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CREMS

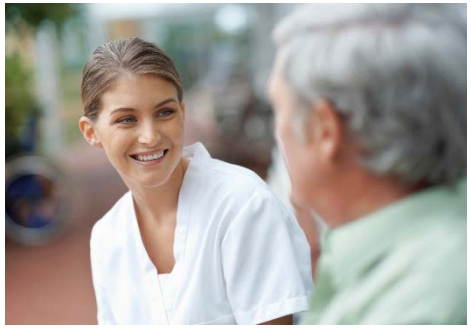
Managing the physical health of people with co-occurring mental and substance use disorders

Dr Christina Marel

A/Prof Katherine Mills

CESPHN-CREMS Webinar Series: Welcome!

Previous webinars from this series...



Co-occurring substance use and mental disorders: Implications for managing and delivering best-practice health care

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

Managing and treating co-occurring mental and substance use disorders

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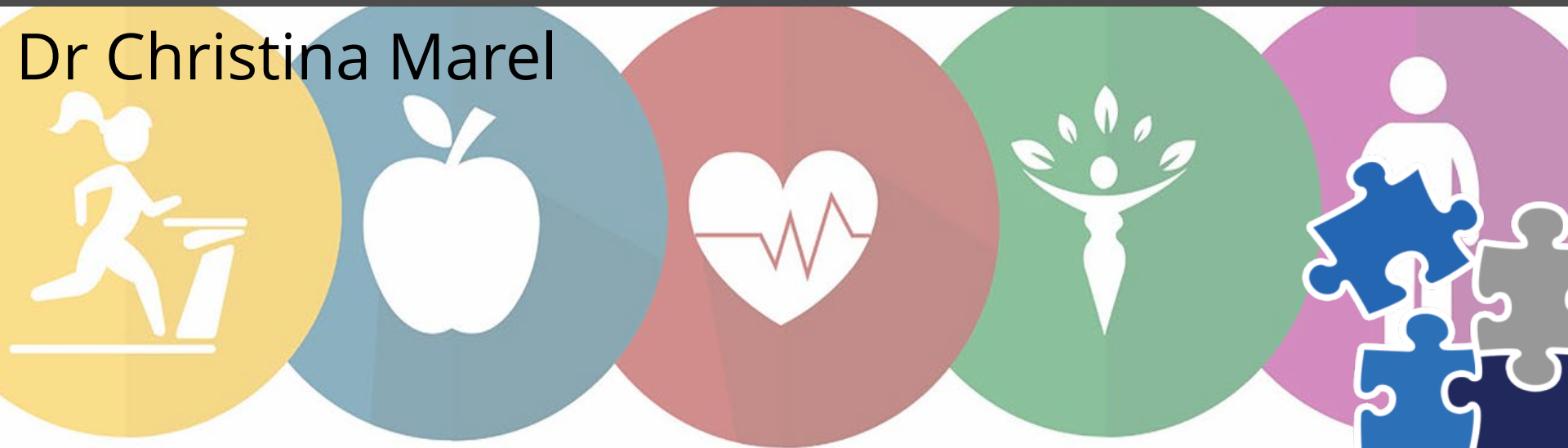
Managing the physical health of people with co-occurring mental and substance use disorders

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*
- Access and download: https://comorbidityguidelines.org.au/guidelines/

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Learning outcomes

- Improved understanding of behavioural risk factors and metabolic syndrome among people with comorbidity
- Understanding of ways to overcome patient and practitioner barriers to address physical health and lifestyle factors
- Improved understanding of need for collaboration and techniques to facilitate coordinated care

Welcome poll

Overview

- Brief background: What do we know about comorbidity?
- Behavioural risk factors
  - Metabolic syndrome
- Patient and practitioner barriers to address physical health and other lifestyle factors
  - Strategies to overcome barriers
- Coordinated care

Case study: Tim

- 38-year old male
- History of psychosis dating back to late teens
- Several admissions to inpatient psychiatric units in early 20s, managed within community mental health care
- Recent lifestyle more chaotic, moved house 5 times in past 12-months
  - Several different community mental health services → no clinician knows him well
  - Several different GPs

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Tim's presentation

- Presented to Emergency following altercation with fellow hostel resident
- High blood pressure, overweight and cough were observed
- Assessed by community mental health nurse, liaised with GP
- Prescribed antipsychotic medications and mood stabilisers over many years → increased weight gain

- Never been tested for type II diabetes or had blood tests

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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
- 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

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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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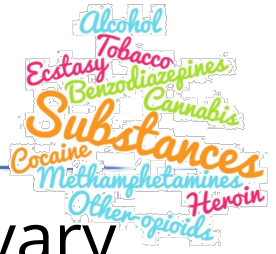
Mental health continuum

