VAADA 2019

JACK OF ALL TRADES MASTER OF ONE

# Enhancing mastery across mental, physical and substance use domains

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## OVERVIEW

- PREVALENCE
- TREATMENT SERVICE SILOS
- HEALTHY LIFESTYLES
- RECOMMENDATIONS FOR PRACTICE

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| Comorbid 12m mental disorder class | Affective | Anxiety | Substance | Total population |
|---|---|---|---|---|
| Affective | - | 25.4 | 21.4 | 6.2 |
| Anxiety | 58.5 | - | 33.5 | 14.4 |
| Substance | 17.6 | 11.9 | - | 5.1 |

% WITH A COMORBID MENTAL DISORDER
N=8841
*(NSMHWB, Teesson et al, 2009)*

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PSYCHOSIS
N=1825
*(Morgan et al, ANZJP, 2012)*

| Substance | % |
|---|---|
| Any illicit drug abuse or dependence (lifetime) | 63% men 42% women |
| Cannabis use (past year) | 33% |
| Daily cannabis use | 38% of users |
| Amphetamines (past year) | 13% |
| Tobacco | 72% men 59% women |

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| Mental disorder | Percentage daily smokers |
|---|---|
| Harmful use/dependence on drugs | 73.9 |
| Harmful use/dependence on alcohol | 50.1 |
| Schizophrenia related conditions | 47.4 |
| Bipolar affective disorder | 39 |
| Panic disorder | 38.1 |
| Post traumatic stress disorder | 31.3 |
| Attention deficit hyperactivity disorder | 28 |
| Phobic anxiety disorders | 27.9 |
| Anxiety disorder, including GAD | 27 |
| Obsessive compulsive disorder | 25.1 |
| Depression | 25 |

PREVALENCE OF DAILY SMOKING BY MENTAL DISORDER

(ABS 2014-15)

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- Self-medication of MH conditions
- SU induce MH symptoms
- One disorder has an effect on an intermediary factor (e.g., education)
- Common factors (shared biological, psychological, social, or environmental risk factors)

EXPLANATIONS

*(Kingston et al DAR, 2017)*

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## COMPLEX PSYCHOLOGICAL SYMPTOMS

*(Kingston et al DAR, 2017)*

- Potential to interfere with treatment
- People with co-existing problems present with:
  - More severe clinical profile
    - Physical health, substance use, homelessness, social, occupational, interpersonal and family relationships

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>2.5 m Australians live with a MH & at least one chronic health condition

29.3% are living with one chronic disease

30.5% are living with 2 or more chronic diseases

## CHRONIC HEALTH CONDITIONS

*(ABS, 2015)*

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## DUAL DIAGNOSIS

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## TREATMENT SILOS

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## MULTIPLE DRUG AND ALCOHOL SILOS

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## MULTIPLE MENTAL HEALTH SILOS

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DITCH THE SILOS??

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ONE INTEGRATED / UNIFIED TREATMENT?

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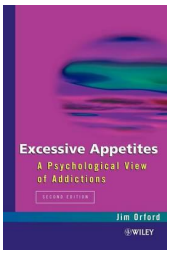
EXCESSIVE APPETITES
*(Orford, 1985; 2001)*

More comprehensive model of behavioural addictions

- Drugs
- Eating
- Sex
- Gambling

Strong attachment

Tx simpler, more universal

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ADDICTION IS A DISORDER OF CHOICE
*(Heather, 2017)*

Addiction can be defined as **"repeated failures to refrain from or radically reduce a specified behaviour despite prior resolutions to do so."**

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DUAL PROCESS THEORY
*(Heather, 2017)*

COGNITIVE FUNCTION

EXECUTIVE CONTROL

AUTOMATIC PROCESSES

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TREATMENT IMPLICATIONS (HEATHER, 2017)

- Assist people achieve greater self control over their addictive behaviour
  - Self control training; relapse prevention
  - Cognitive bias modification
  - Cognitive therapy
  - Mindfulness
  - Medications can only be *adjunctive*

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## UNIFIED TREATMENT FOR EMOTIONAL DISORDERS

*(Barlow et al, 2004)*

**EFFICACIOUS TREATMENTS BUT**

- Numerous manuals
- Highly complex
- Restricting effective training & dissemination

