Breaking barriers - stigma can kill: can education/training change professionals' attitude towards people with co-existing mental and substance use disorders?

Breaking Barriers

Stigma can kill: can education/training change professionals' attitude towards people with co-existing mental and substance use disorders?

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She became a successful psychiatrist despite suffering form schizophrenia

"We who suffer from mental illness have a much bigger purpose in life that becoming pills swallowers…Recovery cannot happen in a vacuum.."

Click on the picture to watch Pat Deegan's talking in a 4 min video

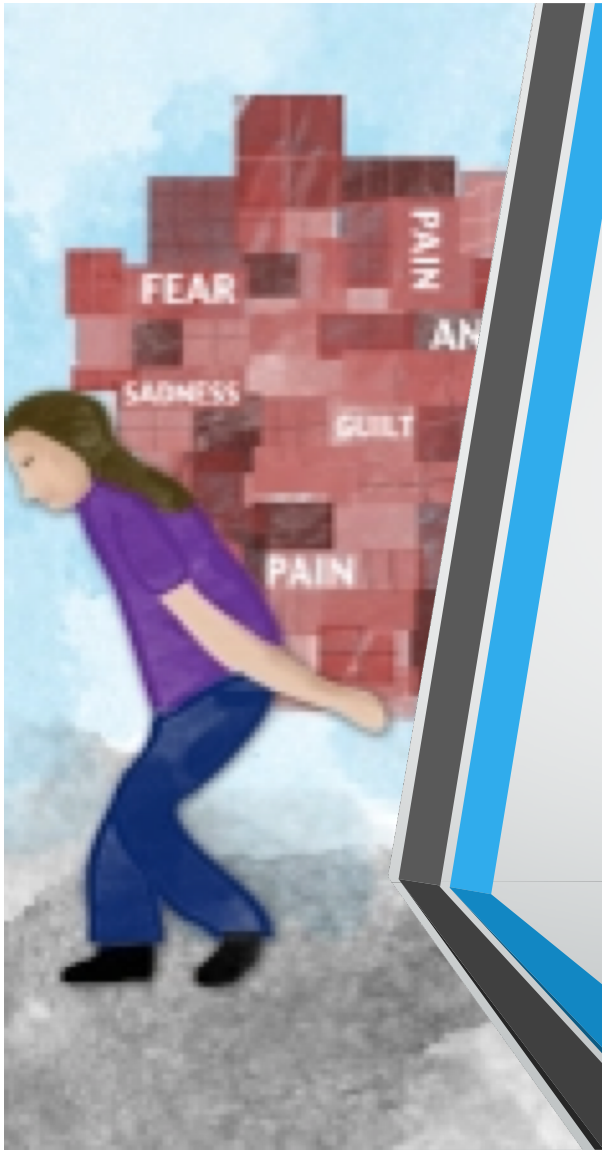
Stigma

"A mark of disgrace associated with a particular circumstance, quality, or person" (Oxford Dictionary, 2019)

From the Greek word of the same spelling meaning "mark, puncture," came into English through Latin to mean a mark burned into the skin to signify disgrace

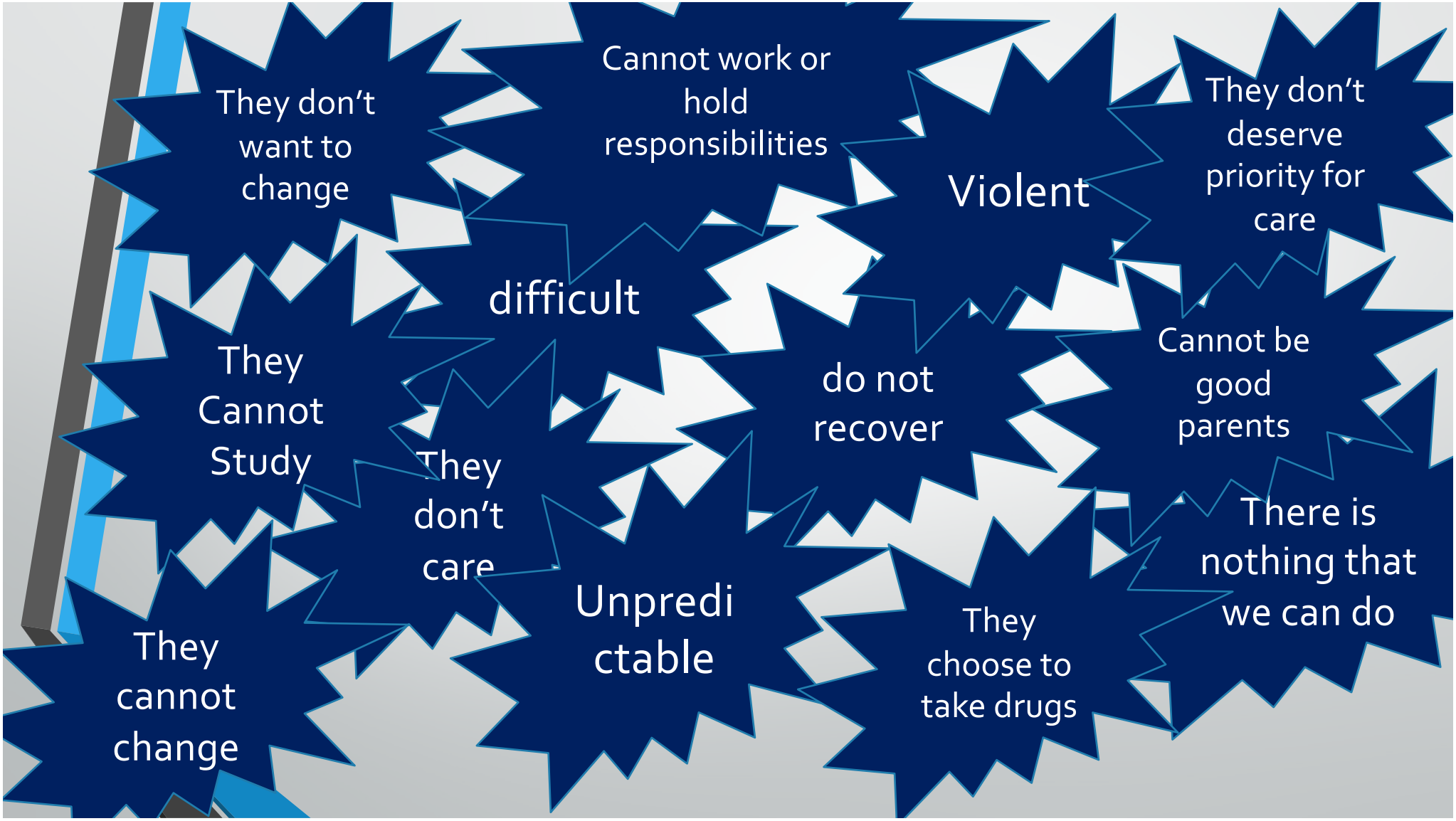
Exposure to negative attitudes, structural and interpersonal experiences of discrimination or unfair treatment, and violence perpetrated against persons who belong to disadvantaged social groups.

