Myth exploded

Working effectively with patients with comorbid mental illness and substance abuse: a case study using a structured motivational behavioural approach

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SUMMARY

This case describes the use of innovative person-centred motivational behaviour change tools to enhance chronic condition self-management with a person with chronic paranoid schizophrenia, significant drug abuse and multiple psychosocial issues. In standard care, the complexity of this patient’s presentation, their cognitive impairment level and history of violence would likely exclude them from many therapies and treatment programs as unsuitable or in the “too hard” basket. In fact, using a motivational and highly person-centred approach proved to be extremely necessary and rewarding for the person and their mental health worker. This approach provided a clear structure, actual tools and a clear rationale for what many would argue, yet is often ill-defined, was “just good clinical practice”. However, it also facilitated the development of “something special” in the relationship between the person and their worker that is central to person-centred care. Through a semistructured, motivational, sequential process that encouraged gradual disclosure and greater self-awareness by the client and active listening by the worker, greater collaboration and shared responsibility was enhanced.

BACKGROUND

This case report offers a new perspective on an old problem: that of comorbid drug abuse and chronic mental illness and how to effectively treat this problem in mental health community service settings. Comorbidity is often associated with high service utilisation, severe and complicated illness course, poor treatment outcomes,¹ and multiple social, economic, legal and interpersonal costs for the person involved and their community.

Traditionally, mental health services have struggled to address or effectively treat patients with comorbid drug abuse because they have focused on what they assess as the primary psychiatric disorder and largely ignored the secondary drug abuse problem. Mental health workers often accept comorbidity as part of the patient culture, feel overwhelmed by the chaos it creates for the person, or avoid it due to lack
of skills to take any action to address it. As a consequence, the comorbidity has often confounded treatment effectiveness for these populations who either overutilise services as a result of the chaos they create or are excluded from services altogether as rigid boundaries are drawn. This continues to be a pervasive problem for mental health services, addiction services and primary care providers such as doctors in their attempts to treat comorbidity effectively.

Treatments for substance abuse have relied heavily on the transtheoretical model of change and motivational interviewing\(^2,3\) to assess peoples' readiness to change and hence the timing, type and targeting of interventions. However, people with comorbid drug abuse and mental illness are often judged to be at the precontemplation stage, either by choice or circumstance, with little prospect of change. The transtheoretical model has offered little to the person or service providers in assisting these people to move from this position to contemplate change.\(^4\) Over the past decade, the Flinders Human Behaviour and Health Research Unit has developed a person-centred model to support behaviour change. This “Flinders Model” is based on a structured assessment process that is performed in a motivational way, combined with problem solving and goal setting, underpinned by cognitive behavioural therapy principles and procedures that can be monitored and systematically measured over time to record progress. The model has been used in populations with a broad range of health conditions in Australia and internationally.\(^5-8\) Several clinical trials using the model have been completed or are currently underway within Australia, New Zealand and the USA in the areas of veterans with alcohol abuse, cardiac and respiratory rehabilitation, diabetes management, stroke management and indigenous health, as well as more general applications in primary care. The Flinders Model is firmly endorsed by a number of Australian State Departments of Health and health service sectors in Australia as part of their efforts to address the growing burden of chronic disease.\(^9,10\)

The subject of the following case report was 1 of 38 participants in an Australian feasibility study testing the effectiveness of the Flinders Model tools with a community mental health service population sample.\(^6\) The Flinders Model tools comprise four steps:

- The Partners in Health (PIH) scale, a brief 14-item self-assessment questionnaire filled out by the patient assessing their perceived current self-management knowledge and behaviours, and the physical, social and emotional impacts of their chronic conditions.

- The Cue and Response (C&R) interview, a clinician-administered interview using open-ended questions related to the domains from the PIH, enquiring about the patient’s condition and treatment knowledge and understanding, symptom monitoring and management, involvement in decision making, how they manage the impact of the condition on physical, emotional and social life, and healthy lifestyle behaviours. The worker and the patient compare and discuss their individual scores on each item and negotiate issues for a care plan in a client-centred way. Barriers and enablers to self-management emerge from this conversation.

- The Problems and Goals (P&G) formulation, which allows identification of the main problem from the patient’s point of view which may be physical, social and not their primary diagnosis. This allows a key issue
or barrier to be identified that may be interfering with the patient’s behaviour change or adherence to recommended treatment. This is undertaken through open-ended questioning by the worker, adapted from behavioural psychotherapy, to determine the person’s self-identified main problem(s), including the problem, what happens because of the problem and how it makes the person feel. The person is then asked to set a SMART (specific, measurable, action-based, relevant, timely) medium-term goal to directly or indirectly address the problem, with the problem and goal scored over time to review progress.

