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Assessment and Treatment of Patients with Comorbidity of Mental Health Problems and Alcohol Use Disorders: Experiences of Clinicians and Patients in the UK and Poland

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Abstract

Aims: Treatment of patients with comorbidity of mental health problems and alcohol use disorder (AUD) constitutes a challenge in many countries. The article aimed at exploration of personal experiences of clinicians and patients with the comorbidity regarding its assessment, treatment and organization of care in Poland and the UK.

Methods: Data were collected via in-depth, semi-structured interviews with clinicians ($N = 28$) and patients ($N = 81$) in both countries, according to a unified study protocol. Maximum variation sampling was applied to both study groups. All interviews' transcripts were coded (CAQDA) and the consistency of coding across centres was assessed. Data analysis was performed according to the principles of thematic analysis.

Results: Our data show that most patients with AUD admitted at the psychiatric wards—apart from assessment which is a standard procedure during admission—receive only minimal support during their hospital stay. This is the consequence of two factors: lack of trained staff prepared to help those patients and a priority given to self-referrals by AUD units. At the same time, it is recognized by clinicians and patients that more support is needed to encourage the utilization of AUD services and to prevent the drop-out.

Conclusions: In order to improve the system response, the use of screening instruments in the process of the assessment of AUD and establishment of special procedures supporting motivation and adherence to treatment and preventing drop-out merits consideration. Moreover, the psychiatric wards and the AUD services could possibly profit from formalization of the collaboration between services.

INTRODUCTION

Both general population studies and mental health services studies show that alcohol dependence, anxiety disorders and affective disorders covary (Regier *et al.*, 1990; Kessler *et al.*, 1996, 1997; Petrakis *et al.*, 2002; Błachut *et al.*, 2013; Klimkiewicz *et al.*, 2015a). Moreover, the comorbidity of alcohol use and mental disorders might be more

prevalent than is commonly believed, because patients asking for psychiatric advice do not spontaneously disclose their problems related to drinking (Helzer and Pryzbeck, 1988; Anthenelli, 1997; Klimkiewicz *et al.*, 2015a). Therefore, an accurate diagnosis in this case is of a great significance.

Unfortunately, the assessment of comorbidity of alcohol use and mental disorders implicates serious difficulties. To establish an accurate diagnosis, a comprehensive substance use history should be obtained. The routine administration of standard screening instruments designed for assessing problematic substance use is recommended—including the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), (WHO, 2002); the Alcohol Use Disorders Identification Test (AUDIT), (Philpot *et al.*, 2003); and the CRAFFT Screening Test for adolescents using alcohol and other drugs (Knight *et al.*, 2002)—otherwise cases of psychiatric comorbidity might be missed (Torrens *et al.*, 2017). Moreover, the different acute or chronic pharmacological effects of alcohol can mimic the symptoms of other mental disorders, making it difficult to differentiate psychopathological symptoms, which represent a primary mental disorder, from symptoms of substance intoxication or withdrawal (Anthenelli, 1997; Modesto-Lowe and Kranzler, 1999; Klimkiewicz *et al.*, 2015b; Torrens *et al.*, 2017).

Treatment of comorbidity of alcohol use and mental disorders also implicates difficulties. Wu *et al.* (1999) found that if other mental disorder coexists with alcohol dependence the probability of seeking medical advice is more than three times higher (Wu *et al.*, 1999). However, seeking advice is not necessarily followed by more efficient treatment because substance abuse or dependence complicates the treatment and worsens the prognosis of coexisting psychiatric condition (Lesch and Walter, 1996; Department of Health, 2002; Petrakis *et al.*, 2002; Błachut *et al.*, 2013; Klimkiewicz *et al.*, 2015a, b). In comparison with patients with a single disorder, dually diagnosed patients show higher psychopathological severity and frequency of emergency admissions (Martín-Santos *et al.*, 2006; Curran *et al.*, 2008; Booth *et al.*, 2011; Langås *et al.*, 2011; Schmoll *et al.*, 2015; Torrens *et al.*, 2017) and a higher prevalence of suicide (Aharonovich *et al.*, 2006; Conner, 2011; Marmorstein, 2011; Nordentoft *et al.*, 2011; Szerman *et al.*, 2012; Torrens *et al.*, 2017). Moreover, the potential interaction of antidepressants and alcohol represents a particular high risk situation (Kranzler and Rounsaville, 1998; Klimkiewicz *et al.*, 2015b).