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

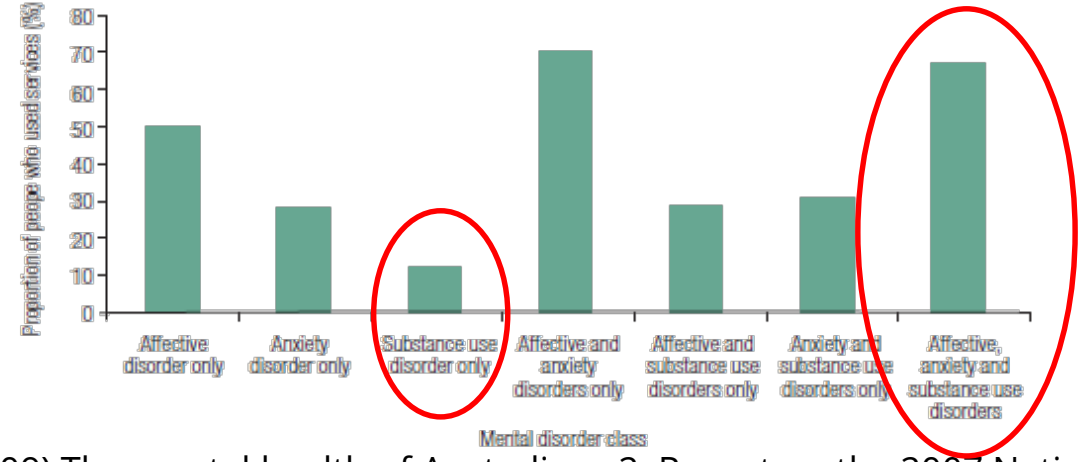


- Prevalence of mental health disorders may vary between substances
- Little research comparing the rates of mental health disorders across different types of AOD use disorders
- Substance use among those with mental health disorders mirrors general population trends in availability and fashion
  - Most 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.

