Looking at the Horizon:
Facing the Challenges and Opportunities for Future of Drug and Alcohol Services

Professor Michael Farrell, Director NDARC
Acknowledgement of collaborative work

Thanks for work from Jo Ross, Shane Darke, Maree Teesson and Kath Mills
As well as John Marsden in London
Summary

- Need for focus on improving quality and impact of community based integrated treatment and care planning
- Need for better care planning across a wide range of services
- Difficulty in predicting the future
- Need for integration across substances and understanding of the nature of the problem
- Brief overview of all substances
- Outline of some challenges
- Discussion on Recovery Debate
- Exploration of some comorbidity issues eg Suicide Risk and PTSD
- Post prison and post detox risks
Political and moral values of the social system

A model for evidence-based clinical decisions (from Haynes et al, 1996)
Classification of Addicts and Recommended Treatment

Types of Addicts

- Correctional cases
- Mental defectives (degenerates)
- Social misfits
- Otherwise normal

Treatment

- Internment camps
- Sterilization
- Vocational guidance
- Psychoanalysis
# Classification of Addicts and Recommended Treatment

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- Mental defectives (degenerates)
- Social misfits
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## Treatment
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- Sterilization
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- Psychoanalysis

American Medical Association 1930s Indications for Treatment
Shaping and planning services for the 21st century

- Data indicates that people with alcohol problems have problems for over 10 years before seeking help and less than half seek help.

- Problems with ageing treatment cohort now moving towards issues of methadone in residential care for the elderly.

- Criticism of existing services now too narrowly focused not adequate planning across different treatment modalities and poor linkage and care planning across different modalities.

- Poly drug use population with mixture of alcohol, benzodiazepine and opioid and heroin dependence.

- Also falling numbers of new heroin users replaced with psychostimulants.

- Cocaine and methamphetamine.
The future

- Very impertinent to attempt to predict the future
- Take stock of challenges and success of the past decade
- Look for opportunities for active work for the future
- Grasp the bigger picture from our own particular world perspective
- Agree on what should be achieved and set goals to do so
Over the past decade

- Some sense of maturation within the field with an attempt towards integration tobacco, alcohol and other drugs
- Embedded approach to policies is a mixture of battles won and battles lost
Tobacco Cessation

- Major advances in concerted approaches mixing both policy and practice to increase cessation rates and reduce the overall population of smokers
- Such impact is a major attributable fraction to the increased life span in many western countries
- Need for approaches to hardened and marginalized smokers
- Smokers and mental health issues need specific interventions
- Poor smokers need support to achieve cessation and abstinence
Alcohol

- Trends in tobacco not reflected in alcohol
- Young people drinking heavier and drinking more concentrated alcohol
- Marked increase in liver cirrhosis and complications in some countries
- Some progress in pharmacotherapy and psychosocial interventions but not comprehensively applied
- Serious delays in help seeking
- Need for broader prevention and intervention strategy.
- Including coherent controls of price and availability.
Opioids

- Globally broader application of maintenance treatments for heroin dependence with significant and important impact on HIV transmission and harm reduction
- Aging population of heroin users
- But major growth in prescription opioid dependence
- Overall solid impact on achievable goals
- Services need better links with chronic pain services and appropriate service models for pharmaceutical opioid dependence
Stimulants

- Global fluctuation in distribution and patterns of use
- Limited treatment impact and no evidenced based pharmacotherapy
- Negative impact on psychiatric comorbidity
- Cyclical Epidemics but regional levels of production and supply high and moving into new style of stimulants through internet delivery
Cannabis

- Still most common illicit drug used
- Considerable debate about health consequences and optimal social and health policies
- Increasing understanding of chronic long term use and complications and need for understanding dependence and withdrawal
- Need better provision of help and treatment for long term cannabis users
- Presents big challenge for field to communicate credible position on risks of different drug use
New Legal Highs

- Whole range of synthetic drugs designed to circumvent approaches to drug control and to obtain market share through the internet,
- Currently makes existing control strategies look flexible and cumbersome and ineffective
- Likely to consume significant time and resource responding time and again to new branded drugs
Challenges

- Ever increasing range of stakeholders
- Challenge to maintain pragmatic view of achievable outcomes
- Need for upscaling of studies that clearly deliver translational benefit to interventions in both prevention and treatment
- Utilise technology to find new and innovative interventions
- Supporting and skilling up the workforce and properly understanding the long term needs and capacities of the field.
- Overall limited access and delivery of both prevention and treatment interventions. Probably opioids and injecting drug users the exception.
Issues in UK and other EU settings

- Growing debate on the relationship of recovery to treatment,
- Marked funding squeeze on residential sector perception that methadone with not great outcomes dominating
- A debate on quality and duration of methadone treatment in UK and Ireland
“The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society”.

www.ukdpc.org.uk/resources/avisionofrecovery.pdf
Recovery definition

- Aspirational vision
- Inclusive of abstinence and maintenance goals.
- Recovery more than dealing with harms.
- Must encompass building a fulfilling life.
- Relationship with the wider world is part of the recovery process for an individual.

