Psychosocial Interventions Example

Introduction

This report aims to critically appraise psychosocial interventions (PSI) that are utilised when working with complex cases. In order to do this the term complex is explored with reference to people with psychosis. Different types of complexity are discussed with a more detailed examination of a specific complexity; the relationship between substance misuse and psychosis (dual diagnosis). The effects that substance misuse and psychosis have upon the service user and their care givers are outlined. An overview of the use of psychosocial interventions when working with complex cases is given. This discussion is then focused on particular interventions for dual diagnosis that show promise for enhancing service user and carer experience, namely a integrated treatment approach of cognitive-behavioural therapy, motivational interviewing and family therapy.

These interventions are critically appraised with reference to evidence base, policy and guidelines. Examples from clinical practice are given to illustrate potential barriers, and outcomes when implementing such interventions with service users with complex needs and their caregivers. Strategies to overcome such barriers are generated and recommendations are made. Aliases are used within the scenarios of this report in order to maintain

anonymity of the service users and carers described to illustrate points and examples.

Complexity

The term complex case is referred to frequently within mental health literature, policies and guidelines but there are very few definitive explanations of what the term actually means. Griffiths & Allan (2007) discuss how the term complex case is ill defined within mental health literature summarising how the term is often used to denote circumstances where people appear to have many interrelated needs that require several, coordinated responses from multiple services. The term complex case is often used to denote needs that services do not fully understand or provide for effectively.

This report aims to explore the term complexity in relation to individual cases of those with serious mental illness.

Complex:

'Made of many different things or parts that are connected; difficult to understand' (Soanes & Stevenson 2005) Interpreting the above definition of complex within the Oxford Dictionary of English one could describe a complex case as a service user with more than one problem or need that are connected making the case more difficult to work with. For example having a diagnosis of schizophrenia and being detained within a medium secure unit. A person fitting this example would potentially present the mental health professional with more challenges than a person with moderate depression living with their supportive family. Wilson, Holt and Greenhalgh (2001) discuss the term complexity in relation to human health and illness. They suggest there are a number of factors (outlined in Table 1) that we all posses that makes us all complex.

They go on to suggest that human illness and behaviour are not predicable and neither can be thought of as a simple cause and effect system. Again, adding to the complexity of individuals that because one individual responds one way to an event does not mean all will. Although this list of human complexities was written with medical practice in mind it applies to all and provides the baseline of those service users we work with in mental

health services.

Table 1 (Wilson, Holt, Greenhalgh 2001 p685)

Factors that add the human complexity The human body is made up of multiple interacting and self regulating physiological systems including biochemical and neuroendocrine feedback loops. An individual's behaviour is determined partly by an internal set of rules based on past experiences and partly by unique and adaptive reaction to external stimuli. The web of relationships in which individuals exist contained varied and powerful determinants of their beliefs expectations and behaviour. Individuals and their immediate social relationships are embedded within wider social political and cultural systems which can influence outcomes in entirely novel and unpredictable ways. All of these interacting systems are dynamic and fluid. A small change in one part of the web of interacting systems may lead to a much larger changes in another part through amplification of effects. If we bear this in mind, that all humans are complex, then maybe the term complexity needs to be described as a continuum (Figure 1). That the more problems a person has or the more difficulties they face the further they move up a complexity continuum. People with a diagnosis of serious mental illness (as with all people) can face a large number of problems and difficulties through the course of their lives for example, positive symptoms, negative symptoms, anxiety, depression, mania. When adding this to the complexity of an individual this produces more challenges for the health care professional, the individual and their carers/families. However, these experiences also produce problems and difficulties for the service user making their case even more complex.

For example the impact of experiencing voices does not end here but effects other areas of a person's life (see Table 2).

Table 2.

Laura – Case study

Laura first started to hear voices at the age of 9 and at first these did not bother her. As she got a bit older and

discovered that this wasn't 'normal' her voices started to become critical of and derogatory towards her. To cope with this Laura started to experiment with Illicit drugs and alcohol as this blocked out the voices for a short time. However, this also made Laura lose her inhibitions and she would participate in sexual acts with men in her local area. This fuelled the voices and they became much more negative. So to cope Laura would take more drugs.

Eventually Laura would run out of money and so would shoplift and resorted to prostitution. Her life became very chaotic and at 16 her mother kicked her out. Laura was now sleeping in neighbours gardens, sheds, anywhere she could. Laura lost touch with all her family and friends, her physical health suffered and she ended up very underweight and her voices became worse. Eventually Laura was found by the police sleeping semi-clothed in a car park under the influence of drugs and alcohol. It was at this point she was admitted to an acute mental health unit. From the case of Laura it can be seen how not even having a diagnosis of schizophrenia, but experiencing positive symptoms can result in stigma, social exclusion and have a huge impact on a person's life.

Laura's case was exacerbated by the use of illicit substances and alcohol demonstrating how substance misuse can add greatly to the complexity of an individual. Within the literature it can be seen that there are many factors that add to the complexity of a person with mental health needs including: medication resistant symptoms (Tarrier et al 1993), receiving care within secure forensic units (DOH 2005), psychological reactance (Moore, Sellwood, & Stirling 2000), poor social functioning (Cather 2005, Couture et al 2006), , learning disabilities (DOH 2001a), insight (David 1990 and Buckley et al 2001), physical health (Marder et al 2003) homelessness (Randall et al 2006), and dual diagnosis (DOH 2002). These complexities have been recognised by the government and national drivers have been produced to guide mental health professionals and services to enable delivery and provision of the best services. For example 'The National Service Framework for Mental Health' (1999a) outlines a number of interventions for several complex groups including some of those mentioned above. Rankin & Regan (2004) discuss how the term complexity means that there is no generic complex needs case.

