Co-occurring Depression and Alcohol/other Drug Use Problems: Developing Effective and Accessible Treatment Options

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B Sc (Psych) Hons

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Volume 1 of 2
Declaration

I hereby certify that the work embodied in this thesis is the result of original research and has not been submitted for a higher degree to any other University or Institution.

Signed: _________________________________________________________________
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Date: __________________________________________________________________
Acknowledgements

So many people have contributed to the completion of the body of work contained in this thesis. Apologies to anybody I may have missed...

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Abstract

A large body of population- and treatment-based evidence exists to indicate depression and alcohol/other drug (AOD) use are highly prevalent on a global scale, and co-occur with considerable frequency. Despite this evidence, significant gaps exist in treatment research and clinical services, as people with co-occurring depression and AOD use problems have typically been excluded from randomised controlled treatment trials, and also face many individual- and service-level barriers to accessing treatment. Consequently, a well-defined and adequately tested treatment strategy does not currently exist for people experiencing the complexities of concurrent depression and AOD use problems.

A small body of evidence exists to suggest that co-occurring mental and AOD use disorders (“comorbidity”) leads to poorer treatment outcomes, increased risk of relapse, higher levels of problematic symptomatology, and poorer quality of life. However, little consistent information is currently available to suggest what additional impact comorbid depression and AOD misuse produces relative to the experience of a “single” condition (such as depression or AOD misuse in isolation). Studies 1 and 2 attempted to address this important gap in knowledge by examining the presenting characteristics of 246 people with AOD use problems, according to the presence of comorbid depressive symptoms. One hundred and thirty seven participants were drawn from AOD treatment services, and a further 109 were referred via mental health services and also met criteria for a psychotic disorder. Results indicated that the presence of depression was associated
with a significantly higher severity of psychiatric symptoms and personality disorder, significantly decreased social and occupational functioning and significantly reduced quality of life. Current depression was also associated with a significant increase in the experience of cravings and self-reported dependence on amphetamines. These difficulties were over and above the already high rates of disability and distress reported by each sample as a whole. Furthermore, treatment for mental health problems was rare among the AOD treatment participants, as was AOD treatment among the mental health sample. This is despite the presence of moderate to severe levels of depression and AOD use reported by each sample. In particular, Studies 1 and 2 highlight the vulnerabilities for people with comorbid mental health and AOD use problems who present to treatment in the mental health or AOD use settings, and in particular how depression significantly increases the disability and other challenges experienced by these people. These results provide a strong rationale for the development of an appropriate treatment protocol for depression and AOD use comorbidity.

