



*from worlds apart
from different directions
paths cross
minds merge
new connections are made
thoughts arise
anything can happen
solutions are found
nothing is set in stone*

Impact of cannabis on mental health service delivery

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What should guide service design?

- Ethical principles
- What works
 - Controlled trials
 - Ability to transfer to practice
 - Cost-efficient service delivery models

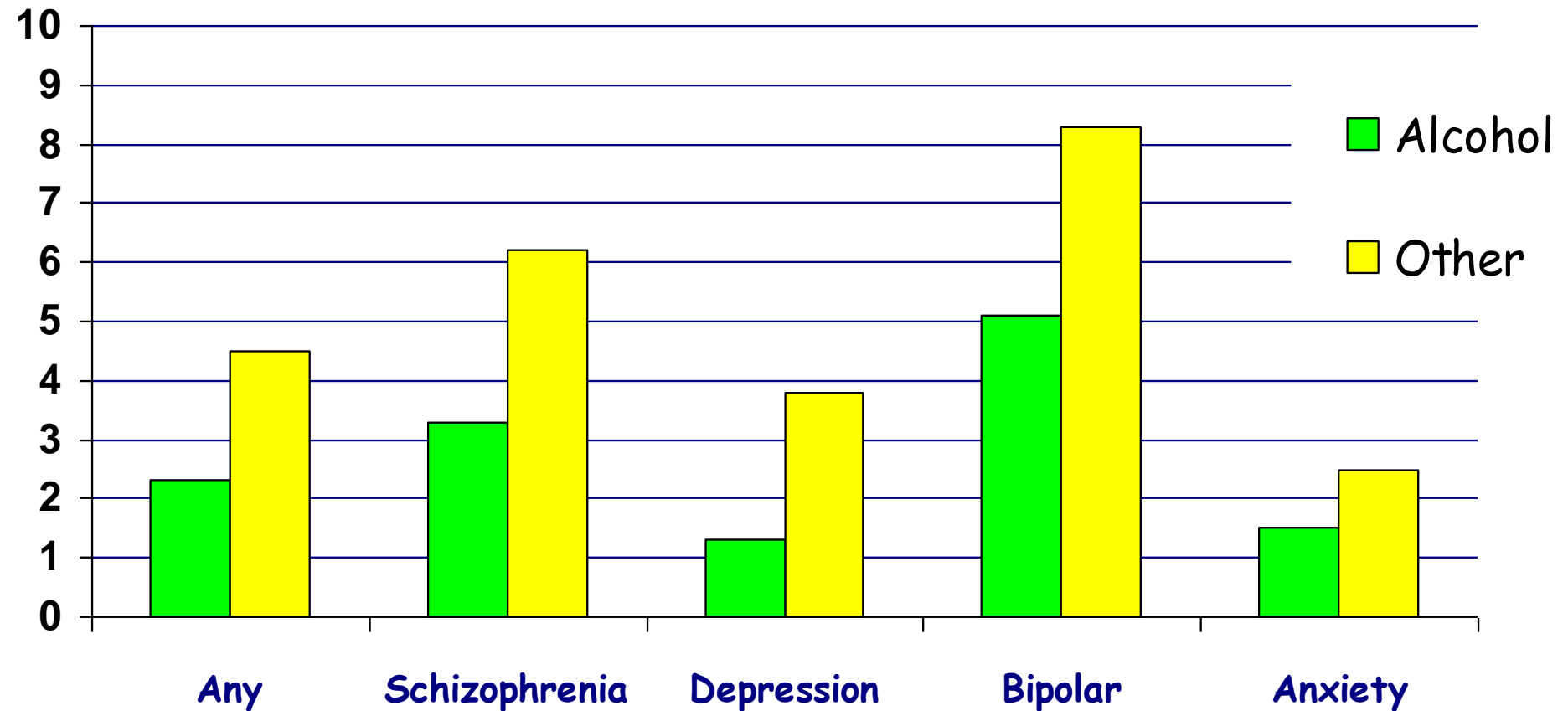
What else guides service models?

- Practical/political realities
 - How much we want to spend (& visibility of costs)
 - Preferred model of health service delivery
- Inertia of current practices

Let's review the context

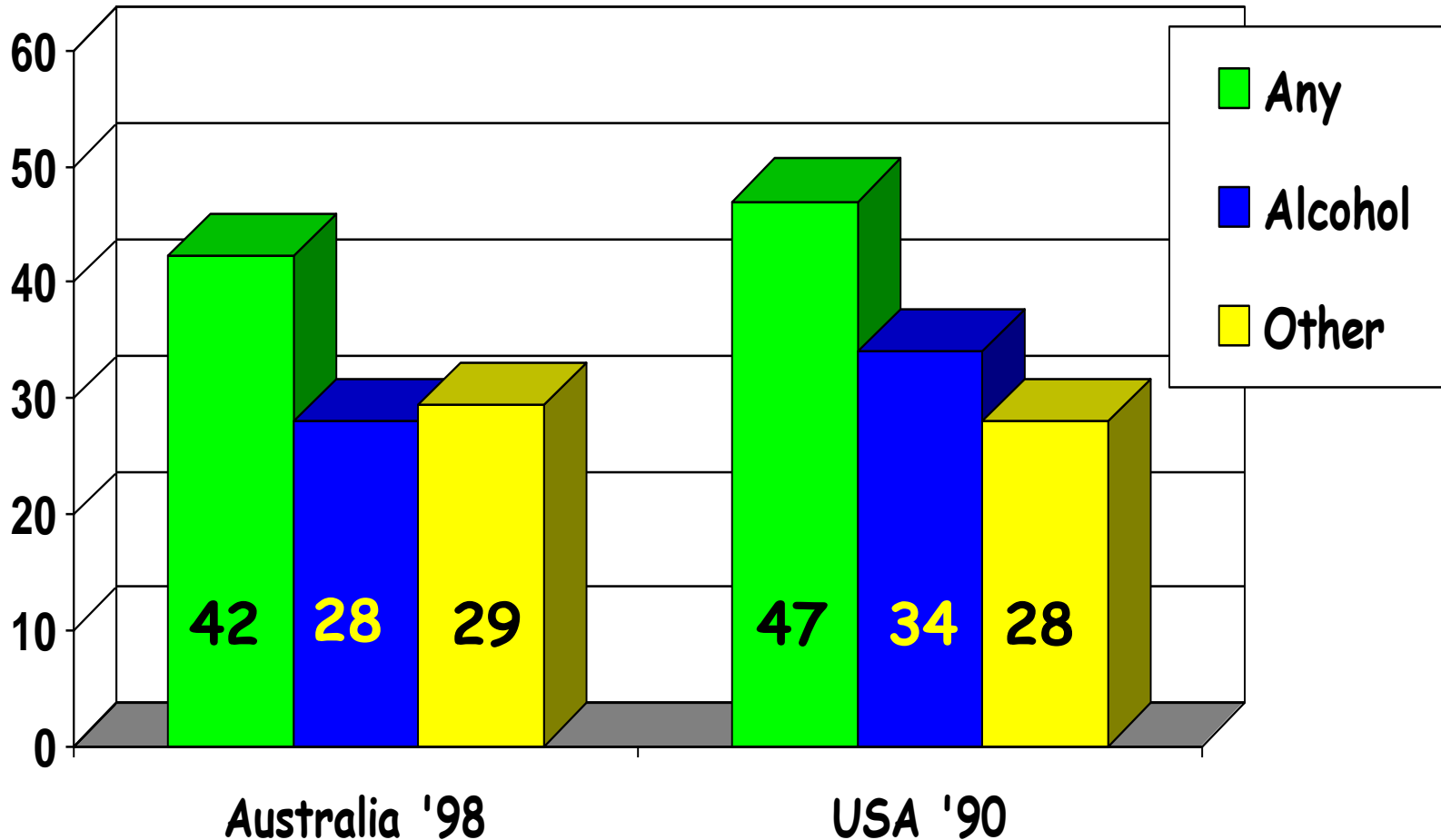
- Very common—40-50% lifetime SUD in SMI
 - up to 40% *current* Mj in acute samples