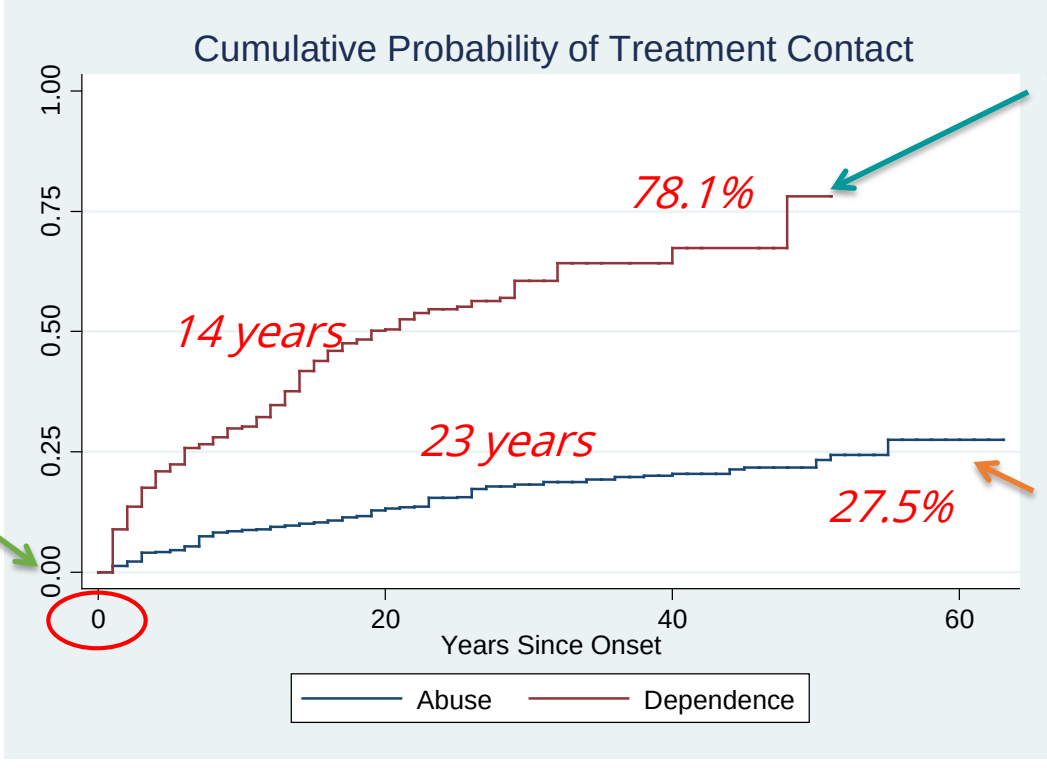
The delay to seek treatment is long…

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

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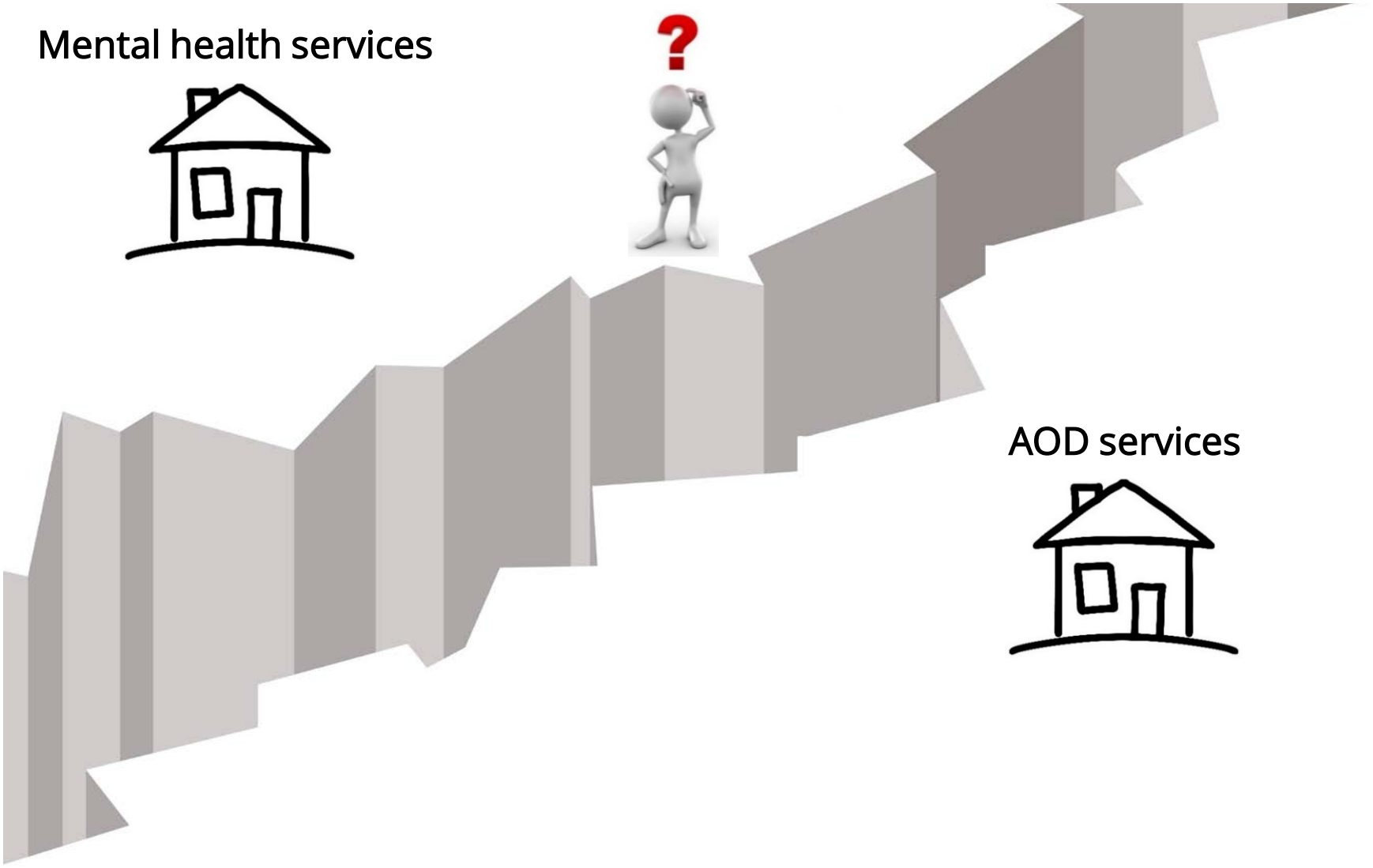
Fragmented care

- “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
- Shorter life expectancies than the general population, spend the last 10-years of life living with chronic illnesses

Overview

- Brief background: What do we know about comorbidity?
- Behavioural risk factors
  - Metabolic syndrome
- Patient and practitioner barriers to address physical health and other lifestyle factors
  - Strategies to overcome barriers
- Coordinated care

Behavioural risk factors and metabolic syndrome

Poll: Compared to the general population, what is the mortality rate of consumers of mental health services?

Why is this a problem?

Why should we address physical health?

- Consumers of mental health services have **more than double the mortality rate** of the general population
  - Especially due to cardiovascular disease (CVD)
- Risk factors for CVD are also prominent among people with AOD and mental health conditions
- These risk factors place people at risk for metabolic syndrome

Why is addressing physical health important?