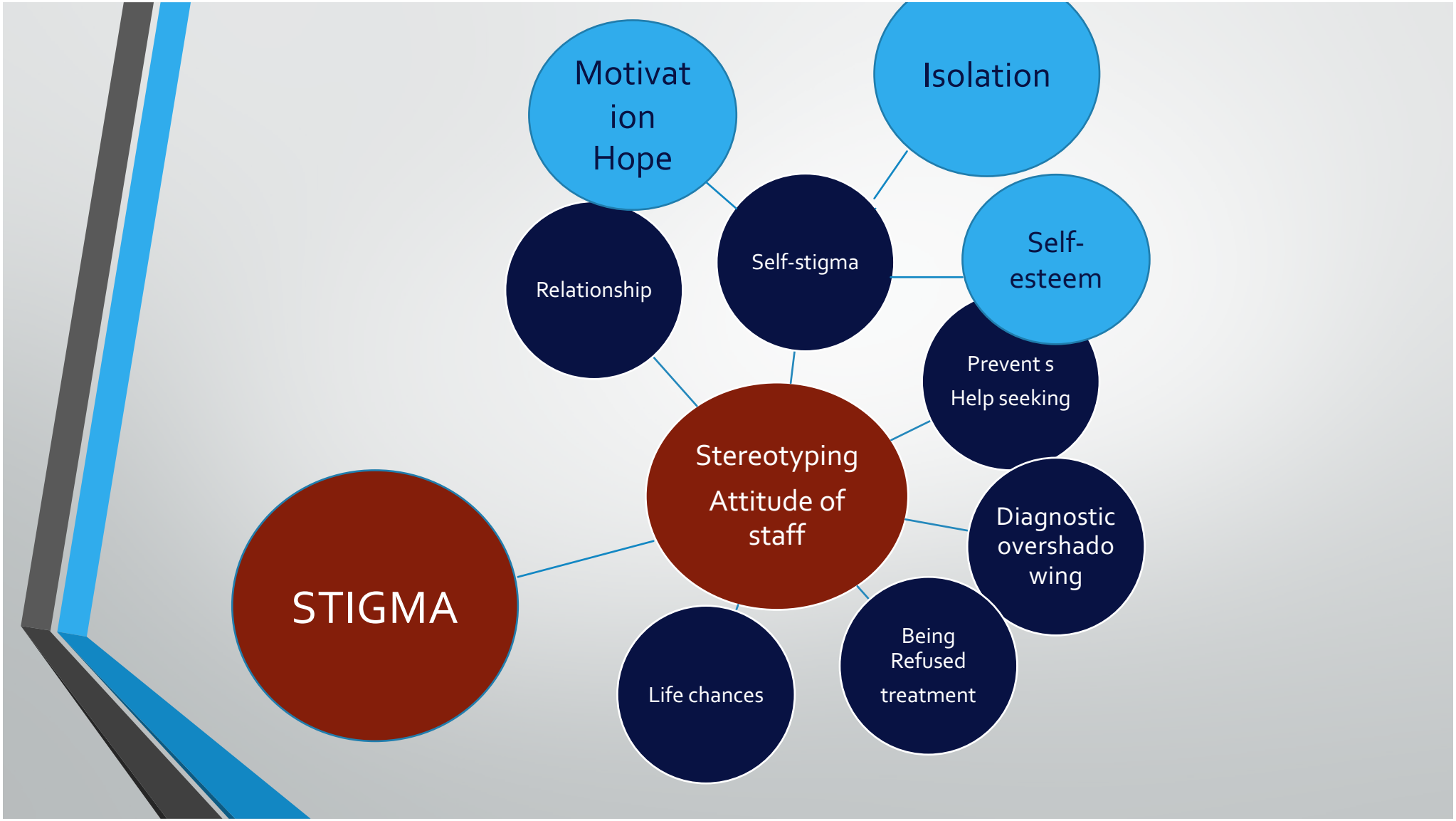
For stigmatization to occur, power must be exercised (Stuber et al., 2008)



Mental & Substance Use Disorder "Double Baggage"

