PsyCheck

Responding to mental health issues
within alcohol and drug treatment

Program Introduction

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Background to the development of the *PsyCheck* Program

Concurrent mental health and alcohol and other drug (AOD) problems continue to pose a complex clinical and management issue for treatment services, despite increasing recognition of the high rates of these co-occurring or 'comorbid' conditions. Research indicates that people with concurrent mental health and alcohol and other drug problems are more likely to suffer lower levels of psychosocial functioning than individuals who do not have these co-occurring issues. These may include homelessness, family disruption, poorer social supports, and financial and legal issues. They are also at higher risk of harm to themselves and others (Bradley & Toohey, 1999; Brown et al., 1995).

A significant part of the challenge for AOD treatment services, in Australia and elsewhere, is the current focus of mental health resources towards the low prevalence disorders (such as schizophrenia) with little available for treating people who are not considered to have a "serious mental illness" (Hunter et al., 2005). As a result, people with comorbid depression or anxiety and alcohol or other drug use problems will frequently be managed within AOD treatment settings, without specialist mental health intervention.

Mirroring this situation, much of the research and the materials developed to treat and manage comorbid AOD use and mental health problems have focused on the low prevalence disorders and have been conducted within mental health services. Research and treatment materials targeting anxiety and depression among AOD treatment clients represent a significant deficit in the resources available for the management of comorbid conditions.

By far the greater proportion of mental health problems among AOD clients fall under the categories of mood and anxiety disorders, with relatively few presentations of the more 'serious' disorders. Affective disorders are most prevalent among clients of AOD services, occurring in more than 50 per cent of cases (Hall & Farrell, 1997), in contrast to rates of comorbid schizophrenia of around 3–7 per cent. Yet these more prevalent and potentially treatable forms of comorbidity remain relatively overlooked in the allocation of resources. This is despite the significant negative impact of affective disorders on the outcomes for people with AOD use problems.

A fundamental step in addressing this problem is to increase the skill and training of professionals in the AOD treatment services in the recognition and treatment of co-occurring affective symptoms among their AOD clients. In particular, Hall and Farrell (1997) recommend that staff in AOD service settings should focus particularly on anxiety and depressive conditions, and the detection and treatment of associated symptoms. The development of standardised screening and manualised

treatment packages, targeting comorbid anxiety and depression, is recommended for use in the AOD setting (Proudfoot et al., 2003). As there is a wide range of mental health experience among alcohol and other drug clinicians, these packages need to be easy to implement for new AOD workers, but comprehensive enough for experienced clinicians. There are few appropriate resources currently available, and very little research exists to suggest how best to implement these strategies within the existing AOD treatment system.

Evidence for comorbidity screening and intervention

Epidemiology of comorbidity

Comorbidity is a serious treatment issue for AOD clinicians. Up to one-third of clients with mental health conditions have an alcohol or other drug use problem (Regier et al., 1998; Teesson et al., 2001) and may be referred to AOD services. On the other hand, up to 80 per cent of clients in AOD treatment also have a co-occurring mental health problem (Burns & Teesson, 2002; Callaly et al., 2001; Darke & Ross, 1997; Degenhardt et al., 2001). Even greater numbers may have 'subclinical' symptoms of mental health problems, which may also result in significant distress and impact on relapse and recovery rates (Kay-Lambkin et al., 2004).

What is clear is that people with co-occurring problems have a poorer prognosis than those with a single problem. Co-occurring problems are more likely to become chronic and disabling, and result in greater use of health services (Teesson et al., 2000). Effective management of comorbidity is, therefore, critical to the cost-effectiveness of services as well as for the wellbeing of clients (Kavanagh et al., 2004).

Risk of self-harm among AOD clients

People with co-occurring problems are more likely to be at risk of harm to themselves and others (Wallace, Cutler & Haines, 1988). Alcohol and other drug use can impair judgement and increase the likelihood that people will act impulsively. Clinicians must always be aware of the potential for clients to harm themselves or others. Although self-harm and suicidality are quite distinct clinical phenomena, with different causes and intentions, for the purpose of this discussion they will be considered together in terms of the risk to the client's safety. There is a strong link between alcohol and other drug use and suicidality, particularly when mental health problems are added to the picture (McCloud et al., 2004). Assessment and management of suicidal ideation and self-harm are included in the *PsyCheck* Screening Tool and discussed further in the *PsyCheck* Screening Tool User's Guide.

