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There is a growing evidence base that a healthy lifestyles approach, addressing mental health and/or substance abuse problems within a context of overall health, can contribute to the effective prevention and treatment of mental health and substance use disorders. We know that just one bout of exercise can help improve mood, and new evidence suggests quitting smoking can likewise lead to more positive feelings.

In this issue of the CREMS Newsletter, Prof Amanda Baker opens with an article that explores the history of the healthy lifestyles approach and how it became a key research focus for CREMS. We then hear from CREMS members working across our range of healthy lifestyles projects: Ms Yasmina Nasstasia discusses her work exploring the links between exercise and depression, Dr Alison Beck explains the need to assess the SMART Recovery approach to addiction support groups, Dr Sarah Hiles explores why the symptoms of depression sometimes match a common cold, Ms Katrina Champion describes her efforts to develop an early lifestyles intervention for teenagers, and Ms Kristen McCarter discusses her research aimed at helping head and neck cancer patients with mental health comorbidities through a healthy lifestyle intervention. Finally, Ms Alexandra Voce gives us a taste of the CREMS Colloquium from the perspective of an early career researcher.

We conclude the issue with our regular sections, including the latest news, events and publications from the CREMS team as well as our Spotlight On section, this issue featuring Dr Christina Marel.

ABOUT

Funded in 2012 by the Australian National Health and Medical Research Council, the Centre of Research Excellence in Mental Health and Substance Use (CREMS) aims to increase the knowledge base regarding the effective prevention and treatment to comorbid mental health and substance use disorders. The research centre is a world first, bringing together the largest concentration of internationally recognised comorbidity researchers from around the world.

The CREMS newsletter is just one of the ways you can learn more about our work. Connect with us on Facebook, Twitter and through our website to keep up to date with latest research in comorbid mental health and substance use.

This issue of the CREMS Newsletter was edited by Ms Stephanie O’Donnell, A/Prof Katherine Mills, and Prof Amanda Baker.
Taking a healthy lifestyles approach to mental health and substance use comorbidity

Our Centre of Research Excellence in Mental Health and Substance Use (CREMS) focuses on prevention and treatment of co-existing mental health and substance use problems. It’s exciting to see this development and for so many early and mid-career researchers to gain valuable experience with this complexity.

For many years, people living with mental illness who also used alcohol and other drugs tended to ‘fall between the cracks’ in services, as a well-intentioned service referred the person for treatment of the ‘other’ problem. The trouble was that the ‘other’ service would do the same thing!

Service providers were not alone in this ‘silto’ type of approach to presenting problems. A very similar approach was taken in research. Mental health researchers tended to exclude potential participants...
from their studies if they had an alcohol or other drug problem and researchers working in the area of alcohol and other drugs tended to exclude people with mental health problems like depression. Thankfully, over the years, things have progressed and many services try to adopt a ‘no wrong door’ approach, and screen or assess for problems in both domains and either refer on for treatment elsewhere or offer treatment within the same facility. A lot more research is needed to find out how best to assist people with mental health and substance use problems. Because they have more or less been excluded from the existing research knowledge base, CREMS is working hard to answer some basic questions. For example, is it more effective to treat mental health and substance use problems together at the same time or sequentially, and in what order?

As co-existing mental health and alcohol and other drug problems began to gain recognition as important to address, it became obvious to clinical researchers like me that whilst we were finally focusing on the aforesaid co-existing problems, most people attending mental health or alcohol and other drug treatment services were smoking very heavily, often around 30 cigarettes per day, and this was not regarded as ‘substance use’ in the same way as other drugs. Together with Prof Robyn Richmond from the University of New South Wales, we set out to address smoking among people with severe mental disorders in the late 1990s. We allowed people into these smoking intervention studies whether or not they were using other drugs, and people entering the studies were keen to participate! We learned that although some people quit, many preferred to initially reduce their smoking, by as much as half or more, and they kept attending sessions, showing interest in talking about other aspects of their lifestyle. Many were excited about their smoking reduction achievements as they could now afford to buy items for their homes or other goods they previously could not afford due to smoking so heavily. They spoke about their poor diet and lack of activity.
Around this time, there was also concern about the weight gain being seen in association with medications and growing realisation that the longevity gap seen in other groups also applied to people with mental health and/or alcohol and other drug problems. It became evident that the approach to take might involve addressing multiple health behaviours as well as mental health. There is evidence accumulating to suggest that multiple health behaviour change is possible in the general community and that some behaviours go ‘hand in glove’ so that changing one behaviour has a serendipitous impact on other behaviours. Alcohol consumption and smoking are an example. Unhealthy behaviours like watching lots of TV or playing a lot of computer games and eating high fat/high salt snack foods also go together. Interestingly, recent evidence suggests that giving up smoking can significantly improve mood.