- Individuals with comorbidity often face greater stigma and challenges and poorer outcomes than those with only a substance use disorder (Laudet, *et al*., 2000)
- The stigmatising processes can affect multiple domains of people's lives, has a dramatic bearing on the distribution of life chances in such areas as earnings, housing, criminal involvement, health, and life itself. (Link and Phelan, 2001)
- Stigmatisation leads to discrimination and compromised psychological wellbeing, psychosomatic symptoms and cardiovascular and psychological reactivity (Stuber et al., 2008)


They don't want to change
Cannot work or hold responsibilities
Violent
They don't deserve priority for care
difficult
They Cannot Study
do not recover
Cannot be good parents
They don't care
There is nothing that we can do
Unpredictable
They cannot change
They choose to take drugs


Motivat ion Hope
Isolation
Relationship
Self-stigma
Self-esteem
Prevent s Help seeking
Stereotyping Attitude of staff
Diagnostic overshado wing
STIGMA
Life chances
Being Refused treatment

1.2 Referral to secondary care mental health services

- Do not exclude people with severe mental illness because of their substance misuse.
- Do not exclude people from physical health, social care, housing or other support services because of their coexisting severe mental illness and substance misuse.

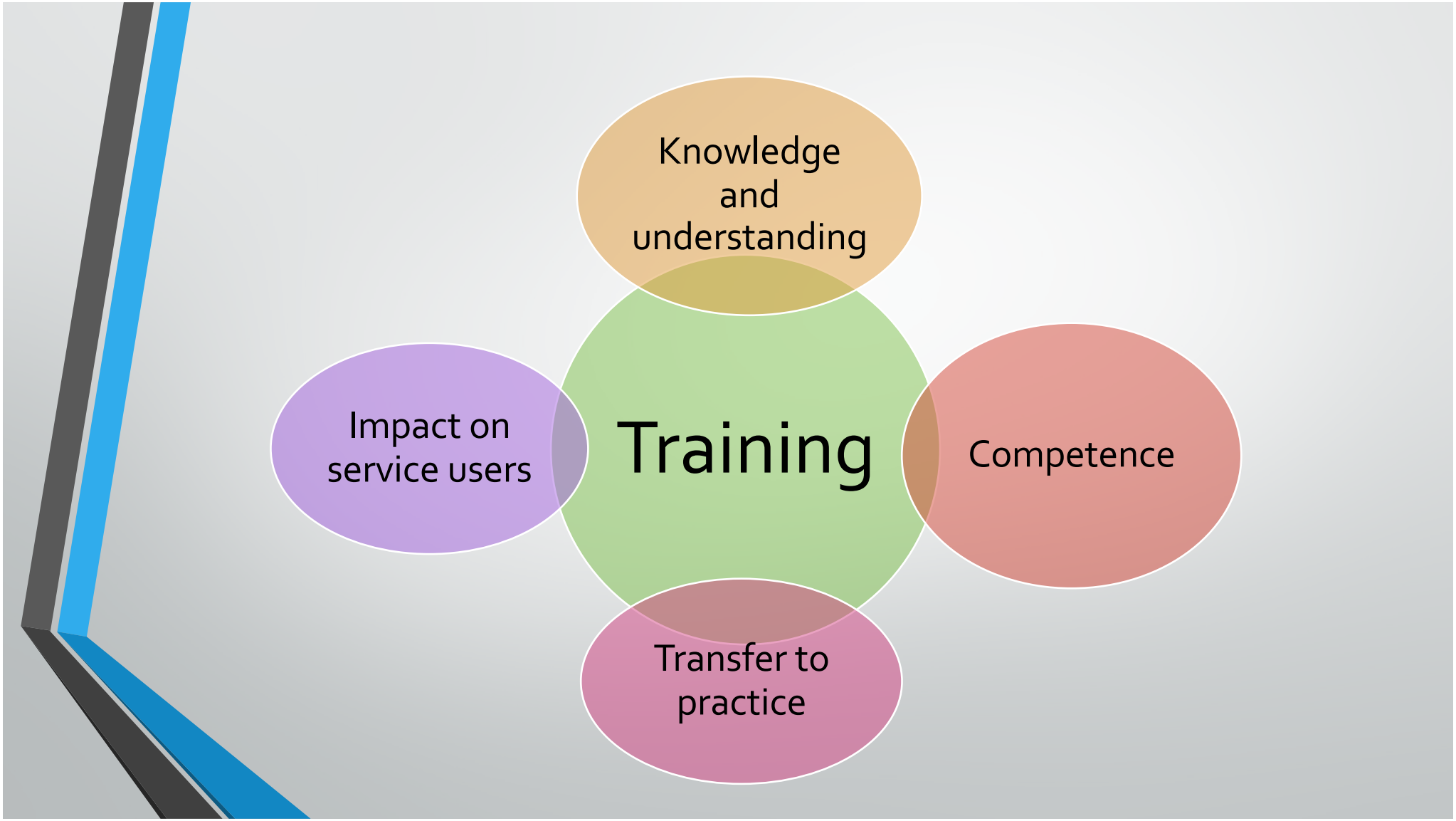
A survey of 140 services working with people with multiple needs, co-existing conditions are often employed as exclusion criteria, preventing access to vital care and support (MEAM coalition, 2015).

MEAM Coalition., (2015), "*Making Every Adult Matter (MEAM) coalition. Voices from the Frontline: Listening to people with multiple needs and those who support them*."

Independent review of the Mental Health Act (Dec 2018 – updated Feb 2019)

"We are also aware that alcohol and drug use, and dependence, play a major role in both acute psychiatric presentations and psychiatric ill health. Existing guidance outlines good practice in this area,110 and as a minimum we must seek to ensure that patients are not turned away from mental health services in a psychotic or suicidal crisis because it is perceived by professionals to be substance induced. The reverse is also true- those attending substance misuse services should not be turned away because they have significant mental health problems. The division between health and social care has had a substantial impact on the care of those with what we call "dual diagnosis".

