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

Co-occurring substance use and mental disorders:

Implications for managing and delivering best-practice health care

Dr Christina Marel

A/Prof Katherine Mills

CESPHN-CREMS Webinar Series: Welcome!

Coming up...

7 November 2017

Identifying mental disorders and related conditions among patients with alcohol and other drug conditions

21 November 2017

Managing and treating co-occurring mental and substance use disorders

5 December 2017

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

Full details available at: https://www.cesphn.org.au/events; http://comorbidity.edu.au/training/webinars
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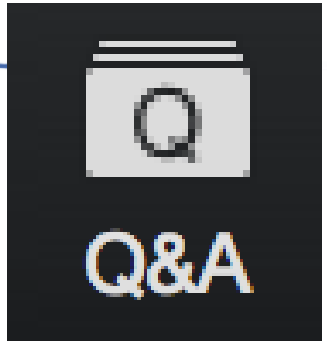
Before we get started…



- Questions/comments “Q&A”
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UNSW SYDNEY

NDARC National Drug & Alcohol Research Centre
The Difference is Research

Co-occurring substance use and mental disorders:

Implications for managing and delivering best-practice health care

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

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Learning outcomes

- Understanding of what is comorbidity, why it occurs, and why it is concerning
- Improved awareness of how to access a range of evidence-based options for identifying, managing and treating mental health symptoms within a holistic health care approach
- Understanding of a coordinated approach to managing comorbidity, and how to involve multiple services to deliver coordinated care

Overview

- Background: What do we know about comorbidity?
- How is comorbidity identified?
- Developing a plan: holistic health care
- Management and treatment
- Coordinated care

Overview

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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

What is meant by ‘comorbidity’?

- Other types of comorbid conditions:
  - Other AOD use disorders (including tobacco)
  - Physical health conditions (e.g., cirrhosis, hepatitis, heart disease, diabetes)
  - Intellectual and learning disabilities
  - Cognitive impairment
  - Chronic pain
- Often referred to as ‘dual diagnosis’ - misnomer

What do we know about comorbidity?

- Mental and substance use disorders are two of Australia's most common and burdensome health conditions, affecting 1 in 5 each year
- They frequently co-occur
- Estimated that up to ¾ of entrants to AOD treatment have a co-occurring mental health condition

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What do we know about comorbidity?

- Comorbidity has always been a feature among patients with AOD conditions

So why the increase in attention?

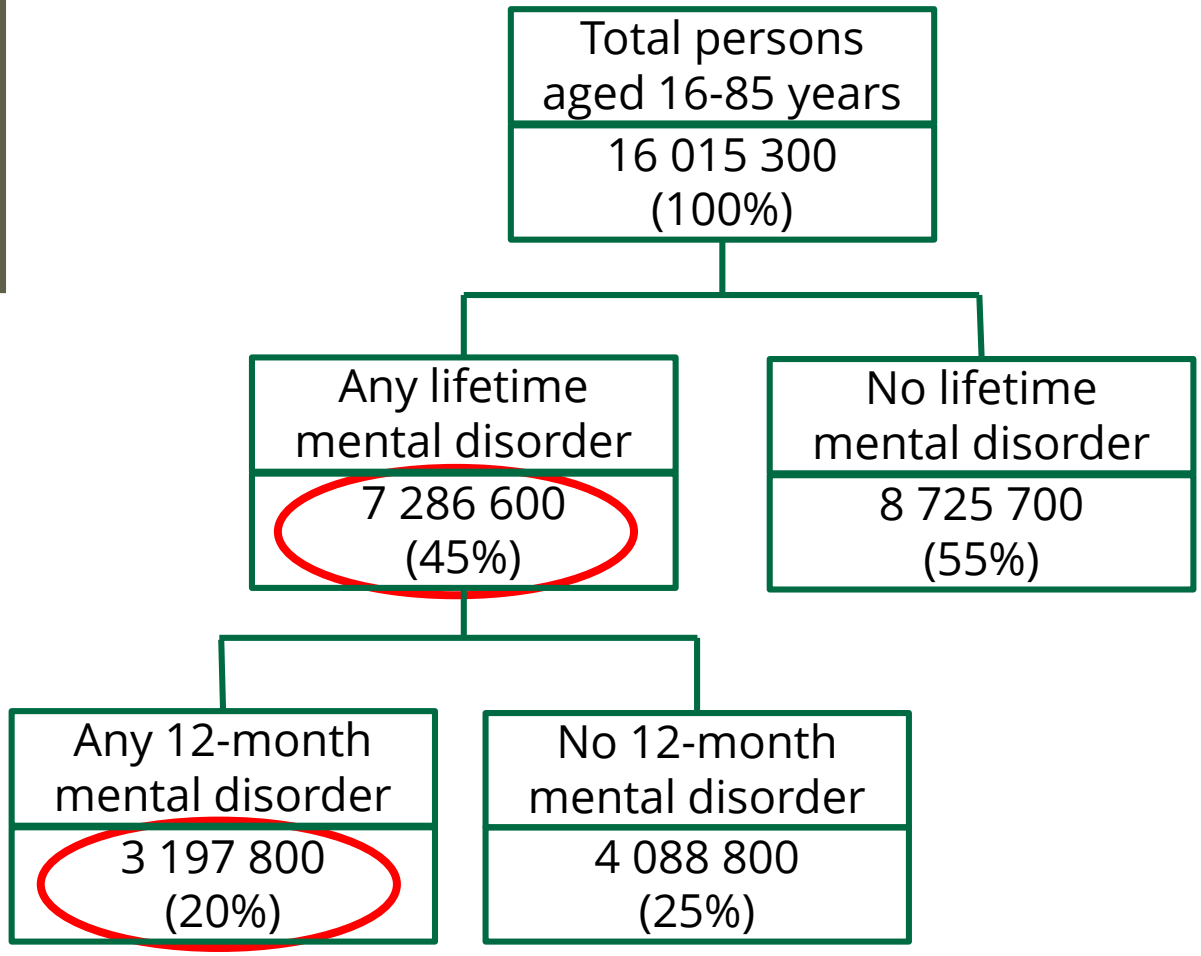
- The development of structured diagnostic interviews, which facilitated large scale population surveys in North America (ECA, NCS, NESARC)

How common is comorbidity?

- The 1997 National Survey of Mental Health and Wellbeing (NSMHWB), the first Australian general population survey; and
- The 2007 NSMHWB
- These and other population surveys have highlighted high rates of comorbidity between substance use and mental health problems

2007 NSMHWB – lifetime & 12mth disorders

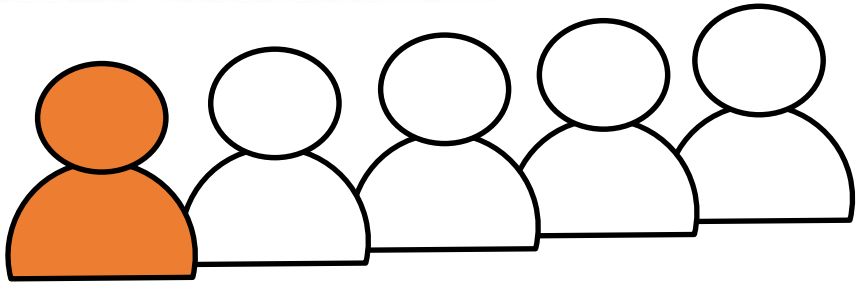
Overall mental health status of Australians aged 16-85 years



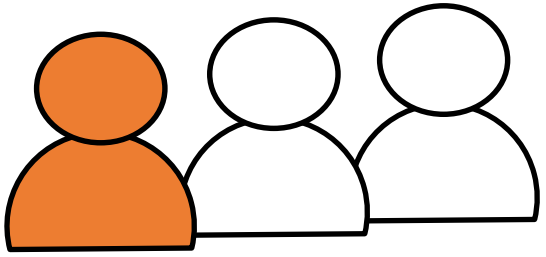
Source: Slade, et al (2009) The mental health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing. Department of Health and Ageing, Canberra.

High rates of comorbidity: 2007 NSMHWB

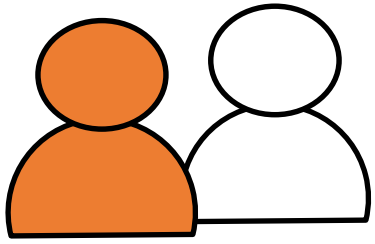
- 1 in 5 people with a SUD have a comorbid affective disorder



- 1 in 3 people with a SUD have a comorbid anxiety disorder



- ~ ½ people with psychotic disorder have a SUD



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Specific populations: Homeless

- Higher rates of AOD and mental health conditions, complex AOD histories
- Extensive polydrug use
- 42% severe depression
- 57% current PTSD
- 37% lifetime psychotic disorder

- Homeless: Sleeping rough, staying with friends or relatives, couch surfing, homeless services, boarding houses, caravan parks with no secure lease or private facilities

Source: Larney et al., (2009) Factors associated with violent victimisation among homeless adults in Sydney, Australia. Australian and New Zealand Journal of Public Health, 2009; 33, 347-351.

