“Drugs on the Mind”

Dual diagnosis: The experience of mental health professionals.

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DECLARATION OF AUTHORSHIP

Except where explicit reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis which I have qualified for or been awarded another degree or diploma. No other person's work has been relied upon or used without due acknowledgement in the main text and bibliography of the thesis.

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Signature of applicant

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Date

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DEDICATION

This article is dedicated to the four girls in my life, Jacinta, Jessica, Hannah and Molly. Thankyou for your patience and support!

This research shows that “miracles do happen”.

Abstract

Recent publicity has focused on the problems created by the usage of illicit drugs in the community. The growing use of illicit drugs throughout the Grampians region and the lack of resources and professional services available to regional and rural areas raise many questions as to treatment options and the accessibility and appropriateness of drug and alcohol and mental health services.

Despite the fact that mental health professionals in rural/regional areas are expected to deliver the most appropriate care to individuals with a comorbid drug and alcohol and psychiatric disorder, a number of these rural/regional mental health professionals have limited preparation and experience in dealing with dual diagnosis issues. This phenomenological study focuses on the area of dual diagnosis, specifically the experiences of health professionals who care for clients diagnosed with a serious mental illness and a coexisting drug and alcohol disorder.

Results are described in the form of four themes, which emerged from data collected during in-depth interviews with 13 mental health professionals who care for clients with a dual diagnosis. The themes captured in this research will be described using metaphors as headings. The first theme Sink or swim represents mental health professionals' initial preparation to care for this group of complex clientele. Treading water symbolises mental health professionals' endeavours to keep their head above water and reflects on their feelings while endeavouring to do so. Rowing against the tide describes mental health professionals' understanding of clients' drug misuse, which impacts greatly on the level of care.

The final theme of smooth sailing, represents mental health professionals awareness of the need to provide appropriate care. A discussion, recommendations and conclusion will be provided at the close of the thesis.

Preface

The following quotation from Lehman and Dixon (1995:1) highlights the problems faced by many clinicians within the mental health field who care for clients with a dual diagnosis:

> The voices taunt Paul incessantly as they have for years, forcing him to recall horrible past misdeeds, whether real or imagined, he cannot tell. Waves of guilt and depression wrack him. What has he done to deserve this? Attempts over the past few days to drown the tormenting demons with alcohol have provided some hours of relief, only to invite the voices back with even more vengeance. The alcohol no longer provides the escape that it has on so many occasions in the past, but the desire to drink is as persistent as the voices. He has tried other escapes - marijuana, downers, even cocaine – but these only make things worse, feeding the voices and driving his family away from him. Paul's desperation now leads him to one painful conclusion – he must kill himself to be free of his living hell. Paul now waits in the emergency room for your evaluation, pacing and talking loudly to himself.

The majority of the clinician's initial thoughts are to refer Paul to someone who is more capable of handling this complex situation. The clinician often reports that he or she feels inadequate, as there seems to be no specific service that can help Paul. Those who have treated Paul in the past may have diagnosed him with a variety of possible conditions including schizophrenia, cocaine dependence, alcohol dependence, organic hallucinosis, psychotic depression, antisocial and borderline personality disorder. He may have been treated with antidepressants, lithium, antipsychotics and antibuse. It appears nearly impossible to comprehensively determine Paul's illness, as it regrettably seems Paul's problems are too complicated for us to treat or the services he requires do not exist. An increasing number of mental health clinicians are coming upon people like Paul (Lehman & Dixon 1995).

CHAPTER ONE - INTRODUCTION TO THE INVESTIGATION

1.1 Introduction

The study reported in this thesis takes as its focus the exploration and description of issues and problems of dual diagnosis clients and the experiences and feelings of mental health professionals caring for them. This exploratory approach is justified in the absence of prior research in this area. The study was designed to be narrow in scope to allow for meaningful analyses of qualitative data collected through in-depth interviews of 13 mental health professionals employed in the Grampians Psychiatric Services (GPS). This chapter briefly provides an introduction to dual diagnosis with an overview of the incidence and issues associated with this diagnosis.

1.2 Dual diagnosis

Adults who suffer from a dual diagnosis have increasingly come in contact with health professionals working in mental health services. These consumers face a bleak future without appropriate treatment. Sadly neither Drug and Alcohol nor Psychiatric Services are sufficiently prepared to deal with these clients (Lehman, Schwartz, & Myers 1993). The recent Australian National Council on Drugs report described how "co-morbidity is poorly understood and managed" (ANCD, 2002:12). McKenna and Ross (1994) state that dual diagnosis clients often present as a diagnostic challenge as each disorder may complicate the other. Bricker (1995) describes clients with dual diagnosis as rapidly growing, vastly under-served, highly mobile, chronic over-users 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. Kavanaugh et al. (1998) assert that a large number of clients who respond poorly to psychiatric treatment may have an undiagnosed

substance misuse problem. This problem increases the burden for clients, families, health-care systems and the community.

Rasool (1998) states that psychiatric nurses are frequently exposed to individuals with a substance misuse problem. These nurses encourage the clients to adhere to psychotropic medication, while discouraging alcohol and other drug use. Inaba and Cohen (2000) consider that there are several possible reasons why there has been an increase in dual diagnosis clients since the 1970s. These reasons include a reduction in the amount of inpatient units and more effective medication for psychiatric illnesses enabling clients to be treated in the community.

Many theories have been offered to explain why people with a psychiatric illness misuse drugs. For example, Rassool (1998) suggests they use drugs to self-medicate to treat their psychiatric illness. Stimulants for example have been used to counteract extra pyramidal side-effects caused by some psychotropic medication. Clients with a psychiatric diagnosis who misuse alcohol and various psychoactive substances have an increase in delusions, hallucinations, hostility, homelessness and suicide behaviour. These clients have been shown to have a worsening of symptoms associated with poor self-care and disruptive behaviour (Banks & Waller 1988; Caton, Shrout, Eagle, Opler & Felix 1994; Conner, Silverstein, McCullock & Maxey, 1995; Drake, Teague, Noorsby & Clark 1993; Drake & Wallack, 1989; Kavanagh et al. 1998; Osher & Kofoed, 1989; Rassool, 1998; Warner, et al., 1994). Bachrach (1986) found that during the era of deinstitutionalisation, the number of clients experiencing a chronic mental illness and problems associated with substance use increased. Stuart and Laraia (1998) stated that misused substances include alcohol, prescription drugs,

opiates, cocaine, psychostimulants, cannabis and inhalants. A dangerous and escalating problem is the use of numerous substances simultaneously.

1.3 Incidence

Reiger, Farmer, and Rae (1990) conducted an epidemiological study in the United States of America which determined that there was strong evidence to suggest that substance misuse is more prevalent in those with a psychiatric illness than in the general population. In Europe, Takala, Ryynen, Lehtovirta, and Turakka (1993) also found that individuals with a mental illness had a higher rate of drug misuse than the general population. Teesson, Hall, Lynskey and Degenhardt (2000) state that until recent times, Australia was dependent on data from surveys conducted in the United States of America. In 1997 the National Survey of Mental Health and Wellbeing (NSMHWB) was undertaken in Australia producing similar results to studies performed in other countries.

The rate of individuals with a coexisting drug and alcohol disorder has been found to fluctuate by various authors. For example Crawford (1996) found that the co-morbidity range was from 25% to 80% in psychiatric populations, whilst El-Guegaly (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 drug or alcohol disorders at some time during their lives (Conner et al., 1995; Drake Teague, Noorsby & Clark 1993; Fox, Fox & Drake, 1992; Gafoor, & Rasool, 1998; Kavanaugh et al. 1998).

Lanning-Smith (2001) argue that although it has been determined that a higher rate of dual diagnosis exists, this disorder frequently goes undetected within acute inpatient settings. This undetected diagnosis or non-detection of substance misuse is serious as it leads to inappropriate treatment and interventions.

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1.4 Treatment Difficulties

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 (Appleby, Dyson, Luchkins, & Cohen 1997). The centre for Mental Health Services (1995) 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.

Differences of opinion and theoretical beliefs between health professionals employed by drug and alcohol and mental health services for clients with both problems resulted in difficulties associated with bringing these services to this population. This issue is further complicated by the difficulties of providing a service to clients in rural and regional areas (Bricker, 1995).

1.5 Treatment difficulties within Rural Services

One of the recommendations of the recent report from the Australian National Council on Drugs (ANCD 2002: 10) was for rural and regional areas to identify and implement their own strategies. The ANCD stated, "it is not feasible to simply apply urban-based strategies to the rural and regional setting". The report also identified the following difficulties for rural communities, namely a high level of unemployment,

service reductions such as telecommunications, banks and other public services with limited hours of operation, and a reduced capacity to respond to drug and alcohol issues as a result of dwindling infrastructure in these rural communities. Many towns have only one doctor, leading to limited health services, limited operating hours and limited options for drug and alcohol treatment concerns.

The problems associated with the treatment of dual diagnosis clients in rural areas have been reported in the literature as complex. For example, Howland (1995:33) 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…." Bricker (1995) argued that difficulties in rural areas result from a geographical dispersal, under-funding, diffuse infrastructure, lack of specialist training opportunities for health professionals, stigmatisation, community prejudices and a lack of continuity of care.

Barry, Fleming, Greenley, Kropp and Widlak (1996) conducted research in a rural county in Wisconsin (USA), and found that high rates of alcohol and other drug use exists in rural communities. McDermott and Pyett (1993) claim that although clients with a dual diagnosis in rural/regional areas do not differ remarkably from urban areas, they may experience a greater amount of stigma.

1.6 Background to Study

The Grampians region covers 48 112 square kilometres extending from Bacchus Marsh in Victoria to the South Australian border. The population within this area was 199 561 in 2001 (Australian Bureau of Statistics 2001).

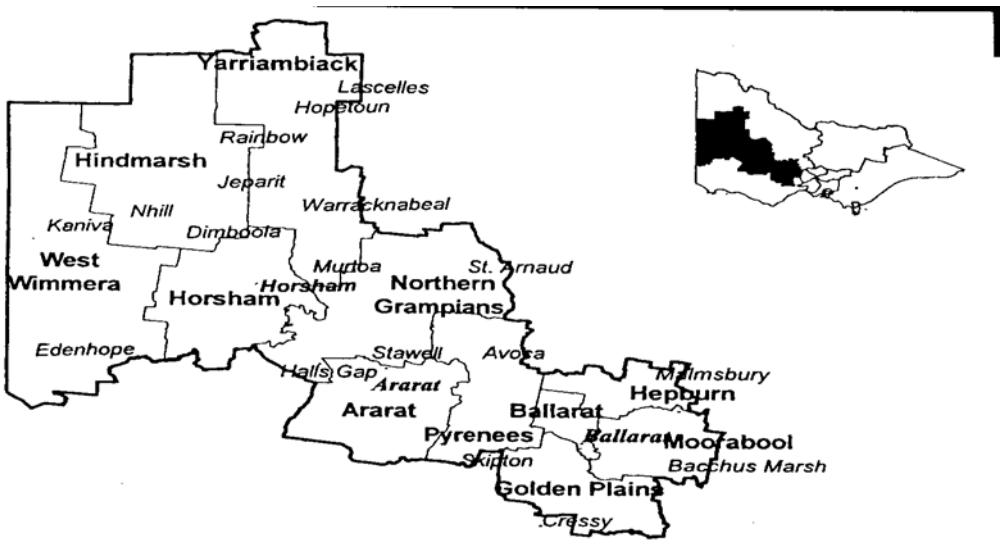

Figure 1. Grampians Region

Both Ballarat and Ararat previously had large psychiatric institutions within their cities, their present population is 83 000 and 6 700 respectively. During this time both institutions housed over one thousand in-patients. These previously hospitalised clients went through the process of deinstitutionalisation and are now members of the local community living in either supported housing or privately rented abodes.

In 1997 the Department of Human Services (DHS) called for submissions to develop a dual diagnosis service in Victoria, Australia. The Western Consortium, comprising of the Grampians Psychiatric Service, Palm Lodge (Horsham), Western Healthcare Network Mental Health Program and Drug and Alcohol Services (DAS) and the

Centre for Young Peoples Mental Health (CYPMH) submitted a successful proposal resulting in the formation of the Substance Use and Mental Illness Treatment Team (SUMITT).

The objectives initiated by the Western Consortium were to establish a specialist dual diagnosis team (DDT), which would provide direct clinical services to clients who required the service of both Mental Health (MH) and Drug and Alcohol (D&A) agencies. One of the identified roles of this service was to incorporate staff training and promote service development. At the conclusion of the two-year secondment a report prepared by the dual diagnosis clinician highlighting the need for dual diagnosis services in the Grampians Region of Victoria was produced (Soar, 2000). In 2001 funding for one dual diagnosis clinician to be attached to all MH services was allocated to Victorian Mental Health programs.

1.7 Statement of the Purpose – Research question

As mentioned previously, the aim of this study is to identify and describe the experiences of mental health professionals in the Grampians Psychiatric Services/Ballarat Health Services while caring for clients with a dual diagnosis. The following research question will be answered:

What are the lived experiences of mental health professionals who care for clients with a dual diagnosis?

1.8 Overview of thesis

This thesis will be presented in five chapters. Chapter one will provide an introduction to dual diagnosis; Chapter Two will report on the literature that describes drugs, mental illness and dual diagnosis. The researcher considered it important to provide definitions and the history of drugs and mental illness and then combine both disorders under the heading of dual diagnosis. Chapter Three will describe and justify the research method used in this study while also providing a brief outline of the steps used to analyse data collected in this study. Chapter Four presents the research findings where data relating to mental health professionals perceptions of caring for clients with a dual diagnosis is provided. The results will be explained using four metaphors, which link specific experiences. The metaphors used are 'sink or swim', 'rowing against the tide', 'treading water' and 'smooth sailing'. Results demonstrate a lack of professional preparation, limited and inappropriate services, misunderstanding and frustration experienced by mental health professionals caring for this group of individuals. This lack of appropriate services and poor professional preparation created many frustrations and negative experiences for professionals, which are presented in the results section.

The final chapter provides a discussion and recommendations. The discussion section will explain those areas, which mental health professionals feel hinder or reduce their effectiveness in delivering a high standard of care to dual diagnosis clients. Finally, recommendations regarding the delivery of appropriate treatment to individuals with a dual diagnosis in the Grampians region will be provided.

1.9 Conclusion

This introductory chapter described the increasing incidence of dual diagnosis clients within the mental health service and the treatment difficulties encountered by mental health professionals delivering care in rural/regional areas. The following chapter will review the literature regarding drug misuse and mental illness. It argues that drug misuse has a major effect on a person's mental health, complicating already unpredictable and complex behaviour. This predicament creates increased difficulties for health professionals.

CHAPTER TWO - LITERATURE REVIEW

To assist the reader to understand the difficulties encountered by mental health professionals caring for clients with DD, the effects individual drugs have on a person's behaviour is described. This drug-related behaviour is made more difficult if the client also suffers with a mental illness. This chapter will review the literature covering the area of classification of both mental illness and substance misuse, a description of terms, definitions and conditions of both disorders. The final section will link both disorders together and explain dual diagnosis. A description of the terminology used in this thesis is described under the heading of clarification of terms.

2.1 Clarification of Terms:

An **overdose** is when the amount of drug taken exceeds the ability of the body to cope (Australian Drug Foundation, 2001).

Addiction refers to psychological behaviours that are related to substance dependence (Stuart & Laraia, 1998).

Dual Diagnosis refers to the coexistence of psychiatric and substance misuse disorders within the same person (Stuart & Laraia, 1998). The description of clients with a dual diagnosis used in this study will be clients with a serious mental illness and alcohol and other drug misuse disorder. This definition is used as health professionals of the Grampians Psychiatric Services who participated in this study have a client target group of serious mental illness.

Harm minimisation is a public-health approach to dealing with drug-related issues that places first priority on reducing the negative consequences of drug use rather than on eliminating drug use or ensuring abstinence (Byrne, 1996).

Health Professional is defined as any person who has completed a health related course of study as a psychiatrist, registered nurse, psychologist or social worker. This individual is registered by the government (Urdang & Harding Swallow, 1983). Health professionals that took part in this study were mental health professionals.

Health is defined as physical, mental, and social well-being with an absence of disease or other irregular condition (Urdang & Harding Swallow, 1983).

Individual Service Plan (ISP) is a plan collaboratively designed by both the psychiatric case manager and the client. It outlines goals, strategies and responsibilities and is reviewed every 6 months (Psychiatric Services Division, 1995).

Mental Health Services are defined by Otto (1990) as 'services which have the responsibility to define, treat, manage, rehabilitate or support those who have difficulties with mental well being. This includes hospitals, clinics, day centres, supported accommodation services, nursing homes and private practitioners' (p. V).

A **metaphor** is described as 'an imaginative way of describing something as another thing, and so suggesting that it has the typical qualities of that other thing. For example, if you wanted to say that someone is shy, you might say they are a mouse' (Treffry, 1999:453).

Physical addiction is when the body has become used to functioning on a certain drug level, but when that level falls the drug user experiences symptoms of withdrawal (Brands, Sproule, & Marshman, 1998).

Poly drug use is the use of two or more drugs used simultaneously or within a short period of time (Australian Drug Foundation, 2001).

Psychological dependence is seen as a state that produces non-physical symptoms when stopping or abruptly reducing drug use (Brands et al., 1998).

A **Region** is "a large area of land" (Treffry, 1999:596).

Rural is described as "related to or involving the country side" (Treffry, 1999:625). Seriously Mentally Ill as defined by the Psychiatric Service Division (1995) is 'a diagnosable psychiatric disorder resulting in significant impairment, disability **or** disadvantage' (p. 25).

Substance Abuse describes the continued use of substance after the occurrence of problems (Stuart and Laraia 1998).

Tolerance to a substance can develop if a person uses it frequently resulting in the need to use an increased amount to obtain the desired effect (Australian Drug Foundation, 2001).

2.2 Alcohol and Other Drugs

2.2.1 Description of Drugs

Drugs are described as any liquid, gas or solid that changes the structure (or function) of the body (Bellhouse & Munro, 2001). Throughout history, drugs have always been a large part of our lives. For thousands of years plants have been used to assist with the function of the body and mind (Brands et al. 1998). Many drugs are derived from plants, ranging from caffeine in coffee, nicotine in tobacco, cocaine from the coca plant as well as morphine and codeine obtained from the opium poppy. Marijuana is the leaf, buds and seed heads of the cannabis plant, whilst hashish and hash oil are the plant's resin. Alcohol is derived from a natural process of fermentation, which occurs when fruits, vegetables or grains decay. Certain fungi such as cactus plants and magic mushrooms are considered to be drugs because of their hallucinogenic properties (Australian Drug Foundation, 2001). Drugs are also produced in registered and illegal backyard laboratories (Bellhouse & Munro, 2001).

2.2.2 Classification of Drugs

There are many methods of drug classification (Brands et al. 1998, Inaba & Cohen, 2000; Palin & Beatty, 2000; Schuckit, 2000). These include origin, use, structure, site of action (Moffitt, 1998), method of action or street name. Drugs stemming from natural sources (for instance plants) are regularly classified by their origin. The classification of use is well situated for medical professionals but it does not reflect the drugs' non-medical use and abuse. The classification by their site of action has limited usefulness as one drug may act on several areas of the body, whereas classification due to the mechanism of action is centred on understanding how the drug produces its effect. A non-medical classification that emerges from the substance-using community and the street market is by street name (Brands et al. 1998, Inaba & Cohen, 2000; Schuckit, 2000). Palin and Beatty (2000) mention how the drugs are classified in a variety of ways including their legal status, reasons for use, the drug's perceived harm and the drug's potential risk to health.

For the purpose of this research, drugs will be classified according to their effect on the central nervous system (CNS). Classifications of drug misuse in Australia are stimulants, depressants and hallucinogens (Inaba & Cohen, 2000). Stimulants speed up the CNS, depressants cause a reduction in CNS activity while hallucinogens mix up and distort mental functioning (Campbell, 2001; Inaba & Cohen, 2000; Palin & Beatty, 2000; Royston, 2000). The following section will describe the action and impact of groups of drugs on the psychological, emotional and social responses of individuals who misuse them. To a large extent the effects of drug misuse are responsible for a major component of the difficulties experienced by health professionals.