The treatment of patients with alcohol dependence accompanied by other psychiatric disorders is also complicated by organizational difficulties as alcohol use disorders (AUD) services are provided by different teams, in different settings and within different financial schemes. In UK, the treatment of patients with comorbidity of alcohol use and mental disorders may be provided in either specialist addiction services or mental health services or through a combination of both (Torrens *et al.*, 2017). In Poland, only few rehabilitation clinics specialize in comorbidity therapy (Torrens *et al.*, 2017). Therefore, in many regions of Poland, it is difficult to refer a patient to a clinic, in which both alcohol dependence and coexisting psychiatric disorders could be treated (Klimkiewicz *et al.*, 2015b).

Little is known about the personal experiences of patients and clinicians regarding the assessment and treatment of comorbidity of alcohol and mental disorders. This article explores those experiences on the basis of qualitative data collected in mental health care settings in Poland and in the UK, in order to shed some light on the issue of the implementation and efficacy of the existing procedures.

METHODS

Data collection and analysis

Data were obtained via in-depth, semi-structured interviews with clinicians and patients conducted in Poland and the UK within the framework of the COFI study (full name: Comparing policy framework, structure, effectiveness and cost-effectiveness of functional and integrated systems of mental health care) according to the unified study protocol and interviews' guidelines (Giacco *et al.*, 2015).

Participants of the study were recruited from the hospitals/wards or community mental health teams in Poland and the UK. Patients with primary diagnosis of psychotic disorders—F20-29, affective disorders—F30-39, or anxiety disorders—F40-49 were invited for in-depth interviews as a subsample of the COFI study quantitative data collection (Giacco *et al.*, 2015). To assure diversity of the sample (maximum variation sampling), recruited patients had varying personal characteristics (gender, age, psychiatric diagnosis and treatment history). The sample of clinicians also was recruited with varying characteristics regarding gender, years of experience and profession: psychiatrists, psychologists, nurses, social workers.

The interviews covered a range of issues related to the experiences of study participants, such as accessibility; procedures and assessment of alcohol disorders in mental health patients; and experiences of providing or receiving treatment of comorbidity of alcohol use and mental disorders.

The semi-structured interviews with patients and clinicians were audio taped and transcribed verbatim, ensuring the removal of any identifying information to maintain anonymity and confidentiality. As a first step of the analysis, research teams in both countries conducted an analysis of pilot interviews using computer assisted qualitative data analysis (CAQDA). The emerging codes were discussed between the teams and summarized into unified codebooks, separately for patients and clinicians. The consistency of coding across both centres was assessed by the Polish research team and discrepancies were discussed till it had reached a satisfactory level. In the second step, the research teams in both countries applied codebooks to code all transcripts using line-by-line analysis (Atlas.ti), (Miles and Huberman, 1994). If new codes emerged during the analysis, they were communicated and approved. Consequently, both research teams produced coding reports containing information about the national sample, research memos regarding the coding procedure and data analysis, and a list of all used codes with selected quotations. In the third step, coding reports from each country were analysed through a thematic analysis method by the Polish research team (Hsieh and Shannon, 2005). More specifically, the emerging categories and codes were organized and grouped to obtain meaningful themes. Researchers summarized the qualitative results using descriptive categories.

Sample characteristics

The patients' sample consists of 81 persons, 44% male, 56% female, interviewed between April 2016 and February 2017. Full details of sample characteristics are presented in Table 1.

The clinicians' sample consists of 28 professionals interviewed between January 2016 and May 2017. In both countries, psychiatrists are the main clinicians and decision-makers regarding patients' treatment, therefore making up 2/3 of the sample. Remaining interviews were conducted with other staff members: including psychologists, psychiatric nurses and social workers. Detailed sample characteristics are summarized in Table 2.

