The theory underpinning one intervention with a dually diagnosed client nursing e...

Dual diagnosis has been described as one of the most significant problems facing the health services (Phillips et al 2010). The term was first used in America in the 1980s and in its most basic elements describes someone who has a combination of a mental illness and substance misuse problem. Dually diagnosed patients are often frequent users of emergency services and of in-patient care (Bartels et al 1993). There is also a much higher rate of offending and imprisonment amongst this group (Yesavage and Zarcone 1983 cited in Menezes et al (1996). Yesvage and Zarcone cited in Menezes (1996) believe that alcohol and drug misuse interact with the symptoms of psychotic illness to produce a more severe acute illness. Due to the complication of treatment approach recovery is often slower than a psychotic episode uncomplicated by substance abuse. This places a great burden on resources and staff (Drake et al 1993), which is corroborated by the London survey (Menezes et al 1996) discovering on average that this group of patients spends almost twice as much time in hospital than those without a substance misuse problem.

Clients with the most severe psychiatric disorders tend to have the highest rates of co-occurring substance use disorders (Drake 2007). It has been well documented that the co-existence of severe mental health and substance misuse problems are common (Regier et al 1990; Krausz et al 1996; Menezes et al 1996 cited in Graham 2003). Prevalence figures vary across studies however the latest study by Weldon and Ritchie (2010) estimate the lifetime prevalence rate of substance abuse amongst persons with severe mental illness at 50%, which is 4. 6 times higher than that of the general population (Blanchard et al 2000). One of the challenges of mental health

providers is how best to meet the needs of this group of clients (Graham 2003).

The most recent government guidance is one of integrated treatment whereby the treatment for drug and alcohol problems are provided primarily within mental health services, integrating this with the treatment of mental health problems (DoH 2002). This is to be provided by one team and involves a flexible combination of treatments targeting the specific needs of those diagnosed with co-morbid severe mental illness and substance misuse (Horsfall 2009). Researchers and clinicians have developed a number of interventions that combine, or integrate mental health and substance abuse interventions (Drake et al 2007). An example of one element of integrated treatment is Cognitive- Behavioural Integrated Treatment (Graham and Carnwath 2004). C-bit incorporates an integrated approach with personalised formulation to deliver improved treatment outcomes to dual diagnosis patients.

The focus of this essay will be on the use of C-bit (Graham and Carnwath 2004) and its application with a client who has been has been diagnosed with schizophrenia and alcohol problems. For the purpose of this essay and confidentiality his name has been changed to David. C-bit can be split into 4 distinct phases, Engagement and Building motivation, Negotiating some behaviour change, Early relapse prevention Relapse management. The essay will concentrate on negotiating behavioural change and what this entails. The author will then compare its effectiveness with an alternative approach.

An introduction to C-Bit

Hermine Graham (2004) describes C-bit as a psychological multi-purpose tool designed specifically for people with both a mental illness and a problematic substance misuse. It was developed from CBT which had a strong evidence base for mental health (Grant et al 2004) and substance use problems (Conrod and Stewart 2005). The evidence base of CBIT in dual diagnosis remains poor as studies have tended to focus on engagement and building motivation as appose to the maintenance of change that CBIT encompasses (Callaghan and Jones 2010). However early studies would suggest that the skilful use of analysis, disputing cognitions and homework assignments improve the skills required to promote abstinence including self-efficacy in finding, establishing and maintaining appropriate support networks (Rassool 2002).

CBIT follows the cognitive model and treatment approach (Graham 1998, 2003). A client's beliefs about substance misuse are often linked to their own experience of mental health problems. David would often say in therapy that the side effects of his anti-psychotic medication made him feel over sedated and this had a knock on effect in social situations. He found that alcohol improved this and allowed him to integrate better in social situations. By continuing to use alcohol it was maintaining a negative maintenance cycle.

