D·D·U
DEVELOPMENTAL DISABILITY UNIT

DUAL DIAGNOSIS PROJECT

Chapter 4

Survey of Psychiatrists

Queensland Government
Queensland Health

THE UNIVERSITY OF QUEENSLAND

Chapter 4 Survey of Psychiatrists

1. Introduction

This Chapter analyses trends in a survey of attitudes, opinions and beliefs held by Queensland Psychiatrists about adults with an intellectual disability. Psychiatrists have a pivotal role to play in meeting the mental health needs of adults with an intellectual disability. They are important gatekeepers to the mental health system because of their assessment and diagnostic responsibilities, therapeutic interventions and treatment recommendations, including psychopharmacology.

This Chapter provides an overview of the methodology, survey tool used, data collection and discusses findings from a survey sent through the Royal Australia and New Zealand College of Psychiatrists (RANZCP) to Queensland Psychiatrists and Psychiatric Registrars in mid 2001. Inclusion of the views of Psychiatrists was considered essential to the Dual Diagnosis Project.

2. Rationale and Aims

The Project Team considered that an attitude survey was the most effective and efficient approach to involve Psychiatrists in the Dual Diagnosis Project. The survey aimed to identify the views of Psychiatrists when the patient had an intellectual disability. Dual diagnosis education and training priorities were also to be determined and prioritised.

Attitudes, opinions and beliefs held by professionals can act as a barrier to effective clinical responses. There can be both direct and indirect effects upon patients. For example, attitudes can directly influence the clinician: patient relationship or more indirectly influence the person with an intellectual disability through effects upon their relationships with other people (Beckwith & Matthews, 1995).

Understanding what Psychiatrists perceive about adults with an intellectual disability and what they need in order to improve clinical outcomes in this group, has the potential to improve service responses to adults with an intellectual disability, and in particular those with dual diagnosis. Findings from the survey were also expected to be helpful in targeting dual diagnosis education and associated information strategies to a range of stakeholders, not just Psychiatrists themselves.

2.1 Attitudes

The terms “attitudes, opinions and beliefs” have related meanings therefore they tend to be used interchangeably. Commonplace definitions exist although social scientists have developed more complex explanations. The classic definition suggests that an attitude is a mental or neural state of readiness, organised through experience, exerting a directive or dynamic influence upon an individual’s response to all objects and situations with which it is related (Allport, 1935). More simply, whether favourable or unfavourable, attitudes are evaluative judgements that are expressed in thoughts, feelings and actions towards a person or an object. Attitudes are multi-dimensional, involving affective, behavioural and cognitive components.

Reasons for the Project Team's interest in the attitudes of Psychiatrists relates to the relationship between attitudes and behaviour. Although it might seem logical that attitudes can determine behaviour, the exact nature of the relationship is a subject of conjecture (Beckwith & Matthews, 1995). Research suggests that attitudes tend to be poor predictors of behaviour (Festinger, 1964) although attitudes can have behavioural ramifications (Beckwith & Matthews, 1995). A range of factors may influence the inconsistent relationship between behaviour and attitudes, including strength of the attitudes, accessibility in memory and relevance of the behaviour in question. However, attitudes may be more likely to determine behaviour if those attitudes were formed through familiarity or personal experiences (Fazio & Zanna, 1981).

Australian research has suggested that values are implicated in attitude formation. Values provide a structure for organising attitudes and have the following characteristics (Feather, 1991):

- consist of general beliefs about desirable behaviour and goals;
- involve goodness and badness and an "oughtedness" quality (unlike wants and needs);
- provide standards for evaluating actions, justifying opinions and conduct, planning behaviour, for deciding between different alternatives, engaging in social influence and presenting ourself to others;
- organised into hierarchies for any given person and their relative importance varies over time; and
- vary between individuals, across groups and cultures.

It is also worthy to note that concerns about mental health professionals expressed by consumers and carers may focus upon attitudes and values rather than deficits in knowledge and skills. The Report of the Evaluation of the National Mental Health Strategy (1997) advised that consumers and carers identified the attitudes of mental health professionals as the main source of stigma and discrimination that they experienced.

Whilst acknowledging that the relationship between attitudes and behaviour is complex, the Dual Diagnosis Project Team recognised that attitudes do play a role in the behaviour of clinicians and professionals. Attitudes and belief systems can ***influence*** behaviour. Understanding perceptions about people with an intellectual disability could provide information about current clinical challenges faced by Psychiatrists. The identification of misconceptions or problematic approaches could be identified and targeted for future interventions. Strategies for change would be driven by factual insight rather than conjecture. At this time, additional benefits included:

- promotion of the critical roles played by Psychiatrists in the mental health assessment and treatment of adults with an intellectual disability,
- assessment of the culture of psychiatry (the "mood") towards adults with an intellectual disability;
- scan of the clinical environment of Psychiatrists today when working with adults with an intellectual disability, as well as in the future; and
- individual opportunity to be involved, to voice a personal opinion, identify needs and gaps, anonymously and confidentially.

3. Survey Instrument

The survey instrument used was a 28 item self-administered questionnaire featuring multiple choice and open-ended questions. The questionnaire was comprised of five sections that sought:

Section 1: Information about adults with an intellectual disability seen by the Psychiatrists within the last six months;
Section 2: Responses to 18 statements of opinion regarding the management of adults with an intellectual disability (scored using Likert scales);
Section 3: Recommendations regarding strategies for improving mental health and community based services for adults with an intellectual disability;
Section 4: Demographic information regarding the respondents; and
Section 5: Details regarding training and education needs, including preferred presentation mode and venue.

The tool used was derived from a questionnaire that was used to surveyed the attitudes of Psychiatrists to adults with an intellectual disability in Victoria during 1995 (Lennox & Chaplin, 1996). Revision of the Victorian questionnaire involved minimal changes to the original questionnaire including modified language and additional questions regarding training and education preferences. The questionnaire used in the Dual Diagnosis Project was trialed with staff from the Baillie Henderson Hospital, Toowoomba. This hospital was chosen because there are a number of adults with an intellectual disability living here.

4. Method

The questionnaire was mailed on two separate occasions to Psychiatrists and Psychiatric Registrars practicing within Queensland, with the assistance of the RANZCP (Queensland). The mail outs occurred approximately six weeks apart, during 2001.

The College was provided with the surveys and subsequently addressed each envelope to ensure confidentiality. The Project Team extend their sincere thanks to Dr Eileen Burkett and the RANZCP, for their assistance in the survey. The RANZCP advised that the survey was mailed to 306 Psychiatrists and 104 Psychiatric Registrars across Queensland. Eight surveys were returned due to incorrect addresses or had moved from known addresses. A total of 410 surveys were mailed on each occasion.

The survey did not specifically seek identifying details of respondents. However, respondents were given the choice of providing identifying details if they had a special interest in adults with an intellectual disability and were interested in further contact or follow-up.

Each questionnaire was accompanied by explanatory information regarding the purpose of the survey and the Dual Diagnosis Project. Brief information regarding the survey and the project was posted in the Royal Australia and New Zealand College of Psychiatrists (RANZCP) newsletter (included in Appendices). Data from the returned questionnaires was entered into a secure database. The SPSS statistical program was used to analyse the responses.

5. Results

The Dual Diagnosis Project team received 177 completed questionnaires, a response rate of 43% from the mail out (n=410). There were 140 responses (46%) from Consultant Psychiatrists (n= 306). 35 or 34% of Psychiatric Registrars responded (n=104). Only 2% of respondents (n=3) did not indicate their appointment status.

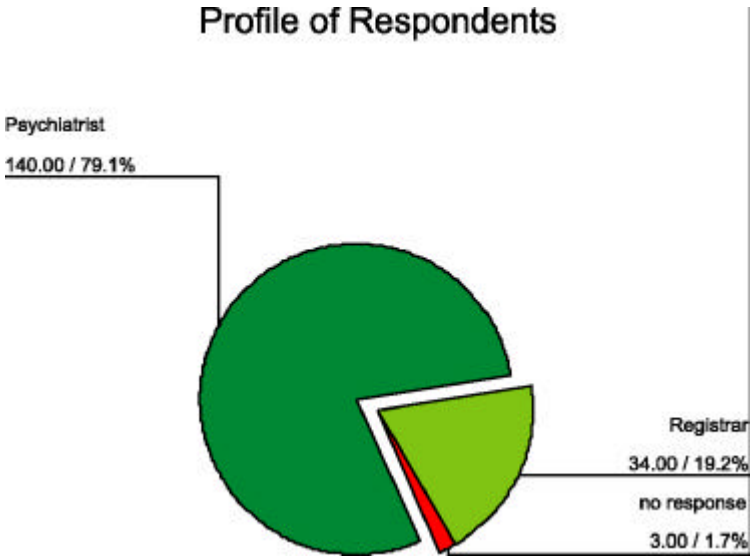
The response rate may have been influenced by the accuracy of the address list provided by the College. In particular, because of state wide training obligations, Registrars tend to be more mobile than Consultants. Another possible reason for the response rate may relate to failure by Adolescent and Child Psychiatrists to respond eg they may have considered a response inappropriate in light of the survey being targeted at psychiatric treatment of "adults" with an intellectual disability. Anecdotal evidence suggests that Adolescent and Child Psychiatrists could remain involved in the treatment of patients who move from childhood to adulthood because of limited alternatives for referral. Alternatively, interest in the topic, relevance of the topic to their practices and general problems associated with survey completion and return, may have had an impact upon response numbers.

