



Caring for clients with dual diagnosis in rural communities in Australia: the experience of mental health professionals

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DEANS C. & SOAR R. (2005) *Journal of Psychiatric and Mental Health Nursing* 12, 268–274

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This paper identifies and describes the experiences of 13 rural mental health professionals who care for clients diagnosed with a mental illness and a coexisting alcohol and other drug disorder (dual diagnosis). Dual diagnosis is a common problem which is often poorly understood and managed by mental health professionals. The effect of excessive substance use on a person's mental well-being can present as a diagnostic challenge as each condition may mask symptoms of the other. The authors utilized a phenomenological approach to discover the experiences of a group of mental health professionals working in rural communities in Victoria, Australia. Caring for clients diagnosed with dual diagnosis was found to be a complex and stressful role that involved high levels of skill and knowledge. Despite the fact that health professionals in rural areas are expected to deliver the most appropriate care to individuals with a dual diagnosis, a number of these rural health professionals have limited preparation and experience in dealing with arising clinical diagnosis issues. Clinicians experience frustration, resentment and powerlessness in their attempt to understand their clients' drug misuse whilst simultaneously endeavouring to provide a quality mental health service.

Keywords: comorbidity, dual diagnosis, mental health, rural health

Accepted for publication: 12 January 2005

Introduction

The incidence of individuals with a mental illness and a coexisting alcohol and other drug disorder (dual diagnosis) has been found to fluctuate by various authors. According to Williams (cited in Rassool 2002), 'dual diagnosis' and 'comorbidity' are now used interchangeably. In its broadest context, 'dual diagnosis' or 'comorbidity' refers to the coexistence of any psychiatric disorders and substance use disorders in the same individual. Crawford (1996) found that the comorbidity range was 25%–80% in psychiatric populations, whilst El-Guebaly (1990) suggests that it is

between 20% and 75%, whereas Buckley (1998) suggests that it is between 30% and 50%. Several authors have postulated that approximately 50% of people with a severe mental illness will develop a mental illness with a coexisting alcohol and other drug disorder at some time during their life (Conner *et al.* 1995, Gafoor & Rassool 1998, Kavanagh *et al.* 1998). Rieger *et al.* (1990) conducted a large epidemiological study in the USA which determined that substance misuse is more prevalent in those with a mental illness than in the general population.

Lanning-Smith (2001) suggested that, although it has been determined that a higher rate of coexisting mental ill-

ness, alcohol and other drug disorder exists within acute inpatient settings, this disorder is generally missed, which can be serious as it leads to inappropriate treatment and interventions. Kavanagh *et al.* (1998) assert that a large number of clients who respond poorly to psychiatric treatment may have an undiagnosed substance use problem. Lack of early identification and treatment increases the cost for the clients, the family, health care systems and the community.

Inaba & Cohen (2000) believe there are several possible reasons why there has been an increase since the 1960s and 1970s in clients with a coexisting mental illness and alcohol and other drug disorder. These included a reduction in the amount of inpatient units and more effective medication for psychiatric illnesses enabling clients to be treated in community.

Background

Adults who suffer from a coexisting mental illness, alcohol or other drug disorder have increasingly come in contact with health professionals working in mental health services. The Australian National Council on Drugs report described how coexisting disorders are poorly understood and managed (ANCD 2002, p. 12). McKenna & Ross (1994) state that clients with a coexisting mental illness, alcohol or other drug disorder often present as a diagnostic challenge as each disorder may complicate the other. Bricker (1995) describes this group of clients as being rapidly growing, vastly underserved, highly mobile, chronic overusers of inappropriate emergency services and treatment-resistant. A proliferation in the literature has occurred since the 1980s describing the complexities of treating the dually diagnosed population.