So, given that people attending mental health or alcohol and other drug treatment centres are interested in addressing their smoking as well as improving their other health behaviours, including alcohol and other drug use, the CREMS team is endeavouring to develop more research in this area. Examples include: my research investigating the effectiveness of telephone delivery of healthy lifestyles interventions; Dr Peter Kelly investigating the effectiveness of Healthy Lifestyles groups addressing smoking, diet and
physical activity in residential rehabilitation settings; A/Prof Frances Kay-Lambkin evaluating the effectiveness of a web-based intervention to improve health behaviours. One area in which there is a lot of potential is to evaluate this sort of approach in conjunction with CBT among methamphetamine users. Methamphetamine dependence is often associated with severe mental and physical health issues, and working on these together might help improve longer term outcomes from treatment.

One of the most positive things about a healthy lifestyles approach is that it helps break down the stigma of raising a mental health or alcohol and other drug problem. Within a health context, people can identify what health issues may be of concern to them and understand how they might relate to each other. Clinicians can provide a rationale regarding that “What’s good for your physical health is good for your mental health” and ask people to consider a more holistic approach. As we enter our half term as a CRE, we are looking forward to developing more healthy lifestyles initiatives in the prevention and treatment areas. We would love to hear of your experiences in this area and any ideas you might have for collaborative research.

‘What’s good for your PHYSICAL HEALTH is good for your MENTAL HEALTH’
What are the specific effects of exercise on the depressive symptom profile?

‘Melancholy
Sits on me as a cloud along the sky,
Which will not let the sunbeams through, nor yet
Descend in rain and end; but spreads itself
‘Twixt heaven and earth, like envy between man
and man, and is an everlasting mist’

Lord Byron

Depression needs very little introduction. Most of us are familiar with the experience of depressive symptoms in response to adversity, loss or change. The psychological and physical withdrawal engendered by depression provides adaptive space to process and integrate experiences. However, for some people, depressive symptoms can become protracted and disabling leading to a pervasive state...
which Lord Byron poetically refers to as an ‘everlasting mist’. Major depressive disorder (MDD) has been documented since classical times and reported by well-known individuals such as Ernest Hemmingway, Michelangelo, Leo Tolstoy, Arthur Schopenhauer, Emily Dickinson and Charles Dickens. Fast forward to the modern era and results from epidemiologic studies show MDD is a fast growing, ubiquitous disorder, cutting across borders, age, gender, socio economic status, race, religion and sexuality. As a human race we are more depressed and while there are many different theories as to why, the latest science disconcertingly shows MDD is implicated in the development of chronic, medical diseases including: cardiovascular disorders, metabolic syndrome, Type 2 diabetes, and obesity. MDD can even shorten your life, with new research showing telomere length is significantly shorter (equivalent to around 10 years of life) in depression sufferers.

For all of these reasons most would agree treating MDD is an important research and clinical priority. Imagine what it would be like if we could treat depression successfully. The personal, social, and economic benefits would be incalculable. Now imagine what that treatment would look like? MDD has been treated with varying levels of success...
using pharmacotherapy, psychological therapies and electro convulsive therapy. Similarly, exercise also appears to have beneficial effects. There are over 200 cross sectional, longitudinal, and randomised controlled trials with different populations and age groups which show exercise can reduce depressive symptoms mostly in adults and older people. We know that even a single bout of exercise can help improve mood but we don’t know why. At this stage science cannot definitively tell us what is it that exercise does when it treats depression, in other words, what are its active ingredients? We also don’t know how long, how often and what type of exercise you need to do, to achieve beneficial effects. A review of the literature reveals there are many different theories as to why exercise works and some research has attempted to quantify the dose response question, however, more research is needed.

We now appear to have a number of different treatments which successfully treat MDD including exercise, suggesting there are some underlying principles that each of these treatments target in one way or another. By the same token, all of these treatments have partial or limited efficacy in some cases. In other words, they do not work for everybody. Moreover, half of the time, those successfully treated will experience a recurrence in symptoms, and for some MDD is more like a chronic disorder. How do we make sense of this? Are we treating the same disorder? The summed, sweeping, diagnostic criteria for MDD leaves us with a one size fits all approach, yet recent thinking in this field suggests MDD is a heterogeneous disorder with a diverse symptom profile with cognitive, affective, somatic and behavioural components. Perhaps depression is not one thing and maybe that's why so many different treatments work?

