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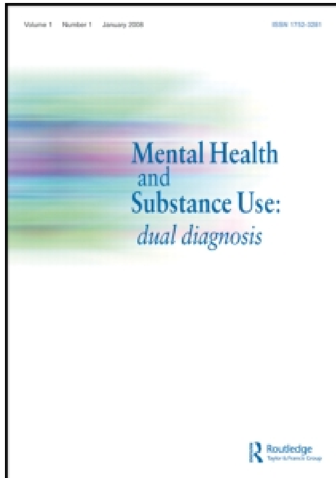

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Changes in attitude to, and confidence in, working with comorbidity after training in screening and brief intervention

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Background: Attitude to, and confidence in, working with comorbidity is an important feature of effective engagement when working with clients with mental health and substance use issues. Substance use treatment clinicians continue to voice concerns about their own skill and abilities to work with this complex client group. PsyCheck is a package designed to support drug and alcohol workers to implement screening and brief intervention for common mental health problems.
Aim: This study used a whole workforce approach to training using the PsyCheck package, and examined changes in clinicians' attitude, skill and confidence in working with comorbidity post training.
Method: A pre-post test evaluation design was used. Thirteen national alcohol and drug services were offered a two day training program in the PsyCheck package. Clinicians' attitude to comorbidity was measured by the Comorbidity Problems Perceptions Questionnaire. Semi-structured interviews were also conducted.
Results: Results indicate that involvement in the training program was, overall, a positive experience for clinicians. Attitude to, and confidence in, working with comorbidity appeared to improve following exposure to the training.
Conclusions: Although there are limitations in the design, training appears to have a positive impact on clinicians self reported attitudes and confidence in dealing with comorbidity issues.

Keywords: comorbidity; mental health; PsyCheck; screening; staff attitudes; training

Introduction

Among alcohol and other drug (AOD) treatment clients, comorbidity of mental health problems is common and generally overrepresented (Andrews, Hall, Teesson, & Henderson, 1999) and the types of mental health problems are different to those usually seen in public mental health services (Kavanagh et al., 2000). As a result, relatively few AOD clients with mental health problems are suitable for referral to mental health services, while most mental health service clients with substance use issues are suitable for AOD treatment (Kavanagh et al., 2000). As a result, clinicians in AOD treatment services require skills in both AOD and mental health screening, assessment and treatment, particularly relating to the commonly presenting issues of anxiety and depression (Farrell & Marshall, 2007).

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The attitude and confidence of clinicians is an important feature of effective engagement when working with substance users and comorbid clients (Adams, 2008; Albery et al., 2003; Munro, Watson, & McFadyen, 2007; Richmond & Foster, 2003). As a clinician's negative attitude to drug use increases, positive attitude towards clients decreases (Ford, Bammer, & Becker, 2008) and negative or judgemental attitudes of clinicians' are a specific barrier to optimal treatment for clients with comorbidity (Todd, Sellman, & Robertson, 2002). A recent review concluded that mental health nurses' and other health workers' attitudes to and perceptions of comorbidity were mixed, but indicated an overall negative perception of service provision and training (Adams, 2008).

Most research in this area has focused on primary health and mental health services and nursing is the main discipline represented in study samples (Adams, 2008). Ford, Bammer and Becker (2008) note that effectively increasing positive attitude of nurses towards substance using clients includes role support in combination with workplace illicit drug education. A randomised controlled trial of the impact of comorbidity focused training on mental health nurses' therapeutic attitudes and knowledge found that training was very effective in improving therapeutic attitudes to working with comorbid clients (Munro et al., 2007).

Although there is a recognised need, there is little reporting of attitudes, confidence and effect of training for workers in AOD treatment settings and the evaluation of training courses targeted at improving the capacity of AOD workers has been minimal at best. The present study builds on the literature by examining attitudes and confidence to comorbidity in AOD workers.

The dissemination and evaluation of a national comorbidity capacity building initiative using the manualised screening and intervention package, known as PsyCheck (Lee et al., 2007), was undertaken between November 2006 and December 2007. An accompanying training guide was developed and a whole workforce approach to capacity building, with training for clinicians, supervisors and managers, was undertaken.

This paper presents the findings from one component of the impact evaluation, which focused on changes in clinicians' attitudes toward and confidence in comorbidity.

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Methods

Participants

A total of 195 staff, across 13 sites, participated in the training, including clinicians ($n = 147$) and supervisors/managers ($n = 48$). Fifty-five clinicians completed semi-structured interviews post training. Twenty-nine clinicians completed both the baseline and follow-up attitudes questionnaire.