USA: Increased Lifetime risk



(Regier et al., 1990)

Lifetime risk of substance misuse in schizophrenia



Let's review the context

- Substance use particularly common in young men

Let's review the context

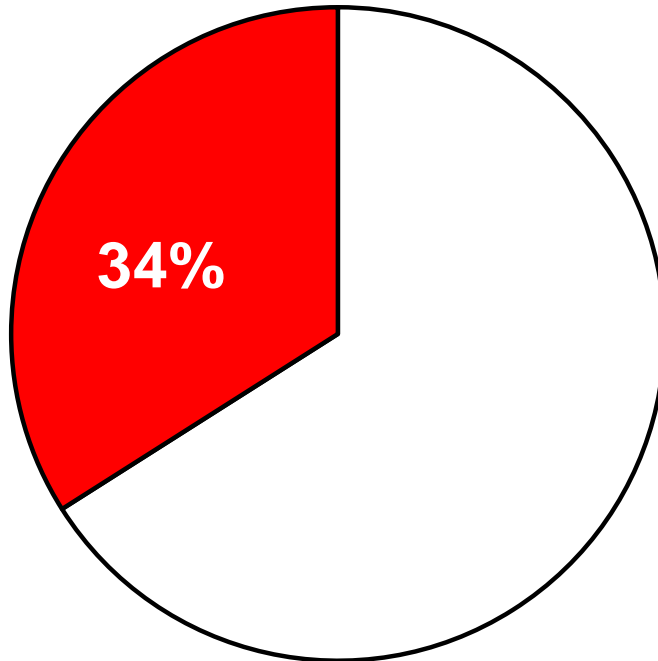
- SU/MH comorbidity produces much higher service costs
- Association of SUD/MH comorbidity with suicide, assaults, accidents
- *(strong political drivers)*

Let's review the context

- Very common—40-50% lifetime SUD in serious mental disorder
 - Up to 40% *current* Mj in acute samples
- More than dual diagnosis—
 - multiple co-occurring disorders the norm

Current cannabis use in psychosis

(Last 12 months, 1998)



Low Prevalence Disorders,
National Health & Wellbeing, Australia, 1998

Multiple substance use is common

All 3 drugs



26%

Few have none

11%

None

Nicotine only

Alcohol only

Cannabis only

Nicotine + Alcohol

Nicotine + Cannabis

Alcohol + Cannabis

All

14%

4%

3%

17%

24%

1%

Cannabis only
is rare



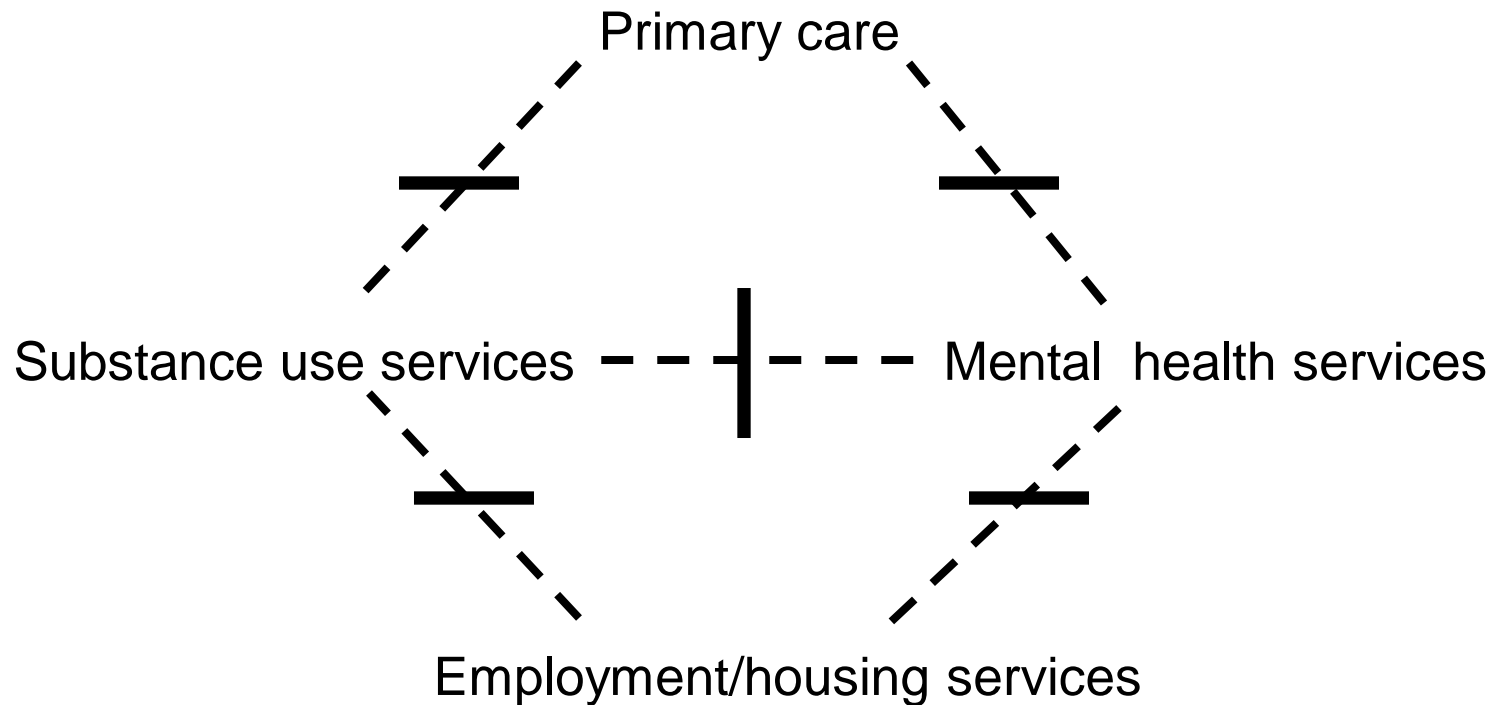
Let's review the context

- Very common—40-50% lifetime SUD in serious mental disorder
 - Up to 40% *current* Mj in acute samples
- More than dual diagnosis—
 - multiple co-occurring disorders the norm
 - Not only other drugs
 - Better seen as complex problems