A recommendation of the recent report from the ANCD (2002, p. 10) recognized the need for rural and regional areas to develop their own strategies when managing clients with dual diagnosis. The council states: 'It is not feasible to simply apply urban-based strategies to the rural and regional setting'. The report also mentioned many difficulties arising from service issues. For example, there was a high level of unemployment and service reductions such as telecommunications, banks and other public services with limited hours of operation. There was also a reduced capacity to respond to drug and alcohol issues as a result of dwindling infrastructure in these rural communities. Many rural communities have only one general practitioner (GP), with limited health services, limited operating hours and fewer options for drug and alcohol treatment concerns.

The treatment of dual diagnosis clients in rural areas has been reported in the literature as being complex. Howland (1995, p. 33) identified the following difficulties in treating

people with a dual diagnosis in rural areas as 'a fragmented system of services, centralised services in a large geographic area, overly restrictive regulations, conceptual differences in treatment approaches, confidentiality and stigma in rural culture, and the academic and professional isolation of mental health workers . . .'. According to McDermott & Pyett (1993), clients with a dual diagnosis in rural areas do not differ remarkably from those in urban areas, but dual diagnosis clients in rural areas may experience a greater amount of stigma.

Neither drug and alcohol, nor psychiatric services are sufficiently prepared to deal with clients who have a dual diagnosis (Lehman *et al.* 1993). The recent ANCD report described how 'comorbidity is poorly understood and managed' (McKenna & Ross 1994), whilst others (Mental Health Branch 1994) argue that dual diagnosis clients often present as a diagnostic challenge as each disorder may complicate the other.

Dual diagnosis is an important treatment concern because of the effect of misused substances on psychiatric symptoms, creating a quandary with the design of new therapies (ANCD 2002). Health and Community Services (1994) found that some of the biggest obstacles to the effective treatment of those with a dual diagnosis include a lack of public support, funding issues, lack of concurrent treatment, insufficient data, inadequate training and differences between systems. An Australian study by Seigfried *et al.* (1999) was conducted to determine mental health clinicians' knowledge, experience and attitudes to clients with a problematic drug use. Results showed that staff believed working with clients who had a dual diagnosis was more difficult than working with other clients. Eighty percent of the respondents believed that as professionals they had a role in providing assessment, education and information to these clients. A small percentage (15%) felt they did not see a role for themselves, while a further 12% were unsure.

Ryrie & McGowan (1998) conducted a small study among staff rostered on two psychiatric wards in England. Results showed that staff welcomed opportunities to increase their knowledge and skills of treating dual diagnosis. The researcher concluded that nursing staff were ill-equipped to meet the needs of this client group. The problem was compounded by the 'lack of consensus between disciplines regarding the management and treatment of this patient group' (Ryrie & McGowan 1998, p. 141).

Whilst it is apparent that previous research has identified issues associated with providing quality services in rural communities for clients diagnosed with a coexisting mental illness and an alcohol and other disorder, what has not been identified are the experiences of mental health professionals who care for them. This phenomenological study aimed to identify and describe the experiences of

mental health professionals while caring for clients with a dual diagnosis. This exploratory approach is justified in the absence of prior research in this area.

Method

The majority of research on dual diagnosis has used quantitative approaches with data collected from metropolitan services. The quantitative method used in the majority of research articles utilized surveys and standardized tools, which determined the number of psychiatric clients with an alcohol or other drug misuse problem. These studies have neglected to discuss and communicate health professionals' thoughts and feelings about caring for clients with a dual diagnosis. As this study aims to explore and describe the experiences of health professionals working with dual diagnosis clients, phenomenology is ideally suited to obtain health professionals' thoughts and feelings toward this client group. The researcher selected phenomenology for this study as it offered freedom to elaborate, explore and support health professionals' feelings and experiences of caring for these complex individuals.

The phenomenological movement commenced in Germany in the early part of the 20th century with Husserl, Heidegger and Schultz being credited as leaders of the movement (cited in Streubert & Carpenter 1999). The method was further developed by Merleau-Ponty in France during the last century (cited in Rice & Ezzy 1999). Both Merleau-Ponty (1962) and Spielberg (1975) describe phenomenology as a philosophy and also a method. Becker (1992) believes that phenomenologists study everyday events or situations from the view of the person experiencing this phenomenon which provides nursing with a new way of translating world events. Streubert & Carpenter (1999) also acknowledge the importance of phenomenology to nursing as the practice of professional nursing is interlocked in the life experiences of people.