2.2.3 Stimulants

Stimulants include amphetamines and ecstasy, whilst caffeine and nicotine are classed as mild stimulants (Bellhouse & Munro, 2001). These drugs stimulate the central nervous system which increases the heart rate and blood pressure. They can also decrease appetite and cause insomnia, symptoms which usually occur in response to small to moderate doses of the drug. Strong stimulants, for example, methamphetamines or cocaine, may also cause signs of anger and dilated pupils, and may result in the person becoming aggressive. When a large amount of the drug is used or the person using the drug is extra-sensitive to it, problems with the heart, blood pressure fluctuation and seizures can occur. Regular use over a few days will deplete the user of energy and eventually result in exhaustion. Small to moderate amounts of the strong stimulants can have an effect on the individual's mental and emotional well-being. They can make the user feel more confident, eager to perform, excited and euphoric. Larger amounts or the prolonged use of stronger stimulants may cause paranoia, anxiety and mental confusion, which can mimic a psychosis (Inaba & Cohen, 2000).

Amphetamines were first produced in the 1930s as a treatment for nasal congestion. These drugs were later found to be effective in the treatment of attention deficit hyperactivity disorder (ADHD) and narcolepsy. They have also been prescribed as a weight-loss option and for the treatment of disorders involving depression. The therapeutic value of their use in the treatment of obesity and depression is short-lived as benefits are offset by serious side effects of chronic use, tolerance, psychological and physical dependence and disorders of sleep. Amphetamines are produced by a

chemical synthesis by pharmaceutical and backyard laboratories (Brands et al., 1998; Nadelson, 2000).

Cocaine is produced using the leaves of the coca plant grown in South America. The Inca Indians discovered the stimulant effect of the drug well before it was first used in North America and Europe. Priests of the Inca Indians believed that the chewing of coca leaves allowed a greater and direct communication with the gods. Spanish explorers wrote how the Indians of Peru were able to sustain hard labour for longer periods following the chewing of leaves from the coca plant. Samples of the plant were taken to Europe in the latter part of the sixteenth century and approximately two centuries later cocaine's use in medicine as a local anaesthetic was discovered (Palin & Beatty, 2000; Yoslow, 1992). As a result of its ability to increase energy and euphoria, it was widely abused in the latter part of the nineteenth century, resulting in legislation being introduced to restrict its use early in the twentieth century (Brands et al., 1998; Palin & Beatty, 2000).

2.2.4 Depressants

The depressant drugs slow down the central nervous system but do not necessarily cause a person to feel depressed. They include cannabis, alcohol, Benzodiazepines, opium/opioids and most inhalants (Bellhouse & Munro, 2001). Inaba and Cohen (2000) explain that this group of drugs are divided into four categories: opiates and opioids, sedatives/hypnotics, alcohol and others. Opiates are described as drugs obtained from the opium poppy, whereas opioids are the synthetic version of opiates. This group includes morphine, heroin, codeine and methadone. The opium poppy has been used as a drug in various countries for at least 2,500 years. Morphine, which is

extracted from opium, is converted to heroin using a simple chemical process. All of these drugs are narcotic analgesics with the ability to alleviate pain, whereas a narcotic is a drug which produces a stupor. In 1850 the syringe was invented which allowed for easy administration of morphine and other drugs (Brands et al. 1998; Palin & Beatty, 2000; Schuckit, 2000; Yoslow, 1992).

The second group comprises the Benzodiazepines (Xanax, Rohypnol and Valium) which are the most widely-prescribed drugs in the world and are used in the management of anxiety, tension and insomnia. In low to medium doses they are effective in relieving mild to moderate anxieties and are also effective in controlling more severe emotional states with larger doses. These drugs, while mostly prescribed appropriately, have the potential for abuse, with Diazepam and Alprazelam having a greater abuse potential than other drugs in this class, making them attractive to drug misusers (Brands et al., 1998).

Alcohol is the third group consisting of all alcoholic beverages whether light, or heavy beer, mixed drinks or wine. If taken in small doses they slow the heart rate, cause tiredness and a dulling of the senses. However, excessive alcohol intake may result in slurred speech and digestive problems. According to Palin and Beatty (2000:115), “Alcohol is a powerful and toxic depressant. It contains the drug ethanol (Ethyl alcohol) and is a depressant, not a stimulant as many people think”. Alcohol is one of the three most widely-used drugs in the world and produces more health problems and deaths than all illegal drugs combined. Beverage alcohol is produced by the fermentation and distilling of fruit or grains while beer and wine are a direct product of fermentation. Further distilling of products produced by fermentation

increases the alcohol level. This procedure produces spirits, which average 40 percent of alcohol volume (Brands et al., 1998).

Large doses of alcohol and sedative/hypnotics can result in a dangerous respiratory depression while small doses of depressant drugs, especially alcohol, initially lower inhibitions acting like a stimulant but as the dose is increased the depressant effect of the drug dominates. The drug tends to have a relaxing effect, dulls the mind and controls some forms of neurosis (Inaba & Cohen 2000).

2.2.5 Hallucinogens

Ecstasy (MDMA), LSD, MDA, mescaline, PCP (angel dust) and marijuana are just a few drugs within this classification. There are three main groups categorised as hallucinogens. The first group includes D-Lysergic acid diethylamide (LSD), which comes from the ergot fungus which grows on grains such as a wheat, corn and rye. Psilocybin (magic mushrooms) is another drug in this group. One of the drugs included in the second group is mescaline, which is the dried buds of the peyote cactus grown in the southwest United States and Central America. The third group are the designer drugs MDMA (ecstasy) and DOM (STP) (Brands et al., 1998; Yoslow, 1992). Hallucinogens (psychedelics) distort perceptions producing illusions, hallucinations and delusions. Most hallucinogenic plants cause dizziness and nausea. Bloodshot eyes and an increase in appetite are caused by marijuana use while LSD raises the blood pressure and induces sweating (Inaba & Cohen, 2000).

Using the CNS classification many drugs fall into more than one section. For example, cannabis, the most commonly used illicit drug in Australia, is not only

classified as a depressant drug but also as a hallucinogen (The Australian Drug Foundation, 2001; Palin & Beatty, 2000). Yoslow explains that cannabis is extracted from the cannabis sativa plant by processes, which have been known for approximately 5000 years. Cannabis, which can be smoked or eaten, is often regarded by many young people as not being dangerous. However, as Yoslow (1992:65) points out:

> Of all illegal drugs, marijuana has the most complex chemical effect on the body. Marijuana does not contain one drug but many, and is the least understood of all abused drugs because accurate research results have only recently become available. The research on the effects of marijuana conducted in the 1960s was very limited, unrealistically planned, and poorly executed. Rather than comparing the mental and physical performance of non-users and consistent users, for example, researchers at that time compared non-users with occasional users. This led to underestimating the toxic effects of the drug and how addictive it can be. We now know marijuana affects every organ system in the body.

The researcher believes that this lack of understanding and appropriate research creates many obstacles with health professionals attempting to understand and case manage a client with a mental illness that misuses cannabis.

Phencyclidine (PCP) was first developed in the mid-1950s by Parke Davis laboratories. In the early 1960s there were a number of cases reporting extreme agitation, hallucinations, delirium and rage causing the drug to be removed from medical use (Brand et al., 1998; Inaba & Cohen, 2000; Yoslow, 1992).

Ecstasy or MethyleneDioxyMethAmphetamine (MDMA) is relatively new to the drug-using culture of Australia and was unknown in this country prior to the mid-1980s. It has a stimulant-like effect but also has some hallucinogenic properties (Palin & Beatty 2000). Pharmaceutical researchers first produced ecstasy in 1912 as an appetite suppressant and during the 1970s it was used in a few cases of

psychotherapy in the United States of America. It is produced via a chemical synthesis in both backyard and authorised research laboratories (Brands et al., 1998; Nadelson, 2000).

Asaad (1995) mentions how the misuse of solvents and inhalants, especially in adolescents has increased. Substances used include petrol, varnish removers, spray paints, cleaning fluids, glues, lighter fluids as well as many others. Substances which appear to create the addictive behaviour include benzene, toluene and hydrocarbons. These agents are responsible for the creation of excitement, euphoria and a feeling of increased power. Some users experience lability, changes in personality and hallucinations. These symptoms generally occur within a few minutes of use lasting from one to two hours. Severe intoxication may cause convulsions, coma and even death as a result of central nervous system depression or cardiac arrhythmias. Irreversible brain damage may be a result of prolonged heavy use (Asaad, 1995; Brands et al., 1998; Inaba & Cohen, 2000; Schuckit, 2000).

2.2.6 Drug Effect

The amount of the drug taken, the number of times used and the manner in which it is administered determine the effect of the drug (Australian Drug Foundation, 2001; Inaba & Cohen, 2000). Drugs enter the body in many ways including ingestion, snorting, injection, inhaling and inserting. Substances that are inhaled or injected have a rapid effect and are more intense, while the effects of ingested drugs take longer. A person's height, weight and gender influence the effect of the drug. Emotions can also impact on the effect of the drug as can the social atmosphere. For example, in a comfortable and social environment those using the drug are more likely to have a good time; however, if the setting is threatening or the person feels they are estranged

within the group, they may become anxious, paranoid, fearful or depressed (Australian Drug Foundation, 2001).

The way in which a person sees themself and others can change as a result of their drug use behaviour. No matter which way the drug enters the body, it eventually ends up in the bloodstream where it travels through organs and tissues of the body and is either absorbed, ignored or transformed.

2.2.7 Drug Time-Lines

Yoslow (1992) describes how all drugs have an effect on the human body or brain. In order for a drug to reach the brain it must enter the bloodstream. The time it takes to reach the brain depends on the route taken and the way it was manufactured. The fastest route in most cases is smoking or inhaling. Oxygen and vapours in the smoke can dissolve in blood and reaches the brain in approximately seven or eight seconds and it then travels to the remaining areas of the body.

The second fastest route is injection into the vein, which takes approximately one to two minutes (PCP is an exception, taking 3-5 seconds to reach the brain). Either sniffing or snorting a drug after having transformed it into a fine powder is the next fastest route. Blood vessels in the nose take one to five minutes to carry the powder to the brain. Generally drugs that are eaten are slow to reach the brain, taking approximately 20 minutes to one hour.

2.2.8 Conclusion

The previous section has explained how the misuse of certain drugs changes the behaviour and characteristics of individuals. The drug misused has an influence on the users' central nervous system, which is determined by the time it takes to have an effect on the body. This explanation of drug misuse demonstrates how changes in the person's personality and behaviour are severely influenced by drug use. This variability of behaviour incurred with drug misuse creates many complicated and complex problems for health professionals. Regardless of the type and method of drug misuse, the potential to effect the individual in a negative way poses serious management crises for health professionals. The following section will address mental illness.

2.3 Mental Illness

2.3.1 History of Mental Illness

Individuals who have cared for the mentally ill throughout history have had a variety of names, for example, in the Middle Ages they were known as masters. During this era a priest would appoint workers to care for the insane in special institutions known as hospitals. These were not medical institutions but had an emphasis on care rather than cure, catering for the relief of the body and the refreshing of the soul by observing religious rituals. During the sixteenth and seventeenth century the insane either wandered from place to place or were inmates of a house of correction. The workers were known as basketmen or keepers. During the late seventeenth and eighteenth centuries physicians who had previously played no role in the early confinement of the mentally ill emerged as essential figures. Along with these changes came private madhouses and the madhouse trade. The high demand for

private madhouse accommodation resulted in many single medical people owning a number of madhouses but residing in none, instead, delegating responsibilities to superintendents, keepers, servants and attendants. The role and nature of the duties of the madhouse attendant or keeper changed considerably over time. In the nineteenth century the title, attendant, replaced the name of "workers" during the development of the asylum years, with their role governed by the establishment of a rulebook. The middle of the nineteenth century saw the establishment of the asylum system in institutions designed specifically for care, control and the treatment of the insane, with these asylums not promising a cure but instead providing places where inmates could be controlled. In the early twentieth century the development of the modern mental health service began (Forster, 2001). Through improved administration practices, philosophies, and treatment technologies, a large reduction in the number of mentally ill people living in large institutions occurred (Hull & Thompson, 1981). Lakeside Hospital, Ballarat, part of the Grampians Psychiatric Services within Victoria Australia was no exception.

Ballarat has had a psychiatric institution within the city for over 100 years. This service began in August 1877 when the then industrial school was converted to accommodate 42 patients from the overcrowded Kew Asylum in Melbourne. Among many developments along the way, Dana Street house was opened in 1912, offering more pleasant conditions. The years between 1952 and 1968 were regarded as years of great change, with an 'open door policy', integration of sexes, enhanced quality of life and treatment methods for patients and improved education for psychiatric nurses. The direction from 1968 saw a new community focus. The reduction in numbers at Lakeside hospital commenced in the early 1960s but accelerated toward the end of the

decade with the policy of deinstitutionalisation introduced. This process continued with the establishment of community services (Murphy & Hodges, 1993).

The previous section illustrates the changes in the treatment of individuals with a mental illness. This treatment process has again changed with the influence of deinstitutionalisation (Bachrach, 1986) and the major impact drug misuse has had on mental illness.

2.3.2 Classification of Mental Illness

The principal mental illnesses associated with dual diagnosis are schizophrenia, major depression and bipolar affective disorder. Schizophrenia, considered to have an incidence of 1 % in the general population is a disorder of thought characterised by hallucinations and delusions. Other symptoms that may occur are inappropriate affect, ambivalence, poor job performance, autistic symptoms, poor association, strained social relations and impairment of a person's ability to care for themselves (Inaba & Cohen 2000; Kaplan & Sadock 1991; World Health Organisation (WHO), 1997).

Major depression is described as one or more feelings of depressed mood lasting for two weeks or more, accompanied by a minimum of four additional depressive symptoms (Kaplan & Sadock 1991; Stuart & Laraia, 2000; WHO, 1997; Wilson & Kneisl, 1996). Other symptoms that may occur are weight loss, psychomotor retardation or aggravation, insomnia, recurrent death wishes, feelings of worthlessness, fatigue and a loss of concentration and cognition. A person who has a history of experiencing mania or hypomania may not be classified as having a major depressive disorder but a bipolar disorder. Bipolar disorder is a disorder of mood,

which includes both episodes of mania, and depression (Kaplan & Sadock 1991; WHO, 1997; Wilson & Kneisl, 1996).

2.3.3 Summary

The researcher believes that it is important to include the previous two sections to draw attention to the variation of problematic behaviours, which contribute to the complexity of providing appropriate care. If these mental health disorders are combined with drug misuse, there is an additional layer of complexity in caring for these clients. It is this that causes additional problems for the health professional. The next section will combine and discuss both disorders known as dual diagnosis.

2.4 Dual Diagnosis

Osher and Kofoed in the United States of America (USA) first utilized the expression dual diagnosis during the 1980s. Comorbid drug and alcohol misuse and mental illness has been a major subject of study particularly during the 1990s and onward (Department of Human Services, 2002). Forster (2001) emphasised that the treatment of the dually diagnosed client is an ever-increasing problem in psychiatric units. A portion of this problem is a result of the confusion over whether the symptoms and abnormal behaviours are attributed to a mental disorder or the misuse of drugs. The client may also be attempting to conceal the symptoms of their illness. Berglund and Ojehagen (1998) state how recent studies have confirmed that individuals who are prone to psychosis have a higher rate of substance misuse, whereas substance misuse on initial assessment did not lead to an onset of psychosis or similar experiences.

Asaad (1995) believes that environmental factors, inheritance, and the misuse of psychoactive drugs have an effect on mental health in a similar way that drug use affects the brain. Psychoactive substances have a profound effect on the central nervous system where they produce a variety of emotional, behavioural and cognitive changes in some individuals. Many psychiatric disorders have been mimicked with the use of these substances; for example, mood disorders, paranoid states, anxieties, panic attacks and hallucinations are included in this group of disorders. Reactions to intoxication and withdrawal may precipitate certain physical and psychological signs and symptoms. The exact way drugs produce psychiatric symptoms is not known. Present thinking about the link between drug use and psychiatric symptoms involves possible alterations to and an imbalance among several neurotransmitters. These include serotonin, dopamine, norepinephrine, acetylcholine and endorphins to name just a few.

2.4.1 Theories of dual diagnosis etiology

A variety of hypotheses have been proposed to explain the high rates of coexisting substance use and psychiatric disorders. For example, Hall (1996) suggests that coexisting disorders are a result of common causes such as genetic and environmental factors, whereas Dixon, Haas, Weiden, Sweeny and Frances (1991) describe two models that explain episodes of dual diagnosis. The first, known as the vulnerability model suggests that drug misuse may cause schizophrenia or increase the likelihood of symptoms in vulnerable individuals. The second model suggests that people with schizophrenia misuse drugs to self-medicate to alleviate their symptoms. Dixon et al. (1995) also found that family history of drug misuse was more common in using clients.

Mueser, Bennett and Kushner (1995) suggest that there may be four possible models that explain the increase in individuals with a dual diagnosis. These are described as the secondary substance abuse model, the secondary psychiatric disorder model, the common factor model and the bi-directional model. The secondary substance abuse model suggests that mental illness increases the client's susceptibility to substance misuse. This notion is popular with clinicians, as clients are able to provide reasons for their misuse of substances. People with a serious mental illness may experience extreme levels of depression, apathy, anxiety and negative feelings, explaining their tendency to use alcohol and other drugs to avoid or decrease these feelings. Clinicians believe that people with a serious mental illness have fewer social contacts than those unimpaired. Drugs used in social settings may be a convenient way of encountering social acquaintances; by belonging to such a group, psychiatric patients can or may gain identity and acceptance independent of their illness.

The secondary psychiatric disorder model suggests that psychiatric illnesses occur as a result of substance misuse in individuals who have an existing vulnerability to a mental illness. According to the common factor model, the increased rate of co-morbidity can be credited to a third variable. This variable involves genetic factors.

> It appears that familial factors may contribute independently to a risk for psychiatric or substance abuse disorders, but such factors do not account for etiologic substrate for both conditions, and therefore cannot explain the increased rate of comorbidity. It is possible that other, non-genetic common factors exist which increased vulnerability to both mental illness and substance abuse. Socioenvironmental stress (e.g., poverty, unemployment), poor social competence, and neurological "soft signs" are examples of such common factors, which may increase the risk of either type of disorder. The role of such common factors in accounting that the high rate of comorbidity between substance abuse and mental illness remains to be examined. (Mueser et al., 1995 p. 20-21)

The bi-directional model asserts that mental disorders and substance misuse interrelate so either disorder may have an influence on the other.

2.4.2 Neurotransmitters – Psychiatry versus drug misuse

Inaba and Cohen (2000:424) describe chemicals that transmit messages or impulses between nerve cells, the central nervous system and the body organ receptors, as neurotransmitters. Psychotropic drugs work by acting on specific neurotransmitters. The receptor sites and other mechanisms of the brain which are involved in emotional and mental problems are the same sites affected by the misuse of psychoactive drugs. Psychoactive drugs disrupt the process of transmitting messages, producing desired or undesired reactions. Drugs that produce signals are called agonists and those that block the signals are known as antagonists. Drugs are capable of imitating a neurotransmitter either by creating a false message or the blocking of another. They can prevent transmitters from being absorbed, causing an increase in their effect. They may set off the release of transmitters in excess, producing an exaggerated effect or they can initiate a slowing down of the release of neurotransmitters.

Extein and Gold (1993) believe that the study of neurochemistry in psychiatry and individual substance misuse of dual diagnosis clients may lead to advances in treatment. The neurochemistry theory involving explanation of disorders of mood has been studied extensively since the 1950s. This theory in regard to depression and manic depression have focused on the brain monoamine neurotransmitters, serotonin, dopamine and norephedrine. These transmitters are thought to be involved with the regulation of pleasure and the reward mechanism in the brain.

Stuart and Laraia (2000) explain how many research articles lend positive support to the dopamine hypothesis in schizophrenia. Drugs that have proven to increase levels of dopamine are capable of producing a psychosis. Amphetamines increase dopamine levels by blocking their reuptake while the use of cocaine causes the release of dopamine at the presynaptic membrane.

> Although the dopamine hypothesis explains the reinforcing properties of cocaine and amphetamine it has also been suggested that other drugs of dependence may have similar neural substrates. For example, alcohol, nicotine, caffeine and cannabis all increase dopamine levels in the limbic regions of the brain … although experimental evidence to the situation in humans is difficult, the dopamine hypothesis provides a useful basis on which to develop ideas and treatments for drug dependency (White 1992:371).