HIGH RISK OF CVD

FOCUS ON WELLBEING

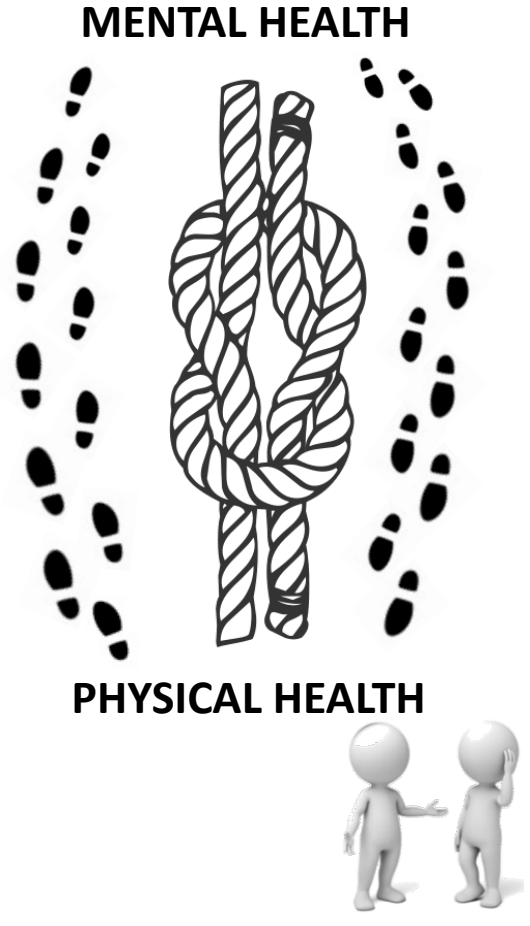
Reduce smoking

Improve diet

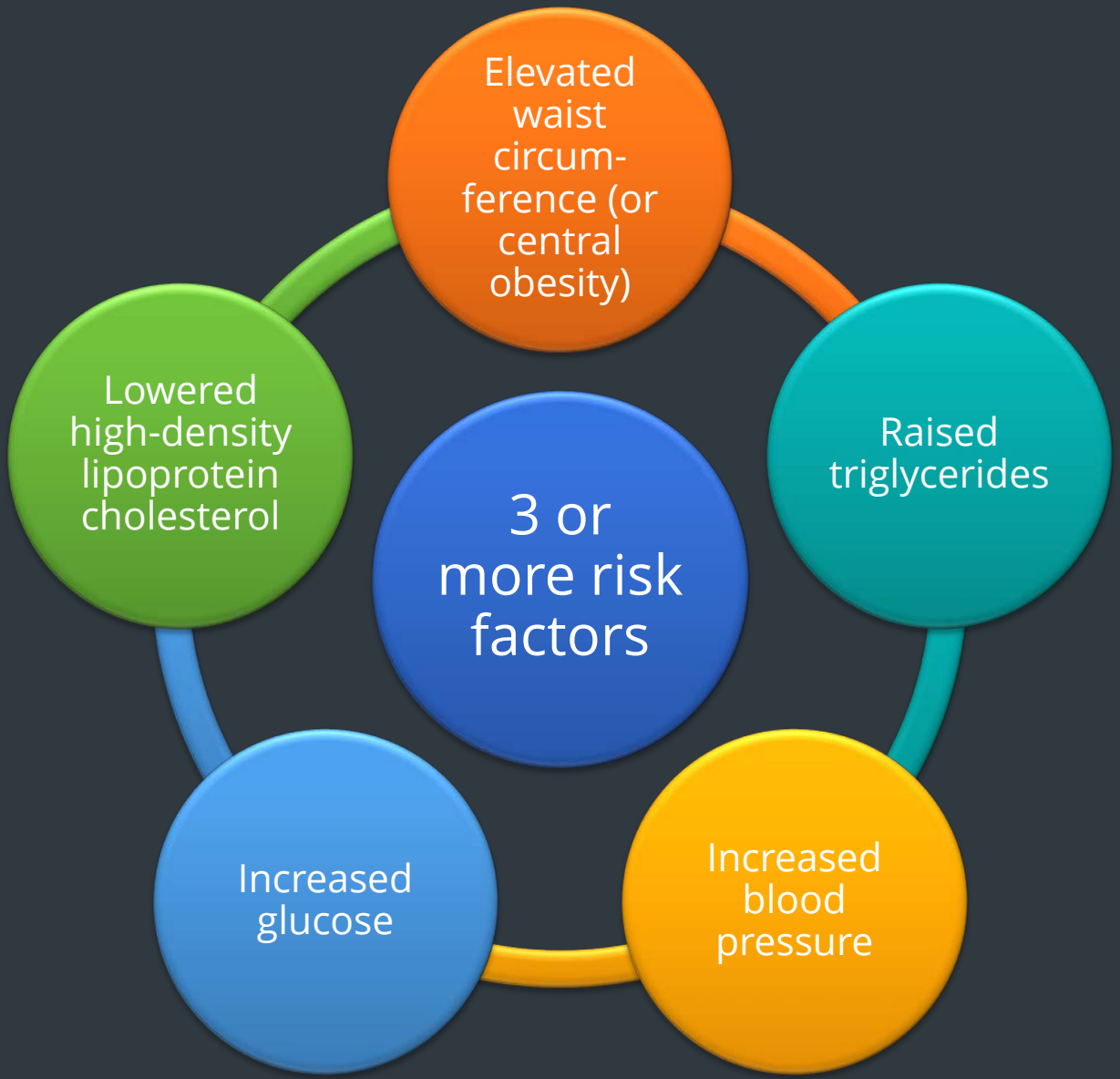
Increase physical activity

Improve sleep patterns

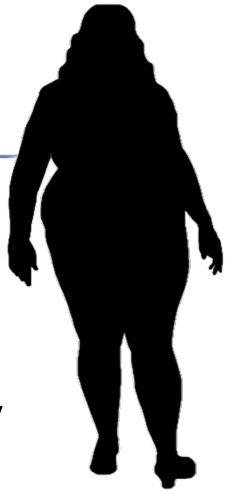
CLIENT-CENTRED APPROACH



Metabolic syndrome



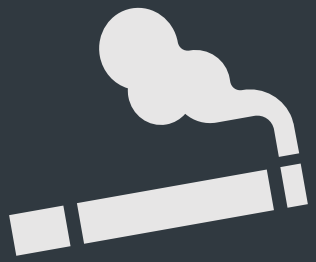
Metabolic syndrome



- One-third of Australians currently diagnosed with metabolic syndrome
  - Directly affected by sleep, physical activity, dietary behaviours
- People with mental health disorders high-risk for metabolic syndrome and associated morbidity and mortality – particularly those prescribed antipsychotics

Poll: What are the four primary behavioural risk factors that we need to consider among people with comorbidity?

Behavioural risk factors

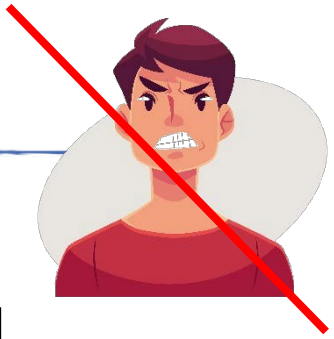


Smoking

Smoking among people with comorbidity

- Substantial smoking rates among people with comorbid mental health and AOD use problems
  - Particularly high in AOD treatment settings, range between **74-98%**
- Compared to the general population, people with comorbidity:
  - Smoke substantially more cigarettes per day
  - More likely to be nicotine dependent
  - Accounts for the highest rate of mortality
- Despite this, focus of treatment primarily centres on substances other than tobacco

Healthcare workers and smoking

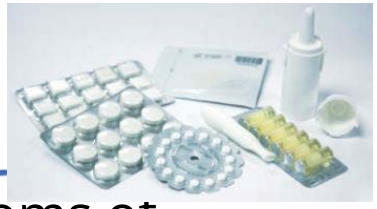


- Reluctance to address smoking
  - Belief that other AOD use will be exacerbated
  - Increase psychiatric symptoms and aggression
- Not supported by the evidence → no adverse outcomes on symptoms of psychosis

Nicotine and NRT

- Nicotine interacts with the metabolism of some medications and drugs
- Can be changes in how some medications are metabolised (clozapine and olanzapine) following cessation of smoking or NRT
- If AOD clients are withdrawing from nicotine, they should be advised about:
  - Potential changes in metabolism
  - Increased absorption of caffeine (i.e., coffee, tea, chocolate, soft drinks) → can lead to restlessness and lack of sleep

NRT



- NRT can be used to minimise the physiological symptoms of withdrawal
  - Available in patches, gum, inhalers, lozenges, microtabs