Setting

This study was conducted in the Grampians Psychiatric Services/Ballarat Health Services, Victoria, Australia. The Grampians region covers 48 112 km² extending from Bacchus Marsh in Victoria to the South Australian border. The population within this area is 199 561 (Australian Bureau of Statistics 2001). It contains three major regional centres including Ballarat, Horsham and Ararat. The health professionals in the adult psychiatric services within the Grampians Region include 84% nursing staff, 4% social workers, 6% psychiatrists, 5% psychologists and 1% occupational therapist. Ethics approval was gained from both

the University of Ballarat and the Ballarat Health Service Human Ethics and Research Committees.

Sample

Permission was gained from the management of the Grampians Psychiatric Services to distribute invitations to health professionals to participate in this study. The sample consisted of 13 mental health professionals who responded and agreed to be interviewed. The sample consisted of 10 nursing staff, one social worker, one psychiatrist and one psychologist. There were three females and 10 males, aged 30 years or less ($n = 3$), 31–40 years ($n = 5$), and 41–50 years ($n = 5$). Their experience as a mental health professional were: three with less than 2 years' experience; two with 6–10 years' experience; two with 11–15 years' experience and six with 15 years' or more experience. Ten participants described their most frequent place of work as the Community Mental Health Service; two worked in other areas with one from the inpatient area.

The collection of data was obtained using in-depth interviewing. In-depth interviewing allows the researcher to gain access to motives, actions/reactions and meanings of individuals in the context of their lives. This approach facilitates an understanding of the informants' perceptions. The physical locations of the interactions were the participant's place of work in Ararat, Horsham or Ballarat.

Data analysis

The data analysis technique used in this study was the process recommended by phenomenologists. Parse (2001, p. 83) describes Colaizzi's procedure of data validation and collation by

- the reading of all participants' descriptions;
- extraction of significant statements;
- formulation of all meanings whether hidden or disclosed;
- themes are then placed into clusters;
- the development of an exhaustive description;
- the exhaustive descriptions are formulated into 'an unequivocal statement of identification of the structure;
- the findings are then validated with participants;
- the information gained through this validation is then incorporated into the final description.

Analysis involved the initial transcribing of data obtained from participants, reading the data and listening to the audio tapes to ensure validity and to become familiar with participants' own words. These transcripts were then returned to participants who were asked to change words

or sentences they felt did not reflect their experiences of caring for dual diagnosis clients. The researcher then identified significant words, statements or themes. The data was continually examined until all the narrative from participants was listed.

Finding

Thirteen mental health professionals consented to be interviewed. A limitation in the study was the absence of information on specific educational courses on substance use undertaken by participants.

Frustration was the dominant emotion expressed throughout interviews. Examples of this frustration were the description of working with clients who were slow to respond to treatments.

Participant 11

I felt frustrated because you find it is very slow progress. Any goals that you set between yourself and your patient are very slow to achieve. There are a lot of setbacks because they are sabotaged because of the drugs.

Participants suggested that it was easier to treat a person with a diagnosis of schizophrenia, as the response to treatment was more positive.

Participant 6

It's not like you are treating a person with paranoid schizophrenic where you get them stabilised and everything is okay. With dual diagnosis patients you've always have the difficulty of them using drugs, especially when they think it's helping their symptoms.

Participant 13

I have to accept the fact that there are quite a few people I don't like working with but it is my job. . . . I often wonder am I doing the right thing? Am I setting the person up to fail? Is there some factor that I am missing out on?

