Mental Health and Substance Use
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/rmhs20

Problematic substance use in two mental health NGOs, and staff, client and general public attitudes towards problematic substance use amongst people with mental illness

Grenville Rose a, Ivan Beale b, John Malone a, Judi Higgin c, Melanie Whiticker a & Loren Brener d
a Aftercare, Sydney, Australia
b School of Psychology, University of New South Wales, Sydney, Australia
c New Horizons, Sydney, Australia
d National Center in HIV Social Research, University of New South Wales, Sydney, Australia

To cite this article: Grenville Rose, Ivan Beale, John Malone, Judi Higgin, Melanie Whiticker & Loren Brener (2012): Problematic substance use in two mental health NGOs, and staff, client and general public attitudes towards problematic substance use amongst people with mental illness, Mental Health and Substance Use, 5:4, 275-286
To link to this article: http://dx.doi.org/10.1080/17523281.2012.702518

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: http://www.tandfonline.com/page/terms-and-conditions

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae, and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings,
demand, or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.
Problematic substance use in two mental health NGOs, and staff, client and general public attitudes towards problematic substance use amongst people with mental illness

Grenville Rose*a*, Ivan Bealeb, John Malonea, Judi Higgin,c, Melanie Whitickera and Loren Brenerd

aAftercare, Sydney, Australia; bSchool of Psychology, University of New South Wales, Sydney, Australia; cNew Horizons, Sydney, Australia; dNational Center in HIV Social Research, University of New South Wales, Sydney, Australia

(Accepted 11 June 2012)

A significant proportion of people with mental illness are thought to have co-occurring problematic substance use but there is little published information available and that which is published can be contradictory and vary according to a number of factors. Additionally, the stigma surrounding co-occurrence is little understood and an exploration of attitudes would benefit mental health service design and delivery. The study aimed to measure the rates of concurrent problematic substance use in community-based health services and to compare attitudes of staff, clients and the public towards people with this population. Create an exploratory model of attitudes. Surveys distributed to staff and clients of two mental health non-government organisations (NGOs) and to a comparison sample of members of the general public. Eighty-two staff, 333 clients and 545 members of the public were surveyed. Rates of alcohol and substance use amongst service clients were similar to levels previously reported of 25% and 39%, respectively. Staff were shown to have better attitudes towards people with mental health and problematic substance use issues compared with service clients and the general public. The rates of problematic substance use in community-based psychosocial support services are consistent with high levels found in other studies of mental health services. Workers hold less stigmatising attitudes than either the public or service clients. An exploratory model of attitudes suggests that personal responsibility may not be an important component of the stigma surrounding co-occurring mental illness and problematic substance use.

Keywords: substance misuse; mental illness; comorbidity; stigma; attitudes

Introduction

Problematic substance use amongst mental health service clients has been shown to be strongly associated with poorer mental health outcomes (Mueser, Drake, & Wallach, 1998) and is also related to less engagement with mental health services (Small, 2010). Substance use in this article broadly includes all substances that may be used to alter consciousness; for example, alcohol, prescription drugs, illicit drugs and inhalants. Steroid use was not investigated. Further, stigmatising attitudes towards clients with mental health and or substance use problems can result in lower
help seeking behaviour and a disruption to the therapeutic alliance (Bell, Johns, Rose, & Chen, 2006; Corrigan, 2004; Corrigan, Green, Lundin, Kubiak, & Penn, 2001; Edlund, Unutzer, & Curran, 2006; Holmes & River, 1998; Holt & Treloar, 2008; Treloar & Holt, 2006). Clients with problematic substance use/mental health issues have also been shown to have higher support needs than clients without co-occurring issues (Koegla & Rush, 2011). So that adequate support can be provided for people so affected it is important that the prevalence of the issues in the particular services is known; however, estimates of the rate of substance use vary greatly according to the population from which they are sampled and methodology used. An Australian study, for example, found that 32% of people with Bipolar Disorder also had an alcohol use disorder, whereas 13% of people with Agoraphobia were found to have an alcohol use disorder (Burns & Teesson, 2002). Similarly, the rate of co-occurring substance use and mental health disorders was found to be 12% in those attending 386 general practice surgeries in Australia (Hickie, Koschera, Davenport, Naismith, & Scott, 2001) and the rate when either a mental health disorder or a substance use disorder is present has been estimated at between 45% and 55% (Teeson & Proudfoot, 2003). Patterns of use can also vary by location. Community Mental Health Services in London, for example, observe higher rates of problematic substance use than those in smaller urban centres (Baldacchino et al., 2009). The differences in the reported prevalence may also be a function of the use of different timescales within survey measures (Wittchen, 1996) cites the example of lifetime use as opposed to use in the last 12 month.