Specific populations: Prisons

- In 2010:
  - 31% of prison entrants reported comorbidity diagnosis (2.5 times higher than general population)
  - 16% on current medication for mental health disorder
  - 14% experiencing very high levels of psychological distress
  - More extensive prison histories, education levels, higher rates of unemployment and AOD use
  - Higher rates of risky alcohol, illicit drug use, and smoking than general population, particularly among those with high psychological distress

Source: AIHW (2012) The mental health of prison entrants in Australia, 2010. Bulletin 104, Canberra Australia

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

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Mental health continuum

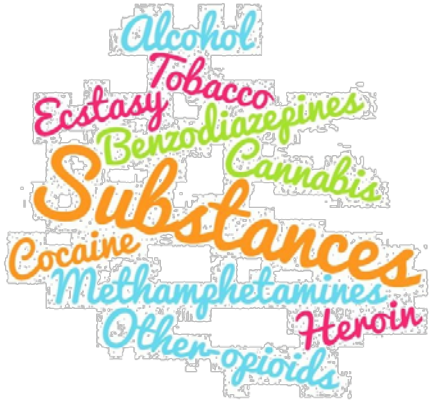
E.g., Mild depression responsive to medication

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

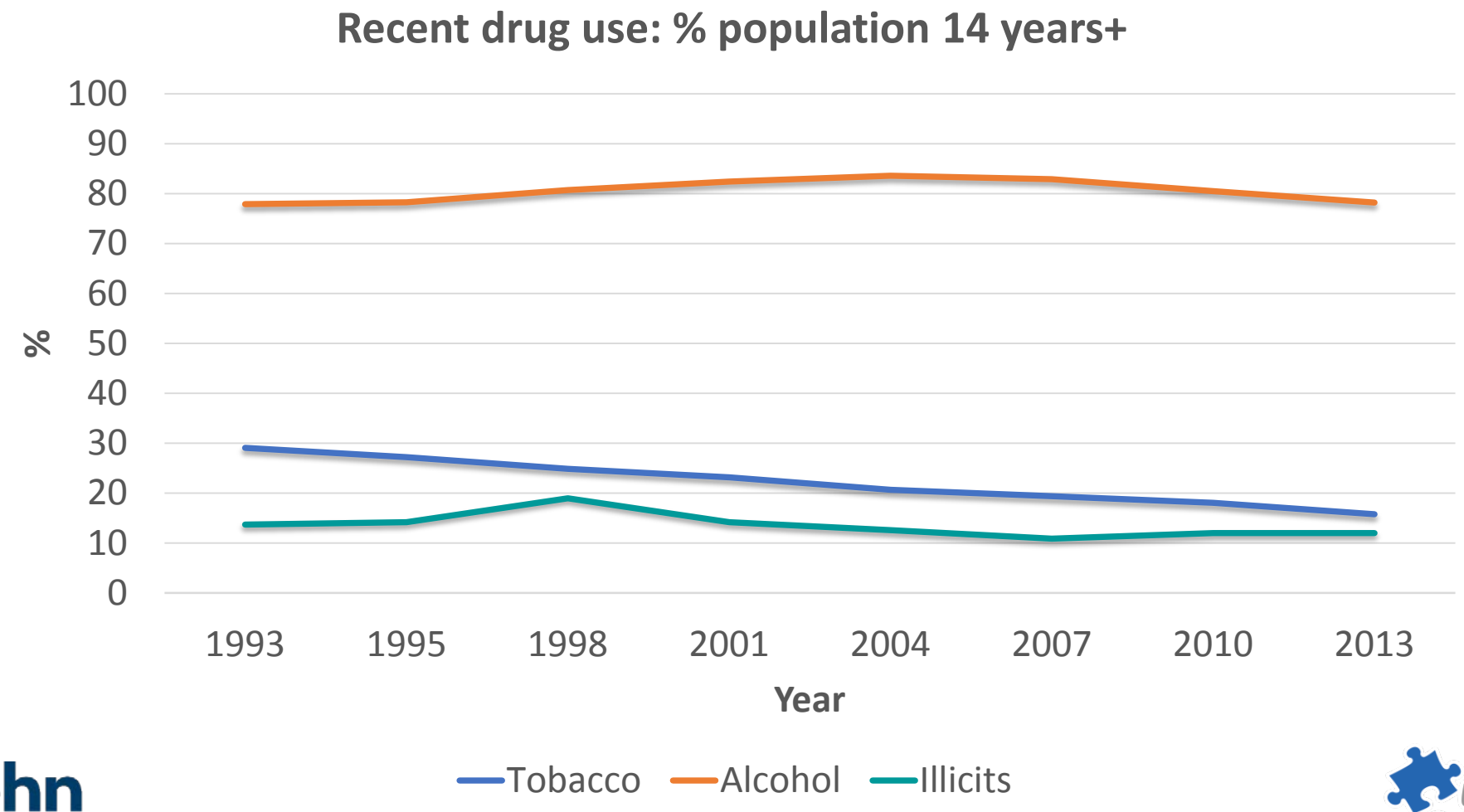
Move towards dimensional understanding of disorders in DSM-5

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

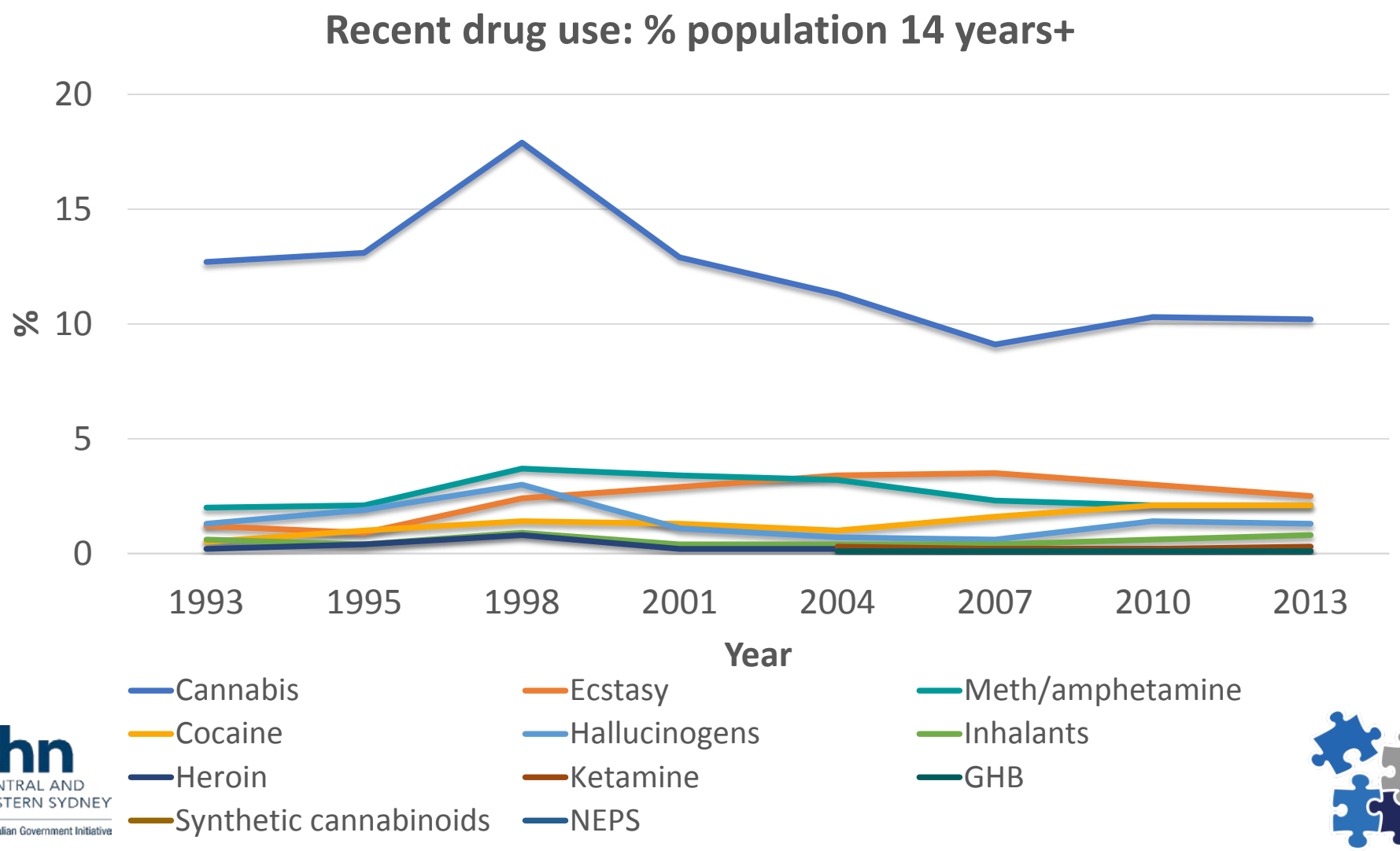


Prevalence of substance use: NDSHS



Source: https://www.aihw.gov.au/reports/illicit-use-of-drugs/ndshs-2013-detailed

Prevalence of substance use: NDSHS



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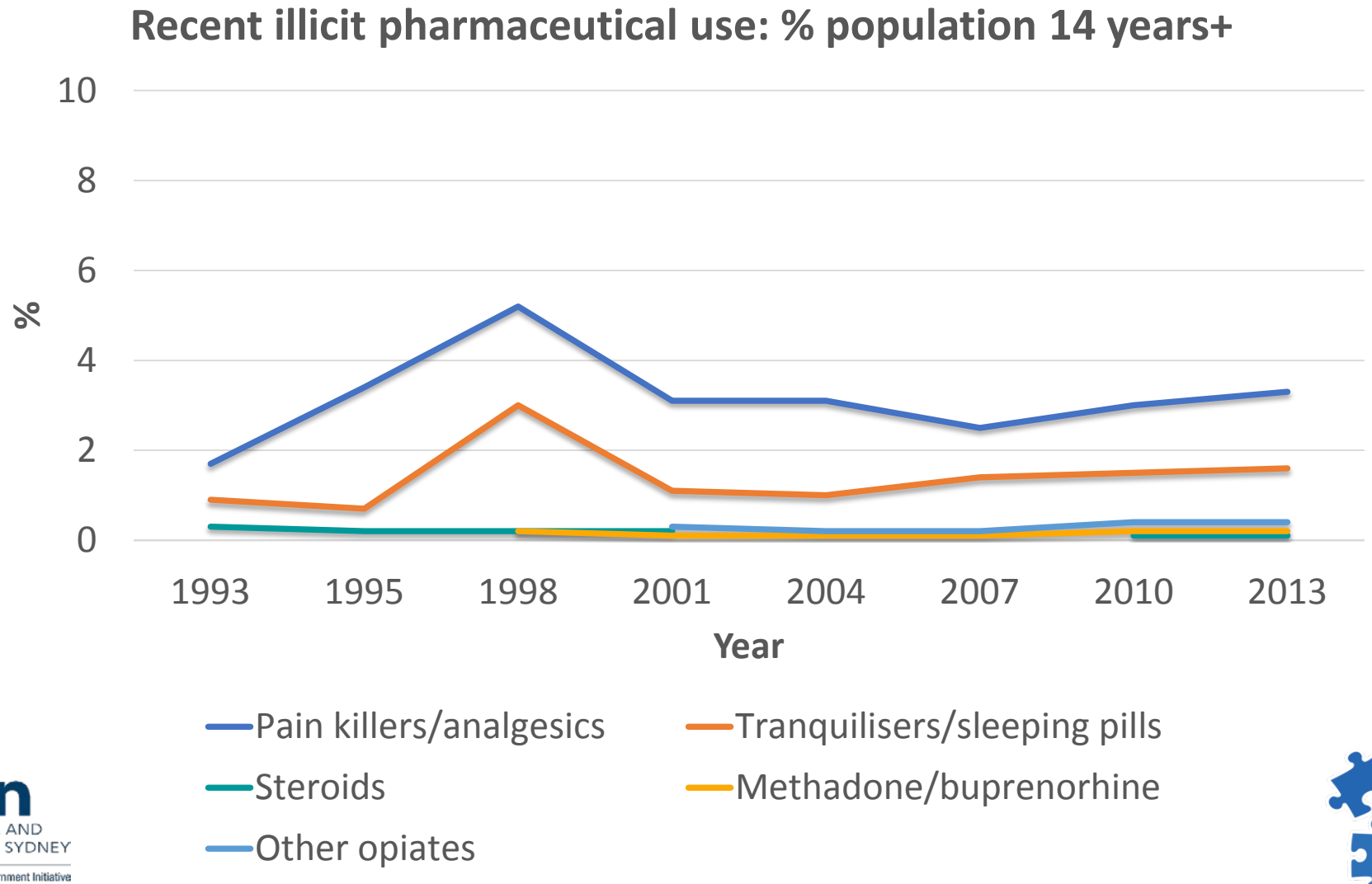

