Editorial

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Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings in Australia

I have had the privilege of being involved in the field of comorbidity of substance use and mental health, in both the UK and Australia (as well as observing practice in other countries, notably in a number of visits to the USA) for more than two decades. More recently, I was a member of the group that drafted the Australian guidelines on management of co-occurring alcohol and other drug and mental health conditions (Marel *et al.*, 2016)[1].

At this point it is worth emphasising that the commonly used term for comorbidity in the UK (including this journal) is "dual diagnosis". It could be argued that both "comorbidity" and "dual diagnosis" are misleading. However, for the purposes of this editorial I will use comorbidity.

Since the completion of work on the Australian guidelines, the National Institute for Health and Care Excellence (NICE) in the UK has published draft guidance on severe mental illness and substance misuse in community, health and social care settings. While it is obvious that the NICE Guideline Development Group are to be congratulated for an authoritative document which in many ways, mirrors some of the recommendations of the Australian guidance, the major obvious difference between the UK and Australia is the UK's continuing concentration on problems of comorbidity associated with those suffering from psychotic disorders, whilst the Australian approach includes the so called "common mental disorders". The Australian guidelines, although aimed at alcohol and other drug workers, have, in my opinion, great relevance for mental health professionals and all those involved in providing services to populations with comorbidity. The guidelines commence with a section entitled "In a Nutshell" which summarises the aims and content of the comprehensive document which runs to more than 350 pages. That said, many sections stand-alone and recognising the needs of busy people at the clinical "coalface", the document is designed to provide easy access to those who work with this population on a daily basis. There is a central focus on implementing the growing body of evidence and providing succinct accounts of what that evidence is.

At the outset, the guidelines make it clear that anyone who presents with comorbidity should be able to enter services and have their all their needs met in an integrated fashion, not only in respect of mental health and substance use, but also social and other needs. Thus, regardless of the portal of entry into services, each individual should be availed of a comprehensive, integrated and evidence-based approach. Thus, for the individual, there should be "no wrong door" to access help. Although the reality of services in the UK and Australia includes many challenges for implementation, these guidelines, commissioned by the Australian Federal Government provide the basis for real change. Each section of the guidelines is designed so that key points are readily conveyed. The document also includes case studies across a wide range of disorders, so as to exemplify the recommended approaches. The appendices to the guidelines conclude by pulling together an array of resources including very usable assessment tools and measures of outcome.

Arguably, the problem of comorbidity in "common mental disorders" has the same significant effect on the individual and society, as in those with psychotic disorders. Indeed, the lack of attention to those with anxiety disorders and other conditions has long been recognised (Strathdee, 2002). In turn, it sadly remains the case that those with say, post-traumatic stress disorder and alcohol problems, or those with attention deficit disorders and substance use are denied appropriate services for their mental health problem, until they have dealt with their addictive behaviours. This position is of course contrary to the evidence that concurrent and integrated treatments are the most effective approach (as referenced in the Marel *et al.* (2016) guidelines). Common mental disorders are also characterised by high levels of comorbidity with

