions
  - Aware of potential interactions between medications and other substances
- Symptoms are less likely to return on completion of psychological treatment compared to pharmacotherapy, where relapse on cessation is common
- Some clients may be better able to respond to psychological interventions if they are taking pharmacotherapies (e.g., acamprosate/naltrexone may help free from distracting cravings)

Pharmacotherapies

- When prescribing medications take into account:
  - Possible interaction effects with other prescribed and non-prescribed substances
  - The possible presence of medical problems such as liver dysfunction related to long-term AOD use or hepatitis
  - The abuse potential of the medication being prescribed
  - Strategies to improve compliance (e.g., simple regimes, clear instructions, pill dispensers, alarms, link medication to meals etc)

Psychological approaches

- Number of psychological approaches that are commonly used in the treatment of many mental health disorders:
  - Motivational interviewing
  - Cognitive-behavioural therapy
  - Relapse prevention techniques
  - Psychosocial groups
  - Self-help groups
  - Mindfulness training
  - Contingency management



- May be necessary for a substantial reduction in substance use and withdrawal symptoms to occur before more intensive psychotherapies can be effective

Other approaches

- E-health interventions
- Physical activity
- Complementary and alternative therapies (e.g., yoga, dietary and nutritional supplements, and herbal remedies)

Treating depressive disorders*

Treatment	Overview
Psychotherapy	• CBT techniques • CBT + contingency management • Behavioural activation
Pharmacotherapy	• Use a medication with a good side effect profile, proven efficacy in depression and minimal negative interactions with the substance of abuse • Similar side effect profile to substance of abuse
ECT	• Effective for depression as single disorder, no evidence for ECT in treating comorbid depression and AOD use
E-health	• Based on CBT therapies • *SHADE program* • *DEAL project*
Physical activity	• Various physical exercises of different durations & intensity
Complementary and alternative therapies	• Yoga • Omega-3

*More research on comorbid disorders needed

Source: Marel et al 2016 *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: CREMS, NDARC, UNSW

Treating anxiety disorders*

Treatment	Overview
Psychotherapy	• CBT • CBT + motivational interviewing
Pharmacotherapy	• Dearth of research • Use a medication with a good side effect profile, proven efficacy in the anxiety disorder and minimal negative interactions with the substance of abuse • SSRIs commonly prescribed
E-health	• Based on CBT therapies • *FearFighter* (anxiety only) • *Anxiety online* (anxiety only)
Physical activity	• Various physical exercises of different durations and intensity
Complementary and alternative therapies	• Yoga • Dietary supplements

*More research on comorbid disorders needed

Source: Marel et al 2016 *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: CREMS, NDARC, UNSW

Treating bipolar disorders*

Treatment	Overview
Psychotherapy	• Dearth of research • Psychosocial group treatment program based on cognitive behavioural relapse prevention model • brief version of integrated group therapy
Pharmacotherapy	• Multiple medications • Mood stabilisers, antipsychotics, and/or antidepressants + medication for AOD use
ECT	• No research for comorbid bipolar and AOD use • Second line treatment option in very severe cases of bipolar disorder
E-health	• None for comorbid bipolar and AOD use • *MoodSwings, Living With Bipolar, Beating Bipolar*, the *Bipolar Education Programme*, and *HealthSteps for Bipolar Disorder*
Physical activity	• Monitored physical exercises of different durations and intensity
Complementary and alternative therapies	• Dietary supplements

*More research on comorbid disorders needed

Source: Marel et al 2016 *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: CREMS, NDARC, UNSW

Treating PTSD*

Treatment	Overview
Psychotherapy	• Past and present focused therapies • EMDR
Pharmacotherapy	• Dearth of research • Use a medication with a good side effect profile, proven efficacy in PTSD and minimal negative interactions with the substance of abuse • SSRIs
E-health	• *PTSD online* (PTSD only) • *PTSD coach* (PTSD only) • *PTSD program* (PTSD only)
Physical activity	• Various physical exercises of different durations and intensity
Complementary and alternative therapies	• Yoga

*More research on comorbid disorders needed

Source: Marel et al 2016 *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: CREMS, NDARC, UNSW

Treating psychosis*

Treatment	Overview
Psychotherapy	• Integrated psychosocial treatments (treatments addressing both disorders, in combination with case management, vocational rehabilitation, family counselling and housing, as well as medications) • Motivational interviewing + CBT • Contingency management
Pharmacotherapy	• Dearth of research (most people with psychosis/AOD use excluded from trials) • Antipsychotics (BUT caution should be taken when selecting pharmacotherapies for AOD use -> some are contraindicated in individuals with psychotic disorders as they may exacerbate symptoms)
E-health	• Early stages of research
Physical activity	• Various physical exercises of different durations and intensity