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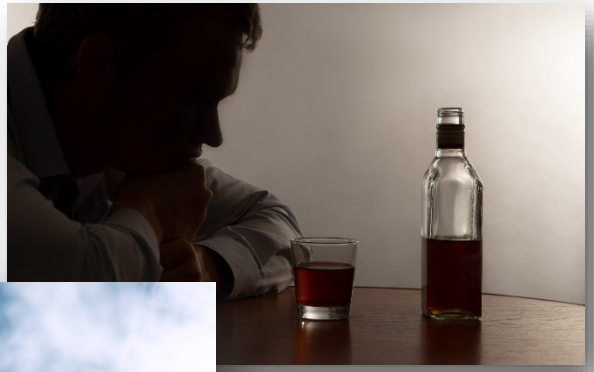
Not everyone who uses becomes dependent

- When do we need to become concerned?
  - Use vs use disorder
- Tobacco (8.5%-67.5%)
- Cocaine (16.7%-24.2%)
- Heroin (21.1%-23.1%)
- Alcohol (4.8%-22.7%)
- Cannabis (3.9%-19.7%)



- Many people drink/use at high levels without meeting criteria for a disorder, they may be nonetheless be at risk of physical harm

Source: Marel et al, forthcoming

Poll 1: Who is most likely to have a substance use disorder?

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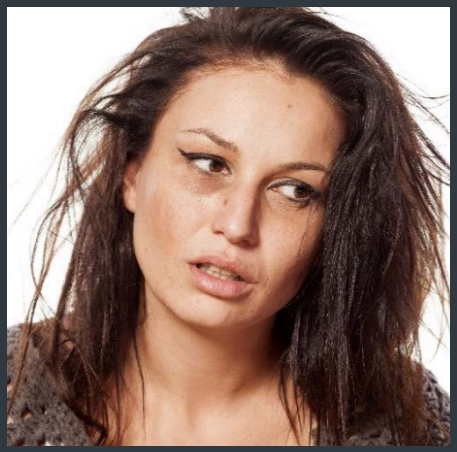
2. 

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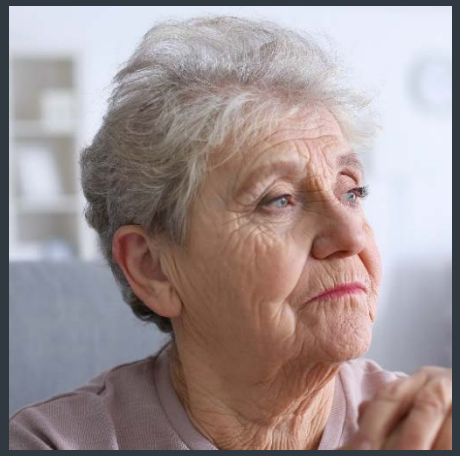
4. 

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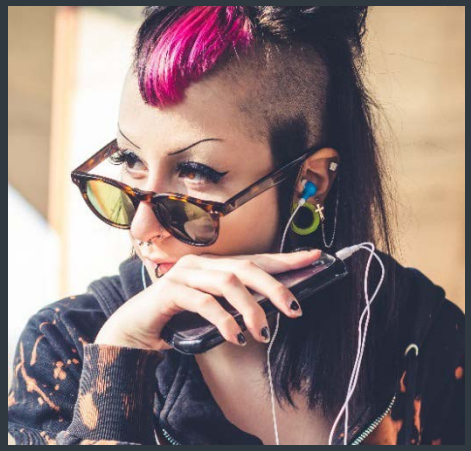
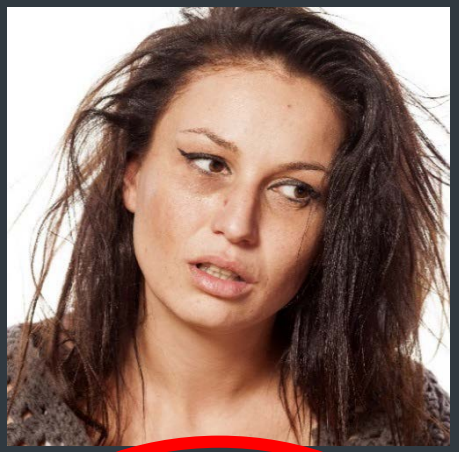
6. 

Poll: Who is most likely to have a substance use disorder?

1. 

2. 

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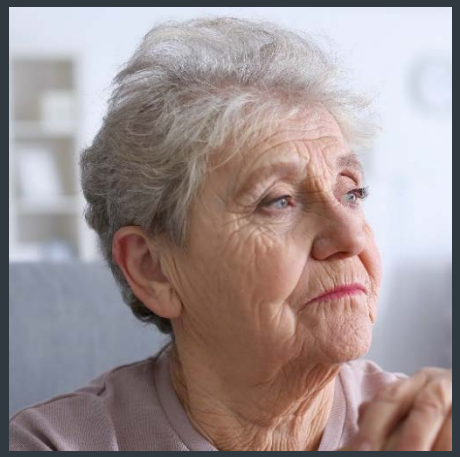
4. 

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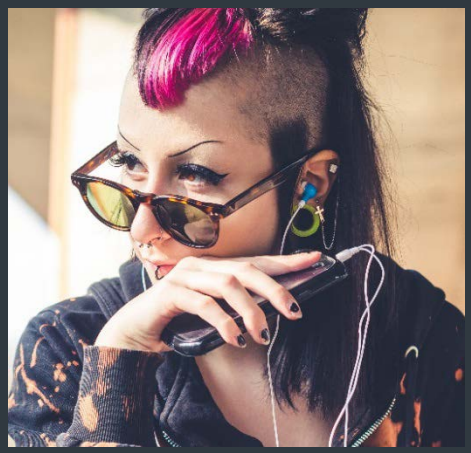
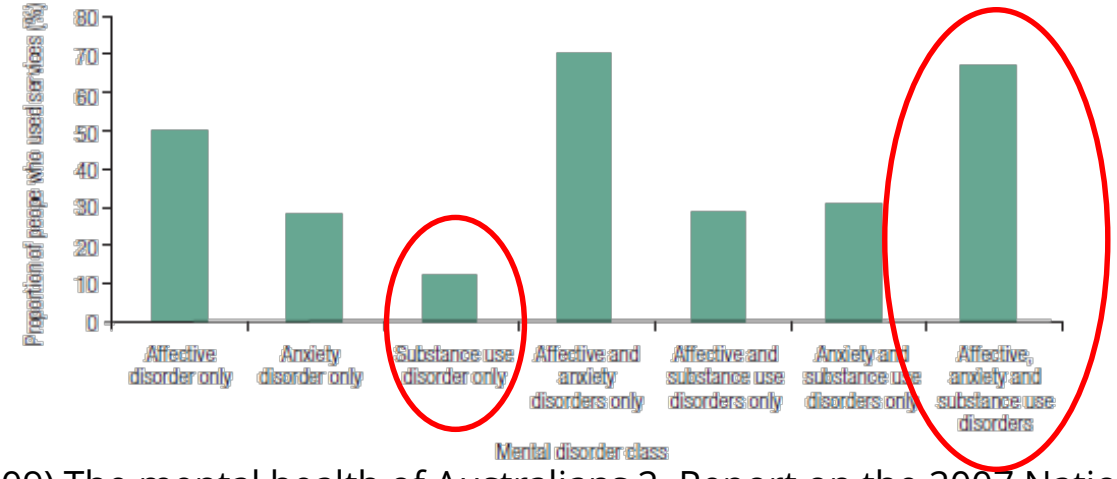
6. 

