Building Comorbidity Capacity in AOD Services: What Works?

PCC
PATHWAYS TO COMORBIDITY CARE
PROJECT

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Pathways to Comorbidity Care

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- A/Prof Kirsten Morley (NSW Health Translational Research Fellowship)
- Ms Eva Louie (APA)
- Prof Paul Haber (MRFF/NHMRC Practitioner Fellowship)

LHD contributions:

- SLHD, SWSLHD, CCLHD, HNELHD, MNCLHD

Pathways to Comorbidity Care

Researchers:

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Clinicians at:

Sydney Local Health District, South West Sydney Local Health District, Central Coast Local Health District, Hunter New England Local Health District, Mid North Coast Local Health District

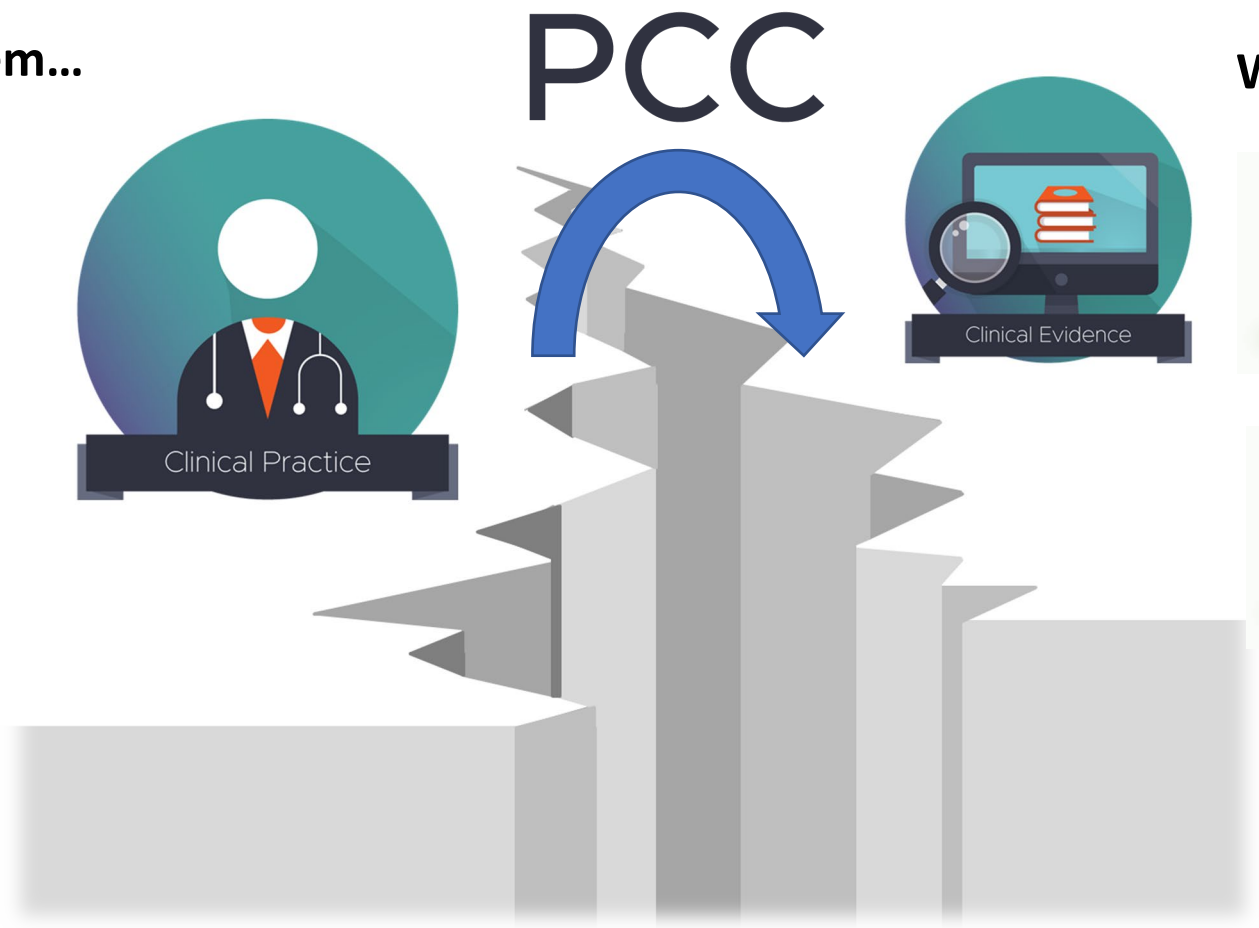
Comorbidity: Clinical Evidence to Practice Gap