Is training effective in challenging stigma and changing attitude towards clients with Dual Diagnosis ?


Knowledge and understanding
Impact on service users
Training
Competence
Transfer to practice

Literature review effectiveness of training

Overall findings from the eleven included studies suggested that participants valued the training, increased some professional competencies, and that some transfer of training occurred. The effect at the patient level showed mixed results.

Pinferup, P., Thylsrup, B., Hesse, M. (2016) Critical Review of Dual Diagnosis Training for Mental Health Professionals. *International Journal of Mental Health and Addiction* 14(5)

Education/training and attitude

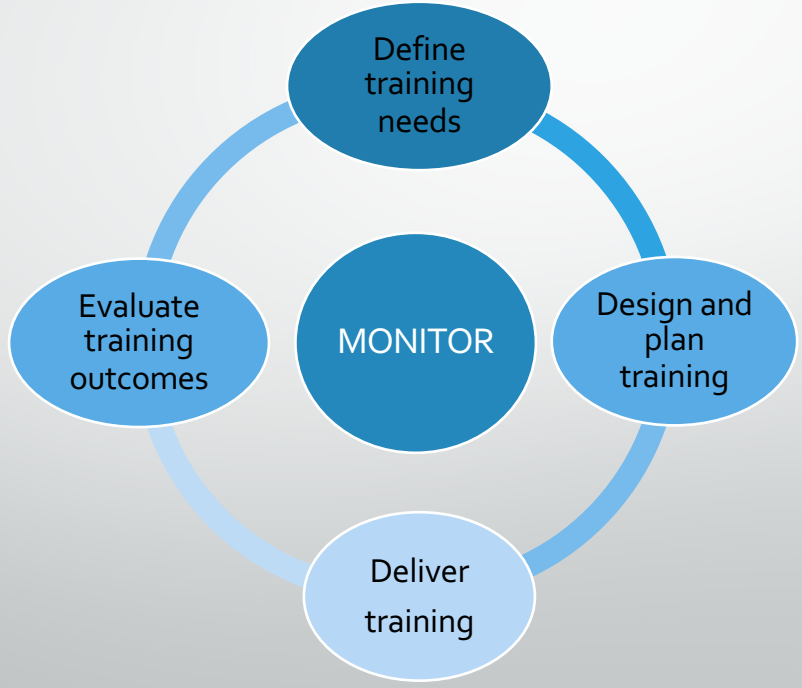
- Several studies have suggested how a better education and consequent improved skills and more in-depth training about substance misuse and mental health problems can significantly reduce stigma and improve the attitude and approach to comorbid patients (Ewan & Whaite, 2009; Livingston et al., 2011; Osher & Kofoed, 1989).

Randomised trial

- 79 case managers from 12 community mental health teams in South London were randomly allocated to either receive training and follow-up supervision (experimental group) or no training and supervision (control group).
- Baseline measures of attitude, self-efficacy and knowledge were collected prior to randomisation, and were repeated at 18 months post-training.
- An intention to treat analysis of follow-up data (adjusted for baseline score for that outcome and team) was performed
- A brief training course in dual diagnosis interventions had a significant effect on secondary measures of knowledge and self-efficacy that was detectable at 18 months post-training.
- Improvements in attitudes towards working with drinkers and drug users in mental health settings failed to reach statistical significance.

Hughes et al. (2008) Training in dual diagnosis interventions (the COMO Study): Randomised controlled trial. *BMC Psychiatry Open Access*

"Dual Diagnosis" training – Berkshire mental health services (Milani, R.M. 2017, unpublished report)



Dual Diagnosis capabilities (Huges, 2006)

	Capability	Level 1	Level 2	Level3
4	Non-judgemental attitude	Be able to accept people with dual diagnosis as they are and value them as individuals	Be aware of ones own attitudes and values in relation to dual diagnosis and be able to suspend judgement when working with service users, and carers. Challenge others' attitudes in an appropriate and useful manner	Role modelling non-judgemental attitudes, and assist others in exploring their own attitudes and help them to develop a non-judgemental approach
5	Demonstrate empathy	To be able to understand the current and past difficulties that a person with dual diagnosis may have experienced	To be able to understand the unique experiences a person with dual diagnosis may have had, and be able to communicate this understanding effectively and empathically to service users, and their carers	To be able to educate others in the understanding of the complex history and needs of this client group in order to generate empathic responses in others. To role-model the demonstration of empathy

Training objectives

1. Achieve a common definition of "Dual Diagnosis" and critically discuss the terminology.

2. Review and challenge own attitude towards working with clients with "Dual Diagnosis".

3. Increased awareness on alcohol and drug effects, particular emphasis on Novel Psychoactive Substances (former "legal highs").

4. Implement routine assessment of substance use using the Maudsley Questionnaire (which is available on RIO).

2 full days training

Locality	Dates	N of attendees
Slough CMHT/Crisis	23rd – 30th June 2016	25
Maidenhead WAM (Windsor Ascot Maidenhead)	11 & 18 October 2016	20
Bracknell/CMHT	8th – 15th November 2016	24
Wokingham Crisis	19 & 26 January 2017	21
Bracknell CMHT	23rd Feb – 2nd of March 2017	20
Reading CMHT	20th – 27th April 2017	6
Bracknell EIP	5th – 13th May 2017	21
Thatcham EIP/CMHT	27t June – 4th July 2917	15
	Total	**152**

Trainees included Consultant Psychiatrists, Service managers, Dual Diagnosis Clinical Leads, MHPs, CPNs, Support Workers, Social Workers, IPS, Consultant Psychologists, Assistant Psychologists, Psychotherapists, Family Support worker, one Housing Worker