5.1 Profile of Respondents

Results reported in this Chapter combine responses from Consultants and Registrars. It is however, important to recognise that the majority of responses reflect the views of Consultant Psychiatrists. Figure 1 demonstrates that 79% of respondents were Consultant Psychiatrists (n=140), with the remaining 19% of the sample comprised of Psychiatric Registrars (n=34).

The majority of the respondents were male (97 males). There were 73 female respondents. Six respondents did not indicate their gender. In recent years women have comprised approximately half of all medical graduates and similarly, a high proportion of applicants for psychiatric training are women (Adler & Mathieson, 1999). Consequently, female Psychiatrists may be under-represented in the sample.

Figure 1



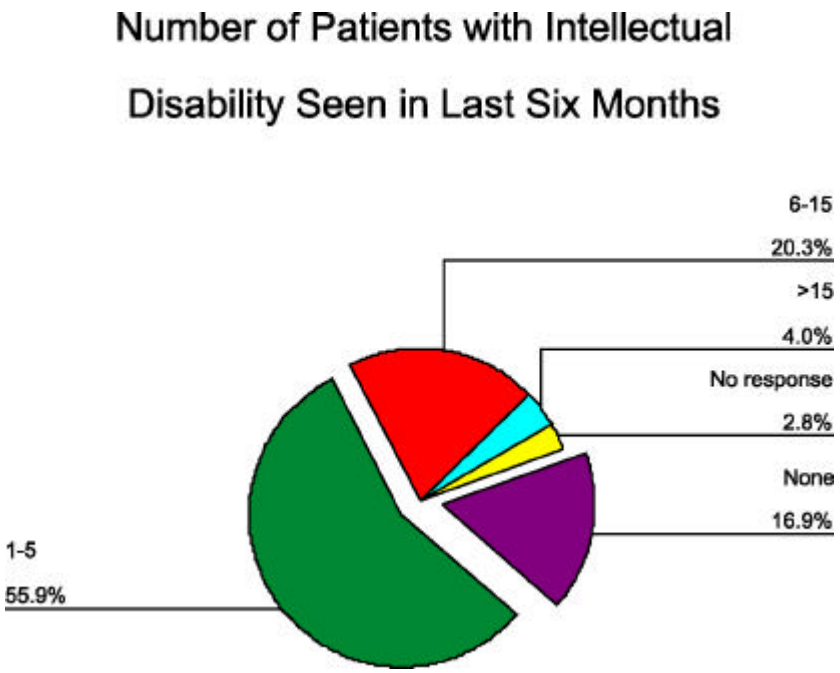
5.2 Clinical Contact with Adults with an Intellectual Disability

The majority of respondents were involved in the active treatment of adults with an intellectual disability and therefore were familiar with issues that the survey addressed. Figure 2 shows that 56% (n=99) of Psychiatrists had seen between 1-5 adults with an intellectual disability within the last six months. In fact, 20% (n=36) of the respondents had seen between 6-15 patients with an intellectual disability within this period.

Few respondents (n=7) had seen more than 15 patients with an intellectual disability (4%). The minority, 17% of respondents (n=30) had seen ***no*** adults with an intellectual disability, within the last six months.

Caseloads appear to reflect small numbers of adults with an intellectual disability although the respondents were not asked about total patient caseload. Movement from institutional care and the mainstreaming of inpatient services within acute general hospitals has led to much shorter lengths of stay, higher admission rates per bed, and a more acutely disturbed clientele than was previously the case (Adler & Mathieson, 1999). The referral of adults with an intellectual disability to Psychiatrists is likely to continue, if not grow, in response ongoing community care policies.

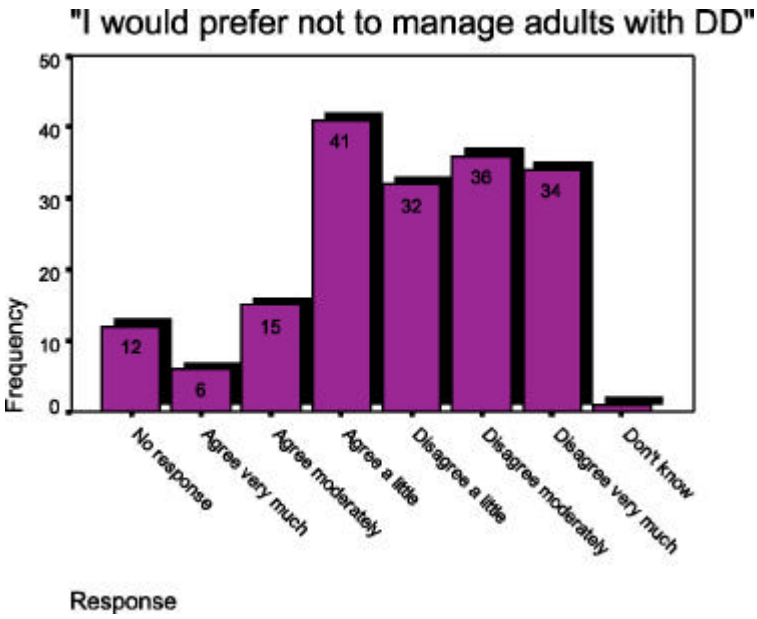
Figure 2



5.3 Attitude to the Management and Treatment of Adults with an Intellectual Disability

The survey showed that not only are the majority of the respondents actively treating adults with an intellectual disability, but they were also interested in managing and treating the mental health needs of adults with an intellectual disability. Figure 3 demonstrates responses to being asked if they preferred ***not*** to treat adults with an intellectual disability. 58% (n=102) disagreed. 35% of respondents concurred with the statement although of the respondents who agreed (n=62), only 23% (n=41) agreed a little.

Figure 3



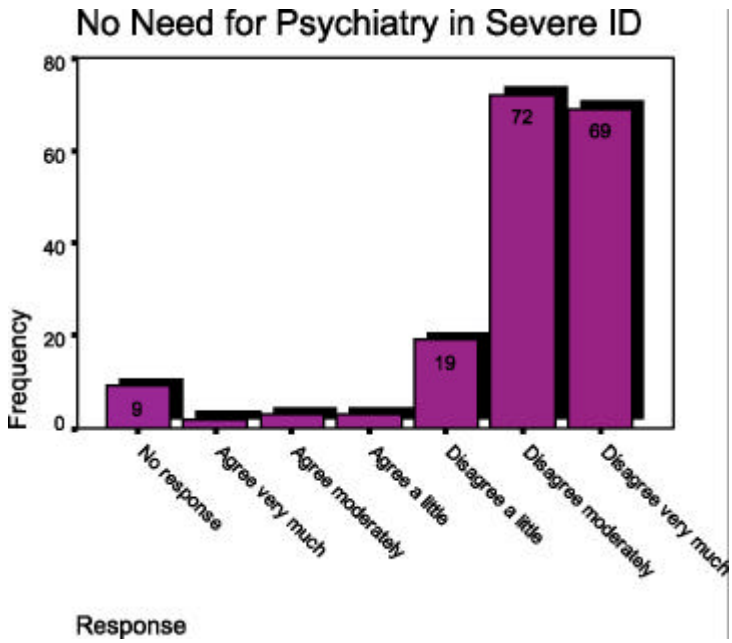
5.4 Relationship between Psychiatry and Intellectual Disability

Psychiatrists were questioned about their potential utility when treating adults with a severe intellectual disability. They were to respond to the statement, "there is seldom the need to investigate psychiatric symptoms in the more severely intellectually disabled".

Adults with a severe intellectual disability are likely to have high support needs, be reliant upon others for activities of daily living and experience communication problems. Patients with more severe levels of intellectual disability will have major difficulties when describing complicated, internal feelings therefore making diagnosis difficult (Deb et al, 2001).

Responses strongly affirmed the role of Psychiatrists when there was a severe level of intellectual disability. Figure 4 shows that 160 respondents (90%) acknowledged the need to investigate psychiatric morbidity in adults with a severe intellectual disability.