We know about the problem…

Very Common:
90% comorbid mental health problems

Poor Outcomes:
- Greater symptom severity
- Less quality of life
- Reliance on treatment

Systemic Issues:
Segregated services
Sustainability of initiatives



We have good solutions…

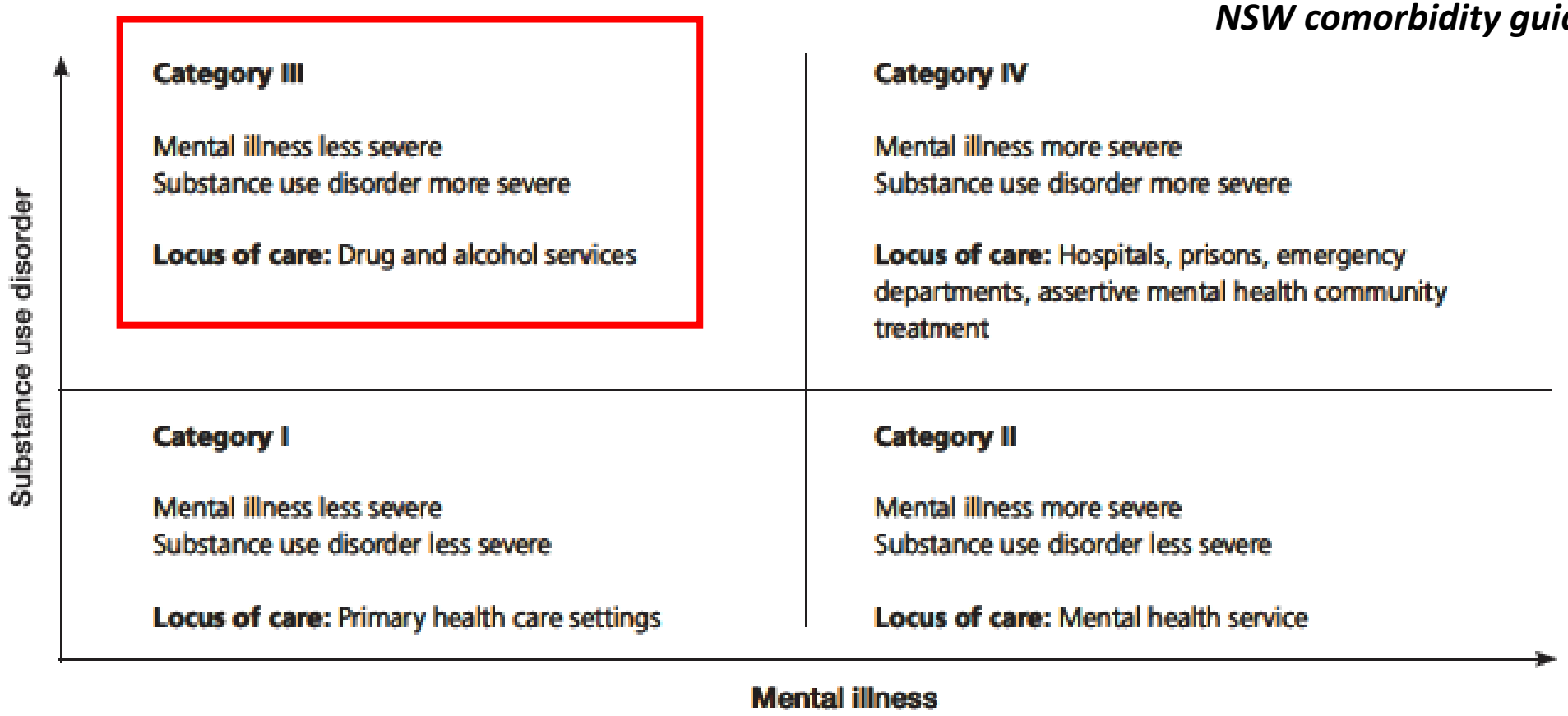
Guidelines:
National Comorbidity Guidelines