Perceived outcomes

- Pre-post questionnaire on attitude and confidence in working with clients with "dual diagnosis" and perceived knowledge of drug effects (included open questions).
- Pre-post questionnaire on use of drug and alcohol screening/assessment tools (included open questions)..
- UWL Short courses feedback form.
- Group discussion and qualitative comments on flip charts– World café' exercise
- On-going feedback from the co-ordinator, Geoff Dennis, Head of MH Services, Slough
- Response from the Commissioners and CEO of Berkshire

	Not applicable	Strongly disagree	Disagree	Agree	Strongly Agree
1. Working with people with dual diagnosis is a routine part of my role					
2. It is clear what is expected of me when working with dual diagnosis clients					
3. I feel confident about working with dual diagnosis clients					
4. I regularly assess clients' substance use/misuse					
5. I consider substance use/misuse when assessing risks					
6. I feel hopeful about the possibility of dual diagnosis clients to recover and improve their quality of life					
7. I accept and respect the fact that some clients use psychoactive substances					
8. I respect clients' choice of lifestyle, even if it might be very different from mine					
9. I believe that using drugs is morally wrong					
10. Using drugs is a choice and people can decide to stop if they want to					
11. I am aware of my own values and I can suspend them when I work with clients that choose a different kind of lifestyle					
12. I am able and confident in challenging my values and attitudes regarding substance use/misuse					
13. I am able and confident in challenging my colleagues' values and attitudes regarding substance use/misuse					

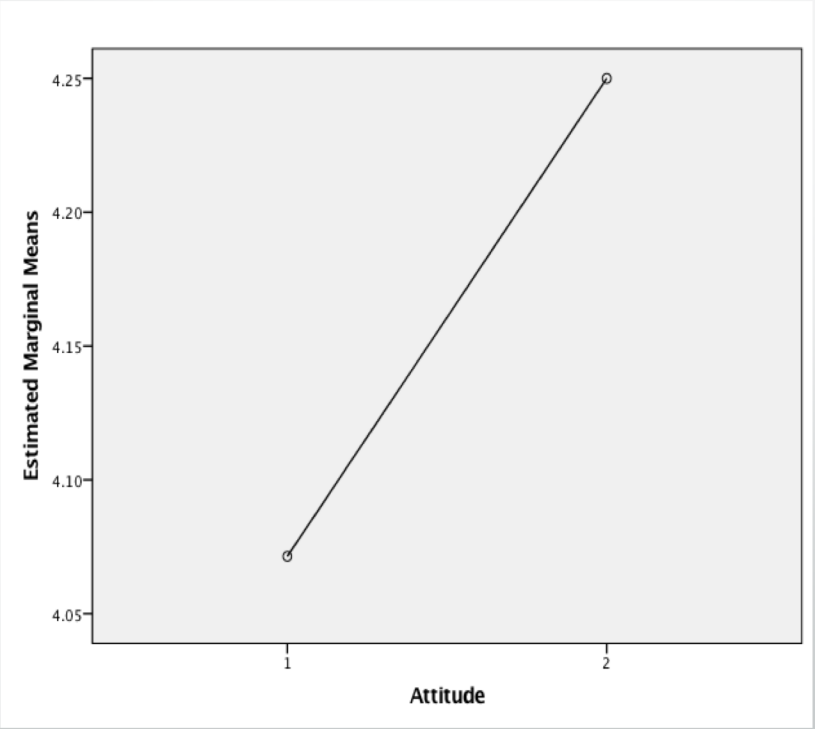
Scales: Attitude, Confidence, Role perception, Knowledge

