Engaging precontemplative dual diagnosis clients

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It can be difficult to engage with clients with co-existing substance misuse and mental health problems, known as dual diagnosis. This article describes a project that used music to engage service users with dual diagnosis problems.

Following a research review predominantly made up of US studies, Smith and Hucker (1994) pointed out that substance misuse in people with schizophrenia should be seen as usual rather than exceptional. UK research by Gafoor and Rassool (1998) supports this view. Alcohol is the substance most commonly misused, closely followed by cannabis.

The problems associated with working with clients with dual diagnosis are well documented. The Department of Health’s Mental Health Policy Implementation Guide (2002) identified significantly poorer outcomes in individuals with psychiatric disorders who misuse substances than in individuals with psychiatric disorders who do not (Box 1). Although poorer outcomes can be expected among the client group, the DoH guide points out that substance misuse in people with schizophrenia is the most damaging effect of an enduring disorder on quality of life.

Patients with a dual diagnosis of substance misuse and psychiatric illness often have daily routines structured around planning and engaging in substance use (Hodgson et al, 2001). Severe mental illness often causes people to have major problems forming relationships. Creer and Wing (1975) found the four most frequently occurring ‘abnormalities’ associated with chronic schizophrenia were: social withdrawal, under-activity, lack of conversation and few leisure interests. Mayers (2000) identified this as the most damaging effect of an enduring disorder on quality of life.

Positive self-rewarding activities have also been identified by Tuchfeld (1981) as important in influencing recovery and preventing relapse. Hodgson et al (2001) found that clients who had made positive changes found developing new leisure activities important to their recovery. Prior to treatment they defined substance misuse related activities as leisure (for example, sitting in a club drinking) but found these activities boring and unfulfilling after positive change. Redefining leisure was identified as important during recovery, not only from the substance misuse related problem but also holistically for the respondent’s mental health.

Practical activities with achievable goals where success is easily measurable are effective tools to aid the process of engagement. Shifting the focus from cessation of substance misuse or compliance

REFERENCES


THEORETICAL FRAMEWORK

The staged kinds of interventions – engagement, persuasion, active treatment and relapse prevention – described by Osher and Kofoed (1989) and developed by Robert Drake et al (2001) have become standard for substance misuse. These are based on Prochaska and DiClemente’s four stages of change (Prochaska et al, 1992).

Engagement is therefore concerned with the development of a therapeutic alliance between a service and a ‘precontemplative’ service user. Focusing on substance misuse and treatment too early can promote disengagement. An essential part of engaging with clients is to be optimistic about their ability to recover control over their substance misuse and mental health difficulties (Sainsbury Centre for Mental Health, 1998).

Interests and hobbies can play an important part in the process of engagement. Taking time to find out what an individual enjoys is a useful early objective. This information can then be used to engage/relate to that individual. An enjoyable activity that is inhibited by increased substance misuse or poor mental health can be a powerful motivator to elicit change.

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BOX 1. ASSOCIATED OUTCOMES

- Worsening psychiatric symptoms
- Increased use of inpatient services
- Poor medication concordance
- Poor social outcomes
with medication to activities that inhibit excessive misuse of substances or mental ill health can promote change.

Care should be taken to involve users when developing this type of recreational day service. In a report that researched and evaluated the experiences of mental health service users, Rose (2001) discovered that some service users found day services ‘patronising’. There was also a perception that these services were something that was done to them rather than with them.

**Project outline**

The project began in response to an expressed interest from a core group that met at a young persons’ mental health support group. The range of musical talent and interest within the group led the facilitators to set up a meeting to explore the possibility of running a music-based project. Other potential members known to the facilitators through their clinical work who had an interest in music were also invited.

Members of the group were all diagnosed with severe mental illness with at least two acute admissions to psychiatric hospitals. Most members were reluctant to attend the local day hospital. The entire group had substance misuse issues of varying complexity. Initially there were eight members of the group and one joined later. All were between the ages of 20 and 35. In terms of substance misuse treatment they would therefore be regarded as in the stage of precontemplation (Prochaska et al, 1992), raising issues of engagement.

The facilitators made it clear from the outset that they saw the aim of the project as being to enable the group to pursue an interest in music. It was hoped that artwork and video would accompany the musical core of the project as secondary goals. The group chose a name for themselves and their initial aim was to record a CD using facilities at a local youth centre.

Additional expertise such as a studio technician and an IT facilitator were brought into the project. Funding for the initial project was secured from the local health group, and drugs and alcohol action team (Drugs and Alcohol Treatment Fund).

**The sessions**

The group soon organised itself into smaller groups with similar interests and goals. One band formed and they planned to spend their time rehearsing and recording their own material. Others worked together with the music technician on computers to put together backing tracks for their own lyrics. Overall, 20 sessions were held, each lasting approximately three hours.