Evidence-based approaches:
Integrated care

- Identify and treat within one service
- Unsegregated treatment

How do we approach management?

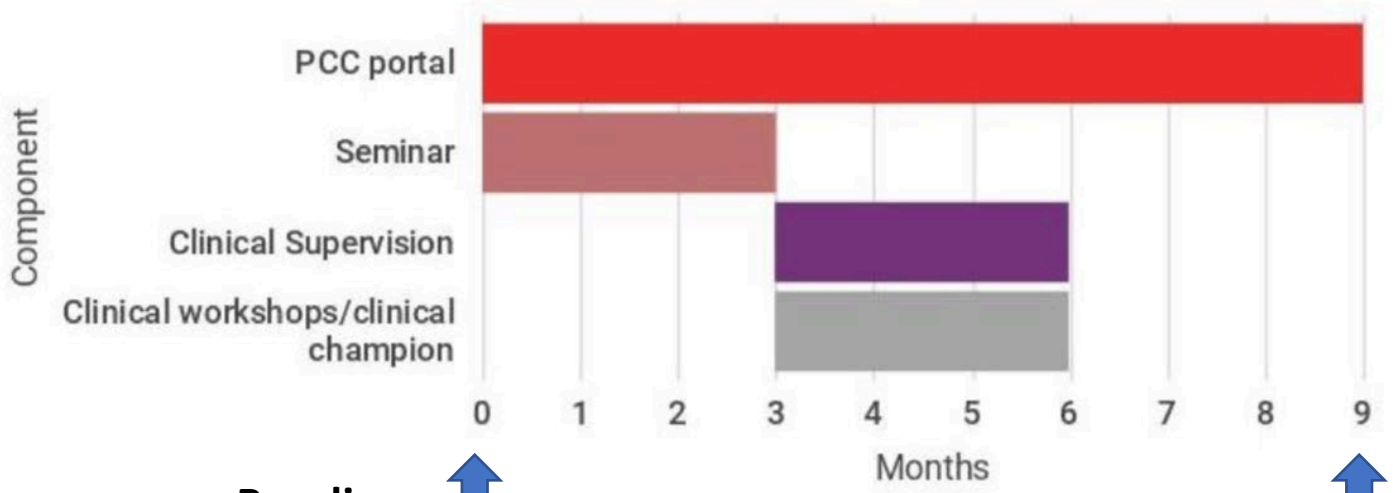
NSW comorbidity guidelines 2009



Adapted from Center for Substance Abuse Treatment. *Substance Abuse Treatment for Persons With Co-Occurring Disorders. Treatment Improvement Protocol* (TIP) Series 42. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

PCC Training Package

Figure 1. PCC multimodal training package across time (active sites)



Baseline (Active and Control):
Questionnaire
File audit

Follow-up (Active and Control):
Questionnaires
File audit
Interview

Research Design

Before-and-after study PCC intervention versus control on uptake of the integrated care approach.