*More research on comorbid disorders needed

Source: Marel et al 2016 *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: CREMS, NDARC, UNSW

Treating personality disorders*

Treatment	Overview
Psychotherapy	BPD • Dialectical behavioural therapy-S (DBT-S) • Dual Focus Schema Therapy (DFST) • Dynamic Deconstructive Psychotherapy (DDP) • CBT-based approaches for both bulimia nervosa and binge eating disorder ASPD • Dearth of research – addition of contingency management and/or CBT to methadone maintenance
Pharmacotherapy	• Dearth of research
E-health	• DBT Coach for BPD
Physical activity	• Various physical exercises of different durations and intensity
Complementary and alternative therapies	• Limited evidence

*More research on comorbid disorders needed

Source: Marel et al 2016 *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: CREMS, NDARC, UNSW

Treating ADHD*

Treatment	Overview
Psychotherapy	• CBT + pharmacotherapy • Meta-cognitive group therapy • therapist-led structured skills training • therapist-led cognitive remediation
Pharmacotherapy	• Psychostimulants following medical assessment
E-health	• E-health programs incorporating apps to assist people with organisation (e.g., calendars, schedules, timers, reminders, shopping lists, and cleaning and laundry schedules)
Physical activity	• Various physical exercises of different durations and intensity
Complementary and alternative therapies	• Dietary supplements

*More research on comorbid disorders needed

Source: Marel et al 2016 *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: CREMS, NDARC, UNSW

Treating OCD*

Treatment	Overview
Psychotherapy	• Exposure and response prevention (ERP) • CBT and ERP
Pharmacotherapy	• Dearth of research • Use a medication with a good side effect profile, proven efficacy in OCD and minimal negative interactions with the substance of abuse • SSRIs, TCAs commonly prescribed
E-health	• Based on CBT therapies • *ICBT* (OCD only)
Physical activity	• Various physical exercises of different durations and intensity
Complementary and alternative therapies	• Some evidence for mindfulness meditation, electroacupuncture, yoga, nutrient glycine, borage, and milk thistle for single-disorder OCD, but based on methodologically weak studies

*More research on comorbid disorders needed

Source: Marel et al 2016 *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: CREMS, NDARC, UNSW

Treating eating disorders*

Treatment	Overview
Psychotherapy	• CBT-based approaches for both bulimia nervosa and binge eating disorder
Pharmacotherapy	• Dearth of research • Use a medication with a good side effect profile, proven efficacy in eating disorders and minimal negative interactions with the substance of abuse • Useful adjunct to the treatment of single disorder ED • Not recommended in the absence of psychotherapy
E-health	• Internet-based therapy as adjunct to other treatment
Physical activity	• Monitored physical exercises of different durations and intensity
Complementary and alternative therapies	• Many examined but no intervention identified as effective, evidence-based treatment for this comorbidity • Promising preliminary findings relating to the use of yoga, hypnosis, therapeutic massage

*More research on comorbid disorders needed

Source: Marel et al 2016 *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: CREMS, NDARC, UNSW

Key points

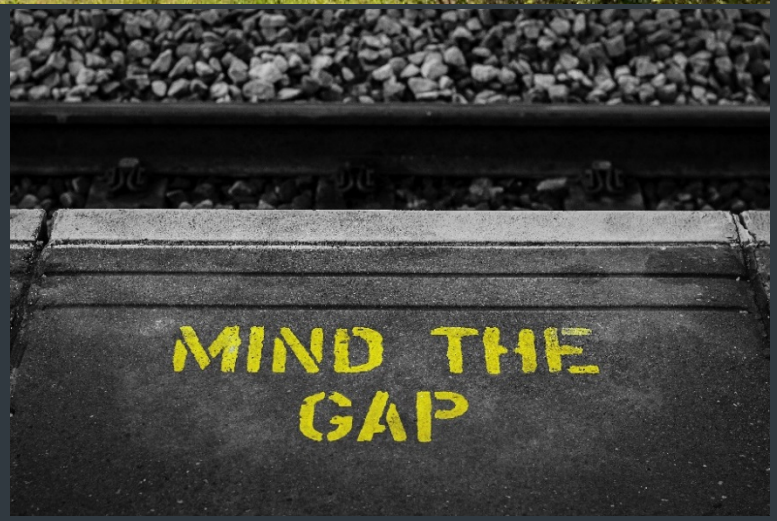
- Good treatment requires a good therapeutic alliance
- Some interventions have been designed for the treatment of specific comorbidities, but these interventions generally have not been well researched
- In the absence of specific research on comorbid disorders, it is generally recommended that best practice is to use the most effective treatments for each disorder. In some cases this can be carried out at the same time for both disorders, but in others it must be carefully calibrated
- Both psychosocial and pharmacological interventions have been found to have some benefit in the treatment of many comorbidities. When pharmacotherapy is used, this should be accompanied by supportive psychosocial interventions
- Support for e-health, physical activity and complementary and alternative therapies