Perceived positive attitude pre-post training

Repeated measures ANOVA

80 matched pre-post

$F_{(1, 79)} = 2.385$, $p=0.134$

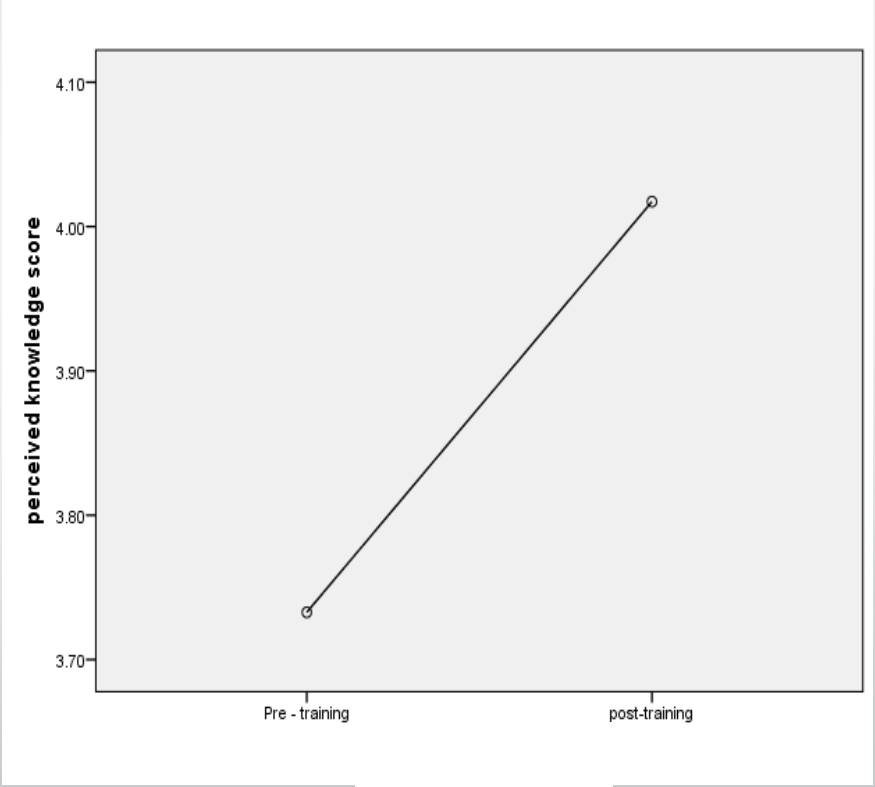


Perceived knowledge on drug effects, pre-post training

Repeated measures ANOVA

80 matched pre-post

$F_{(1, 79)} = 7.89$, $p=0.014$ *

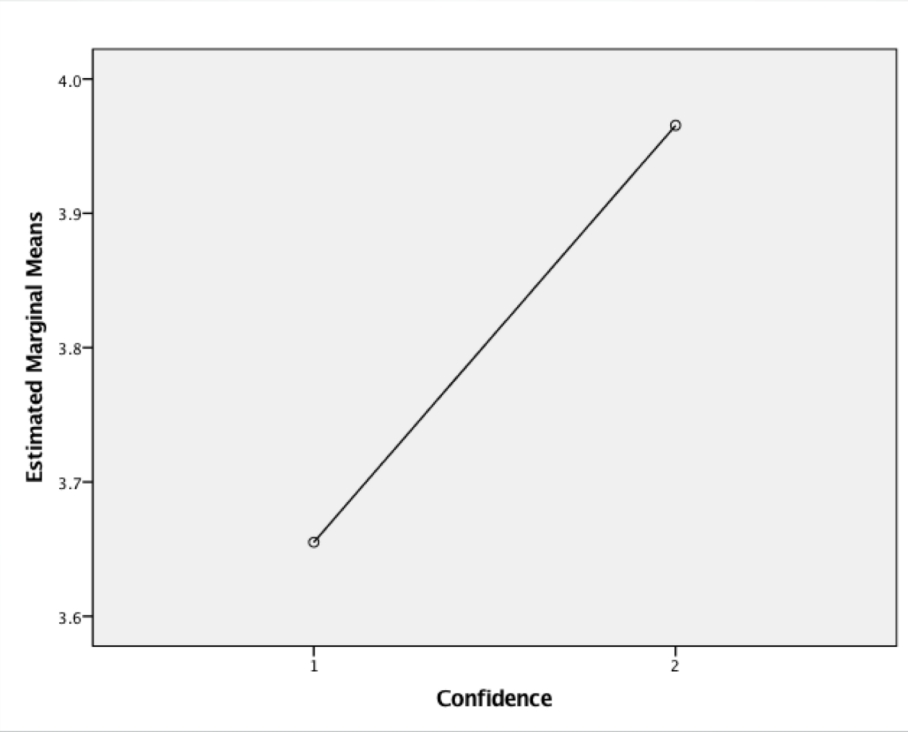


"I am confident that I can to talk to clients about their drug use"

Repeated measures ANOVA

57 matched pre-post

$F_{(1, 56)} = 6.04$, $p=0.017$ *




I understand now how they affect the brain, there is a reason why it is difficult for them to resist the urge to use
It is important to understand how drugs help them to cope
I feel more confident now about asking questions on their drug use
I need to ask questions about the use painkillers
We should not turn them away if they use drugs, we still need to treat them
…but we don't have enough resources
These clients are difficult to engage

Midwifery Students

Method

Quasi experimental, between and within subjects design

Participants

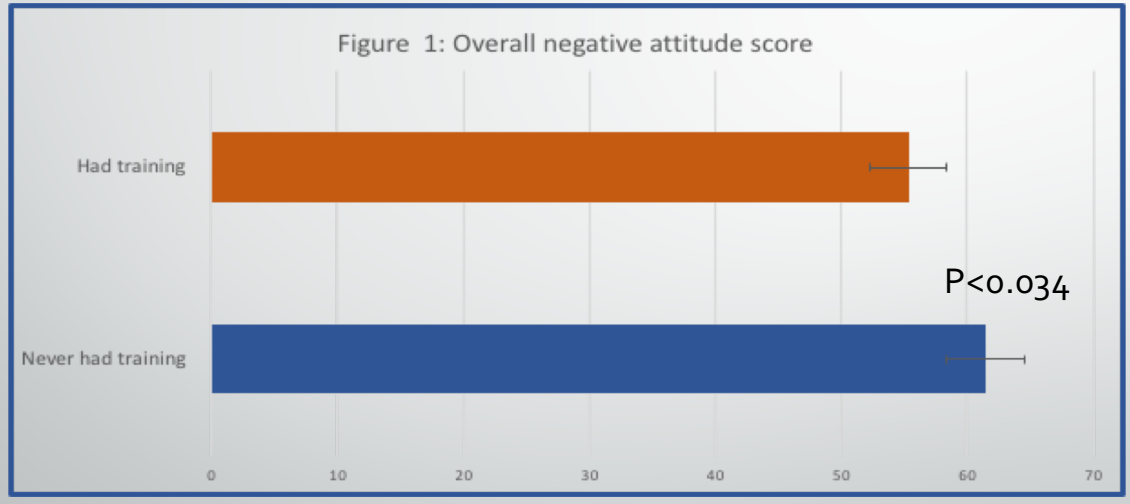
- 56 midwifery female students, age range (range 18-45).
- 24 were in the first year and 32 in their final year of their midwifery BSc.
- 30 students completed the questionnaire pre and post one substance misuse training session at UWL.

Materials

52 items self-report questionnaire exploring *knowledge* of an *empathetic or punitive attitude* towards substance misuse during pregnancy (Coles et al, 1992).

