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Practical Interventions for Co-occurring Disorders: Dissemination from Efficacy and Effectiveness Studies

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Today's presentation

- *Primary* and *Secondary* Challenges - D&A & MH context
- Treatment approaches / Summary of findings
- "*Efficacy*" / "*Effectiveness*"
- From "*Evidence Based Practice*" → To "*Evidence Based Thinking*"
- Putting it all together

- *A note on terminology - (comorbidity / co-occurring disorders / dual diagnosis / dual disorders / co-existing disorders)*

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Presentation to MH Settings

- Several "*head counting*" studies from MH and D&A
- About 50% of all clients with severe mental illness have a SUD
- About 50% of clients diagnosed with schizophrenia abuse alcohol
- Figures from our Services (e.g Paringa) alcohol / marijuana

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'Difficult to Treat Expensive to Manage' MH Settings

- **D&A problems in people with severe and persistent mental illness**
- One of the most significant problems facing the public health system
- Substance use disorders begins early in the course of mental illness
- Impacts almost every area of patient functioning and clinical care

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'Difficult to Treat Expensive to Manage'….cont

- **More** severe symptoms of mental illness, frequent hospitalizations, relapses
- **Higher** rates of violence, suicide, homelessness
- **Greater** health care utilization
- **Poor** compliance, treatment outcome, information processing
- **Pose** major problems for themselves, families, health care professionals, health system

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Presentations to D&A settings

- Common presentations

- *Alcohol misuse
  *Anxiety disorders
  *Affective disorders

- Similar to the 1st National Household Survey - top 3
- Anxiety
- Alcohol
- Affective

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Issues from D&A Settings

- **Concurrent mood / anxiety & substance use**

- **High** relapse rates
- **Higher** rate of medication use
- **Poor** response to both psychological and pharmacological treatments
- **Greater** probability requiring additional treatment

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Clinical Challenges

MH issues in D&A populations

- **Most** common mood and anxiety disorders
- How can D&A staff screen / detect / diagnose accurately?
- Do they have the knowledge / skills confidence? (Kavanagh et al, 2002; Sitharthan et al, 2002, 2005)

- **Screeners / Case ID Tools** - screening instruments - use??
- Early stages of development
- e.g.MYAMI Screener (Sitharthan et al, In prep)
- Taps into previous presentations to MH facilities / professionals, depression, GAD, suicidality, OCD, PTSD, etc)

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Clinical Challenges (cont..)

- **Other** screeners e.g. K10 (mood and anxiety)
- **Caveats** e.g. mood and substance use - wait for several weeks prior to making a definitive diagnosis

- Detecting D&A problems from MH settings - relatively straightforward (Sitharthan et al, 1999)
- How about skills / comfidence? (Kavanagh et al, 2002)
- Can improve via specific workshops / training
- (Sitharthan et al, 1999)

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Other Complicating factors

- Challenges in engagement / treatment
- Clinically Frustrating
- Services / Staff can play the '*blaming game*'
- Scary outcomes data /figures
- Arrival of new players (e.g.'ice') complicates "who should treat?"

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Treatment Approaches

- **1.Sequential** one disorder (e.g. psychiatric illness) is treated before initiating treatment for the second disorder (e.g. SUD)
- **2. Parallel** both disorders treated simultaneously, but by different clinicians, usually working for different agencies

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Limitations

- **Sequential and Parallel**
- Both ineffective in producing changes
- Poor liaison between services
- Ineligibility to participate problems
- High drop out rates
- *Caveats:* MH vs D&A
  [e.g. sequential - address SU first followed by Rx for Depression /Anxiety - Compelling evidence Mood and Anxiety Improve with reductions in SU]
- PTSD /ED / PD = DK

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Treatment Approaches Cont….