A central focus of my PhD research is to investigate the specific effects of an exercise intervention on the depressive symptom profile in young people diagnosed with MDD. Building an understanding of any differential effects may offer important clues as to the underling treatment mechanisms of exercise and tell us, who may benefit from exercise prescriptions. It may even offer clues as to how exercise works. In the near future we
hope to publish the results from our pilot study and are currently in the last stage of recruitment as part of an RCT which we commenced in 2013. Although it is still too early to make a call, preliminary results from our pilot study suggests there were differential rates of improvement in depressive symptom groups (somatic, affective, cognitive) across the 12 week exercise intervention. It may that the ‘everlasting mist’ is actually a rainbow.

References


The consequences of alcohol, substance use and other addictive behaviours are far reaching. The yearly cost to Australians from harms associated with alcohol and illicit substances has been estimated at $15.3 billion\(^1\) and $8.2 billion\(^2\), respectively. The social cost to the community of other addictive behaviours, such as problem gambling is estimated to be at least $4.7 billion a year\(^3\). Moreover, the impact of addiction on health and wellbeing can be devastating, including premature mortality, elevated morbidity and considerable financial burden\(^4\). In light of these consequences, and due to the often chronic and relapsing course of addiction, there is a need to improve access to evidence based support. Mutual aid groups represent a promising avenue.

SMART Recovery: An alternative mutual aid support group for addiction?

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Mutual aid groups offer free, largely accessible, long-term support. The majority of mutual aid-support groups adopt a twelve step philosophy (e.g. alcoholics anonymous). Within this model, addiction is conceptualised as a medical and spiritual disease, with recovery reliant on relinquishing control to a higher power. While evidence supports the efficacy of twelve step approaches, potential barriers to engagement have been identified. For example, individuals may report conflict between personal values and the twelve step philosophy due to low spirituality and/or difficulty with the concept of surrendering to a higher power. Self-Management and Recovery Training (SMART Recovery) was borne from this need for an alternative to twelve step approaches. Enhancing choice over mutual support options represents an important step in enhancing engagement, thereby treatment outcomes for individuals recovering from addictive behaviours.

SMART Recovery is a not-for-profit organisation offering group and on-line mutual aid support for individuals with experience of problematic alcohol, substance and/or other addictive behaviours (e.g. gambling, eating, technology, pornography). SMART Recovery focuses on self-empowerment and adopts key principles (e.g. self-efficacy) and therapeutic approaches (e.g. motivational interviewing and cognitive behavioural
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Accordingly, we are in the process of conducting a systematic review. Our aim is to provide an overview of the current state of evidence for SMART Recovery including outcomes, potential mediators and a critical evaluation of the methods used to evaluate this mutual aid support group. Preliminary searches have identified eleven evaluations of SMART Recovery. Initial impressions suggest that although positive findings are apparent, the existing evidence is largely cross-sectional, seems to focus on process relative to outcome measures and/or evaluates SMART Recovery within a specific treatment context (e.g. dual diagnosis).

Campaigning for change in healthcare practice and policy relies on a solid evidence base. This systematic review represents an important step in generating the evidence needed to refine, disseminate and raise the profile of SMART Recovery as an effective alternative to traditional twelve step approaches for long-term addiction recovery support.

References
Runny nose, scratchy throat, lethargic, miserable, unsettled, foggy head... As I write this from sunny Amsterdam in July, I think about the “Antarctic Vortex” back at home and the many Australians probably experiencing cold and flu symptoms. The latter symptoms – lethargic, miserable, unsettled, foggy head – sound very similar to the type of symptoms someone experiences during an episode of major depression. However, in depression they occur for a prolonged period with no obvious physical illness to attribute them to.

Intriguingly, perhaps the reason that a person experiences depression is the same reason that someone feels sick when they have a cold. The inflammatory hypothesis of depression positions subclinical inflammation as a possible cause of depression.

The inflammation response is an important part of the body’s reaction to an invading pathogen or an injury. It involves a biochemical cascade of inflammatory mediators which induce the classic “inflammation response”, characterised by redness, warmth, pain, swelling, and loss of function at the site of the problem. When these obvious classic inflammation indicators are absent but inflammatory mediators are still elevated, it is often considered “subclinical inflammation”.