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…

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

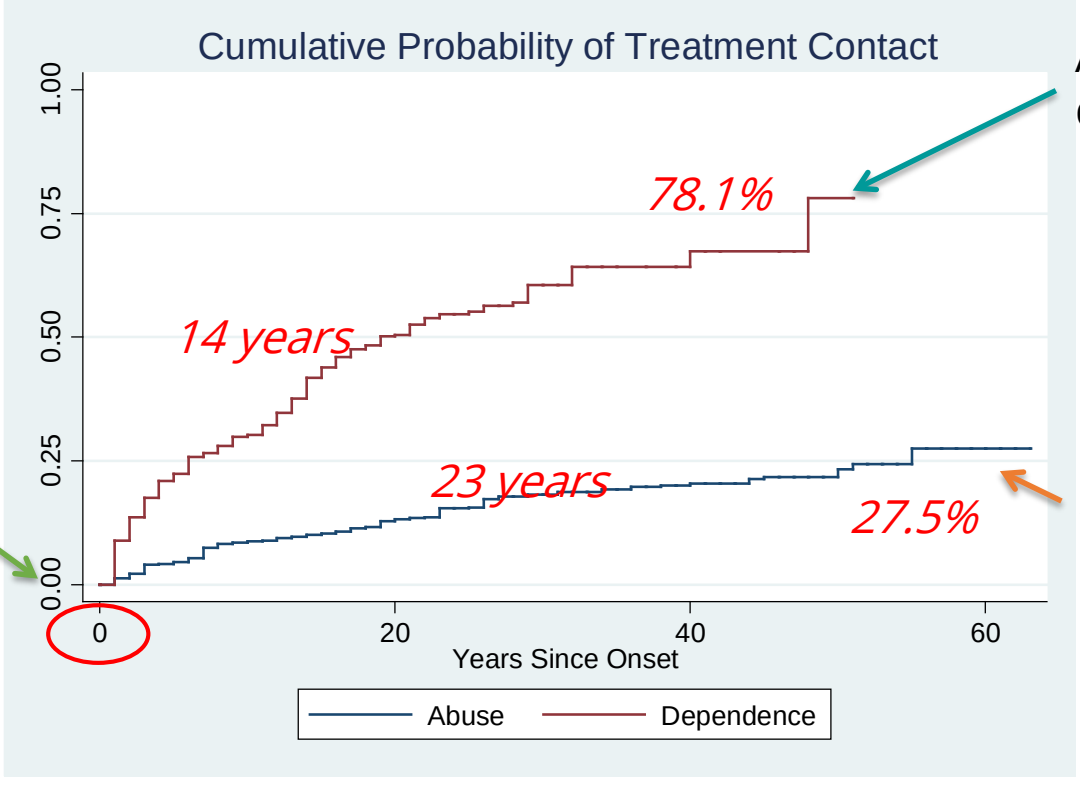
The delay to seek treatment is long…

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



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

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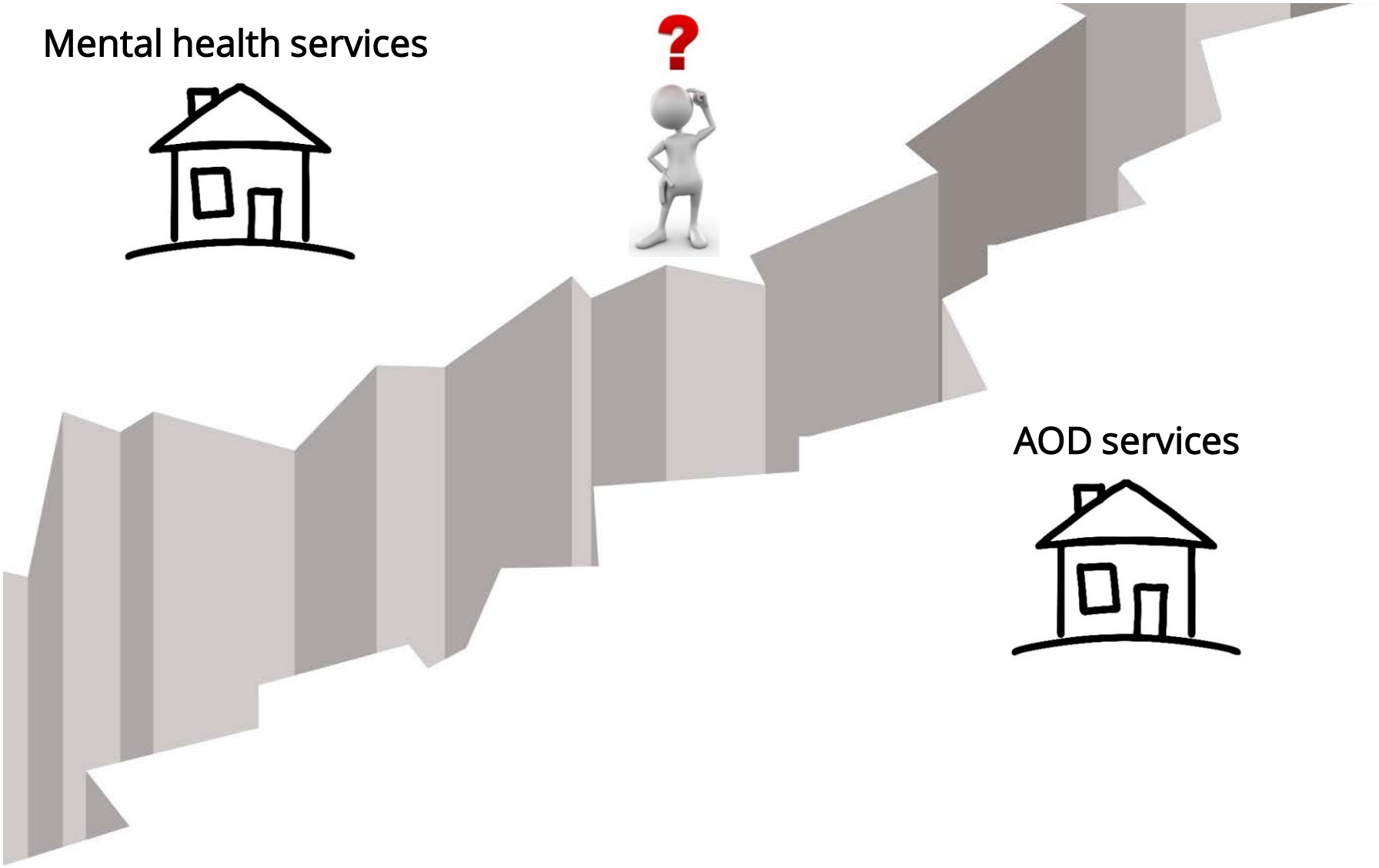
Fragmented care

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

Fragmented care



The comorbidity roundabout

Source: Kay-Lambkin et al., (2004). 'The "comorbidity roundabout": A framework to guide assessment and intervention strategies and engineer change among people with co-morbid problems', Drug and Alcohol Review, 23, 407–24.

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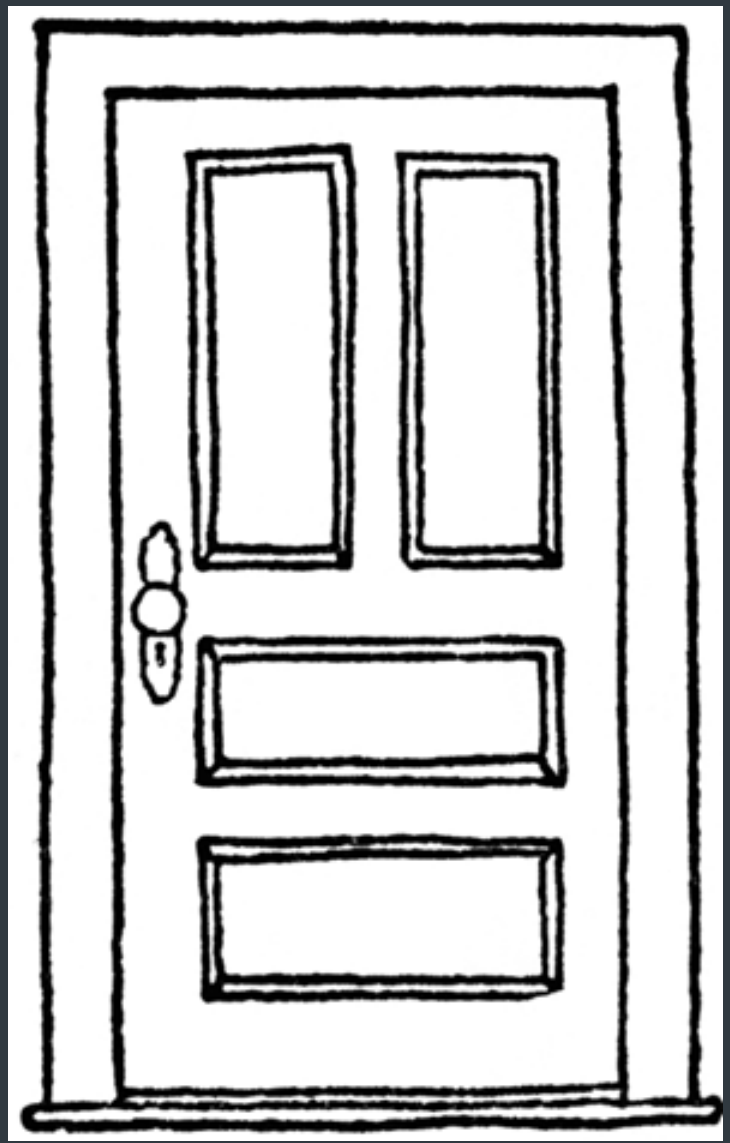


Why is comorbidity a problem?

- 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
- Complicates treatment and recovery

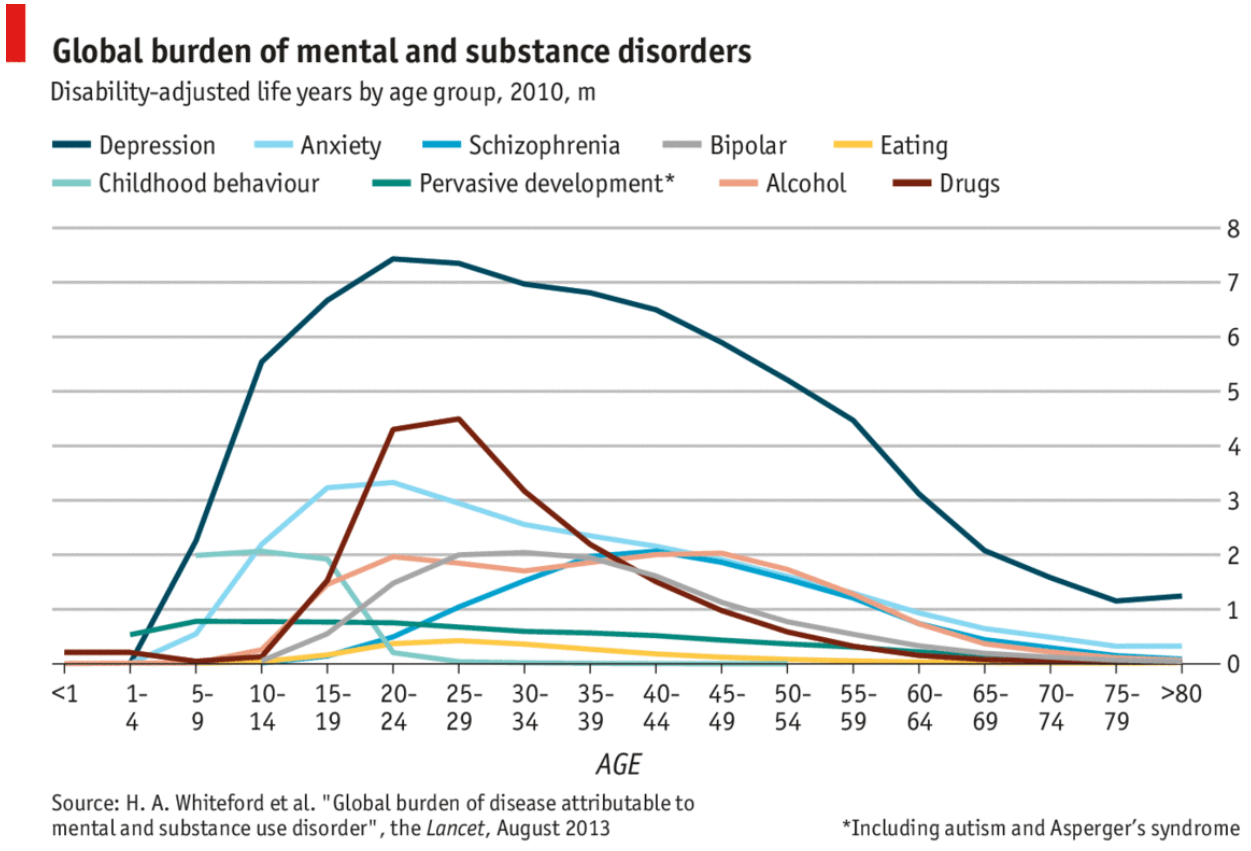
People with mental or substance use disorders die an astonishing 20 - 30yrs earlier than the general population, and spend the last 10yrs of life living with disabling chronic illnesses