Of the 29 clinicians that completed both baseline and follow-up attitudes questionnaires, professional backgrounds included psychology ($n = 3$), social work ($n = 6$), nursing ($n = 11$), and AOD or other certified training ($n = 6$) and no qualification provided ($n = 3$).

Measures

Comorbidity problems perception questionnaire (CMPPQ; Munro et al., 2007)

Therapeutic attitudes about comorbidity were measured using the Comorbidity Problems Perception Questionnaire. The CMPPQ is a measure of clinicians'

'therapeutic attitude' regarding comorbidity. The CMPPQ is self-completed, containing 33 statements with response options ranging from 'strongly agree' (1) to 'strongly disagree' (7). The items are divided into statements regarding knowledge, such as 'I feel I have a working knowledge of comorbidity problems', and 'I feel I know enough about the causes of comorbidity to carry out my role when working with comorbidity clients'; in addition to statements about attitudes, such as 'I am interested in the nature of comorbidity problems and the responses that can be made to them', and 'I want to work with comorbidity clients'. When collated, all 33 items provide a mean therapeutic attitude score. A low total score represents a positive therapeutic attitude and a high total score represents a more negative therapeutic attitude.

Semi-structured interview

In-depth semi-structured interviews were undertaken to discuss the training and implementation process. Interviews were conducted pre- and post-training. As part of the post-training interview, clinicians also completed a short, self-completed questionnaire (not validated) on their experience of using PsyCheck. This included questions such as 'PsyCheck has improved my skills and knowledge in dealing with comorbidity clients', 'I have noticed improvement in my confidence in dealing with comorbidity clients', and 'I have noticed improvement in my confidence in dealing with comorbidity clients'. The questionnaire contained 25 statements on the use and implementation of PsyCheck, and uses a 5-point scale.

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Training and treatment manuals

The PsyCheck screening and intervention package was developed for alcohol and other drug clinicians to support their work with drug treatment clients with common mental health symptoms. It includes a modified version of the World Health Organisation-validated screening tool known as the Self-Reporting Questionnaire (SRQ; Beusenberg & Orley, 1994; Lee & Jenner, 2010) and an articulated manualised intervention from 4 to 12 sessions (Lee et al., 2007).

Two supporting guides have been developed to assist dissemination: an implementation guide for service managers, and a supervision and training guide for supervisors or senior clinicians to support the implementation of PsyCheck within a service (Lee et al., 2007). The training manuals are available online (www.psycheck.org.au), so contents have only been briefly described here.

Procedure

Training was offered using a 'whole workforce' approach; that is, the whole service including managers, clinical supervisors and clinicians participated in the training within their workplace. The PsyCheck supervision and training guide was used. All the guides were available online after the training along with 12 months post-training support via telephone or online (Turning Point Alcohol & Drug Centre, 2009).

Clinician training consisted of two days covering screening, assessment, case formulation and the PsyCheck four-session intervention and extension material. Clinical supervisors were identified by the services and received one day of training on key areas for supervision in comorbidity centred around the PsyCheck clinicians

training. In addition, they attended the clinicians' training if they were unfamiliar with the PsyCheck package. Managers received a half-day training concentrating on implementation principles that support capacity change, such as policies and procedures. Whilst the training was a one-off event at each of the services, the development of an online portal was managed for the duration to assist with queries regarding the use of the PsyCheck tool and implementation. Researchers visited each site one week prior to, and six months after, training, when clinicians completed the CMPPQ and a semi-structured interview.

Results

Descriptive analysis was undertaken and a Wilcoxon Signed Rank Test was used when appropriate. The level of statistical significance for the study was set at $p < 0.05$ and the SPSS software package was used.

Attitude to comorbidity

Each of the 13 sites were rated by the researchers during the follow-up site visit based on structured interview data. The structured interviews provided an opportunity to gauge the extent to which each site had implemented PsyCheck based on their use of the PsyCheck Assessment tool, the SRQ, the intervention and worksheets. The sites were then allocated to a group based on the level of implementation.

- Group 1: Extensive implementation – evidence of implementation across the site with the PsyCheck package including use of the screening tool, SRQ, intervention and the worksheets.
- Group 2: Partial implementation – evidence of implementation amongst individual workers using the PsyCheck package including use of the screening tool, SRQ, intervention and the worksheets.
- Group 3: Minimal implementation – no evidence of implementation beyond limited use of SRQ by some staff.