This therefore suggests each individual has a unique interaction between their own health and social care needs, therefore, requiring personalised responses from mental health services. Adopting an approach that incorporates

psychosocial interventions could help to achieve a personalised response and provide individualised, tailored care for the service user and their care givers.

Psychosocial Interventions

The use of psychosocial interventions (PSI) is advocated in national drivers such as 'Schizophrenia: Core intervention is the treatment and management of schizophrenia in adults in primary and secondary care' (NICE 2009). This guidance recommends that all service users and their families are offered psychosocial interventions as a treatment of schizophrenia. Also, documents such as 'From values to action: The chief nursing officers review of mental health nursing' (DOH 2006) recommends the use of psychological therapies to improve outcomes for service users and 'The mental health policy implementation guide' (DOH 2001b) advocates the use of psychosocial interventions through a variety of service delivery modes. Demonstrating the emphasis that is placed upon such interventions in the treatment of serious mental illness.

Mairs and Bradshaw (2005 page 28) suggest PSI is –

"… a range of evidence-based interventions for people with psychosis and their care givers. The term is generally used to include both models of service delivery such as assertive outreach and specific interventions, for example Family Intervention and Cognitive Behavioural Therapy (CBT). PSI's aim is to reduce stress experienced by an individual with psychosis or help him or her to cope with stress more effectively." As a result of adopting a PSI approach an individualised service is offered to the service user to help meet their needs utilising a variety of interventions and services with great emphasis being placed upon collaboration. Psychosocial interventions assume a complex link between biological, environmental, and sociological factors which suggests that ambient stress, together with life events may trigger onset or relapse of, mental health in some people (Gamble & Curthoys 2004). A model which displays this link is the Stress Vulnerability Model by Zubin and Spring (1977 cited in Norman, & Ryrie 2004). This model helps explain the aetiology, course and outcome of mental illness, demonstrating how stress has different effects on individuals. The Stress Vulnerability Model (See figure 2)

suggests that some people are more vulnerable to stress than others and that when an individual's stress threshold is passed they can become unwell i.e. experience positive symptoms. In terms of a complex case it could be proposed that an individual's complexities cause stress in themselves and/or increase a person's vulnerability to stress. An example of how 'The Stress Vulnerability Model' can be illustrated to enable it to be shared with a service user with complex needs, using an easy to understand analogy can be seen in Appendix 1. As previously mentioned the aim of PSI is to reduce stress or to help cope with stress better; therefore, it can be seen how the Stress Vulnerability Model plays a central role in providing psychosocial interventions.

Substance Misuse and Psychosis

Over 50% of people with a severe mental illness also use illicit drugs and/or alcohol at hazardous levels (Cleary et al 2009) and even low levels of substance misuse can have detrimental effects and cause serious complications (Barrowclough et al 2001). The combination of substance misuse and mental health problems (dual diagnosis) is associated with a range of social, behavioural, physical and psychological problems (see table 3) providing challenges for mental health services and adding to the complexity of an individual (Hussein 2002). In addition to this complexity 'The national service framework of mental health' (DOH 1999a) identifies patients whom misuse substances and have a diagnosis of serious mental illness as a population of greater risk of stigmatisation and exclusion from existing service provision. Demonstrating some of the factors that add to an individual's complexity.

Table 3

Complications posed by dual diagnosis (Cleary 2009, Drake & Mueser 2000, Clark 1996, Dixon, McNarey & Lehman 1995, Griffiths & Allen 2007 and Gibbins & Kipping 2006) Increased risk of – Suicide, Self Neglect, Violence, Poor compliance with treatment, More inpatient stays – worsening psychiatric symptoms Relapse, Homelessness, HIV and Hepatitis, Contact with criminal justice system Prejudice and Stigma. Negative impacts on – Social relationships Financial resources (of individual and/or family/friends) Family Relationships i.e. increased burden,

increased expressed emotion Within literature the most commonly reported reason that people with serious mental illness use illicit drugs is to self medicate, for example, to relieve negative symptoms of schizophrenia (Littlejohn 2005). However, as Conley & Benishek (2003) report there is the additional complexity of trauma that has lead to the use of substances for various reasons including dissociation, and modelling from parents. They continue recommending that nurses working within the substance misuse field should be trained in picking up such information. If an approach adopting psychosocial interventions was utilised and therapies such a cognitive behavioural therapy were delivered then this historical information may be identified and dealt with appropriately. Therefore, leading to a different delivery of services compared to someone who uses substances to self medicate.

However, the mental health professional must also bear in mind that service users also use substances for the same reasons as others (Littlejohn 2005). Even though the NICE (2007) Guidelines, 'Drug Misuse: Psychosocial Interventions' recommends that CBT be offered to those with anxiety and depression who are stabilised with their drug use, but does not discuss its use with those with psychosis. There is growing literature examining the use of CBT for those with a dual diagnosis (Cleary et al 2009, Barrowclough et al 2001, Baker et al 2006, Weiss et al 2007 and Haddock et al 2003) although, as mentioned earlier the amount of literature in this area is limited. Also the CBT that is delivered to the participants within the studies has been adapted to suit the needs of those with dual diagnosis. This integrated treatment, namely C-BIT (Cognitive-Behavioural Integrated Treatment), has a number of components; Cognitive Behavioural Therapy, Motivational Interviewing and Family Interventions. C-BIT is not only about adapting psychosocial interventions to suit those with dual diagnosis but it is also about service provision and development (Thylstrup & Johansen 2009, Graham et al 2006, Graham et al 2003). Such interventions are used as part of an individualised treatment plan that incorporates the key principles of working with dual diagnosis (see table4).