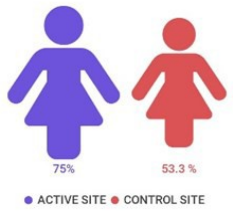
	Active	Control
Metro	RPAH (SLHD) Hospital outpatient based	Liverpool (SWSLHD) Hospital outpatient based
Outer Metro/Inner Regional	Gosford (CCLHD) Community Health Service	Wyong (CCLHD) Community Health Service
Regional	Port Macquarie (MNCLHD) Community Health Service	Taree (HNELHD) Community Health Service

Baseline Findings

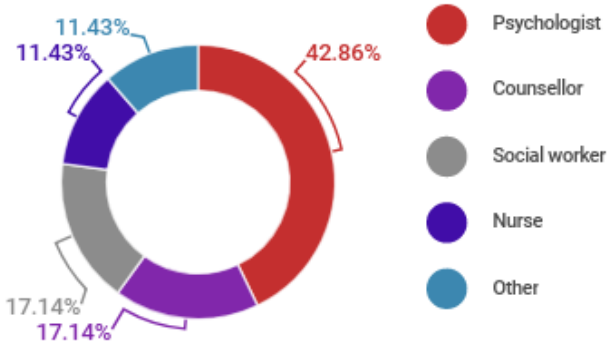
Baseline demographics (PCC and controls)

N° Clinicians (n=35)

Gender distribution



Occupation



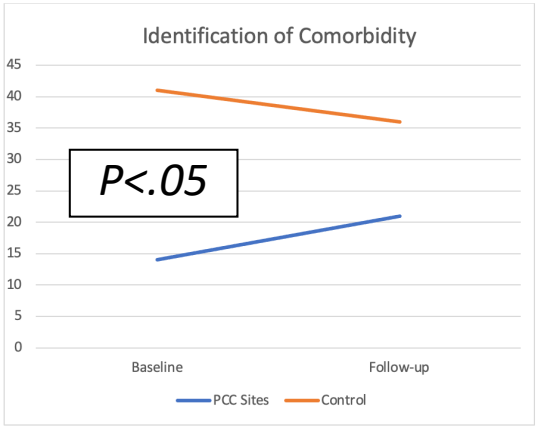
Baseline needs assessment (PCC and controls)

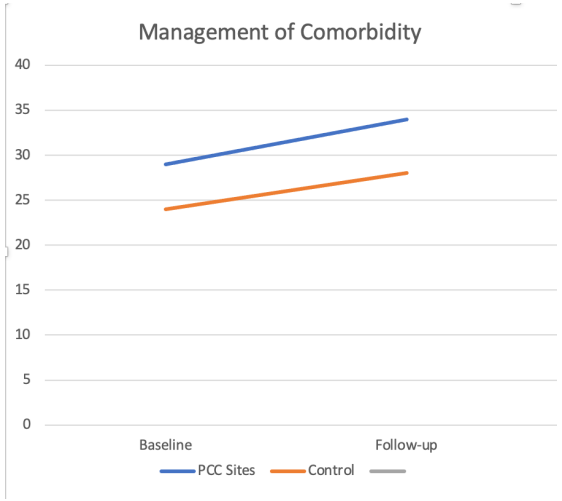
Measure	Result
Self-efficacy in Comorbidity Counselling	Moderate
Comorbidity Knowledge	Moderate
Evidence-based Practice Attitudes	Moderate
Attitudes Towards Therapist Manuals	Low-Moderate
Organizational Readiness for Change	Moderate
Dual-diagnosis Capability	Addiction Only – Dual Diagnosis Capable
Non-evidence Based Therapies Used	29% of clinicians

Clinical Outcomes

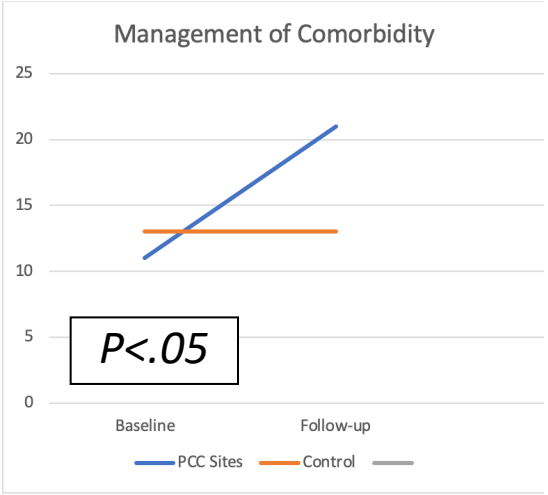
Improvements in Comorbidity Practice (CP)