*Comorbid mental health and alcohol/other drug use disorders are one of health's most significant challenges**

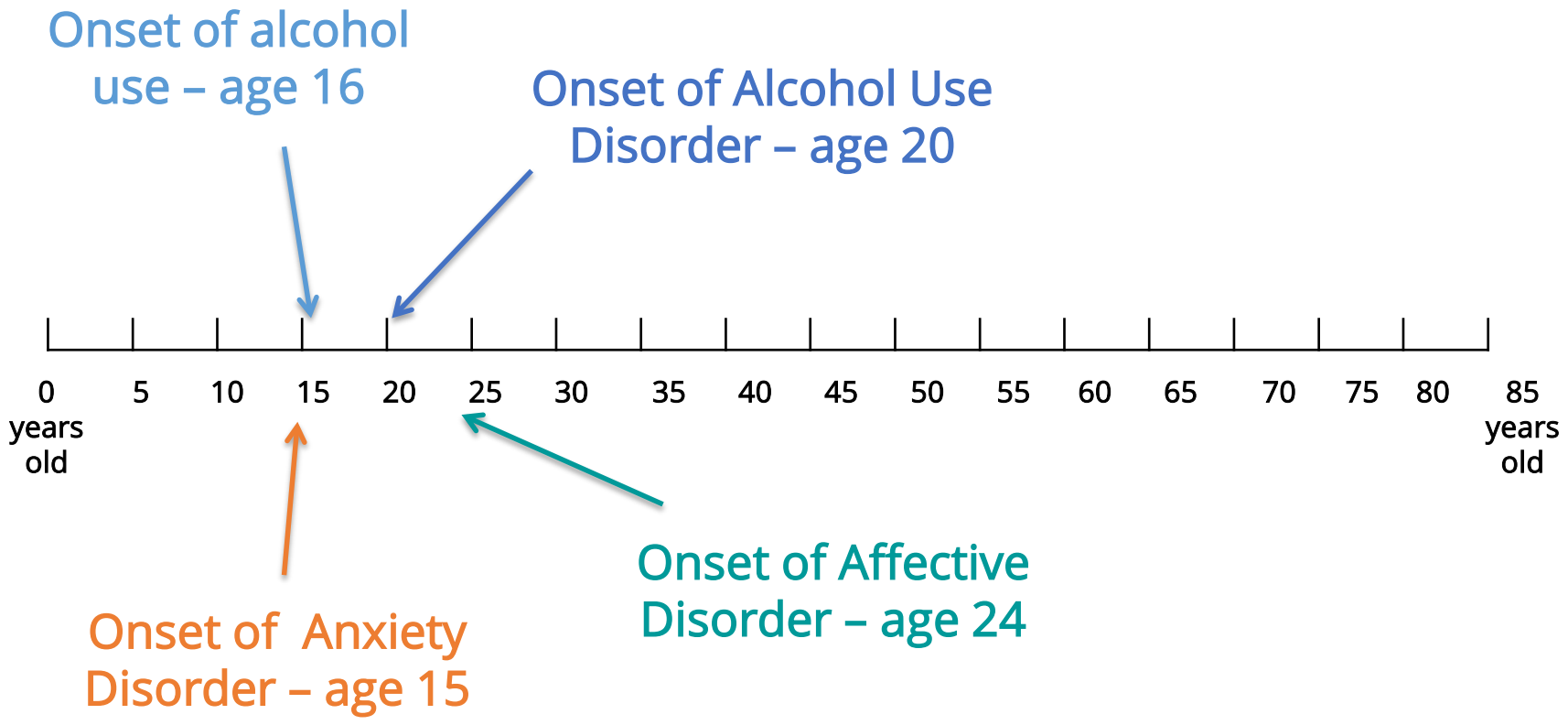
*Mental Health Commission National Report Card, 2012

Chronic diseases of the young

- 75% of incident cases of mental and substance use disorders emerge by age 25



When do mental disorders begin?



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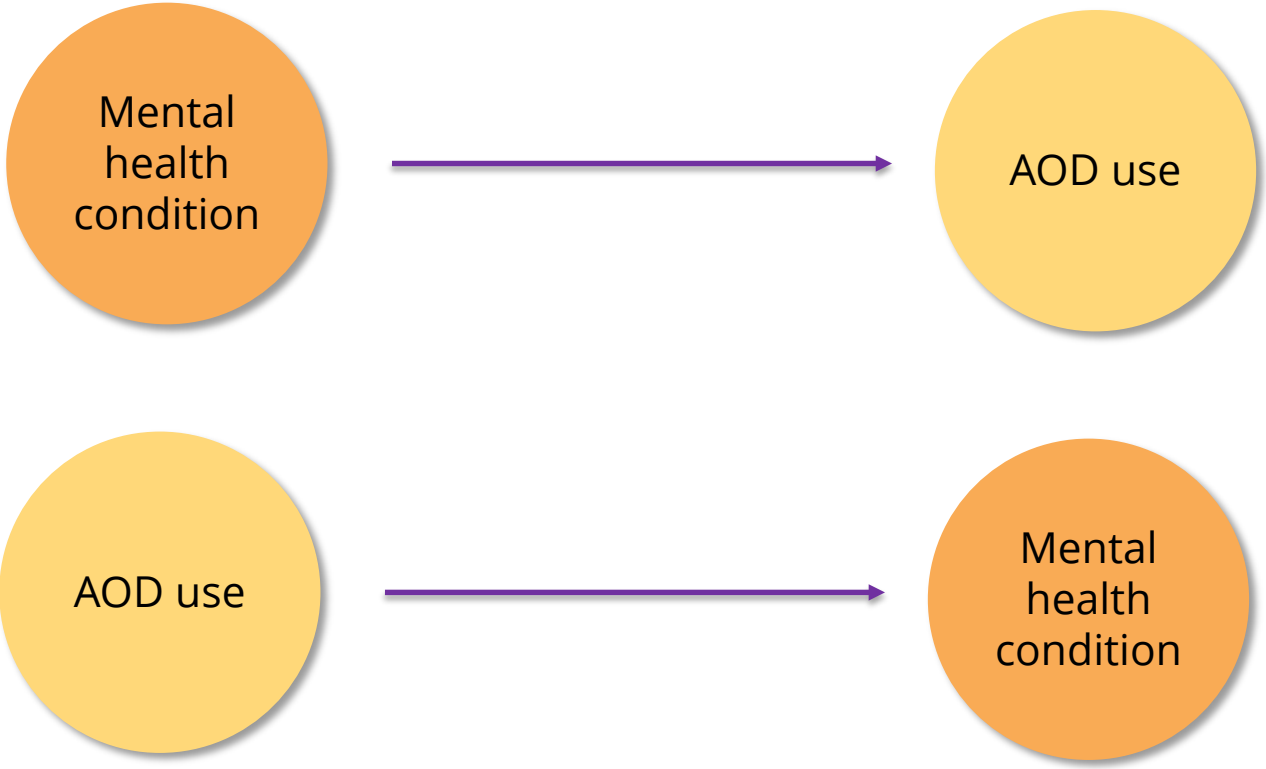
How does comorbidity occur?

Why does comorbidity occur?

Direct causal relationship



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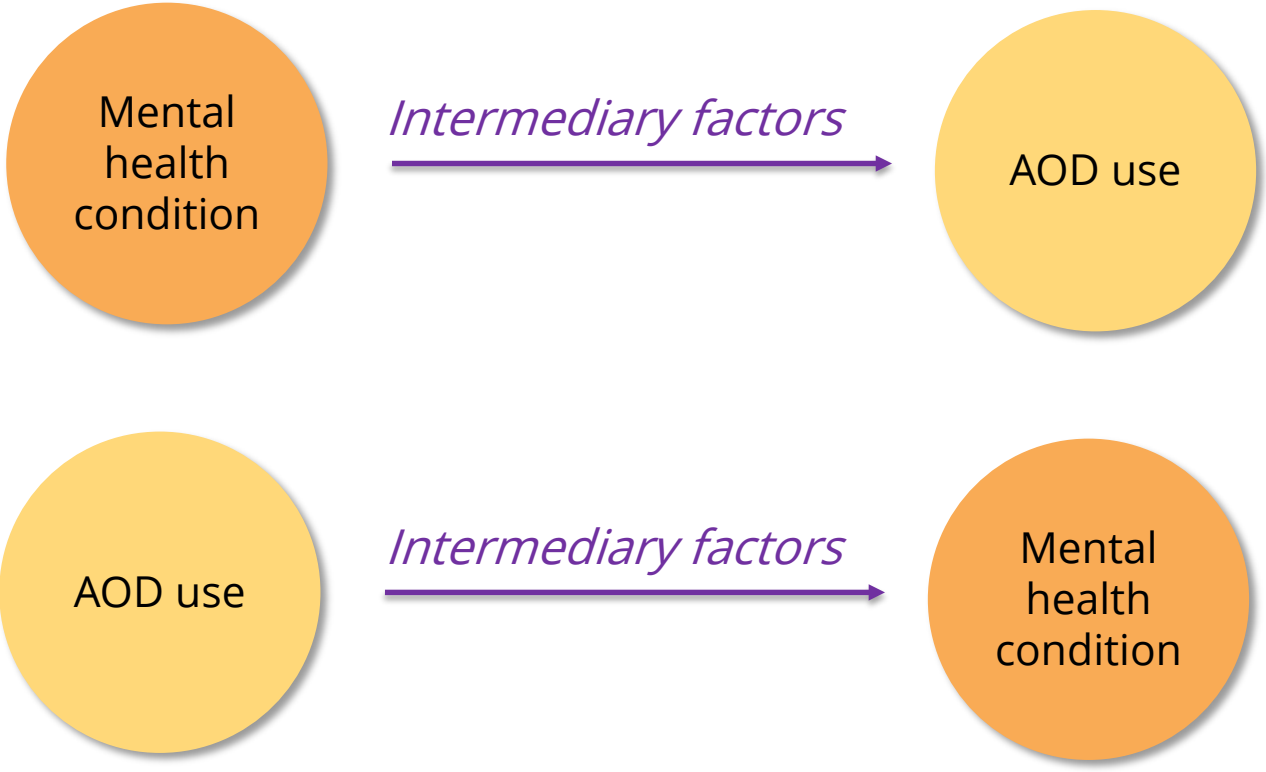
Why does comorbidity occur?