2.4.3 Drug-Induced Mental Disorders

Literature suggests that individuals use psychoactive drugs for the emotional, mental and physical effects they produce. In some cases they are precise about the desired effect, while in others they are more abstract. Some of the reasons for drug misuse by the general population are curiosity, self-medication, pain relief, increase in confidence, increase in energy, control of anxiety, social confidence, peer pressure, relief of boredom, altered consciousness, isolation and as a way of dealing with life's pressures and problems (Inaba & Cohen, 2000). Mueser (1998) observed that similar reasons were given for substance misuse in the psychiatric population. These include euphoria and craving, socialisation, peer pressure, lifestyle, habit, side-effects of medication, self-medication, poor social skills and as a method of coping with stress and tension. An awareness of the increased risk or susceptibility in people with a mental illness of developing a substance use disorders has been identified. This susceptibility to alcohol and other drug misuse among people with a psychiatric disability presents numerous problems for health professionals in the treatment and

care of such clients. Substance misuse often affects the function of psychiatric medication, which leads to frequent relapses and subsequent admissions, causing frustration to health professionals (Mueser, Bennett and Kushner, in Lehman & Dixon, 1995).

Khantzian (1985) believes that the self-medication model is one of the most compelling reasons why clients use drugs. Brady, Anton, Ballenger, Lydiard, Ardinoff and Selander (1990) found that individuals with schizophrenia who were also depressed used cocaine to treat the underlying depression. Dixon et al. (1991) identified that people with a diagnosis of schizophrenia used drugs to alleviate certain symptoms, for relief from depression and negative symptoms, and to increase energy. Mueser Yarnold, and Bellack (1992), on the other hand, argue that there is little evidence to support the self-medication model as a reason for those with schizophrenia to misuse drugs.

McDermott and Pyett (1993) suggested that service providers believe clients use drugs to decrease anxiety, as an agent to induce sleep, to reduce pain, for excitement, to change a person's mood, and to increase confidence. Socialisation, peer group pressure, achieving feelings of belonging, avoidance or escape, increasing motivation, helping with creativity, meeting recreational and spiritual needs, experimentation, reducing self-consciousness, rebellion or attracting attention are other reasons for use. Drug misuse may also be used to treat the client's disorder and to assume a different identity. McDermott and Pyett (1993) stated that it was seen to be more acceptable to be identified as a drug and alcohol client rather than a psychiatric client. Drugs were also used to reduce side effects of psychotropic medication.

As mentioned previously, individuals with a severe mental illness who were dependent on alcohol and other drugs had an increase in psychotic symptoms, hospitalisation, poor treatment compliance, medical and psychosocial problems and increased suicide risk compared to other psychiatric clients (Barry et al., 1996; Berglund & Ojehagen 1998. Poole and Brabbins (1996) mention how the use of drugs, in particular cannabis and stimulants, precipitates a relapse of an existing psychosis. They feel that there are three possible causes:

1. Psychiatric clients attempt to treat themselves with illicit drugs during the early part of psychiatric relapse. The drug misuse is therefore a symptom rather than a cause of the psychotic illness;
2. Clients are more likely to misuse drugs when they are unwell due to impaired judgment; and
3. Intoxication may directly provoke a psychotic relapse.

The misuse of sympathomimetic drugs such as cocaine, amphetamines, cannabis, LSD or phencyclidine may cause acute psychotic symptoms. These symptoms may also be caused by drug withdrawal states from opiates, sedatives, depressants, or alcohol (Bordwine-Breeder & Millman, 1991). Poole and Brabbins (1996) stated that the literature suggests that there is no doubt that cannabis and stimulant use can mimic a psychosis. They further suggest that this probably also occurs with the use of solvents, ecstasy and LSD. Ziedonis and Trudeau (1997) state that previous research in the USA has shown that the five main drugs used by individuals with schizophrenia are caffeine, tobacco, alcohol, cannabis and cocaine.

2.4.4 Depressant drugs

Mueser, Bellack and Blanchard (1992) believe that the choice of drug is often made according to availability rather than the effect the drug has on the central nervous system. They also state that literature suggests that alcohol is consistently the most misused drug in both the general and dual diagnosis population. Inaba and Cohen (2000) affirm that individuals who use alcohol face a 21 times greater risk of contracting an antisocial personality disorder, are six times more likely to have a bipolar condition, and four times more likely to have schizophrenia. Berglund and Ojehagen (1998) concluded that studies over the past 10 years support earlier findings that clients with a psychiatric illness who misuse alcohol are more inclined to have a worse course with their psychiatric illness. Several psychiatric syndromes result from prolonged consumption of alcohol (Brands et al., 1998; Inaba & Cohen, 2000). Alcohol withdrawal may lead to delirium tremens, seizures and hallucinations. The mechanism that causes delirium tremens and other hallucinatory disorders associated with alcohol is unknown but heavy and prolonged alcohol use has a deteriorating effect on the brain structure, leading to long-term cranial changes, which produce the symptoms of delirium tremens. The blood flow to the cerebellum is increased which appears to have a relationship with the onset of hallucinations and agitation in clients during alcohol withdrawal. An individual who has been consuming alcohol for a protracted period of time and who suddenly ceases or decreases the amount they normally consume may develop delirium tremens, which usually occurs on the second or third day following a cessation or reduction in alcohol. In some cases though, the symptoms commence during the first day and in others up to one week later. Symptoms of delirium tremens include disorientation, clouding of consciousness, hallucinations, tremors, agitation and an increase in blood pressure. The

commencement of the condition is generally abrupt and often occurs at night. Perceptual disturbances are early signs; these include nightmares, startled responses, increased excitability, hallucinations and illusions associated with severe anxiety with these illusions becoming more explicit. Ceiling cracks and spots on the wall are mistaken for snakes and spiders. Tactile and visual hallucinations are also common. A significant mortality rate occurs with delirium tremens if not treated promptly (Asaad, 1995; Bochner, 2000; Priest & Woolfson, 1986; Stuart & Laria, 1998). Dual diagnosis clients who use alcohol have more severe symptoms than clients who do not misuse alcohol (Berglund & Ojehagen 1998). Serious brain abnormalities such as Korsakoff's psychosis, dementia and Wernicke's encephalopathy occur as a result of nutritional deficiencies (Asaad, 1995; Bochner, 2000; Priest & Woolfson, 1986; Stuart & Laria, 1998).

A person using cannabis can experience a feeling of euphoria, a sensation that time is slowing down, paranoia, anxiety, social withdrawal and impaired judgment. The user occasionally experiences panic attacks, dysphoria and inappropriate laughter. Some individuals experience feelings of dying or a feeling that they are losing their mind. With severe intoxication, derealization or depersonalisation, hallucinations and an increased sensitivity to sound can occur (Asaad, 1995). Linszen et al. (1996) found that the heavy use of cannabis may be considered a stressor causing a relapse in clients with schizophrenia. Similar findings were expressed by Martinez-Arevalo, Calcedo-Ordonez and Varo-Prieto (1994) who found that a combination of stress, non-compliance with treatment and a history of cannabis use constitute a higher probability of relapse. Grenyer, Solowij and Barlow (1999) found that the use of cannabis was associated with elevated levels of psychotic symptoms in both

psychiatric and non-psychiatric community samples of cannabis users. Manic symptoms may also occur with cannabis psychosis; however, cannabis use by manic clients tends to modify the symptoms pointing toward a schizophreniaform illness (Banks & Waller, 1988). Capolov et al. (1999:26) state that there is now evidence that suggests cannabis, acting via its receptors, may moderate the action of the dopamine system:

> Because disturbances of dopaminergic transmission in critical regions of the brain have been implicated in the pathogenesis of schizophrenia, the possibility that cannabis use might result in the precipitation or exacerbation of schizophrenia needs to be considered.

Warburton (1990) found that opiates did not appear to affect dopaminergic synaptic action directly but did activate dopamine neurons by an activity at the cell body area. Individuals intoxicated with opioids generally have an initial feeling of euphoria that is followed by apathy and dysphoria. Opioid intoxication has also been reported as a cause of some hallucinations (Asaad, 1995). Benzodiazepines and barbiturates have a similar depressant effect on the central nervous system to that of alcohol. Hallucinations and delusions have been reported in association with these drugs (Asaad, 1995).

2.4.5 Hallucinogen drugs

Hallucinogens are drugs that make an individual hear, see and feel experiences that have no external basis. Symptoms of this drug group were once considered to resemble those of mental illness. These substances were used as a treatment and a method to study mental illnesses until it was discovered that they caused completely different brain changes. They temporarily change the brain chemistry and the perceptual process, changing the way a person sees, understands and feels. They cause no memory loss, confusion or loss of understanding (Brands et al., 1998;

Yoslow, 1992). Distortion of reality as a result of LSD use may cause affective disturbances in vulnerable people. Depressive symptoms associated with LSD are noted for their severity. Other forms of extreme anxiety and panic are associated with the use of various hallucinogens (Banks & Waller 1988). Inaba and Cohen (2000:31) claim that "Most often, psychedelics overload or distort messages to and from the brain stem, the sensory switchboard for the mind, so that many physical stimuli, particularly visual ones, are intensified or distorted. Imaginary messages (hallucinations) can also be created by the brain".

Severe intoxication of various hallucinogens can lead to delirious states in some users. These states can be induced by the use of hallucinogens often accompanying or following the hallucinosis syndrome. This is usually brief, but longer episodes of these delusional states mimic schizophrenia. Depression may occur shortly after the use of hallucinogens. This depression usually commences within one to two weeks lasting for more than 24 hours. The symptoms of this drug related depression may resemble a primary depression and can be difficult to distinguish from a pre-existing depressive illness (Asaad, 1995). Flashbacks often occur with the use of hallucinogens (Banks & Waller, 1988). Flashbacks are also known as hallucinogen persisting perceptual disorder, which occur during a drug-free period and mimic the hallucinations the user experienced during intoxication with the drug. These flashbacks occur in 25% of hallucinogen users, commencing months after the last use of the drug. These are more likely to occur under stress, alcohol intoxication, fatigue or a severe physical illness. With time, the intensity and frequency of flashbacks diminish (Asaad, 1995), however, on occasions they have been known to occur years later (Banks & Waller, 1988).

2.4.6 Stimulant drugs

The use of stimulants causes some users to experience hallucinations whether tactile, visual or auditory. Paranoid delusions are also experienced (Asaad, 1995). The longer the length of amphetamine binges, the greater the increased hyperactivity, anxious feelings and irritability merged with euphoria. Paranoid psychosis and a feeling of panic may also occur (Brands et al. 1998).

Withdrawal from amphetamines may cause severe depression, fatigue, anxiety and insomnia or hypersomnia (Asaad, 1995). Banks and Waller (1988) state that in situations where the drug has been used for years the depression is often problematic In 1976 an abstinence theory for cocaine was recognised with a feature of this syndrome being the individual's description of depression which results from the regular use of cocaine. Research identified that crack smokers and freebasers experienced anhedonia (inability to enjoy any pleasure). High doses of these drugs may also result in panic attacks, anxiety and restless agitation.

Brands et al. (1998) found that psychologically normal individuals who use amphetamines may have a psychotic reaction. This reaction is named amphetamine psychosis. Initially the person experiences a feeling of euphoria and a sense of well-being. This state later changes to grandiosity, agitation, impaired judgment and hyper-vigilance. A state of delirium may result from severe intoxication. High doses of central nervous system stimulants may produce hypomanic symptoms (Asaad, 1995).

An individual suffering with a psychotic illness is often more susceptible to stimulant toxicity and misuse. Clients suffering with depression often experiment with

amphetamines and cocaine to treat their fatigue. Twenty percent of cocaine misusers experience mood disturbances such as bipolar and cyclothymic disorders, whereas with opiate misusers it falls to one percent. These findings suggest that individuals with mood swings prefer stimulants over opiates (Gold, 1997).

2.5 Professional training – Preparation

The following section will provide research literature that examines health professionals' preparation and dual diagnosis treatment strategies. The researcher believes this is important to help improve frustration levels of health professionals as mentioned previously.

Rasool (1998) states that health professionals are generally the initial contact for many substance misusers. Negative attitudes and social prejudice toward substance misusers are evident amongst health professionals. This may lead to limited care of health-related problems resulting in the continuation of these untreated physical and mental complaints, which in turn may result in exacerbation. Rasool (1998) argues that "These negative and ill informed beliefs about drugs can be expected to translate themselves into negative and ill judged reactions to users" (pp. 69-70). Substance misusers have extensive contact with health-care professionals as risk factors associated with health problems are high. Nurses, whether specialist or not, must assume many roles focusing on the provision of care, prevention and education. The World Health Organisation and International Council of Nurses highlighted the roles of a nurse in relation to substance misuse in 1991. These are to be a provider of care, education, counselling and advocacy. Nurses also must promote health, be involved in research, consult with others and provide supervision and leadership (World Health

Organisation, 1997). Attia (1988) stated that if a person who is delusional and hallucinating is seen in an emergency department they must be assessed for cocaine, alcohol, PCP or LSD use, as the use of these drugs may result in the same symptoms. Lehman and Dixon (1995) believe that the successful treatment of patients with a dual diagnosis requires the clinician to have a large reservoir of knowledge and wide-ranging clinical skills. Chappel (1995) believes that clinicians require training in order for appropriate integrated treatment of dual diagnosis disorders to occur.

A major goal in the training of health professionals employed by the drug and alcohol and psychiatric services is co-operation and respect for each service and clinician. For the training to be effective, preconceived and negative attitudes of both services need to be addressed. Rassool (1998) states that the role of health professionals is to make available education support available and to provide care for those with a substance use disorder. Health education, promotion and the prevention of psychoactive drug misuse should be included in the development of education and health policies.

2.5.1 Relevant research

A series of surveys were completed at an Australian medical school to determine drug and alcohol knowledge following educational initiatives. These surveys were conducted using 5th - year medical students at the University of Sydney in 1986, 1990 and 1993, prior to the introduction of the national campaign against drug abuse and following drug and alcohol education initiatives. Results reveal that there was a major increase in medical students' knowledge. The study also found that in recent times students were more accepting, tolerant and confident interacting with clients with Benzodiazepines and alcohol dependence (Roache, 1997).

Questionnaires were sent to training psychiatrists enrolled in the Royal Australian and New Zealand College of Psychiatrists with the respondents located in Victoria, NSW, South Australia and Queensland. These questionnaires focused on drug and alcohol knowledge and attitudes. Knowledge about opiates, barbiturates and stimulants were found to be poor. Psychiatrists' views and treatment options varied; however, overall they found that psychiatric trainees had adequate levels of drug and alcohol knowledge (Roche, Parle, Campbell, & Saunders, 1995). Roche et al. (1995) suggest that if sufficient education is not provided the effectiveness of treatment and therapeutic approaches will decline.

Aalto, Pekuri, and Seppa (2001) explained how the researchers mailed a questionnaire on skills, attitudes, knowledge and training needs to nurses and physicians employed at primary health care settings in two separate cities of Finland. Results showed that only 18% of those surveyed felt that they had enough knowledge of brief interventions for heavy drinkers, with over half believing that they required more training. Of the professionals who participated in the study, 76% had a positive attitude toward talking about a person's alcohol intake. The researchers also found that physicians more readily discussed alcohol issues with their clients than nurses.

> The main result in the present study is that the subjects' attitudes and trust in their own skills were good. That most of the respondents should express positive attitudes is no surprise, because it has been assessed that about 90% of general practitioners felt that they have a legitimate role to work with patients with drinking problems (p.309).

A study to determine mental health staffs' knowledge, experience and attitudes to clients with a problematic drug use was undertaken in Australia (Seigfried, Ferguson, Cleary, Walter & Rey, 1999). They found that staff believed working with clients who

had a dual diagnosis was more difficult than working with other clients. Eighty percent of 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 and McGowan (1998) conducted a small study among staff rostered on two psychiatric wards in England. The results of the questionnaires showed that staff welcomed opportunities to increase their knowledge and skills of 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, 1998:141).

2.6 Treatment

According to Bordwine-Breeder and Millman (1997) the treatment of clients with co-existing substance misuse and mental illness requires a careful integration of psychiatric and chemical dependency models. In the past, both psychiatric and drug and alcohol services functioned separately but at present the direction in treatment is towards the integration of services. A review of the literature suggests the importance of integrated treatment approaches (Fischer et al., 1996; Rosenthal, Hellerstein & Miner, 1992; Lanning-Smith, 2001; Loneck & Way, 1997; Minkoff, 1989; Mowbray et al. 1995; Rosenthal et al., 1992; Ridgley, 1991). Ridgely (1991:30) recommends enabling a coordinated approach of mental health and drug and alcohol services by

> breaking out of the conventional categorical boundaries now separating the two service systems … individuals with dual diagnosis suffer from the excess burden of service systems designed for single disabilities that are as yet unable to accommodate their particular needs.

Several authors speak about a theoretical model for administering treatment to the dually diagnosed (Drake, Antosca, Noorsdsy, Bartels & Osher, 1991; Rassool, 2002; Osher & Kofoed, 1989). This model proposes that clients enter and pass through four different stages of recovery, namely engagement, persuasion, active treatment and relapse prevention. The fundamentals of this model include group therapy, case management, detoxification, pharmacology, family involvement and participation of clients in self help groups. Engagement signifies the procedure of convincing clients that the mental health service has something beneficial to offer. These benefits may include help with obtaining food, housing, clothing, avoiding legal penalties, relief from psychiatric symptoms or as an access to entitlements. During the first stage the person becomes engaged in a relationship or treatment procedure. Once engaged the person is then persuaded that substance misuse is an obstacle to life and they have the capacity to accomplish greater life gratification by reducing their use of illicit/non-illicit drugs. When motivated to achieve sobriety or abstinence, active treatment techniques will help the person to acquire skills and supports required to achieve this goal of abstinence. Following the establishment of abstinence, the person can be helped to abstain from drug use by using whatever resources and changes of behaviour are needed to prevent a relapse.

The most popular explanation of motivation within the alcohol field is that it is an idiosyncrasy of the individual, a personal quality or state. In an attempt to design a pragmatic therapeutic approach, a system called motivational interviewing was developed. The purpose of motivational interviewing is to motivate the client to change (Miller & Hester, 1989). Miller and Rollnick (1991) describe the key concepts

of motivational interviewing, namely express empathy, deploy discrepancy, avoid argument, roll with resistance and support self efficacy:

- Express empathy – the crucial attitude is one of acceptance, skilful reflective listening is essential, ambivalence is seen as normal and the therapist seeks to respond to the clients perspectives as understandable and labelling is seen as unnecessary.

- Deploy discrepancy – the aim is to create and amplify a discrepancy in the client's mind between current behaviours and goals. It involves the clarification of important goals for the client and exploring the consequences of present behaviour that conflict with these goals. The approach is one that results in the client giving reasons to change.

- Avoid argument – arguments are counter-productive and defending only leads to defensiveness. Client resistance is a signal to change strategies.

- Roll with resistance – the key idea is to avoid resistance but if it surfaces, statements that a client makes can be reframed slightly to create a new momentum toward change.

- Support self-efficacy – a person's belief in the possibility of change is an important motivator. The client is responsible for choosing and performing personal change. There is hope in the range of alternative approaches available.

2.6.1 Community

A study by Moos et al. (1996) identified that clients in a community-based program were less likely to relapse than those in a hospital-based program. Crawford (1996) indicates that with the use of multidisciplinary teams experienced in both drug and alcohol therapy and psychiatry, treatment may be tailored to the clients' needs. The process of engagement, persuasion, active treatment and relapse prevention may be used.

Australia has had limited attempts at developing an integrated treatment program for clients with a dual diagnosis. A practice was established in Coffs Harbour (New South Wales) commencing as a collaborative approach by a worker from the drug and alcohol service and another from the psychiatric services for the treatment of a single client. This program has developed into a group approach combining both treatment strategies (Wood, 1995). Another was the SUMITT program established in Victoria in 1998 and evaluated positively in 2000 (Fox, 2000).

