IAPT positive practice guide for working with people who use drugs and alcohol

Introduction

1. This guide seeks to assist IAPT teams and substance misuse services to work confidently and inclusively with those who have drink or drug problems and common mental health problems. It explains how simple assessment techniques and protocols can identify potential IAPT clients with drink or drug problems. It outlines criteria for deciding whether people with different kinds of drug and alcohol use are suitable for IAPT services. And it summarises how IAPT and substance misuse services can work together more closely to improve outcomes for clients.

Background

2. A new national drug (and alcohol dependence) strategy was published in December 2010 (HMG, 2010), and a mental health strategy a few months later (HMG, 2011). Both strategies acknowledge the association between mental health problems and drug and alcohol problems. Successful outcomes for both problems need early intervention and effective joint working between drug and alcohol treatment and mental health services in integrated, recovery-oriented local systems.

3. People with a history of drug and alcohol problems, and receiving treatment, do not necessarily pose any special challenges for IAPT services but there are often substantial clinical gains to be made in working with them. Substance misuse clients with mental health problems should have access to NICE-recommended psychological interventions, including CBT for depression and anxiety and there is no evidence that substance misuse *per se* makes the usual psychological therapies ineffective (NICE, 2007).

4. Illicit drug use, misuse of and dependence on over-the-counter and prescribed medicines, and alcohol use are common in Great Britain. It is estimated that 1.6 million people have mild, moderate or severe alcohol dependence (McManus *et al.*, 2009). Thirty six per cent of adults report lifetime use of illegal drugs, with eight per cent using in the last year and five per cent in the last month (Hoare and Moon, 2010). A significant number of IAPT clients are therefore likely to be using illicit or prescription drugs and/or drinking at hazardous or harmful levels that may be contributing to their mental health problems.

5. Between 70 and 80 per cent of clients in drug and alcohol services have common mental health problems, largely anxiety, depression and trauma (Weaver, 2003). The same study also found high levels of drug use and hazardous and harmful drinking in the populations using mental health services. The study concluded that 'substance misuse services should work more collaboratively with local psychotherapy services and GPs to improve management of co-morbid patients who do not meet the criteria for access to community mental health services'.

6. IAPT services do not provide complex interventions to treat substance use problems but drug and alcohol use should not be an automatic exclusion criterion for accessing psychological therapy. Most drug and alcohol users do not need specialist or clinical interventions to change their substance use behaviour and, of those that do, many will respond to brief interventions delivered in primary care. Only a small proportion of drug and alcohol users will require specialist treatment services and, in some circumstances, referral to drug and alcohol services will be appropriate.

7. The expertise available within drug and alcohol treatment services to provide evidence-based psychological interventions will often be limited. IAPT services may provide one of the only local resources for clients of drug and alcohol services to access psychological therapy for common mental health problems. It is important, therefore, for IAPT and drug and alcohol treatment services to work together to address the needs of people with co-occurring problems. Information-sharing and communication between IAPT and drug and alcohol services at the local level can be a significant first step.

Understanding the needs of users of drugs and alcohol

8. While people with serious drug and alcohol problems come from all walks of life and different backgrounds, they are often affected by multiple disadvantages, either as a consequence or as a cause of their dependent drug use (Carpentier, 2002).

9. Socio-economic factors related to drug use include low educational levels, early school leaving and drop-out; unemployment, low salaries and difficult jobs; low income and debt; insecurity of accommodation and homelessness; mortality and drug-related diseases; poor access to care; and social stigma. Relative differences in the social conditions of drug users are found by substance used; the worst conditions being found among those dependent on opiates, particularly heroin (EMCDDA, 2003). While these social factors may complicate aspects of psychological work, they also highlight the extensive need within the population and the importance of working inclusively with this group.

Identification and engagement by IAPT of substance misusers

10. The NICE guideline for alcohol-use disorders recommends that all NHS-funded services should be competent to identify harmful drinking (NICE, 2011). Routine assessment of current use of drugs and alcohol is therefore recommended for all IAPT clients.

11. The Alcohol Use Disorders Identification Test (AUDIT) is a useful screening tool for alcohol problems. The NICE guideline for alcohol suggests that for clients who typically drink over 15 units of alcohol per day, and/or who score 20 or more on the AUDIT, should be assessed for community-based assisted withdrawal. This may be through the General Practitioner or, if there are safety concerns, may require assessment and management in a specialist alcohol service.