Table 1. Patient sample characteristics—Poland and the UK

		PL	UK	Total
No. of interviews		40	41	81
Gender	*n* (%) Female	23 (58%)	22 (54%)	45 (56%)
Age (in years)	mean	43	48	44
ICD-10 diagnosis (no. of cases)	F20–29	10	14	24
	F30–39	17	21	38
	F40–49	13	6	19

Table 2. Clinician sample characteristics—Poland and the UK

		PL	UK	Total
No. of interviews		13	15	28
Gender	*n* (%) female	8 (62%)	4 (27%)	12 (44%)
Profession (no. of cases)	Psychiatrist	8	11	19
	Psychologist	3	1	4
	Social worker	2	1	3
	Nurse	0	2	2
Average years of experience		19	19	19

RESULTS

There is a high level of homogeneity of the data collected across the UK and Poland, which validates the results across borders. For that reason, the results from both countries are presented together, even though some differences between countries are highlighted. Moreover, clinicians and patients showed high level of consistency when describing their experiences and the accounts of experiences of patients and clinicians are often complementary, therefore we present them side by side.

The result section is divided into three thematic areas: assessment, treatment and organization. In order to illustrate the homogeneity, we are presenting quotations from clinicians (C) and patients (P) from both countries (PL/UK). Clinician quotations are marked by profession (differentiated by id number) and patients' quotations are marked gender—F/M, age and type of disorder.

Assessment

Clinicians in both countries stressed that the assessment of alcohol and drug abuse is a standard procedure during admission to the inpatient ward, and those patients are often admitted to the psychiatric wards.

> C: [I talk about substance use] with every patient – always and with every one (PL: psychologist_3).
>
> C: Of course we discuss [substance use] with [patients] during the admission, because many admissions are due to drug and alcohol abuse (UK: psychiatrist_7).

Patients in both countries confirmed being routinely assessed in mental health services regarding their alcohol use. As to the form of the assessment, patients rather describe being asked questions regarding their substance use in the flow of conversation or being warned about drinking than being assessed by drug tests or other forms of screening.

> P: They asked me about alcohol in a normal sort of way without getting pompous. It was worked into the conversation in the form of delicate but firm questions asked tactfully (PL: F51/affective disorder).

Patients in both countries also confirmed being informed about the relation between alcohol use and their mental health problems as well as interaction of alcohol with medications they were prescribed.

> P: When I got medication that can't be combined with alcohol, the clinician informed me that I absolutely cannot drink while on it and I believe the clinician also assesses if I tell the truth about drug use when he talks to me and asks those questions (PL: F25/anxiety disorder).
>
> P: (…) they were just saying drinking is going to be a depressant, so if you drink a lot, you're going to be in a more depressive mood, so just be aware of it, yeah. Which I am (UK: F36/affective disorder).

Some patients described a strong reluctance to address the subject of their alcohol use, which highlights the importance of initiating that topic by the clinician.

> P: We rarely talk about it unless I raise the subject. Let's say I started drinking again and the question is 'What happened?' [the patient lowers her voice] And that's what happened recently – something broke in me. I spent the whole weekend away from home partying (PL: F32/anxiety disorder).
>
> P: It's a bit embarrassing for me. It's actually quite good that the clinician is interested in these things as I shouldn't allow myself too much what with all that medication I'm on. From time to time [I drink] because everything is there for people to enjoy. (…) I've had my problems. (…) I was in rehab for two months. (…) (PL: F36/psychotic disorder).

Treatment

Clinicians. Polish clinicians discussed also the ways of treating patients with comorbidity, claiming that simultaneous treatment of both disorders is not feasible.

> C: Very often the treatment stops at the psychiatric problem, as patient is abstinent at the ward. The abstinence takes place kind of by default as they are in hospital… There is continuation later—we transfer the patient to the clinic that deals with dependence. We don't really do AUD therapy at the same time … Alcohol and drug services don't want to receive patients with psychosis or suicidal tendencies. That has to be dealt first before the patient can receive dependence treatment (PL: psychiatrist_6).