The mean attitude to comorbidity score at each data collection point is shown in Table 1. The higher the score, the more negative the attitude. A Wilcoxon Signed Rank Test indicated a statistically significant reduction in negative attitude scores 6 months after participation in PsyCheck training ($z = -2.89$, $p < .005$), with a medium to large effect size ($R = .38$).There was an overall improvement in mean

Table 1. Mean CMPPQ attitude scores by implementation group.

	Pre training Mean (SD)* ($n = 29$)	6 months follow-up Mean (SD)* ($n = 29$)
Group 1: extensive implementation	96.333 (15.80)	80.833 (22.35)
Group 2: partial implementation	85.461 (18.57)	80.076 (15.54)
Group 3: low implementation	101.50 (18.54)	91.80 (23.31)
All participants	93.24 (18.90)	84.27 (19.96)

*Note: A decrease in score represents an 'improvement' in perceived knowledge and attitudes.

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score from 93.24 (SD 18.9) to 84.27 (SD 19.6) from pre training to 6 months follow-up.

A comparison of the mean attitude to comorbidity score by implementation group is also presented in Table 1. An overall improvement in attitude to co-morbidity was indicated by mean scores for all of the implementation groups. Moreover, the Group 1 sites with the most extensive PsyCheck implementation also demonstrated the lowest scores from pre-training 96.33 to 80.83 at six months follow-up (16% change).

Knowledge skill and confidence

Forty-one percent ($n = 12$) of clinicians interviewed agreed that PsyCheck had improved their screening and detection of mental health issues. Sixty-eight percent ($n = 19$) agreed or strongly agreed that PsyCheck had improved their skill and knowledge in responding to comorbidity clients, and 45% ($n = 13$) acknowledged improvement in their confidence in dealing with comorbidity clients:

> I guess it's brought those issues to the fore more. While we're an alcohol and drug service, we don't just do alcohol and drug stuff (clinician #1)

> I think it – like the SRQ has certainly given me a better awareness and kept it more at the forefront the sort of issues that might be going on with the client. So it's helped – it's helped that way (clinician #2)

> ... and PsyCheck actually sort of walks you through that process. And it just is, again, just that knowledge that you've got somewhere to go if you run into a brick wall. So that – I think that, in itself, can give somebody confidence and it's certainly given me confidence (clinician # 3)

In addition, participants noted changes in skill level and knowledge:

> ... it's a lot easier for me to assist a client to make a link between a past experience and a present behaviour. And that's come as a direct result of having watched and worked with the PsyCheck stuff and being part of that process (clinician #3)

> It's improved my ability to look at how the two impact on each other, and how to assist the client to help themselves in terms of both of those issues at the same time. And in terms of my service delivery as well, it's certainly improved my skills in delivering CBT and other therapies to clients, to address various issues ... It's increased my knowledge and skills and comorbid service delivery (clinician #4)

Discussion

This study was part of a larger evaluation of a dissemination project that aimed to improve service responses to alcohol and other drug clients with common mental health symptoms. The focus of this paper was to evaluate changes in attitudes to comorbidity among clinicians who participated in the training.

Results showed attitudes to comorbidity and knowledge, skill, and confidence in working with clients with co-occurring mental health and substance use conditions improved after relatively brief whole workforce training. Even those clinicians from services that participated in the training, but that did not implement the screening and brief intervention within their services, showed some improvement in attitudes to comorbidity.

There are a number of limitations to this study that was an evaluation of a 'real world' initiative conducted in a large number of sites spread across an extensive

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geographical area. A pre-post test design was used. There were high levels of staff turn-over and part-time staff. Although caution is required in interpretation, the results suggest that even brief training has the capacity to influence attitudes. In addition, the CMPPQ is still in the process of being validated, but has been found to be useful in measuring clinical level changes in attitudes (Munro et al., 2007). The results need to be considered with this in mind but changes to measurable attitudes, coupled with the semi-structured interview data is encouraging.

The changes from before and after training were relatively small; however, keeping in mind the brevity of the initial training, the study was consistent with the findings of Munro et al. (2007) that training is effective in improving the attitude of clinicians to working with clients who have comorbidity issues. Improved attitude and confidence is likely to have positive impacts on clinicians' engagement with clients and in potentially reducing worker burnout.

Although a more controlled study is required, brief training appeared to be associated with improved attitudes, and ongoing familiarity with comorbidity intervention through more extensive workplace implementation appeared to be associated with greater improvement. The current data suggest that greater exposure, including ongoing training in comorbidity among AOD clinicians has the potential to change and maintain positive attitudes to clients with co-occurring mental health and substance abuse disorders. The study suggests that further work using a more controlled design is both feasible and warranted to look at the most effective ways to improve attitudes and confidence among clinicians.

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