Percentage of total *files* demonstrating CP





Percentage of total clinicians demonstrating CP in ≥ 50% of files



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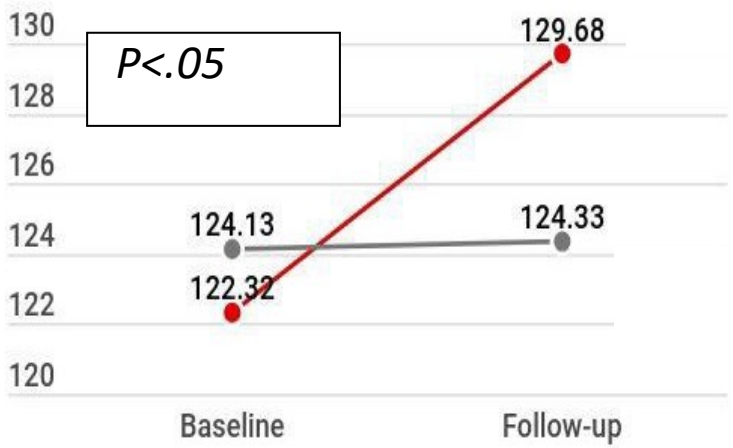
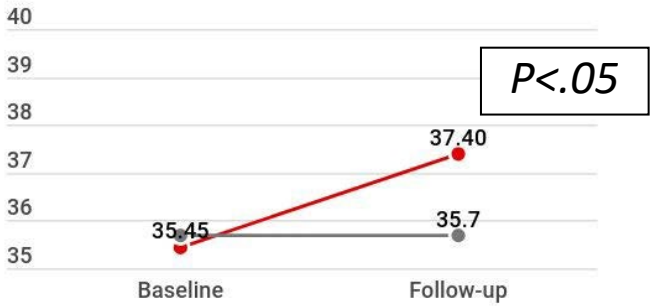
Clinician Outcomes

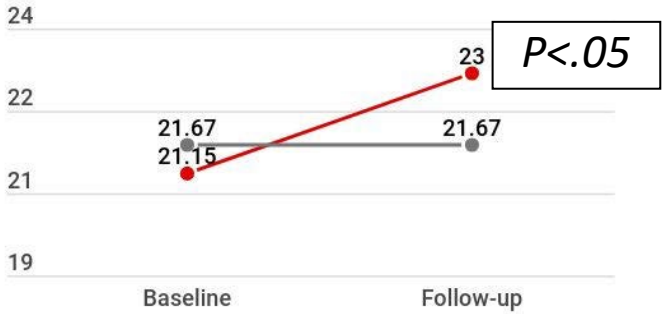
Increased Self-efficacy in counselling



Self-efficacy: Assessment, treatment planning and referral skills



Self-efficacy: Co-occurring disorders skills



= PCC sites

= Control sites

Evaluation of the PCC Package

Overall PCC package

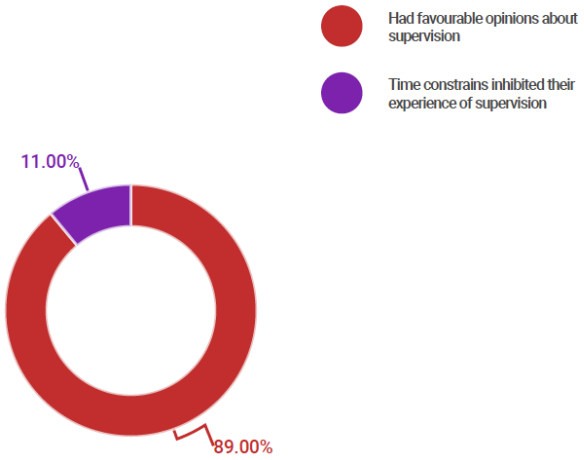
Helpful aspects of the PCC package rated by clinicians:

Evaluation of the PCC Package

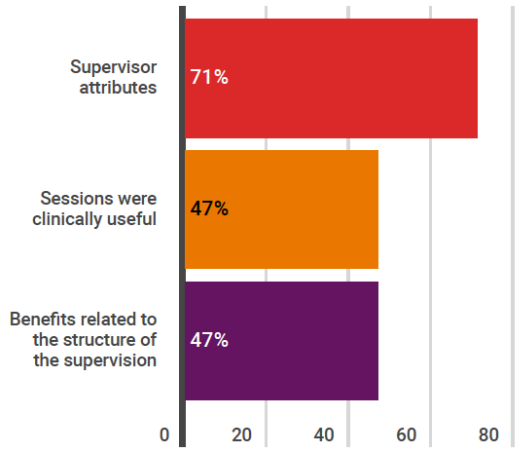
Facilitators of the PCC Package

Clinical supervision

Thoughts about supervision:



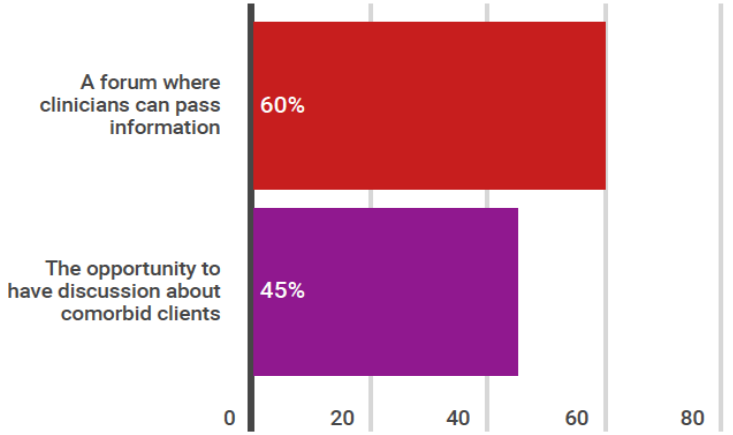
Favourable thoughts were based on:



Clinical champion workshops

100% of clinicians felt that the clinical champion appointed within their organisation was well equipped to perform his/her role

Advantages of clinical champion workshops:



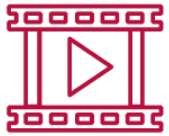
82% of clinicians thought that having a clinical champion was a good idea

Evaluation of the PCC Package

Room for improvement in PCC package…

Seminar day

Clinicians' endorsement of presenters' expertise for each video (as part of seminar day):



75% Of clinicians reported the quality of videos as 'good' or 'very good'

50% of clinicians suggested that future seminar days should have presenters in person

PCC portal

44% of the sample reported that they downloaded resources from the portal

55% of clinicians had a positive comment to make about the PCC portal

50% of the sample reported no issues when accessing the portal

Clinicians reported that:

'the site looked good'

'had some good resources'

'was easy to navigate and was very comprehensive'

Clinical Champions in the implementation of evidence based practise for comorbid D&A and mental health

What is a Clinical Champion ?

A clinical champion is defined as ***an individual within an organization who has a responsibility to advocate for change, motivate others and use their position and expert knowledge to facilitate the adoption of a particular innovation*** (Cranley et al., 2017).

We know that passive approaches to encouraging use of evidence based practise, like websites and treatment manuals, alone do not work.

What we know about Clinical Champions :

We know from a systematic review on Clinical Champions in comorbid substance use and mental health (Wood et al., 2020) that they help with:

- faster initiation of new practises
- providing education and training in new treatments
- persistence in the use of novel therapies/practises
- enhance staff engagement and motivation
- help overcoming systems barriers

What makes a good Clinical Champion?