other mental health problems and personality disorders (Roca *et al.*, 2009), thus serving to complicate further our efforts to develop treatment approaches. One other dimension of comorbidity, which has also been largely overlooked, is the importance of personality dimensions as a causative factor in the development of drug and alcohol problems in all mental disorders. This issue was investigated by Khan *et al.* (2005) in their study of over 7,000 participants from a population-based twin registry. The study demonstrated, among other findings, high neuroticism as a broad vulnerability factor for comorbidity and also identified "novelty seeking" as modestly important. Therefore, when one begins to reflect, one sees not only the need to apply different approaches and priority setting for services, but also the need to further explore aetiology. Just to add to the matter of complexity, Langan *et al.* (2013) has identified the challenge of dealing with the comorbidity of mental disorders with physical problems. The authors identified the need to integrate physical health interventions into already complex approaches for people with complex needs. Langan *et al.,* also identified factors relating to social inequalities, which of course are so prevalent in populations with comorbidity. While both Australia and UK have appeared, to some extent, to have risen to the challenge, by providing comprehensive guidelines, further reflection leads one to conclude that the guidelines themselves serve to open the proverbial Pandora's box. Both the UK and Australian guidance broadcast a clear message, i.e. that one needs to integrate treatment approaches, which address not only the specific conditions, but also the wider range of social needs. However, when one gives this topic further thought, one is struck by the problems associated with the treatment outcome research which is needed to test innovative treatments. One obvious problem is that of heterogeneity. Thus, for example, if one considers a treatment approach directed to anxiety disorders and substance/alcohol use, it is clear that the usual sample size is woefully inadequate, because of the wide range of types of substance used (or combinations thereof) and the strong probability that there may be more mental disorders than the primary presenting problem. It is therefore clear that the traditional randomised controlled trial will not suffice. Thus, the usual sample sizes of treatment outcome research will be grossly insufficient to deal with the diversity of the population under study. To some extent, the matter of investigating complex problems with complex treatments, is addressed in an authoritative collection of essays published this year by the UK's National Institute for Health Research, entitled: "Challenges, solutions and future directions in the evaluation of service innovations in health care and public health" (Raine *et al.*, 2016). This document is, in my opinion, required reading for anyone involved in research in comorbidity, as it addresses a very wide range of relevant matters including the need to consider important issues, such as the use of appropriate quantitative and qualitative approaches, patient reported outcomes, major system change and the challenge for implementation science.

Both Australia and the UK face enormous challenges in respect of implementation of the respective guidelines, i.e. of the translation from research findings into ordinary practice. As a member of a research group in the UK that conducted a trial of training for professionals in dual diagnosis services, I joined my colleagues in our great disappointment when we found, at the end of a randomised trial, that training that had taken several years to develop produced little or no benefit to patients managed by the graduates of said training (Craig *et al.*, 2008; Hughes *et al.*, 2008). The two obvious candidates to explain the disappointing outcomes were the barriers caused by separate service structures for drug and alcohol services and mental health services and the long recognised problem of poor fidelity to model.

Where, then, does this leave us? What can we do, as a professional community for such a disadvantaged population?

It appears to me that one of the most obvious interventions within the various professions is to ensure that the knowledge and skills involved in approaches to comorbidity are developed very early on in professional education and training. Thus, all those involved in efforts to improve services for our population should attempt to ensure that the topic of comorbidity is included in undergraduate curricula. It is arguable that if one only begins to improve knowledge and skills when, for example, a nurse is three or four years post-registration, or when a medical doctor enters psychiatric training, then the task of changing fixed attitudes becomes truly

Herculean. Sadly, I know from personal experience that my own efforts to raise the topic of the need for early intervention in professional education and training have so far gone unheeded (Gournay *et al.*, 1997).

In conclusion, there are clear differences between the approaches of the UK and Australia to address the challenges of comorbidity. However, there is consensus about the need for greater investment in this area by fostering greater levels of integration between services and the need to improve knowledge and skills in the workforce. The bottom line however, is for government to both commission research into effective treatment as well as support the subsequent translation of research findings into the real world.

This issue includes three articles. In the first of these, "Informing service responses to co-occurring complex needs", Stathopoulos and Jenkinson describe a cross-sector mixed-methods approach to developing shared practice guidelines to guide practice towards the identification, assessment, response and referral of clients with co-occurring sexual victimization and substance use. The second study authored by Bekke *et al.*, uses qualitative methodology to describe "First-person experiences of recovery in co-occurring mental health and substance use conditions" in a Norwegian local community as consisting of both personal and social processes. Their findings highlight the need for health care practitioners to focus on societal and community factors in recovery, and support the need for improved communication, collaboration and integration of social and health care services to achieve this. Finally, in their literature review, "Personal and relational empowerment: a framework for family recovery", Buckley-Walker *et al.*, critique existing family recovery frameworks and conclude that a broader focus than the traditional education and stress and coping support frameworks alone is required to support individual and family members of people with comorbid disorders. The authors describe the personal and relational empowerment framework of family recovery.

Note

1. www.health.gov.au/internet/main/publishing.nsf/Content/F669373C89CBFF50CA257FCD001658E2/$File/Comorbidity-Guidelines-2016.pdf

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Further reading

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