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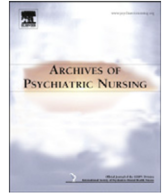

A Qualitative Study of Barriers to Care for People With Co-Occurring Disorders

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ABSTRACT

The present qualitative study used face-to-face and telephone interviews with service providers in the Tampere area in Finland to describe the provider viewpoint on barriers to care for people with co-occurring disorders. The core barrier concerns the definition and understanding of the problems: client and professional perspectives often differ, and both can be out of step with what the care system actually proposes. Professionals need to take into account contexts with potentially multiple barriers to care. Providers in each local area should examine possible barriers and find solutions together, integrating the client perspective at each step in the process.

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INTRODUCTION

Although contemporary healthcare philosophy, particularly with regard to the nursing profession, places emphasis on both a holistic approach and on individualized care, there is still considerable evidence at an international level to show that delivering effective services to people with co-occurring mental health and substance misuse disorders (COD) is problematic (Coombes & Wratten, 2007, Adams, 2008, Baldacchino et al., 2011, Peterson, 2013). Staff in mental health services and substance misuse services often hold divergent views about treatment approaches (Grella, 2003, Adams, 2008, Baldacchino et al., 2011), with people with COD frequently falling through the cracks between the two treatment systems (Drake et al., 2001, Adams, 2008, Clark, Power, Le Fauve, & Lopez, 2008, Griffin, Campbell, & McCaldin, 2008, Baldacchino et al., 2011, Greacen et al., 2011). The terminology of co-occurring mental health and substance misuse disorders is complex, since in mental health contexts the terms *concurrent disorder*, *dual diagnosis*, *dual disorder* and *co-morbidity* are used alternately with COD, implicating a complexity of treatment and the presence of mental and substance use disorders (Drake et al., 2001, Todd et al., 2004, Adams, 2008, Staiger, Long, McCabe, & Ricciardelli, 2008, Baldacchino et al., 2011). Furthermore, people with COD are often poorly compliant and have poorer care outcomes (O'Brien, Fahmy, & Singh, 2009). They often prove difficult to engage in supportive relationships, with intermittent involvement with services (Coombes & Wratten, 2007).

On a European level, policy guidelines have been established seeking to counter systemic barriers to care (Drake et al., 2001, Clark et al., 2008, Baldacchino et al., 2011). Too often, clients with COD are considered as "someone else's problem", with health care workers reluctant to take full responsibility for their care (Coombes & Wratten, 2007). Targeted strategies such as the *No Wrong Door* policy have been set up to address their specific needs (Clark et al., 2008). Improved networking between care providers (Baldacchino et al., 2011) and more integrated approaches to care (Greacen et al., 2011) are key issues.

Understanding facilitators and barriers to care provision in mental health and substance abuse settings is clearly a key issue, in that delayed care-seeking may result in worse outcomes with more symptoms, poorer functioning and lower quality of life (Clement et al., 2012; Greacen et al., 2011). Barriers can be administrative or clinical (Drake & Wallach, 2000). Clients may also encounter financial difficulties in accessing multiple services (Sareen et al., 2007, Clement et al., 2012) or practical problems coordinating access to multiple services (Wang et al., 2007, Peterson, 2013).

In Finland, care for persons with COD has been developed as part of an overall mental health policy encouraging mental health and substance use services to move closer to clients' everyday lives. Client needs are at the core of service planning (MIELI, 2010). Mental health and substance use services are organized for all age groups in a way that emphasizes basic and outpatient services. In Finland,

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the main responsibility for arranging health services lies with the 313 municipalities, who can either provide services themselves or call upon non-profit organizations and voluntary services. The central government determines the general health policy guidelines and directs health care at the national level. All Finnish citizens have access to care and health insurance.

Although, in Europe, methods encouraging service co-operation and an outreach model are generally favoured, Baldacchino et al. (2011) suggest that centers with larger proportions of clients with COD may necessarily have developed more effective networks involving different types of providers. Facilitators for interagency collaboration identified in this study included: 1) the opportunity to collaborate, 2) mastery of networking skills, 3) being knowledgeable about the needs of dual diagnosis clients and 4) the motivation to network.

ROLE OF PSYCHIATRIC AND MENTAL HEALTH NURSING

Nurses form the largest professional contingent within the mental health workforce (Adams, 2008). Their viewpoint is crucial when aiming to provide quality care to any client or patient. Joint training and reciprocal training agreements between addiction and mental health services would facilitate sharing good practices and understanding partners' different roles (Coombes & Wratten, 2007). Since those with COD can be especially difficult to engage (O'Brien et al., 2009), the question of barriers to care is crucial.