- A structured Care Plan, devised by the patient and their worker, that outlines the main problems or issues to be addressed, what actions and resources are needed, who is responsible and timeframes for action and review.

**CASE PRESENTATION**

The patient is a 45-year-old single man, living alone in public housing accommodation with his dog. He has been a client of public community mental health services for the past 20 years receiving twice-weekly contact from a female key worker (community mental health case manager). His diagnosis is chronic paranoid schizophrenia complicated by longstanding drug abuse beginning in his early teens. He has impaired cognition as a consequence of his illness and lifestyle history, this presenting as significant problems with planning, concentrating, memory and problem solving. He has a significant history of violence in the context of psychosis and alcohol and other drug abuse, with multiple admissions to hospital in the past. He has a strong history of violence towards male workers and feels highly threatened by men generally. He regularly doctor-shops for "benzo" prescriptions for "acquaintances" as part of a subcultural ethos of helping others in his street and exchange of "goods". In the community, he is a two-person contact for appointments with the psychiatrist and for his injection of antipsychotic medication. He has been on a treatment order for several years due to his history of violence when untreated and his refusal to take medication without an order in place. His usual presentation is of a persistent level of paranoia and suspicion with those he does not know, regardless of medication effects. This includes ideas of reference from TV and radio and beliefs that people have been changing the locks and are breaking into his house; ideas that fluctuate in intensity depending on mood changes, financial and other stressors and degree of drug abuse. His neighbourhood is known for its high crime rate and high prevalence of illicit and licit drug dealing and drug use, domestic violence and mental illness among its population. His usual day would be to stay at home, smoking cigarettes much of the time and drinking coffee excessively. Payday is often celebrated with intravenous amphetamines bought or traded with one of the local dealers or with methylphenidate (Ritalin) bought from one of the local parents who have children diagnosed with attention deficit disorder. Most other days, he takes between 20 and 60 biperidin (Akineton) tablets (used to alleviate the side effects of antipsychotic medications with the correct standard dose being 2 tablets daily) depending on availability in order to get "high". He has made a number of high lethality suicide attempts, the last of these being approximately 6 months prior to his participation in the "Flinders Model" project. This last attempt involved serious deep cuts to his forearms, damaging tendons and nerves permanently in both arms.
The patient had been perceived by the mental health service as unlikely to be able to cope independently (ie, to be a client of the service for the rest of his life) due to his level of disability and level of risk to the community if he was not assertively followed-up on a very regular basis. He has a number of compounding psychosocial factors that impinge on his well-being. He exists hand-to-mouth with pension use each fortnight, booking up credit at the deli (a local shop/convenience store) and the belief that it will always be this way. He lives within an environment of trade and intimidation; a street culture in which he is generous to others and gives away most things of value that he has because he perceives himself as “different” and stigmatised and just wants friends. This contrasts with him presenting as volatile and “scary” to some people in the neighbourhood. He presents as vulnerable and childlike in his relationships with others, easily led and impressionable. He smokes up to 100 cigarettes per day, often spending up to half of his government pension on cigarettes and going without food as a result. His house is spartan in appearance and he has no possessions of any value. The dog always gets fed. His nutrition is poor, usually pies booked up at the deli as he says he is too paranoid to go to large supermarkets alone. He is socially isolated and has been institutionalised into receiving care from community mental health services for all of his adult life.

The patient’s general wants that emerged from the C&R Interview between him and his worker included:

- To feel normal.
- To feel like a man. This involved better body image. He wanted to use weights at home but had problems with negative symptoms compounded by perceiving his social situation as hopeless anyway, consequently having little motivation and problems building routines for himself.
- To feel worthwhile. He had a strong sense of social duty and felt inadequate because he did not have a job. He compensated for this feeling by doing things for others, for example, walking all night with the dog, looking for valuables on the streets or in bins, only to give them to others.
- To need less medication and to be off the treatment order.
- To stop abusing side-effect medications.
- To be less financially stressed every week and to take better care of himself and his dog.