Overview

- Brief background: What do we know about comorbidity?
- What to do once comorbidity is identified
  - Management
  - Treatment from a holistic health care approach
- Referral pathways

Referral pathways

Referring to services: Mind the gap



Referral process and coordinated care

- Linked to improved treatment outcome:
  - Prolonged client retention
  - Increased treatment satisfaction
  - Improved quality of life
  - Increased use of community-based services

Referrals

Passive referral

Passive referral occurs when the client is given the details of the referral agency in order to make his/her own appointment. This method is almost never suitable for clients with comorbidity.

Facilitated referral

Facilitated referral occurs when the client is helped to access the other service; for example, with the client's permission, the worker makes an appointment with the other service on his/her behalf.

Active referral

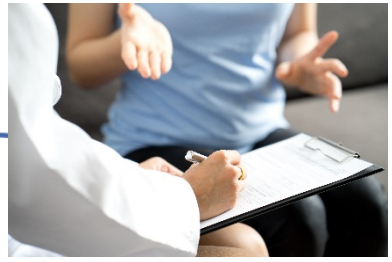
Active referral occurs when the worker telephones the other agency in the presence of the client and an appointment is made. The worker, with the client's consent, provides information that has been collected about the client with his/her professional assessment of the client's needs. Such referral is necessary when clients are unmotivated, unlikely, or unable to do so themselves. This method of referral is recommended for clients with comorbidity.

In a nutshell

- 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***
- Although some interventions developed for specific comorbidities, in general these have not been well researched
  - In the absence of specific research, generally recommended to use the most effective treatment for each disorder
- In addition to mental health services, health workers may need to engage and develop strong links with range of other services

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Michelle

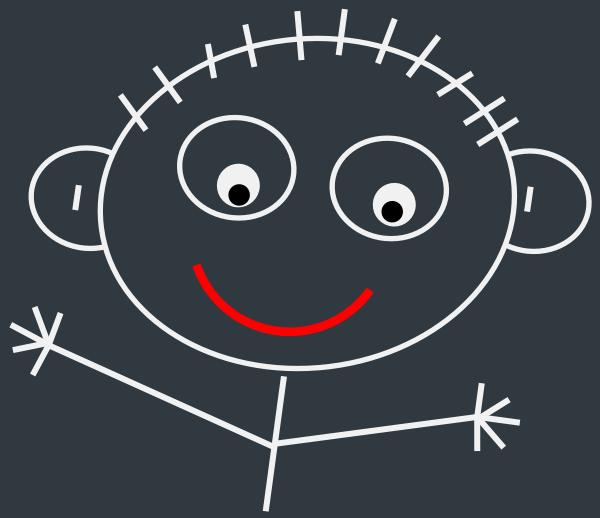


- Michelle and her counsellor looked at different treatment options together
  - Michelle decided on women-specific rehabilitation program, starting with detoxification
  - Option for trauma-specific treatment when she was ready
- Comprehensive physical health assessment
- Making plans for her discharge (accommodation, TAFE courses etc)

- Key points:
  - Important to provide clients with options
  - Work within therapeutic, collaborative partnership
  - Consider holistic health care approaches (not all will suit everyone)
  - Trauma -informed care

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

People can and do, get better!



Thanks for being part of the CESPHN-CREMS Webinar Series

Thank you!

c.marel@unsw.edu.au

Video recording and handouts of this and past webinars are available at: comorbidity.edu.au/training/webinars

Join our mailing list to receive webinar updates

Join us again:

5 December 2017

Managing the physical health of people with co-occurring mental and substance use disorders

To complete CPD assessment **(available until 1 Feb 2018):**

https://unsw.au1.qualtrics.com/jfe/form/SV_71H5r94lWVn6y45

Any questions?