Inflammatory mediators have broad effects throughout the brain and body, inducing “sickness behaviours”, such as lethargy, that aid in recovery from injury or infection. These include effects on many of the biological systems that are dysregulated in depression, such as the activity of neurotransmitters and stress hormones.

Besides being a nice analogy, the idea of depression as “sickness behaviour” resulting from an inflammatory response is supported by epidemiological evidence. My PhD thesis focused on unlocking the scope of this evidence. In a series of meta-analyses, we found that certain inflammatory mediators are elevated in depression and that they decrease with antidepressant treatment. In another meta-analysis, we saw that treating people with a medication that has anti-inflammatory effects leads to inadvertent reductions in depressive symptoms.

Dr Sarah Hiles is a Marie Skłodowska-Curie Research Fellow at VU University in the Netherlands, analysing longitudinal data from the Netherlands Study of Depression and Anxiety (NESDA). She completed her PhD at the University of Newcastle under the supervision of Prof Amanda Baker and Prof John Attia in 2014.

Underlying subclinical inflammation may also help explain why there is such high comorbidity between mental and physical health problems. For instance, people with depression are at higher risk of developing cardiovascular disease, and vice versa. In the Hunter Community Study – a cohort study of older Novocastrians – we saw that elevated inflammatory mediators may partly explain the association between baseline depressive symptoms and subsequent hospitalisations for heart attack, stroke or angina. But the question remains: What is the source of the subclinical inflammation observed in people with depression?

The origins of subclinical inflammation are unclear because there are many factors present in people with depression that are associated with inflammation. Psychosocial stress induces subclinical inflammation. People with depression may also have high likelihood of apparent or nascent physical illness. We were interested in the impact of a person’s body fat and their lifestyle: their diet, exercise, smoking and alcohol consumption. In the Hunter Community Study we identified smoking, body fat and psychosocial coping as likely sources of elevated inflammatory mediators in depression, in women but not men.

The next phase of my work in Amsterdam will look further into the relationship between depression and unhealthy lifestyle, particularly whether someone’s genetic risk for depression is modified by their lifestyle.

Even so, whether inflammation plays a causal role in the development and maintenance of depression remains uncertain. These are questions which will in part be answered by further clinical trials and genetics research.

Inflammation is increasingly linked with a wide spectrum of mental and physical health problems: depression, anxiety, schizophrenia, suicidality, smoking, cognitive decline, cardiovascular disease, diabetes, cancer and so on. Aiming to reduce levels of inflammation may be a way to address an array of problems, in treatment as well as primary or secondary prevention. Making positive changes in a person’s lifestyle may be one way to achieve this goal of addressing the comorbidity of physical and mental health problems.
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References


Although Australians are living longer, the proportion living with chronic diseases is increasing.\textsuperscript{1} Four main behavioural risk factors: risky alcohol use, smoking, physical inactivity and poor diet (the “Big 4”) are the strongest determinants of poor health outcomes in Australia.\textsuperscript{1,2} Fortunately, these behaviours can be modified. In fact, it has been estimated that up to 80% of heart disease, stroke, and diabetes, and more than a third of cancers worldwide, could be prevented by eliminating the Big 4 risk factors.\textsuperscript{2}

Alarmingly, data indicate that 85% of 12-17 year olds do not meet physical activity guidelines,\textsuperscript{3} 27% are overweight,\textsuperscript{4} 95% do not consume enough fruit and vegetables,\textsuperscript{5} 74% have used alcohol and 23% have used tobacco.\textsuperscript{6} Not only are these behaviours risk factors for chronic disease later in life, in the

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**REDCURING THE “BIG 4” RISK FACTORS FOR CHRONIC DISEASE**

*The Climate Schools: Healthy Lifestyles Program*

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**MS KATRINA CHAMPION**

Ms Katrina Champion is a Research Officer and Doctoral Candidate at CREMS. Her thesis aims to advance responses to substance use prevention for Australian adolescents. Katrina is submitting her thesis in October this year and will continue her research in online prevention for substance use and other risk factors for poor health.
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Alarmingly, data indicate that 85% of 12-17 year olds do not meet physical activity guidelines, 27% are overweight, 95% do not consume enough fruit and vegetables, 74% have used alcohol and 23% have used tobacco. Not only are these behaviours risk factors for chronic disease later in life, in the short-term they are associated with a range of problems including diabetes, obesity, mental health problems and alcohol-related harms. It is therefore critical to target these behaviours early to ensure they do not persist throughout adolescence and into adulthood.