"*Personal interest, commitment, confidence, passion & dedication*"

Rycroft-Malone et al 2019

Able to increase clinician self-efficacy for managing comorbidity
Able to increase rates of implementation
Need to have good communications skills
Happy to be a mentor
Good personal qualities (personable, respected, credible)

Clinical Champions are usually:

- Senior clinicians, some managers/team leaders, some physicians, mostly psychologists, social workers
- Selected by management for the role usually due to experience in delivering the EBP
- Not formally trained in being a clinical champion
- Role & responsibility : no one universal job description
- Only half studies have clear job description – “assist with implementation plan, formal and informal support for staff”

Clinical Champions

In the Pathways to Comorbidity Care Project :

- Clinical champions were rated by clinicians as important
- Weekly workshops with Clinical Champion chairing and guiding clinicians
- Workshops run by champions provided an opportunity to discuss complex comorbid cases & share information on comorbidity management
- Incorporating National Comorbidity Guidelines in workshops helped

Workshop Case Presentation Proforma

- **Client Name (de- identified):**
- **Presenting Problem:** *referral source, reason for referral.*
- **Demographics:** *gender, age, relationship status, educational attainment, employment, financial issues, legal issues, ethnicity, social support network, living arrangement.*
- **Drug & Alcohol Use History:**
- **Mental Health History:** *admissions (voluntary & involuntary), diagnoses, previous treatments, suicidality, aggression/violence. Include impact of mental health symptoms on D&A use and vice versa. Stage of change for changing mental health problem. Level of insight into mental health problems.*
- **Medical History:**
- **Forensic History:**
- **Treatment Summary:** *brief outline of treatment to date including client's treatment goals.*
- **Issues:** *treatment issues/ difficulties / challenges (e.g. treatment noncompliance, resistance to change, differential diagnosis), ethical issues, legal issues, safety issues, client risk factors which may influence treatment outcome (e.g. unstable accommodation, poor social support).*
- **Recommendations & Action Plan (completed by clinical champion and forwarded to presenter):**

_____
_____
_____
_____
_____

Clinical Supervision in the implementation of evidence based practise for comorbid D&A and mental health

Clinical Supervision is

- The most widely used technique for assisting clinicians in implementing EBP and maintaining quality care (Martino et al., 2016)
- Distinct from clinical case review or performance review
- Clinical supervision can be defined as "*a social influence process that occurs over time, in which the supervisor participates with supervisees to ensure quality clinical care*" (Centre for Substance Abuse Treatment, The Technical Assistance Publication (TAP) 21-A, 2007, p. 3).
- Effective components of clinical supervision : multimodal teaching methods, an agenda, providing feedback to clinicians, and employing a collaborative approach

Clinical Supervision

- Research suggests that supervision is one implementation tool which can be used post-training to assist in increasing the chances of any EBP being put into clinical practise in the mental health field (e.g., Bambling et al., 2006; Bradshaw, Butterworth, & Mairs, 2007; Milne et al., 2008; Watkins, 2011)
- Supervision plays an important role in improving counsellor's self-efficacy for managing comorbidity and implementing CBT skills (e.g., McHugh & Barlow, 2010; Wilkerson & Ramirez Basco, 2014), with high self-efficacy predictive of higher fidelity in AOD counsellors (Campbell et al., 2013).

Supervision in the PCC Project

- A CBT model of clinical supervision was used
- Clinicians were encouraged to use integrated EBP based on National Comorbidity Guidelines
- Clinicians need to be able to identify symptoms of common comorbid mental health disorders, be able to routinely screen all clients for comorbid mental health conditions, and provide ongoing management of these conditions from an AOD setting using a non-judgemental collaborative approach using up-to-date EBP.

What we did

- 3 one-hour long telephone supervision sessions approximately one month apart over a three-month period.
- Supervision for NSW public health staff working as AOD counsellors is commonly of one hour's duration on a monthly basis (NSW Health Drug and Alcohol Clinical Supervision Guidelines, 2006).
- Clinicians were provided with written information on their roles and responsibilities during supervision as well as the supervisor's role, the confidential nature of supervision, when confidentiality would need to be breached (e.g., evidence of serious misconduct), and how records of supervision would be kept.