No clear treatment model or evidence-based approach exists to suggest how depression and AOD use comorbidity is best managed. When people with this comorbidity do manage to access clinical treatment services, they typically receive treatment targeted at one aspect of their presentation (e.g. depression-focussed or AOD-focussed treatment). Yet, it is not known whether a singular focus of treatment is effective in producing sustainable change in the outcomes of people with comorbid problems, nor whether failure to treat all components of the comorbid presentation confers a worse outcome. Studies 3 and 4 reported on two randomised controlled clinical trials of psychological
treatment for AOD use problems among a sample of 246 people with AOD use problems, drawn from AOD treatment services (n=137) or mental health services (n=109). In doing so, these studies provide some of the first available data on these issues. Participants were categorised according to the presence of comorbid depression (as per Studies 1 and 2) and response to treatment was analysed over a six- to 12-month follow-up period. In spite of high levels of current depressive symptoms at entry to the studies, and equally hazardous use thresholds of a range of substance, people enrolled in Studies 3 and 4 reported some gains via their experiences with these single-focussed treatments. Attendance and retention rates were higher than reported in previous research, and the presence of depression did not adversely influence the motivation of project participants to change their current AOD use patterns. A treatment effect was generally not detected among the Study 3 and 4 participants, regardless of the presence of depression, with those receiving an assessment-only control treatment in both studies reporting similar patterns of change in outcome. Regardless of the magnitude of change reported by all study participants, people with depression reported significantly higher levels of depression, poly-drug use, amphetamine dependence, hazardous use of a range of substances, HIV risk taking and criminal activity and lower levels of functioning and self-concept across the follow-up assessment period. These residual symptoms were present at sufficiently high levels of severity to increase the risk of relapse to AOD use and continued morbidity. These results suggested the potential value of targeting depression in the context of comorbid AOD use problems.
One previous study has examined the impact of an adjunctive psychological treatment of depression for people hospitalised for alcohol use disorder. Results indicated that people who received the additional depression treatment reported significantly greater improvements on depression- and alcohol-related outcomes over the short-term relative to people receiving a relaxation-only control treatment. These improvements were suggested to be enhanced if treatment had integrated depression- and alcohol-related approaches into the one treatment program. In the first study of its kind, Study 5 developed and evaluated the efficacy of an integrated psychological treatment program for comorbid depression and AOD use problems. Sixty-seven participants received integrated treatment delivered by a therapist, computer-delivered integrated treatment or a brief intervention (control) treatment delivered by a therapist. Depression scores, daily use of alcohol and cannabis, hazardous use of a range of substance and poly-drug use fell significantly over a 12-month follow-up period across the integrated treatments and brief intervention (control) conditions. The small sample size of Study 5 meant that very few treatment effects were detected at a statistically significant level, however important reductions in key outcomes for depression, AOD use, quality of life and general functioning were noted for people in the integrated treatment relative to controls over a 12-month period. The magnitude of change in Study 5 across these domains was comparable with the only other study of psychological treatment of depression and alcohol-use disorders described above. The integrated treatment in Study 5 was associated with higher levels of improvement in depression, alcohol use and cannabis use (where present) than did the AOD-focussed treatment examined in Studies 3 and 4. The results further suggest that a brief intervention targeting both depression and AOD drug use problems is associated with reductions in key outcomes in the short-term, with
integrated, lengthier psychological treatment potentially associated with longer-term changes on the same outcomes.

No previous study has directly compared the outcomes for people completing psychological treatment delivered via a computer program with those completing treatment with a ‘live’ clinician over an extended follow-up period of 12-months. Given the barriers people with comorbid depression and AOD use problems face in accessing available treatment services, the consideration of alternative modes of delivery of evidence-based treatment to this group is timely. Study 6 expanded on the Study 5 results by presenting further analysis of the performance of the computer-delivered version of the integrated treatment relative to the clinician-delivered equivalent, matched for content. Given the small sample size of participants, Study 6 devised a four-point criterion which, if satisfied, would suggest that the computer-delivered and clinician-delivered integrated treatments were approximately equal. Based on these criteria, the results indicated that the outcome profiles for people engaged in the computer-delivered treatment were equivalent to those reported by people involved in clinician-delivered therapy over a 12-month follow-up period. Additionally, computer-delivered integrated treatment was associated with similar rates of improvement as the therapist-equivalent on depression scores, risky drinking patterns, hazardous use of substances, poly-drug use, levels of daily cannabis use, suicidality, treatment retention and therapeutic alliance. This result requires further replication to test these assumptions, however it is promising that a treatment requiring an average of 12-minutes face-to-face of “generic” clinician time per week
produces a similar pattern of improvement to a treatment requiring an average of 60 minutes of face-to-face specialist psychologist input over the same time period.

Studies 1-6 resulted in the development of a menu of treatment options for people with depression and AOD use comorbidity, with each treatment approach providing evidence for at least some benefit among the study participants. While encouraging, these results again raise the issue of how treatment may be incorporated into existing services (mental health, AOD use, primary care, etc.), which typically remain segregated, with little opportunity for collaboration and cross-fertilisation of skills and expertise between service settings. Chapter 7 discusses a new model of treatment for comorbid depression and AOD use problems that incorporates the results of Studies 1-6, and involves a stepped care approach to developing a treatment plan tailored to the specific needs and levels of distress experienced by people with depression and AOD use comorbidity. The stepped care model of treatment could be incorporated into existing service settings and structures, with the potential for computer-based therapy to provide access to specialised treatment for depression and AOD use comorbidity that might otherwise be unavailable. As a result, stepped care treatment could foster earlier engagement with treatment services and encourage motivation and optimism among people with comorbid depression and AOD use problems. These are important issues for service development and delivery of appropriate treatments to this underserved population.