**COMMONALITIES AMONG EMOTIONAL DISORDERS**

- Distill a set pf psychological procedures to comprise a unified intervention

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3 fundamental therapeutic components

- Altering antecedent cognitive appraisals
- Preventing emotional avoidance
- Facilitating action tendencies not associated with dysregulated emotion

Pre: a module focused on motivation and psychoeducation

Final: relapse prevention strategies

## UNIFIED PROTOCOL

*(Barlow et al, 2004; Farchione et al, 2012)*

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'Transdiagnostic'

- Pragmatic
  - Disorders more similar than different
  - Treatment components are quite similar
- Theory driven
  - Address a core process or mechanism

## ADVANCES IN UNIFIED TREATMENT

*(Norton & Paulus, Beh Ther, 2016)*

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## POTENTIAL TRANS-DIAGNOSTIC PROCESSES NEGATIVE AFFECTIVE STATES

*(Norton & Paulus, Beh Ther, 2016)*

- Emotion regulation
- Anxiety sensitivity
- Attention biases
- Distress tolerance
- Intolerance of uncertainty
- Perceived control
- Perfectionism
- Psychological flexibility
- Repetitive negative thinking
- Shame
- Sleep disturbance / insomnia
- ? Unique constructs (vs one core latent process)
- Prospective studies needed (vs by-product of the 'pathology')

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## POTENTIAL TRANSDIAGNOSTIC PROCESSES / MECHANISMS (WITH SUBSTANCE USE PROBLEMS)

- Cognitive impairments (attentional bias, approach bias, sustained attention, response inhibition, working memory) *(Sofuoglu et al, 2016; Campbell et al, 2018)*
- Emotion regulation *(Sloan et al, 2017)*
- Personality *(Rodriguez-Seijas et al, 2015; Eaton et al, 2015)*
  - Internalizing disorders: neuroticism and detachment
  - Externalizing: antisocial, disinhibition and antagonism
- Coping skills & self-efficacy *(Litt et al, 2018)*
- Unique and shared variance *(Rodriguez-Seijas et al, 2015)*

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## CLINICAL IMPLICATIONS

- Integrated treatment
  - Review depression and alcohol: Hobden et al (2018)
    - 7 RCTs (parallel or integrated)
    - Parallel: CBT for depression more effective than residential alcohol treatment alone (n=3 studies)
    - Integrated: 2/4 demonstrated superior outcomes for integrated (both CBT; others were 'disease management' by phone and web-based psychoeducation)

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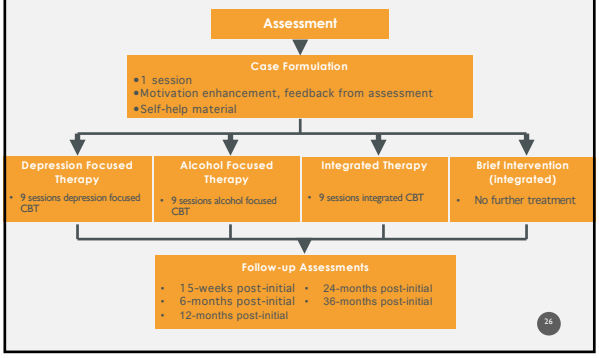
## RANDOMISED CONTROLLED TRIAL OF CBT FOR CO-EXISTING DEPRESSION AND ALCOHOL PROBLEMS: 6-, 12-, 24- AND 36-MONTH OUTCOMES

(The DAISI Project, JSAT, 2014)

A.L. Baker, D.J. Kavanagh, F.J. Kay-lambkin, S.A. Hunt, T.J. Lewin, V.J. Carr & P. McElduff

## DAISI METHODOLOGY (N=284)

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| Depression Focus | Alcohol Focus | Integrated |
|---|---|---|
| • Mood monitor | • Craving monitor | • Craving & mood monitor |
| • Negative automatic thoughts | • Permissive thoughts about drinking alcohol | • Permissive thoughts about alcohol as a response to negative automatic thoughts |

## TREATMENT FOCUS

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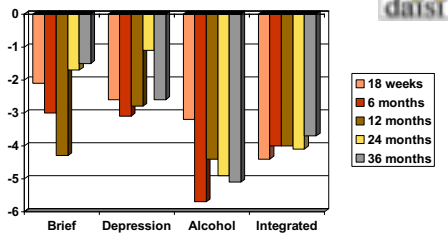