Figure 4



5.5 Consultation Setting

The majority of respondents saw adults with an intellectual disability within a ***public sector setting***. 32% (n=57) saw adults with an intellectual disability in a public setting sector as ***outpatients.*** However, 38% (n=67) of respondents indicated that they saw adults with an intellectual disability as ***inpatients***. One possible explanation for this difference is that Psychiatrists may be called to assess inpatients with an intellectual disability, perhaps in general wards or mental health settings, but may not necessarily take them on as outpatients.

Consultations in the ***private sector*** were quite different. 33% of respondents (n=58) had seen adults with an intellectual disability within the private sector as outpatients. There were only 4 respondents who had seen adults with an intellectual disability as inpatients (2%).

5.6 Common Diagnoses

Respondents were asked to rank the three most common diagnoses given to adults with an intellectual disability that they had seen within last six months. Diagnoses were listed in detail and were drawn from the DSM-IV. Figures 5,6 and 7 show the responses.

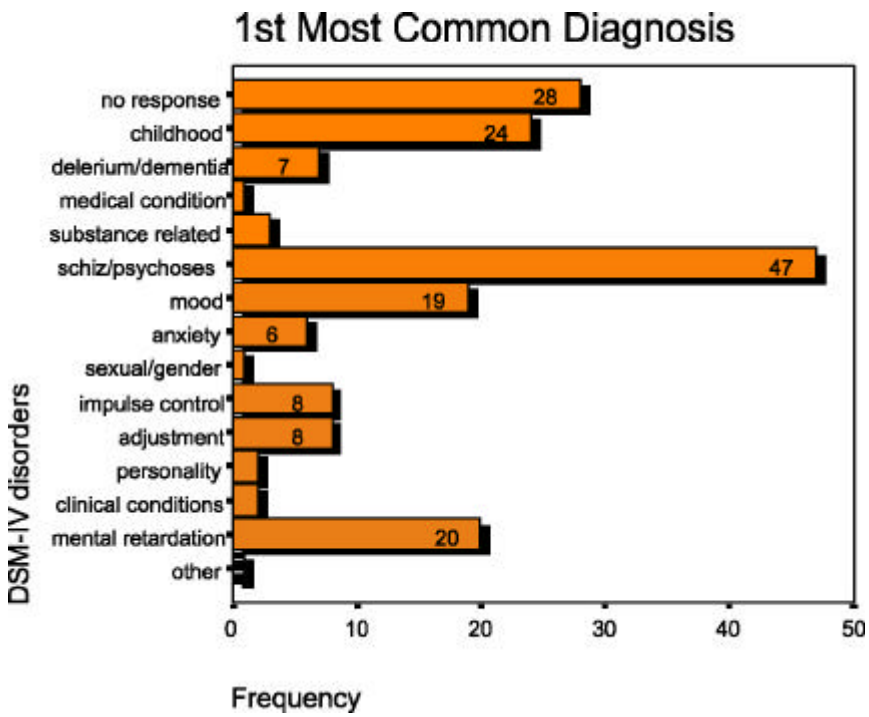
5.6.1 Most Common Diagnosis

The ***most common*** diagnoses were schizophrenia and other psychotic disorders. Figure 5 shows that 27% of respondents made this choice (n=47). In the general population, schizophrenia has a point prevalence of approximately 0.4% (Meltzer et al, 1995). The literature suggests that the prevalence of schizophrenia in adults with an intellectual disability is approximately 3% with lower limits of 1.3% through to upper limits of 3.7% (Deb, 2001).

The 11% of respondents (n=20) who indicated that "mental retardation" was the most common diagnosis are also of interest. Fundamentally this means that those adults with an intellectual disability had not received a psychiatric diagnosis because intellectual disability is not a mental disorder, despite inclusion within the DSM-IV and the ICD-10. Standardised classification systems, whether DSM-IV or ICD-10 are not always useful when assessing adults with an intellectual disability (Deb et al, 2001).

Mood disorders were another frequent diagnosis with 10% of respondents making that their first choice (n=19). The point prevalence of depressive disorder within the general population is around 2% (Meltzer et al, 1995), with a lifetime prevalence of between 6-17%. By comparison, depressive disorder in adults with an intellectual disability ranges between 1.3% and 3.7% (Deb et al, 2001a). People with an intellectual disability can be diagnosed with hypomania and mania although mixed affective states appear to be a more common presentation of bipolar disorder (Berney & Jones, 1988).

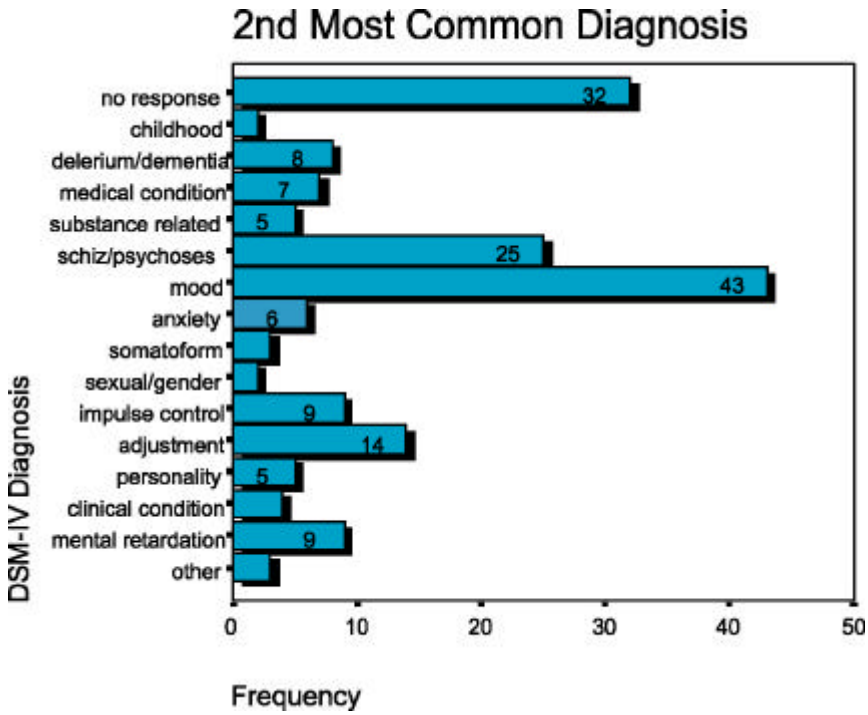
Figure 5



5.6.2 Second Most Common Diagnosis

Mood disorders emerged as the ***second most common diagnosis*** given to adults with an intellectual disability by the survey respondents. Figure 6 shows that twenty-four% of respondents made this choice (n=43). However, schizophrenia and other psychotic disorders was another frequent choice (14% or n= 25). 14 (8%) respondents suggested that adjustment disorders were the second most common diagnosis. Prevalence of this disorder in adults with an intellectual disability it not known (Deb et al, 2001).

Figure 6

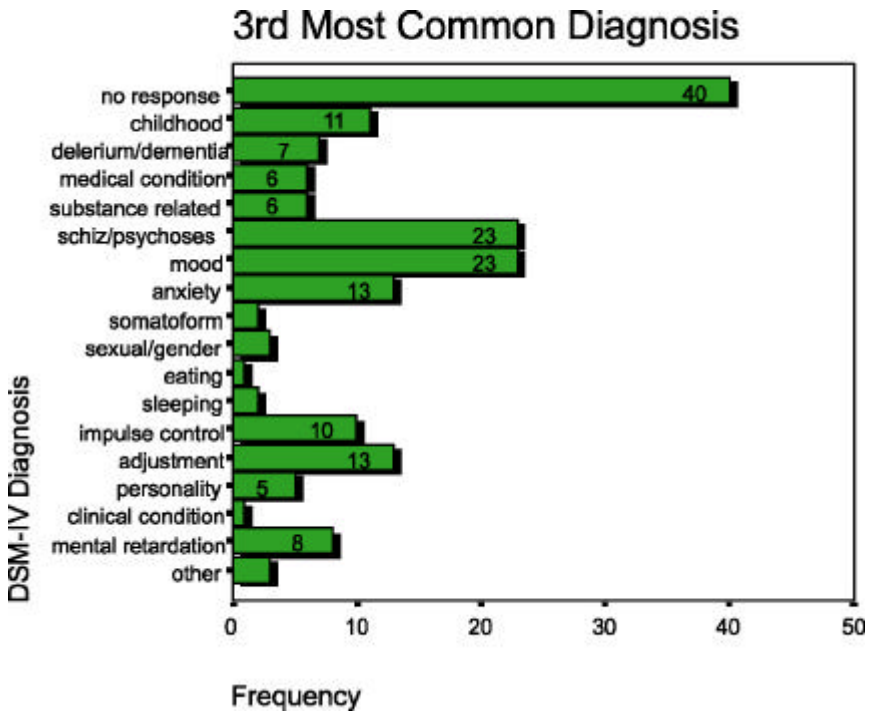


5.6.3 Third Most Common Diagnosis

The ***third most common diagnosis*** was shared by schizophrenia and other psychotic disorders *and* mood disorders. Figure 7 shows that 13% of respondents (n=23) chose the former and an additional 13% (n=23) chose the latter.