Table 4 (Drake et al 1993 cited in Abou-Saleh 2004)

Principles of treatment of substance misuse in people with severe mental illness Assertive outreach to facilitate

engagement

• Close monitoring to provide structure and social reinforcement

• Integrated concurrent service

• Comprehensive, wide range of interventions

• Stable living situation

• Flexibility and specialisation (modified approaches)

• Stages of treatment: engagement, persuasion, active treatment and relapse prevention

• Longitudinal perspective for relapsing and chronic disorder

• Optimism – instilling hope in patients and carers

Motivational Interviewing (MI)

The aim of this intervention is to increase a person's ability to recognise and do something about any problems they have (Gamble & Curthoys 2004) and that change would be desirable (Kipping 2004 and Miller & Rollnick 2002). This approach conveys hope and is non-confrontational in it style (Kemp et al 1996) and is largely used within substance misuse services (DOH 1999b). This intervention is used alongside Prochaska & DiClemente (1986 Cited in Kipping 2004) Model of Change (see Figure 3) to provide a framework of which interventions should be used at which stage of change a service user is at. Motivational Interviewing is mainly used as a persuasion tool to move people from precontemplation/ contemplation to decision and active change. Four General principles are followed as outlined by Miller & Rollnick (2002); expressing empathy, developing discrepancy, rolling with resistance, and supporting self efficacy in order to facilitate this change. When a service user demonstrates that

they have arrived at the decision or action stage of the cycle of change cognitive behavioural interventions are then commenced.

Cognitive Behavioural Therapy (CBT)

The aim of CBT is to lessen distress caused by negative feelings; it attempts to do this by changing the thoughts (cognitive) and beliefs that underpin them. It can also alter actions (behavioural) and circumstances that are affecting these thoughts and feelings (Nelson 2005). This approach has been written about for many years and has arguably evolved from the work of Aaron Beck, a psychiatrist whose work dates back to the 1950's. There is a vast amount of literature examining the use of CBT with psychosis (Jones et al 2004). Generally the research and literature supporting the use of CBT for Those with serious mental illness often excludes people who misuse illicit drugs and/or alcohol for example Garety et al (2008), and Jackson et al (2008). The topics covered within CBT sessions for those with dual diagnosis differs from that of someone who does not use substances. For example Baker et al (2006) outlines components of CBT sessions used within their trial. They include, presenting the model of problematic substance use and psychotic symptoms (Graham et al 2004), specific techniques for managing substance use, and identification of triggers and beliefs that could lead to substance use and increase psychotic symptoms.

Finally a large component of CBT for dual diagnosis is around relapse prevention, identifying unhelpful thinking patterns and managing cravings.

Family Interventions (FI)

A relative of a person with a diagnosis of schizophrenia may experience negative consequences in many areas including: emotionally, socially, psychologically and economically, as they adjust to their new role as a care giver (Reader 2002). How the care giver attempts to cope with these consequences can have an effect on their relative. Research has shown that expressed emotion within families could lead to relapse in schizophrenia (Brown et al 1962, Kavanagh 1992). Often a person with dual diagnosis is only marginally engaged with services but may have

regular contact with their families who provide financial and psychological support (Thylstrup & Johansen 2009). Putting them under immense strain; but also in prime position to work with mental health services to promote engagement and treatment adherence. There is a vast evidence base to support FI for promoting recovery from psychosis (Pharoah et al 2006, Pilling et al 2002). The family dynamics of a person with a dual diagnosis is often impacted greatly due to the complexities discussed earlier and there is growing evidence to suggest how family involvement can have positive impacts on outcomes for both the service user and their families (Fischer et al 2008; Dixon, McNarey and Lehman 1995). Within integrated treatment Barrowclough et al (2001) use family interventions as a means of encouraging care givers to adopt motivational interviewing styles to improve motivation, and treatment adherence amongst other interventions. See Table 5 to illustrate how minimal family work in the form of psycho-education enhances the experience of service users and their care givers, even when staff have had no formal training. Unfortunately, family relationships of those with dual diagnosis can often be put under vast amounts of strain that cause the family dynamics to breakdown.

Leading to people losing contact with their friends and families. This therefore makes family interventions very difficult as often one or both parties (care giver(s) and service user) do not wish to accept family work. In addition to this there are service users who do not wish their care givers be informed of their illicit drug use as they are worried of the consequences this may bring, for example: negative appraisal due to the stigma surrounding substance misuse. From experience this can be overcome in some cases through normalisation and psycho-education. Providing a good rationale of why care givers should be informed and how doing this can help the situation. Although, this often takes a lot of guidance and motivational interviewing techniques.

Table 5

Psycho-education with Laura and her Father.

Once Laura was admitted to the rehabilitation unit where she is currently residing her father got in touch. Laura was keen to build on the relationship between her and her father and started to visit him once a week. Staff at the

unit (whom are not trained in family interventions) thought it would be a good idea to spend some time with Laura and her father to help them both gain an understanding of each others situation, thoughts, feelings and behaviours.

After explaining the benefits of this to Laura she consented and her dad was offered to come and have a few informal sessions with Laura and her named nurse. Lauras dad explained how he had never been given any information about schizophrenia or substance misuse and how he knew very little of how these effected his daughter. This information was shared with both Laura and her dad. The stress vulnerability model was explained to Laura's dad with a view to building on his understanding of why his daughter experiences psychotic symptoms and providing a reason why she uses drugs. Leading on to state how this only causes more problems (all of this was discussed with Laura at an earlier date). Lauras Dad was given the opportunity to voice any concerns he had about regaining contact with Laura i.e. financial drain, crime, and 'picking up the peices'. These problems were discussed and brainstormed with both Laura and her dad to identify ways to prevent these happening, and produce a contingency plan if either person felt they needed support.