The frustration experienced by health professionals increased with their knowledge of the probable outcome. An example of this was the participant's description of the present structure of psychiatric services where clients are transferred to the supervision of GPs on the closure of individual cases. Several participants stated that some GPs possess a limited understanding of dual diagnosis issues, which, unfortunately, sometimes result in negative out-

comes for clients. Younger GPs were viewed as more understanding than the older generation of GPs. Participants suggested that this was possibly due to a lack of knowledge and understanding of dual diagnosis strategies. Also GPs from small or one-doctor towns tend to harbour judgmental attitudes, resulting from isolation and limited support. The small number of GPs in many rural/regional settings was also seen as problematic, as identified by ANCD (2002).

Participant 6

I think that there is a small percentage of GPs who understand people with a combined mental illness and drug and alcohol problem. The majority are less tolerant or they don't have the interest in it.

Participant 4

Maybe they don't want to know, maybe it's that the knowledge hasn't been offered to them or the education hasn't been offered. Maybe they are just too busy to have time, not interested I mean. I'm sure there are reasons, but that's what I find anyway and then occasionally you will get a really good GP who will go out of their way to be helpful.

Mental health professionals also demonstrated sympathy toward clients with dual diagnosis as clients.

Participant 12

I find them the saddest client group. From what I've seen a lot of people use substances when they have got a specific mental illness, usually to self medicate. If they are not dealing with their symptoms, or they are not feeling good, they will use the substance as a form of escaping from their symptoms or feelings of unhappiness.

Participant 5

It's a sense of belonging that they normally wouldn't have. Maybe their families can't provide this for them any more, their friends can't provide this for them, the school can't provide this for them, and occupation can't provide this for them.

In the past, drug use issues were not identified as prominent in psychiatric services. Clients experiencing a coexisting mental illness and drug and alcohol problem were referred to specialist services. Psychiatric services' policy (ANCD 2002) is now changing by recognizing and treating more of these people. Findings show that health profession-

als experience a degree of resentment at having to care for this group of clients.

Participant 11

Sure you might put them into hospital to straighten them out, stabilise them, send them home but they are still addicted to the drugs and they don't get the specialist services follow up they require, I'm not saying that is a fault of the services I am just saying they don't get the follow up and they relapse and start using again especially if the drugs they are on precipitate their illness.

Participant 12

I think they're the most complex clients. I found them the most challenging and difficult and they tend to slip through all the service systems because health workers hand ball them all over the place.

Participant 10

Probably a bit harder to look after especially if they are deep into their drug taking because from my background I really want to concentrate on their mental illness, getting them well so that they can get independent again in the community. The drug taking though puts a whole new avenue on your steps for discharge.

Currently, psychiatric services' policy on the care and treatment has not resulted in additional education for mental health professionals on dual diagnosis, and consequently they lack the necessary skills and knowledge. When treating a dual diagnosis client, health professionals found these clients to have a general lack of motivation in their treatment. These situations made health professionals feel helpless and powerless, leading them to believe there is a need for a specialized agency.

Participant 11

Sure you might put them into hospital to straighten them out, stabilise them, send them home but they are still addicted to the drugs.

Participant 2

What do you give these people, how do you tackle it? We can't change what has happened to them, you just feel completely powerless.

Participants from all disciplines believed that their initial training was limited in regard to dual diagnosis.

Participant 5

Throughout my university training I was not once informed of the term dual diagnosis. We did receive some general training in drugs and how they affect the body. That was about it.

Participant 10

I don't think I was that prepared at all especially being young in psychiatry . . . it was quite daunting to work with people who had a dual diagnosis . . . Only maybe a lecture or two at University and then a lecture in a tutorial that was geared to the postgraduate as well so nothing really extensive.

Some participants found that the care they provided was more of a trial and error process. They described feelings of nervousness, naivety and being overwhelmed when confronted with their first client with a dual diagnosis. These emotions contributed to a feeling of inadequacy. Their initial lack of knowledge placed them in humiliating situations where they were unable to accurately answer questions the client asked.

Participants believed that mental health professionals should be provided with knowledge and understanding of dual diagnosis options before commencing employment in psychiatric services. Some participants mentioned that a postgraduate programme on dual diagnosis is warranted for professionals who choose to specialize in the field of psychiatry.