2.6.2 Inpatient

Mowbray et al. (1995) stated that the initial entry points for care of individuals with a dual diagnosis are inpatient services. They established a program in a public psychiatric hospital near Detroit, Michigan, USA for clients with a dual diagnosis. Mowbray et al. (1995) considered their approach to dual diagnosis as an innovative and integrated program. If mental health services are to progress in the treatment of individuals with a dual diagnosis, providers must attend to the gaps in care within psychiatric and drug and alcohol services with as much enthusiasm as shown when criticising drug and alcohol services.

Conner, et al. (1995) spoke of a partial hospitalisation program at Strong Memorial Hospital in USA. Clients attended a program for four and a half hours per day (five days per week). The majority of treatment was delivered in a group format with the individual treatment provided through weekly meetings and regular psychotherapy sessions. The treatment/program is built around 10 areas: abstinence, stabilization/reduction in symptoms, skill attainment, goal setting, problem solving, emotional release and working through, family support, social support and discharge planning. The number of participants is a maximum of 20 with a therapist – patient/staff ratio of one employee to four patients. Staff in the program are multidisciplinary representing nursing, psychiatry, psychology, social work as well as an activities and arts therapist. The hospital's on-call administrator and the psychiatric emergency department provide after hours and weekend support. Conner et al. (1995) believed that this program provided a comprehensive and intensive mental health service to clients with a dual disability.

Saxon and Calsyn (1995) described research undertaken in a drug dependency clinic in the USA, which also provided psychiatric care. The outcomes produced showed that in the first six months dual diagnosis clients gave a significantly higher percentage of positive drug urine screens than those with a substance use only diagnosis. In the second six months the dual diagnosis subjects showed a reduction in their substance use to levels comparable with the substance use only group. The study also found that dual diagnosis clients had a better treatment retention rate.

2.6.3 Residential

People with dual diagnosis often cannot engage in treatment because they lack suitable housing. Their substance misuse and erratic behaviour often leads to instability and homelessness making stable housing a critical problem. Housing programs for clients with a psychiatric disorder often exclude substance misuse, while the reverse happens in drug and alcohol services. As a result clients with a dual disorder tend to migrate to homeless shelters or undesirable living situations such as jails, hospitals or substandard housing. This lack of suitable living situations is a major problem for these individuals (Drake, Teague & Reid Warren 111, 1990; Fox, Fox & Drake, 1992). Clenaughan, Rosen, Van Bysterveld, Friel and Spilsbury (1996) described a residence that was opened in 1995 for people with a dual diagnosis in the lower North Shore area of Sydney, Australia. The principal aim of this home was to provide rehabilitation and to minimise substance misuse, which can only be achieved when a person's basic needs are met. The house is referred to as a damp house where drugs and alcohol are excluded but the person is not evicted if they use or misuse substances. The house offers a safe, therapeutic and supportive living environment. This house was modeled on damp houses in the New Hampshire program (Fox et al., 1992).

Another residential option for the treatment of drug misuse disorders is the therapeutic community for clients with a dual diagnosis. Zavrou and Blyth (1998) discussed modifications they feel needed to be made to a therapeutic community. Staff ratios must be adequate so all requirements whether unusual or appropriate may be responded to. They found that dual diagnosis clients attending Odyssey House, Melbourne, Australia, are sensitive to staff availability both physically and

emotionally. They also have high needs, therefore a program must be structured and low-key.

Shilony, Lacey, O'Hagen and Curto (1992) described a community treatment program specifically designed to meet the needs of the dual diagnosis clientele. This program has been based on an integrated model, which allows the team to create a specific plan for each client. It provides a rehabilitation service where a person can live and receive treatment for their dual diagnosis. It has been stated in various literature that the lack of appropriate housing and aftercare creates a major block in successful rehabilitation. Shilony et al. (1992) believed this community treatment program addresses the problem of housing and suitable treatment for dual diagnosis clients.

2.6.4 Other services

Bergmann Carey (1989) discussed a program established to treat individuals with a dual diagnosis and who have displayed an inability to benefit from or participate in other community-based programs. The major goals of the program are:

- Abstinence,
- Stabilisation/remission of psychiatric symptoms; and
- To be involved with a drug free social network.

Findings show that clients can be engaged in treatment and can benefit from therapy that is tailored to their lifestyle, needs and limitations. It was also important for the clients to feel supported and to feel they will not be punished for what they are unable to do. Treatment of these clients requires flexibility, creativity and a non-judgmental attitude.

Alfs and McClellan (1992) described a day hospital program in Minnesota which uses non-confrontational group therapy as its treatment. This program runs for six to eight weeks with the goal being to reduce substance misuse, improve medication compliance and to reduce the number of hospital readmissions. After care facilities are provided to clients following completion. Alfs and McClellan (1992) found that the ability of the clients to relate to each other during group therapy influenced the success of the program.

A review of the literature shows that, as well as the treatment programs mentioned, other services exist. Some of these are the Beth Israel Centre, USA (Rosenthal, Hellerstein, & Miner, 1992), California Centre, USA (Minkoff, 1989), Bond Place, USA (Bartell & Thomas, 1991), St Anthony's medical centre, USA (Wich, 1994) and the Gladstone treatment program, USA (Ridgley, Golman & Talbott, 1986). The review of the literature unearthed treatment options for clients with a dual diagnosis which shows the importance of integrated services, low staff – patient ratios, increased funding and the importance of residential options. Also, the literature emphasised the importance of drug education for health professionals in dealing with these difficult clients. This education would assist in the reduction of any frustrations and negative attitudes the health professional may have.

2.7 Summary

This section described the complexity and the effects drug misuse have on mental illness. Drug misuse worsens the already unpredictable behaviour of a psychiatric client. An integrated service is necessary to relieve the frustration and pressure of health professionals caring for these complex clients. Chapter 3 explains the methodology used, description of the respondents, the setting and ethical considerations within this thesis.

CHAPTER THREE - RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

As previously discussed, the aim of this study is to explore and describe the perceptions of mental health professionals caring for clients with a dual diagnosis. Critiques of both quantitative and qualitative styles of research were studied, allowing the researcher to select the most appropriate research method to ensure an accurate answer to the research question. Beanland, Schneider, LoBiondo-Wood and Haber (1999) state that the choice of research method is guided by the research question. The explorations of human experiences are best addressed using a qualitative approach (Beanland et al., 1999). This research explored and described the world of mental health professionals caring for dual diagnosis clients in rural/regional areas. The researcher was seeking personal views establishing what it was like to care for dual diagnosis clients. Statistical research defining the number of dual diagnosis clients and other information is available but little literature on rural/regional dual diagnosis services exists (Barry et al., 1996; Fischer et al., 1996). The researcher has been unable to discover any research that explores the perceptions of mental health professionals who care for these clients whether in rural/regional or urban services. Drug policies and program developments are based on statistical data with the majority of these services in metropolitan areas and services in rural/regional areas limited (Australian National Council on Drugs, 2002). This may suggest that the training regimen of clinicians in the treatment of dual diagnosis clients requires an investigation of their perceptions of managing and caring for clients with a dual diagnosis.

This chapter will describe the selection of the methodology, ethical considerations and data collection and analysis using the chosen methodology.

3.2 Qualitative Research - Phenomenology

Qualitative researchers endeavour to unearth a person's thoughts, feelings and perceptions of their experience (Minichiello, V., Aroni, R., Timewell, E., & Alexander, L. 1995). Denzin and Lincoln (1998) describe qualitative research as an area of inquiry that cuts across different disciplines, topics and themes. Burns and Groves (1999) state that data retrieved using a qualitative approach leads to a greater understanding of the phenomenona under investigation, giving insights which can be used more broadly. These insights can guide nurses and nursing practice aiding in the important development of a theory, which expands nursing knowledge.

The phenomenological movement commenced in Germany in the early part of the twentieth century with Husserl, Heidegger and Schultz being credited as leaders of the movement (Streubert & Carpenter, 1995). The method was further developed by Mariel, Satre and Merlau-Ponty in France during the last century (Rice & Ezzy, 1999). Both Merlau-Ponty (1962) and Spielberg (1975) describe phenomenology as a philosophy and also a method. Phenomenology has been extensively used in nursing literature where it is described "as a philosophy, a perspective, and an approach to practice and research" (Munhall, 1994:14). 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 and Carpenter (1995) also acknowledge the importance of

phenomenology to nursing as the practice of professional nursing is interlocked in the life experiences of people.

The focus of a phenomenological inquiry is how people interpret experiences regarding certain phenomena:

> The phenomenologist believes that lived experience gives meaning to each person's perception of particular phenomena. The goal of phenomenological inquiry is to describe fully the lived experience and the perceptions to which it gives rise (Polit & Hungler, 1999: 246).

Burns and Groves (1999) describe phenomenological research approaches as inductive and descriptive. The focus is to understand the response of the entire human being, not just distinct parts or behaviours. Steubert and Carpenter (1999) believe phenomenology is a science with the purpose of describing certain phenomena, lived experiences or their appearance. They state that the goal of phenomenology is to describe events as they happen. Burns and Grove (1999: 340) believe the aim of phenomenological research "is to describe experiences as they are lived - in phenomenological terms the lived experience".

LoBiondo-Wood and Haber (1998) state that phenomenology is the study of the lived experience; the researcher is likely to choose this type of research method if studying a day-to-day dimension of a particular group. Within the current study the researcher is endeavouring to uncover thoughts and feelings of mental health professionals caring for clients with a dual diagnosis. The study seeks to uncover feelings and thoughts, therefore the use of the process of phenomenology is appropriate. The justification of this method's appropriateness will be discussed further in the following section.

3.3 Justification of research selection

A qualitative approach is suggested to be appropriate if little is known about the subject as was the case in the current study. As previously mentioned, much research has been conducted using dual diagnosis as the subject, the majority of which have used a quantitative approach and data collected obtained from metropolitan services as the setting. The quantitative method used in the majority of research articles utilised surveys and standardised 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 mental 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 caring for these complex individuals. The aim of this study was not to generate any form of theory but to provide a rich supply of information and data, which can be utilised by other health professionals, and to generate future research questions in this area.

3.4 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 does not rely on predetermined or rigid application of predictive and prescriptive requirements of the quantitative methodologies, but facilitates an understanding of the informants' perceptions. The aim of qualitative research is to

ascertain the description of the phenomena as experienced by people (Minichiello et al. 1995).

Kahn and Connell (1957) believe that, as well as understanding the mechanics of an interview, the researcher must understand the world of the participants which may retard or stimulate their responses. This was important in the current study, as influences in different health professions are unique with participants in this study engaged in different training methods, curricula, models and processes for registration. These differences have an effect on a professional's response to a given situation. For various reasons the researcher was ideally positioned to conduct in-depth interviews with other health professionals as the researcher has twenty-five years experience in the health field and is aware of the cultural and organisational structure of the service. Being the dual diagnosis clinician for the region, the researcher has knowledge and understanding of caring for this client group. As the participants had knowledge of the researcher it aided to ensure the interviews were relaxed and un-pressured, which enabled participants to provide accurate information. Finally, the researcher's experience of interviewing clients and fellow professionals over his career was an advantage as the researcher's knowledge and unthreatening interview skills lead to appropriate and honest responses, which ensured accurate research.

The purpose of conducting unstructured interviews was to establish a rich supply of information regarding health professionals' perceptions in treating clients with a dual diagnosis. Denzin and Lincoln (2000) describe how we live in a society where individuals believe that interviews are useful in generating information about the lived

experience. However, the process of asking specific questions and being provided with answers is more difficult than it initially seems. This style always contains a degree of ambiguity both at the interview and coding stage, no matter how well the researcher codes and reports the answers as it is a subjective procedure. In-depth interviews were used to gain relevant information for use in this study. Minichiello et al. (1995) define interviews as a face-to-face verbal exchange where the interviewer will attempt to obtain information or opinions from another individual. Structured, semi-structured or unstructured interviews are types of in-depth interviewing. The interview style used in this research was semi-structured as the researcher maintains a small control over the questions asked and the direction of the interviews.

3.5 Funnelling

A technique described as funnelling was used during the interviews. Funnelling is a type of questioning where the interviewer directs the type and flow of information participants reveal. This is done by commencing interviews with general questions designed to start the participant thinking about the issues the researcher will explore. As the participant engages in conversation, the researcher guides the participant toward a more precise subject. The benefit of this process is that it enables the participant to be more relaxed and feel that they are involved in a non-threatening conversation. Later in the conversation they are asked to give a more specific response (Minichiello et al., 1995).

All interviews were conducted face-to-face using a semi-structured interview technique over a three-month period during December 2001, January and February 2002. Interviews commenced with a description of the research and any questions by

participants were answered. A brief overview of the areas the interview would explore was given, allowing all participants a chance to lead the conversation as much as possible. The researcher used different types of questioning as proposed by Minichiello et al. (1995: 88). The interviews commenced with general descriptive questions seeking their experiences, age group and discipline, which helped the participant to relax. The interviewer also used contrast questioning which "enables the informants to make comparisons of situations or events within their world, and to discuss the meanings of these situations" (p. 88). This type of questioning was used on many occasions combined with an opinion/value type of question in order to obtain and gain access to the thinking of the participant. An example of this was:

"How would you describe a person with dual diagnosis, behaviour wise"?
"Can you describe to me your comparison of these clients with others"?

Probing questions were also used in an endeavour to elicit more in-depth information and clarify what the previous question revealed. A process named a nudging probe was used e.g. "Tell me more", "Go on", "How did you feel"? "Tell me a little bit more about what you found"?

It was also identified that the use of "feeling questions" was successful in obtaining individual meanings and perceptions. Silence was also used to encourage participants to reveal further information. "Closing house" questions were used to signal the end of the interview. For example:

"Is there anything else you would like to mention"?

In general the interviews ran smoothly with a relaxed and informal flavour. Many participants commented on how fast the interview time had gone and were surprised at the amount of information given when transcripts were returned.

3.6 Tape Recording

All interviews were recorded using a tape recorder ensuring a record of all information surrendered by participants. Audiotaping is considered an appropriate and important part of this research approach. According to Tyler and Bogdan (1998, in Rice & Ezzy, 1999:63) it will "provide the level and accuracy … [and] Allow for grown-up eye contact … not obtainable from memory or by taking notes". This was a way of obtaining an accurate record of the interview. By using a common conversational style the researcher was able to create a more relaxed climate, therefore providing a greater connection. This allowed the researcher to be a caring and alert listener. The researcher ensured that all interviews were recorded using a small, un-obtrusive tape recorder, enabling all data to be available for future analysis. Tape recording ensured greater accuracy in the research as all information remained available; this process increased validity. The cassettes used were clearly labelled and all equipment checked prior to the interview.

3. 7 Population sample

Permission was gained from the management of the Grampians Psychiatric Services to distribute invitations to mental health professionals to participate in this study. An invitation to participate (Appendix A) was placed in health professionals' pigeonhole at their place of work at Ararat, Horsham and Ballarat Mental Health Services. These

invitations to participate were also placed in all community psychiatric service areas. Invitations were also given to unit managers of the Ballarat Adult Acute Unit and Eastern View to distribute to staff. Those who wished to participate completed the expression to participate in research project form (Appendix B), which was attached to the invitations and returned to the researcher using the internal mail system. Participants were asked to sign a consent form before commencing the interview (Appendix C). All participants involved in this study were given a participant number to ensure confidentiality in the results. As some disciplines are few in number, the professional's gender was not included, diminishing the risk of possible identification. It was also necessary to conceal the person's discipline and location of work and other demographic data to avoid identification. The transporting of all data from one destination to another was in a locked briefcase ensuring security of data. When data analysis was conducted, all tapes and transcripts were kept separately in a locked cupboard at the home of the researcher. Computer access required a password only known by the researcher.

3.8 Setting

Drug and Alcohol services in the Grampians region are located in Ararat/Stawell, Ballarat and Horsham. A funded Alcohol and Other Drug Withdrawal Service is provided on a limited basis by some rural acute hospitals. There are no current alcohol and other drug rehabilitation services in the region. Palm Lodge in Horsham previously provided alcohol and other drug rehabilitation services. Drug and alcohol services in Ballarat are located at the Ballarat Community Health Centre, Uniting Care and the Ballarat and District Aboriginal Cooperative. In the Stawell/Ararat area, services are provided by the Grampians Community Health Centre (GCHC) and in

Horsham by Palm Lodge (which is also attached to the GCHC) and Goolum Goolum. These services provide counselling, consultancy and continuing care, youth outreach, rural withdrawal, needle and syringe exchange and a Koori community alcohol and drug worker. Bed days for Grampians clients are purchased at Drug and Alcohol Services Western region, Footscray (DASWest) for drug and alcohol withdrawal and the Windana Society and Odyssey house for alcohol and other drugs rehabilitation.

The Adult Mental Health services in the Grampians region provide a community service at Ballarat, Ararat/Stawell and Horsham. Inpatient services and a community care unit are provided in Ballarat. The community services in Ballarat provide a Crisis Assessments and Treatment Team (CATT), Continuing Care, Clinical and Consultancy Team (CCT) and the Mobile Support and Treatment Team (MST). The teams in Ararat/Stawell and Horsham provide an integrated service. Crisis assessment and treatment teams provide a 24-hour, seven-day per week service to accept and assess new referrals to the area mental health service. The CCT provides assessment, treatment and consultancy in addition to providing continuing care and case management to the large majority of clients within the area mental health service. The MST provides an "intensive long-term community support to clients with substantial and prolonged severe mental illness and associated disability" (Mental Health Branch, 1994:29). Continuity Care Units (CCU) are community-based services that provide residential rehabilitation (Mental Health Branch, 1994).

The physical locations for the interviews was selected by the participants, the options given and used were the participant's home, place of work or the researcher's home. Health professionals from nursing, psychiatry, psychology and social work discipline

representing all available sectors throughout the region participated in this study. The breakdown of professionals in the adult psychiatric services within this region is as follows:

- 84% nursing staff
- 4% social workers
- 6% psychiatrists
- 5% psychologists
- 1% occupational therapist (Unavailable to participate in research)

3.9 Ethical considerations

The University of Ballarat research committee was contacted and an outline of the proposed research was submitted (Plain language statement - Appendix D), with permission granted by both the University of Ballarat and the Ballarat Health Service. Participants remained anonymous to all persons except the researcher. During the interviews no participant's name was mentioned with the researcher citing only participant numbers.

The possibility that discussing previous care of dual diagnosis clients may evoke painful memories in participants was anticipated but did not eventuate. The researcher believes that his twenty five years experience as a psychiatric nurse made him well-equipped to assist participants if the need arose. Consent to participate in the study was obtained prior to the interview, and participants were clearly informed that they may withdraw at any time.

The researcher is employed as the dual diagnosis clinician in the Grampians region and it was important that no employee felt pressured to be involved in this research. It

was important that the researcher's role in his employment did not influence the views and thoughts of participants.

The researcher considers that all ethical considerations were followed, ensuring that this research was conducted to high ethical standards.

3.10 Data Analysis

Crotty (1996) describes how a number of authors have adapted or embraced phenomenological methods created by Giorgi (1971), Van Kaam (1969) and Colaizzi. (1973). The method used in this study was one develop by Colaizzi in 1978. Parse (2001:83) describes Colaizzi's procedure of data validation and collation as follows:

- 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.

By adding Parse's (2001) description of Colaizzi's data validation and collation the accuracy of the researcher's coding interpretations is improved and ensures that the participants' views are expressed. The procedure used in this study involved the transcribing of all data. Following this, the researcher read all transcripts to gain an

understanding of the data, significant statements were then extracted and organised into various categories. The next stage involved an attempt to consolidate the themes by collapsing them into broader themes. A final list was produced resulting in four themes with metaphors used to describe these findings. Following the identification of the themes all interviews were read again to ensure accuracy. All transcripts were returned to the participants for confirmation and validity. Written copies and tape recordings of the original interviews were kept and referred to during the transcribing of all results in order to interpret their original meanings. The description and understanding of all themes used were discussed and validated with the participants to ensure an accurate account.

3.10.1 Bracketing

In an endeavour to understand the participants' lived experiences, researchers must set aside their own ideas, which is known as bracketing. The researcher's beliefs, biases and assumptions about the study were suspended. This detachment was made difficult by the researcher's own beliefs and views of this clientele in the researcher's role as dual diagnosis clinician. In order for the researcher to understand and discover health professionals' interpretation of the world of dual diagnosis, the researcher's own bias must be reduced. This is an important aspect of phenomenology because the questions to ask and the areas to observe may not become apparent until after the commencement of the study. The process of bracketing should achieve the reduction of bias. Streubert and Carpenter (1999: 21) describe bracketing as "putting aside one's beliefs, not making judgments about what one has observed or heard, and remaining open to data as they are revealed". Various theorists have supported the concept of bracketing (Giorgi, 1971; Van Kaam, 1969).