Lauras Dad reported that these sessions made it easier for him to build on lost relationships with his daughter and reduced his fears that he would have to 'deal with it all if things went wrong'. Laura also felt much more positive as now she was starting to rebuild relationships providing more motiviation to change and sustain change. Her mood improved slightly and she had more hope for the future.

Arguably the benefits Laura experienced may have inevitably occurred without staff intervention.

Literature Review

A small number of studies examining interventions for use with people with dual diagnosis will now be appraised.Two of the Studies are Randomised Controlled Trials (RCT's) and are considered the gold standard method for evaluating treatment efficiency (Greenhalgh 2006). They are said to produce the least biased results as random samples are used to minimise the possibility of error in design and conduct (Roberts, 1999).

Barrowclough et al (2001) and Haddock et al (2003)

Barrowclough et al (2001) produced one of the first robust RCT's to examine the impact an integrated intervention programme consisting of CBT,MI and FI had upon service users. The design of the trail was robust in that it was a RCT, ensured as far as possible good treatment fidelity (making certain that the treatment being delivered is the one intended (Leeuw 2009)) and the assessors in the trial were blind to group allocation (reducing the risk of bias). However there were some limitations of this study such as small numbers of participants, short follow up period, and treatment was delivered by cognitive behavioural therapists. In reality it is not possible for all service users with dual diagnosis to receive interventions from a cognitive behavioural therapist. All of these limitations question the generalisibility of the results. Although care givers were in receipt of interventions their outcomes were not reported in this study. It would have been interesting to see these results; even those whom were in the control group received more interventions than the majority of families of substance misusers get (based on experience). One could hypothesise that the results of the two groups were not too dissimilar due to the fact that both sets of care givers were being supported. The Haddock et al (2003) study is a follow on from the Barrowclough et al (2001) study reporting further service user outcomes, cost effectiveness and carer outcomes over an 18month period.

The robustness of the study was discussed above. This study found quite significant positive outcomes of those whom received the integrated intervention programme. Results demonstrated improved outcomes for the service users general and social functioning, and reduced number of negative symptoms to a significant degree. When examining this result with experience from practice it could be hypothesised that when a service users level of functioning increases they rely less upon their care givers. Thereupon improved functioning has a positive indirect effect upon carers.

There was also a small difference in the percentage of days of abstinence between the two groups with the treatment group proving more favourable. However, the clinical significance of this is questionable.

Although carer outcomes were reported within the Haddock et al (2001) paper they are only briefly examined with more of an emphasis based on cost effectiveness. However, the results do show promise for care givers within the treatment programme, showing some trends towards better personal outcomes. At the 12 month follow up the treatment group demonstrated a reduction in needs and objective and subjective burden. However, these results were not statistically clinically significant. Haddock et al (2003) suggest more intensive work should be done with families due to the high rates of expressed emotion.

Baker et al (2006)

Baker et al (2006) also produced a RCT to examine the impact a series of sessions of CBT and MI has upon service users with a dual diagnosis. This study was not as robust as the Barrowclough et al (2001) study in relation to randomisation and assessor blindness. Within this study participants were paid for their expenses and time attending assessments.

Although the authors suggest this was not enough to influence responses, this procedure was not carried out in similar studies such as the one by Barrowclough and colleagues (Barrowclough et al 2001 and Haddock et al 2003) which should be considered when comparing results. Another negative to this study as with that of Barrowclough et al(2001) was that the interventions were carried out by highly trained psychologists; Echoing the argument of generalisability. On a positive note this study did have a larger number of participants almost double that of Barrowclough et al (2001). Baker et al (2006) suggest both this trial and the one carried out by Barrowclough and colleagues suggest improvements in substance misuse. However from the results these improvements appear minimal. Baker et al (2006) also report that there was no significant difference in improvement of functioning or positive symptoms; providing opposite and contrast results of the Barrowclough et al (2001) study. Baker et al (2006) conclude that this study demonstrates that this challenging case group (service users with dual diagnosis) is able to engage in CBT and demonstrate positive results. Although this ‘excellent therapy-attendance’ could be questioned due to the use of payment for time and travel.

Graham et al 2006

This study carried out by Graham et al (2006) differs from those discussed above in that it is not a RCT, it is a preliminary evaluation of the impact of C-BIT training on 3 assertive outreach teams and service user outcomes and is not an RCT. Care co-ordinators from 5 assertive outreach teams were allocated to two groups. One of which received immediate C-BIT training and the other groups training was delayed. Results of the training demonstrated increased confidence of care co-ordinators in working with substance misuse and mental illness.

Graham et al (2006) suggest these findings illustrate the effectiveness of such training and highlights the extent to which implementation actually occurs. They suggest their findings add evidence to the recommendations made for implementation of interventions for this client group presented in Mental Health Implementation Guide: Dual Diagnosis Good Practice (DOH 2002). Graham et al (2006) also discuss the impact of such training upon service user outcomes. The results highlighted an improvement in engagement, reduction in alcohol use and a reduction in positive alcohol related beliefs. Demonstrating that this team approach to C-BIT shows promise. This report does not measure impact on care giver outcomes. All of the reports mentioned here suggest further research is needed to establish a firm evidence base for integrated treatment programmes that use interventions such as CBT, MI and FI. Nonetheless, they do provide a good grounding for recommending that such interventions show promise for enhancing service user and carer experience. In order to do this there may need to be a change in service provision.

For example for a change within treatment philosophy of a team may mean that all staff must be trained preferably at the same time (Graham 2004). This causes barriers on numerous levels such as cost implications of all staff receiving training, back fill of their hours, cost of trainer and venue etc.. Potential barriers may occur when implementing these newly acquired skills and knowledge due to feelings of diminished confidence as part of the learning process (Atherton 2008).