Case Presentation

- Total of 3 different comorbid cases currently seeing or in the past
- Case with *any* mental health condition or suspected condition
- Prior to each supervision session forward the client's de-identified counselling electronic health records and complete a one-page proforma outlining certain clinical issues for each client.
- The supervisor provided written feedback to participants immediately following each supervision session by email . Feedback linked to recommendations made in the National Comorbidity Guidelines.

Supervision Case Presentation Proforma

- **Client Name (de- identified):**
- **Presenting Problem:** *referral source, reason for referral.*
- **Demographics:** *gender, age, relationship status, educational attainment, employment, financial issues, legal issues, ethnicity, social support network, living arrangement.*
- **Drug & Alcohol Use History:**
- **Mental Health History:** *admissions (voluntary & involuntary), diagnoses, previous treatments, suicidality, aggression/violence. Include impact of mental health symptoms on D&A use and vice versa. Stage of change for changing mental health problem. Level of insight into mental health problems.*
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- **Issues:** *treatment issues/ difficulties / challenges (e.g. treatment noncompliance, resistance to change, differential diagnosis), ethical issues, legal issues, safety issues, client risk factors which may influence treatment outcome (e.g. unstable accommodation, poor social support).*
- **Recommendations & Action Plan (completed by supervisor):**

_____
_____
_____

Supervision resulted in

Improved clinician self-efficacy :

- Mean self-efficacy scores on the ACSES improved significantly following supervision (M = 129.68, SD = 17.13) compared to prior to commencing supervision for the active site (M = 122.60, SD = 19.57) (t (13 = -2.442, p = 0.025); a small to medium effect size was found (d = 0.38).
- For controls, there was no significant change in ACSES self-efficacy scores over time (t (13= 0.041, p = 0.9676).

Clinical Note Auditing

- Evidence of adaptation of EBP and fidelity was obtained from independently conducted clinical note audits
- Large variability in content and quantity of clinical notes was observed
- Improvement in note keeping quality scores following supervision compared to prior to supervision ($\chi 2$ (20, N = 20) = 40.697, p = 0.04).
- Increased rates of reported use of *mental health screening and assessment tools* as well as *treatment strategies* in participants' clinical notes. Notes of the control group for the PCC Program (who did not receive supervision) also were examined for comparison; no significant changes in clinical note auditing scores was noted over time on any of the audit item scores ($\chi 2$ (19, N = 9) = 13.208, p = 0.153).

Clinical Supervision

Responding to mental illness in drug and alcohol services

Scoring Criteria for Clinical Note Review

General scoring criterion: If response is to give a label, give 1 point per action, i.e. total of 8. Only give extra points for an action where specific detail is given.

Component of clinical file responses	0 points (no mention or inadequate response)	1 point (superficial) only one assessment	2 points (specific details) 2 or more
Ongoing mental health assessment	No mention of any assessment to the patient	Mentions any one of the following: • Assessment current mental health symptoms (brief attempt)	Mentions more than one of the following: • Give more details such specific disorder and symptoms.
Mentioning mental health, mood or psychiatric condition			
Mental health screening*	No mention of any screening performed	Mentions any of the following: • Use of scale or measure to screen for specific mental health problem • General Mental Health Screen	• Provide specific details of the screening • History of mental health symptoms
Treatment strategy/ management	No mention of any strategy on how to manage both AOD and mental illness	Mention to strategy mentioning a component of <u>any</u> evidence-based treatment	Give examples and identify the therapy used describe what was done - <u>CBT, MI</u> etc.

Clinical Note Templates for Comorbidity

- SLHD Drug Health developed a template after PCC to encourage ongoing *identification and management* of comorbidity
- Embedded “comorbidity & management” in clinical notes

Barriers preventing successful implementation of EBP through supervision

Organisational factors :

- a lack of supervisors trained in EBP,
- a tendency for services to use line managers as supervisors,
- lack of finances,
- time-poor clinicians

Clinician factors :

- clinician's negative attitudes towards supervision and/or EBP,
- fear of change,
- low confidence,
- use of an opposing model of practise/ non-EBP