In our field this requires a long-term commitment and a balance of specialist care and building recovery capital.
What predicts recovery?

- Resilience to social stressors.
- Social supports.
- Family life.
- Identity shift to functional from dysfunctional.
- Employment.
- Stable housing.
Recovery

Treatment Renewal Movement

- (e.g. continuum vs. unit or episode, medication assisted treatments, performance and outcome, etc.)

Recovery Advocacy Movement

- (e.g. support groups, clubhouses, recovery support centers, recovery housing, recovery educational programs, recovery job co-ops, etc.)

- In UK broad debate on definition of recovery with an important emphasis on the value of medication treatment as a core part of recovery

- Also focus on developing recovery advocates who are external to and beyond traditional treatment delivery “Recovery Advocates”

- A real risk that a vigorous recovery debate polarises the field into abstinence versus medication and overall regressive approach
The Australian Treatment Outcome Study (ATOS)

- First Australian large scale longitudinal study of treatment outcomes for heroin dependence
- Involved treatment entrants from RR, detoxification & ORT services, and a non-treatment group

Findings:
- RR services attract a more ‘hard core’ group of heroin users than other modalities
- More drug entrenched
- Higher rates of severe psychological distress, overdose, suicide, PTSD & borderline PD.
ATOS Findings continued...

- Treatment works: Improvements across all modalities in drug use, criminality, and psychopathology at 3, 12, 24 & 36 month follow-up.
- Longer retention & fewer treatment episodes were associated with better treatment outcomes.
- Successful graduation (programme completion and separation with consent) from a RR predicted better outcome, independent of treatment length.
- 18% of RR entrants maintained continuous heroin abstinence across 24 months.
- 41% of the cohort met criteria for PTSD at baseline, and the disability associated with PTSD remained at follow up.
- At baseline 1/3 had a lifetime history of attempted suicide, with 13% having attempted in the preceding 12 months. The annual prevalence was unchanged at 12 month follow up.
Psychological Distress

Prevalence (%)

- PTSD: 42
- M Dep.: 26
- ASPD: 71
- BPD: 45
Has their mental health improved?

Severe psychological distress: SF-12

- Predictors of better mental health
  - Younger age
  - Better baseline mental health
  - More treatment days
  - Fewer treatment episodes

<table>
<thead>
<tr>
<th>Group</th>
<th>Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>MT</td>
<td>44/17</td>
</tr>
<tr>
<td>DTX</td>
<td>52/29</td>
</tr>
<tr>
<td>RR</td>
<td>65/21</td>
</tr>
<tr>
<td>NT</td>
<td>26/23</td>
</tr>
</tbody>
</table>
Has their mental health improved?

CURRENT MAJOR DEPRESSION: CIDI

- Predictors of Major Depression
- Being female
- Depression at baseline
- Fewer treatment days
- More treatment episodes

MT | DTX | RR | NT
---|-----|----|----
23 | 26  | 35 | 13
7  | 14  | 10 | 15

Group

percentage
Suicide Risk Assessment Study

How is suicide risk assessed and managed in RR services?

- Managers & volunteers from staff in 64 RR programmes across Australia were interviewed.
- 1/3 of agencies had no documented policies or procedures for managing suicide risk.
- 1/4 of staff were never formally trained in SRA.
- In > 1/3 of agencies the use of structured suicide risk assessment tools was not expected.
- Inconsistency in the tools used across agencies.
- Agencies were gathering information about psychiatric co-morbidity, but this was not being routinely integrated into the client’s suicide risk assessment.
Development of the Suicide Assessment Kit (SAK)

1. Acute Suicide risk Screener (Suicide-AS)
2. Suicide Risk Formulation Template (Suicide-RFT)
3. Suicide Policies and Procedures Pro-forma (Suicide-PPP)
For further information on Suicide Assessment Risk Project please contact: j.ross@unsw.edu.au

National Drug and Alcohol Research Centre
http://ndarc.med.unsw.edu.au
Concurrent treatment of PTSD and substance use disorders using prolonged exposure (COPE)

Katherine L Mills, Sudie Back, Kathleen Brady, Amanda Baker, Maree Teesson, Sally Hopwood, Claudia Sannibale
How common is PTSD among TC clients?