Discussion

Substance misuse services separated for mental health services some time ago (Conley & Benishek 2003) and as a result mental health professionals have limited training and experience in working with people who misuse substances. In addition, many drug and alcohol workers have only had minimal education in mental health issues (Frankel 1996). This could result in mental health professionals and substance misuse workers feeling unequipped in working with people with a dual diagnosis; resulting in them receiving inadequate care. A way to overcome this is for more health professionals to acknowledge their deficits in knowledge and attend training. Perhaps as a result of having minimal education in the field of substance misuse, negative attitudes towards those who misuse substances is still present (Howard & Chung 2000 and Richmond & Foster 2003). This can take the form of moralistic and stereotypical attitudes leading to mistrust, suspicion and avoidance on both sides. Evidence indicates that when such attitudes are held problems of substance misuse are often overlooked and not dealt with or referred on (Howard & Chung 2000).

Table 6:

Luke – Case Study

Luke was brought up in a deprived area of a large city and often experimented with illicit substances with his friends. He had a very poor relationship with his mother and siblings (although he did reside with them) and never saw his father. Luke started to hear voices at the age of 18 and was soon admitted to an acute unit where he commenced anti-psychotic medication. Luke was discharged from hospital back to his home.

Luke's motivation was draining and he was experiencing little enjoyment in life. it wasn't long before he stopped taking his anti-psychotic medication because it was making him put on weight and causing side effects. Luke soon found that taking crack cocaine provided a release from his 'blues' and was now using frequently. Luke self referred to a local drug scheme (under the pressure of his mother and the threat of becoming homeless) but they

were reluctant to take him on because he was self medicating. His Community Mental Health Team found it difficult to meet all of his complex needs and Luke ended up back on an acute ward. Luke's Mother had now had enough and didn't want Luke back home. A place was found for Luke at a rehabilitation unit but he must first give up the use of any illicit substances or he would not be admitted.

Luke managed to do this for a few weeks and was admitted to the rehabilitation unit. He was only there a few days when he relapsed and used excessive amounts of alcohol and crack cocaine and his mental health deteriorated dramatically. He was re-admitted to the acute ward. Staff at the Rehabilitation unit were dubious about taking Luke back because of their rule of abstinence and the chaotic lifestyle that surrounds Luke.

Fortunately a nurse went to reassess Luke to return back to the unit and gained a greater picture of why he relapsed. Using the Stress Vulnerability Model (Bucket Analogy) she helped Luke to see how his behaviour impacts negatively upon him and that crack cocaine only provides a short term fix. Luke returned to the unit and he has had occasional relapses since but his and the staffs attitude towards them has changed. Despite there being a huge drive from government produced documents and guidelines for people within mental health services to have access to psychological therapies Bird (2006) identifies a number of populations that have difficulties accessing such services. One of which are those with dual diagnosis as services have difficulty providing for their multiple needs.

This can lead to people slipping through the net or being passed from service to service with no one willing to take responsibility for a person's care (see table 6: The case of Luke). This is where effective case management comes into play. Onyett (1998) discusses the need for effective case management when meeting the needs of service users and their care-givers. He describes a part of case management as the identification and co-ordination of services that can appropriately meet the service users' needs. In essence brokering out to other services and not trying to meet all of the services users needs alone. This means the service user and their care givers should get the best appropriate evidence based care/interventions. This supports the recommendations of Graham et al (2003), Abou-Saleh (2004), and Graham et al (2006) where effective service delivery means teams are

developed to meet tailored needs of particular client groups i.e. assertive outreach teams, home treatment, as recommended in the National Health Service Plan (DOH 2000). Unfortunatly, from experience, this is still not a reality and although such teams are present, there is too much demand for such specialised services. Perhaps the answer is to attempt to incorporate evidence based treatments such as those outlined earlier in to practice in more general services too for example Community Mental Health Teams. With a view to provide evidence based interventions for dual diagnosis to those even when not in a specialised team. If health professionals have more of an awareness of the evidence base for psychosocial interventions for all the problems service users with serious mental illness face.

Then maybe confidence to work with complex cases may increase, enhancing the service users experience of mental health services and improving individualised outcomes. This suggestion itself produces barriers though; for all health professionals to provide evidence based care they must stay abreast of new knowledge, research, and guidelines in order to practice competently (Turner & Mjolne 2001). Although this appears an impossible task when so much information is being published. Unfortunately, figures for production of mental health related literature could not be found Khan et al (1999) suggest over 2 million bio-medical articles are published annually. This number cannot be too dissimilar to mental health literature. With such vast amounts of information how can one stay truly up to date with evidence based practice. A method to help tackle this is the formation of journal clubs within mental health services.

Turner & Mjolne (2001) and Khan et al (1999) both suggest Journal clubs are an effective way of promoting wider reading and utilization of research. It also supports those who may not have proficient skills at critical appraisal of research. From experience and evidence it could be concluded that the majority of mental health professionals are not fully trained in delivering cognitive-behavioural therapy, amongst other interventions to those with dual diagnosis. Even if people are aware of the evidence base; if they are not trained, then they are not likely to provide efficient treatment. Additionally, when people are trained to deliver specific interventions they require ongoing clinical supervision to build on skills and knowledge, improving competence and confidence (Brooker & Brabban 2004). Clinical supervision it thought to reduce burnout, increase job satisfaction and alter dysfunctional attitudes

(Bradshaw, Butterworth & Mairs 2007 and Hykras 2005). Therefore, the use of clinical supervision may also provide a method of reducing the number of negative attitudes towards those who misuse substances, ultimately reducing another barrier that those with dual diagnosis may face when receiving effective psychosocial interventions.