**DIFFERENTIAL DIAGNOSIS**
Paranoid schizophrenia, schizoaffective disorder, polysubstance abuse.

**TREATMENT**
Fortnightly depot flupenthixol 200 mg, 4 mg biperidin daily (note abuse beyond this recommended dose), compulsory treatment orders (CTOs) sought annually since he was in his early 20s.

**OUTCOME AND FOLLOW-UP**
Identifying problems and setting goals
The patient identified his main problem within the P&G tool cognitive behaviour therapy (CBT) framework of (problem, impact, feeling) as:
What do you see as your main problem? "Tiredness and lack of physical strength".

How does this problem change the way you live? "I sleep a lot and lack energy and use drugs to make me feel more alert. I sit around and smoke and don’t get motivated to do anything".

How does this problem make you feel? "I feel weak and depressed".

He rated it as 6 out of 8 on 0–8 Likert scale with 0 representing no problem and 8 representing severe problem.

The patient’s main SMART goal was to, "Use my weights to build up my muscle strength and feel fitter at least once a week at home on my own". His subgoal was, "To walk my dog three times per week for at least 30 minutes in the evening".

He rated progress towards achievement of these goals as 6 out of 8 with 0 representing full achievement and 8 representing no progress towards achievement.

The patient had two connected problems and goals, which were also supported by interventions negotiated between the patient and the worker:

(1) Problem: "Feeling anxious and suicidal due to using too many drugs leads to problems with my memory, going out, keeping my cool around other people, and managing my money which makes me feel even more depressed like there’s no hope for the future".

Goal/Intervention: stop abusing biperidin (side effect medication) by sticking to withdrawal plan worked out with key worker over the next 2 months.

(2) Problem: "Being a smoker means that I’m poor all the time and other people are more able to book smokes up in my name at the deli and this make me more poor and annoyed that people keep thinking they can use me".

Goal/Intervention: together with key worker, visit the deli next week to devise limit setting plan with deli owner regarding cigarette purchases.

**Action taken by the key worker to support the patient**

The key worker had an established 7-year relationship and rapport with the patient that enabled them to persuade the patient to participate in the study. Together they completed the Flinders Model tools and devised a care plan with the patient’s doctor. This was a new experience for the patient (and his doctor), as he had usually only gone to his doctor with an intimidating style to obtain benzodiazepines and other prescriptions for sale to "acquaintances". The plan outlined a range of activities for which the patient and his worker held shared responsibility. The primary goal set by the plan was for withdrawal from side-effect medication with the institution of a strict management plan and withdrawal regime involving daily delivery initially, building to weekly, with dose reductions at fully negotiated points. This was combined with intensive motivational interviewing and positive feedback and encouragement in the context of regular visits by the key worker to support the patient to achieve his physical activity goals. The patient felt that these three goals were interconnected and so wanted to work on each as part of an overall
strategy for beginning to address his concerns. This gave him clear evidence of progress in the short term that motivated him to continue. The display of commitment and perseverance by the worker helped the patient build self-esteem, hope, trust and also motivation. The worker also provided adjunct supports by brokering house cleaning and shopping support and taking the patient to dental appointments for his badly decaying teeth. The patient felt respected and cared for.

**The patient's achievements**

The patient went from 20–60 2mg biperidin per day to 2 tablets (the standard dose) over a 2-month period. He built a routine of walking his dog in the evenings at least three times per week but did not pursue the goal of using his weights regularly. The psychiatrist was amazed by the progress, previously perceiving the patient as having little self-control. The next goal set by the patient was to give up smoking. He made a shared plan with the deli proprietor, with the support of the key worker. The patient was encouraged to exercise self-control over his level of consumption, being pleasantly surprised that he had money left for food when previously this was a vicious cycle of debt and credit and relying on charity food parcels on a regular basis. He led this process of identifying how much he wanted to cut down and how the deli owner would be involved. The patient successfully quit smoking within 1 week of setting this goal. He used nicotine replacement therapy patches for 5 days, received daily motivational phone calls from his key worker during that period followed by graded support calls and visits after then as part of regular case management contact. He has been abstinent for 2 years and has suggested to several "acquaintances" that they also quit smoking. He plans to follow a similar process with his addiction to stimulants.