Indirect causal relationship



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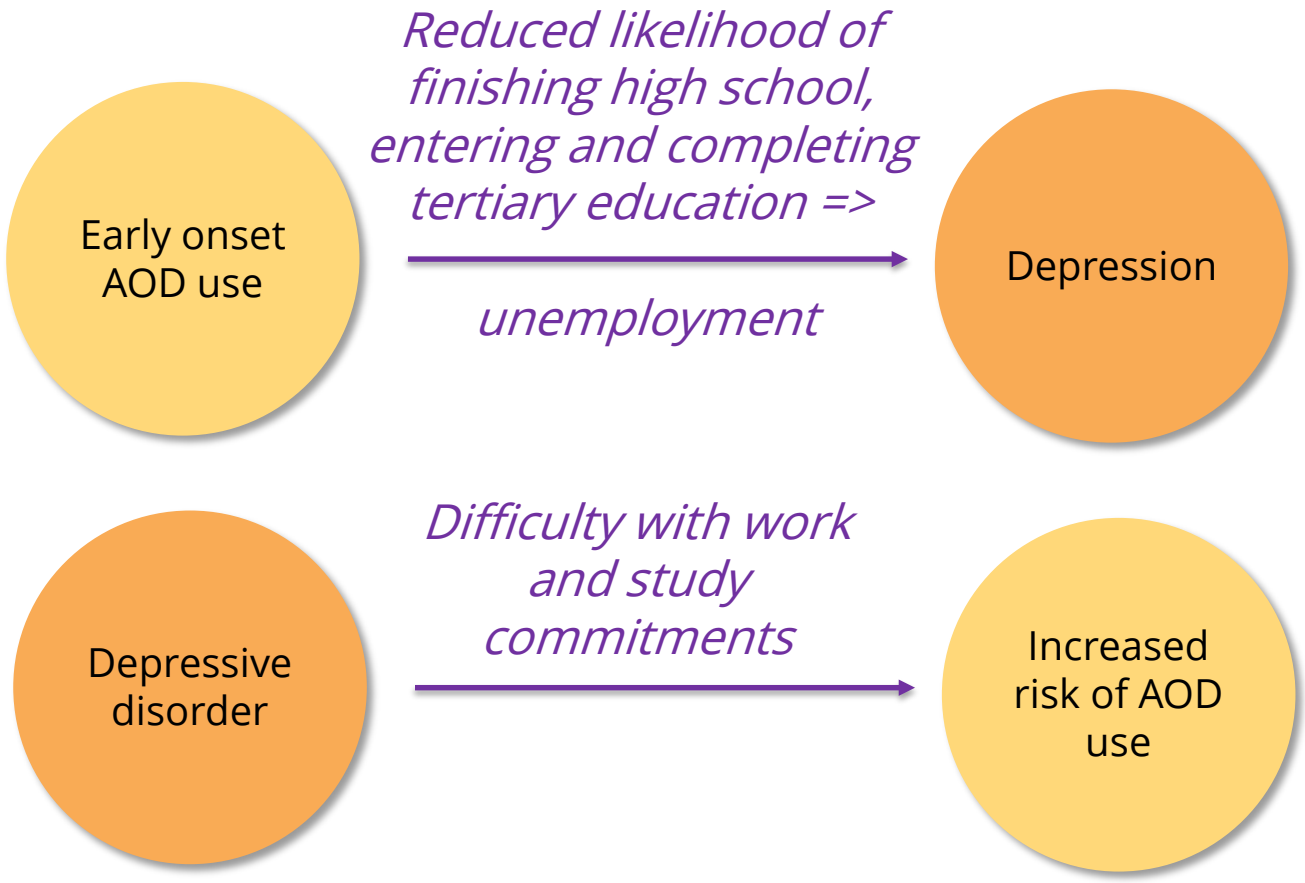
Why does comorbidity occur?

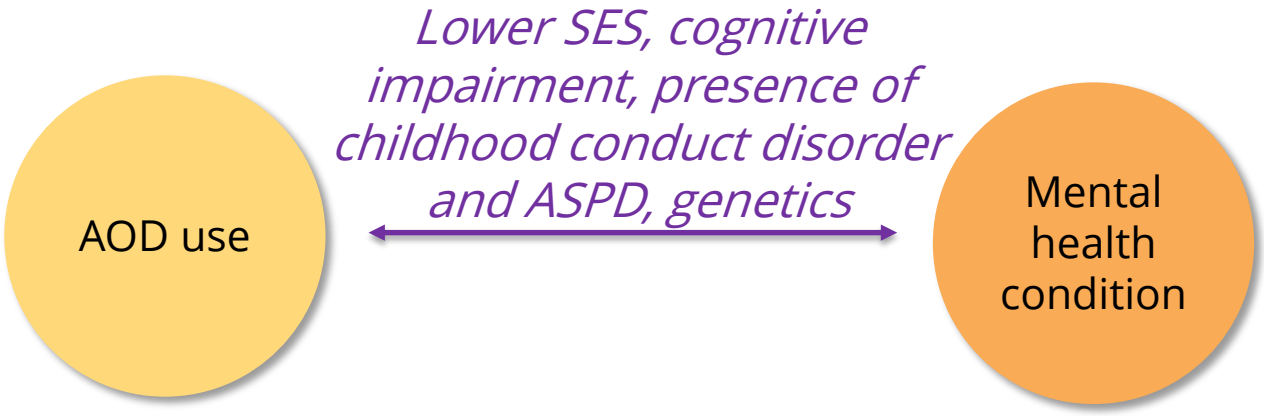
Indirect causal relationship: example



Why does comorbidity occur?

Common factors

Example:



So what?

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Key points

- Comorbidity is common
- Complicates treatment and recovery
- Relationship of mutual influence
- Irrespective of order of onset, management strategies are the same
- A number of barriers make it difficult for people with comorbidity to receive effective treatment

Overview

- Background: What do we know about comorbidity?
- How is comorbidity identified?
- Developing a plan: holistic health care
- Management and treatment
- Coordinated care

How is comorbidity identified?

Case study: Layla

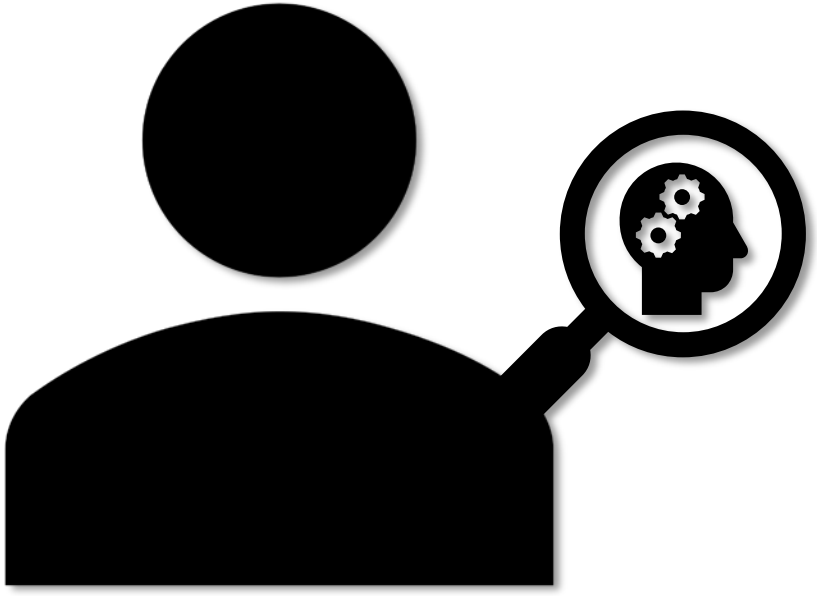
- 30 year-old female
- Felt good, but trouble sleeping
- Went to her GP to get her mother off her back
- Full-time work as a bank teller, distracted and irritable at work
- Huge credit card bills, weight loss
- In general, feels amazing
- Increasing difficulty at work - only able to keep her job because her employer is a family friend

Identifying comorbidity

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

How is comorbidity identified?