Visiting unpredictable clients at home to render care and treatment was highlighted as increasing the risk factor to professionals. Health professionals do not know what state they are going to find the client in, given that drug/s can mask the illness.

Participant 8

I mean it's really difficult to deal with someone when you go around to visit; they are drunk or high on drugs. You wonder if they going to be violent towards you, have they got hepatitis from using drugs? You might walk in to visit someone when they have got four people sitting around abusing drugs. You don't know if they are going to turn on you.

Conclusion

This research has identified negative experiences and feelings of health professionals who care for clients with a dual diagnosis. Although dual diagnosis was prominent in the Grampians region, mental health professionals felt they

were underprepared, with limited dual diagnosis knowledge. Dual diagnosis or alcohol and other drug information were stated to be only a small portion of their initial training, and as a result mental health professionals were often placed in difficult situations with obvious knowledge deficits. This in turn affected the attitudes of health professionals toward this clientele, resulting in a feeling of inadequacy and lack of power.

Dual diagnosis issues should be included in the curricula of generic courses for mental health professionals. Some participants suggested that dual diagnosis is a specialist field requiring an appropriate postgraduate course. Information regarding an understanding of different drugs and treatment options must be provided in a generic course. An area that the participants referred to and lacking in the community was an understanding of the connection between mental illness and substance misuse. This needs to be addressed in the content of education policies to schools and to the wider community.

All participants identified further education and the training of professionals as important. The literature provides various options for education but implementation of such projects would require an increase in funding. It is debatable as to how extra funding should be allocated. If funding was increased, a core specialist dual diagnosis team could be established that would provide education to schools, clients, parents, health professionals and GPs. Alternatively, funding could be used to educate all mental health professionals, which may result in more appropriate initial assessments and treatments.

Results of this study unearthed the need to render professional support and supervision to clinicians caring for clients with a dual diagnosis in rural areas. The establishment of dual diagnosis services in rural areas requires innovation and creativity in recognizing, acknowledging and understanding the demands of a vast rural area. The development of a specialized team in rural regions requires the availability of appropriate funds to support a fully effective team, otherwise a substandard service to this group of clients will exist.

Participants in this study reported experiencing negative emotions. These emotions contribute to many conflicts which influence the professional's judgement and coping responses, resulting in difficulties with deciding how to treat clients with a dual diagnosis best. The researchers maintain that this situation presents as fear of the unknown, which creates a frustration that would only improve with the availability of appropriate education and supports.

The researchers view frustration levels of professionals working with this clientele as an important factor in the client's treatment and care. This frustration, if not resolved,

may lead to negative attitudes toward clients with a dual diagnosis.

Recommendations

Community dual diagnosis services

Teams specializing in dual diagnosis need to be developed and strategically located in rural areas. An alternative to this would be the up-skilling of present staff with a coordinator of dual diagnosis services within the region. Access would have to be ensured to drug and alcohol agencies either by the location of a dual diagnosis clinician in their service, or the availability of a designated worker within the psychiatric services. The seriously mentally ill client would be treated by the psychiatric services, with the drug and alcohol services using their allocated worker for those who do not meet the criteria for case management in the psychiatric service.

Training

Health professional undergraduate education requires review. Many of the participants believed that more specific dual diagnosis strategies should be incorporated in their generic training. Alternatively, a dual diagnosis component should be incorporated into graduate programmes for health professionals working in psychiatric services.

Funding structure

Because of the constraints of distance and other identified service difficulties, two separate funding structures are required to ensure uniform services across the state between metropolitan and rural/regional services. The pricing structure of petrol and other cost components, plus the large geographical area which widens the gap between travelling time and clinical time, make rural/regional and metropolitan regions impossible to compare. These rural/regional areas must be treated as unique, as often rural/regional psychiatric and drug and alcohol workers are more independent, services are limited and accessibility is difficult.

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