Historically,
people with co-occurring disorders
have had less treatment
for one or more disorders

shorter duration
restricted options
exclusion

In terms of the service system



Guiding ethical principle

Equity:

People with co-occurring disorders
have a right to the same quality of service
as if each disorder occurred alone

Profound implications

- Health services cannot ignore the issue
- Given finite budget, may require reallocation of resources
- May require redesign of facilities, procedures
- Will need a coherent treatment

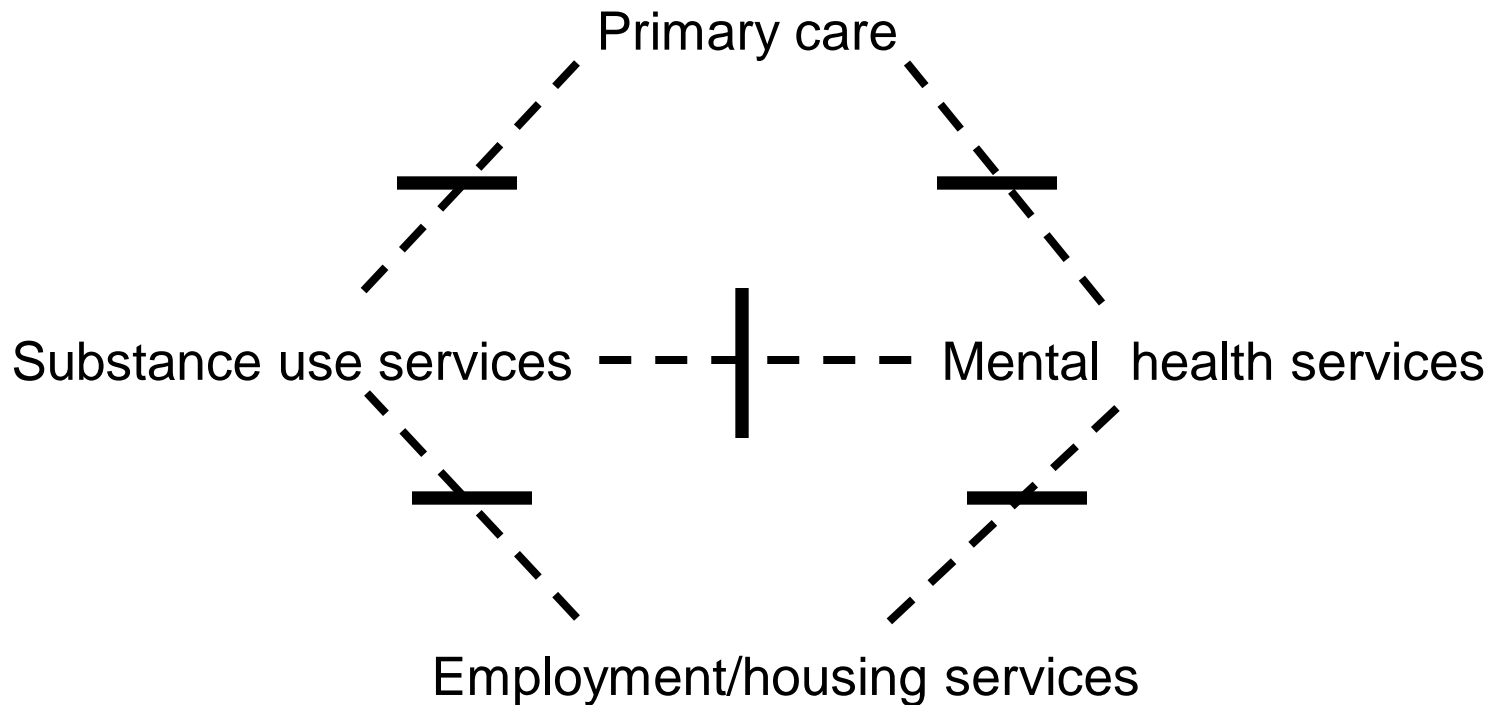
What works

- What works
 - Controlled trials
 - Ability to transfer to practice
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Historically...

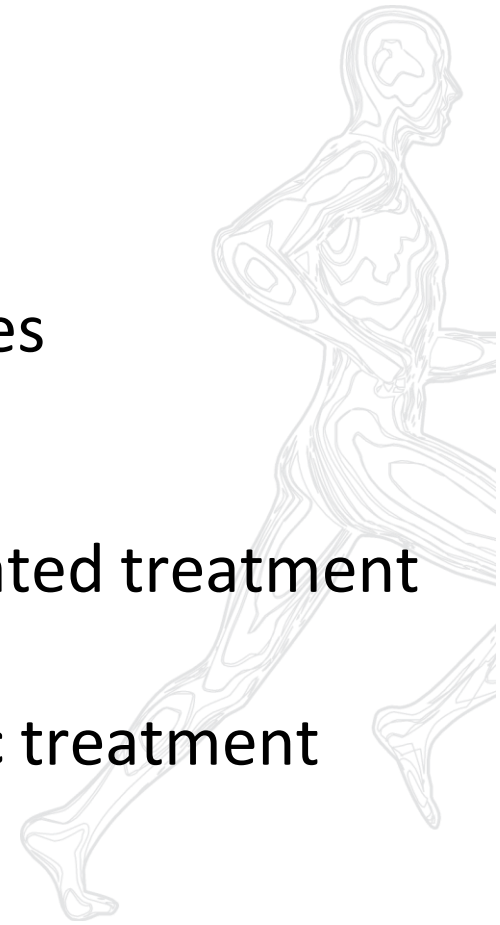
- co-occurring disorders not routinely assessed
- treatment has been fragmented
 - different services;
 - inconsistent priorities/practices)
- staff lacked skills, confidence in dealing with companion problem/s