Only when the researcher has put aside ideas about the subject can they experience the phenomenon through the eyes of the participant. In this type of investigation the researcher must study the participant's description in quiet deliberation. The researcher then attempts to discover the meaning of the lived experience from the person participating in the study. Themes and patterns are sought in the data with the collection of data and the data analysis occurring simultaneously (Nieswiadomy, 1998). The researcher requires a sound understanding of the literature in the chosen research field and with the emergence of themes from the data the researcher then searches the literature specific to these themes. It is important that the researcher is clear about what literature is initially read and what occurs after the presentation of themes, so a delicate balance occurs. The collection of this data was obtained using a process called in-depth interviewing.

3.10.2 Computer assisted data analysis

Interview data was subjected to initial analysis utilising ATLAS/TI. The use of this program aided the researcher in coding and retrieving narrative data. Even though ATLAS/TI is capable of manipulating and exploring emerging ideas the researcher also used human data analysis, linking concepts between different data segments. Seidman (1991) states that computer programs are unable to produce all the associations the researcher makes while studying the text and qualitative computer programs manage rather than analyse data, so with this in mind the researcher combined both computer-based analysis and human analysis. Weitzman and Miles (1995) believe that the use of qualitative computer software supports qualitative data analysis in an intellectual and meaningful way.

3.10.3 Data reduction

According to Miles and Huberman (1994: 320) three main biases exist in research; these are:

> (1) the holistic fallacy: interpreting events as more patterned and congruent than they really are, lopping off the many loose ends of which social life is made;
> (2) elite bias: over weighting data from articulate, well-informed, usually high status informants and under representing data from intractable, less articulate, lower-status ones;
> (3) going native: losing one's perspective or one's "bracketing" ability, being co-opted into the perceptions and explanations of social informants.

Going native caused some difficulties as the researcher is a practising specialist nurse in dual diagnosis. The researcher had to ensure that all thoughts and perspectives were bracketed out as previously discussed.

With these points in mind, the researcher commenced phenomenological reduction. The process of selecting, simplifying, focusing, transforming and summarising raw data into field notes is known as data reduction. Miles and Huberman (1994) believe that the reduction of data occurs simultaneously to the collection of data throughout the life of the qualitative project and this data reduction is part of the data analysis. Miles and Huberman (1994) further state that data reduction should occur following each interview, with the researcher assigning codes to raw data. Codes are labels used to assign elements of meaning to descriptive information gained during the study. It is not the words themselves that are important, but their meaning. A code is also described as a symbol applied to a segment of words in order to classify words in regard to their themes. Coding enabled the data to be retrieved quickly and accurately for comparison with similar data. This process led to the generation of new ideas.

The researcher utilised three types of coding to assist with the assembly and presentation of data. The coding used was: -

1. Descriptive codes which categorise words by using similarities of their meanings, which can be compared with responses from each interview.

2. Interpretive codes are words, which are classified by the meanings as perceived by the researcher. As interviews progress, ideas emerge regarding the participants' meanings.

3. Explanatory codes are developed as categories begin to emerge and are then used to attach innate meanings to the phenomena. Ideas and concepts that were similar in nature are classified and this classification is condensed to formulate themes.

3.11 Auditability, Credibility and Fittingness

Beanland et al. (1999) believe that the criteria used to gauge the scientific rigor of qualitative research are the general concepts of auditability, credibility and fittingness. Auditability enables the reader to follow the thoughts of the researcher. By adhering to this procedure in this study it enabled all health professionals and health related authorities to gain an understanding and thoughts of those caring for dual diagnosis clients in rural/regional areas. Credibility is described by LoBiondo-Wood and Haber (1999) as accountability judged by how well the research guides the reader from the research question and raw data to the interpretation of the findings. The researcher believes this study steered readers from the initial research question, the linking of raw data into significant clusters and the interpretation of these findings using nautical metaphors which only enhanced the interpretation of such findings. Fittingness is

defined by Beanland et al. (1999) as an answer to the question and are the findings applicable elsewhere. Do the findings have meaning to others not involved in the research? The researcher believes that the findings of this research answers the research question and is applicable to other regional/rural services and correspondence with other readers who are not employed in the health services convey that audibility, credibility and fittingness have been achieved.

CHAPTER FOUR - RESULTS

4.1 Introduction

This chapter will present the findings under four major themes that emerged from the analysis of data which was obtained from 13 participants. The researcher envisaged the four themes as having a nautical flavour as participants conveyed an overall picture of delivering mental health services to clients with dual diagnosis without having a solid foundation upon which to base their clinical practice. The nautical metaphors also produce an image of health professionals being exposed to elements of risk as they expose themselves to more complex issues associated with this specific group of clients. Finally the nautical metaphors express the need for health professionals to learn survival skills in this new and challenging field.

4.2 Results

Thirteen professionals consented to be interviewed with the collection of data continuing until saturation occurred with all consenting participants. Twenty three percent of participants were female with 77% male. Their ages ranged from the early twenties to the late forties. The cooperation of health professionals in consenting to participate ensured at least one participant from all available professions employed by the Grampians Psychiatric Services/Ballarat Health Services. The only discipline unavailable was an occupational therapist. This cooperation and willingness to provide time for the interview enabled a near representation of each discipline employment percentages in this region. Twenty-four percent of the participants were aged 30 years or less while 38% were aged between 31 and 40 with a further 38% aged between 41 and 50 years. Health professionals' years of experience range from less than two years to more than 15 years. The breakdown of experience as a health

professional in this field shows that 23% had 2 years or less experience, 15.5% had 6 - 10 years experience, 15.5% had 11-15 years experience while 46% had 15 years or more experience. Seventy-seven percent of participants described their most frequent place of work as the Community Mental Health Service. Fifteen percent worked in other areas with a further 8% from the inpatient section.

The data analysis technique used in this study was the process outlined by Colaizzi (1978). The data analysis involved the initial transcribing of data obtained from participants, reading the data and listening to the audiotapes 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. These were assembled on a thematic conceptual matrix. The data was continually examined until all the narrative from participants was listed. Categories were then combined producing four themes.

As mentioned previously, the aim of this study was to identify and describe health professionals' perception while caring for clients with a dual diagnosis in the GPS.
The research question was: -

- What are the lived experiences of health professionals who care for clients with a dual diagnosis?

4.3 Emergence of Themes

The procedure of phenomenological data analysis described in Chapter Three resulted in the emergence of four major themes. Each matrix was assembled using the method developed by Miles and Huberman (1994). Actual words used by the participants were employed to convey participant feelings, thoughts and observations and were listed as descriptive codes in the first column of each matrix. These words were used exactly as presented in the transcripts of the interviews. The next step was the identification of interpretive codes. This phase involves the interpreting of all meanings indicated by the complete list of descriptive codes. This is displayed in column two of the matrix. Explanatory codes were then assigned to each classification of interpreted meanings. This process enabled the placing of all interpreted meanings into shared ideas and concepts into a specific theme. Metaphors have been used to group these common themes.

4.4 THEMES

1. Sink or Swim
2. Treading Water
3. Rowing Against the Tide
4. Smooth Sailing

Sink or swim represents health professionals' initial preparation to care for this group of complex clientele. The second theme, Treading water, symbolises health professionals' endeavours to keep their head above water and reflects on their feelings while endeavouring to do so. Rowing against the tide describes health professionals' understanding of clients' drug misuse, which impacts greatly on the level of care. The final theme of smooth sailing, represents health professionals awareness of the need to provide appropriate care.

4.5 THEME 1: SINK OR SWIM

The first theme emerging from the data analysis was the limited preparation of health professionals to care for clients with a dual diagnosis. Health professionals felt that they were thrown in the deep end and would either sink or swim (Table 1).

TABLE 1. Matrix showing the three codes for Theme 1. Sink or Swim.

Descriptive codes	Interpretive codes	Explanatory codes
Very limited, perhaps more education in that area.	Lack of initial dual diagnosis preparation and training, a need for more education.	Lack of knowledge to deal with presenting situations, resulting in a feeling of professional humiliation.
Psychiatrists understand that we have a big role to play when it comes to providing assessment and treatment for people with a dual diagnosis.	Psychiatrists understanding of dual diagnosis issues and the major need for services.	Acceptance of dual diagnosis service.
GPs are sometimes a bit frustrated they don't know where people fit.	Health professionals feeling that attitudes of general practitioners are generated by frustration and a lack of understanding.	GP frustration and lack of education – Caught in the rip.
I don't use drugs myself I guess initially I think drug use is wrong but not in the case that I would judge that person for it. My experience with drugs on the street is pretty naïve [limited].	Sympathetic attitudes of health professionals.	Attitudes of health professionals – Play it safe by the water.
My initial training, we were given was actually very poorly prepared to manage people with substance abuse.	Lack of drug experience and knowledge leading to frustration.	Professional humiliation - Boating skills.
I'm just as guilty as all the rest of them I have very poor knowledge too.	Initial training was limited with little drug education and management skills leading to professionals feeling inadequate.	Feeling overwhelmed, under prepared and under resourced. Professional inadequacy. Thrown in the deep end.
We haven't had much training.	Feelings of guilt, lack of power and knowledge. Training neglect.	

4.5.1 Preparation – Thrown in the deep end

An observation by participants was that more recently the service had been referred an increased number of clients who are using drugs. It was felt by participants that clients with a dual diagnosis were becoming more prominent and mental health professionals were under-prepared to deal with them as they believe their drug and dual diagnosis knowledge is limited.

Illustration 1: Participant 3

> In the people we have had under thirty years old in the last two years I would say about 75% of these people have had some form of substance abuse problem be it mild or major.

Illustration 2: Participant 5

> I'd say out of the 15 or 16 clients that I manage at least seven have a dual diagnosis.

Participants believed that health professionals frequently used a trial and error method of gaining the required knowledge. Concerns evident with drug and alcohol use/misuse were only a small portion of undergraduate training. Participants explained how they felt very nervous and were not confident about dealing with these clients. Most of their learning was from the information and guidance they received from other clinicians. Younger professionals expressed how they initially felt under - prepared and at times overwhelmed. They regarded their understanding of dual diagnosis strategies as very limited and felt they required more education to deliver adequate treatment to dual diagnosis clients.

Illustration 1: Participant 7

> I've asked questions about what is this drug? My experience with drugs on the street is pretty naïve. So some of the names I have to ask.

Illustration 2: 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 Uni and then a lecture in a tutorial that was geared to the postgrad as well so nothing really extensive.

Illustration 3: Participant 7

> No really poorly prepared at University … I can recall the only drug stuff we did was your normal drug education … we did watch a video once in a psychiatric lecture about drugs and drug issues that was about the extent of the education I received on drugs.

Illustration 4: 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.

But this feeling was not only confined to the young: -

Illustration 1: Participant 3

> With my initial training, I felt I was actually very poorly prepared to manage people with substance abuse.

Illustration 2: Participant 1

> In my training as a student [health professional] yes a lack of education. Poorly prepared.

Illustration 3: Participant 11

> Not a lot no, see drug and alcohol dual diagnosis issues only really became identified as a significant part of our practice in the last five or six years.

Only one participant relayed that during their initial training they were able to choose electives.

Illustration 1: Participant 12

> I did a four-year course and there were three electives that I did. One was substance use. It wasn't compulsory. It's just that I chose that elective so that certainly helped and I worked in other settings with people with substance use issues.

4.5.2 Boating skills - Professional Humiliation

This lack of preparation and dual diagnosis knowledge often placed health professionals in embarrassing situations

Illustration 1: Participant 11

> I just felt I didn't even know what I was doing. It was like a general nurse looks at psychiatry I think, oh shit, the dark side. So I was a bit confused about what was the way. We sort of managed it in our original models but I don't know if that was the best way, but it was the best method we had at the time.

Illustration 2: Participant 2

> Before, when I lived in Melbourne, I didn't know anything about psychiatric illness and I didn't know that there was any correlation between taking drugs and mental illness. I mean why would you know that and it's taken me a few years to see that working in the area.

4.5.3 Play it safe by the water - Attitudes/conflicts

This lack of preparation appeared to influence health professional attitudes toward dual diagnosis clients, creating various conflicts. The health professionals felt that drug misuse was wrong but this did not create a judgmental view toward the person using drugs. The view was expressed that no personal bias existed with the majority of health professionals and they were not concerned if the person misuses drugs. Professionals accepted it was part of their job and some said that they found it quite enjoyable and challenging working with people with both drug and mental health issues. The researcher believes that a person's views and values have an influence on their behaviour. This includes consciously setting beliefs aside when caring for a dual diagnosis client. Examples of some of the conflicts existing with a number of health professionals are highlighted in the following illustrations.

Illustration 1: Participant 7

> It doesn't bother me I am pretty open-minded, - it doesn't bother me at all. I don't have any preconceived ideas that people who use drugs are bad or anything like that. I don't find it a problem at all really. … If I had to care for someone that was a dealer I suppose I would never let it get in the way of my work, obviously, but I think it would be a little bit challenging. I suppose, because my beliefs are that I don't think drug dealers are good people.

Illustration 2: Participant 1

> You just get in and do your assessment and treatment and care the same for anybody else. You don't bring your views into it. I suppose it's your background as a … [health professional] you don't characterise people into pigeonholes. You treat what you have got there in front of you.

Illustration 3: 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?

Illustration 4: Participant 2

> No I'm not down on people that use drugs, gee everyone uses drugs. No I don't get down on people using drugs. It is not a moral dilemma to me.

Other professionals stated how they initially felt quite apprehensive working with dual diagnosis clients whom they felt had a major effect on a professional's judgment.

Illustration 1: Participant 6

> They tend to give me the shits a bit.

Illustration 2: Participant 3

> I really felt what the hell are you doing working with these people. They are just bastards who are taking advantage of the situation using the community up. In more recent years my views have moderated considerably.

4.5.4 Caught in the Rip - General Practitioners

The present structure of psychiatric services is based on the care for the client in the least restrictive environment. With the closing of a client's case they are transferred to the care of general practitioners (GPs) sometimes with negative outcomes. Health professionals observed differing views and delivery of treatment by GPs. The attitudes and preparation of GPs was found to vary. Some health professionals felt that some of the younger general practitioners were much more understanding and more in touch with drug issues.

Illustration 1: Participant 7

> I've found that some GPs have bad attitudes to both client groups [Psychiatric and drug and alcohol clients].

Illustration 2: Participant 6

> I think that there is a small percentage … that are understanding of our people. That is mental illness and those that have drug and alcohol issues. They are very good but that is a small percentage the others are less tolerant or they don't have the interest in it.

Participants felt it was different in rural settings, as small towns only possess a small number of GPs. If a client is known as a 'doctor shopper' it becomes common knowledge. Some GPs are seen as sympathetic to people with drug and alcohol problems and have taken a specialty approach in the drug and alcohol field. The knowledge GPs possess was seen by some professionals as a problem. A number of professionals expressed the option that some GPs find it hard to separate a drug issue from a mental illness. Occasionally it was seen as easier for the GP to say that the mental illness is caused by the drug use rather than the opposite. Many professionals felt that GPs are as frustrated as mental health professionals, as they do not understand dual diagnosis issues any more than the professionals. Some were seen as possessing very poor knowledge.

Illustration 1: Participant 4

> I think it's their (GPs) ignorance. I don't think it's because they are trying to be judgmental of people. I just think they have a lack of knowledge in general terms. I think that deficit is there equally with mental health issues as well.

Illustration 2: Participant 4

> Maybe they (GPs) 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.

4.5.5 Summary

Participants believed that clients with a dual diagnosis were becoming more prominent as recently there had been an increased number of clients referred to GPs who are misusing drugs. Mental health professionals feel they are under-prepared and felt very nervous and were not confident about dealing with these clients. Most of their learning was from the information and guidance they received from other clinicians. This lack of preparation and dual diagnosis knowledge often placed health professionals in embarrassing situations.

4.6 THEME NUMBER 2: TREADING WATER

An important theme emerging from the data analysis was health professionals' attempt to explain and understand clients' drug use. The researcher felt that health professionals used this time to release feelings of frustration and despair.

TABLE 2. Matrix showing the three codes for Theme 2 Treading Water.

Descriptive codes	Interpretive codes	Explanatory codes
It was an acceptable kind of culture in that time where as what we see now is somehow different. A lot of patients I have use cannabis daily. Alcohol and marijuana probably Most commonly the user does it for pleasure for recreation.	Differing groups vary in views. Also there is a drug-using culture. Knowledge of drugs used and the effect on psychosis. Reason for drug use and a degree of sympathy expressed by health professionals.	Culture - Know your environment. Powerlessness – Always enter the water feet first. Cannabis – The great white shark. Frustration with clients and the community. SOS! Why do they use – Creating the frustration. Medical model vs. drug misuse reasons – Swimming between the flags – self-medication.

4.6.1 Know your environment - Culture

Various views on drugs and drug misuse exist in different groups or cultures in metropolitan, regional Australia or other countries. The legality and cultural beliefs in countries determine the acceptability of the drug. Also the drug community has a culture of its own which dual diagnosis clients patronise for personal gains.

Illustration 1: Participant 9

> There are certain festivals, where it is legal; it is like having a Christmas party where everybody coming is having a turkey. In India they have festivals where they use cannabis, father, daughter and everyone is enjoying it, and after two or three minutes everything is over. Because I think it has social approval because it has a religious touch people know when to have it and when not to have it and there are shops actually legally licensed shops where you can walk in and buy it. You can buy whatever you want, but it is all controlled and so I think that sort of problem is left there.

Illustration 3: Participant 2

> It was an acceptable kind of culture in that time where as what we see now is somehow different. I think when we were young it was part of our culture, a social thing. It wasn't necessarily a life style. It was part of a social interaction and it didn't involve theft or prostitution to get some money to pay for drugs. It didn't really affect the rest of your life.

Illustration 4: Participant 12

> It's about the group of people that they're socialising with and what they have access to.

Illustration 5: Participant 5

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

4.6.2 Always enter the water feet first - Powerlessness

The health professionals throughout the interviews identified a feeling of a lack of power. Drug use is so common, and acceptable to some members of the community and even the client's family, health professionals felt it was difficult to alert individuals to the dangers of drug use. This resulted in a sense of frustration and despair. Health professionals find themselves case-managing clients who do not feel a need to cease their drug misuse.

Illustration 1: Participant 8

> There is a lot of young people just drinking and drug taking their life away, which we are unable to help because they are not willing to seek help themselves due to lack of insight or whatever it might be. … A lot of them are just easily led and get into a group of people who booze or use drugs and just go along with the flow. They haven't got the personality I suppose to stand up for themselves. They are easily led because of their illness.

Illustration 2: 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 drug and alcohol follow up they require, I'm not saying that is a fault of the drug and alcohol services I am just saying they don't get it and they relapse and start using again especially if the drugs they are on precipitate their illness.

Illustration 3: 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 … that issue of powerlessness that's the one I find so difficult to deal with.

Illustration 4: Participant 11

> He sort of failed his placement here, it felt like it didn't work out and I felt really awful when he had to leave.

Illustration 5: Participant 2

> The other thing that is very hard is trying to break down their social circle. It's really hard if you've got some young kid that comes in and has been smoking dope for a number of years. They have got to the point where they have a psychotic episode.

Illustration 6: Participant 12

> The client I case managed, I felt like he was heading towards a really early death. I felt really helpless and powerless, you could see where he was headed but there was nothing much you can do to stop it.

4.6.3 The Great White Shark - Cannabis

Health professionals report marijuana as the most widely used drug along with alcohol by the psychiatric clientele. Although the general community views cannabis as 'pretty harmless' health professionals recognise the drug as a major influence in the relapse of people who have schizophrenia. This study showed that health professionals are concerned with a perceived lack of concern the community displays when comparing various drugs. The difficulties health professionals unearth while educating the community on drug misuse and mental illness is a major cause of frustration.

Illustration 1: Participant 3

> Marijuana is a major problem because it's cheap, it's available and is seen as harmless by the community.