Graham (2004) identifies three key aims of CBIT with dual diagnosis patients. The first concentrates on client and therapist identifying and challenging unrealistic beliefs about substance misuse and substituting them with alternatives that aim to break negative maintenance cycles. The second facilitates an understanding of the link between substance misuse and

mental health problems and thirdly CBIT aims to give the client the ability to self-manage substance misuse and recognise the early signs of relapse. Although there are 4 distinct steps in treatment approach the flexibility of the treatment means a client does not need to progress through them all. The harm reduction philosophy that underpins the intervention (Heather et al 1993) puts more emphasis on a client setting more realistic goals and achieving these. Although flexibility is a key asset of CBIT it would be wrong to assume there was no structure to therapy sessions. In later sessions especially, before commencing a session client and therapist must set an agenda to discuss which ensures key areas are discussed (Graham 2004).

In practice, teams trained in the use of CBIT tend to use the general principle of the approach rather than the distinct components or techniques (Graham et al 2006). The author believes this shows the flexibility of the therapy and therapists and clients find what proves useful to them . Graham et al (2006) also discovered that when trained members of the team used various assets of CBIT, engagement increased, alcohol intake was reduced and a reduction in alcohol-related beliefs. The study however noticed similar findings when the client had been seen by teams that had not yet received CBIT training suggesting that CBIT alone was not responsible for the change in behaviour and belief. However, qualitative information recorded from the teams' staff suggested that treatment integration increased over the course of the study, and that CBIT was a useful tool for integrating & planning substance misuse treatment. Qualitative information from the team managers suggested that CBIT training improved the ability of teams to address substance use by

themselves, rather than avoiding substance issues & referring clients to specialists.

Achievable Goal setting

Following treatment phase one the client will be able to identify some of the negative effects of substance misuse. David could recognise the negative effect that alcohol use had on his ability to find any form of employment and how he had no real supportive social network besides ‘ drinking companions’. Graham (2004) highlights that in treatment phase two it is probably too early for a client to consider complete abstinence. David was beginning to make links with the amount he drank and the negative effects he was having. Due to this he negotiated with the therapist that he would reduce his alcohol input by stopping all spirits but remaining on his strong lager. This follows the harm reduction philosophy that there are several levels in which change can occur that would reduce the negative impact it causes to the client. David identified his long-term goal as eventually getting some form of employment. Following treatment phase one David was able to see the impact excessive impact alcohol was having on his ability to make appointments on time (if at all), and how this would have a negative effect on any chance of employment. Graham (2004) suggests that for a client to get to this long-term goal a series of short term harm reducing steps need to be identified by the client in therapy that will in-turn have a positive impact upon his life. David had already agreed to stop drinking spirits but further steps included reducing contact with fellow drinkers, attending all appointments on time, getting his body back into a work routine. These steps would move David closer to the eventual long term goal and give him the

belief that this was achievable. The therapist found that the use of the recovery star was a useful tool with aiding the client identify and plan how to achieve these goals. The recovery star helps both client and therapist measure change and visually see progress made. At times when David struggled to achieve goals it provided an opportunity for discussion on how to change the approach. David found the tool useful in between sessions where he could refer back to past successes to give him the confidence to continue. On reflective sessions what proved important for David was to identify and discuss possible obstacles that he may experience in trying to achieve his goals and to recognise that if things do not go as planned it should not be automatically assumed to be a failure. Simmons and Griffith (2009) believe that there is never a failure but an opportunity to learn and do things differently.

Behavioural Experiments

By treatment phase two of CBIT the client will have identified an unhelpful thought, the nature of which will be maintaining a negative maintenance cycle. David had begun to plan harm reduction goals to reduce the negative aspects of his substance misuse however there was clearly some situations he was avoiding, and some underlying maladaptive thoughts there were perpetuating his problems. To address this the therapist and David discussed and designed a Behavioural Experiment. Beck (1995) believes that BEs strengthen an intellectual belief by helping the client test out alternative beliefs and thoughts in practice in order to gain evidence to discover the validity of a belief . Beck (1979) believed through altering behaviour a cognitive change occurs. BEs are significant as a means of explicitly