In terms of the service system



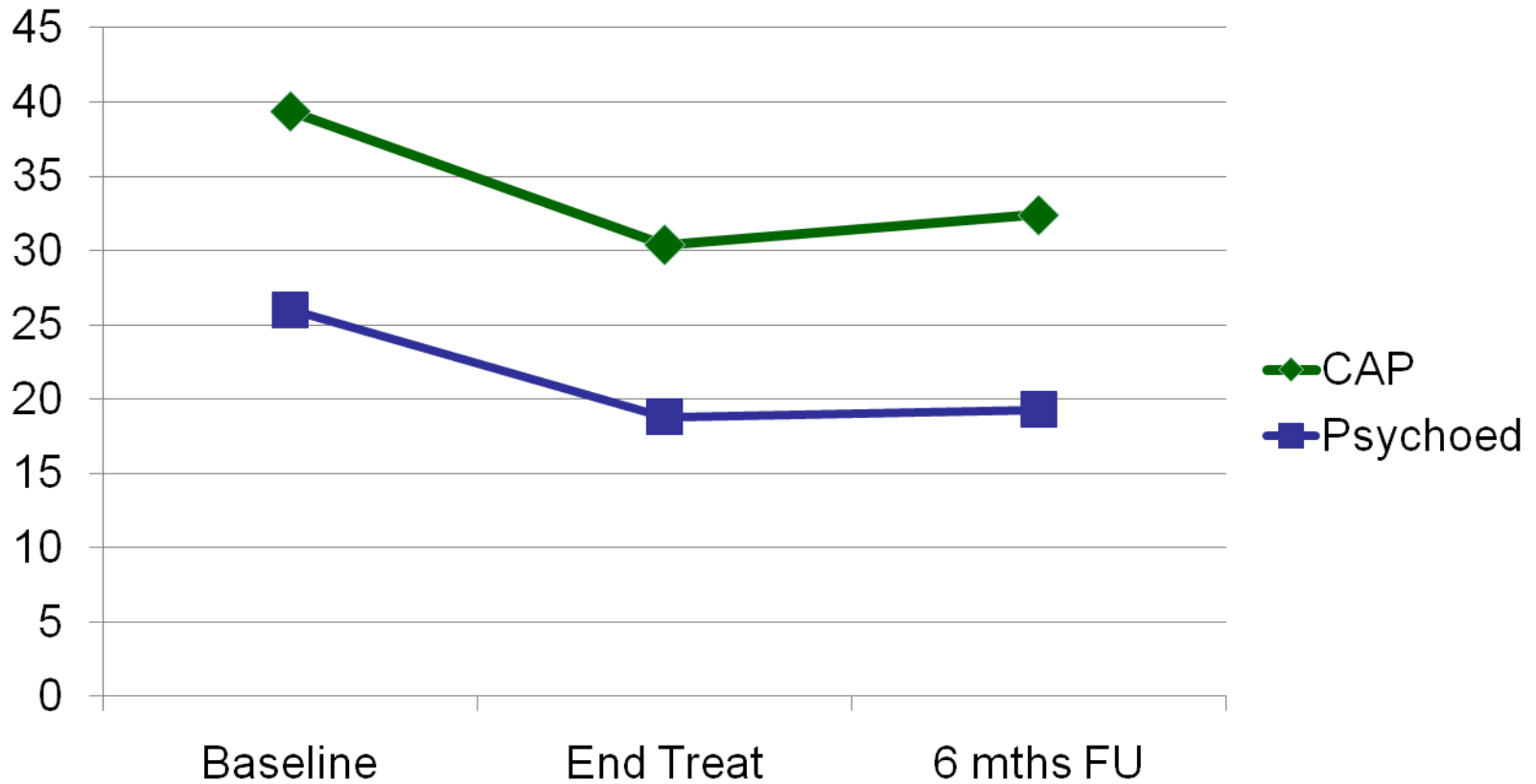
What works

- Screening essential for good detection rates
 - Several screening instruments that work
- Substantial & growing evidence for integrated treatment
- Motivational interviewing the only specific treatment with strong evidence as yet
 - *(engagement stronger than stand-alone)*
- *Treatment effects modest, not always > good control*
- *Initial changes often unstable; inconsistent*



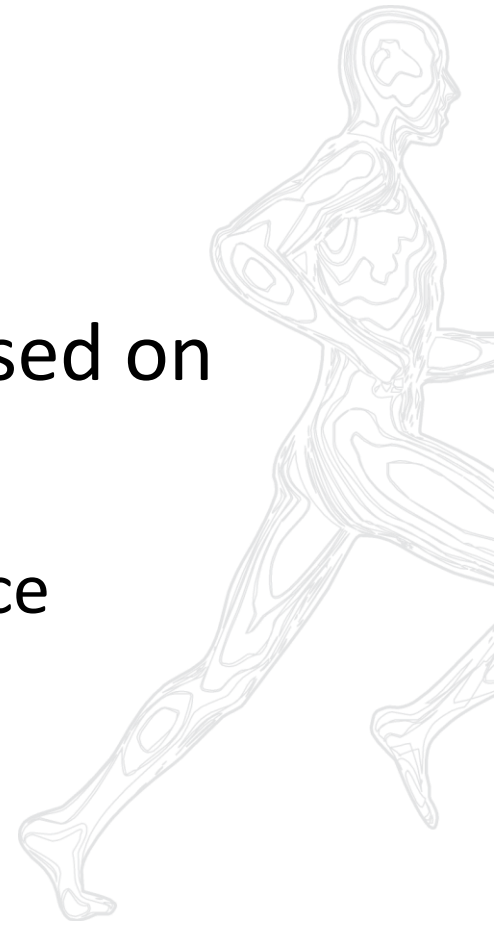
% Days used Cannabis

Edwards et al. (2006)



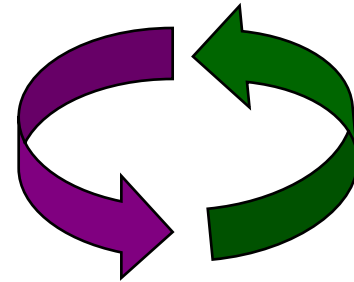
Implication

- Much of what we recommend is based on
 - analogies from single-disorder evidence
 - Epidemiology
 - First principles