Illustration 2: Participant 2

> The one that frightens me most is cannabis because we see so much of it here and the fact that it's seen as a soft drug. It's not like heroin and LSD and all those sorts of drugs, it's smoked at parties, it's no big deal but it is for some kids. It's a huge deal, and it can cause a lot more harm than heroin and it's very difficult to get that message across to kids at school.

Illustration 3: Participant 2

> I suppose the other thing I have noticed is the second generation of dope smokers. Parents that are in their 40's to 50's that grew up in that era when they did smoke dope and probably still do and it wasn't a problem. Now they have got kids who are eighteen, fifteen, twenty whatever, they are smoking dope. It was all right for their parents but because of the changes in the way they grow dope with the whole hydroponic movement, skunk, the chemicals, it has a very different effect than it did in their parent's era. I think it's very difficult to understand why their parents have smoked for years and nothing happened to them. Why is this happening to the kids? … Its difficult for parents to understand, well I smoked dope when I was a kid and nothing ever happened to me, why should it be a problem for my kids?

During this study the researcher identified a degree of sympathy and empathy displayed by health professionals for clients with a dual diagnosis. The cultural beliefs of drug use appeared to be shared by some health professionals. Some of the comments appear to be giving positive reasons for using drugs.

Illustration 1: Participant 4

> You can understand why they get to the point they are at in their lives.

Illustration 2: Participant 5

> A very natural process for some people with a mental illness to gravitate towards drug use because it is probably the most socially accepted group in society.

Illustration 3: Participant 11

> I don't know if you have ever heard of hand brakes, it is where they have a handful of Temaz or something, they may be on speed or acid and it is getting a

> little tough for them and they want to chuck on the hand brake so they can sleep it off. Not bad management I suppose, it's abuse of a prescription drug all the same.

Illustration 4: Participant 12

> I find them the saddest client group. I think a lot about what got them to the point of where they are now and life experiences they must have had, what sort of pain they must have to end up with such complex disabilities or issues.

Illustration 5: Participant 5

> I suppose a lot of times people can self medicate with drugs and I know of people who last a long time in the community without psychiatric medication by using illicit drugs.

4.6.4 SOS! Why do they use? - Creating the frustration

Participants divulged that many of the case managed clients will talk about drug use but they won't actually elaborate on why they use it or they do not surrender much information to mental health professionals. This situation makes it difficult and frustrating for health professionals as they attempt to render care, as it contradicts the sick role and questions what the relationship between the health professional and the client is. This raises the question of how else can the health professional feel if this role/relationship is compromised through a lack of honesty?

It was felt by participants that a lot of the drug choice was about availability because the individuals may use various substances over the course of a decade. A general view was that, most commonly, the user takes drugs for pleasure or recreation and there is also a lot of peer pressure on the young. Health professionals felt that clients use drugs simply because they like the way it makes them feel. This drug-taking behaviour is seen as a social activity which makes them feel included and an accepted part of a group.

Illustration 1: Participant 5

> Generally speaking it is the enjoyment, the high, to a degree the notoriety that you are doing something that is risky. Whether it is risky to your health or risky with the police or whatever, often the younger people are just more destructive to the family unit.

It was conveyed by participants that clients reported they commenced using drugs at an early age through the peer pressure they received, and they were unable to cease their intake. It was also conveyed that individuals commence using at secondary school during the perceived pressure years. Professionals felt that a lot of drug misuse was attributed to the fact they had been using it for years and so it has become a habit. One participant observed the difference in young clients with a dual diagnosis since moving to the country from a metropolitan area. It was observed that rural/regional clients compared to their metropolitan peers have trouble gaining employment, support, or learning new skills, and the use of drugs seem to be a way of passing time.

4.6.5 Swimming between the flags – Self-Medication

A number of participants stated that a lot of their clientele' described how they used drugs to relieve anxiety and to reduce depression. It was also a way of coping with the everyday stresses incurred through living in the community. Many participants stated that clients believed that drugs provide a relief from their symptoms. It is a way of self-medicating.

Illustration 1: Participant 4

> 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 just feelings of unhappiness.

Illustration 2: Participant 9

> There have been some people I have come across where they said that they use it to remove the anxiety and for depression also.

Illustration 3: Participant 11

> One person told me it relieves their anxiety, it helps with coping with their everyday stresses.

Illustration 4: Participant 8

> Some of them reckon they use it to hide their symptoms. Smoking marijuana relaxes them and helps them to forget about their thoughts.

Health professionals perceived that the majority of individuals treated by the mental health services are easily led or bored. Many of the case managed clients do not have any structure in their life, so they spend the day sitting around smoking cigarettes and drinking alcohol. Boredom and a monotonous life style were seen as a major problem. They may have a fixed low income, or may have had a very dysfunctional upbringing or a traumatic past, and so they may have difficulty dealing with specific life events. Their drug use behaviour may be secondary to other social problems like a relationship breakdown. Professionals felt that the drug use becomes habitual and a large part of their adopted life style. This dilemma makes it difficult to break that cycle.

Illustration 1: Participant 3

> Boredom seems to be the major cause for substance abuse from personal experience.

Illustration 2: Participant 8

> Well probably with a lot of the people we deal with it is probably because of the nature of their illnesses they are easily led or bored because they haven't got anything in life bar sitting around smoking, drinking and that sort of thing so that is the main reason I reckon.

Illustration 3: Participant 13

> Mainly it is probably boredom based the fact that their circumstances are such that every day is much the same.

Illustration 4: Participant 3

> Boredom seems to be the major cause for substance abuse.

Sexual assault and other sorts of abuse in life, for example, childhood abuse and domestic violence create a very strong link with misuse. The client tends to use substances to cope. The next quotation supports this position but also inadvertently acknowledges that the professional is not coping with the situation as they are under-prepared, which leads to professional humiliation.

Illustration I: Participant 12

> In mental health we often forget about sexual assault, we're not aware of the underlying issues. We haven't got the time to acknowledge these people that have had really traumatic pasts and I don't think we take that into account in our assessment and interventions with them, we're at the superficial level.

4.6.6 Summary

This section described many emotions and thoughts experienced by health professionals including a lack of power which results in feelings of frustration and despair. The community intensifies these emotions with a lack of perceived seriousness. A degree of sympathy was also displayed with some professionals providing positives for the clients drug use.

4.7 THEME NUMBER 3: ROWING AGAINST THE TIDE

It is important for future treatment of dual diagnosis clients to identify their reasons for use of certain drugs. Health professionals conveyed a great understanding of some of the reasons given by clients as to their misuse of drugs, but unfortunately were not prepared or trained to care for such difficult behaviours. The researcher feels it is important for health professionals to understand a client's reasons for drug use so the appropriate treatment and advice may be given. The next theme identified will further describe these complex clients and discuss the frustrations experienced by health professionals. Table three shows the matrix outlining Theme 3, Rowing Against the Tide.

4.7.1 Choosing the correct lifejacket: Dual diagnosis – A description of clients by health professionals

The description of dual diagnosis clients produced a variety of explanations expressing many concerns, feelings, frustrations and difficulties incurred while treating this client group. Participants spoke of some clients who refused counselling or were not ready or able to make changes to their drug and alcohol misuse. Health professionals described caring for an individual with a dual diagnosis as extremely complicated and difficult. Participants felt that with a person using substances they see a higher intensity of acute presentations. The symptoms are more pronounced when the individual presents as acutely psychotic requiring more medication to manage the symptoms. They are more violent which also leads to an increase in psychotropic medication and they are more likely to have no insight and to relapse. The comments made by health professionals almost imply a sense of hopelessness

suggesting that no one can help the client with dual diagnosis. They appear to feel that no matter how you treat the client or how much effort the health professional puts into their care, there appears to be no progress.

TABLE 3. Matrix showing the three codes for Theme 3. Rowing Against the Tide.

Descriptive codes	Interpretive codes	Explanatory codes
I guess there's a drug dependency behaviour, drug seeking behaviour in the context of intoxication.	A description of a dual diagnosis client's behaviour	Client Description – Choosing the correct life jacket.
I felt frustrated because you find it is very slow progress.	A feeling of frustration as the treatment of dual diagnosis is difficult.	Acceptance of behaviour. Feelings of hopelessness/frustration – Man overboard.
From what I'm aware of there is limited treatment options. I don't think there's enough resources, I think we need more, I think what we get now is good quality but I don't think there is enough of it.	Limited D&A and dual diagnosis services in this region. Description of dual diagnosis services in the Grampians region.	Cry for help – Increased resources required. Lack of resources, inadequate services – Know the limitations of your boat.
I suppose our first contact with people with a dual diagnosis is often in crisis and pretty much after hours and it probably becomes apparent as to how limited the resources are to actually address their needs which are complex.	Treatment needs of dual diagnosis clients in crisis occur after hours displaying the complex nature of these individuals and how limited the resources are.	Dual diagnosis – Mental Health verses drug misuse
More recently it's other agencies in the community we depend on in relation to referring people on for counseling of alcohol and other drugs.	Drug and alcohol treatment options.	Limited resources – Lifeguards - Services.
Communication lines are not there. There is a gap between the continuity of care	Communication is poor between services Treatment coordination breakdown	Junction - Let's row together.

Illustration 1: Participant 12

> I think they're the most complex clients. … I found them the most challenging and difficult. I found them to be the ones who slipped through all the service systems and end up not getting any service because the workers hand ball them all over the place. I think that they don't belong to just one service system they should be shared and they should be getting services for all their issues.

Illustration 2: 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.

Illustration 3: Participant 6

> The more severe the problem becomes there is a lot of social stuff going on usually forensic stuff and sometimes there are children involved, families.

Participants feel that there is a drug dependency or drug seeking behaviour that presents as risk-taking and manipulating actions. Professionals felt the clients were more concerned about their next fix than obtaining treatment for their mental illness. It was perceived that each client with a dual diagnosis seems to have a different presentation. Participants found it difficult to differentiate which client disorder occurred first and what their primary problem was. One participant described some people with a dual diagnosis as very intelligent, articulate and a pleasure to visit. The same participant could also see the negatives involved.

For clinicians of the psychiatric services, their first contact with people with a dual diagnosis is often in crisis after hours. This situation highlights how limited the resources are to address these complex needs. It was also felt that they are difficult people to treat. The treatment depends a lot on the clinician's experience and basically whether he/she has enough experience to deal with both issues or to define which is

the primary cause and which is the secondary. Health professionals felt that only then can a proper assessment and management plan be developed. Some health professionals mentioned how the majority of clients did not identify their drug-taking as a problem as often it has been a long-standing issue and that is how the person chose to live.

The health professionals spoke of many skills they have developed through working in different settings with a range of people with disabilities and problems. When assessing people with a drug and alcohol problem the misuse tends to complicate the clinical picture as far as diagnosis goes. The health professionals found that as the individual ceases the drug use, the symptoms are alleviated.

Visiting unpredictable clients at home to render care and treatment was highlighted as increasing the risk factor to professionals. Participants felt this situation makes it very difficult to deal with dual diagnosis clients. The professional does not know what state they are going to find the client in, given that drug/s can mask the illness. Professionals felt that in the past they were sheltered from clients with drug and alcohol abuse which the researcher interpreted as feelings of resentment. Clients who may not want help confront health professionals and the same professionals are not equipped to help.

Illustration 1: Participant 8

> The person was just an alcohol abuser and we were sort of being told that it is an alcohol problem and don't worry about it. You know, refer them on to alcohol agencies. But now it's obvious we have been asked to pick up these people a lot more.

Illustration 2: Participant 3

> I do know if they have got a mental illness, but I don't know if they have taken substances.

Illustration 3: Participant 8

> I mean it's really difficult to deal with someone when you go around to visit; they are drunk as a skunk or high on drugs or whatever. It makes it very difficult plus you've also got the risks … are they going to be violent towards you, have they got hepatitis from using drugs, you know if you are giving these people injections and that sort of thing. You have always got the fear of wondering what other sort of stuff they have picked up along the way. When you deal with them what sort of situation do you walk into, do you 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 or so you do get a lot more stress dealing with these sorts of people, you just don't know what you are going to come up against.

Illustration 4: Participant 4

> When you assess them it complicates the clinical picture as far as diagnosis goes because they go off the drugs and then they have no symptoms.

Illustration 5: Participant 3

> When they are mentally unwell the substance abuse is much worse and when mentally settled the substance abuse often stops.

4.7.2 Man overboard - Frustration

One subject, whether expressed verbally, or observed or interpreted by the researcher, which kept occurring throughout the interviews was frustration. This frustration is a major feature of rowing against the tide. Many of the participants describe the care of dual diagnosis clients as very frustrating. The treatment of dual diagnosis clients was seen as very slow with many setbacks. Participants found that many clients tend to sabotage treatment with drug misuse.

Illustration 1: Participant 2

> They want to know everything about it and yet they will buy something from someone in a pub. They have no idea what it is, what the side effects are, or what's in it, and they pay for it and they still won't take their medication. This is because they don't know what's in it, or it's not natural. The other issue we have are people on the natural trip who won't take anything that isn't herbal. They won't eat dairy foods; they won't do this or won't do that because it's not natural and won't take our medication because it's chemical. They take alcohol because it's natural and smoke dope because it's natural but they won't take our medication because it's not natural. If you argue you get nowhere.

Illustration 2: Participant 10

> My first experience with it was when I was working down in Melbourne. I was working with quite a few Koori patients on the inpatient ward. A few of those would come in and they would have serious drug problems. … That was very hard I guess to treat them because quite often they just would go off and use the drugs. It would be very hard to work out plans and things for discharge because of the drug use.

Illustration 3: Participant 3

> We had one young man I can think of in particular, he came here with a serious substance abuse problem. We treated his schizophrenia and he stopped abusing substances within a week of being here … when he left he used substances again.

Illustration 4: Participant 6

> It is frustrating because you know that it's recurring and that there is nothing you can do.

Illustration 5: 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.

Illustration 6: Participant 8

> They are insightless and they don't want help for their problem and our hands are tied.

4.7.3 Know the limitations of your boat - Cry for Help!

Some participants found it frustrating as well as sad when the client, having achieved abstinence, commenced using again. They see the person deteriorating again and the cycle recommences. Also revealed was the frustration with treatment programs for dual diagnosis clients. They are admitted to the adult acute unit and taken off the illicit/non illicit drug they have been misusing but it doesn't take away their pain.

Illustration 1: Participant 2

> What do you give them to take away the pain, you've got nothing, so when we discharge them and you haven't replaced what you have taken away. They have this void, they still have the pain, what can you offer them.

Illustration 2: Participant 11

> I felt frustrated as I said before. I felt it was the blind leading the blind a bit. You sort of managed the behaviours rather than the illness, because we didn't know anything about it.

Illustration 3: Participant 4

> I mean with some people you get to a point where I think you know they do really well but other people never seem to be able to make that connection and I don't know why that is.

Illustration 4: Participant 12

> I could see that he needed assistance. He did need support and some sort of service. There was always this feeling that he didn't quite fit here and I got that feedback from other staff all the time. Some staff didn't want to work with him and he was quite different to other clients that I'd ever worked with. It was really hard to build up a rapport with him, to build up a relationship and to this day I don't think that happened very well at all. He had a lot of trouble trusting and disclosing anything to anyone. I don't know for what reason and it felt like I failed him on his placement here. It felt like it didn't work out and I felt really awful when he had to leave. Well I feel like even to this day I didn't know him very well. He found it really hard to trust people and he didn't share much. So I knew about him from what I read about him in the file and the little bits I found out. I don't know what drove him into the direction of using drugs and alcohol. I don't know what would have helped him.

Several participants expressed their frustration by referring to how much easier it was to render treatment to a person with schizophrenia.

Illustration 1: Participant 3

> Nothing like a good old fashioned schizophrenic. They're straightforward and these people aren't.

Illustration 2: Participant 6

> It's not like you are treating a straight good old paranoid schizophrenic where you get them stabilised and everything is okay. With the others you've always got the difficulty of especially when they think it's helping their symptoms, that seems to be the thing with a lot of them.

Illustration 3: Participant 3

> Well to look at a person here with plain old fashioned schizophrenia. You can give them a dose of Olanzapine or an injection. We set up a social structure for them, teach them to cook we do all those sorts of things and we expect them to move on to a more intensive living.

Another frustration participants identified was the inability of or lack of effort made by a dual diagnosis client to help him or herself. Time restraints placed on clinicians also led to a feeling of frustration. This frustration may lead to an inappropriate or inadequate treatment response.

Illustration 1:Participant 6

> I find I can be too busy to worry about them. If I put in the time initially and make the referrals and they are off playing around not even getting to step one, well I think then that's a specialty agency job or they have got to the party a bit or I concentrate on some of the others.

Illustration 2:Participant 8

> To the most part some people probably worked out OK, other people don't. I just don't know whether it's because of our efforts or despite our efforts.

One participant describes caring for a client with dual diagnosis as frustrating work, but if the health professional ever succeeds, it is quite rewarding. Unfortunately this rarely occurs.

4.7.4 Lifeguards - Services

Another constant expressed by participants was that the Grampians region is under-resourced. Health professionals felt that it is an enormous area for one person to cover and that dual diagnosis needs would only expand. They felt it was impossible for people to spread themselves across the region and be expected to do a reasonable job. An area of concern that was constantly conveyed by all participants was that funding of one staff member for the whole region did not adequately support the needs of the dual diagnosis client.

Illustration 1: Participant 13

> It is the same tyranny of distance everywhere like they work on population numbers and we are the lowest population per square kilometre in the State. Unfortunately they don't all live in one place. In that regard it is just a logistic argument. You are pretty naive to expect the best results and that I suppose is what they are seeking all the time the best of the best, the benchmark, the best practice. But how can you when resources are stretched to the limit. It can obviously be made better but probably we need more resources.

Illustration 2: Participant 4

> I think it's an enormous area. I think it's just going to keep getting bigger and bigger and I think it's just impossible for people to spread themselves across the region and to be expected to do a good job, it's just too big an ask on people that's all.

Illustration 3: Participant 3

> I think you can't run a place with just one worker, you have to have a team.

Dual diagnosis was one area that participants felt needed a lot of attention. It should be further addressed to help young people to feel more connected. Participants felt it was important that people who are trained to deal with both issues at the same time were available and hoped that dual diagnosis services would continue to grow.

4.7.5 Junction - Let's row together

The lack of drug and alcohol services was an issue mentioned by participants on many occasions. Participants felt that there were very limited drug and alcohol treatment options. The distance the services cover and the staff ratio contribute to this problem. All drug and alcohol rehabilitation and withdrawal facilities for adults are located in Melbourne, a situation which participants believe is inadequate for people who live in rural areas.

Illustration 1: Participant 3

> I know that there isn't a [adult] drug and alcohol service in the region. I know it is very hard to get people detoxed. Very very hard to get people in to any sort of care when the substance becomes the major problem not the mental illness.

Illustration 2: Participant 11

> Anyone that needs to be detoxed … has to go to Melbourne, unless they are under 21 they go to Ballarat. That is the dilemma I had the other day. This bloke I was telling you about has to go to Melbourne. He doesn't like going to Melbourne but he has to go through a detox. It deters people from taking the next step.

Illustration 3: Participant 2

> While here, they get past that stage of psychosis and are just about ready to go home. Who are we sending them home to? The same group of friends the same family and the same situation. They might have the best intentions in the world while here, but how on earth are they going to maintain it if that's all they have got.

A need for more drug and alcohol workers in this region was expressed. This statement shows that health professionals feel overwhelmed, under-prepared, under-

resourced and require extra support. Participants also feel that the placement of mental health staff in drug and alcohol type settings would be beneficial for the treatment of clients. Health professionals also view the lack of drug services coordination as problematic, stating that clients who had been through drug withdrawal had to then wait a significant time if they required further rehabilitation. They believed that this service should be a continuum. Participants felt that both services were moving closer together and that psychiatric services were always able to refer and discuss issues with drug and alcohol agencies. Health professionals suggested that staff of both services should be exposed to each other's work areas as this may assist with greater understanding of the respective limitations and further enhance collaboration between services. This process would help staff feel more comfortable and more accepting with enhanced knowledge of the other service. People who are not case managed by the mental health or drug and alcohol services were seen as a major concern. One of the uncertainties professionals have encountered is when the client may have a minor psychiatric problem and therefore does not fall within the psychiatric services target group.