Most group members attended all of the sessions although there were interruptions due to their illnesses. By the end of the first 10 sessions the participants had clearly defined what they wanted to achieve and this work moved forward surprisingly quickly. By the end of the 20 sessions, eight tracks had been recorded in total. The project came to an end with a CD launch at the youth centre. Representatives of the funding organisations were invited as well as the local press. Care had to be taken to protect the group members’ anonymity. The articles that appeared in the local papers referred to the project as a support group with no mention of mental health or substance misuse. Most of the group decided to have their photograph taken even though this was optional.

**Evaluation**

**Participants’ perspectives**

Evaluation of the project was conducted via a semi-structured client questionnaire. All of the questions were designed to obtain qualitative data from the group in a non-threatening way. All the group members completed questionnaires.

- Expectations of the project were mostly focused on musical experiences although some of the group sought potentially more therapeutic outcomes (Box 2).
- All but one respondent indicated that the project had met their expectations. This one person wanted to explore video work, which had not proved possible.
- Responses indicated that people thought being involved with the project would be helpful for the future (Box 3).
- Both the experience of making music and ‘the feeling of getting together, sharing ideas’ were seen as enjoyable. The least enjoyable aspects were varied – two members cited relationships with specific group members, two cited travelling.
- Suggestions for improvement to the project concentrated on the structure and work (Box 4).

**References**


Eight of the nine group members said that continuing the project would be helpful and one member wanted to explore musical opportunities outside the group.

Seven respondents expressed a desire for ‘getting the music heard’.

Facilitators’ perspectives
A great deal of the project facilitators’ time and attention went on practical and organisational tasks and on sharing these with the project members. A key activity was trying to ensure a feeling of inclusion and involvement for all members and entailed providing individual encouragement and promoting interaction and communication between members.

The facilitators thought it was important from the outset to be fully involved in the project. This was in order to try and enable the group members to plan the sessions ahead but also to integrate themselves into the project and not be seen as solely ‘workers’. Being part of the project enabled project members to discuss a range of common problems and concerns in a supportive environment. Topics included medication, side-effects, psychotic experiences, substance use and misuse and social isolation.

All of the six group members who had active substance misuse problems have made significant progress. Four have completely stopped their illicit drug use and this has been maintained for over a year. One project member gradually reduced a long-standing benzodiazepine prescription, eventually stopping. Alcohol consumption has also reduced although almost all the group members consider themselves social drinkers.

The success of the initial project enabled the facilitators to run a further project. The results of this project were even more favourable, both ‘therapeutically’ and ‘creatively’.

Discussion
It can be argued that mainstream substance misuse services often fail to engage dual diagnosis clients because they focus on motivating people who are already contemplating change rather than trying to engage precontemplators with services. While this is a valid exercise driven by the need to maximise limited resources, the emerging specialism of dual diagnosis nursing cannot cherry-pick motivated clients and must develop innovative ways to engage with a difficult client group.

Engagement is seen as a core objective of assertive outreach teams and a key component of the treatment used in dual diagnosis (Sainsbury Centre for Mental Health, 1998). Yet as engagement is the foundation of a therapeutic alliance it could be argued that it should be a major component of mainstream mental health and substance misuse services anyway.

Although mental health and substance misuse often have a central role in a client’s ability to cope it has been recommended that a much wider view be taken of a person’s problems. Social interaction, daytime activity, recreational activities and employment and educational opportunities are therefore valid activities for services.

In Keys to engagement, the Sainsbury Centre for Mental Health (1998) suggest that services are often focused on outcomes rather than engagement, but that engagement can be viewed as a valid outcome in itself. There is a need for flexibility in the way services work with the client group. Success should be measured in terms of engagement and fairly low-level interventions that on the surface have little to do with mental health. They suggest giving primacy to engagement seems likely to address at least some of the reasons why people are avoiding services. The experiences of this project seem to support this view.

The Sainsbury Centre (1998) also suggest that ‘daytime activity has a major role in care’ and that ‘users still complain of a shortage of satisfying daytime activities’.

Structured activity is a useful form of therapy in itself. It is common for clients to reject the idea that their problems are associated with either substance use or mental ill health.

The stigma of having a mental illness and the stigma of being involved with the services that cater for these problems can promote disengagement. The literature highlights the fact that clients may be avoiding more traditional mainstream mental health services because of a fear of being drawn into a patronising or oppressive system of care (Sainsbury Centre for Mental Health, 1998).

The Royal College of Psychiatrists Research Unit (2002) identifies ‘listening to the individual’ as the first step to engagement. We need to listen to clients and offer them services that help to meet their very real social and recreational needs and not services that are developed in isolation from clients’ views. By doing so we may even make ‘traditional’ services more attractive to the client group and gain a greater understanding of our clients’ needs.