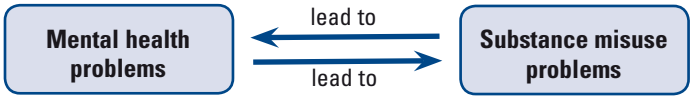
Models of comorbidity and implications for treatment

Comorbidity has implications for prevention, treatment and relapse prevention of both mental health and alcohol and other drug problems. Several hypotheses exist as to why comorbidity might occur. The primary consideration is whether mental health conditions cause AOD symptoms, or vice versa, in those with combined problems. A number of models have been proposed (Crome et al., 2000; Hall & Farrell, 1997; Kushner & Mueser, 1993).

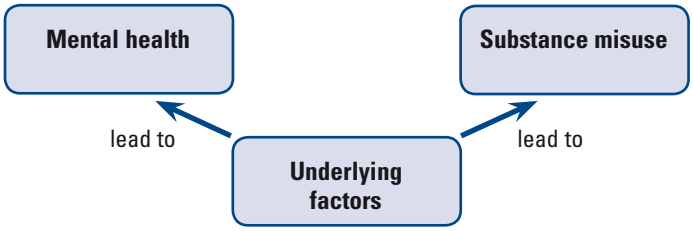
1. **The secondary substance use model** suggests that mental health problems lead to problematic substance use by mechanisms such as self-medication of distressing symptoms and increased vulnerability to stress.

2. **The secondary psychopathology model** suggests that problematic substance use triggers mental health problems, for example, cannabis-induced psychosis.

3. **The bidirectional model** suggests that multiple factors may serve to trigger and maintain mental health problems and substance misuse problems.



4. **The common-factor model** suggests that there are one or more underlying factors (such as genetic vulnerability, personality disorder, stressful events, neurobiological problems, etc) that lead to an increased risk of both conditions.



5. **The no relationship model** suggests that the two conditions are unrelated and co-occur by coincidence.

There is some limited evidence to suggest that determining which disorder occurred first may be important for treatment. For example, Brown and colleagues (1995) found that depressive symptoms remitted more rapidly among patients with primary alcohol dependence (model 2 above) than those with a primary depressive condition (model 1 above). However, in practice, it is difficult to establish which condition existed first or to determine which of the above models best characterises a person's symptom presentation (Kay-Lambkin et al., 2004). A person does not need to have a specific, diagnosed mental health disorder to gain benefit from an intervention to address mental health symptoms, regardless of the cause of those symptoms. Therefore, both disorders should be addressed.

The focus of comorbidity treatment should be based on the impairment and distress caused by the person's presentation, rather than on diagnostic subtype or classification (Schuckit et al., 1997). Using this model, three treatment approaches for co-occurring problems have been considered.

1. **Sequential treatment** offers the client treatment for both the mental health and AOD issues. The client is treated for one problem first (often detoxification and treatment for the AOD use) and then the second problem (often the mental health problem).
2. **Parallel treatment** occurs when both mental health and AOD use problems are treated simultaneously, with the client receiving treatment for their mental health symptoms from a different service or treatment provider than that which is providing treatment for their AOD use problem. In practice, an example would be when a client attends both a mental health service and an AOD treatment service at the same time, but the treatments are independent of one another.
3. **Integrated treatment** approaches offer clients simultaneous treatment for both their mental health and AOD use problems, provided by the same service or treatment provider. This approach allows the client to explore for themselves the relationship between their mental health and AOD use problems, and to examine the links to current distress and impairment from both mental health and AOD perspectives. Integrated treatment has received the most empirical support in the research literature. A report into the managed care of persons with dual diagnoses in the US recommended that:

   When mental illness and a substance use disorder coexist, each disorder should be considered as primary, and integrated dual primary treatment should be provided; the treatment for each disorder should be matched to the diagnosis and the stage of change (Minkoff, 2001).

Australians in treatment indicate a preference for integrated treatment given in a single treatment setting with which they are engaged. For example, a project reviewing psychosocial interventions for opiate pharmacotherapy clients (Lee et al., 2002) found a preference for a 'one stop shop' model of service provision. Integrated treatment was also nominated as the model most likely to encourage the client to access other psychosocial services, including mental health treatment.

Psychological interventions for common mental health problems

In 1998, the American Psychological Association published a list of empirically supported psychological treatments for mental health problems in adults (DeRubeis & Crits-Christoph, 1998). This large-scale review of the clinical trial literature indicated that the best psychotherapeutic treatments for anxiety problems were cognitive behavioural therapy (CBT) and applied relaxation, and the best treatments for depression were CBT and interpersonal therapy (IPT).

Cognitive behavioural therapy – the treatment of choice

Cognitive behavioural approaches have received widespread support in clinical tests and have been applied to a range of adult mental health problems, including comorbid AOD and mental health problems. For this reason, they form the basis of the *PsyCheck* Program.