Illustration 1: Participant 9

> I think we need to think about the drug and alcohol area. My experience here has revealed that there is a gap in the continuity of care. The person comes to the attention of the GP and the people of the drug and alcohol services. The person needs detoxification, he is detoxified but then if he needs long-term follow-up there is a long waiting list and by the time his time comes for rehab program he requires the detox program again. This vicious cycle needs to be broken somehow.

Illustration 2: Participant 9

> I think the attitude is that it is not our problem. It is a drug and alcohol problem that should be dealt with by the other agency. Perhaps the same thing might be happening in drug and alcohol services because the moment it is decided they have a mental health problem they wash their hands and here it goes. There might be a group of people who are left in limbo; nobody is willing to accept

> them. I think education, awareness programs, support to professionals in both areas is so important to address these issues.

Communication between both services was seen as a vital part in the successful treatment of clients with a co-morbid disorder. Participants expressed having little knowledge as to the availability of services and felt that this would change if both services worked more closely.

Illustration 1: Participant 7

> Also the other thing we talked about was the communication. Because they mostly deal with the drug stuff and we mostly with the psychiatric stuff, sometimes communication lines are not there.

Illustration 2: Participant 13

> So much has to do with communication and protocols these days. Making sure the left arm knows what the right arm is doing.

Participants felt that they were unsure how the drug and alcohol service works or what model they use.

Illustration 1: Participant 11

> I should get over and have a chat. I don't know how they operate. Whether they operate on more harm minimisationation and acceptance rather than … I really don't know much about it, how they go about their job.

Participants observed that clients try several different therapies or methods of drug control. If this is not successful, the client becomes despondent and professionals find it hard to motivate the person again. It was conveyed that psychiatric services should offer help and support to other services as they see drug and alcohol issues as a primary prevention area.

4.7.6 Summary

This section described professional frustration which was a large part of rowing against the tide. This frustration was evident with health professionals experiencing feelings of sadness, through to anger. Health professionals felt that this frustration was amplified by the lack of resources and services in the Grampians region.

4.8 THEME NUMBER 4: SMOOTH SAILING

Participants have previously described in this thesis their feelings toward and descriptions of dual diagnosis clients. The data also provides insight into participants' thoughts and feelings toward the treatment and availability of services.

TABLE 4. Matrix showing the three codes for Theme 4 Smooth Sailing.

Descriptive codes	Interpretive codes	Explanatory codes
Education is the key.	Importance of education for schools, professionals and the community.	Survival skills - Education to all members of the community.
Look at providing a specialist service. Specialist area requiring specialist skills.	Specialist service required for dd clients. Suggested services required for this region.	Survival skills - Development of community based teams for dd clients.
I would probably set up a small residential service.	Residential programs are required.	Survival skills - Development of residential services – inpatient/withdrawal/community/ residential.

During the interview several different options surfaced for dual diagnosis services, with the most common being the formation of specific teams, case management as opposed to the present shared structure and specific residential options. Participants

believe that you cannot run a rural/regional service with just one worker. They suggested that in order to create an appropriate dual diagnosis team the service would require several workers. Dual diagnosis was one area that participants considered required a lot of attention and it should be further addressed to help young people to feel less isolated than they presently seem to be. Professionals felt it was important that people who are trained to deal with both issues at the same time were available. Participants declared that they hoped dual diagnosis services continue to grow. The theme of smooth sailing is demonstrated below by the following comments from participants.

4.8.1 Survival Skills

4.8.2 Teams

Illustration 1: Participant 2

> I would like to see different age groups, some about my age, in their 40's who have been through that early age and know what it's like from their point of view. Staff in their early twenties who would get the other end of it. There would be a mixture of males and females because there are various issues so it's really important to have both. You would also be looking at needle exchange programs, … prevention stuff, and minimum risk; there are so many issues involved. So you need funding, staff, a core team that goes out into the schools.

Illustration 2: Participant 10

> I would set up a team of maybe three or four people. …That is if I have lots of money. I know that they are really working hard on it and doing a lot in terms of educating staff here that has been really helpful to staff. It's really good. It's been really helpful providing support for the sort of patients that we get in here to have someone to refer them to.

Illustration 3: Participant 10

> To have a dual diagnosis team that we can ring up and say we have got this person in here. These are the issues. Come in, do an assessment and help them with a follow up for when they leave.

Illustration 4: Participant 8

> The main thing I'd like to see are perhaps teams developed specific to dual diagnosis to manage these people. That is what is really needed. It is getting to be a bigger problem and it has become more common in … than it has been in the past. I think there must be funding around somewhere to help these people, because, at the moment they are in limbo. If they are not willing to seek help themselves then there is not much anyone can do about it.

One participant suggested an emergency on-call service. This would enable access to someone with drug and alcohol experience in the emergency department and would be accessed when a person presents under the influence of drugs. This service would be an additional option rather than the psychiatric unit being the only venue.

Illustration 1: Participant 4

> It's not appropriate even if they are drugged off their heads and you're worried about what they might do. … There should be somewhere where people with the primary problem being that of drug and alcohol could go as opposed to a psychiatric unit. - Because I don't think it's appropriate that these people end up with clients with seriously mental illnesses and the next morning they wake up and they go "Oh my god I'm in a mental hospital".

Participants suggest that the Grampians region do not receive enough resources. They believe that the service they receive now is good quality but they do not think it is complete. It was felt that if there were more staff, a team could be developed to care for individuals with a dual diagnosis. At present they are treated by the psychiatric services and probably do not need to be case managed, except they still have drug problems. A specific team would have provisions to take on a case management role. The present model is not feasible as there is one clinician in the region and this role is intensive. This situation was mentioned on several occasions.

Illustration 1: Participant 10

> Well you would have to attract staff for starters and being realistic obviously you would have more than one. You would have a structure where there is

probably more than one person. You would have to have someone responsible for the overall management I suppose.

Illustration 2: Participant 11

It is spreading a bit thin; I think I would sink money into clinicians on site. I think, maybe, a consultant that specialises as well. I would make it a specialised program, which would be nice. I suppose that if you had an endless supply of money that would be great, but with the economic rationalism that we work under it's not possible. You would just make it the brief of the clinician, yes but definitely educate the clinicians up. As we discussed before there is not a lot of information given to clinicians [in their training].

Illustration 3: Participant 8

I would have a specific team that could case manage these people. They would be well trained and set up to deal with them. They would know all resources and actually case manage them. I think consultancy is really good but in the end on top of our other workload, it's just more work for us. We are not only managing their mental illness but also then we have got the drug and alcohol side as well. I really think that a service should be set up similar to an MST [Mobile Support and Treatment Service] where you have got low caseloads. You can pick up these people from the start of the problem and see it through.

4.8.3 Accommodation

Options that participants felt would help people with a psychiatric disorder who are also misusing drugs were inpatient and residential services. They see the lack of suitable accommodation as an enormous problem for these people who are at a real risk of homelessness as a result of their complex needs, with the problem exacerbated by the refusal of many services to accommodate them. Frustration of participants interviewed was evident when discussing accommodation options.

Illustration 1: Participant 12

I think accommodation is a huge factor. I know there is counselling there [in drug and alcohol]. There is a whole group of clients who don't want that. They're the clients who we are not sure what to do with exactly because you know with the client I case managed I felt like he was heading towards a really early death and I felt really helpless and powerless. You could see where he was headed but there was nothing you can do much to stop it. If you had the option of a residential facility a clinician could structure a clients life.

Illustration 2: Participant 3

> If I had a magic wand and unlimited money I would probably set up a small residential service for dual diagnosis. … It would probably have about four to six beds with an outpatient component to it. You would have to have a psychiatrist there that has an understanding of dual diagnosis. It would have to be well resourced. You would need to employ people at a very high level perhaps an RPN 4 to give that position some sort of creditability. I think if you set up a small centre it would have to have creditability within the whole region if you want it to be taken very seriously.

Illustration 3: Participant 1

> If you have got say a six bed residential area you are probably going to need about a total of about ten workers to provide a twenty-four hour service. Maybe over-night might be an on-call service, but you need to have enough staff to be able to cope. You require sufficient resources to cover costs of consultants, staff training and resources. You need to pick up a person who is out of control and in a crisis and say hang on we'll put you in here for a little while to regain control.

Participants felt that the advantage of a residential service would be the ability to provide differing strategies of treatment. Firstly, it could be used to limit client access to money. It was suggested that an organization like the State Trustee Administrators could be used to reduce financial access. Participants felt that the key to a dual diagnosis client's substance abuse is treatment of their psychiatric condition. In order to maintain this stability, psychiatric reviews and monitoring of their medication is required. It may also require a more drastic solution such as a community treatment order so a person is required to take their medication and remain compliant to the treatment, which could be received in a residential service.

Some participants interviewed believed that the region needs to provide at least a 10–bed-based withdrawal service for dual diagnosis clients. An option given was to look at providing a specialist service with a wider scope.

Illustration 1: Participant 12

> You would have an inpatient facility that would offer service access to other areas like Bendigo, Warnambool and Geelong.

But it was felt that a specialist inpatient unit was the more realistic option.

4.8.4 School Education

Health professionals believed that more education in schools was required, as one of the concerns expressed by many participants was the ineffective transmission of the drug message to pupils at school. It was suggested that school education programs neglect to mention the correlation between drugs and mental illness. The researcher believes that if school education programs were designed to provide a greater understanding of drug misuse and mental illness to students, future admissions to mental health services could possibly be prevented, thus reducing the frustration and powerless feelings experienced by health professionals. This would also create a greater understanding by other members of the community by inadvertent teaching by pupils to their parents.

Illustration 1: Participant 2

> You've got the safe sex talk, this is the safe drugs talk you know it goes hand in hand. … Just saying smoking dope is bad, is going to get you nowhere. Somehow trying to get the message across about the correlation between drugs and mental illness. These are the figures, these are the facts, these are a few case studies, whatever it takes to get that message across. It's really, really important.

Illustration 2: Participant 5

> I think it is important to skill young children or young people to acknowledge when their friends may actually use drugs and realise the obvious difference in the person when they are using drugs. I think that you could teach the students to be early identifiers of drug use.

A need exists for extra funding to finance an increase in staff to enable the establishment of a core team that is able to venture out into all schools. This

education issue was seen as a major concern, not only for the clinicians but also for the community.

Illustration 1: Participant 7

Education is the key but if it is all hush hush you know everybody hides the drug issue then the kids seem to be attracted to it more. But if they are aware of drugs different names for drugs, what they look like, what their effects are and how easily it is to get sucked in makes a big difference. I don't think ads on telly are enough.

Illustration 2: Participant 9

> Nobody is willing to accept them so I think education, awareness programs, support to professionals in both areas is so important to address these issues.

Illustration 3: Participant 4

> As a case manager education is such a vital part of people paying attention to their mental health in my book. I mean obviously they are never going to have excellent mental health when they continue to use substances that make them psychotic or keep them depressed or whatever the issue is.

It was suggested that education for parents with adolescent children was important, as it would enable them to provide drug information to their children.

4.8.5 Staff Training

Health professionals believe that they require drug and alcohol training to be covered in their initial course, which would provide a basic understanding, with an option to follow up with postgraduate education. Professionals indicate that before they enter the workforce, they need an understanding of drugs so they are better able to relate to the issues. Many participants emphasised the frustration incurred by feeling they were under prepared.

Illustration 1: Participant 2

> Oh I suppose most of the time it is difficult for us to know how much is the effect of whatever drugs they've been taking and how much is psychosis. It takes time for us to understand where one begins and the other ends. Where they merge can be difficult.

This preparation was described as totally inadequate. Many participants believed they were completing a straightforward assessment when instead they found a person under the influence of substances causing hallucinations and other psychiatric symptoms. More experienced participants were unsure of the state of present training but had not observed any evidence of dual diagnosis issues among student objectives. They indicated it should be included in the course curriculum so the student could receive an understanding of terms used in drug and alcohol services. It was suggested this knowledge would aid in equipping professionals with the relevant knowledge so they may be more prepared in advising people on dual diagnosis issues.

Illustration 1: Participant 4

> I think given that the way the community services are going I think it should be part of the training. I think it's necessary for people to know about this stuff now because people are using drugs more and more, recreationally whatever that's the way society seems to be headed.

Illustration 2: Participant 3

> I think the answer probably is firstly to start with people who are currently in the education system being trained, as in Bachelor of Nursing. These people need exposure to the concept of substance abuse and mental illness. Often [they] go together and you can't treat them independently so we start at the grass root level and as you move through I think you need to have some extra curricular experiences … workers need to be able to work with people who have a dual diagnosis and see that they are actually people that actually have got needs.

Health professionals also felt that it would be advantageous to provide a specific course designed for professionals to learn about the effects of drugs and alcohol on a person with a mental illness.

Participants stated that if the health services were going to persist with one dual diagnosis clinician, it needs to be one person on a full-time basis attached to each rural mental health service. By following this model, the worker would be able to have time to educate clinicians, community, schools and also provide education to

clients. This would ensure there were more clinicians educated on dual diagnosis issues in all areas. The structure at present was described by one participant as 'More than less' (Participant 11). When asked to elaborate more on what is meant by 'more than less', the reply was 'they are not just inadequate they are really inadequate, there is a real need for it' (Participant 11).

4.9 Summary

In the course of these interviews important information emerged regarding the perceptions of health professionals who care for individuals diagnosed with a dual diagnosis. The chapter highlights the experiences of health professionals and demonstrates a complex range of emotions, from feelings of being challenged, satisfaction with role, through to anger, frustration and dissatisfaction. These themes highlight a lack of preparation, treatment options, services and finances to rural/regional services. The description health professionals used were feelings of frustration, powerlessness and professional inadequacy. This section concluded with a description by health professionals of a "wish list" for dual diagnosis services.

The final chapter will discuss the implications for health professionals and the mental health services and present a number of recommendations, which may contribute to more effective service delivery to clients with a dual diagnosis thus reducing feeling of frustration, sadness and anger expressed by health professionals.

CHAPTER FIVE

DISCUSSION, RECOMMENDATIONS AND CONCLUSION

5.1 Introduction

For the first time in regional Victoria research has been undertaken to explore health professionals' experiences while caring for clients with a dual diagnosis. The research question formulated at the commencement of the study and detailed in chapter one was used to gain an understanding of this issue. The question was "What are the lived experiences of mental health professionals who care for clients with a dual diagnosis?"

Chapter four provided a description of mental health professionals' experiences whilst caring for clients who are diagnosed with a mental illness and an associated drug misuse problem. The discussion covered in Chapter five is directed toward the research question with recommendations and a conclusion following. This chapter discusses the many emotions displayed by health professional and the effect drugs have on this already difficult job. The recommendations suggested aim to reduce the identified concerns, frustrations and difficulties health professionals have unearthed in this study while caring for dual diagnosis clients.

5.2 Discussion

5.2.1 Health Professionals' Emotions

Throughout the first three themes described previously in chapter four, health professionals expressed a variety of emotions relating to the care of clients with a dual diagnosis ranging from feelings of frustration to sympathy and sadness. These

emotions contribute to many conflicts which influence the professional's judgement and coping responses, resulting in difficulties with deciding how best to treat clients with a dual diagnosis.

5.2.2 Frustration

Frustration was a feeling expressed throughout the interviews, whether communicated verbally or non-verbally. An example of this frustration was the description of the large number of clients whose main focus is where their next drug would come from and who were seen as preoccupied with this situation to the detriment of their psychiatric welfare. Dual diagnosis clients were observed to have individual drug-seeking behaviour displaying various negative traits. The care of a client with a dual diagnosis is described as frustrating because the treatment response is, among other things, very slow. It was suggested that it was easier to treat a person with a diagnosis of schizophrenia, as the response to treatment was more positive. Visiting case managed clients at their place of abode was seen as problematic because of the risk involved with unpredictable states of intoxication. The researcher maintains 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. This frustration contributes to a professional's negative attitude to dual diagnosis clients.

According to Kalat (1993) a frustration-aggression hypothesis exists which identifies that most, if not all, angry and aggressive behaviour is as a result of frustration. Milleken (1987) believe that there are many ways frustrations may be evoked and describes a person whose job is not providing satisfaction as being frustrated. The researcher believes this may be one of the reasons for the frustration of health

professionals in this study as the lack of support to regional/rural health professionals is mentioned on many occasions. Milleken (1987) states that individuals react differently to frustration but it generally involves withdrawal or hostile behaviour. Hostility toward the service was observed by the researcher during interviews in this study. A combination of negative emotions including anger, fear, anxiety, or resentment also plays an important part. The researcher views 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 and, at worst, the professionals becoming verbally or physically aggressive. The researcher believes that if the lack of education and inadequate services are not addressed, this frustration may lead to aggression, which is a concern to the researcher. Milleken (1987) believes that health care providers' attitudes affect their adjustment, that is, if they have an intense prejudice they may find it difficult to work with certain clients. If the professional feels their work is worthwhile, this will help them to find job satisfaction.

Another cause for frustration incurred by health professionals was the lack of community understanding of certain drugs. Inaba and Cohen (2000), state that cannabis is still viewed as harmless by the community, especially younger people, and it was recognised that the strength of cannabis has increased since the 1960s. This lack of understanding by the community makes health professionals feel frustrated and unsupported. The frustration experienced by health professionals appeared to increase 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. As stated

by several participants, some GP's themselves appear frustrated and possess a limited understanding of dual diagnosis issues which unfortunately sometimes result in negative outcomes.

5.2.3 Attitudes

Health professionals' attitudes seem to stem from their level of fear, frustration and lack of preparation and education. It was suggested by Kalat (1993) that misinformation and a lack of understanding contribute to this situation. Kalat (1993:688) describes an attitude as "a learned like or dislike of something or somebody that influences our behaviour toward that thing or person". Attitudes are a mix of beliefs, feelings and behaviours. Milleken (1987) believes that many attitudes are learned by the imitation of adults in early life, while others are developed unconsciously through experiences. Attitudes can be developed unconsciously through certain experiences. The researcher believes this is a concern with the care of dual diagnosis clients, as past experiences, poor treatment supports, lack of preparation and education may lead to negative attitudes by health professionals.

Although some participants conveyed a positive attitude in words, an underlying prejudice became apparent when not directly answering questions related to their attitudes. A professional's attitude was also influenced by the client's drug-seeking behaviour. An example of this was the client using deception to obtain their prescribed drug of choice. The research also showed that professionals observed how clients have negative attitudes towards themselves as both illnesses have a stigma attached and this creates a complex negative attitude.

5.2.4 Sympathy

Another emotion displayed by health professionals was sympathy. Health professionals demonstrated this by displaying concerned emotions and feelings toward the client's predicament of having both disorders. The client faces a double stigma – they are unable to misuse drugs with the same results as other members of the community because of mental deterioration and its consequences.

5.2.5 General Practitioners

Participants also recognised that frustrations incurred by GPs were reflected in their treatment of individuals with a dual diagnosis. Younger GPs were viewed as more understanding than the older generation of GPs. The participants suggested 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 the Australian National Council for Drugs (ANCD, 2002). A need was identified for more GPs and health professionals in the Grampians region.

5.2.6 Support

In the past drug issues were not identified as prominent in psychiatric services. Clients experiencing a drug and alcohol problem were referred to specialist alcohol and other drug services. Psychiatric services' policy is now changing and recognising and treating more of these people. Findings show that health professionals experience a degree of resentment at having to care for this group of clients. The policy has not altered the education on dual diagnosis and consequently health professionals feel that

they lack the necessary skills and knowledge, and that with the change in policy a more intensive program for the preparation of health professionals should have been introduced. When treating a dual diagnosis client, the health professionals found that these clients were slow to respond, that some would sabotage the treatment and that there was a general lack of effort and motivation in their treatment. These situations made the professionals feel helpless and powerless, leading them to believe there is a need for a specialised agency. A general consensus was that the treatment of a client diagnosed with schizophrenia was straightforward whereas the management of the client with a dual diagnosis was more complicated. This situation saddened many professionals but they acknowledged that sometimes their efforts could be rewarding.

5.2.7 Health Professional – Preparation and Education

Participants from all disciplines believed that their initial training was limited in regard to dual diagnosis. Some participants found that the care they provided was more of a trial and error process. They describe feelings of nervousness, naivety and being overwhelmed when confronted with caring for 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. They believed that professionals should be provided with knowledge and understanding of dual diagnosis options prior to commencing employment as health professionals in the psychiatric services. It was also mentioned that a postgraduate program on dual diagnosis is required for professionals who choose to specialise in the field of psychiatry. No variance in training deficit was identified between hospital- and university-trained professionals.