**DISCUSSION**

This case and its outcomes offer a number of lessons for workers generally. The first of these is how important it is for workers to check their assumptions about the patients' ability to self-manage and to contribute to decisions about their care. This case highlights the importance of always seeking the person's view in the first place and understanding what is important to them in order to support effective behaviour change, as well as clearly looking holistically at the range of interconnected issues people face and using a structured approach to problem solving, regardless of the person's level of disability. This case also highlights how systems of care can help or hinder collaborative relationships with patients, perpetuate or overcome dependency, and ultimately impact on health outcomes. The Flinders model provides an example of a structured, motivational and holistic approach, in partnership with the person. Such approaches are pivotal for these highly disadvantaged and stigmatised populations and are in line with recovery-based approaches. When such person-centred approaches are used with such individuals, the highly subjective aspects of the interaction between the patient and their key workers cannot be understated. Something special happens between the worker and patient that is profoundly personal and highly germane to achieving better treatment outcomes. This is facilitated by the semistructured approach that, while appearing mechanistic, actually provides a safe way of exploring the patient's knowledge, behaviours and barriers to self-management. During the process there are moments of shared understanding of the links between the person's self-management issues or "blocks" and their causes whether external (practical; financial, housing, transport etc) or internal...
(psychological; fears, grief, self-esteem, depression etc). This process, common to many psychotherapeutic modalities, provides the pathway to change.

Gender and cross-gender issues as part of therapeutic dynamic are also pertinent to the interactions described in this case, particularly due to the patient’s response to male workers and his apparent effective engagement with female workers. The role of gender has been subject to only limited research. Marshall\textsuperscript{12} argues that "In all the literature about counselling and psychotherapeutic relationships, there is almost nothing on the subject of the impact of gender". Felton\textsuperscript{13} has stressed the importance of acknowledging gender components within the transference between patient and worker. Gehart and Lyle\textsuperscript{14} argue that therapists have tended to avoid discussing gender or have underestimated its impact despite it accounting for 30% of outcome variance. They argue that "this oversight has significant implications for the practice of ethical, gender-sensitive therapy". Research has shown that female therapists are generally more successful in forming therapeutic alliances with patients,\textsuperscript{15} though the exact role of gender is complex. There are many other variables at play and situations where male therapists form equally effective relationships with patients.\textsuperscript{14} This case indicates that the impact of gender should not be underestimated as part of the therapeutic relationship when working with people with severe and complicated mental health and psychosocial issues.

This approach also fits well within the framework of functional cognitive behaviour therapy (FCBT), which was developed primarily to remediate social functioning deficits in people with psychotic symptoms. FCBT does not focus directly on symptom reduction. Rather, it supports the person to focus on persisting towards goals in the face of symptoms.\textsuperscript{16} In developing this approach, Cather hypothesised that the positive effects of CBT on psychosis are more a function of reducing distress rather than symptom frequency, which suggests that patients need to develop a goal of "living with the illness" rather than eliminating symptoms and then moving on with life\textsuperscript{16} and that insight was not a necessary prerequisite for such work.\textsuperscript{17} This case also demonstrates the value of a motivational interviewing approach for people with psychotic illness. It can facilitate positive changes by supporting the achievement of valued goals which psychotic symptoms and their consequences may impair.

Furthermore, this case also highlights the importance of recognising the neurotoxicity of stimulant drugs, particularly amphetamine-related stimulants, and shows that efforts by the treating team to support patients to curtail such drug use are likely directly relevant to patients’ positive psychiatric outcomes. For patients such as ours, whose mental health, drug use and psychosocial problems are so intertwined and interdependent, this case also demonstrates the imperative for mental health key workers to have skills across all of these areas, particularly in the use of motivational interviewing for drug use problems as part of their core case management role. This case also demonstrates that patients with chronic mental health issues can address their tobacco addiction safely and effectively using nicotine replacement therapy when adequate worker knowledge and skills in how to provide effective support are also present. We acknowledge that more research is needed to confirm the usefulness of this approach for people with chronic psychotic illness and substance abuse problems.\textsuperscript{18}
LEARNING POINTS

• Shared responsibility between the worker and the patient is possible, even for patients with highly complex and chronic health and psychosocial presentations.

• A structured approach that is client-centred and has been fully negotiated with the person to promote ownership of the problem and its solution by the person is important.

• A structured motivational approach is possible, regardless of the person’s level and severity of disability or circumstances. Clinicians should check their assumptions and expectations of the person’s capacity to self-manage their health so as not to reinforce disability and create institutionalised dependency.

• Negative cultural assumptions and practices within mental health services can undermine patients’ efforts to effectively participate in their own care, with adverse impacts for their long-term health and well-being.

We gratefully acknowledge the subject of this case report who has taught us well about the value of patient-centred care.

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