- NOT recommended without clinical assessment, or as first line of treatment for AOD clients who:
  - Are pregnant, or are likely to become pregnant
  - Are currently breastfeeding
  - Have significant cardiac or active vascular disease
  - Have nicotine sensitivities or allergies
- Clients withdrawing should be closely monitored and their NRT dose tailored, so triggers, cravings and stress can be addressed through accompanying psychosocial interventions

Image source: Colin Mendelson, *Nicotine replacement therapy not effective without counselling,* 2014

Barriers to addressing smoking

- Inconsistencies in implementation of smoking interventions
- A greater number of AOD staff smoke in comparison to the general population
  - Sometimes smoke with clients to promote therapeutic relationship
- Negative attitudes among treatment staff potential barriers
  - Staff who smoke less likely to initiate smoking cessation strategies among their clients
  - Less successful when they do

Image source: Schmidt E, *UCLA study reveals smoking's effect on nurses' health, death rates, UCLA Newsroom*, 2008

Diet

Diet

- AOD clients tend to have poor dietary habits
  - Nutrient-poor
  - Energy-dense
  - Excessive portions
- Unhealthy eating patterns, weight gain, obesity among those accessing AOD treatment → energy dense diets are sometimes used to substitute AOD during recovery

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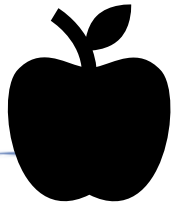
Promoting healthy weight loss

- Programs targeting preparation of nutritional food can produce lasting weight loss among people with mental health conditions
- Healthcare workers can help by encouraging adherence to the Australian dietary guidelines

Source: www.eatforhealth.gov.au

Strategies to promote healthy eating



- Australian dietary guidelines:
  - Eat a variety of foods that are high in fibre and low in fat
  - Eat seven or more fruits and vegetables per day
  - Drink plenty of water
  - Make healthy food choices and eat regularly
  - Manage healthy eating patterns (e.g., ensuring that breakfast is eaten every day, and eating patterns are maintained on weekends and weekdays)