12. In addition to alcohol, questions should also capture the most prevalent illicit drug use; cannabis, cocaine, ecstasy (MDMA) amphetamine, ketamine and heroin – as well as prescribed drug use: benzodiazepines and opioid based pain relief. Local drug partnerships may have agreed simple screening tools that can be used by non-drug specialist services, including IAPT.

13. It is important to appreciate clients' potential sensitivities to direct questions about their drug and alcohol use. Their experience may have led them to believe they will be criticised about their use or denied access to a service and they may have concerns about confidentiality. Many clients feel shame about their drug use or drinking. It is important to maintain a non-judgmental and proportionate attitude to information about substance use, neither minimising the extent of a problem nor over-stating its significance.

14. Drug and alcohol users may be concerned about discussing a drug or alcohol problem and accessing services because they fear that information about illegal activity (in the case of use of controlled drugs) could be passed to the police or other criminal justice agencies. In addition, people with children in their care may be reluctant to admit a drug or alcohol problem. It is therefore important to be clear and explicit about confidentiality constraints, as per your service's standard policy. As for all clients, a policy for addressing any child protection concerns that may arise should be in place. While drug or alcohol use may raise child protection concerns in some circumstances, it is important to recognise that people with substance misuse problems are often caring and effective parents. Drug use or drinking alone is not sufficient grounds for child protection concerns.

15. Questions about use of drugs and alcohol over the previous month – specifically, days used and amount typically used per day – give a good indication of pattern of use and an idea as to whether specialist treatment is required as an adjunct or precursor to engaging in psychological therapy. The aim of these questions is to inform a judgement of the extent to which substance use is problematic and needs direct targeted intervention. They are a platform to facilitate an understanding of the extent to which a client's life is organised around the acquisition and use of substances, recovery from the ill-effects of using, the extent of the client's recognition of their problem and their desire for change. Local drug and alcohol treatment agencies should be able to offer advice and guidance on individual cases.

16. Asking clients their view of the relationship between their substance use and their psychological distress has the potential to open up a constructive dialogue and help to identify any function the substance use serves. The use of drug and alcohol diaries can also help to explore inter - relationships and can be easily integrated with daily thought records in standard CBT practice.

17. Many clients whose use is not significantly problematic can respond well to simple advice to cut down their drug and alcohol use, particularly if the reasons to do so are articulated in a coherent psychological formulation. However, if there are concerns that the client may be dependent on alcohol, GBL (gamma-butyrolactone) or benzodiazepines then the GP should review the situation first, as attempting to stop their use abruptly and without clinical support can be damaging.

18. If the level of use is considered to have the potential to interfere with psychological therapy, questions concerning the extent to which the client has considered making changes and how confident they would be in initiating these changes will give an indicator of motivation for

change. Again, an explanation of why change is relevant, couched in terms of a psychological formulation with reference to the client's anxiety or depression, can be very influential.

19. As part of treatment contracting, it is good practice to specify that clients must come sober to sessions, and that they should not use if engaging in specific between-session behavioural experiments. This conversation can be integrated within a general socialisation to cognitive and behavioural therapy.

20. If a client comes intoxicated to a session, it is advised to reschedule it rather than make any attempt to have a session. If the client struggles to attend sober or fails to do so two sessions in a row, the contract should be reviewed. It may be an indicator that drug and alcohol service intervention is necessary.

Assessment and engagement – Good Practice Tips

- Use screening questions that encourage discussion about substance use, rather than seeking to screen out any drug and alcohol user from services or phrasing questions in such a way that the client may react defensively or lie.
- Consider a client's current involvement with a drug and alcohol service an advantage to psychological therapy.
- Offer an assessment to any drug using or drinking client referred to your service, even if substances feature heavily in the referral. A client may come for an appointment with a therapy service when they might be reluctant to attend a drug and alcohol service, and this provides an opportunity to engage with and influence the person's use, motivation and understanding of their difficulties. Many clients have repeated experiences of exclusion and refusal, and a positive experience of consultation can be a helpful counterpoint to this.
- Talk about these issues in supervision. Once a client is being assessed face to face, some attention to the attitudes of therapists is important. These may lead to judgments and beliefs which can be overly negative or condone the extent of the issue being assessed.
- Use core skills to develop a therapeutic relationship. Professionals in IAPT services may feel anxious about a lack of knowledge about illicit drugs. This need not interfere with psychological work nor be a barrier to taking on drug using clients. Suspending judgement and embracing a spirit of curiosity will enable the client to speak openly about their experiences and foster a collaborative relationship.