...Cannabis use, symptoms often
influence each other

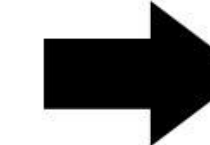
...Especially in psychosis



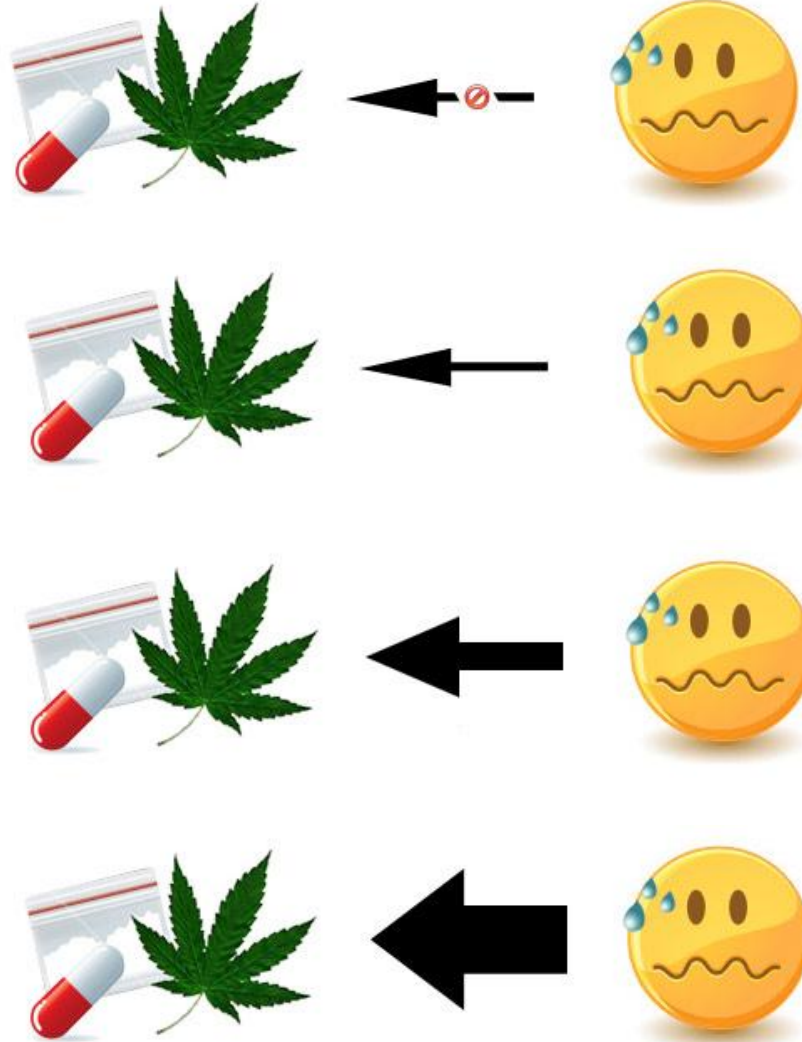
*further supports
integrated treatment*

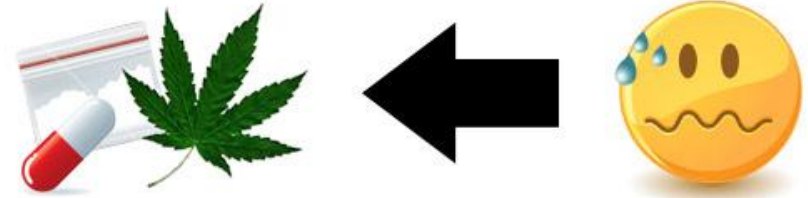
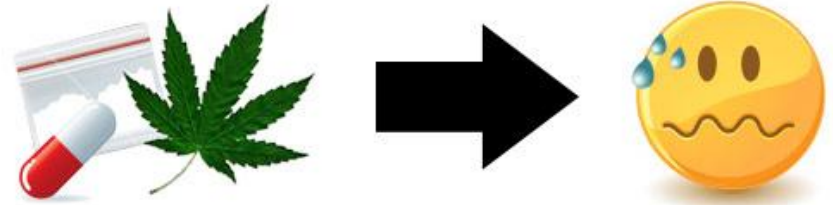
...Different emphases needed
for different people/times

Do you feel worse
when you use
more?

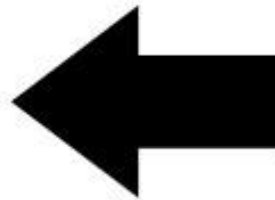
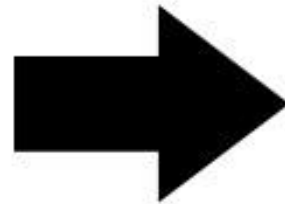


Do you use more
when you're feeling
worse?









...Complex disorders may need
simpler treatment!

- Lots of potential treatment foci
 - Confusing goals, priorities
- Cognitive deficits endemic
- Motivation often tentative

Focus on one behaviour or skill
at a time

Focus on changes that will
impact on more than one
problem

Focus on adding good things
(not taking away pleasures or just on
problems)



What works

- What works
 - Controlled trials
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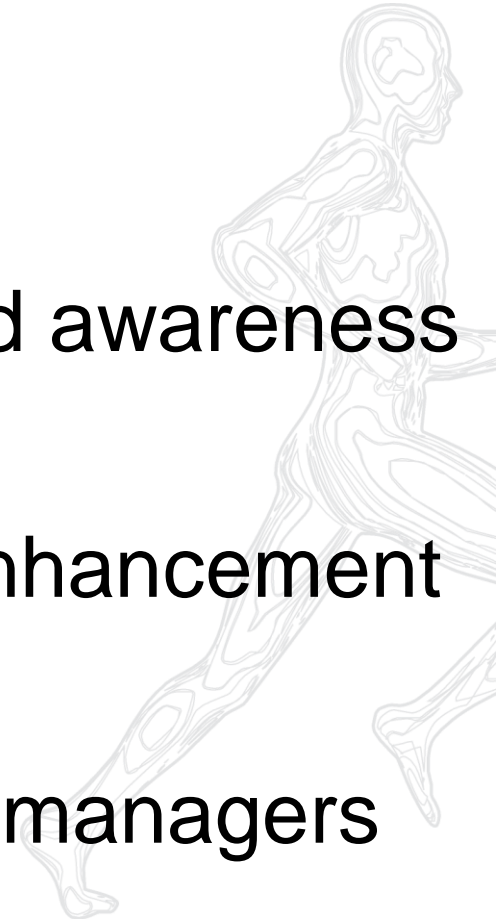
Transfer to practice

- Workshops alone don't work
 - *Short term changes in knowledge and skills*
 - Negligible impact on routine practice
- Dissemination easier if
 - Simple, low-cost treatment that is easy to use
 - Supportive context (Management, workload, resources)
 - Sustained training/consultation
 - Champions to reinforce, cue use



Queensland experience

- General staff workshops promoted awareness
- Focus on screening, motivation enhancement
- Support from central office, some managers
- 13 enthusiastic “dual diagnosis coordinators” appointed



So

- Gave DD co-ordinators
 - Training in
 - Comorbidity assessment & treatment
 - Consultation, mentoring
 - Organizational change
 - Opportunities for
 - informal problem solving
 - role clarification



And...