- **3. Integrated Approach**
- Common features - assertive outreach to engage difficult clients, use of motivation based interventions, comprehensive focus on multiple areas of functioning, takes a long term perspective towards improving the course of dual disorders
- + more successful in engaging, comparatively less drop out rates
- - poor experimental designs, very brief follow-up periods, RCT rare

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Lets look at a few studies

- Barrowclough et al (2001) "*Comorbid schizophrenia and SUD*"
- Compared Routine Care vs Integrated approach (MI+CBT+Family Intervention)
- Intervention period = 9 months (MI for 5 weeks, followed by CBT for 18 weeks, followed by 6 bi-weekly sessions of more MI, followed by 10 to 16 sessions of FI

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Final sample = of 66 eligible patients, 23 pts and 7 carers refused to participate, 3 died

- 17 received Integrated Rx, 15 in usual care
- 92% male, mean age 31 yrs, initial follow-up 3 months
- Limitations = short f/up, small sample size, Rx group received more therapy time
- Results = Rx group - better general functioning, increases in days abstinent

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Depression and SUD (Beck et al, 2005)

- Recruited 350 subjects, 230 refused, 120 assigned to CT or TAU
- At 6-mo f/up - 13 in CT and 23 in TAU
- 68% of the sample had a SUD (e.g. alcohol/heroin/cannabis)
- But NO mention of Q/F at pre/post/f-up
- So we don't know if CT reduced D&A

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An overview of what *(we think)* we know

- 4 recent reviews, all using different criteria for identifying and evaluating trials.

- Drake et al (2004) – generally positive – but concluded "As yet there is little evidence for any specific approach to treatment"

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An overview of what *(we think)* we know (Cont…)

- Dumaine (2003) – somewhere in-between

- Ley et al, (2003) – least optimistic view – "There is no clear evidence that supporting an advantage of any type of substance misuse program ….. No one program is clearly superior to another"

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An overview of what *(we think)* we know (Cont…)

Bellack et al (2006)

"Motivational enhancement approaches – several published studies have failed to find a relationship between motivation to change and treatment participation …….. Raising questions about the hypothesis that increasing motivation to change is critical in this population"

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The Efficacy / Effectiveness Continuum

- **Efficacy**
- Does the treatment work under ideal conditions?
- Trials testing efficacy of a particular intervention are of an explanatory nature, the aim being to establish a causal relationship.

- **Effectiveness**
- Does the treatment work in everyday life?
- A more pragmatic approach is taken with the aim of assessing an intervention in routine clinical practice.

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Efficacy / Effectiveness…Cont

- **Can Interventions Work Under Ideal Condition – Efficacy**
- e.g. randomised clinical trial
- Strict inclusion criteria (includes patients who are likely to cooperate fully with the medical / psychological treatment advice)

- **Can Intervention Work Under Real Life Setting – Effectiveness**
- e.g. routine clinical care
- Inclusion criteria more relaxed (patients are allowed to accept or reject the treatment, much as would be the case in real-life situations)

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Efficacy / Effectiveness

Objective:	
Does it work under optimal circumstances?	Does it work under usual circumstances?
Intervention:	
Fixed regimen	Flexible regimen
Comparator:	
Placebo / Arbitrarily chosen comparator	Usual care
Subjects:	
Selected or "eligible" / usually high compliance	"Any" subjects / can expect "low" compliance

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Efficacy / Effectiveness

- **Outcomes:**

Condition specific – short term horizon

A treatment is efficacious when it proves to be superior to (usually) placebo or another treatment of known efficacy.

Analysis:

Usually "protocol" adherers

- Usually "comprehensive" Short and long term horizon

- In such a trial, the question is whether the treatment does more good than harm among those to whom it is offered

- Usually "intent to treat" (Bombardier and Maetzl, 1999)

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The Consumers Journey …

- depends on which train they take

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The Tale of the Two Trains

- D&A and MH settings often operate independently of one another, with little opportunity for collaboration or consultation
- (Sitharthan et al, 1999; Williams, 1999)

- This results in confusion and incongruence for the client – needs to assimilate advice from 2 separate systems / often 2 different treatment philosophies

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"Evidence based practice" and "Evidence based thinking"

EBP = a practice which is based on expert opinion about available evidence
(widely accepted across medical, D&A and MH fields)

EBT = a process by which diverse sources of information (Theory, Research, Practice principles, Practice guidelines, and Clinical experience) are synthesized by a **CLINICIAN**, in order to identify or choose the optimal clinical approach for a given clinical situation

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How can "Evidence based thinking" guide us?

"Opportunistic Interventions" –
from MH settings (Sitharthan et al, 1999) and
from D&A settings (Sitharthan et al, 2001)

"Integrated Interventions"
(Drake et al, 2000; Sitharthan et al, 1999)

"Conceptualize treatment as an ongoing process"
(Minkoff, 2000)

"Harm reduction model may be more appropriate than an abstinence model"
(Carey et al, 2002; Sitharthan et al, 1990; Ziedonsi et al, 2000)

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How can "Evidence based thinking" guide us?