Self-completed forms at time of entry to an Australian mental health non-government organisation (NGO) show that approximately 3% of clients state that they have a drug or alcohol use problem (Aftercare, 2008) which is well below the published estimates, whereas anecdotal reports by staff in the same service suggest the rate could be closer to 30%. More accurate estimation would assist in the planning and design of support services.

Both mental illness and problematic substance use are associated with stigmatising attitudes which are, in turn, associated with lower help-seeking behaviour (Corrigan, 2004) and less favourable treatment and health outcomes (Ahern, Stuber, & Galea, 2007; Brener, Von Hippel, Von Hippel, Resnick, & Treloar, 2010). There are a number of psychological attributes that contribute to the formation of stigmatising attitudes towards people with a mental illness and substance use problems, including perception of dangerousness and perception of personal responsibility for illness (Corrigan et al., 2002; Niv, Lopez, Glynn, & Mueser, 2007). Perceptions of the extent to which people are responsible for difficulties, in particular, plays a role in the formation of stigmatising attitudes towards substance use (Corrigan et al., 2002; Niv et al., 2007). While it has been shown that contact with the stigmatised group can reduce stigmatising attitudes (Alexander & Link, 2003; Corrigan et al., 2001; Couture & Penn, 2003; Reineke, Corrigan, Leonhard, Lundin, & Kubiak, 2004), it has also been suggested that the effect of contact can vary based on the nature of the contact and interpersonal interaction (Alexander & Link, 2003; Couture & Penn, 2003; Servais & Saunders, 2007). Health professionals are not, therefore, rendered immune from holding stigmatising attitudes towards those who are mentally ill and have problematic substance use simply due to their regular contact and choice of profession.

Comparisons of the attitudes of the general public with mental health clinicians have yielded conflicting results. A large Australian study found that psychiatrists and mental health nurses had more negative attitudes towards positive patient outcomes than the public (Jorm, Korten, Jacomb, Christensen, & Henderson, 1999), and clinical psychologists in the US have been found to hold stigmatising attitudes
towards people with specific mental health conditions such as borderline personality disorder and schizophrenia (Servais & Saunders, 2007). A further study comparing general public and health professional attitudes found that psychiatrists held more stereotyped attitudes towards people with a mental illness than the general public and that the greater knowledge of mental health professionals does not decrease stereotyping or increase willingness to closely interact with mentally ill people by staff (Nordt, Rössler, & Lauber, 2006). It has also been found, however, that health professionals with more mental health training had more positive attitudes towards people with mental illness and their prognosis compared with others who had not (Peris, Teachman, & Nosek, 2008). A recent review of the extant literature since 2004 (Wahl & Aroesty-Cohen, 2010) found 19 studies that investigated the attitudes of mental health professionals towards those with mental illness and found that mental health professionals generally had positive attitudes, but retained some negative elements to their conception of the mentally ill.

Mental health NGOs in Australia differ somewhat from other mental health services in that they deliver community-based psychosocial services using less highly trained personnel than other mental health services. These types of services are largely outreach services, where staff support clients in their own homes. The clients of these services have needs ranging from high support requiring up to 40 h of contact with the service per week, to very low support clients who may only have 1 h of contact a fortnight. At the time of the study, both services use goal setting as a part of the broad psychosocial support and community engagement but one service used the Collaborative Recovery Model which uses three forms to produce a structure approach to identifying strengths and weaknesses and producing meaningful goals which can then be monitored for progress or difficulties (Oades et al., 2005). Training for the model at that time was over two days. As previously stated, the workers in these services are not psychologists or counsellors and will have a lower level of formal training than most mental health professionals. It may be expected then that the workers might have less positive attitudes as some previous research has found that more positive attitudes related to higher levels of training (Peris et al., 2008). Yet the attitudes of these workers towards people with co-occurring substance use and mental illness issues are currently unknown.