targeting belief change through experience and as such offer prime opportunities for sustained therapeutic change (Padesky 2004). David held the belief that if he did not drink alcohol he would appear boring and no-one would have any time for him. For this reason when David was going to be in the company of anyone he would drink excessively, therefore getting intoxicated became a safety behaviour. By allowing a client to see what will happen if they drop safety behaviour and then testing out what actually happens in that situation proves to be a powerful challenge to unhelpful assumptions (Whitfield and Davidson 2007). Sloan and Telch (2002) support this view adding that experiments target safety behaviours result in significantly greater changes than exposure alone. Safety behaviour may seem helpful and protective to a client but can lead to maintenance cycles of maladaptive processes perpetuating the initial belief. If a threat is not disconfirmed the maladaptive cognition continues (Salkovskis 1991, Sloan and Telch 2000, Clark 1989, Salkovski et al 1998). The notion of experimentation, derived from scientific principles, can be applied to the patient’s experience of the therapeutic process and it is this active experience which can be so meaningful; the validity of a new cognition being generally more memorable when followed through from conceptualisation to active experience (Westbrook 2007). Once the evidence contradicts the initial belief it allows the client and therapist to explore the validity of new more adaptive beliefs (Westbrook et al 2007). David and the therapist designed an experiment in which he would limit his alcohol approach and would then engage in general conversation in his local pub. Initial experiments gave David the confidence to build on further experiment supporting the work of Bennett-levy (2004) who believe early experiments

increase confidence and independence BEs can be active, where the patient takes the lead role in either real or simulated situations to test the validity of thoughts, or observational, where data is gathered. Lewin and Kolb propose a learning cycle in which it suggests that for learning and retention to be enhanced the client must build upon knowledge and understanding gained through the experiment which in turn forms a foundation for the next step of the experiment. (Lewin 1946; Kolb 1984). The five key aspects of this learning cycle, Experience, Observation, Reflection, Planning and then further experiment underpins BE work.

Establishing supportive social networks

In the field of substance misuse social factors are seen as important in the onset, aetiology and maintenance of substance misuse (Graham 2004). David recognised that as his alcohol intake increased the friends he associated with were also using alcohol regularly. This supports the work of Drake (2004) who identified that clients with both severe mental health problems and substance misuse problems would have social networks of solely fellow substance users. David felt increasingly isolated from anyone outside of this network as his behaviour would draw attention towards himself. Trumbetta et al (1999) suggest that for anyone to make changes in substance misuse they need to reduce contact with such peers. Healthier networks need to be formed which provide positive support where there is excessive substance misuse is not the norm (Drake 1993a). David identified his sister as someone who was willing to and who he would like as a supportive person away from mental health services. In crisis David could contact his sister who could give him some level of support. Graham (2004)

emphasises the importance of working closely with family members as they often know very little about dual diagnosis problems. David was only close with his sister. The rest of his family had isolated him due to his substance misuse. Ideally psycho-education information is often given in the group setting as family members may benefit from the experience and support of fellow members (Graham 2004). David's sister became a key figure in David's recovery and was encouraged to attend sessions on psycoeducation so she could best understand the problems associated with dual diagnosis clients and how best she could support David.

Limitations of its use

Prochaska and DiClemente (1992) recognised certain barriers to treatment for dual diagnosis patients in regards to therapeutic engagement, treatment continuance and goal setting. In the case of CBIT it makes assumptions of a certain level of coping skills and ability to facilitate cognitive change. Symptoms of schizophrenia can inhibit a client's impetus to change behaviour (Horsfall et al 2009). Negative symptoms which have a negative effect on motivation and energy affects individuals internal drive to initiate the complex behavioural routines needed for abstinence (Ballack and DiClemente 1999). An integrated treatment approach incorporating CBIT does not make dramatic changes in the short term, it is a long term therapy. Evidence based studies are always plagued by attrition rates as clients relapse or do not return to the study. This may suggest that CBIT may suffer from the same poor treatment compliance/attendance. For clients who complete a full programme of treatment 10-20 per cent achieves a stable remission of their substance use problems per year (Graham 2004). This

seems a low figure for the intensive input required on the part of the therapist and client. Bellack and Gearon (1998) believe the therapist must become tolerant of this client group dropping in and out of therapy and abstaining then relapsing. David's attendance was at times sporadic but the therapist never criticised him for this but used it as a platform for discussing problems experienced through the week. Drake et al (2001) suggests the importance of assertive outreach teams in retaining clients within programmes. Hellerstein et al (1995) cited in Philips et al (2010) highlight that without this input dropout rates may be high, especially amongst those identified as having difficulties participating in treatment.