Anxiety disorders also featured frequently with 7% of respondents making this choice (n=13). There is minimal literature on the prevalence of neurotic and stress-related disorders in this population. However, adults with an intellectual disability experience increased exposure to stress and a range of risk factors associated with psychiatric morbidity, including biological, psychological and social factors (Deb et al, 2001).

Figure 7



Results should be considered with some caution as Figures 5,6 and 7 demonstrate that a large number of respondents made "no responses" when asked to prioritise the three most common diagnoses. For example, 16% (n=28) of the sample did not respond when questioned about most common diagnosis. Similarly, 18% (n=32) for the 2nd most common diagnosis and 23% (n=40) for the 3rd most common diagnosis.

The number of no responses could possibly reflect difficulties associated with the assessment and diagnosis of mental health problems in adults with an intellectual disability. It would be reasonable to expect that use of the DSM-IV for this population challenges clinicians. Alternatively, some patients with an intellectual disability being treated by some Psychiatrists simply may not have a diagnosis. It is beyond this survey to respond to these issues.

5.7 Training in Dual Diagnosis

Respondents were asked if they had attended dual diagnosis training within the last 12 months. The majority had received ***no*** training in dual diagnosis within this period (88%). Only 15 responded, "yes" to having attended dual diagnosis training. There were 6 "no" responses. However, 103 respondents did indicate interest in attending training in dual diagnosis (58%).

The survey also asked respondents if they had an ongoing interest in dual diagnosis and would they like to be contacted in regard to future activities. 55 (30%) provided their name and contact details. This interest in the mental health of adults with an intellectual disability was an encouraging finding within itself, given the virtual invisibility of this population within the current mental health and disability services systems.

Queensland Psychiatrists and Psychiatric Registrars are likely to have few formal opportunities or other methods of access to knowledge and information about the mental health needs of adults with an intellectual disability. Traditional methods for ongoing education including conferences, special interest groups or even "Grand Rounds" do not routinely address dual diagnosis within the Queensland setting and there are only rare opportunities across Australia. Whilst lack of awareness or even lack of interest is likely to be a key factor, the need exists to establish formal training mechanisms and links that both alert and upskill Psychiatrists in the mental health needs of adults with an intellectual disability.

5.8 Statements of Opinion

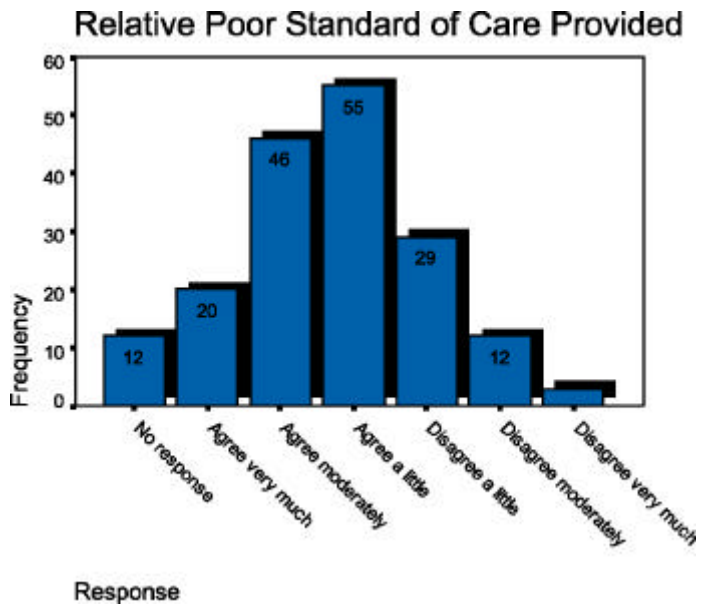
Statements of opinion regarding the psychiatric treatment and management of adults with an intellectual disability were presented in the questionnaire. Responses were recorded on a six point Likert scale that ranged from "very much agree" through to "very much disagree".

5.8.1 *The survey asked: "Adults with dual diagnosis received a relatively poor standard of psychiatric care?*

Recognition of the mental health needs of adults with an intellectual disability is critical to the issue of quality of life. However, when respondents were questioned about quality of psychiatric care, the majority confirmed that the group received poor standards of psychiatric services.

Figure 8 shows that 68% (n=121) responded affirmatively to the survey question and only 23% disagreed (n=41). This response means that the majority of Psychiatrists believe that adults with an intellectual disability receive a poor standard of mental health care. Given that adults with an intellectual disability experience an increased prevalence of mental health problems when compared with the general population, this result is of major concern and calls for a concerted response by Government and service providers.

Figure 8

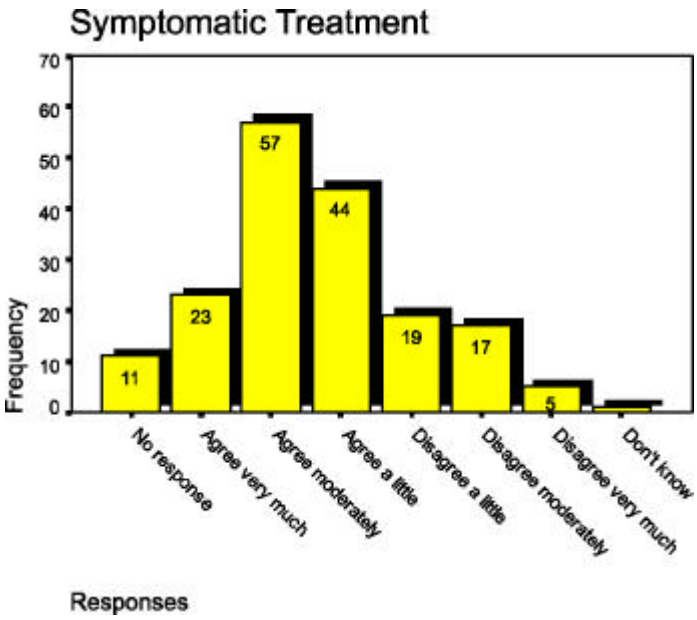


5.8.2 *The survey asked: "Psychiatric treatment of these adults is usually symptomatic, rather than based on diagnostic classification"*

Signs and symptoms of mental health problems vary considerably in adults with an intellectual disability for a variety of reasons that relate to the heterogeneity of this population. Communication abilities, as well as hearing, vision, memory and concentration skills impact the assessment process (Deb et al, 2001).

Figure 9 infers that majority of respondents believed that assessment and diagnosis of adults with an intellectual disability was based upon symptom management rather than diagnoses. 70% agreed with this statement (n=1twenty-four) with only 23% (n=41) disagreeing. This result may suggest that Psychiatrists need to develop skills and expertise in the assessment of adults with an intellectual disability

Figure 9

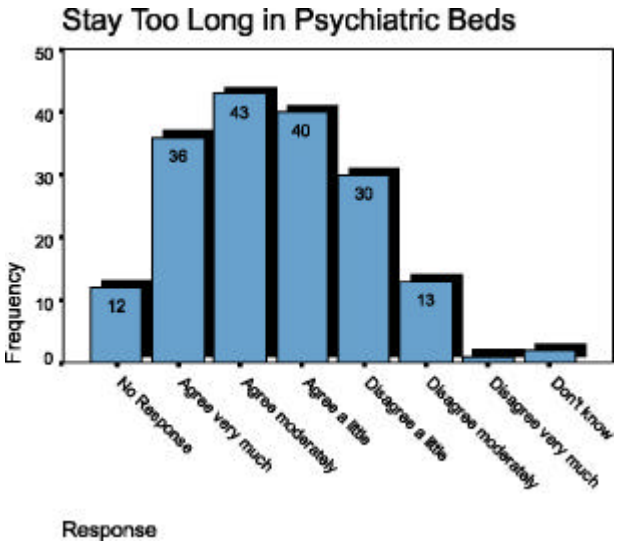


5.8.3 *The survey asked: "Adults with dual diagnosis commonly stay too long in psychiatric beds"*

Figure 10 shows that 67% of respondents believed that adults with dual diagnosis spent too much time in psychiatric beds (n=119). A minority of 25%, disagreed (n=44).

Anecdotal experience suggests that beliefs reflected within this finding are a major barrier to adults with an intellectual disability appropriately accessing the mental health system. For example, those with admission rights are often concerned that when an adult with an intellectual disability enters an inpatient facility, they become homeless and therefore chances of a timely discharge is unlikely.