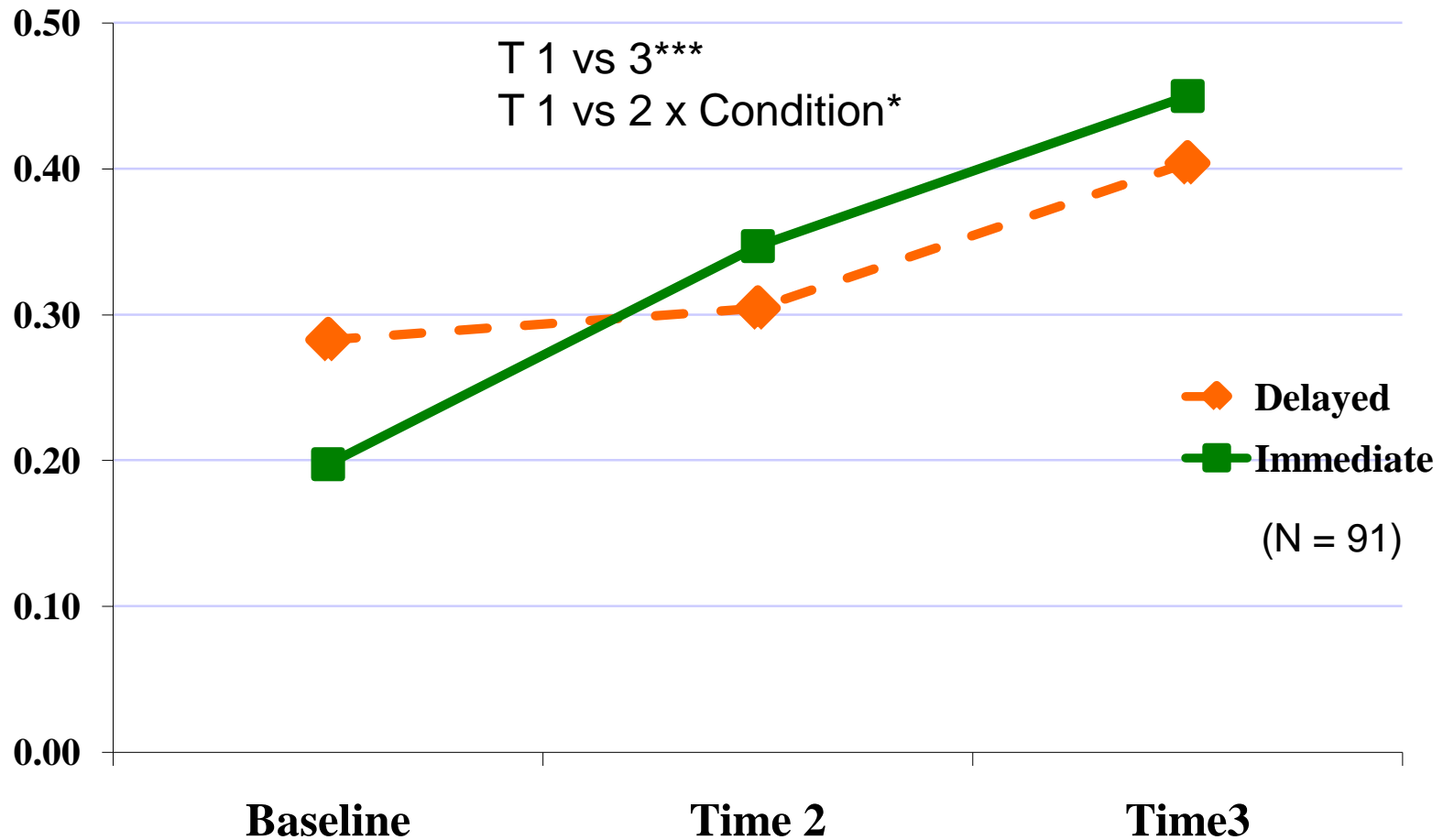
- Looked at a group of keen staff
- Randomly selected half to get 3 months of consultation first



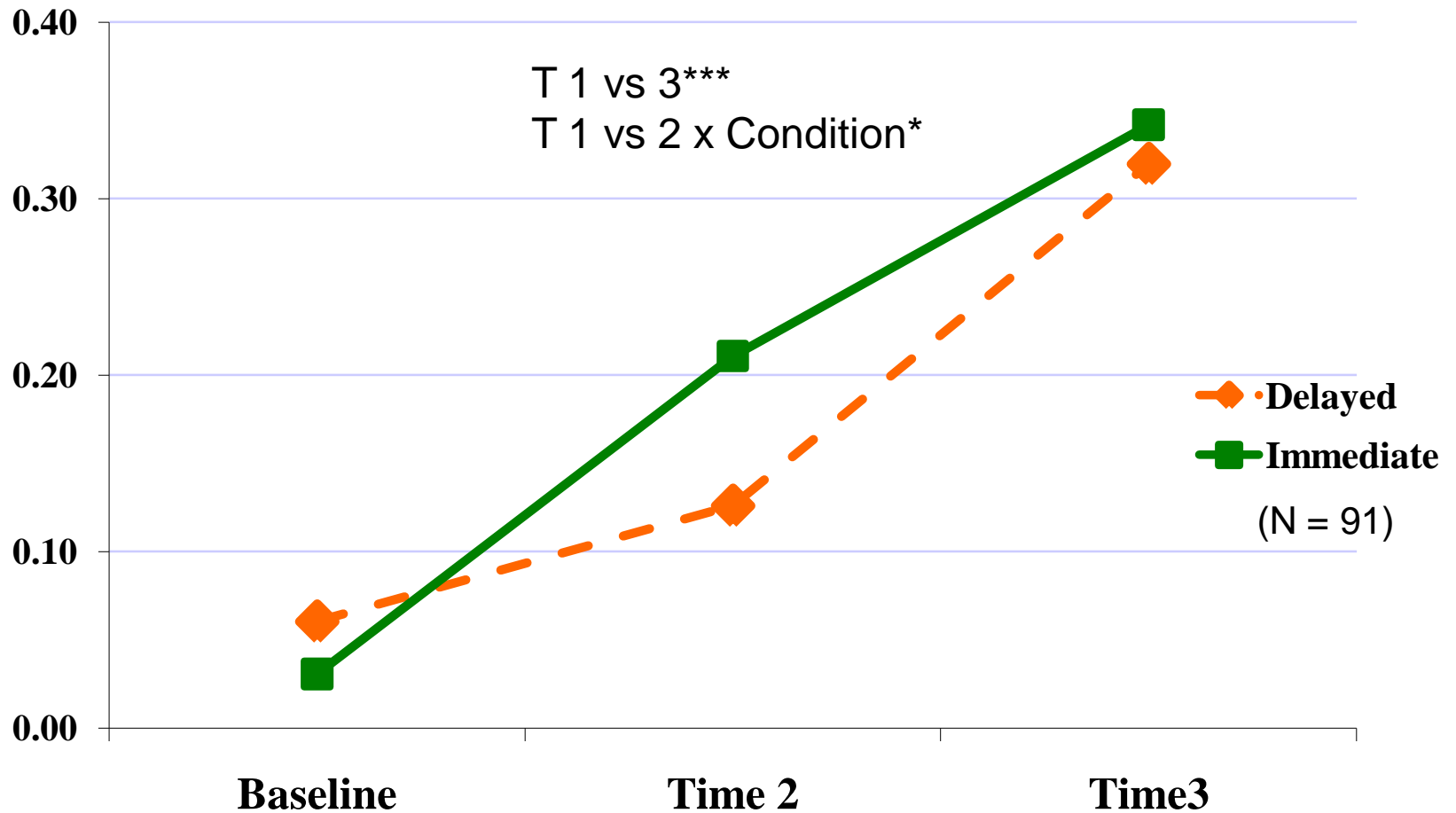
File audit

- N = 91
- 62% female
- 49% aged between 30-49
- 83% employed full-time
- 40% - Nursing
- 23% - Psychology
- Average years practising: 11

Use of a drug screen: Proportion of files (0-1)



Motivational interview for drugs: Proportion of files (0-1)



What works

- What works
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Dual services

- Inefficiencies in multiple staff involvement

This work assumes

- an integrated model of care
 - by a single agent
 - in existing services

Not the only possible integrated model

A specialist DD service?