Both, Polish and British clinicians claim that for highly motivated AUD patients, the self-referral track is accessible and they can get support they need.

> C: It is a group of patients who are most taken care of. (…) There are a lot of centres, they are free, a lot of forms of support and self-help groups. If someone only wants to face their dependence, then they have easy access to support (PL: psychologist_3).
>
> C: If the patient expresses the desire and we can get consultation at the dependency therapy ward, (…) the date of

admission is set up and the patient knows what to do next (PL: psychiatrist_8).

C: We don't have Alcohol & Drug Services anymore – it's been decommissioned – but we will refer to other local services. However, a lot of this hinges on the patients' own views and engagement with those services. So we very much advise them and we can offer them contact details for that service but at the end of the day it's very much up to them whether they are going to use that help and engage in those services. (…) I don't think there is a proactive approach in dealing with Alcohol & Drug Services. I think the attitude is very much it's the patient's choice whether they want to deal with this issue or not (UK: psychiatrist_2).

At the same time, clinicians in both countries recognize that a some of their patients do not have a high motivation to undergo alcohol treatment, therefore do not use services they were referred to or drop-out from the treatment during early stages.

C: It is the worst with alcoholic patients as they either don't start rehab therapy and openly declare so, or they pretend to start but relapse (PL: psychiatrist_6).

C: Most of the patients that we see do not really think that their substance use contributes to their illness and they are not very keen to access drug and alcohol services themselves (UK: psychiatrist_8).

Patients. This was confirmed by patients' accounts who discussed the barriers related to self-referral, and expressed the need of a more proactive approach in motivating patients with comorbidity to contact AUD services.

P: Every time that I mention that I'm over drinking, and I say: 'I'm going to stop', they always say: 'that's good, why don't you contact AUD service?' It is just… I don't want to. But sometimes it's embarrassing to ask for help, it might be better if they actually said: 'we've set up a meeting for you at eleven o'clock'. Yesterday I got given a scrap of paper, with: 'this is the phone number for AUD service'.. Give me something tangible—maybe set up meeting, maybe a contact name as opposed to phone number (UK: M49/anxiety disorder).

Polish and British patients with comorbidity described their reaction to the AUD treatment referral. Some of them rejected the clinician advice completely, others agreed with the diagnosis, but were coping with the problem on their own, and some took it up and went to treatment. The patients' accounts are presented in Table 3.

In both countries, there were patients who reported generally positive experiences with treatment offered by AUD services they were referred to.

P: She's [AUD consultant] voluntary, she did two evenings, three hour sessions if you like and she got me from drinking massively every single day of the week, every morning, to nothing. So people like that are worth their weight in gold and she was great at what she did (UK: M46/anxiety disorder).

P: I recently [annoyed] got rid of alcohol problem. It was the cause of that depressive nature of mine. I think that therapy was the best of all of this (PL: F46/anxiety disorder).

Another indicator of the positive experience with an AUD treatment is when a patient who relapses knows where to ask for help.

P: Well, I'd used [AUD services] years before, and had found it really helpful and so when I approached them again I knew most of the stuff is still there and I had an assessment with them and signed up for the programme (UK: M47/affective disorder).

P: I've been through a number of anti-alcohol therapies, I know all the mechanisms and can handle myself. (…) There is plenty of AA meetings in my town. (…) If something bad is going on I can always go to people like me who know what alcoholism is about and I can take care of myself (PL: M52/affective disorder).

However, in both countries there were patients who perceived the treatment offered to them as inadequate to their individual needs and problems.

P: It's difficult to say, only because of the kind of conflict of my diagnosis, and the cause and effect with regards to alcohol, my psychiatrist's way of looking at it was just to abstain from alcohol, all problems will be resolved (UK: M46/anxiety disorder).