1. Screening
2. Assessment
3. Case formulation



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1. Screening

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

Some useful screening instruments

- For mental health:
  - Camberwell Assessment of Need Short Appraisal Schedule (CANSAS)
  - Kessler Psychological Distress Scale (K10)
  - Depression Anxiety Stress Scale (DASS)
- For AOD use:
  - CAGE Questionnaire (problem drinking)
  - Michigan Alcohol Screening Test (MAST; lifetime problems with alcohol use)
  - Drug Abuse Screening Tool (DAST; past 12-month drug abuse)
  - Alcohol Use Disorders Identification Test (AUDIT)
  - Drug Use Disorders Identification Test (DUDIT)

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

Other useful info

- Additional mental health screening tools in the Guidelines body (B2) and appendices - broad range of conditions
- Deady review of screening tools for use in AOD settings (2009):
  - Comprehensive review of all available screeners and assessment tools, including where to access, costs, validity and reliability
  - Report available for free download here: http://www.drugsandalcohol.ie/18266/1/NADA_A_Review_of_Screening,_Assessment_and_Outcome_Measures_for_Drug_and_Alcohol_Settings.pdf

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2. Assessment

- Detailed investigation of a person's mental health
- Ongoing process rather than a one-off event – involves the ongoing monitoring of clients' mental health symptoms and AOD use
- Ongoing assessment important because clients' mental health symptoms and AOD use may change throughout treatment


Assessment
Presenting issues
Source of referral
AOD use history
Medical history
Risk assessment
Psychiatric history
Trauma history
Mental state
Readiness to change
Family history
Criminal history
Current situation
Strengths and weaknesses
Personal history

Case study: Layla

- Visited psychological services as a uni student, described depressive episodes
- Started using methamphetamines during the day to lift her mood, and cannabis to help her sleep

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3. Case formulation

- Organises information relevant to treatment planning
- Should be aware of:
  - What problems exist? How did they develop? How are they maintained?
  - All aspects of the client's presentation, current situation, and the interaction between different factors/problems
- Generates an hypothesis as to how these factors fit together to form the current presentation
- Person-centred, NOT service-centred

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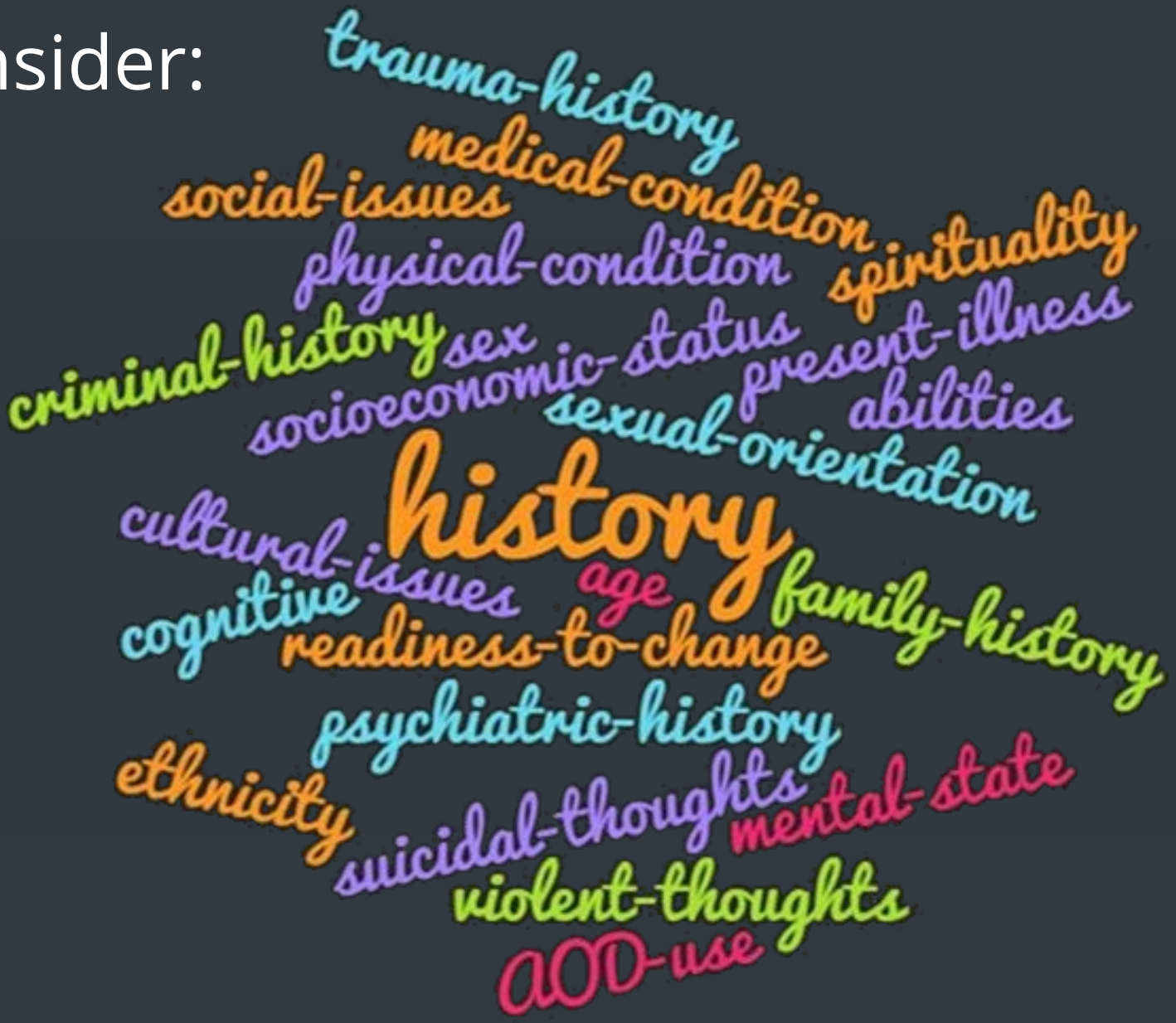
Consider:

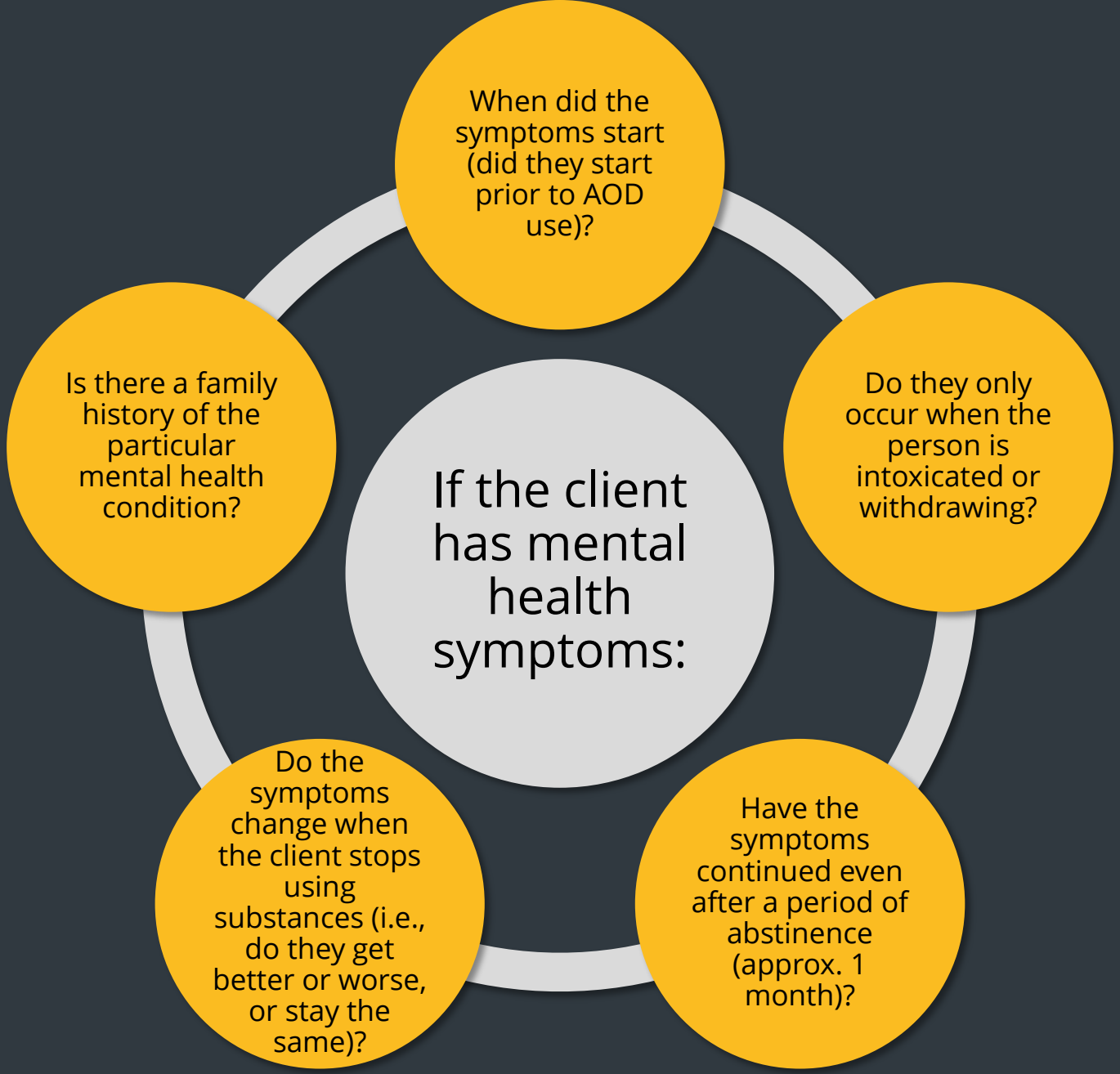

trauma-history
medical-condition
social-issues
physical-condition
spirituality
criminal-history
sex
socioeconomic-status
present-illness
sexual-orientation
abilities
history
cultural-issues
cognitive
age
family-history
readiness-to-change
psychiatric-history
ethnicity
suicidal-thoughts
mental-state
violent-thoughts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

Differentiating substance-induced disorders

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

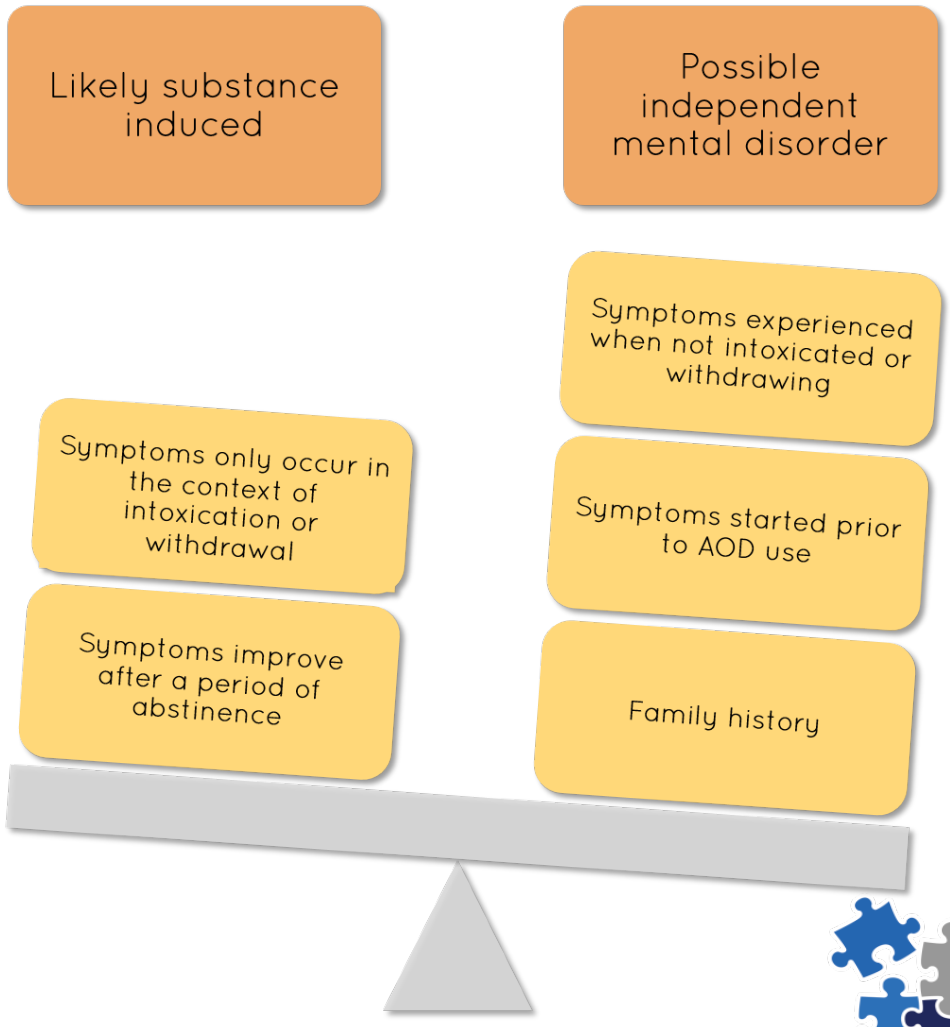
Differentiating substance-induced disorders