In Finland, although at policy level services are designed to be client-focused with service networking being encouraged, it is clear that, at a practical level, service gaps appear for people with multiple health problems. The aim of the present study is to describe the service provider viewpoint on facilitators and barriers to effective care for people with co-occurring mental health and substance use disorders. The data were collected in the Tampere area in Finland.

MATERIALS AND METHODS

Qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyses words, reports detailed views of informants, and conducts the study in a natural setting (Morse & Field, 1996, Creswell, 2012).

DATA COLLECTION

Data were collected between 2004 and 2007 in the Tampere area in southern Finland, a region with some 200,000 inhabitants, in the context of the European ISADORA study on services for people with dual diagnosis (Sorsa & Laijarvi, 2007, Baldacchino et al., 2011, Greacen et al., 2011). In this study, provider points of view were collected by researchers at each European site using two parts of the three-part Treatment of Dual Diagnosis (TODD) tool, an instrument describing treatment and support options for people with co-occurring substance use and mental health problems in a given geographical area. The TODD Overview of Centers (OC) consisted of a survey describing all centers across the research localities that could potentially provide any form of support for people with COD. The TODD Provider Zoom (PZ) focused on those centers identified in the OC as potentially playing a key role in the management, support and/or treatment of people with COD in the study area. The PZ survey was completed during face-to-face or telephone interviews with a center representative with substantive knowledge of their center's configuration and way of operating. The survey included questions on personnel numbers, skills and training, size of services, numbers of people with dual diagnosis using services, networking partners, followed by a series of open questions (Table 1). The face-to-face interviews took place in the centers in question and took from 30 to 40 min to complete.

Table 1
Open questions in the Provider Zoom (PZ) interview in the Tampere area in Finland.

The open question	Prompts
With regards to the needs of PWDD, are there services that in your opinion need improving?	How?
Are you planning to change policy with regard to PWDD?	How?
How is dual diagnosis defined at your site?	What do you mean with a dual diagnosis? How should one speak about dual diagnosis?
What is the basic premise of your work?	Why do you operate the way you do? How do you justify your work?
What is the goal of your work?	What is the purpose of your work? From the perspective of the client/patient/consumer?
How do your goals realize in work with dually diagnosed clients?	…in regard to the principles and goals you just mentioned? …in regard to dual diagnosis or simultaneous mental and substance disorder? Collaboration with different centers? Conflicts?

PWDD = people with a dual diagnosis.

Whilst all possible centers providing support or care of any sort for people with mental health or substance use disorders were included for the OC, the PZ tool was only completed for those centers whose client profile included a significant number of people with either substance use (including alcohol) or mental health problems or both. A ‘significant number’ was defined as ‘at least 20% of service users fitting into one of these three categories’. In the Tampere area, 160 centers were identified in the TODD OC survey (Fig. 1) and a total of 138 services were included in the TODD PZ (Baldacchino et al., 2011). Of the 138 centers with a significant number of people with either substance use (including alcohol) or mental health problems or both, 112 were providing inpatient or outpatient services specifically for people with substance misuse or mental health problems. All eligible 138 services/centers were contacted and asked to identify a professional to participate in the PZ interview. It is to be noted that, in certain cases, participants represented several centers, for example with a representative from a health care center replying on behalf of several local health care stations, a participant in social services replying with regard to several local social service centers, or a mental health outpatient staff member replying on behalf of several services. In all, 104 professionals were interviewed. The present study presents results from this study concerning these 104 healthcare, social care and mental health care providers in the Tampere area (Fig. 1).

As mentioned above, the interviews were conducted either face to face on site or over the telephone. After a complete description of the study to participants, their informed consent was obtained. The participants cannot be identified and they have been fully anonymized. The study conforms to the principles of the Declaration of Helsinki (WMA, 1995/2004) and was approved by the ethical committee of the Pirkanmaa Hospital District (R03102H).

DATA ANALYSIS

All data were transcribed verbatim and were analyzed using conventional content analysis. The method is suitable for analyzing open-ended questions (Hsieh & Shannon, 2005), and is used to systematically organize data into a structured format (Tong, Sainsbury, & Craig, 2007).

The analysis began with a thorough reading of materials, to obtain a sense of the whole. Words and phrases (meaning units) were

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