Owens, Gilmore and Pirmohamed (1999:261) believe that nurses are underutilised in the management of clients who misuse alcohol. They conducted a postal survey involving 132 practicing nurses in Liverpool, England. The response rate was 77% and the findings illustrated a knowledge and skills gap. The results show that only one in two women and one in three men are receiving the correct advice on alcohol consumption. The majority of nurses in this study requested further training. The research shows that nurses are happy to become involved in treatment but it is important to ensure that appropriate training is provided. One of the questions asked during this survey was "if patients with alcohol-related problems were cared for in the community, would respondents be happy to be involved in their care?" The majority felt that they were happy to be involved in the person's care if adequate training was given.

Sitharthan et al. (1999) mentioned how clients with a dual diagnosis rarely attend a traditional drug and alcohol service. The authors believes that the training of psychiatric staff to enable them to screen and provide integrated interventions would be of use. A clinical program in the West Sydney Area Mental Health Service was provided with all clients between the ages of 16 and 65 who were able to understand and speak English (only for this trial) who were admitted to the West Sydney area mental health catchment area were routinely screened for alcohol and other drug use. For this trial, they also excluded clients with no fixed abode and those who discharged themselves against medical advice within three days. Rather than recruiting specialists, all ward staff were appropriately trained. The focus of the training program was on current literature of dual diagnosis and staff were trained to facilitate effective assessments. Sitharthan et al. (1999) reported that there were several

attractive features of this program, namely a) Staff may be trained in a minimum period of time b) Clients received treatment in the same setting and c) Clients could be offered substance treatment in conjunction with normal psychiatric treatment. This reinforces the belief of the researcher that the Adult Acute Unit (AAU) could be used to treat both disorders. The findings of Sitharthan et al. (1999) regarding the limited time it takes to train staff compared to the recruitment of specialists would be appealing to the management of Mental Health Services.

Bourke (1995) mentions how the task force on training in Canberra, Australia, during 1986 produced a report that recommended that a minimal standard of nurse training in alcohol and other drug fields be set up in tertiary institutions. She reports that ten years on, these recommendations have not yet been implemented. To the researcher's knowledge these recommendations are not in practice in Victoria in 2003. Halliday (2002) reports that drug and alcohol workers believe that there is a need for extra training resources and for more workers to take responsibility to engage and work with this client group (dual diagnosis).

5.2.8 Implications for clients

What emerged from the data through the majority of themes was the immense impact drug misuse has on clients within the Grampians Psychiatric Services. Health professionals described dual diagnosis clients as complex, with an increased instability and a greater potential to become violent, thereby requiring increased doses of psychotropic medication. The misuse of alcohol and other drugs was reported by health professionals to increase psychiatric symptoms. Berglund and Ojehagen (1998) supports this finding by stating that dual diagnosis clients who use alcohol have more

severe symptoms than clients who do not misuse alcohol. Barlow (1999) found that the use of cannabis was associated with elevated levels of psychotic symptoms. Also Poole and Brabbins (1996) mention how the use of drugs, in particular cannabis and stimulants, are a precipitant to the relapse of an existing psychosis.

Health professionals also described dual diagnosis clients as having little insight. The majority of clients did not identify their drug use as a problem, which made caring for these groups of clients more challenging. They were described by health professionals as difficult to engage and treat, a view that is supported by many authors namely, (Banks & Waller, 1988; Caton et al., 1994; Conner et al., 1995; Drake et al., 1993; Drake & Wallack, 1989; Kavanagh et al., 1998; Osher & Kofoed, 1989; Rassool, 1998; Warner et al., 1994). Professionals' first contact with a drug-misusing client is often as a result of the client experiencing a crisis, consequently health professionals found it difficult to identify which was the primary disorder. The literature has emphasised the importance of ascertaining the primary disorder to enable the clinicians to plan and implement the appropriate treatment pathway. According to Bordwine-Breeder and Millman (1997) it is necessary that clinicians attempt to ascertain which disorder originated first. Lanning-Smith (2001) suggest that a complicated diagnosis of mental disorder and substance misuse is often the result of an unwillingness by health professionals to pursue questions of substance abuse as they feel under-prepared.

The current study identified that many of the reasons given to health professionals by clients regarding their drug use were similar to that of the general population. The results in this research support findings of psychiatric client drug use by McDermott

and Pyett (1993). Table 4 displays a comparison of findings from the current study (Drugs on the Mind), McDermott and Pyett (1993) and Inaba and Cohen (2000). This table displays reasons for drug use by individuals in the general population. The introduction of drugs only complicates symptoms and are made more complex when a mental illness is added, resulting in an increase in health professional frustration.

Table 4 – Reasons for drug use

Drugs on the mind (2002)	McDermott and Pyett (1993) Psychiatric population	Inaba and Cohen (2000) General population
Socialisation	Socialisation	Social confidence
Pleasure/enjoyment	Excitement/ increase	To get high
Recreation	Recreation	Curiosity/availability
Peer pressure	Peer group pressure	Friends/peer pressure/
Acceptance/belonging	Feelings of belonging/ confidence	oblige friends
	Motivation/creativity	
Notoriety	Rebellion/attract attention	Competitive edge
Habit		
Killing time	Self-medication/ decrease	
Self-medication -	anxiety	Self-medication/
anxiety depression	Avoidance/escape	anxiety controlled
	Decrease side-effects	
Coping with stress		
Symptom control	Induce sleep	
/relief of		Confidence/ life
symptoms/hide		problems/isolation
symptoms	Decrease self-consciousness	
Relaxation	Spiritual needs	
Physical and psychological addiction		
Easily lead		
Bored		Boredom relief altered
Pain relief/sexual assault	Pain reduction	consciousness
		Energy pain relief
		Oblivion

Evans and Sullivan (2001) mention that programs to treat individuals with a dual diagnosis are limited. Drug and alcohol, along with psychiatric services, are separate or at best have one dual diagnosis consultant.

5.2.8.1 Resources

Health professionals stated that for dual diagnosis services to advance, an increase in funding for mental health and alcohol and other drug services was essential. This would assist the introduction of services required to close existing gaps and improve access to dual diagnosis and alcohol and other drug services. Participants believed that the development of a team of dual diagnosis clinicians requires consideration. It was also conveyed that if services wish to continue with a similar structure, they must consider one dual diagnosis clinician for each section of the regional area mental health services. Health professionals believed that this would increase treatment and educational options.

5.2.8.2 Alcohol and other drug services

Limited drug and alcohol options available in the Grampians region were also identified and described as inadequate this lack of services only adding to a health professionals' frustration. Health professionals described withdrawal and rehabilitation services within this region as non-existent, which was considered to be problematic. These services were viewed as the greatest rural/regional requirement for both dual diagnosis clients and the general community. It was suggested that a residential service would provide various treatment options and would be able to limit financial access of clients and ensure medication compliance, therefore decreasing the incidence of relapse.

Moos, King and Patterson (1996) propose that there is a need for a non-acute residential care facility for clients with a substance use problem. This view arose from two trends. Firstly, clients are presenting with a more severe and chronic substance misuse disorder, with a large number of these clients having a comorbid psychiatric disorder. Secondly, an emphasis on reducing the cost of healthcare has led to a decline in the length of acute inpatient stays and causes extra pressure to find cheaper care alternatives. Moos et al. believes that this finding justifies the need for residential services in metropolitan areas of the USA. The current research (Drugs on the Mind) has unearthed information that the same situation exists in this rural/regional area. The article states that there has been extra pressure applied to find cheaper alternatives. The researcher suggests that the availability of residential services in this region would be a cheaper option than purchasing bed days from Melbourne.

5.2.8.3 Housing

People with dual diagnosis often cannot engage in treatment because they lack suitable housing. Their substance misuse and erratic behaviour often leads to instability and homelessness, making stable housing a critical problem. Housing programs for clients with a psychiatric disorder often exclude substance misuse, while the reverse happens in drug and alcohol services. As a result, clients with a dual disorder tend to migrate to homeless shelters or undesirable living situations such as jails, hospitals or substandard housing. This lack of suitable living situations is a major problem for these individuals (Drake, Teague & Reid Warren 111, 1990; Fox, Fox & Drake, 1992). Clenaughan, Rosen, Van Bysterveld, Friel and Spilsbury, (1996) describe a residence that was opened in 1995 for people with a dual diagnosis in the

lower North Shore area of Sydney, Australia. The principal aim of this home was to provide rehabilitation and to minimise substance misuse. The house is referred to as a damp house. In a damp house, drugs and alcohol are excluded but the person is not evicted if they use or misuse substances, offering a safe, therapeutic and supportive living environment. This house was modeled on damp houses in the New Hampshire program (Fox et al., 1992). The researcher's initial thought was that this service would be ideally suited to this region, however, the funding situation would limit this. A solution would be to replicate Community Care Units (CCU) on a damp house model to provide a similar structure.

Wilens, O'Keefe, O'Connell, Springer and Renner (1993) tell of Andrew House, a twenty-six bed inpatient unit for medical detoxification for alcohol and other drug treatment. The facility is managed on a voluntary basis. Wilens et al. (1993) believe that the voluntary nature of the unit inspires clients to be responsible for the control of their substance misuse. Wilens, O'Keefe, O'Connell, Springer and Spencer (1993) feel that units for dual diagnosis clients are a safe and cost-effective form of treatment for this dysfunctional and chronic population. The researcher believes this may be an option in the Adult Acute Unit (AAU) of Ballarat where both disorders (alcohol and other drug misuse and mental illness) could be treated. Also the service described by Mowbray et al. (1995) and Shilony et al. (1992) may also be ideally suited to a rural/regional area.

The researcher believes that this study has indicated the need for a funding increase to ensure that appropriate care is provided to individuals diagnosed with a dual diagnosis in the Grampians region. A lack of resources has been identified as having an effect

on various emotions of the health professional, along with their initial lack of preparation and support, which has a major impact on the standard of client care. The NSW Health Department (2000) reports that education for carers, community and consumers should be increased. This will promote a better understanding and increase the ability of services to meet the complex needs of dual diagnosis clientele. The NSW Health Department (2000) recommends that in order to build on the present knowledge of health professionals, dual diagnosis courses should be incorporated with ongoing assistance including: -

Education and training between local services

Non-government and government training for all areas

Divisions of general practice to be provided with education packages

Access to supervision whether formal or informal.

In order to ensure greater outcomes for clients with a dual diagnosis and to reduce health professionals' negative feelings, frustrations, anger and feelings of a lack of power the researcher provides the following recommendations.

5.3 Recommendations

Throughout the interviews feelings of frustration, despair, helplessness and hopelessness were expressed. These emotions resulted from a lack of resources and services in the Grampians region. Dual diagnosis education was also highlighted as limited in the training of health professionals. The following are some recommendations to overcome these problems.

Residential services were seen as a vital part of the treatment of a client with dual diagnosis. Changes to the present psychiatric service structure are recommended to reduce health professionals' adverse feelings.

5.3.1 Withdrawal Unit

A unit to provide drug and alcohol detoxification may be established within the current AAU or in close proximity. This development may prove to be financially viable, as the admission rate should decrease over time, with shorter admission stays becoming more likely as the service becomes proactive. If this recommendation is undertaken, specific data needs to be collected which should be used to evaluate the effectiveness of the service.

5.3.2 Residential Units

The researcher suggests that a radical new focus for Community Care Units (CCU) be developed by trialing a new management structure catering for not only psychiatric rehabilitation but also drug and alcohol rehabilitation. CCUs were developed to provide accommodation and rehabilitation to individuals with a serious mental illness. These units were initially developed for clients who had traditionally been managed in long-term wards of mental hospitals. A specific program and structure for the implementation of this program should be developed. The damp house model may also be incorporated into this service.

5.3.3 Community Dual Diagnosis Services

Teams specialising in dual diagnosis need to be developed and strategically located in all regions. A large number of clinicians would be required for such a team in the

Grampians region to ensure an "intensive approach". An alternative to this would be the up-skilling of present staff with a co-ordinator 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. The development of a "train the trainer" model based on the stages of change model (Jarvis et al., 1995) must be developed to provide necessary skills and direction to rural/regional psychiatric clinicians.

5.3.4 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. However, the researcher questions the cost-effectiveness of this implementation given the majority of the students completing training courses have no desire to specialise in this field. The researcher believes that an introductory information module on alcohol and other drugs included in generic training courses would address this more cost effectively. A dual diagnosis component should be incorporated into graduate programmes for health professionals working in psychiatric services. If these services do not exist they require development. This initial training could be followed by access to a postgraduate course for professionals wishing to specialise in this field. The exchanging of staff from D&A and psychiatric services may also be advantageous.

5.3.5 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 closes 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.

5.3.5 Future Studies

As this small study has a limited sample (13 participants), findings and recommendations may only be confined to the Grampians region, but the researcher believes that these issues require further exploration and recommends that other areas initiate further studies which have a clinical influence which may generalise these results.

5.4 Conclusion

This research has identified many negative experiences and feelings of health professionals. This research also concluded that dual diagnosis was prominent in the Grampians region and health professionals felt they were under prepared, 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 health professionals were often placed in embarrassing situations - professional humiliation. This affected the attitudes of health professionals toward this clientele resulting in a

feeling of inadequacy and a lack of power. Clients with a dual diagnosis case managed by GPS tend to be more violent, possess no insight, often relapse and are not ready to change, this adverse behaviour creates a feeling of helplessness experienced by health professionals complicating the "sick role".

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 a major increase in funding. If funding for this region was increased, a core team could be established that would provide education to schools, clients, parents, health professionals and general practitioners. The results of this research unearthed the need to render professional support to clinicians caring for clients with a dual diagnosis in rural/regional areas. The establishment of dual diagnosis services in rural/regional areas requires innovation and creativity in recognising, acknowledging and understanding the demands of the vast rural/regional area. The development of a specialised team in rural regions requires the availability of appropriate funds to support a fully-effective team, otherwise a sub-standard team will exist. The model suggested by Osher and Kofoed (1989) is intensive, with the clients being seen several times per week. The vast area involved in addition to the lack of clinicians (one) make this model impossible at present. Therefore, the development of services based on the needs of the region rather than services appropriate to metropolitan areas is necessary. The positive finding of this research is that health professionals at the GPS can be influential in the development of treatment options in this region.

This research has concluded that rural/regional areas have the same needs as metropolitan services. Therefore, the above recommendations should be applied to this region to reduce health professionals' frustrations and negative emotions. The researcher believes that care has to be taken with the content of generic courses for health professionals. The researcher suggests 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 the 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.

The researcher endeavoured to present the findings in a way, which enables the reader to follow the thoughts of the participants. The validity of this research was obtained by initially returning all transcripts of the interviews to the relevant participant for clarification and to change unintended comments. The raw data were then transformed into themes using metaphors, which were then discussed with the participants who felt that the interpretation of these themes reflected their thoughts, feelings and experiences. A possible limitation to this research is that the participants may be reluctant to criticise shortcomings of other psychiatric professionals or the present dual diagnosis service. The researcher being a fellow health professional may also inadvertently influence the findings. As mentioned previously, the aim of this study was to identify and describe the views, thoughts, feelings and observations of health professionals in the Grampians Psychiatric Services/Ballarat Health Services while caring for clients with a dual diagnosis. This research successfully answered the research question - What are the lived experiences of health professionals who care

for clients with a dual diagnosis? As a result of this study the researcher was able to make recommendations, and some of the findings from this study have already been introduced to the psychiatric services in this region. For example, a policy for drug using clientele admitted to the Grampians psychiatric services, Adult Acute Unit was developed and introduced in 2002. This has ensured that a more appropriate treatment pathway has been provided and followed.

5.5 Visions of the future

The researcher believes that Victoria has taken an innovative position by establishing dual diagnosis teams. With greater education, understanding and preparation of health professionals, along with an increase in services, the researcher envisages that, in the future, individuals such as Paul (as described in the preface) will be provided with a high standard of care. Clinicians will not feel that they have to refer Paul to other services as their education and preparation will provide an understanding of his illness. Their feelings of inadequacy and frustration will diminish, ensuring a more accurate diagnosis and effective treatment. Paul will not be cornered into drawing the conclusion that "he must kill himself to be free of his living hell" (Lehman & Dixon, 1995 p.1).

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APPENDIX A

INVITATION TO PARTICIPATE IN RESEARCH PROJECT

DO YOU CARE FOR CLIENTS WITH A DUAL DIAGNOSIS?

If you are a health professional caring for clients with a dual diagnosis (co-occurring mental illness and drug and/or alcohol problems) then please read on. My name is Rod Soar. I am a registered nurse, employed as the Dual Diagnosis clinician with the Grampians Psychiatric Services/Ballarat Health Services. At the present time I am undertaking my Master of Nursing at the University of Ballarat. The requirement of this study is to complete a major thesis, and the topic of my research is dual diagnosis (co-occurring drug and alcohol and mental illness).

Dual diagnosis is a growing concern throughout the world. This research will help to enrich the growing body of knowledge about dual diagnosis and the experiences of health professionals who care for clients with this problem. Information gained will be used to provide recommendations for future development of dual diagnosis education and services.

I hope you will be willing to be interviewed for about 60-90 minutes about your experiences in caring for dual diagnosis clients, at a place and time that suits you best. The interview will be audio taped with your permission, and the information gained will be transcribed and a copy forwarded to you for clarification and modification. All participants will remain anonymous and the data will be aggregated in future publications. That is, you will not be identified to others at any stage of the research. You will be free to choose not to answer any questions during the interview and have the right to withdraw from the study at any time.

If you are interested in being interviewed please fill in one of the Expression of Interest form and post it to me via the internal mail. You can also call me (03) 5320 4100 or on mobile 0419 755 806 for more information.

I look forward to your participation in the study.

Yours sincerely,

Rod Soar

APPENDIX B

EXPRESSION OF INTEREST IN PARTICIPATING IN RESEARCH PROJECT

Yes, I would be interested in participating in an interview to discuss my experiences in caring for clients with a dual diagnosis.

Name: _____

Signature:_____ Date: _____

Address: _____

What is your profession? _____

Where did you train? Hospital ☐ University ☐

Telephone Number: Business Hours: _____ After hours: _____

On receipt of your acceptance to participate in an interview, I will telephone you to arrange a time and place to meet.

Thank you

APPENDIX C

UNIVERSITY OF BALLARAT

INFORMED CONSENT

Code number (if any) allocated to the participant

. . . .

Consent (fill out below)

I . . . . . of . . . . . .

. . . . . .

hereby consent to participate as a subject in the above research study.

The research program in which I am being asked to participate has been explained fully to me, verbally and in writing, and any matters on which I have sought information have been answered to my satisfaction.

I understand that:

- all information I provide (including questionnaires) will be treated with the strictest confidence and data will be stored separately from any listing that includes my name and address
- the interview will be audiotaped,
- aggregated results will be used for research purposes and may be reported in scientific and academic journals
- I am free to withdraw my consent at any time during the study in which event my participation in the research study will immediately cease and any information obtained from it will not be used.

SIGNATURE: . . . . . **DATE**: . . . .

APPENDIX D

PLAIN LANGUAGE STATEMENT

One of the concerns of mental health services is that there are a growing number of clients with a dual diagnosis that is a mental illness problem as well as a drug and/or alcohol problem. It has only been in recent times that health-care workers have been employed specifically to assess these individuals. These clients are difficult to treat, but little research has been undertaken to establish the effects of dual diagnosis clients on service provision or the education and training required by health professionals.

This exploratory project aims to describe the experiences of health professionals who work with dual diagnosis clients, as well as to ascertain their views on the resources and treatment modalities for the clients in the Grampians Region. Importantly it will describe their views of the education and training required for their roles. Approximately 15 health professionals will participate in this study. They will be employees of the Grampians Psychiatric Services/Ballarat Health Services. The research will be qualitative and will require detailed interviews of 60-90 minutes. Participants will be asked to describe their experience and knowledge in dealing with clients with a dual diagnosis. The data obtained will be analysed to enable the researcher to describe the lived experiences.

Information gained will be used to provide recommendations for future development of dual diagnosis services, and education and training of health professionals who deal with dual diagnosis clients.