Research shows that risk behaviours commonly co-occur as risk behaviour ‘clusters’ and that adolescents tend to engage in multiple risk behaviours simultaneously. For example, adolescents who use alcohol and drugs are also more likely to eat poorly and engage in sedentary behaviour.

A multiple health behaviour change approach, in which two or more health behaviours are promoted at once is thus ideal for chronic disease prevention. Targeting the Big 4 risk factors together can promote multiple health behaviours, thereby reducing the shared risks for multiple chronic diseases in an efficient manner. School is an ideal location to equip adolescents with the skills to lead healthy lives and to empower them to take control of their health, yet there is no successful school-based program addressing the Big 4 risk factors in Australia.

To address this gap, we are proposing to develop and trial the first online intervention to simultaneously target alcohol use, smoking, poor diet and physical inactivity among adolescents. The Climate Schools: Healthy Lifestyles program will build on the successful Climate Schools prevention programs for substance use and bring together members of CREMS (Dr Nicola Newton, A/Prof Frances Kay-Lambkin, Dr Cath Chapman, Prof Bonnie Spring, Dr Matt Sunderland, Ms Katrina Champion, Prof Maree Teesson, Prof Amanda Baker and
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This will be the first trial, internationally, of an online school-based program that concurrently targets the Big 4 risk factors for chronic disease among high school students. Addressing the Big 4 risk factors during adolescence, will not only improve the health of young Australians in the short term, but also carries enormous potential to enhance their capacity to lead healthy lives as adults and reduce their risk of chronic disease. It will provide schools with a novel and scalable resource that has the potential to halt the trajectory of chronic disease for young Australians and reduce the overall burden of chronic disease in Australia.

References


Malignancies of the upper aerodigestive tract and its connected structures are known collectively as Head and Neck Cancers. Head and neck cancer (HNC) accounts for an estimated 650,000 new cancer cases worldwide every year, with a mortality rate approaching 50%. In addition to being key risk factors for head and neck cancer, continued tobacco smoking and alcohol use as well as depression are each reported to be highly prevalent in these patients. However, relatively little is known about the prevalence of the co-occurrence of these factors and their effect on treatment outcomes in this patient group.

Malnutrition is also a significant problem in cancer and is particularly overrepresented in HNC patients. Given the impact of malnutrition on the health of people with HNC and their response to treatment, it
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Malnutrition is also a significant problem in cancer and is particularly overrepresented in HNC patients. Given the impact of malnutrition on the health of people with HNC and their response to treatment, it is usual practice for patients to consult regularly with a dietitian throughout the course of their treatment. Due to the integral role that dietitians play in the care of HNC patients, as well as the potential relationship between malnutrition and depression and implications for treatment outcome, dietitians are well placed to screen for psychological distress in this group. Recently developed Australian guidelines recommend the routine screening and referral of head and neck cancer patients for psychological distress as a key component of oncology dietitian care.

Despite the best practice guidelines, distress often goes unrecognised in the clinical oncology setting and fewer than 10% of distressed patients are referred for appropriate psychosocial support and treatments. Multi-component clinical practice change strategies including staff training, performance audit and feedback, prompts and reminders, and executive support and endorsement have been found be effective in improving clinical practice.

My PhD research program of work will be the first study to assess the effectiveness of a clinical practice change intervention in improving dietitian adherence to best practice clinical guidelines, particularly distress screening and referral, when providing care to these patients. The research is embedded within the Eating as Treatment Radiotherapy Nutrition Project; EAT project (Chief investigators are Prof Amanda Baker, Dr Ben...
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Despite the best practice guidelines, distress often goes unrecognised in the clinical oncology setting and fewer than 10% of distressed patients are referred for appropriate psychosocial support and treatments.

In addition to determining the effectiveness of the clinical practice change intervention, I am interested in assessing the rates of the co-occurrence of multiple risk behaviours that persist in the EAT patients; tobacco and alcohol use, in combination with depressive symptoms. These factors will be measured at baseline just prior to patients starting radiotherapy and will the data will form one of her thesis papers. This will be the first Australian study to biochemically verify self-report of smoking in head and neck cancer patients. I am also currently working on two systematic reviews that aim to determine the prevalence of cigarette smoking as well as existing smoking cessation interventions in these patients. The research team hope to use the results of these studies to inform a smoking cessation intervention in HNC patients.
I recently commenced my doctorate at the Australian National University, working under the guidance of my supervisor A/Prof Rebecca McKetin, with a research focus on the relationship between methamphetamine use and the development of psychotic disorders. I attended the CREMS Annual Colloquium in Canberra in late-August and would like to share my experience of the day.