Strategies to promote healthy eating

- Foodcents spending structure:
  - Promotes healthy eating on a limited budget
  - Designed to be used alongside the healthy eating guidelines

Categories	Examples	Recommended spending
Eat most	Bread, cereals, rice, pasta, flour, fruit, vegetables, baked beans, lentils	60% of budget
Eat moderately	Lean meat, chicken, fish, eggs, nuts, milk, cheese, yoghurt	30% of budget
Eat least	Butter, oil, sugar, biscuits, cake, chocolate, chips, soft drink, coffee, salad dressing, sauce	10% of budget

Source: WANADA Healthy eating for wellbeing: A nutrition guide for alcohol and other drug workers 2011; Foodcents 2015 http://www.foodcentsprogram.com.au/about-foodcents/

Physical activity and exercise

Physical activity

- Physical and psychological benefits well established
- Despite this, one-quarter of adults are inactive
  - Few achieve recommended 30 minutes moderate intensity exercise most days
  - Insufficient physical activity accounts for approx. **9% premature mortality worldwide**
- Increasing amount of research focused on potential benefits of exercise in AOD and mental health treatment
  - Safe, alternative behaviour, naturally rewarding and engaging, various health benefits

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Physical activity and exercise

- Associated with:
  - Improved health
  - Improved depression and mood
  - Reductions in anxiety
  - Reduced effects of withdrawal
- Considered to be safe when exercises have been properly tailored
- Appealing, adjunctive intervention to assist with relapse prevention

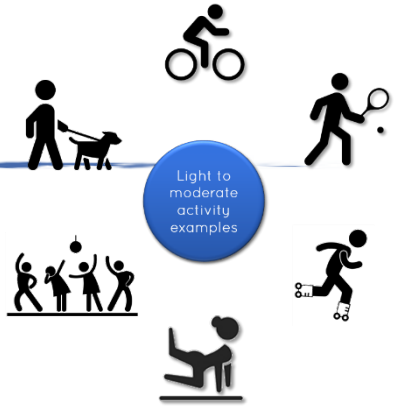
Exercise and smoking

- Inversely related to smoking status, number of cigarettes smoked, nicotine dependence
- May be an effective complementary intervention to smoking cessation
- Physical activity improves cardiovascular, pulmonary and immune functioning → assists with prevention of chronic disease
- Smoking cessation more successful for those who exercise during quit attempts, & exercise can assist with prevention of relapse
- Alleviate symptoms of smoking withdrawal, e.g., irritability, depression, restlessness and stress

Exercise among those with AOD use

- Unclear how often those in AOD treatment regularly engage in moderate to vigorous levels of exercise
- Some social settings, activities, or times of day associated with AOD use can be environmental cues, and can increase risk of relapse
- Instead of AOD use, engaging in rewarding, accessible, sustainable and safe behaviour (e.g., exercise or physical activity) can reduce likelihood of relapse
- Regular exercise associated with other positive behaviours, overall feelings of wellbeing, and motivation to maintain healthy lifestyle practices

Exercise and AOD use



- Promising accompanying treatment for AOD use: reductions in AOD use; improvements in depression, anxiety and stress; fitness improvements
- Ideal dose (type of exercise, duration and intensity) to maximise effects of potential health and psychological benefits is not clear
  - Varies between people, depends on individual preferences and baseline fitness levels

Physical activity and sedentary behaviour guidelines (adults)

- Any physical activity is better than none. If there is currently none, start with a small amount and gradually build up to the recommended amount
- Be active most days, and preferably all days, of the week
- Accumulate 2 ½–5 hours of moderate intensity physical activity (i.e., out of breath but can still say a few words) or 1 ¼–2 ½ hours of vigorous intensity physical activity (i.e., out of breath, difficulty talking), or a combination of both, each week
- Incorporate muscle strengthening exercises each week
- Minimise the amount of time spent in prolonged sitting
- Break up long periods of sitting as often as possible

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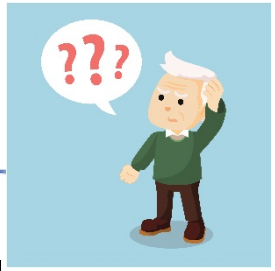
Addressing physical health



- Despite poor physical health among those with mental health conditions, relatively few workers address physical health of clients
- Clinicians may question whether health and wellness are achievable goals for people with mental health conditions
  - Perceived lack of motivation
  - Lifestyle challenges
  - Side effects and complications of many medications (weight gain, glucose and lipid abnormalities, cardiac side effects)
- Research suggests that clients may prefer to make simultaneous behavioural changes, but clinicians may feel ill-prepared to manage the physical health of clients

Food and activity diary

Date	Time of day	Food eaten	Physical activity	Mood

Adapted from Western Australian Network of Alcohol and other Drugs Agencies (2011). *Healthy eating for wellbeing: A nutrition guide for alcohol and other drug consumers.* Perth, Australia: WANADA.