Cognitive behavioural therapy (CBT) has been shown to be one of the most efficacious treatments for a range of anxiety disorders, including social phobia (Heimberg, 2002), panic disorder (Craske, Brown & Barlow, 1991), obsessive-compulsive disorder (Van Noppen et al., 1998) and generalised anxiety disorder (Ladouceur et al., 2000).

Integrated treatments have been developed for anxiety and alcohol and other drug use problems. Examples include the 'Seeking Safety' program (Feeney, 2003) and the 'Concurrent Treatment of PTSD and Cocaine Dependence' (Back et al., 2001) – both developed for PTSD and alcohol and other drug use.

In addition, CBT has the best-documented efficacy of the non-pharmacological approaches for the treatment of depression, with over 80 trials attesting to its success (American Journal of Psychiatry, 2000). Several studies have examined interventions for depression and AOD use problems. For example, Brown and colleagues (1997) randomly assigned 35 patients to either a standard hospital-based program for people with alcohol use disorders or the standard program plus eight individual sessions of CBT for depression. Their results showed that the patients who received CBT had greater improvements in mood symptoms, more days abstinent from drinking and significantly better alcohol use outcomes than their counterparts in the standard treatment.

CBT has been shown to have equivalent effectiveness to pharmacotherapy and is well accepted by people receiving this treatment (Baker & Wilson, 1985; Ellis & Smith, 2002). Furthermore, the benefits of CBT may extend beyond the treatment period, with research revealing that CBT can 'protect' clients against relapse or recurrence after treatment termination (Hollon, Haman & Broan, 2002).

The *PsyCheck* Program

PsyCheck was designed as an evidence-based treatment program. The screening tool has been scientifically validated, the intervention manual contains best practice techniques and there is a focus on the scientist-practitioner approach, including 'hypothesis testing' as part of the case formulation and an emphasis on reflective practice.

The *PsyCheck* Program was designed to draw these elements into a single package that can be easily incorporated into routine AOD practice. CBT is a therapy based on principles used in both AOD and mental health intervention and is thus suitable for an integrated approach to comorbidity treatment.

The *PsyCheck* intervention utilises four core cognitive techniques:

- Educating the client about the cognitive model and the common unhelpful thinking patterns.
- Educating the client about how to identify their unhelpful patterns of thinking.
- Modifying these negative or distorted thoughts by a process called cognitive restructuring.
- Developing strategies to prevent relapse and maintain healthier patterns of thinking.

The intervention is also presented as a manualised but flexible package, so that AOD clinicians with a broad range of experience and backgrounds are able to use it. It outlines the steps of the screening and intervention in detail for clinicians who are new to mental health intervention but is presented so that more experienced clinicians can use techniques and strategies as appropriate in their routine practice.

The *PsyCheck* Program has been evaluated in three phases. The first was the development and validation of a screening tool, funded by Queensland Health, and a manualised intervention, funded by the Illicit Drugs Branch, Australian Government Department of Health and Ageing (DoHA) through the National Comorbidity Initiative. Both are contained in this kit. The second was an implementation trial of mental health screening and intervention within a range of Australian AOD treatment services, funded by DoHA through the National Comorbidity Initiative. Results of the screening validation are outlined in the *PsyCheck* Screening Tool User's Guide and the outcomes of the implementation trial are outlined below. The third is the dissemination of the *PsyCheck* Program throughout Australia, also funded by DoHA through the National Comorbidity Initiative.

PsyCheck Phase I: Screening and intervention development

The *PsyCheck* Screening Tool was constructed from the Self Reporting Questionnaire (SRQ) (Beusenberg & Orley, 1994), psychosis probes, suicide assessment and mental health history questions. A small study was undertaken to examine the psychometric properties of the screen.

Participants were 120 clients recently engaged (in the last three months) in treatment for any AOD use problem and stabilised in treatment before entering the study. Those with serious medical issues, active suicidality or acute psychosis were excluded. There were 89 men (76.1%). The mean age was 30.7 years (range = 18–59 years).