COPE Treatment components

- CBT for substance use (Sessions 1-4 and throughout)
- Psychoeducation relating to both disorders and their interaction (Sessions 1-4)
- *In vivo* exposure (Sessions 5-12)
- Imaginal exposure (Sessions 6-12)
- Cognitive therapy for PTSD (Sessions 8-12)
- Review, after care plan, termination (Session 13)
Collaborators

• Dr Katherine Mills (NDARC)

• Prof Maree Teesson (NDARC)

• Prof Amanda Baker (University of Newcastle)

• Dr Claudia Sannibale (NDARC)

• Ms Sally Hopwood (Traumatic Stress Clinic, Westmead Hospital/UNSW)

• A/Prof Sudie Back (Medical University of South Carolina, USA)

• Prof Kathleen Brady (Medical University of South Carolina, USA)

Funded by the National Health and Medical Research Council (NHMRC)
Participants

N = 103

55 Treatment (53%) (receive COPE)
48 Control (47%) (assessment only)

Main drug of concern

<table>
<thead>
<tr>
<th>Drug</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>21</td>
</tr>
<tr>
<td>Cannabis</td>
<td>19</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>17</td>
</tr>
<tr>
<td>Alcohol</td>
<td>16</td>
</tr>
<tr>
<td>Cocaine</td>
<td>12</td>
</tr>
<tr>
<td>Other opiates</td>
<td>7</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
</tbody>
</table>

- 100% substance dependent
- Median number of drug classes used = 4.0
- 80% injecting drug users

Trauma exposure

<table>
<thead>
<tr>
<th>Trauma Event</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Serious physical attack or assault</td>
<td>93</td>
</tr>
<tr>
<td>% Threatened, held captive, kidnapped</td>
<td>89</td>
</tr>
<tr>
<td>% Witness injury or death</td>
<td>79</td>
</tr>
<tr>
<td>% Rape</td>
<td>68</td>
</tr>
<tr>
<td>% Sexual molestation</td>
<td>66</td>
</tr>
<tr>
<td>% Life-threatening accident</td>
<td>61</td>
</tr>
<tr>
<td>% Trauma occurred to someone else</td>
<td>54</td>
</tr>
<tr>
<td>% Other</td>
<td>32</td>
</tr>
<tr>
<td>% Natural disaster</td>
<td>24</td>
</tr>
<tr>
<td>% Tortured</td>
<td>24</td>
</tr>
<tr>
<td>% Combat experience</td>
<td>2</td>
</tr>
<tr>
<td>% Physical assault</td>
<td>93</td>
</tr>
<tr>
<td>% Threatened, held captive or kidnapped</td>
<td>89</td>
</tr>
<tr>
<td>% Multiple traumatic events</td>
<td>100</td>
</tr>
</tbody>
</table>

Median no. of trauma types (range) 6 (2 – 10)
Severity of PTSD symptoms

Mean between group difference between baseline and 9mth follow-up: -16.09, 95%CI: -29.00 to -3.19

A reduction of 15 points on the CAPS total score is considered clinically significant.
Integrated Exposure-Based Therapy for Co-occurring Posttraumatic Stress Disorder and Substance Dependence: A Randomized Controlled Trial

Katherine L. Mills, PhD
Maroo Tresson, PhD
Sadie E. Back, PhD
Kathleen T. Budy, MD, PhD
Anastasia L. Baker, PhD
Sally Hopwood, MPsych (Clin)
Gladia Sannibale, PhD
Emma L. Barrett, PhD
Sahine Merz, PhD
Julia Rosenfeld, MPsych (Clin)
Philippe J. Ewer, BPsych (Hons)

Context: There is concern that exposure therapy, an evidence-based cognitive-behavioral treatment for posttraumatic stress disorder (PTSD), may be inappropriate because of risk of relapse for patients with co-occurring substance dependence.

Objective: To determine whether an integrated treatment for PTSD and substance dependence, Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPPE), can achieve greater reductions in PTSD and substance dependence symptom severity compared with usual treatment for substance dependence.

Design, Setting, and Participants: Randomized controlled trial enrolling 108 participants who met DSM-IV TR criteria for both PTSD and substance dependence. Participants were recruited from 2007-2009 in Sydney, Australia; outcomes were assessed at 9 months postbaseline, with interim measures collected at 6 weeks and 3 months postbaseline.

Interventions: Participants were randomly assigned to receive COPPE plus usual treatment (n = 55) or usual treatment alone (control) (n = 48). COPPE consists of 13 individual 90-minute sessions (i.e., 19.5 hours) with a clinical psychologist.

Main Outcome Measures: Change in PTSD symptom severity as measured by the Clinician-Administered PTSD Scale (CAPS; scale range, 0-182) and change in severity of substance dependence as measured by the number of dependence criteria met according to the Composite International Diagnostic Interview version 3.0 (CIDI; range, 0-7), from baseline to 9-month follow-up. A change of 15 points on the CAPS scale and a 1-point decrease on the CIDI were considered clinically significant.