P: I have my own psychiatrist, who is also an alcohol specialist. He takes care of my personality disorders, my obsessive/

Table 3. Types of reactions to the AUD treatment referral

Refusal to take up any form of the AUD Treatment
P: Do I have any intention of reducing my alcohol intake to NICE guidelines? Not on your nelly. (…) Unfortunately I was observed having a bottle of brandy beside my bed [on the ward]. What's wrong with brandy? [Laughter] (UK: F64/affective disorder).
Self-Change
P: Once upon a time I abused alcohol. (…) The clinician asked how it's going. She of course suggested I didn't drink and started getting treatment. [longer silence] I'd say, crikey I've got work now and I can't [go to treatment]. They gave me the phone number [to the two centres]. I called them but you have to wait and I have work and didn't want to give that up as I needed the money. I stopped drinking [on my own]. Now I don't drink and am coping [with satisfaction], (PL: M51/affective disorder).
Using AUD treatment in the past
P: In 1999, I had rehab therapy for drugs. I stopped the drugs but started drinking. In 2010, when first I ended up in psychiatric hospital, the clinician helped me get onto the alcohol rehab ward. She kept me [at the psychiatric ward] an extra week, for which I am grateful as I was scared that if I go home and will have a week free prior to rehab therapy, I might start [drinking] again. (…) I haven't been drinking for three years (PL: M33/affective disorder).
Ongoing AUD treatment
P: I think it was drinking too which was exacerbating my emotional mood, which led to getting in a distressed state which led to me being admitted. They had an alcohol [consultant] come and see me, and we spoke about me going to an alcohol reduction initiative programme which I still go to (UK: F50/anxiety disorder)

compulsive syndrome and alcohol dependence. I am also a patient at the [AUD] centre. I was there in a regular introductory group therapy where we wrote about our dependence and value system, while in 2013 I was moved to a group with central nervous system disturbance. I don't really feel at home in that group. While it is a group of people strongly harmed mentally by alcohol, which I suppose I am, the regular group was better for me. Here everything is simplified and there is no work and no lectures only a sort of talk like with children. (…) This is funny because I am a qualified bookshop manager and am rather well read both in philosophy and theology (PL: M47/anxiety disorder).

Organization of care

CLINICIANS in both countries stress that patients with comorbidity have specific needs and for that reason their treatment happens in specialized units, often in local NGOs and charities working in substance use field.

C: We are not a facility that specializes in this problem. Here the patient receives necessary psychiatric support to get over the delirium in a secure environment, gets rehydration and medication, and then later goes on to (…) the centre specialising in the treatment of this kind of problem. We do the assessment of AUD. Patient gets hospital documentation or we send it to the AUD centre, and then the patient is put on the waiting list (PL: psychologist_1).

C: There is what's called the Specialist Addiction Unit, they offer specialist help with alcohol addiction (…) and they're very, very good; they have consultants, nurses, psychologists; they can get patients in to rehab and so on (UK: senior inpatient nursing manager).

Therefore, at the psychiatric wards, those patients are provided only with the basic care, and—at best—motivational support to undergo further treatment.

C: Alcohol abuse patients (…) are made aware [of their problem]. We aim to ensure the patient leaves [our ward] with an appointment at the detoxication unit or AUD centre. Our focus is more on the motivational level (…) I think what we do is sufficient (…) it's then up to the patients if they take advantage of that, not to us (PL: psychiatrist_4).

As a result of the division and specialization of services, personnel of psychiatric wards in both countries often feels unprepared to deal with AUD, therefore the referral is the only way of dealing with the AUD patients.

C: I mean since we don't have a dedicated alcohol and… addiction service anymore in the NHS – because it's outsourced – it's become a bit more difficult, so it's more relying on self-help groups and more relying on charity (UK: psychiatrist_1).

C: There should be a dependence specialist on those wards to motivate patients to further treatment after detoxification (PL: psychiatrist_1).

Treating patients with comorbidity within specialized system requires collaboration between psychiatric wards and alcohol and drug services. In both countries, the level of collaboration varied greatly between different settings (Table 4).

PATIENTS. However, there are patients in both countries that prefer to deal with their mental health problems and their AUD separately.

