CHAPTER ONE

Introduction

A Window of Opportunity

In healthcare settings, a number of opportunities to talk to clients about health-related behaviors (e.g., tobacco, alcohol, or drug use) are often "missed," which may have indirectly contributed to them being admitted or referred for treatment (e.g., Buchbinder, Wilbur, Zuskov, Mclean & Sleath, 2014). Often viewed as "precontemplators," these clients do not recognize their behavior as causing any problems or as the primary presenting problem. However, it has been suggested that such occasions—that is, when problems are acute—represent "teachable moments" (e.g., Lau et al., 2010; Buchbinder et al., 2014) that present staff in healthcare settings with natural "windows of opportunity" to start conversations about behaviors that may have indirectly impacted on their clients' physical and mental health (Graham, Copello, Birchwood et al., 2016). As such, there exists a significant need for brief interventions that can be delivered in inpatient or acute healthcare settings, when clients who are not necessarily motivated to talk about their substance

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Companion Website: www.wiley.com/go/graham/bimi

abuse are more "open" to considering their use. This period can be viewed as a "window of opportunity" to help clients gain insight into the role of substance use in triggering acute mental health symptoms or hospital admissions, and to improve their engagement in treatment.

Drug and alcohol use and misuse are common in clients who experience severe mental health problems (Regier et al., 1990; Mueser et al., 2000; Graham et al., 2001; Swartz et al., 2006). Substance misuse in this population has been found to be associated with poorer engagement in treatment, more symptoms and relapses, and poor treatment outcomes (Mueser et al., 2000; Graham et al., 2001; Swartz et al., 2006). In addition, these clients often express low motivation to change their drug and alcohol use (McHugo, Drake, Burton & Ackerson, 1995; Carey, 1996; Swanson, Pantalon & Cohen, 1999), and are often poorly engaged in treatment, which forms a significant barrier for change and good treatment outcomes (Mueser, Bellack & Blanchard, 1992; Swanson et al., 1999; Drake et al., 2001; Mueser, 2003). Drug and alcohol misuse have also been found to be associated with increased psychiatric hospital admissions, and seems to have a negative impact on inpatient stays (Lai & Sitharthan, 2012). Therefore, unsurprisingly, 22–44% of those admitted in the United Kingdom into psychiatric inpatient facilities for mental health problems have been found to also have coexisting alcohol or drug problems (DOH, 2006). In the United Kingdom, national health policy guidance has pointed to the need to train staff to improve routine assessment and treatment of substance misuse as part of the clinical management strategy of a psychiatric admission (DOH, 2006). Nonetheless, this has remained a significant gap in service provision (DOH, 2006; Healthcare Commission, 2008), and this natural window of opportunity is often missed.

As the acute symptoms of mental ill health decline for an inpatient, this can be a time of contemplation, when he or she reflects on how they "ended up in hospital." It may be a window of increased awareness and insight into the factors that contributed to him or her becoming unwell and/or being admitted in a hospital. However, this increased "insight" may result in increased emotional distress, and

some research has shown that post-discharge is a time when individuals may "seal over" the experience, in an attempt to reduce emotional distress. That is, the inpatient may deny or minimize any recent mental health symptoms or experiences and precipitating factors, because they may be too upsetting to think about. As a result, he or she may lose awareness of the triggers for becoming unwell (Tait, Birchwood & Trower, 2003). Sealing over the experience of relapse was found to predict low engagement with services 6 months after discharge for inpatients (Tait et al., 2003). However, we know that engagement in treatment is key to improving treatment outcomes for mental health clients (Carey, 1996; Swanson et al., 1999).