Figure 10

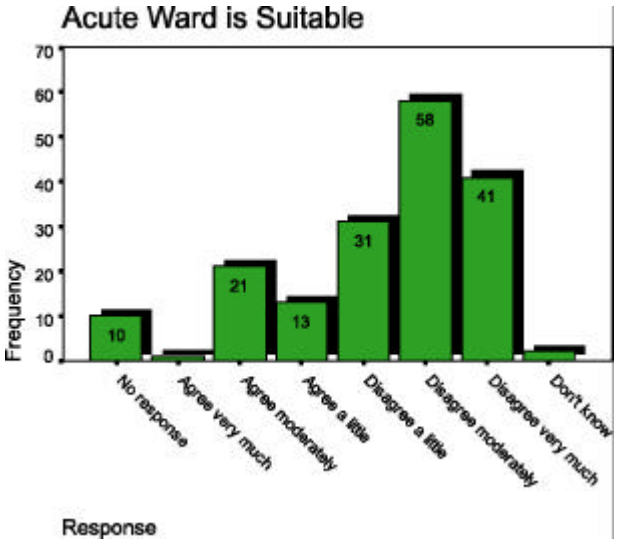


5.8.4 ***The survey asked: "The acute admission ward is adequately suited to the needs of adults with dual diagnosis".***

The majority of respondents did not support the treatment of adults with an intellectual disability within the acute ward setting.

Figure 11 indicates that approximately 20% (n=35) believed that the acute admission ward was suitable whereas approximately 73% (n=130) of respondents did not. This finding may suggest that an alternative mental health setting is required when treating adults with an intellectual disability who have acute needs.

Figure 11

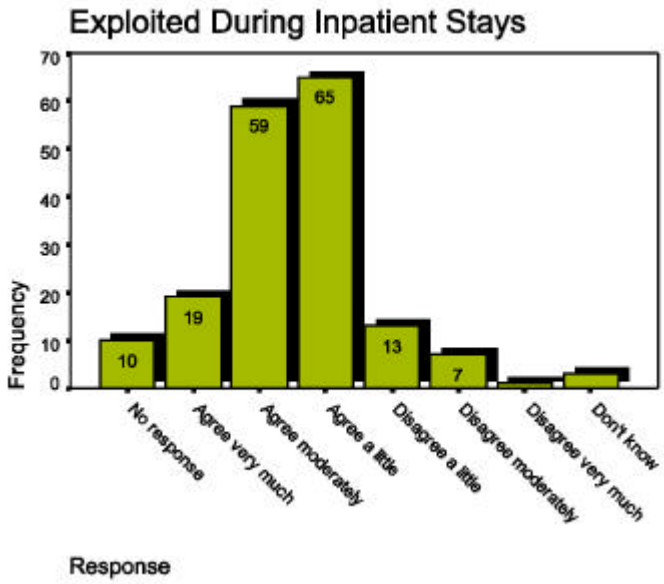


5.8.5 *The survey asked: "Adults with dual diagnosis are exploited by other patients during inpatient admission"*

Just over 80% of respondents agreed that exploitation occurred (n=143) during inpatient admission. Figure 12 shows there was minimal disagreement with this proposition (12% or n=21).

This response provides a possible reason as to why respondents believe that adults with an intellectual disability receive a poor standard of psychiatric care. Further, results shown in Figures 9, 10 and 11 suggest that respondents believe that inpatient mental health services have poor utility for adults with an intellectual disability.

Figure 12



5.8.6 *The survey asked: "Individual supportive psychotherapy is a useful treatment".*

Psychiatric treatment ideally considers a range of therapeutic options including medication and non-medication approaches. Whilst the value of psychotherapy to adults with an intellectual disability is currently undergoing renewed interest within the UK, there is minimal interest here in Australia.

It is interesting to note that few respondents disagreed that psychotherapy could be of benefit to adults with an intellectual disability. Although only 9% of respondents strongly agreed (n=16), Figure 13 shows that 77% of respondents agreed with this statement (n=137). Only one respondent strongly disagreed about the value of psychotherapy in this population.

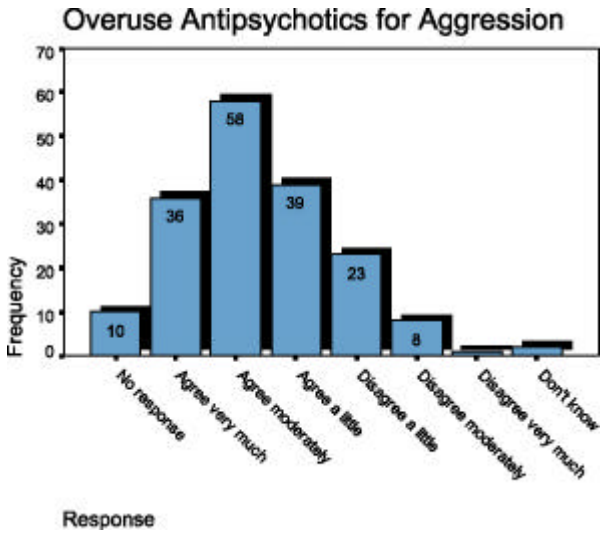
Figure 13

5.8.7 ***The survey asked:"Antipsychotic drugs are overused in the control of aggressive behaviour".***

The use of psychotropic medication to manage the behaviour of adults with an intellectual disability, particularly challenging behaviour, is a controversial issue that has been explored in Chapter 2 of this Report. Antipsychotic medication is an effective and valuable treatment within psychiatry. Rational psychopharmacology, however, is premised upon assumption that medication choice is linked to diagnosis. Aggressive behaviour is not a psychiatric diagnosis although challenging behaviour may be a sign or symptom of mental illness in adults with an intellectual disability.

Figure 14 shows that the majority of responses (75% or n=133) concur with the statement that antipsychotics are overused in the control of aggressive behaviour. Only 18% (n=32) disagreed. This finding may suggest that the prescription of psychotropic medication is ***not*** linked to psychiatric diagnosis when the patient has an intellectual disability.

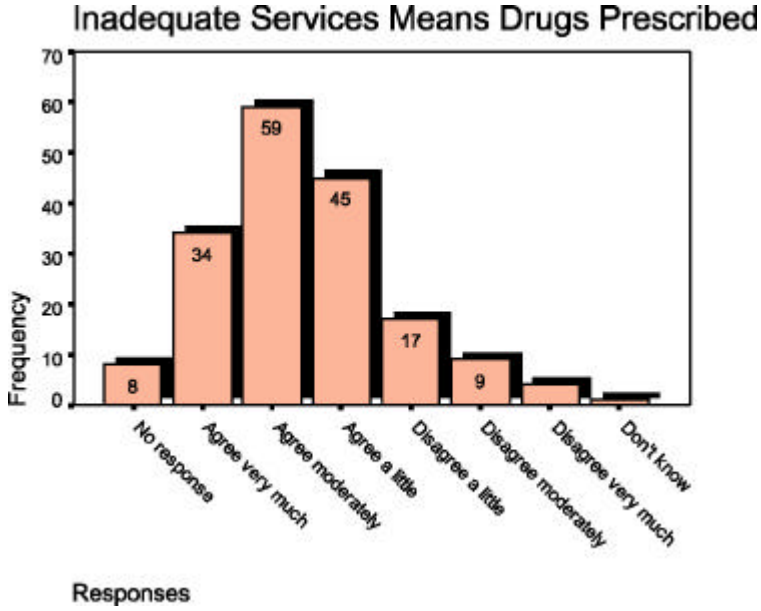
Figure 14



5.8.8 *The survey asked: "Inadequacy of community support services often make the prescription of antipsychotic drugs necessary".*

Figure 15 shows general support for the statement that psychotropics are prescribed to adults with an intellectual disability because inadequate community services are available to support this group. 138 respondents agree that antipsychotics were overused (78%), with 34 of that group, indicating that they strongly agreed. The minority (n=30) or 17% disagreed. This result reinforces concerns already raised in the survey (see Figure 14) regarding appropriate prescription of antipsychotics to adults with an intellectual disability.