Conclusion

This report has aimed to discuss the term complexity. Demonstrating that being human makes us all complex and complexity should be viewed as on a continuum. All service users are complex cases but some are faced with and present more challenges to themselves, their care givers and mental health services.

There are some psychosocial interventions that show promise for enhancing service user and care giver experience of mental health services and improve individual outcomes. For example the interventions explored in this report (CBT, MI and FI) display potential for improving service users and care givers outcomes and optimising service delivery. Although the evidence for these are still limited and more research is required also a number of barriers make the implementation of such interventions difficult. As possible methods of overcoming these a number of recommendations have been made. In order for mental health professionals to provide interventions such as the ones explored in this report, training will need to be given and adequate support and supervision. This will allow professionals to build on skills, knowledge and competence when working with complex cases. Supervision also allows a forum for dysfunctional attitudes to be explored and discussed.

Hopefully, overcoming any negative thoughts and feelings towards those with dual diagnosis. In addition to this mental health services need to be clear on their admissions criteria, accepting that substance misuse and psychosis are co-morbid and not two separate entities where one must be eradicated before a person can access services. The services do not necessarily need to meet all the needs of the individual but have mental health professionals that are effective case managers.

Thus ensuring that if people do not have the skills to deal with such complex needs then they have the skill to

recognise this and re-refer to other services. As mentioned within this report it is very difficult for mental health professionals to keep up to date with current evidence based practice due to the large amounts published each year. One way of attempting to overcome this it the use of journal clubs. This would allow for sharing of evidence and encourage staff to remain up to date through reading. All of the above recommendations would enhance service user and care giver experience through staff being more knowledgeable about working with dual diagnosis and providing evidence based psychosocial interventions.

Reference List

Atherton, J.S. (2008) Doceo;Learning as Loss 1 [On-line] UK: Available: https://www.doceo.co.uk/original/learnloss_1.htm Accessed: 16 May 2009 Baker, A.; Bucci, S.; Lewin, T.J.; Kay-Lambkin, F.; Constable, P.M. & Carr, V.J. (2006) Cognitive Behavioural Therapy for Substance Use Disorders in People with Psychotic Disorders. British Journal of Psychiatry. 188, 439-448 Barrowclough, C.; Haddock, G.; Tarrier, N.; Lewis, S.W.; Moring, J.; O'Brien, R.; Schofield , N. & McGovern, J. (2001) Randomized Controlled Trial of Motivational Interviewing, Cognitive Behavioural Therapy, and Family Intervention for Patients with Co Morbid Schizophrenia and Substance Use Disorders. American Journal of Psychiatry. 158, 1706-1713 Bird, A (2006) We Need to Talk: The Case for Psychological Therapy on the NHS. London: Mental Health Foundation Bradshaw, T.; Butterworth, A. & Mairs, H. (2007) Does structured clinical supervision during psychosocial intervention education enhance outcome for mental health nurses and the service users they work with? Journal of psychiatric and mental health nursing. 14, 4-12 Brooker, C. & Brabban, A. (2004) Measured success: A scoping review of evaluated psychosocial interventions training for work with people with serious mental health problems. NIMHE: Trent WDC Brown, G.W., Monck, E.M., Carstairs, G.M & Wing, J.K. (1962) Influence of family life on the course of schizophrenic illness.

British Journal of Preventative and Social Medicine, 16(2) 55-68 Buckley, P.F.; Hasan, S.; Friedman, L. & Cerny, C. (2001) Insight and Schizophrenia. Comprehensive Psychiatry. 42(1), 39-41 Cather, C. (2005) Functional Cognitive Behavioural Therapy: A Brief Individual Treatment for Functional Impairments Resulting From Psychotic

Symptoms in Schizophrenia. Canadian Journal of Psychiatry. 50, 258-263 Clark, R.E. (1996) Family Support for People with Dual Disorders. New directions for mental health services. 70, 65-78 Cleary, M.; Hunt, G.; Matheson, S.; Siegfried, N. & Walter, G. (2009) Psychosocial Interventions for People with Both Severe Mental Illness and Substance Misuse. Cochrane Database of Systematic Reviews.

Issue 1 Conley, H. & Benishek. (2003) Dissociation in adults with a diagnosis of substance abuse. Nursing Times Clinical. 99(20) Couture, S.M.; Penn, D.L. & Roberts, D.L. (2006) The Functional Significance of Social Cognition in Schizophrenia: A Review.

Schizophrenia Bulletin. 32(s1), s44-s63 David, A.S. (1990) Insight and Psychosis. British Journal of Psychiatry. 156, 798-808 Dixon, L.; McNarey, S. & Lehman, A. (1995) Substance Abuse and Family Relationships of Persons with Severe Mental Illness. American Journal of Psychiatry. 152, 456-458 DOH (1999a) The National Service Framework For Mental Health: Modern Standards and Service Models. London: Department of Health DOH (1999b) Drug Misuse and Dependence: Guidelines on Clinical Management.

London: Department of Health DOH(2000) NHS Plan: A Plan for Investment a Plan for Reform. London: Department of Health. DOH (2001a) Valuing People: a new strategy for Learning Disability for the 21st century. London: Department of Health. DOH (2001b) The Mental Health Policy Implementation Guide. London: Department of Health DOH (2002) Mental Health Policy Implementation Guide: dual diagnosis good practice guide. London: Department of Health DOH (2005) The Offender Mental Health Care Pathway.