The SRQ was compared to the commonly used General Health Questionnaire (GHQ) (Goldberg & Williams, 1988) and both were validated against the Composite International Diagnostic Interview-Auto (CIDI-Auto) (WHO, 1997). The GHQ was amended with dichotomous scoring for comparison with the SRQ. The SRQ is a dichotomous 20-item screening tool designed by the World Health Organization (WHO) to assess general mental health. An amended version was developed, with permission from the WHO, with a secondary question:

> *Look back over the questions you have ticked. For every one you answered **'Yes'**, please put a tick in the circle if you had that problem at a time when you were **NOT** using alcohol or other drugs.*

Receiver Operator Characteristic (ROC) curves were used to determine whether the screening tool showed good specificity (true positives) and sensitivity (true negatives). Both the GHQ and the SRQ showed good predictive ability, but the SRQ (modified) was superior. A cut-off of 5 was determined as having the best clinical utility. In other analyses, the psychosis probes showed a good correlation with the CIDI-auto psychosis diagnoses. It is recommended that intervention and/or further specialist assessment is undertaken post-screening if:

- the client meets the SRQ cut-off of 5 or more
- there is a moderate to high risk of suicide or self-harm
- there is a positive response to the mental health history questions, or
- there is other evidence of previous mental health history

Prior to Phase II a manual was developed drawing together elements of best practice intervention from AOD and mental health fields. This was evaluated during Phase II.

PsyCheck Phase II: Implementation

Alcohol and drug clinicians at five sites across Victoria, NSW and Queensland were invited to participate in the *PsyCheck* Implementation Project. Between them the sites covered large, medium and small services, pharmacotherapy and counselling services, youth and adult clinicians, and regional, outer metropolitan and metropolitan services.

The participants were trained in the use of the *PsyCheck* Screening Tool User's Guide and intervention, and provided with weekly clinical supervision and phone/email consultation as part of the project. Agency management was also engaged in the project to tailor the implementation to each site. An evaluation was undertaken that examined rates of detection, use of the *PsyCheck* resources and the capacity of the alcohol and drug clinicians to undertake screening and brief intervention for mental health disorders among their clients.

The results showed that the *PsyCheck* Program was useful, clinically intuitive and had good face validity. Clinicians increased screening and intervention rates as a result of the project and reported that they were thinking more about treatment and had better skills, better understanding of cognitive behavioural therapy (CBT) and improved confidence as a result of the project.

PsyCheck Phase III: Dissemination

The third phase of the *PsyCheck* Project is dissemination. We have adopted a workforce development approach. Two key findings of the *PsyCheck* implementation that impact on dissemination were that:

- endorsement by management was important in engaging and supporting staff in the program
- training and clinical supervision were an important component of the implementation (with all site managers reporting that it would be necessary in future implementations)

Although in-service professional development courses have been the traditional cornerstone of workplace initiatives, it is now recognised that education and training, in isolation from other strategies, are generally ineffective (Bero et al., 1998). Much of the literature indicates that this way of upskilling clinicians has a disappointing effect on professional practice (Ashendon et al., 1997; Davis et al., 1999).

To create an environment for organisational practice change, support from key staff is vital (Liddle et al., 2002). These include the clinical staff that the change affects as well as senior staff and managers who may oversee the change. With an increased ownership and commitment to change comes an increased enthusiasm and sense of momentum that can assist with the change process. Clinicians often find it difficult to move away from their 'preferred' counselling style to one they are less familiar or comfortable with (Roman, 2002), even when they are interested in taking up these new interventions. Support from management in the change process and clinical support to change practice is an important addition to the usual isolated training or professional development.

Managers and task supervisors develop and assist clinicians to implement plans, policies and procedures, while clinical supervisors assist clinicians to interpret these procedures for their practice. The clinical supervisor's role is also to monitor the quality of professional services and to enhance the professional functioning of the clinicians they supervise (Bernard & Goodyear, 2004).

The *PsyCheck* Program is designed to encompass three levels of training:

- **Managers** – managers are assisted to review policies and procedures and to implement changes to close practice gaps.
- **Supervisors** – senior staff are assisted in developing or refining clinical supervision skills, especially in relation to Cognitive behavioural therapy and mental health interventions.
- **Clinicians** – clinicians are trained in how to use the screening tool and in the components of the intervention.

A 'toolkit' of resources has been developed to support the implementation of the *PsyCheck* Screening Tool and Intervention in AOD treatment settings. This includes a comprehensive set of guidelines to assist managers to implement and embed mental health screening within their AOD treatment settings. There are also training and supervision guidelines, to assist supervisors to support this work, and clinical practice guidelines for clinicians.

Together they make up the *PsyCheck* Program, which is specifically designed to sustainably build the capacity of AOD treatment services to undertake mental health intervention. The *PsyCheck* resources include:

- The *PsyCheck* Screening Tool User's Guide which includes the *PsyCheck* Screening Tool (for clinicians)
- The *PsyCheck* Clinical Treatment Guidelines (for clinicians)
- The *PsyCheck* Training and Supervision Guidelines (for supervisors and trainers)
- *PsyCheck* Program Implementation Guidelines (for managers and senior staff)

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