Figure 15



5.8.9 *The survey asked: "It is easy to refer to and liaise with Disability Services Queensland (DSQ)".*

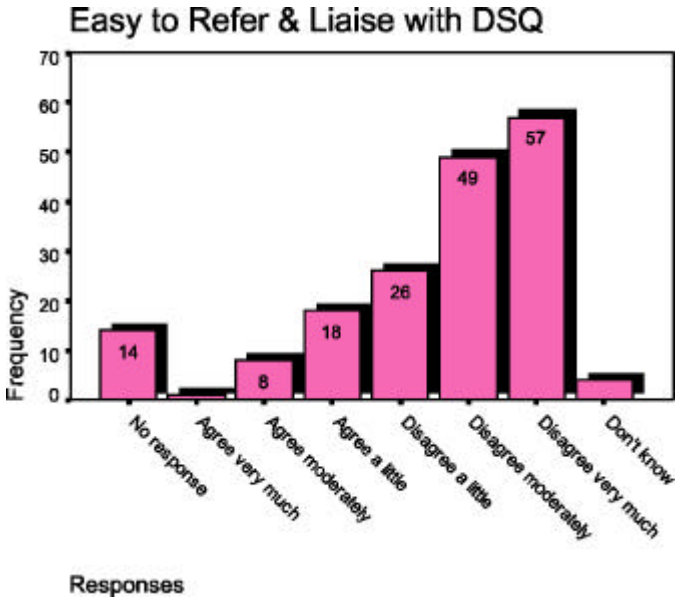
People with a dual diagnosis require a coordinated array of mental health, primary health and disability services. This need can be best met through the collaborative efforts of a range of government and non-government agencies. Unfortunately services that are currently available in most western nations (including Australia) are characterised by complexity, duplication, fragmentation, lack of coordination, polarisation and competition for resources (Baker & Intagliata, 1992).

The survey was interested in identifying the attitudes and views of Psychiatrists towards disability services. Figure 16 shows that 75% (n=132) of respondents did not believe it was easy to refer and liaise with Disability Services Queensland (DSQ). In fact, 32% (n=57) had significant levels of concern. Only 15% of respondents agreed with the survey question, eg that it was easy to refer and liaise with DSQ (n=27).

These responses have significant implications for those people with a dual diagnosis and also ramifications for disability service delivery. For example, Psychiatrists have already stated in the survey that adults with an intellectual disability receive poor standards of psychiatric care and that inadequate services results in over prescription of antipsychotics. Disability Services

Queensland is a major gateway to community services with more than 6,000 adults with an intellectual disability registered as consumers. If Psychiatrists are experiencing difficulty interacting with Disability Services Queensland, the needs of adults with a dual diagnosis are by default, seriously compromised.

Figure 16

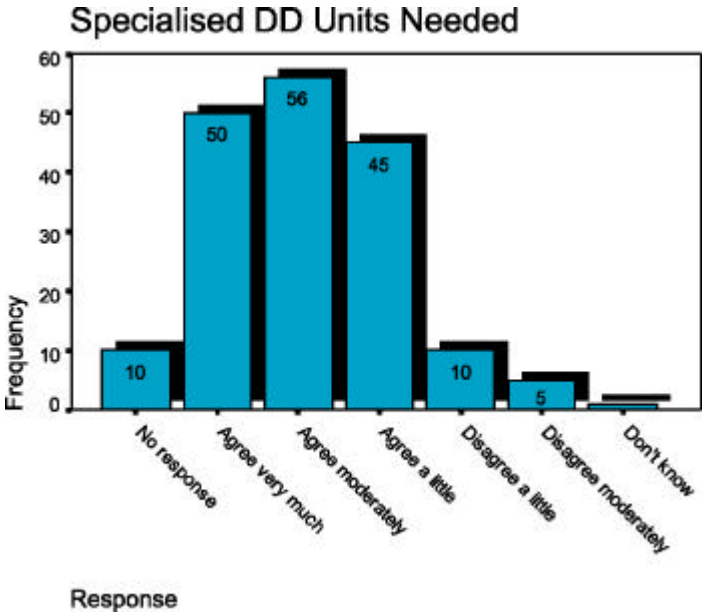


5.8.10 The survey asked: "Specialised psychiatric units for adults with dual diagnosis would provide a higher standard of care"

The majority of respondents have already suggested that the needs of adults with an intellectual disability are not met within the acute admission ward (Figure 11) and that exploitation by other patients occurs during inpatient admission (Figure 12). It is therefore consistent with these beliefs that 151 respondents believe there is value in having specialised psychiatric units for adults with an intellectual disability (85%).

Only 9% of the respondents did not support the development of a specialist psychiatric unit (n=15). Figure 17 demonstrates the strong support for the development of this kind of service for adults with a dual diagnosis.

Figure 17

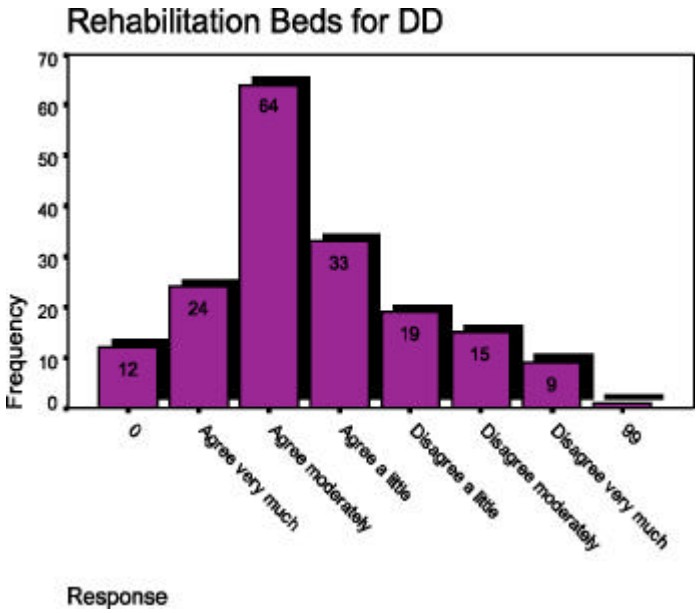


5.8.11 ***The survey asked: "Rehabilitation beds in psychiatric hospitals should be available for their management".***

Contemporary deinstitutionalisation policies have dominated rehabilitation in recent years (McCulloch et al, 2000). Research suggests that psychiatric rehabilitation programs have a positive impact upon the lives of people with mental illness (Corrigan & McCracken, 1995). Potential benefits include symptom management, enhanced interpersonal skills and maintenance of independence. However, the utilisation of rehabilitation strategies can be compromised by insufficient training that results in deficits in clinical knowledge (Corrigan & McCracken, 1995).

Figure 18 shows that more than half of the respondents (n=124 or 70%) supported the use of rehabilitation beds within psychiatric hospitals for the treatment of adults with an intellectual disability. Only 19% (n=33) did not support the availability of rehabilitation beds for this population. These responses reflect the philosophically correct approach regarding equality of access to mental health care, eg adults with a dual diagnosis should be able to exercise identical rights of access to mental health services, as do the general population.

Figure 18



5.8.12 ***The survey asked: "Psychiatrists receive sufficient training in behavioural management of adults with dual diagnosis"***

Challenging behaviour is the major reason why adults with an intellectual disability are referred to Psychiatrists in the United Kingdom. The most likely determinant of help seeking behaviour is when adults with an intellectual disability display violent or aggressive behaviour that is directed towards others or goes beyond community tolerance (Borthwick-Duffy & Eyman, 1990).

There was broad agreement amongst respondents that they require training in the management of behaviour problems displayed by adults with an intellectual disability. This response is consistent with the profile of respondents already detailed, eg the majority of Psychiatrists (n=156) had received ***no*** training in dual diagnosis within the last 12 months (88%).

Figure 19 shows that 35 respondents believed there was enough training for Psychiatrists in behavioural management of adults with dual diagnosis (20%). However, approximately half of those, only minimally agreed. 75% (n=133) thought training in behavioural management was inadequate.

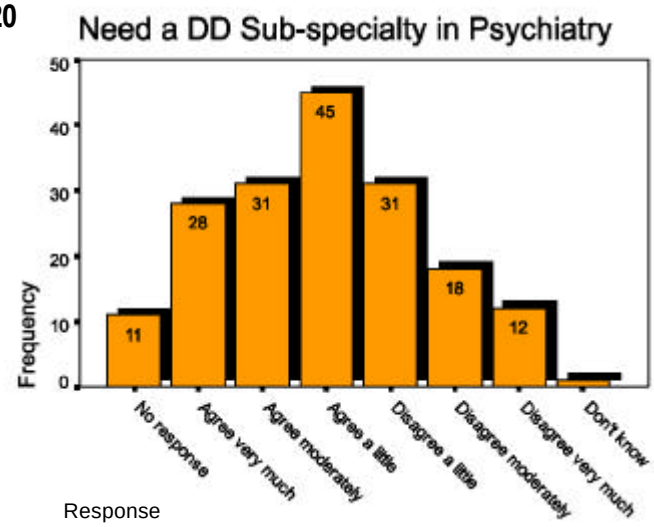
Figure 19

5.8.13 ***The survey asked: "The survey asked "A sub-specialty of psychiatry should be responsible for the treatment of adults with an intellectual disability'.***

Effective clinical outcomes for all patients with mental illness will depend upon the expertise, skills and training of clinicians involved. There is ongoing discussion within the RANZCP regarding the need for the development of a range of subspecialties although dual diagnosis is not mentioned (see Adler & Mathieson, 1999).