Department of Health: London DOH (2006) From Values to Action: The chief Nursing Officers Review of Mental Health Nursing. London: Department of Health Drake, R.E. & Mueser, K.T. (2000) Psychosocial Approaches to Dual Diagnosis. Schizophrenia Bulletin. 26(1), 105-118 Drake et al (1993) Treatment of substance abuse in severely mentally ill patients. Journal of Nervous and Mental Disease, 181, 606-611 Cited in Abou-Saleh, M.T. (2004) Dual Diagnosis: Management Within a Psychosocial Context.

Advances in Psychiatric Treatment. 10, 352-360 Fischer, E.P.; McSweeny, J.C.; Pyne, J.M.; Williams, K.; Naylor,

A.J.;Blow, F.C. & Owen R.R. (2008) Influence of Family Involvement and Substance Use on Sustained Utilization of Services for Schizophrenia. Psychiatric Services. 59, 902-908 Frankel, E.H. (1996) Dissociation: The Clinical Realities. American Journal of Psychiatry. 153, 64-70 Gamble, C. & Curthoys, J. (2004) Psychosocial Interventions. Chapter 10 in Norman, I. & Ryrie, I. (eds) (2004) The Art and Science of Mental Health Nursing: A Textbook of Principles and Practice. England: Open University Press Garety, P.A., Fowler, D.G., Freeman, D., Bebbington, P., Dunn, G. & Elizabeth, K. (2008) Cognitive-behavioural therapy and family intervention for relapse prevention and symptom reduction in psychosis: randomised controlled trial.

The British Journal of Psychiatry, 192, 412-423 Gibbins, J. & Kipping, C. (2006) Coexisistant substance use and psychiatric disorder. Chapter 14 in Gamble, C. & Brennan, G. (2006) Working With Serious Mental Illness: A manual for clinical practice.

Philadelphia: Elsevier Graham, H. (2004) 2004) Implementing integrated treatment for co-existing substance use and severe mental health problems in assertive outreach teams: training issues. Drug and Alcohol Review. 23(4),463- 470 Graham, H.; Copello, A.; Birchwoord, M.; Orford, J.; McGovern, D.; Georgiou, G. & Godfrey, E. (2003) Coexisting severe mental health and substance use problems: developing integrated services in the UK. Psychiatric Bulletin. 27, 183-186 Graham, H.; Copello, A.; Birchwood, M. J.; Mueser, K.; Orford, J.; McGovern, D.; Atkinson, E.; Maslin, J.; Preece, M.; Tobin, D. & Georgiou, G. (2004) Cognitive-Behavioural Integrated Treatment (C-BIT): A treatment manual for substance misuse in people with severe mental health problems. Chichester: John Wiley & Sons Ltd. Graham, H.L.; Copello, A.B.; Max, O.J.; McGovern, D.; Mueser, K.T.; Clutterbuck, R.; Godfrey, E.; Maslin, J.; Day, E. & Tobin, D. (2006)A preliminary evaluation of integrated treatment for co-existing substance use and severe mental health problems: Impact on teams and service users. Journal of Mental Health.15(5),577 — 591 Greenhalgh, T. (2006) How to read a paper: the basics of evidence based medicine. (3rd edition). Oxford: Blackwell Publishing Griffiths, R. & Allan, R. (2007) Whose Health, Whose Care, Whose Say? The opportunities and challenges of contemporary policy for people with complex mental health needs: Report of CSIP Eastern and SPN Study day.

London: Turning Point Haddock, C.; Barrowclough, C.; Tarrier, N.; Moring, J.; O'Brien, R.; Schofield, N.; Quinn, J.;

Palmer, S.; Davis, L.; Lowens, I.; McGovern, J. & Lewis, S. (2003) Cognitive Behavioural Therapy and Motivational Intervention For Schizophrenia and Substance Misuse: 18 Month Outcomes of a Randomised Controlled Trial. British Journal of Psychiatry. 183, 418-426 Howard, M.O. & Chung, S.S. (2000) Nurses Attitudes Towards Substance Misusers. 1 Surveys. Substance Use and Misuse: An International Interdisciplinary Forum. 35(3), 347-365 Hussein, R.G. (2002) Substance misuse and Mental Health: An Overview. Nursing Standard. 16(50), 47-55 Hykras, K. (2005) Clinical supervision, burnout, and job satisfaction mental health and psychiatric nurses in Finland. Issues in Mental Health Nursing. 26(5), 531-556 Jackson, H.J., McGorry, P.D., Killackey, E., Bendall, S., Allott, K., Dudgeon, P., Gleeson, J., Johnson, T. & Harrigan, S. (2008) Acute-phase and 1-year follow-up results of a randomised controlled trial of CBT versus Befriending for first-episode psychosis: the ACE project.

Psychological Medicine, 38, 725-735 Jones, C., Cormac, I., Silveira da Mota Neto. J.I. & Campbell, C. (2004) Cognitive Behaviour Therapy for Schizophrenia. Cochrane Database of Systematic Reviews 2004, Issue 4 Kavanagh, D.J. (1992) Recent developments in expressed emotion in schizophrenia. British Journal of Psychiatry, 160, 601-620 Kemp R.; Hayward, P.; Applewhaite, G.; Everitt, B. & David, A. (1996) Compliance therapy in psychotic patients: randomised controlled trial. British Medical Journal. 312, 345-349 Khan, K.S.; Dwarakanath, L.S.; Pakkal, M.; Brace, V. & Awonuga, A. (1999) Postgraduate Journal Club as a Means of Promoting Evidence-Based Obstettics and Gynaecology.