Being my first conference as an academic, I was pleasantly surprised at the engaging and open atmosphere of the colloquium. At the closure of each presentation the floor was open for feedback, questions and suggestions from clinicians, researchers, students, and even consumer advocates with personal experience of mental disorders. This diverse range of attendees from all around Australia meant that each topic was met with a comprehensive and informative discussion.
The colloquium focused on innovative and novel treatments for comorbid substance use disorders that occur with some of the most common mental issues, such as trauma, depression and psychotic disorders. I found this highly relevant to my own research, as many sufferers of methamphetamine dependence also experience severe symptoms of depression and psychosis that must be recognised and treated effectively. In particular, I was greatly impressed by Dr Louise Thornton’s presentation exploring the potential that new technologies such as the internet and smartphone applications provide for accessible and effective treatment of common mental disorders. It will be exciting to see how her own smartphone application for treating depression and alcohol abuse develops over the coming months.

The workshop also explored diverse methods of conceptualising co-morbidity through different classification systems. In my own research I intend to investigate and document the symptom profile of methamphetamine-induced psychosis in hopes of differentiating it with schizophrenia and other psychotic disorders. As such, I was interested in Dr Matthew Sunderland’s research exploring the underlying dimensional constructs that underpin many psychiatric disorders through latent variable analysis. Such methods could provide insight into why comorbid disorders commonly occur and how
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I believe the most valuable message the colloquium left me with was an awareness of the highly reciprocal relationship that often exists between mental and substance use disorders and the need to treat these issues simultaneously. A continual theme that emerged throughout the day was some of the barriers that both clients and clinician face when attempting to seek treatment for those suffering from substance dependence and severe mental disorders. Mental health services may be reluctant to support those with severe drug intoxication or dependence, whilst drug treatment facilities may not have sufficient resources or training to adequately treat complex comorbid psychiatric illness, such as trauma. There is a need for more cooperation and collaboration between these domains and the field could momentously benefit from a greater research focus on integrated treatments rather than a sole focus on the treatment of discrete disorders. From the discussions that arose throughout the day, it became clear to me that we need greater awareness and understanding of how disorders can influence and predict each other, in order to aid in the diagnosis and treatment of such cases. I was impressed by the multidisciplinary capacity of CREMS and how they are advancing our knowledge of comorbidity and addressing some of these healthcare system inadequacies.

In moving forward with my own research into substance use and psychosis, the CREMS colloquium has enhanced my awareness of how important it is to translate research findings into clinical practice. As a new PhD student, it can be easy to miss the forest from the trees. The colloquium taught me that the implications of comorbidity research must extend beyond the academic world – the ultimate goal should be to aid in the prevention, diagnosis and treatment options available to clinicians who are working with these clients in real world settings, and to translate findings into useful and practical resources for the general public and mental health consumers.

I would like to express my gratitude and appreciation to the organisers for providing me with this opportunity to engage with many passionate and experienced researchers and clinicians from CREMS and benefit from their immense knowledge in the field.

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Tobacco: Health Effects of Smoking Factsheet

Part of a series of factsheets published in 2014, this factsheet provides up-to-date, evidence-based information for the public about the health effects of smoking tobacco.

Clinical Handbook of Co-existing Mental Health and Drug and Alcohol Problems

In this handbook, leading clinicians from the UK, USA and Australia provide practical descriptions of assessments and interventions for co-existing problems encountered in a primary care and clinical settings.

Climate Schools

Climate Schools provides health education courses which aim to empower students to gain knowledge about their health and wellbeing. This knowledge will assist them in making positive and informed choices.

Information Booklets on Comorbidity

These booklets have been written for people who use alcohol, tobacco or other drugs who would like to know more about the most common types of mental health conditions seen among this population, and to find out tips for keeping well.
It was a dark and stormy night. I was sitting in my car, in bumper to bumper traffic, still at least an hour away from home. My bottom was numb, my bladder was full and I was cranky. ‘What am I doing here??’ I asked myself (I may have shouted it). On the other side of Sydney, three other researchers were in similar states of enjoyment: one was still at her desk in Randwick, and two others were stuck in Parramatta. It was early 2012, and the four of us were trying to track down as many participants from the Australian Treatment Outcome Study (ATOS) as possible, the largest and longest study of treatment outcomes for heroin dependence to be conducted in Australia. In practice, this meant spending an almost equal split in time between the phone, the internet, and the car - either travelling to meet up with participants, or going out and about to look for them - from Woollomooloo to Tweed Heads and Katoomba, and most places in between.
I should have known I would find a career that suited my stubbornness – when I was 14, I had a huge bust up with my family while playing Trivial Pursuit when I insisted that ‘furry’ animal was pronounced to rhyme with curry (and definitely not blurry). Reflective of my general lack of direction, I enrolled in, and then dropped out of, a Bachelor of Arts at Macquarie University immediately after high school. For three years, I worked casual jobs, travelled and worked overseas, and trained as a massage therapist. I then enrolled in Criminology at UNSW as a ‘mature age’ student (at 20 years old), and completed my undergraduate and honours degrees, and laughed when my honours supervisor suggested I apply for a PhD scholarship. Incredibly, I was lucky enough to be awarded an Australian Postgraduate Award, and completed my PhD in Criminology in 2011, which focused on responses to volatile substance misuse in Central Australia.