Source: https://comorbidityguidelines.org.au/guidelines/worksheets

Barriers to addressing physical health

- Research indicates most people in AOD treatment interested in physical activity but reluctant due to perceived barriers:
  - Financial costs
  - Lack of motivation
- Useful strategies:
  - Self-monitoring
  - Goal setting
  - Contingency management
  - Relapse prevention planning
- Devices that track physical activity (pedometers, heart-rate monitors, fitness trackers) as motivational tools

Overcoming barriers: The fun theory

Piano stairs

Bottle bank

Speed camera lottery

Source:
www.TheFunTheory.com

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Sleep


Falling asleep
Staying asleep
Maintaining sleep throughout the night
Waking too early or too often
Sleep problems

Sleep problems

- Associated with
  - Long work days
  - Commuting times
  - Increases in evening or night work
  - Overuse of TV, computers or the internet
  - Use and withdrawal from AOD (alcohol, cannabis, tobacco, caffeine, cocaine)
- Some people report AOD use to promote sleep, but this relationship not well understood

Poor health outcomes

- Quality and quantity of sleep linked to chronic disease, with insufficient sleep associated with
  - Higher body mass
  - Weight gain
  - Obesity
  - Diabetes
  - Cardiovascular disease
  - Premature mortality
- Ideal amount of sleep varies with age
  - Adults aged 18-64 recommended 7-9 hours sleep

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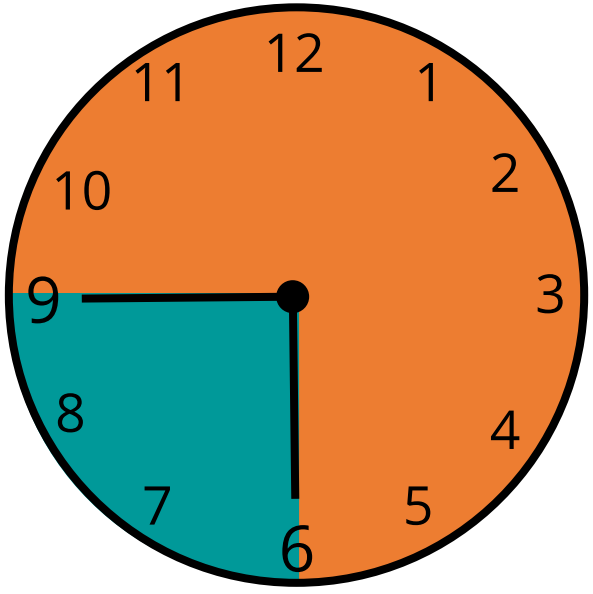
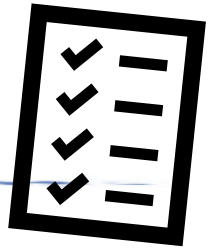
Poor health outcomes

- Increased risk of poor health outcomes associated with <u>too little</u> (less than 6 hours) and <u>too much</u> sleep (more than 9 hours)



Healthy sleep habits



- Maintain a regular sleeping schedule, on weekdays and weekends (i.e., go to bed around the same time each night, and wake at the same time each morning)
- Ensure at least seven hours sleep
- Do not go to bed unless tired
- Get out of bed if not asleep within 20 minutes
- Practise relaxing bedtime rituals (e.g., mindfulness, meditation, relation exercises)
- Only use the bed for sleep and sex
- Ensure the bedroom is calm and relaxing, and maintain a cool, comfortable temperature

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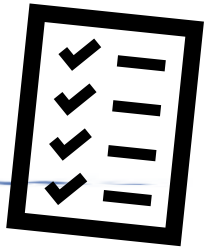
Source: American Academy of Sleep Medicine, Healthy sleep habits 2014

Healthy sleep habits



- Limit exposure to bright lights before bedtime
- Do not eat large meals before bedtime. If hungry, have a light, healthy snack
- Exercise regularly
- Avoid caffeine in the late afternoon and evening
- Avoid alcohol before bedtime
- Reduce fluid intake before bedtime

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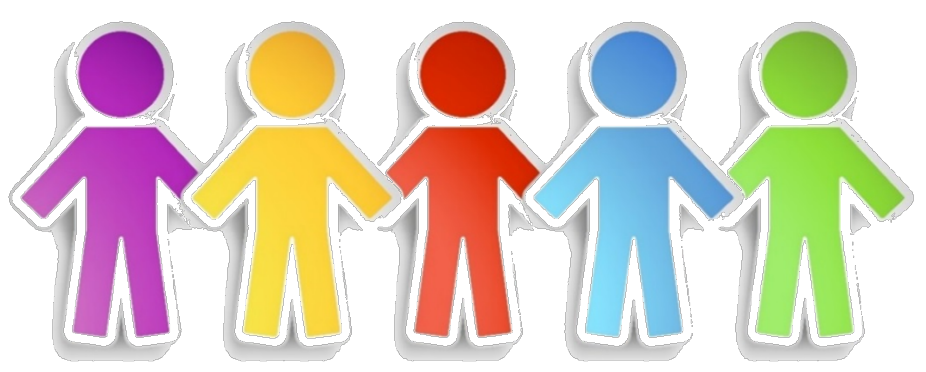
Source: American Academy of Sleep Medicine, Healthy sleep habits 2014