"Opportunistic Interventions" –
from MH settings (Sitharthan et al, 1999) and
from D&A settings (Sitharthan et al, 2001)

- Attractive Features of OI = easy to train a large group of clinicians, large group of patients can be treated - no excessive waiting time, cheap, not dependent on one specific DD coordinator / educator / trainer, can promote a unified change across settings / units, etc
- Key approaches of OI = "Education-Clarification", "Commitment-Enhancement", "Skills-Training" (Sitharthan et al, 1999)

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How can "Evidence based thinking" guide us?

"Stepped Care Approach" Clients receive the simplest, least intensive treatment first, and then proceed to more intensive or different treatment programs as necessary
(Sobell and Sobell, 2000)

- SCA facilitates entry of a large number of people into treatment.
- National Comorbidity Management Program

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How can "Evidence based thinking" guide us?

Engagement problems

due to difficult living situations,
residual psychiatric symptoms,
cognitive impairments,
financial constraints, etc

Some structural procedures to increase engagement

address basic needs
provide mail / telephone reminders before sessions,
provide an initial orientation session,
schedule sessions quickly after initial contact,
provide tangible benefits (child care / transport fare)
OK in D&A - ?? In MH

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How can "Evidence based thinking" guide us?

- Assistance with housing
- Physical health
- Legal issues
- $ management / Time management
- Let the client set the agenda – problem area they want to deal first - e.g. use "The Treatment Goals Form" (sitharthan et al, *in prep*)
- All these are pragmatic outcomes – ***not*** just reductions in D&A use and psychological symptoms

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Secondary Challenges

- Bureaucratic clinical systems that are reluctant to change
- Practitioners unaware of addressing comorbidity
- Lack of specialized clinical role models
- Lack of integrated clinical feedback
- Lack of continued education and training
- Historic practice of referring D&A clients to D&A services
- A belief that people with D&A problems have only themselves to blame for their predicament
- Past failures in treating comorbid clients
- (from Sitharthan et al, 2005)

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Also need to consider

(from Sitharthan et al, 2005)

- Clinical relevance – do practitioners understand & acknowledge that their clients will benefit & improve with changed practices?
- Skills and Confidence – do practitioners have the skills and confidence to assess / treat?
- Organisational support – do practitioners have the organisational support to bring about & sustain changes?
- Impact evaluation – has the organisation designed methods to evaluate the impact of routine screening & treatment / intervention?
- Maintenance – what systems are in place to improve and maintain performance?

What modifications are required to administrative and clinical practices?

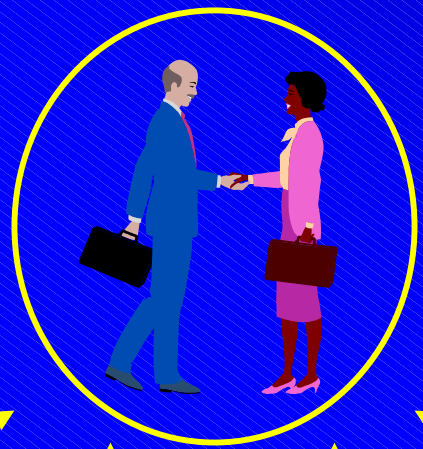
(from Sitharthan et al, 2005)

- For MH settings: Foster a workplace environment that accepts the enquiry about SU as standard practice
- For D&A settings: Foster a workplace environment that accepts the enquiry of MH issues as standard practice
- Disseminate information /materials to promote opportunistic interventions
- Sponsor seminars/specialist training programs/ongoing supervision to practitioners
- Adopt a stepped care approach to manage comorbid patients
- Periodic appraisal of the above for their impact
- Develop strategies to sustain these activities

APPLY EVIDENCE BASED THINKING

LEARN FROM EVIDENCE BASED THINKING

CLINICAL CHALLENGES



VALUE FOR $

ADDRESS

SYSTEMATICALLY/ PERIODICALLY REVIEW PROGRAMS/ PROCEDURES

INTEGRATED APPROACHES

ADMINISTRATIVE/ ORGANISATIONAL CHALLENGES

D+A

M+H

TRAIN / SUPERVISE WORKFORCE

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Integrated - Clinical Practices
Integrated - Clinical Services