Deciding whether the IAPT programme is suitable or not

21. When the assessment process identifies drug and alcohol use as an issue, an informed decision on how best to organise effective interventions for the client can be made.

22. A prerequisite for IAPT involvement is that the client has a depression or anxiety disorder that falls within IAPT's usual criteria.

23. NICE guidelines for alcohol recommend first providing effective treatment for alcohol problems followed by treatment for common mental health problems that may persist after alcohol treatment. Although common mental health problems may improve following a change in alcohol use, this recommendation highlights the value of timely and co-ordinated responses to enabling people to access the services they require.

IAPT should be considered suitable if:

24. The client is able to attend sessions and has motivation to limit their drug or alcohol use. This is demonstrated by control of their drug or alcohol use and / or when it is limited to clearly circumscribed contexts. Some examples include:

    - A weekend user of ecstasy who finds social situations anxiety provoking.
    - A client who is afraid of heights and manages flying by taking diazepam and alcohol.

25. The client is stable, i.e. using medication as prescribed and not using additional non-prescribed medication or illicit drugs. This would include clients on opioid substitution programmes (usually methadone or buprenorphine). No one should be excluded from IAPT services because they are being prescribed substitute medication. Examples of clients suitable for IAPT and stable on, or reducing, their prescribed medication would include:

    - A client experiencing low mood, taking methadone but not using heroin or drinking alcohol on top of their prescription.
    - A client with panic disorder reducing their prescribed benzodiazepine use.

26. The client has a history of drug or alcohol use but is now abstinent, for example:

    - A client with social anxiety who has recently successfully completed a community alcohol detoxification.

IAPT would not initially be suitable if:

27. The client is dependent on illicit drugs or alcohol and not in contact with a treatment service. Examples include:

    - A client reporting panic attacks and drinking alcohol every morning to stop the shakes.
    - A client regularly bingeing on crack cocaine and becoming very depressed in the recovery phase between these binges.

28. These clients would be likely to benefit from referral to a drug and alcohol treatment agency for specialist assessment and a care plan formulated and initiated targeting their substance use.

29. The client is in treatment with a drug or alcohol treatment service but unable to make changes in their substance use as a consequence of mental health issues. Examples include:

- A client continuing to use heroin in addition to their methadone because their low mood is perceived to be intolerable.
- A daily smoker of cannabis whose smoking has become a coping strategy for all daily life events.

30. In such cases, standard keyworking in the addictions service would continue to work on these issues until some stability is achieved. If available, a specialist assessment and intervention by a psychological therapist within the addiction service may be required to develop and deliver a relevant formulation and treatment plan. In line with good practice in care planning it would be helpful to specify a timeframe for reassessment in an IAPT service post detoxification or when stabilisation has been achieved. This may inform a part of an agreed aftercare and recovery support plan.

Training and developing the workforce

31. The IAPT work force would benefit from basic drug and alcohol awareness training to enable them to understand the effects of substances and related health issues including impact on mental health and psychological well-being. Training may be accessed through the local drug (and alcohol) partnership. Similarly, training and supervised practice in the assessment of drug and alcohol use may be indicated for people who are unfamiliar with or lack confidence in this area.

32. IAPT workers are in an ideal position to help people who may not be suitable for specialist addiction services to think about their drug use or drinking. They will benefit from training in brief interventions and should aim to gain familiarity with the ideas of motivational interviewing, a counselling style which looks to help clients resolve ambivalence about change (Miller and Rollnick, 2002). For people not already familiar with these ideas, training will significantly advance their ability to work effectively with IAPT clients.

33. A framework and toolkit for implementing NICE psychosocial guidelines for drug misuse has been produced, adopting the same competency model as that used in training IAPT practitioners. Of particular relevance to IAPT professionals, particularly low-intensity workers, is the section on brief motivational interventions (Pilling *et al.*, 2009).

34. Many of the general cognitive and behavioural techniques used by psychological therapy workers are transferable to working with drug or alcohol use (Mitcheson *et al.*, 2010).

35. IAPT workers should familiarise themselves with the local specialist addictions treatment services as well as local mutual aid groups (Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery). Mutual aid groups can support individuals in achieving and maintaining abstinence. Many hold open meetings and professionals are welcomed to experience them. SMART Recovery uses a mutual aid model similar to the long-established 12-Step groups (AA and NA) but focuses on cognitive and behavioural coping strategies.

36. Joint case-discussion forums, supervision groups and openness to mutual consultation with addiction services are highly recommended.

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