P: I kept the two very separate which worked for me. Although there was a very symbiotic relationship, my drinking and my depression, it was odd for me. Dealing with the two issues separately helped so I didn't ever feel the need for there to be a crossover (UK: M47/affective disorder).

P: I think it's the perfect arrangement. At the AUD services, they take care of my basic illness – alcohol dependence, which is what they concentrate on. The psychiatrist is also a

Table 4. Different levels of collaboration between psychiatric wards and specialized AUD services

Cooperation does not happen
C: Although we can refer patients to them [AUD services], they do not attend our meetings, they do not give us feedback, they do not tell us that 'your patient is not coming' (…) I think that it's again the money, because if they do not have money to attend meetings, they won't do it; it's how the service is commissioned (UK: psychiatrist_8)
Only informal cooperation
C: My friend became a addiction therapist. She used to lead a support group once a week [at the ward]. (…) Since a year, she has stopped. But AUD patients are still often sent to her for consultation. She provides details of AUD services and just briefly explains the mechanisms of dependence to the patient (PL: psychologist_2).
Effective, well-established cooperation
C: We have the possibility to send patients directly for treatment at the ward specialised in dual diagnosis, which is a cooperation that works very well for us. If it is only alcohol dependence then we cooperate with the regional addiction treatment centre and here there are also no problems. We also have experience referring the patients there too (PL: social worker_2).
C: The patient has the opportunity to visit the AUD centre during treatment at our ward to establish a time for rehab treatment. We discuss what can be done in terms of consultations. We cooperate with our former dependence therapist and ask if out-of-ward consultations are possible. Patients even have the chance of going out to [AA] meetings. If someone expresses the desire, then we can deal with dependence on the ward as well (PL: social worker_1).
C: We have alcohol and drug services available locally, and we refer them, and they are invited to attend the patients and while they're inpatient. If it is community we make a referral and ask patients to *do it*, and then we liaise with them, each other, about the outcome if we have serious concerns (UK: psychiatrist_9).
C: There's also Alcoholics Anonymous – they meet actually in [hospital]. (…) [Another mental health charity] offers a lot of help and counselling around drug use, so there are other services out there than can help. We've invited them and they've come [to the ward] in the past (UK: senior inpatient nursing manager).

specialist on dependence but takes a broader view, which is good. I am resistant material and it differs with me. I don't like going to the groups. Sometimes I cheat, lie and have a little binge. But the periods of abstinence are getting longer – up to a few months. There is some kind of progress (PL: M47/anxiety disorder).

DISCUSSION

Our study explored the comorbidity of mental health problems and alcohol use regarding its assessment, treatment and organization of care. The qualitative data on personal experiences of clinicians and patients in Poland and in the UK regarding that phenomenon were collected in the context of a more comprehensive study of mental health care services (Giacco *et al.*, 2015). Consistent methodology was used across both countries and many commonalities in the personal experiences of patients and clinicians regarding assessment and treatment of comorbidity were found. The qualitative data allow us also to understand the shortcomings of the clinical practice regarding both, assessment and treatment of comorbidity.

Strengths and limitations

The data presented here are not without limitations. First of all, almost half of the patients in our study suffered from affective disorders (F30–39), and the remaining suffered from psychotic disorders (F20–29) and anxiety disorders (F40–49). All other diagnoses were excluded from the study, which limits the data to the three specific comorbidities. Secondly, the issue of comorbidity of mental health problems and alcohol use disorder was not a specific topic of the interview, therefore many issues pointed out by study participants should be explored further and in a more detailed way in future studies. Finally, qualitative data allow us the exploration of the whole spectrum of experiences; however we are unable to specify differences in their prevalence in clinical practice. The strength of the study is related to the uniqueness of the data, which were collected in the psychiatric wards among patients with and without comorbidity of mental health disorders and AUD, giving us a chance to look into clinical practice regarding both, assessment and treatment of comorbidity. Moreover, collecting the data from clinicians and patients allowed us to explore the process from a provider and recipient perspective and the high level of homogeneity of the data collected in both countries validates the results across borders.