Alternative approaches

The evidence base for dual diagnosis is still in its infancy. Those studies completed have limited generalisation due to methodological issues such as heterogeneous samples, equivocal descriptions of treatment components and high attrition rates (Weldon and Richie 2010). Horsfall et al (2009) recognises that due to a lack of longitudinal studies long term outcomes have yet to be determined. It also proves difficult to compare C-Bit with alternative interventions as C-Bit is not used in a vacuum it is often used in conjunction with other therapies such as pharmaceuticals of motivational interviewing. Kemp et al (2007) found a significant improvement in substance use in dual diagnosis patients when CBT and MI principle were combined. For the purpose of this essay the author will briefly look at one main alternative approach to dual diagnosis, that of motivational interviewing.

Motivational interviewing

Treasure (2004) describes MI as a patient centred counselling approach that facilitates the patient in resolve and explore ambivalence about behaviour change. The theory of MI centres on the cycle of change and its six components, precontemplation, contemplation, decision, action, maintenance of change and relapse. Miller and Rollnick (1994) describes motivation as something that one does as appose to something that one has. Empathy is vital in the therapeutic relationship and the use of MI. If the client believes the therapist has no appreciation of their experience they are likely to dis-engage or not fully commit to therapy. Rassool (2002) believes active listening also has an important role in MI. Reflecting back to the client their thoughts, fears, hopes and doubts give a feeling of genuineness, trust and empathy. In MI it is important not to offer advice , give judgement or attempt to question. The reason for behavioural change should be acknowledged and stated by the client. MI proves an effective therapy in dual diagnosis if delivered effectively. The therapist needs to avoid confrontation as this will lead to client denial, the role of the therapist as expert proves counter-productive and structured answer formats will inhibit the client in recognising the effects of their substance misuse. Motivational styles that guide a client in discovering alternative ways of thinking about their problems results in positive change (Miller and Rollnick 1991). By combining elements of style and technique MI has proven successful in dual diagnosis patients and has a developing evidence base.

It proves difficult to contrast MI with CBIT as both complement each other so well and have similar approaches. Both are based on a collaborative

relationship with clients, both incorporate a non-judgemental approach and both are approaches are built on empathy, warmth, trust and positive regard (Rogers, 1991). Both approaches also incorporate socratic questioning techniques encouraging the client to discover alternative meanings of their experience (Padesky and Greenberger 1995). One of the key differences is when it is best to use either technique. Those following a transtheoretical model of change may use MI when the client remains undecided about change in the precontemplation and contemplation stage whereas CBIT can be adopted when the client is more committed to change (Treasure 2004). This would support the work of Drake et al (2001) who after studying the work of a number of researchers believe that to enhance attendance and utilisation of treatment motivation interventions are important.

Conclusion

The research on the impact of CBIT as a therapeutic intervention is still in its infancy. Some anecdotal evidence would suggest it provides the skills necessary to promote abstinence (Rassool 2002). Qualitative information gained from Grahams (2006) study suggests CBIT proved a useful tool for integrating and planning substance misuse.

Due to the complex nature of dual diagnosis it seems unlikely that a single intervention will have the desired effect of meeting all the clients' needs. Kemp (2007) supports this finding an improvement in substance misuse when MI and CBIT were combined. Due to this there has been a shift towards the integration of interventions delivered by mainstream mental health services (DOH 2002, 2006; Rassool 2002; Ziedonis et al. 2005). Some of the

strongest treatment effects have come from combining a number of approaches (Barrowclough et al 2001; Bellacket et al. 2006).