Addressing AOD and MH among people with physical health conditions

Healthcare workers' roles in managing physical health

- 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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Key points

- Some service providers reluctant to address multiple health behaviours → belief that making too many lifestyle changes will undermine a person's recovery from AOD use
- Not supported by the evidence

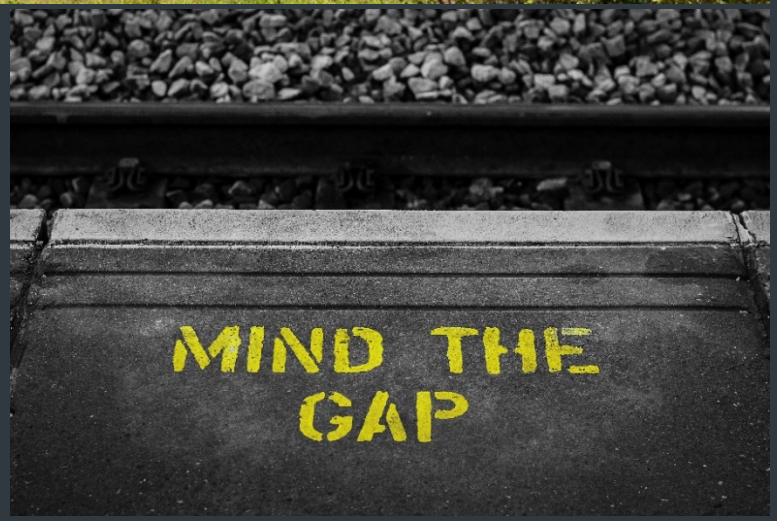
Overview

- Brief background: What do we know about comorbidity?
- Behavioural risk factors
  - Metabolic syndrome
- Patient and practitioner barriers to address physical health and other lifestyle factors
  - Strategies to overcome barriers
- Coordinated care

Coordinated care

Coordinated care

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

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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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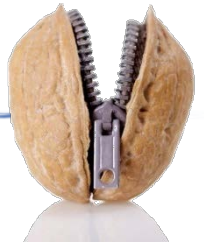
In a nutshell



- AOD and MH disorders are common
- People with comorbid AOD and mental health conditions are at increased risk of physical health problems, with higher mortality rates than the general population
- Those with comorbidity at particular risk of developing CVD
  - Need for interventions to focus on overall wellbeing, including reducing smoking, improving dietary habits, increasing physical activity and improving sleep patterns
- Inclusion of multiple service providers who reflect complex needs of clients, and can deliver the **right care** to the **right person** at the **right time**

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Tim

- GP conducted several physical health assessments (electrocardiogram and blood tests)
- Community mental health nurse liaised between Tim and GP to help with appointments and explain results
- Encouraged exercise class
- GP made referral to a dietician → nutritional advice and healthy eating plan
- Smoking cessation plan (NRT)

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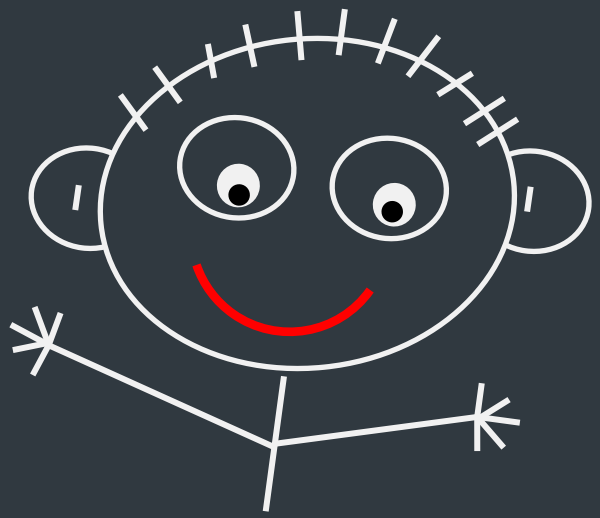
Tim: Longer term plan

- Assertive support and follow up
  - Without this support, possibility for Tim to ‘drift on’
  - Reminded of appointments by text message

- Key points:
  - Focus on physical health
  - Holistic care interventions should be followed, with emphasis on medication compliance
  - Some clients may require more assertive follow-up, with long-term practical support
  - Communication between services is essential

Treat the person, not the illness



Thanks for being part of the CESPHN-CREMS Webinar Series

Thank you!

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Any questions?