Figure 20 demonstrates the range of responses when respondents were questioned about the need for a dual diagnosis subspecialty. Although 59% of the respondents (n=104) were in favour of a training specialty, 45 (25%) only agreed a little. 35% were clearly not supportive (n=61). Given that the Royal College of Psychiatrists (UK) has run a successful sub-specialty in the psychiatry of learning disability since 1975, further discussion and consultation with the RANZCP regarding this issue is warranted.

Figure 20

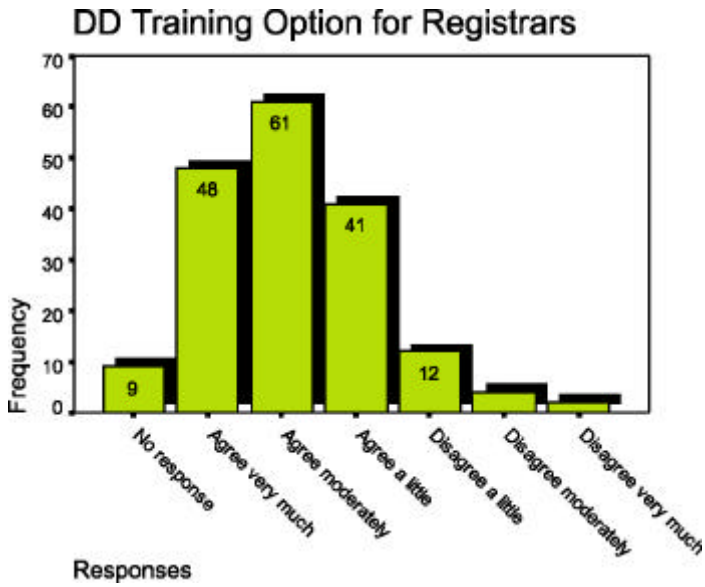


5.8.14 ***The survey asked: "The psychiatry of dual diagnosis should be offered as a training option for all Psychiatric Registrars".***

Respondents appear to prefer this approach when compared to the mental health needs of adults with an intellectual disability being developed into a subspecialty of psychiatry.

Figure 21 shows that there was general agreement that training in dual diagnosis should be offered to Registrars. 85% (n=150) concurred with only 18 respondents (10%) disagreeing.

Figure 21



6. Improvement in Mental Health and Disability Services

Human services organisations, including health, mental health and disability agencies, tend to be organised to respond to an arbitrary set of causes (Patterson et al, 1995). Unfortunately the heterogenous nature of "people" means that their needs and requirements fit poorly into rigid categories or service provision. They are therefore left to struggle with their problems that don't fit well with the neatly organised and segregated human service systems (Patterson et al, 1995). This reality often reflects the lived experience of a person with a dual diagnosis. The frustration of carers to the rigid demarcation of organisations and agencies serving people with and without disabilities is discussed in Chapter 5 of this Report.

Psychiatrists were provided with an opportunity to respond to the context of service delivery. They were asked "how could mental health and disability services be improved?" The Psychiatrists and Registrars who responded covered a wide range of issues. Some responses suggest Psychiatrists were angry and frustrated. For example, one respondent said bluntly, "existing services avoid -reject-neglect". Another suggested "employ psychologists who know how to, and are willing to perform a behavioural analysis". Generally responses were positive and many provided constructive suggestions regarding realistic improvements in service delivery.

The diversity of responses clearly suggest that education and training alone will not be sufficient to improve the mental health of adults with an intellectual disability. Psychiatrists do not operate alone or within a vacuum. Quality mental health care for adults with an intellectual disability depends upon their expertise, in conjunction with other professionals, carers and a range of community based services.

Open-ended responses have not been prioritised by the Project Team but have been themed into the following eight categories. There is some overlap between these categories because of the inter-related nature of the issues addressed. A selection of responses, directly quoted from respondents, have been provided below:

6.1 Awareness

Psychiatrists and Psychiatric Registrars suggested that awareness of the mental health needs of adults with an intellectual disability was lacking within not only mental health services, but also disability services and other human services sectors. Respondents also indicated that clinicians and professionals with expertise or an interest in the area were isolated and unable to make contact with one another. There were also comments about the negative attitudes and views of society towards people with disabilities.

> "we should know each other"
> "reducing stigma in mainstream hospitals"
> "intellectual disability is a variation of normal and is not health endangering"
> "a compassion injection for people"
> "political will and courage"
> "not pondering to the lies and denial of the do-gooders and social influences"
> "education advocates for intellectual disability services….I have encountered strong objections from the advocates to their clients being referred to Psychiatrists"
> "awareness of the different needs of patients with a dual diagnosis"

6.2 Liaison and Collaboration

Many respondents acknowledged the policy directives that required agencies and clinicians to work collaboratively together. However, it was noted that when the patient had an intellectual disability, there was often a flight rather than fight response. Adults with an intellectual disability did fall through the gaps and it was the view of Psychiatrists that teams of professionals need to work together to meet the complex needs of this group of people.

> " a greater willingness of each sector to work together"
> "dual case management for difficult cases"
> "a team approach is required"
> "minimising the gap between services"
> "adequate liaison between mental health and intellectually handicapped services"
> "clearer lines of liaison"
> "constructive liaison"
> "joint case management"

6.3 Specialised Services

The complexity of assessing and treating adults with an intellectual disability was acknowledged. The need for specialist dual diagnosis services was a repeated request.

> "create a new combined service delivery model"
> "special medical services to reduce the trauma of investigations"
> "better infrastructure for their care"
> "needs cannot be met by mainstream services because expertise is required"
> "adults with dual diagnosis deserve equal treatment to those adults with just psychiatric disorders….they deserve a specialist service….with the capacity to carry out the care plan"
> "specialised care coordination"
> "specific service….with a range of …therapeutic options would assist those patients that cannot be assisted by mainstream services"

6.4 Resources

There was much discussion about the need for community based services but there was very little available in reality. Psychiatrists appeared frustrated by lack of options when attempting to connect a patient with an intellectual disability with services available within their local community.

> "real as opposed to hypothetical supports"
> "I believe that Disability Services has been seriously under-resourced for years"
> "need funds and services in the first place"
> "twenty-four hour care about the state"
> "adequate resources to ensure appropriate settings and time for communication"
> "more resources, increase in services, eg increased support as alternative to inpatient admission"

6.5.1 Disability Services

Respondents were very concerned and often negative, about the capacity of Disability Services Queensland to respond to referrals for assistance. Many had the view that DSQ was under-resourced and unable to provide a suitable response when a patient with an intellectual disability was referred to them by a Psychiatrist.

> "they view psychiatric admission as placement"
> "it is currently a waste of time to haul a relationship with disability services as they opt out of any responsibility"
> "seem to lack internal medical information or Psychiatrist input"
> (need) "less stringent criteria from disability services regarding their involvement"
> "better resourced services provided by disability services"
> "acknowledge the medical model and psychiatric aspects"
> "improved non-hospital alternatives for crisis care"

6.6 Mental Health Services

Psychiatrists and Registrars admitted that mental health services staff required increased knowledge and expertise in the mental health of adults with an intellectual disability. Specialised service responses were requested.

> "specialised units for treatment"
> "dedicated beds"
> "formation of specialised dual diagnosis teams that can provide the extra effort and expertise required"
> "dedicated liaison, increased knowledge and access to support services for dual diagnosis patients amongst mental health staff"
> "place it firmly in the HEALTH Department because it is a health issue"
> "there are the rare doctors who take an interest, they should be encouraged and identified"
> "training of staff in psychiatric units"

6.7 Education

There was general consensus that education and training of Psychiatrists in dual diagnosis was required. Many respondents argued that dual diagnosis education and training needed to involve a range of professionals, including those from mental health and disability services.

> "more education of Psychiatrists"
> "specialty terms" (for Psychiatrists)
> "patients could be better managed in the community if more trained case managers were available"
> "training of disability workers and mental health staff – about dual diagnosis but also about each other"
> "improved education and training – better training for nursing staff and medical staff and allied health professionals"
> "shared education and resources (DSQ and Mental Health)
> "more training in the RANZCP course"
> "units of specialised expertise"

6.8 Carers

Some respondents were concerned about the role of carers, particularly ageing family members. In addition to improved support and respite, Psychiatrists suggested that this group would also benefit from dual diagnosis education and training.

> "real respite services for ageing parents of these patients"
> "more support and education for carers"
> "take the burden off family members"

7. Dual Diagnosis Training and Education Needs Analysis

The survey concluded with open-ended questions designed to elicit comments from Psychiatrists and Registrars regarding training and education needs, including preferred presentation mode and venue. Full responses were considered in detail and then themed into the following five categories. The order that the categories are provided in reflect the frequency of the response, eg training falling within the diagnostics category was the most frequently requested category.