Of course, as with most things, there were various snags along the way. But this is where my pigheadedness became an advantage – there was absolutely no way I was going to quit. Then miraculously, I was in the right place at the right time, and happened to know...
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Of course, as with most things, there were various snags along the way. But this is where my pigheadedness became an advantage – there was absolutely no way I was going to quit. Then miraculously, I was in the right place at the right time, and happened to know the right person who sent me an advertisement for a research position at NDARC. Working with A/Prof Katherine Mills, Prof Maree Teesson, A/Prof Frances Kay-Lambkin and Prof Amanda Baker, I not only developed five information resources for people with co-occurring mental health and substance use problems (>100,000 copies distributed across Australia, pictured above), but I began to develop research links that form the foundation of projects I work on today.

I was also incredibly lucky to be able to coordinate the NHMRC funded 11-year follow-up of ATOS participants. ATOS began in 2001, and is Australia’s longest and largest running study to examine the long-term patterns of heroin dependence and treatment. Joanne White, Sonja Memedovic, Philippa Ewer, Louise Mewton, Sarah Ellis and I were given the incredible challenge of following up 615 people with heroin dependence, who had not been contacted since 2005. When I came on the project in 2011, Prof Maree Teesson warned me, ‘we’ll be lucky to find 50%’. Ha! I thought. I know a challenge when I see one!! One year later, and I’m sitting in my car in the middle of a storm on my way back from Katoomba, Sonja and Jo are stuck in Parramatta and Pip is at her desk monitoring us all. What was I doing there?
As if I needed to ask. I was there for the pure buzz of research – the adrenaline kick I would get after finding a participant I had been in search of for 18 months, after completing an interview, after running an analysis. But what was it about these small steps that fed my fire? It was the challenge, but it was also knowing that the research I did contributed to a field that is so important. Being able to reframe the more unsavoury aspects of my personality so they became useful tools for achieving positive outcomes (i.e., stubborn = perseverant!) has helped me focus, driven my creativity, and ultimately provided me with a challenge that I love waking up to. And of course, always remembering the importance of being in the right place at the right time, and jumping on those opportunities when they come around, can never be underestimated! Since ATOS finished, I have been leading the revision of the Australian Government Department of Health funded national comorbidity guidelines, and will soon begin an Early Career Researcher Fellowship from the Society of Mental Health Research. I will use this Fellowship to conduct further analyses of the ATOS data to inform treatment responses. Still an early career researcher duckling, I am so grateful to be part of this incredibly vibrant and dynamic team and am looking forward to continuing to build a career in this important area.
Congratulations!

Dr Lexine Stapinski’s pioneering work in the prevention and treatment of anxiety and substance use disorders has been recognised at the 2015 TheMHS Awards.

Lexine took home the Early Career Research Award for Innovation for her work to enhance interventions that interrupt the cycle of anxiety and substance use.

Strategies that Lexine, her collaborators Dr Nicola Newton, A/Prof Andrew Baillie and Prof Maree Teesson, and the team at CREMS have pursued to achieve this innovation include:

- Developing and trialling an integrated cognitive behavioural treatment to simultaneously address social anxiety and alcohol use, and the interconnections between them.

The prize was awarded by the National Mental Health Commissioner, The Hon

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Prevention resources available on national government website

The Australian Government has released a website featuring drug information resources developed by the Prevention team at CREMS.

The resources include information sheets and booklets for students, parents and teachers. Their development was led by CREMS’ Dr Maree Teesson and A/Prof Leanne Hides spoke at AWS 2015 and their talks are now available for viewing on demand.