The Brief Integrated Motivational Intervention (BIMI) seeks to target this window of contemplation. It provides clinicians with a brief, targeted, easy-to-use intervention that motivates people who experience mental health problems to engage in treatment and make changes in their substance use (Graham, Copello, Griffith et al., 2015). The approach seeks to raise awareness of the impact of drugs and alcohol on mental health. BIMI is empirically grounded in cognitive behavioral therapy (e.g., Beck, Wright, Newman & Liese, 1993; Greenberger & Padesky, 1995) and motivational interviewing (e.g., Hettema, Steele & Miller, 2005). It draws on the initial phases of the longer-term integrated treatment approach C-BIT (Graham et al., 2004), and on developments in the use of brief interventions in the treatment of substance use in those who experience severe mental health problems (Carey, Carey, Maisto & Purnine, 2002; Kavanagh et al., 2004; Edwards et al., 2006; Kay-Lambkin, Baker, Kelly, Lewin & Carr, 2008; Baker et al., 2009). It reflects the research evidence on increasing engagement and motivating behavior change in those with co-morbid mental health and substance misuse. BIMI was initially developed and piloted in a randomized controlled trial in acute mental health inpatient settings and has demonstrated positive outcomes for engaging inpatients with severe mental health problems in addressing their drug and alcohol use (Graham, Copello, Griffith et al., 2015).

Brief Integrated Motivational Intervention (BIMI)

Approach

BIMI is designed to be delivered by routine mental health staff or specialist practitioners. This treatment manual provides a framework, session content, illustrative case material, and easy-to-use worksheets that can be used when delivering it. BIMI promotes a practical conversational style that seeks to build a good collaborative working relationship as you work together toward the client's self-identified goals. It is targeted in its approach and is recommended to take place over a brief period, ideally *2 weeks*. Sessions can range from *one to a maximum of six*, depending on the client, and are intended to be delivered in short bursts, *each of 15–30 minutes* duration. The evaluation of BIMI was performed by staff members who were trained in the approach and who received case supervision. The evaluation found that, on average, an inpatient received *three sessions*, in addition to the initial assessment session, each of an *average duration of 17 minutes*, and that the total time that clinicians (i.e., nurses, occupational therapists, healthcare assistants, activity workers, specialist dual-diagnosis clinicians) spent receiving the intervention was *57 minutes* over the *2-week period*. This short-burst approach was found to be sufficient to produce improved engagement in substance misuse treatment and some behavior change (Graham, Copello, Griffith et al., 2015). The number of sessions and their duration would best be determined by the needs of the client. Small amounts of information can be discussed in sessions, and it is helpful to provide frequent reflections and summaries of key points talked about during the sessions. Information can be presented in a number of ways (e.g., verbal, written).

Timing

The primary aim of the treatment approach is to quickly engage clients in meaningful change talk about their alcohol or drug use. BIMI is provided relatively early on in the treatment process (e.g., within the first few weeks of an inpatient's stay in hospital or when presenting at mental health services

when acutely unwell). The idea is to maximize the potential of this *window of opportunity* and *teachable moment*. This would enable the intervention to take place when problems are acute and clients are "primed" to consider health issues. At this point, the clients are considered to be more cognitively open to engage in considering the links between the issue that led to them being referred or admitted and other health-related behaviors. By providing a few minutes of quiet time, over a short period, clients can reflect on their use of drugs and alcohol and start to consider the impact of such use on their physical and mental health. The timing is key and balanced with the initial acute symptoms subsiding and it being considered clinically appropriate.

Structure

BIMI uses a simple three-step framework (see Table 1.1 for an overview of the structure). The initial step (STEP 1) involves carrying out a brief assessment and then providing clients with personalized feedback of the information gathered in this assessment. The feedback details the clients' patterns of substance use and highlights its potential impacts on their physical and mental health. It is also recommended that clients be provided with individually tailored psychoeducational material/leaflets about the substance(s) they are using. The second step (STEP 2) aims to help clients make decisions about what outcomes/goals they want. This involves using strategies aimed at: increasing awareness of the perceived "benefits" of use and reflection on the "costs" associated with *continued* substance misuse; re-evaluation of positive thoughts and beliefs about substances that promote use; and building awareness of how substance use and mental health may interact and worsen each other by identifying a maintenance/vicious cycle. The third step (STEP 3) encourages clients to contemplate change and develop a change plan based on a self-identified goal, using goal planning. This helps in making change feel possible and achievable. Included are also strategies to cope with setbacks, cravings, and urges, and to provide social support for change. Not all the steps in BIMI need to be delivered. The essential step is STEP 1. The main idea is to

Table 1.1 Overview of BIMI.