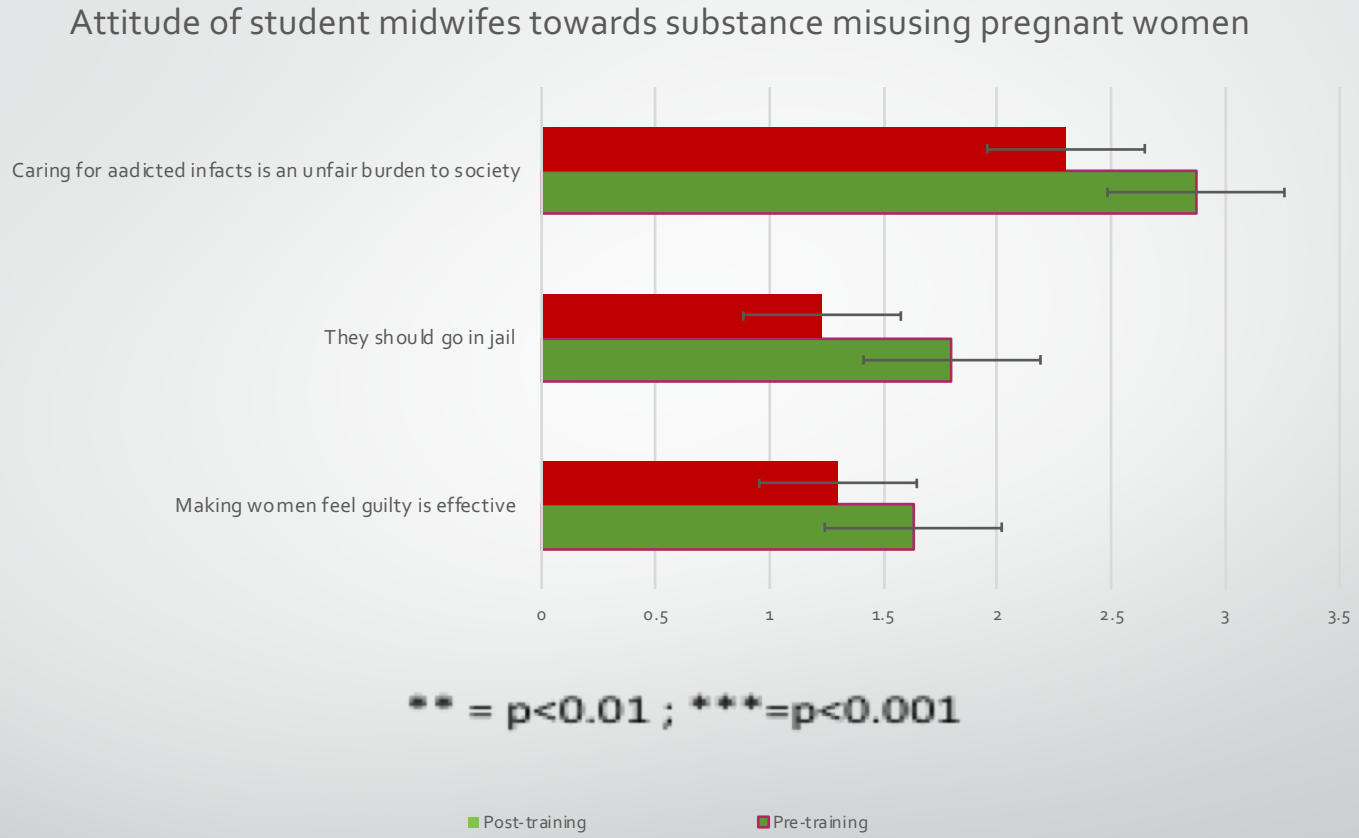
Results

- 46 % of the sample stated that they *strongly agree*, and 23% *agree* that "caring to addicted infants due to their mothers drug use is an unfair burden on society



100% said that they would like more training in substance misuse

Radcliffe, P. (2011). Substance-misusing women: Stigma in the maternity setting. *British journal of midwifery*, *19*(8).



Milani, RM., Perrino, L. & Simbo, A. (2017) *Factors that influence attitudes of midwifery students towards substances abusing pregnant women .* UWL Research Day., London.

When is training more effective?

- Managers, commissioners and different level of practitioners are participating at the same time (Huges,2011)
- When is here is consensus on the need for change and for training
- When it is "hands on", interactive , relevant , includes group discussion
- Safe and on—judgmental environment
- Involvement of service users/ people with lived experience