7.1 Diagnostics

Respondents prioritised training and education in the assessment and diagnosis of mental disorders in adults with an intellectual disability. They specifically asked for training that would assist them to recognise depression, psychosis and mood disorders. The management of anxiety and relevance of psychotherapy was raised. Respondents commented on problems with the variation in the presentation of mental disorders in this population. There were requests for interview techniques that were suitable for people with limited verbal expression or communication problems.

7.2 Behaviour Management and Treatment

Respondents indicated they had skills and techniques that were suitable for the management of problem behaviours, eg aggression or violence. However, approaches suitable for the general population were often unsuited to the complex needs of adults with an intellectual disability. Psychiatrists requested assistance with tailoring known techniques. They also wanted information about or access to additional clinical strategies that reduced challenging behaviour. Respondents also requested knowledge and advice that could be provided to carers, both paid staff and family members.

7.3 Pharmacotherapy/ Psychopharmacology

Respondents were interested in accessing rational prescribing guidelines or best practice recommendations that specifically addressed the needs of adults with an intellectual disability. Respondents requested indications for psychotropic use when managing and treating challenging behaviour.

7.4 Information in "General"

Respondents requested information and advice regarding service options for adults with an intellectual disability. Psychiatrists clearly wanted to know not only ***what*** existed, but also ***how*** to access these options. Other responses suggested that they needed to understand how to collaborate with existing service delivery systems as many suggested they were unable to access needed services. Respondents said that they needed to interact more with disability and other services but lacked opportunities to do so.

Related to the need for "information" was the acknowledged need that clinical practice with adults with an intellectual disability should be evidence based. Respondents requested advice on where to go for contemporary and best practice management and treatment when working with adults with an intellectual disability. Many advised they were interested in knowing about current innovations in the intellectual disability field. Others asked for opportunities to interact with other experts.

7.5 Other Training Needs

A small number of respondents also identified the followed topics for future education and training:

- childhood and adolescents with dual diagnosis - behaviour management - psychopharmacology
- substance abuse – alcohol and drug abuse
- ageing of adults with an intellectual disability – dementia – identification and treatment of other mental disorders
- comorbidity – management of epilepsy and mental disorder

7.6 Training Medium Preferences

Respondents were questioned about preferences for dual diagnosis training and education opportunities. They were encouraged to nominate more than one choice. Preferences for dual diagnosis education and training mediums, in order of priority included:

- Seminars (< 1 day): 86 responses
- RANZCP meeting presentation: 68 responses
- Workshops (> 1 day): 53 responses
- Video: 50 responses
- Lecture series: 46 responses
- Computer based learning: 39 responses
- Manuals/policy documentation: 29 responses
- Audio tape: 25 responses

Responses to prompts about dual diagnosis training and education options suggest that the preference exists for didactic, expert presentations. This preference may reflect the need for contact with experts in the area of dual diagnosis or desire for evidence based approach. The tendency to choose multiple options for training and education may also suggest that Psychiatrists prefer a multi-faceted approach.

The range of preferences chosen suggest that educational and training strategies may need to adopt a blended approach, eg where a number of options are melted into one training event or perhaps a series of events. However, it should be noted that only one respondent chose the following options: Workshop (1/2 day), Conference and RACGP program.

7.7 Training Presenters

Respondents were asked to indicate preferences for "who" should deliver the dual diagnosis education and training. More than one response was encouraged. Responses, in order of priority included:

- Mental health and disability professionals 112 responses
- Developmental Disability Unit 45 responses
- RANZCP 43 responses
- University of Queensland Department of Psychiatry 43 responses

Only a small number of respondents failed to provide a preference (n=18) and most respondents chose more than one preference. It is interesting to note that multiprofessional and multiagency dual diagnosis education and training was the preferred choice. This response is consistent with previous responses of respondents reported within this Chapter where Psychiatrists indicated that they needed opportunities to liaise and interact with both mental health and disability professionals. It is also encouraging that Psychiatrists appear to acknowledge that the treatment and management of adults with a dual diagnosis necessitates shared clinical and professional expertise, eg there are valuable contributions to be made by the mental health ***and*** the disability sectors.

7.8 Training Needs

Respondents were asked to nominate, "those with the greatest need for dual diagnosis education and training". Multiple choices were encouraged and responses have been prioritised:

- Direct care staff/nurses 127 responses
- Professionals 102 responses
- Consumers/families 78 responses
- Managers of services 77 responses

Other responses included "all of the above" (n=5); general practitioners/physicians (n=4); politicians (n=4); Disability Services Queensland (n=2); education staff (n=1); and "those involved with care" (n=1). Only 5 respondents did not respond.

Responses suggest that Psychiatrists consider the treatment and management of adults with a dual diagnosis as requiring a collaborative approach. Respondents prioritised the needs of direct care staff/nurses and professionals. However, they also highlighted the needs of consumers and family members, as well as managers or administrators of services. A responsive education strategy must have a wide-ranging focus.

8. Discussion and Concluding Comments

Survey trends show that approximately three quarters of respondents consistently express concerns about the psychiatric management and treatment of adults with an intellectual disability.

Most Psychiatrists and Registrars who participated in the survey ***were*** treating and managing adults with an intellectual disability despite anecdotal suggestions from disability and other community workers, that they cannot engage the services of these specialists.

Numbers of adults with an intellectual disability who were recently seen by Psychiatrists were small, but the majority of respondents had seen adults with an intellectual disability within the past six months. The impact of continued deinstitutionalisation and problems associated with the management of challenging behaviours within the wider community may increase referrals of adults with an intellectual disability to Psychiatrists and mental health services. Referrals are more likely to increase, rather than decrease, in the future.

The majority of Psychiatrists and Registrars believe that existing mental health services have limited utility for adults with an intellectual disability. Most respondents suggested that adults with an intellectual disability received a poor standard of psychiatric care, that they failed to benefit from acute admission, and they were exploited during inpatient stays. Again, there is majority agreement that specialist services should exist for this group.

Most Psychiatrists and Registrars advised that their approach to management of adults with an intellectual disability was based upon consideration of symptoms, as opposed treatment being based upon diagnoses. There is a large number of respondents who admitted that they overused antipsychotics when managing aggression. Further, the majority of respondents believed that the inadequacy of community services influences the over prescription of antipsychotics to this group of people.

There was general consensus amongst survey respondents admit that they lacked appropriate knowledge and expertise in treating and managing this vulnerable population. They agreed that Psychiatrists required training in behavioural management of adults with an intellectual disability. Most of the respondents were interested in redressing lack of skills. Although some saw value in the development of a psychiatric subspecialty, there was wider agreement that dual diagnosis training options should be made available to Psychiatric Registrars.

Major training and education needs related to the assessment and diagnosis of mental health problems in adults with an intellectual disability. Many respondents appeared eager to access general information about dual diagnosis but more specifically, they requested assistance with behavioural management and best practice guidelines that guided psychopharmacological treatment. The survey results prioritised the need for evidence-based knowledge about dual diagnosis.

In addition to knowledge gaps, the survey findings revealed that Psychiatrists required a range of learning formats. Expert presentations were requested and seminars (one day or less) were preferred. Time constraints mean that “blended” training opportunities that addressed a number of skill deficits in one educational event should be sought. Respondents request multiprofessional presenters for training events. This response may reflect the fact that Psychiatrists are increasingly working as members of multidisciplinary teams that involve a range of professionals. Alternatively, the complexity of managing and treating adults with an intellectual disability may infer value in the involvement of a range of professionals.

Changing Psychiatrists’ attitudes, opinions and beliefs about adults with an intellectual disability may not significantly alter how psychiatry treats this group. Training and education alone will also be an insufficient stimulant for change. The Dual Diagnosis Project reveals that there are many barriers to effective mental health care for adults with an intellectual disability. Regardless, adults with a dual diagnosis will benefit from Psychiatrists who are well-trained and sensitive to the mental health vulnerabilities of this population. Other important collaboration partners in any education and training strategy for Psychiatrists should also include key

stakeholders from the disability and mental health sectors. The needs of general practitioners, who also play an important role in the assessment, treatment and management of adults with an intellectual disability was not addressed by this survey. Further research, with Psychiatrists and general practitioners should remain on the agenda if quality mental health of adults with an intellectual disability is pursued.

The survey revealed that Queensland has a number of Psychiatrists who are already interested in the mental health of adults with an intellectual disability. The level of interest was indicated by the fifty-five Psychiatrists (30%) who provided identifying information and indicated an ongoing special interest in dual diagnosis. Further contact with this group should be made so that their interest can be nurtured and sustained. The needs of those Psychiatrists and Registrars who did not participate in the survey needs to also be factored into future dual diagnosis educational and training opportunities. Ongoing collaboration with the RANZCP should be pursued.