Journal of Obstetrics and Gynaecology. 19(3), 231-234 Kipping, C. (2004) The Person Who Misuses Drugs of Alcohol. Chapter 17 in Norman, I. & Ryrie, I. (eds) (2004) The Art and Science of Mental Health Nursing: A Textbook of Principles and Practice. England: Open University Press Leeuw, M., Goossens, M.J.E.B., de Vet, H.C.W. & Vlaeyen, J.W.S. (2009) The fidelity of treatment delivery can be assessed in treatment outcome studies: a successful illustration from behavioral medicine. Journal of Clinical Epidemiology. 62(1), 81-90 Littlejohn, C. (2005) Links Between Drug and Alcohol Misuse and Psychiatric Disorders. Nursing Times Clinical. 101(01) Mairs, H & Bradshaw, T. (2005) Modernising Psychosocial Intervention Education: the new COPE programme.

Mental Health Practice. 9(3), 28-30 Marder, S.R.; Essock, S.M.; Miller, A.L.; Buchanan, R.W.; Casey, D.E.; Davis, J.M.;

Kane, J.M.; Lieberman, J.A.; Schooler, N.R.; Covell, N.; Stroup, S.; Weissman, E.M.; Wirshing, D.A.; Hall, C.S.; Pogach, L.; Pi-Sunyer, X.; Thomas Bigger, J.; Friedman, A.; Kleinberg, D.; Yevich, S.J.; Davis, B. & Shon, S. (2003) Physical Health Monitoring of Patients With Schizophrenia. American Journal of Psychiatry. 161, 1334-1349 Miller, W. & Rollnick, S. (2002) Motivational Interviewing: Preparing People to Change Addictive Behaviour (2nd Edn). New York: Guilford Press Moore, A.; Sellwood, W. & Stirling, J. (2000) Compliance and psychological reactance in schizophrenia.

British Journal of Clinical Psychiatry. 39, 287-295 Nelson, H. (2005) Cognitive Behavioural Therapy with Delusions and Hallucinations: A Practice Manual Handbook (2nd Edition). Cheltenham: Nelson Thornes Ltd NICE(2007) Drug Misuse: Psychosocial Interventions. London: National Institute for Health and Clinical Excellence. NICE (2009) Schizophrenia: Core intervention is the treatment and management of schizophrenia in adults in primary and secondary care. London: National Institute for Health and Clinical Excellence. Onyett, S. (1998) Case Management in Mental Health. London: Nelson Thorns. Pharoah, F., Mari, J., Rathbone, J. & Wong, W. (2006) Family intervention for schizophrenia.

Cochrane Database of Systematic Reviews, Issue 4. Pilling, S., Bebbington, P., Kuipers, E., Garety, P., Geddes, J., Orbach, G. & Morgan, C. (2002) Psychological treatments in schizophrenia: I. Meta-analysis of family intervention and cognitive behavioural therapy. Psychological Medicine, 32, 763-782 Prochaska, J. & DiClemente, C. (1986) Towards a Comprehensive Model of Change. In Miller, W. & Heather, N. (Eds) Treating Addictive Behaviours: Processes of Change. New York: Plenum. Cited in Kipping, C. (2004) The Person Who Misuses Drugs of Alcohol. Chapter 17 in Norman, I. & Ryrie, I. (eds) (2004) The Art and Science of Mental Health Nursing: A Textbook of Principles and Practice.

England: Open University Press Reader, D. (2002) Working with Families. Chapter 11 in Harris, N., Williams, S & Bradshaw, T. (Eds) (2002) Psychosocial Interventions for People with Schizophrenia. Hampshire: Palgrave Macmillan Rankin, J. & Regan, S. (2004) Meeting Complex Needs: The Future of Social Care. London: IPPR/Turning Point Randall, G., Britton, J., Brown, S. & Craig, T. (2006) Getting through – access to mental health services for

people who are homeless or living in temporary or insecure accommodation: a good practice guide.

London: Department of Health, Care Services Improvement Partnership, Department of Communities and Local Government. Richmond, I.C. & Foster, J.H. (2003) Negative Attitudes Towards People with Co-morbid Mental Health and Substance Misuse Problems: An Investigation of Mental Health Professionals. Journal of Mental Health. 12(4), 393-403 Roberts, R. (1999) Information for Evidence-Based Care. Oxon: Radcliffe Medical Press Soanes, C. & Stevenson, A. (Eds) (2005) Oxford Dictionary of English. Oxford University Press: Oxford Tarrier, N.; Sharpe, L.; Beckett, R.; Harwood, S.; Baker, A. & Yusopoff, L (1993) A Trial of Two Cognitive Behavioural Methods of Treating Drug Resistant Residual Psychotic Symptoms in Schizophrenic Patients. Social Psychiatry and Psychiatric Epidemiology. 28(1), 5-10 Thylstrup, B. & Johansen, K.S. (2009) Dual Diagnosis and Psychosocial Interventions: Introduction and Commentary.

Nordic Journal of Psychiatry. 63(3), 202-208 Turner, P. & Mjolne, I. (2001) Journal Provision and the Prevalence of Journal Clubs: A survey of Physiotherapy Departments in England and Australia. Physiotherapy Research International. 6(3), 157-169. Weiss, R.D.; Griffin, M.L.; Kolodziej, M.E.; Greenfield, S.F.; Najavits, L.M.; Daley, D.C.; Doreau, H.R. & Hennen, J.A. (2007) A Randomised Controlled Trial of Integrated Group Therapy Versus Group Drug Counselling For Patients With Bipolar Disorder and Substance Dependence.

American Journal of Psychiatry. 164, 100-107 Wilson, T.; Holt, T. & Greenhalgh, T. (2001) Complexity Science: Complexity in Clinical care. British Medical Journal. 323,685-688 Zubin, J. & Spring, B. (1977) Vulnerability – A New View Of Schizophrenia. Journal of Abnormal Psychology 86: 103-126. Cited in Norman, I & Ryrie, I (eds) (2004) The Art and Science of Mental Health Nursing: A Textbook of Principles and Practice. England: Open University Press