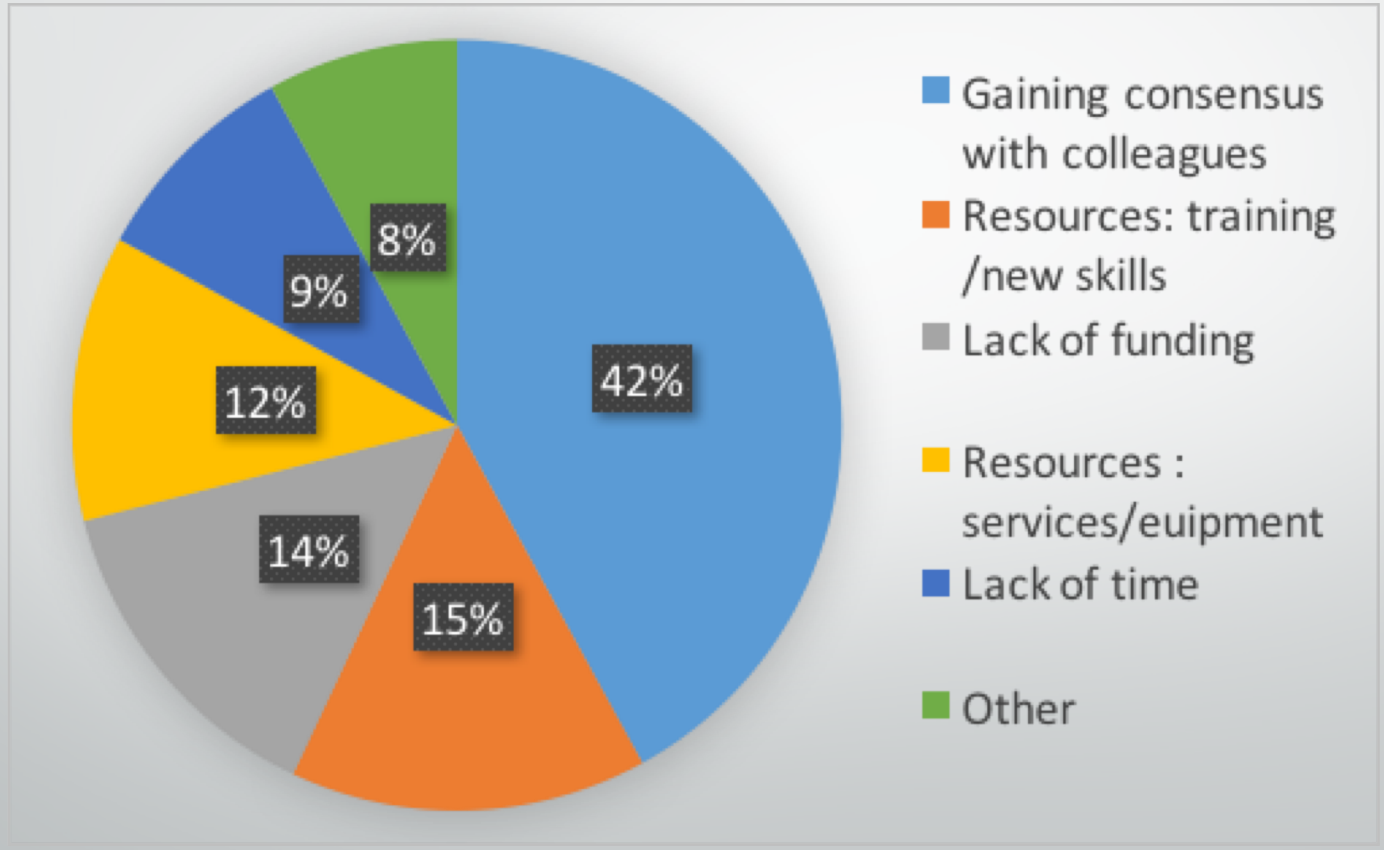
" I think that sometimes I am more useful to the professional staff as well as the users; I am there to remind them that there is hope, if I made it, anyone can!" (Alan Butler)

- When there is a follow up
- When it's followed by a service reorganisation /change of culture

From Intention to action

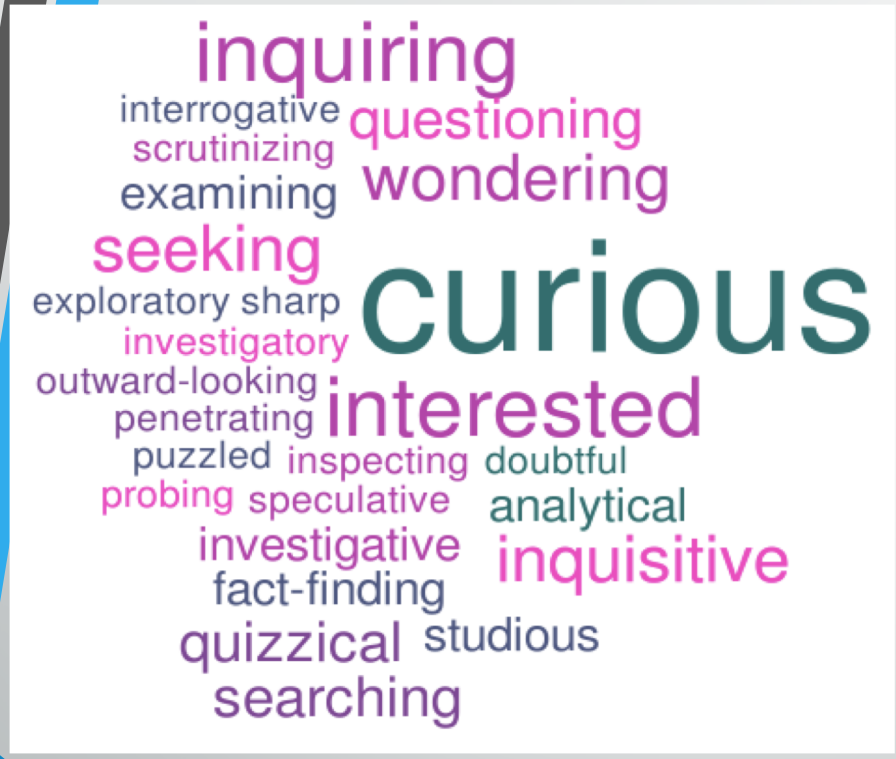
Implementation

Barriers to NICE implementations (survey on 683 clinicians and managers)



Lrng, G., Moore, V., Abraham, S. (2014) *Achieving High Quality Care*. Oxford: Wiley Blackwell.

Professional Curiosity



- Trying to force a serial approach model may constitute a barrier to a client centered approach.
- Curiosity means to be open to the unexpected and to welcome information that may not support the initial assumptions.
- Health care professionals need to be confident to be able to be comfortable asking questions, adequate training on drug is essential
- Organizational culture

Milani, Raffaella (2017) Substance misuse assessment in mental health services: the importance of professional curiosity. *Psychology and Psychological Research International Journal*, 2 (4). 000135.

Slough drama and choir : staff and services users working together

@DrRMMilani