Prof Maree Teesson gave two presentations, ‘Substance use across the ages: Are we losing our young women?’ and ‘What has the Australian clinical research taught us about treating comorbidity?’ Both sessions are available to view by clicking on this link or the image above.

A/Prof Leanne Hides gave talk about ‘Improving the treatment of youth substance use and comorbidity’. This session is can be accessed by clicking on this link or the image below.

Nicola Newton in collaboration with Dr Lexine Stapinski and the National Drug Research Institute in Perth.

The information booklets provide audiences with evidence-based information on substance use, including related harms, and are one of a number of resources CREMS is developing for school communities.

View CREMS Australian Winter School presentations online

The Australian Winter School (AWS) is a national drug and alcohol conference presented by Lives Lived Well, one of Queensland’s leading non-government alcohol and other drug providers. Now in its 28th year, AWS aims to support health care professionals in developing skills and knowledge in responding to and treating alcohol and drug related issues, including mental health.

New Comorbidity Webinar now available on demand

Dr Cath Chapman’s July webinar, ‘Co-occurring mental health and substance use disorders: how do they affect young people’ is now available to view on demand through our comorbidity vimeo channel.

This webinar presents an update on research into co-occurring mental and substance use disorders among young people in Australia. It asks: how many young people experience co-occurring mental and substance use disorders? What is the impact? And what are the implications for research, prevention and treatment? It includes a discussion of some recent trends in drug and alcohol use among young Australians, changing gender patterns across the world, and will raise some questions for future directions in research and prevention of mental and substance use disorders.

Follow this link to view the webinar, or click the image above.
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- Development of the Positive Choices portal and distribution of drug prevention resources to secondary schools across Australia;
- Developing and trialling an integrated cognitive behavioural treatment to simultaneously address social anxiety and alcohol use, and the interconnections between them.

The prize was awarded by the National Mental Health Commissioner, The Hon Dr Kay Patterson, on Wednesday 26 August at the 2015 TheMHS Conference in Canberra. TheMHS Awards are organised each year by TheMHS Learning Network to recognise and encourage best practice, excellence and innovation in mental health service delivery. The Awards have been made annually since 1992.

Congratulations Lexine!

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UPCOMING CONFERENCES

7TH AUSTRALIAN RURAL AND REMOTE MENTAL HEALTH SYMPOSIUM 2015
CRESWICK, AUSTRALIA
26 OCTOBER

INTERNATIONAL SOCIETY FOR TRAUMATIC STRESS STUDIES 31ST ANNUAL MEETING
NEW ORLEANS, UNITED STATES
5-7 NOVEMBER

AUSTRALIAN SOCIETY FOR BIPOLAR AND DEPRESSIVE DISORDERS CONFERENCE
SYDNEY, AUSTRALIA
6-8 NOVEMBER

AUSTRALASIAN PROFESSIONAL SOCIETY ON ALCOHOL AND OTHER DRUGS CONFERENCE 2015
PERTH, AUSTRALIA
8-11 NOVEMBER


OUR PEOPLE

CHIEF INVESTIGATORS
- Prof Maree Teesson
- Prof Amanda Baker
- A/Prof Katherine Mills
- A/Prof Frances Kay-Lambkin
- Prof Paul Haber
- A/Prof Andrew Baillie
- Prof Helen Christensen
- Prof Max Birchwood
- Prof Bonnie Spring
- Prof Kathleen Brady

ASSOCIATE INVESTIGATORS
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- Mr Trevor Hazell
- Prof Robyn Richmond
- Dr Cath Chapman
- A/Prof Tim Slade
- Prof Brian Kelly
- Dr Brian Hitsman
- A/Prof Leanne Hides
- Dr Pete Kelly
- Ms Marion Downey
- Prof Michael Farrell
- Dr Glenys Dore

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- Ms Stephanie O’Donnell
- Ms Sandi Steep

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- Dr Kerry Inder
- Dr Sharlene Kaye
- Dr Nickie Newton
- Dr Joanne Ross
- Dr Wendy Swift

RESEARCH FELLOWS
- Dr Emma Barrett
- Dr Ali Beck
- Dr Erica Crome
- Dr Christina Marel
- Dr Lexine Stapinski
- Dr Matthew Sunderland

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- Dr Rosemary Kingston
- Dr Kirsten Morley
- Dr Louise Thornton

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- Ms Philippa Ewer
- Ms Jenny Geddes
- Ms Joanne Gilsenan
- Ms Sally Hunt
- Ms Julia Rosenfeld
- Dr Alyna Turner

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- Mr Brad Shaw
- Ms Beth Turner

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