Assessment

Clinicians participating in the study stressed that the assessment of alcohol disorders is a standard procedure during admission into inpatient ward and most of the patients confirmed being asked about their alcohol use during their hospital stay. It is unclear however; if any other forms of the assessment—screening instruments, blood tests, family reports—have been used as the data suggest that alcohol related questions were rather asked in the flow of the conversation. That might constitute a potential problem as a comprehensive assessment should be obtained in order to establish an accurate diagnosis. In fact, our data point to the issue of potential overshadowing: one of the patients complained that his mental health problems have been reframed as consequences of alcohol use after his comorbidity diagnosis was confirmed. This might be another factor increasing the reluctance of patients to address the subject of alcohol use with a clinician, which highlights the importance of raising the issue by the clinician during the consultation. At the same time, personnel on psychiatric wards often feel unprepared to address competently alcohol problems of the patients.

Treatment

Our data show that patients with comorbidity admitted at the psychiatric wards receive only minimal support for their AUD during their hospital stay. This is the consequence of two factors: lack of trained staff prepared to help those patients and a priority given to self-referrals by AUD units. At the same time, it is recognized by clinicians and patients, that having in mind specific needs of those patients, more support is needed to encourage the utilization of AUD services and to reduce drop-out, especially as other research shows that patients with comorbidity often drop out from treatment programs (Holder and Blose, 1991; Klimkiewicz *et al.*, 2015b).

Other studies identified some very specific problems of patients with comorbidity entering alcohol treatment programs. Researchers underline issues with group therapy, where requirements do not differ between patients with AUD only and patients with comorbidity. Impairment of cognitive functions and disorganized thinking are strong barriers in seeking help among patients with dual diagnosis. Depressed mood and psychomotor retardation impair functioning and progress during group therapy. Isolation in a therapeutic group decreases motivation to treatment (Petrakis *et al.*, 2002; Klimkiewicz *et al.*, 2015b). On the other hand, our data point out to the need of careful individualization of treatment interventions, as the special groups for patients with the impairment of cognitive functions might be inadequate to the individual needs of some patients.

There is evidence that pharmacotherapy given to patients with AUD can have unwanted effects, and so clarity about diagnosis is of great importance to planning treatment (Chick, 2019).

Organization of care

Personal experiences of clinicians and patients regarding assessment and treatment of comorbidity were similar in both countries despite the organizational differences between Poland and the UK. British clinicians reflected on recent changes in the organization of mental healthcare system which has led to the decline in the availability of health service AUD treatment for patients with comorbidity, as at present external services are commissioned to perform these roles including local non-governmental agencies and charities (Drummond, 2017; Williams *et al.* 2018). In Poland, availability of treatment of comorbid disorders has always been low. Combining individual and system barriers in providing treatment to patients with comorbidity, one can conclude that the actual availability is even lower, as specialized AUD units have a strong preference for highly motivated patients and self-referrals.

Other clinical practice research has shown that comorbid disorders are reciprocally interactive and cyclical, and poor prognoses for both psychiatric and substance use disorders can be expected if treatment does not address both, simultaneously (Flynn and Brown, 2008; Boden and Moos, 2009; Magura *et al.*, 2009; Torrens *et al.*, 2017). However—regardless of the clear recommendations—the combined treatment of dual disorders is not as common in clinical practice as it should be. However, it is worth mentioning that in our study, some patients preferred keeping both problems separately. Moreover, despite all the problems, challenges and barriers related

to the issue of treating comorbidity of mental health problems and alcohol use disorder, some patients participating in our study reported positive experiences with treatment offered by AUD services they were referred to.

CONCLUSIONS

Clinicians in Poland and in the UK face difficulties in providing treatment to patients with comorbid mental illness and AUD. In order to improve the system response, the use of screening instruments in the process of the assessment of AUD, training of mental health specialists in treating AUD, and establishment of special procedures supporting motivation and adherence to treatment and preventing drop-out merits consideration. Moreover, more psychiatric wards and the AUD services could profit from formalization of the collaboration between services.

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CONFLICT OF INTEREST STATEMENT

None declared.

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