## STANDARD DRINKS PER DAY MEAN CHANGE SCORES

(TIME P<.01; ALCOHOL > DEPRESSION AT 6- AND 24-MONTHS (P<.01) AND 12-MONTHS (P<.05)

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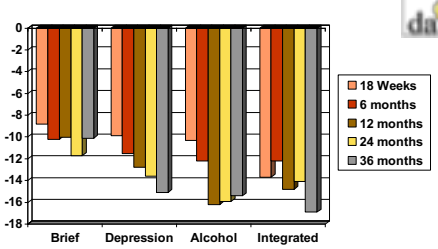


## BDI-II MEAN CHANGE SCORES

(TIME P<.001; BI<10 AT 12- AND 36-MONTHS P<.05; INTEGRATED > SINGLE FOCUS 18 WEEKS P<.05)

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## PTSD

*(Bailey et al, J Mental Health, 2019)*

- ? Effects of having PTSD (38%) symptoms when receiving any of the 4 treatments
- 3 months: reported significant reductions in PTSD symptoms and a lower rate of PTSD
- responded better to integrated CBT

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# TREATMENT OF MULTIPLE HEALTH BEHAVIOURS

## FEARS ABOUT WORSENING MENTAL HEALTH SYMPTOMS & SUBSTANCE USE

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## MULTI-COMPONENT INTERVENTIONS: FEASIBLE, EFFECTIVE, AND MORE EFFICIENT

*(Spring et al 2010)*

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## HEALTHY LIFESTYLE INTERVENTION

Focus on diet, physical activity, smoking & alcohol/illicit substance use

**Advantages**

- Avoids stigma
- Avoids premature focus
- Appealing
- Allows multiple behaviour change

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Psychiatry Research

'Better Health Choices' by telephone: A feasibility trial of improving diet and physical activity in people diagnosed with psychotic disorders

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## BETTER HEALTH CHOICES

- Telephone delivered
- 8 sessions (weekly or twice a week)
- Session 1 = 1 hour; sessions 2-8 = 15-30 min
- Targets F&V and leisure screen time
- Can target smoking and/or alcohol use
- Motivational interviewing approach
- Resources manual & F&V pack sent out at start
- Contingency management ($20/session)

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| Measures | Pre-treatment M (SD) | Post-treatment M (SD) | P-value |
|---|---|---|---|
| Fruit consumption (ARFS) | 5.1 (3.1) | 6.6 (2.9) | .008 |
| Vegetable consumption (ARFS) | 12.2 (4.0) | 13.5 (3.5) | .018 |
| Screen time (min/day) | 298 (200) | 163 (107) | .007 |

## PRIMARY OUTCOMES (*N*=17)

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| Measures | Pre-treatment M (SD) | Post-treatment M (SD) | P-value |
|---|---|---|---|
| Diet Quality (ARFS) | 33.2 (10.5) | 38.2 (8.1) | .001 |
| Weekday sitting (min/day) | 555 (191) | 412 (211) | .008 |
| Walking (min/week) | 252 (353) | 356 (470) | .099 |
| Cigarettes/day (n=5) | 29.0 (10.3) | 13.2 (14.3) | .082 |
| Cannabis use/day (n=3) | 16.2 (18.3) | 4.0 (6.9) | .220 |
| Depression | 4.5 (3.3) | 3.7 (2.8) | .149 |
| Quality of life | 25.6 (5.6) | 28.4 (6.6) | .017 |
| Global Functioning | 57.1 | 62.6 | .008 |

## SECONDARY OUTCOMES (*N*=17)

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## TREATMENT SATISFACTION & FIDELITY

- Client Satisfaction Questionnaire *(Attkinson & Zwick, 1982)*
  - 100% rated service quality as good or excellent
  - 94% mostly or very satisfied overall
- Behaviour Change Counselling Index *(Lane et al., 2005)* practitioner score = 2.4 (0.3)
  - Behaviour change counselling skills utilised "to some extent"/"a good deal of the time".
  - No difference between therapists (*F*=0.51, *df*=5, *P*=0.77).