Session Content	*Session Goals*
STEP 1: Building Engagement and Assessment Carry out brief assessment and score questionnaires Provide personalized feedback to the client from the assessment regarding: ■ Levels of use ■ Identify the client's thoughts and feelings about the personalized assessment feedback ■ Potential impact of substance use on mental health Provide material regarding: ■ Drug and alcohol use and national patterns/norms ■ Impact of alcohol and drug use on mental health, functioning, and relapse	■ Engagement and building rapport ■ Gathering information about client's substance use to build awareness about its impact ■ Ensuring awareness of the impact of substance use on mental health ■ Identifying issues for next session(s)
STEP 2: Making Decisions with Your Client ■ Identify benefits and costs of using for the present and future, and which of these are most important to the client ■ Identify positive/mis-held thoughts and beliefs about substance use that promote or maintain use ■ Identify positive/mis-held thoughts and beliefs about mental health and how it interacts with substance use ■ Begin to discuss how mental health problems and substance use may interact and worsen each other ■ Draw out a maintaining cycle of the triggers for drug/alcohol use and the impact of substance use on mental health and functioning ■ Identify self-motivational statements of concern and intent to change	■ Engagement and building rapport ■ Being able to talk openly about costs and benefits of using ■ Building recognition of how positive/mis-held beliefs may promote use ■ Recognizing maintenance cycle for mental health problems and substance use ■ Being able to state concerns about continued use and state intent to change
STEP 3: Change Plans and Social Support Developing a change plan: ■ Identify a realistic substance-related goal and/or personal goal that cutting down or quitting would help the client achieve ■ Look at motivation to change substance use and achieve the goal ■ Identify how "important" changing is and how "confident" the client feels about making changes ■ Develop an action plan ■ Identify skills to cope with cravings, urges, and triggers for use Social support for change: ■ Identify social supports that can encourage attempts to change substance misuse ■ Draw social network diagram	■ Helping to feel that change is possible ■ Identifying potential setbacks (e.g., cravings/urges and social network) ■ Being able to use skills to cope with setbacks including cravings, urges, and triggers for use ■ Providing social support for change

Box 1.1 In Between Sessions

After the second session, encourage participants to:

1. Access websites offering information about alcohol (e.g., "Down your Drink") and drugs (e.g., "Talk to Frank") in between each session
2. Read specific psychoeducational information regarding alcohol and drug use and their impacts

Table 1.2 Booster Session Content.

Session Content	*Session Goals*
Boosting Change ■ Review self-motivational statements of concern and intent to change ■ Review action plan ■ Review social support for change and introduce to community-based treatment	■ Consolidating motivation and transfer skills from BIMI to the community ■ Reviewing progress with substance-related goal and skills to tackle setbacks ■ Linking client with community-based substance misuse treatment

engage clients in the step suitable for them, so that they can meaningfully talk about and re-evaluate their alcohol or drug use (see Box 1.1, page 7, for an overview of how to decide which step is best suited). If necessary, and if the setting allows, a "booster session" (see Table 1.2) can be offered 1 month after the last session to help consolidate motivation and ensure that clients have the skills and strategies necessary to access longer-term help to address their substance use. It is important, if possible, to provide continuity of care—for example, if the client is an inpatient, liaising with the community team concerning the progress that the client has made during BIMI. This process would be facilitated by having a planning meeting with the client and the clinician from the community services team to discuss the work, the client's goals, and strategies to translate gains to a community setting.