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


If the client has mental health symptoms:
When did the symptoms start (did they start prior to AOD use)?
Do they only occur when the person is intoxicated or withdrawing?
Have the symptoms continued even after a period of abstinence (approx. 1 month)?
Do the symptoms change when the client stops using substances (i.e., do they get better or worse, or stay the same)?
Is there a family history of the particular mental health condition?

Substance induced disorders

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



Substance-induced psychosis

- Difficult to distinguish substance-induced psychosis from other psychotic disorders
- Factors that may help differentiate:
  - Substance-induced symptoms:
    - Tend to appear quickly
    - Last a shorter time (hours to days), until the effects of the drug wear off (can persist for days, weeks, months or longer)
    - Visual hallucinations more common in substance withdrawal and intoxication than in primary psychotic disorders

Key points

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

Overview

- Background: What do we know about comorbidity?
- How is comorbidity identified?
- Developing a plan: holistic health care
- Management and treatment
- Coordinated care

Develop a plan

Developing a plan: Holistic health care

Holistic health care

HIGH RISK OF CVD

FOCUS ON WELLBEING

Reduce smoking

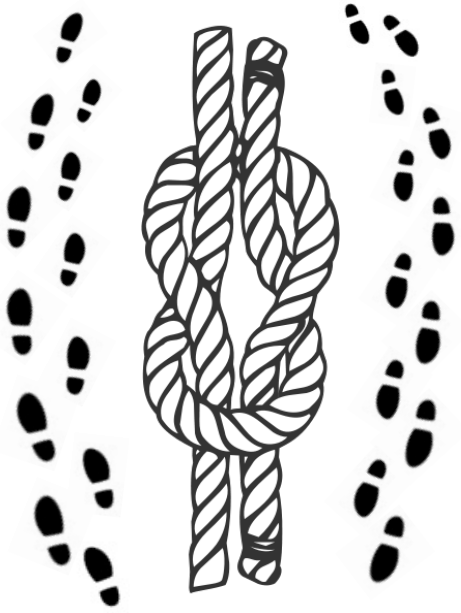
Improve diet

Increase physical activity

Improve sleep patterns

CLIENT-CENTRED APPROACH

MENTAL HEALTH

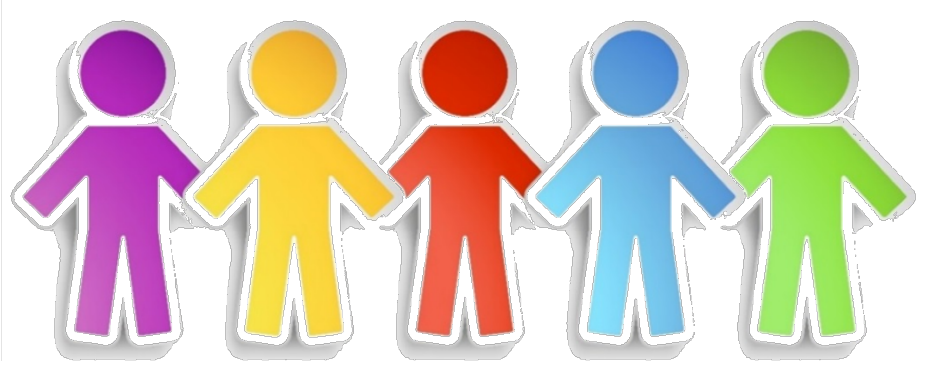


PHYSICAL HEALTH


NRT
Dietary guidelines, food spending structure
Food and activity diary, motivational tools
Healthy sleep habits
Strategies to help overcome barriers

Healthcare workers' role in holistic health care

- Holistic approaches focused on delivering the *right* services to the *right* person at the *right* time
- Involve multiple services in coordinated, client-centred approach
- Be prepared to address mental and physical health, as well as partner with other services to deliver complete individualised care



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Developing a plan: Management and treatment

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

Managing comorbidity

- Management strategies described in the Guidelines provide short term relief and control over symptoms
- Guidelines provide “dos and don'ts” and practical strategies for managing commonly co-occurring conditions

Challenge

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Managing and treating comorbidity

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

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Managing/treating comorbidity

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

- Management techniques:
  - Anxiety, panic and agitation
  - Trauma -related symptoms
  - Confusion or disorientation
  - Cognitive impairment
  - Grief and loss
  - Aggressive, angry and violent behaviour

Layla's management and treatment

- Combination of psychotherapy and pharmacotherapy
- Poor medication compliance
- Ongoing mood disturbances in first 12-months
- Case review conference addressing pharmacotherapy, lifestyle, social connections

Key points

- Four identified models of care, with little definitive evidence that suggests any are more suited to particular comorbidities
  - BUT integrated approaches have a number of advantages of other approaches and some emerging evidence to support their use
- Distinction between management and treatment of comorbidity
- Traditional psychological and pharmacological approaches have limited evidence for comorbidity. Where evidence is lacking, recommended to use to most effective treatment for single disorders
- Some evidence for e-health, physical activity and complementary and alternative therapies for some disorders

Overview

- Background: What do we know about comorbidity?
- How is comorbidity identified?
- Developing a plan: holistic health care
- Management and treatment
- Coordinated care

Coordinated care

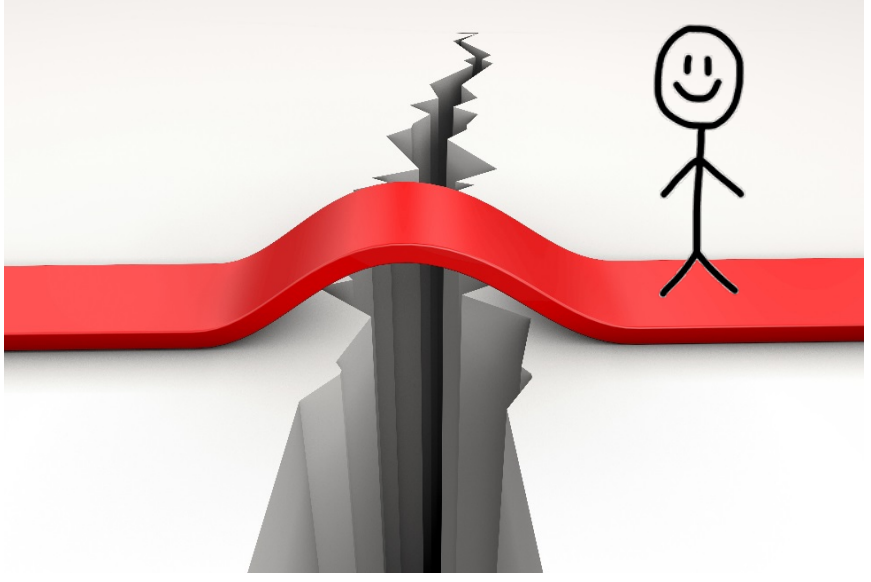
Coordinated care

Coordinated care

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

Coordinated care

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



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Healthcare workers' role in coordinated care

- Coordinate, manage, deliver appropriate services
- Challenge -> managing active engagement of multiple services across professional and non-professional sector
- Challenge -> who coordinates care?
  - Primary healthcare positions ideally placed to coordinate care, and incorporate services that reflect their clients' individual needs, but time poor
  - Deliver **best quality** care

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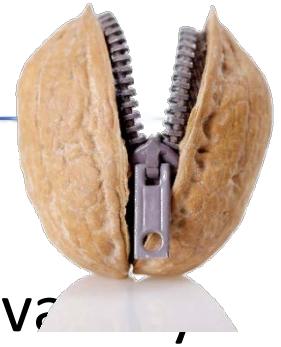
In a nutshell



- AOD and MH disorders are common
- Clients with comorbid MH conditions often have va… of other medical, family and social problems
  - Important to adopt holistic approach to management and treatment of comorbidity that is based on ***treating the person, not the illness***
- Important that comorbidity is identified so that can be managed and treated appropriately
- In addition to mental health services, health workers may need to engage and develop strong links with range of other services

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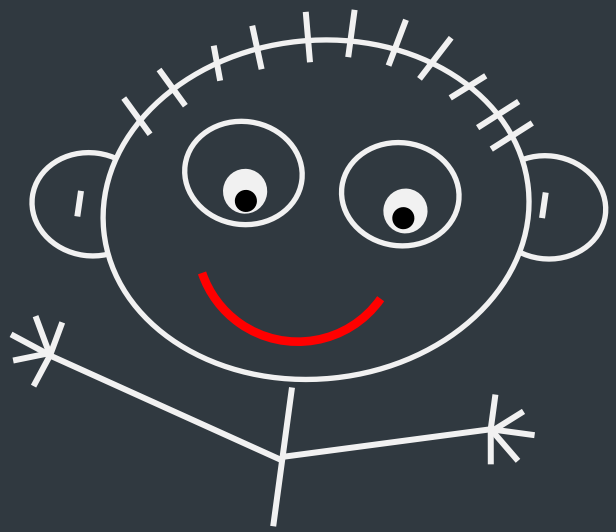
People can and do, get better!



Thanks for being part of the CESPHN-CREMS Webinar Series

Thank you!

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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_0xKjc7WNAYOnJit

Any questions?