Results: From baseline to 9-month follow-up, significant reductions in PTSD symptom severity were found for both the treatment group (mean difference, -21.24 [95% CI, -29.01 to -13.46]; p < .0001) and the control group (mean difference, -22.32 [95% CI, -31.32 to -13.32]; p < .0001); however, the treatment group demonstrated significantly greater reductions in PTSD symptom severity (mean difference, 16.09 [95% CI, 29.00 to -13.19]; p < .0001). No significant between-group differences were found in change in substance dependence (0.64 vs 0.52; incidence rate ratio, 0.85 [95% CI, 0.56 to 1.21]), nor were there any significant betweengroup differences in relation to changes in substance use, depression, or anxiety.

Conclusion: Among patients with PTSD and substance dependence, the combination of COPPE plus usual treatment, compared with usual treatment alone, resulted in improvement in PTSD symptom severity without an increase in severity of substance dependence.

Trial Registration: clinicaltrials.gov NID: ISRCTN12550817

Prolonged Exposure Therapy, a cognitive-behavioral therapy (CET) involving exposure to memories and reminders of past traumas, has long been regarded as a gold standard treatment for posttraumatic stress disorder (PTSD). Although there are other evidence-based treatments for PTSD, such as eye movement desensitization and reprocessing therapy, there is empirical evidence for the efficacy of prolonged exposure than for any other treatment. Indeed, the International Consensus Group on Depression and Anxiety recommends prolonged exposure as the most appropriate form of psychotherapy for PTSD, and it was the only treatment for PTSD endorsed in a US Institute of Medicine study as evidence based. The efficacy of prolonged exposure in reducing PTSD symptom severity has been demonstrated among persons from a number of populations who have been exposed to a wide variety of trauma types. There is, however, a notable absence of research examining the efficacy of prolonged exposure among individuals with co-occurring PTSD and substance dependence.

The epidemiologic and clinical research has demonstrated that trauma exposure among individuals with substance dependence is almost universal, and up to 63% experience comorbid PTSD. Similarly, up to 65% of patients with PTSD have been found to have a comorbid substance use disorder. Although PTSD is perv
Client satisfaction

• Measured using the CSQ-8 (Attkisson & Zwick, 1982)

“\textit{The best thing I have done for myself in years. I hadn’t ever spoken about this stuff so it was really helpful}”

“It \textit{helped me realise how much my addiction is linked to the trauma. I can now talk about the incident without freaking out}”

“No one had ever talked to me about my trauma before. It was good to put a name to my symptoms”

“Treating both drug use and PTSD at the same time was good. It was \textit{easy to understand and practical}.”

“The imaginal exposure was the hardest part but also the most useful.”
For further information on COPE please contact: 

k.mills@unsw.edu.au

National Drug and Alcohol Research Centre

http://ndarc.med.unsw.edu.au
Drug related death on release from prison and other institutions
Excess mortality ratio for different time periods post-release by cause of death (Singleton, Farrell, Marsden et al 2003)
Post-release mortality rates (males)
Farrell & Marsden [2008] n = 36,515
Post-release mortality rates (females)
Farrell & Marsden [2008] n = 12,256
Prison Release Mortality
Total Sample 183780

Deaths per thousand person years  Metanalysis Merrill et al 2010 Addiction

Eng (48771) Scot (19486) NSW (85196) US (30327)
<table>
<thead>
<tr>
<th>Country: studies</th>
<th>Drug-Related Deaths (person-years)</th>
<th>DRD Rate per 1,000 pys</th>
<th>RR in 1st fortnight (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wks 1+2</td>
<td>Wks 3+4</td>
<td>Wks 5-12</td>
</tr>
<tr>
<td>UK: E&amp;W + Scotland</td>
<td>92 (2,588)</td>
<td>20 (2,547)</td>
<td>42 (10,795)</td>
</tr>
<tr>
<td>Australia: NSW + Western</td>
<td>187 (7,759)</td>
<td>64 (7,416)</td>
<td>144 (27,334)</td>
</tr>
<tr>
<td>USA: State = Washington</td>
<td>27 (1,466)</td>
<td>5 (1,426)</td>
<td>10 (5,409)</td>
</tr>
<tr>
<td>USA: State = New Mexico</td>
<td>8 (462)</td>
<td>3 (462)</td>
<td>10 (1,845)</td>
</tr>
</tbody>
</table>
Risk on release from residential and inpatient treatment

- Preliminary data indicates elevated risk but not very well enumerated
- Need for bigger cohort studies to clarify risk and protective factors
- Need good education for individuals and families about possible risk and approaches to reduce risk
Conclusions

- Effective evidence based treatments needed for this high risk population
- Effective approaches need to be delivered across a range of modalities
- Need to look at continuity across different models of treatment in different settings
- Need for integrated multimodality care model
- Need for greater awareness of risk when change occurs
- Need to research better outcomes from planned compared to unplanned termination of service intervention