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## LIMITATIONS OF BHC STUDY

**Limitations**

Non-controlled study with small sample
Short follow-up time period
Self-report measures

**Future directions**

RCT
Delivery by other professionals/ consumers

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## EARLY SMOKING OUTCOMES FROM A STEPPED WEDGE RCT OF A HEALTHY LIFESTYLE INTERVENTION IN RESIDENTIAL SUBSTANCE ABUSE TREATMENT

**Peter J. Kelly**, Amanda L. Baker, Frank P. Deane, Robin Callister, Clare Collins, Isabella Ingram, Camilla Townsend & Jessica Hazleton

## RISK BEHAVIOURS

*Kelly, Baker, Kay-Lambkin, Deane & Bonevski, 2012*

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HEALTHY RECOVERY

8 session group based program

Designed for substance abuse populations

**Program Goals**

- Reduce smoking
- Increase physical activity
- Improve diet

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**Components of the intervention**

Education and rationale

Group based motivational interviewing

Goal setting and monitoring

Contingency management (smoking)

Nicotine replacement therapy

HEALTHY RECOVERY

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**Participants** (N = 172)

Attending The Salvation Army Recovery Service Centres

74% males, average age = 38 years, 72% alcohol problems

All participants were smokers

**Design**

Stepped wedge randomized controlled trial

Intention to treat analysis

**Procedure**

5-week group program delivered

Researcher + drug/alcohol workers co-facilitated the groups

METHODS

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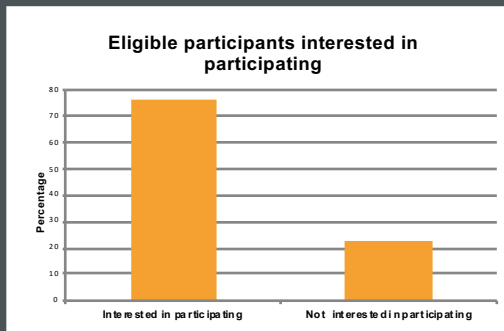


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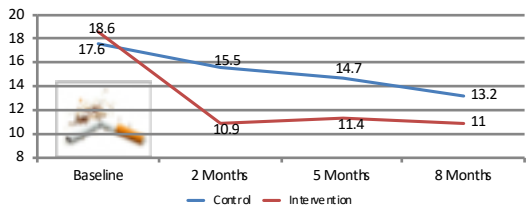


AVERAGE DAILY CIGARETTES SMOKED

| | 2-months | 5-months | 8-months |
|---|---|---|---|
| Control | 2% | 6% | 8% |
| Healthy Recovery | 18% | 12% | 15% |
| P-value | .14 | .36 | .30 |
| Odds Ratio | 22.0 | 3.1 | 3.5 |

QUIT RATES AT FOLLOW-UP

| | 2-months | 5-months | 8-months |
|---|---|---|---|
| Control | 21% | 19% | 26% |
| Healthy Recovery | 60% | 45% | 29% |
| P-value | .001 | .004 | .69 |
| Odds Ratio | 8.3 | 4.5 | 1.3 |

## USE OF NICOTINE REPLACEMENT THERAPY (NRT)

## HEALTHY RECOVERY

- **Healthy Recovery**
  - Significantly better reductions in smoking
- **Self efficacy** mediates reductions on smoking
- **Challenge is to embed** these types of programs as part of routine care

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## MAINTENANCE - MUTUAL AID

- Reliable reductions lowest - alcohol *(Manning et al 2016)*
- Mutual aid attendance predicted treatment success (alcohol) *(Manning et al 2016)*
- Evaluate SMART Recovery and 12-step approaches

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- Common psychotherapies have widespread positive effects (Rodriguez-Seijas et al, 2015)
- Metacognitive therapy could have potential (Hamonniere & Varescon, 2018)
- Vujanovic et al (2017): overview dep & SUD
  - Traditional CBT (integrated)
  - ACT – 2 small RCTs positive
  - Mindfulness – no RCTs
  - BA – no RCT

## FUTURE RESEARCH

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Measure domains of interest but specifically substance use

Use CBT or promising third wave intervention

Address multiple addictive behaviours

Follow-up and recommend mutual aid

## TAKE AWAY MESSAGES

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