- Comforting to staff—can shift responsibility

Substance use services

Mental health services

Comorbidity service

A specialist DD service?

- If up to 40% of MH inpatients with AOD, prepared to have 40% staff in a DD service?
- If around 30% of AOD service users with MH problems—prepared to shrink AOD service?

Substance use services

Mental health services

Comorbidity service

Other considerations

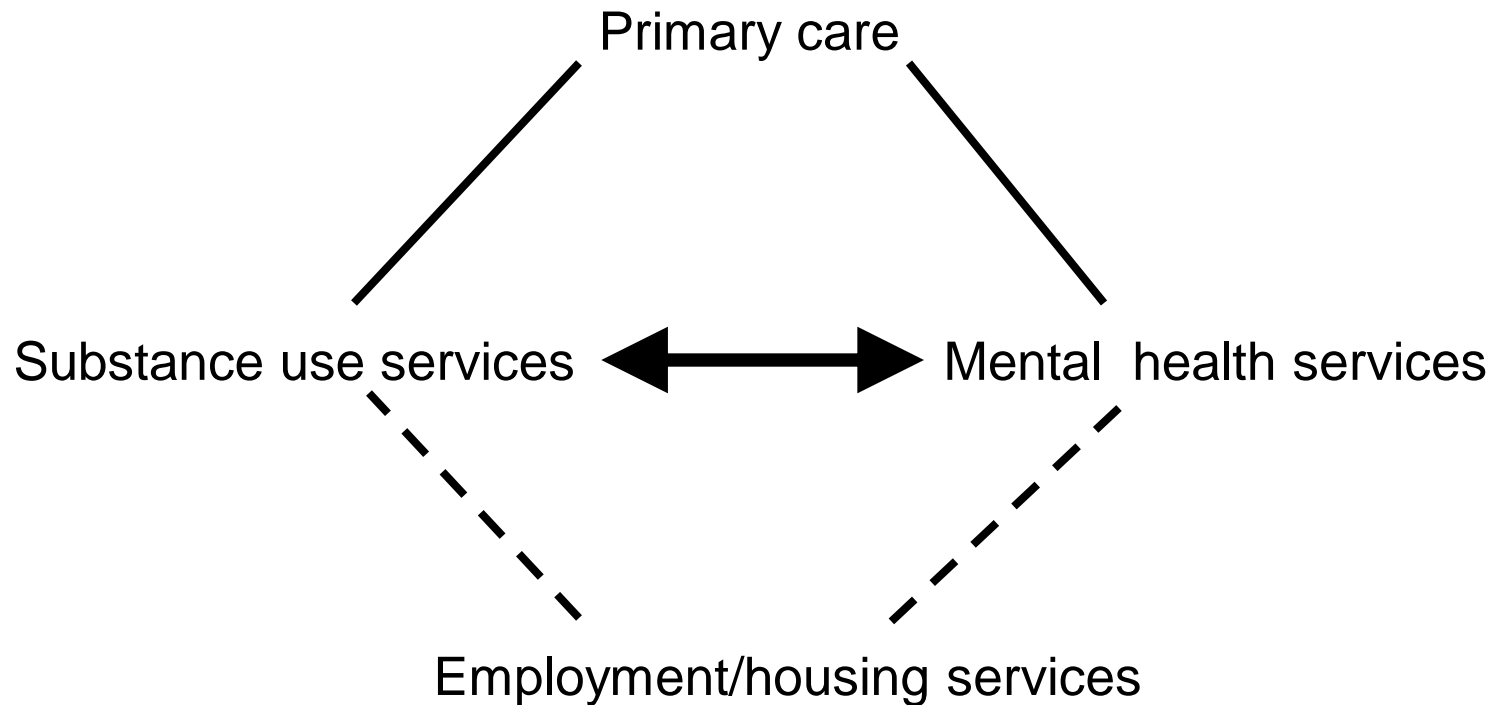
- Not comorbid enough?

A service delivery model...

- MH & A/D services need to address needs of their primary patient group

		Severity of MH problem	
		Low	High
Severity of AOD Problem	Low	Primary care	MH Service
	High	A/D Service	A/D+MH

In terms of the service system



Can't afford extended treatment
for all?

Staged model of care

- **Brief—**
 - Sound pharmacotherapy + Motivational + brief F/U

Staged model of care

- Brief—

 - Sound pharmacotherapy + Motivational + brief F/U

- Longer term—in *MH or AOD service*

- Skills training, leisure groups, support

Staged model of care

- Brief—

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- Longer term—in *MH or AOD service*

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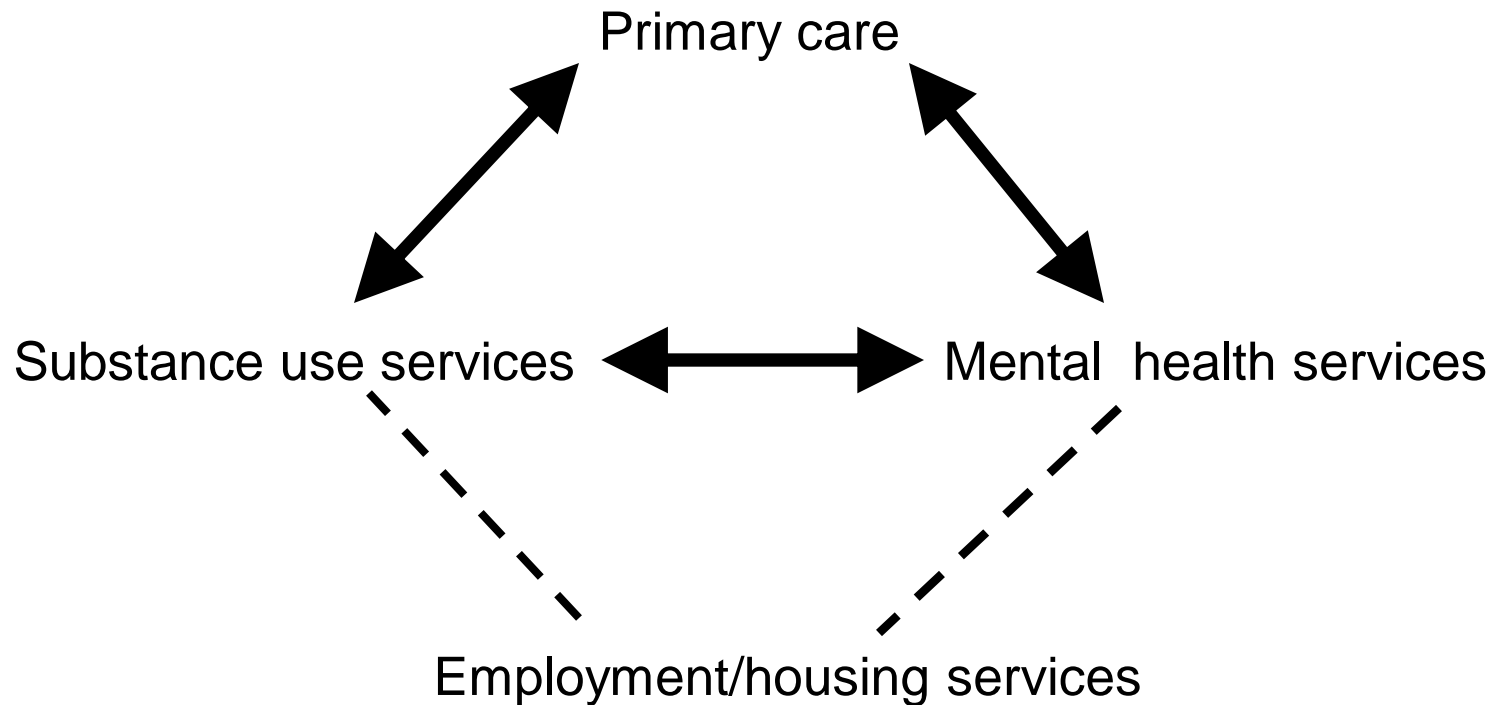
- Increasing environmental support

- *Intensive specialist service/hostel etc.*
- Structured context, activity, prompts

What about primary care?

- Challenges of
 - *Skill, confidence*
 - *Opportunity cost*
 - *Turning over rocks, taking over my practice*
- *Brevity, ease of use, ease of referral critical*
- *Widespread rather than specialty practices*

In terms of the service system



Staged model of care

- **Early/Preventive:**

- Primary Care



- **Brief—**

- Sound pharmacotherapy + Motivational + brief F/U



- **Longer term—in *MH or AOD service***

- Skills training, leisure groups, support



- **Increasing environmental support**

- *Intensive specialist service/hostel etc.*

- Structured context, activity, prompts

What about remote delivery?

- Internet-based—
 - Direct delivery
 - Helping to structure practitioner sessions



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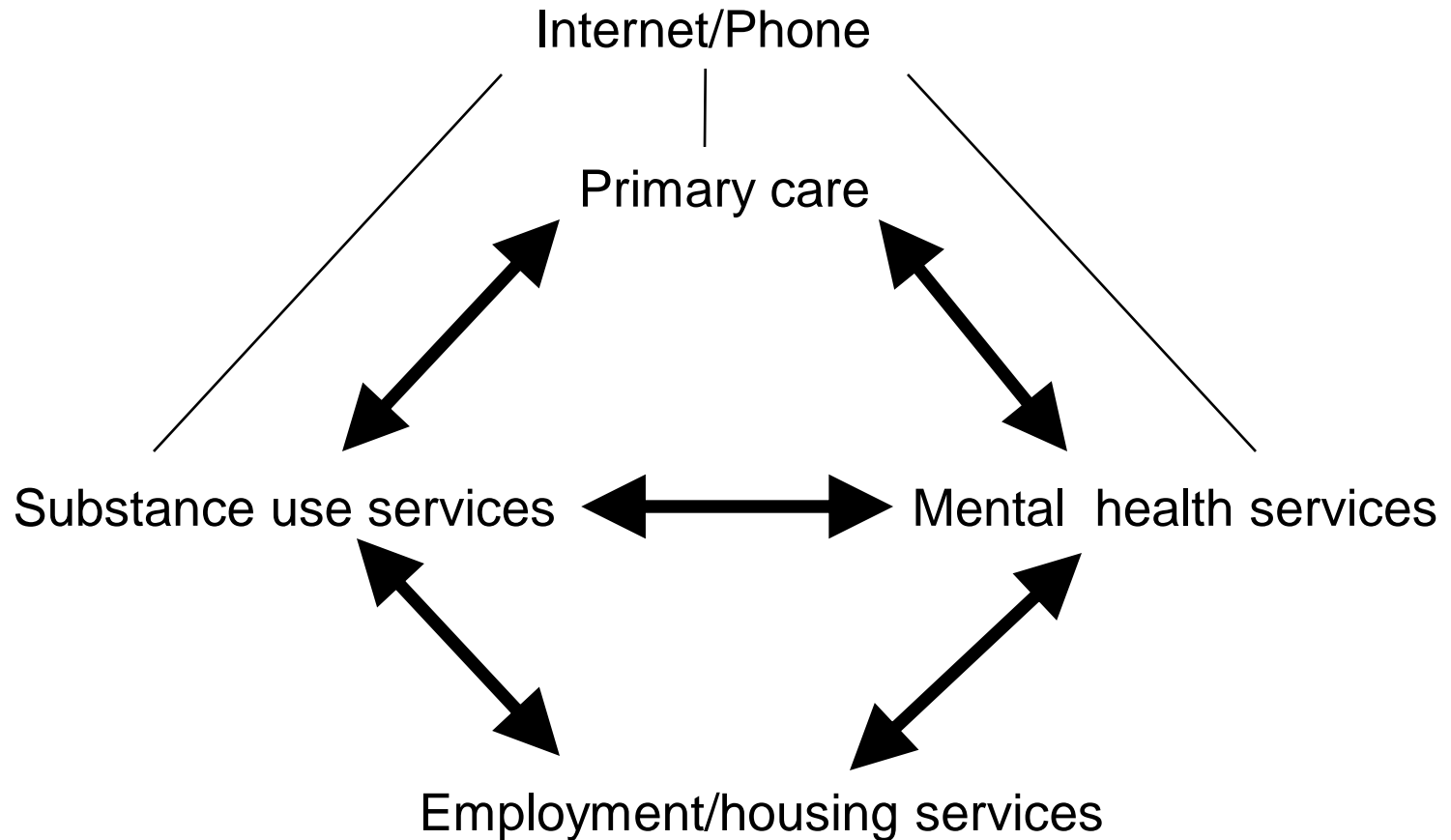


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In terms of the service system



Staged model of care

- **Early/Preventive:**

- Primary Care/Remote delivery



- **Brief—**

- Sound pharmacotherapy + Motivational + brief F/U



- **Longer term—in *MH or AOD service***

- Skills training, leisure groups, support



- **Increasing environmental support**

- *Intensive specialist service/hostel etc.*
- Structured context, activity, prompts

What else guides service models?

- Practical/political realities
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 - Preferred model of health service delivery
- Inertia of current practices

Needs assertive leadership

Queensland Health Policies

September 2008

- Effective partnerships across health, other services
- Co-occurring disorders expected; core business
- Integrated care
- Multiple entry points to same service

Vision of services

- Therapeutic alliance
- Bio/psycho/social
- Harm minimisation, not exclusively abstinence
- Recovery focus
- All co-occurring problems treated as primary
- Participation of family, friends, community
- Needs of special populations addressed

Is the glass half full or half empty?

- Half full:
 - The research is giving hints on what works
 - Sound policies now in place in most states
 - Examples of model programs, good collaboration
- Half empty
 - Still don't know what effective components of treatment are
 - Many people still miss out on service or receive poor service
 - Attitudes, training, service practices still present challenges

We need to keep trying, and help users to retain their hope.