There have been two distinct forms of stigma identified, public stigma and self-stigma (Corrigan & Watson, 2002). Public stigma refers to the attitudes of those that are not a part of the stigmatised group, while self-stigma is the stigma that members of the stigmatised group may hold about themselves, due perhaps to internalising the public stigma. In relation to public stigma, Corrigan et al. (2001) have proposed a model of mental illness stigma that identifies familiarity and perceptions of dangerousness as components of social distance. Social distance is a measure of social acceptance, and the scale used to identify this attitude, the social distance scale (SDS) is taken as a proxy of stigmatising behaviour. A study of attributions of the community college students in the United States (a sample chosen as reasonably representative of general public attitudes) towards those with a mental illness found that dangerousness attributions (fear that people with mental illness would act in a dangerous fashion) was more predictive of discriminatory attitudes and behaviour than a stigma model that included personal responsibility (i.e. the extent to which others perceive that the person is responsible for their condition) (Corrigan et al., 2002). In contrast, in the field of drug and alcohol research, personal responsibility has been identified as being a key factor in the negative attitudes of carers towards the population in the current study (Niv et al., 2007). A model of stigmatising
attitudes relating to this population may, therefore, be expected to differ from a previous model developed in relation to mental illness (Corrigan et al., 2002) with the incorporation of a stronger personal responsibility component, but still including familiarity and perceptions of dangerousness.

Self-stigma is stigma that the marginalised group apply to themselves by internalising the stigma of others towards them. Self-stigma has been found to have negative implications for help seeking and treatment outcomes among people with mental illness as well as those with substance use problems (Corrigan, 2004; Corrigan et al., 2002; Corrigan & Watson, 2002; Holmes & River, 1998; Link, Cullen, Frank, & Wozniak, 1987; Link & Struening, 1997; Room, 2005). While the majority of the research emphasises the negative aspects of self-stigma, it has also been suggested that for some self-stigma may have beneficial consequences (Corrigan & Watson, 2002). Corrigan and Watson posit that some individuals may become “righteously angry” about the stigma they experience, a reaction which may increase help seeking behaviour by empowering them to become more active in their treatment programme.

The current study aims to investigate the rate of problematic substance use amongst users of non-government psychosocial support mental health services, the attitudes of the clients and workers in those services towards that group, and also to compare those attitudes to the attitudes of the general population. An understanding of these relationships would be of significant benefit to workforce training and the development of higher quality services. The review of the literature undertaken did not indicate published evidence on the rate of drug and/or alcohol use in Australian mental health NGOs, which typically provide community-based psychosocial support services, nor on the attitudes of the clients, staff and the general public towards those with co-occurring mental health and substance use issues.

Method

Client survey

A 125 question survey was given to clients of two mental health NGO services, and a shorter, attitudes based questionnaire was given to staff at these NGOs as well as to members of the general public. Support staff individually approached all clients over the age of 18 with sufficient English and literacy skills to self-complete the survey and sufficient current mental competence to understand the participant information statement, which emphasised the anonymous and voluntary nature of the survey. The survey had no identifying information beyond age and gender. Questionnaires were returned directly to the researchers in a reply paid sealed envelope with a response rate of approximately 44% (approximately 750 clients were approached in the two services and 333 participated). Scales investigating substance use were included in the client survey and were the: Alcohol Use Disorders Identification Test (AUDIT – Saunders, Aasland, Babor, & de la Fuente, 1993) and the Drug Abuse Screening Test (DAST – Skinner, 1982), each of which ask about substance use in the last 12 months. Both instruments have been reviewed and recommended as suitable for use with this population (Dawe, Loxton, Hides, Kavanagh, & Mattick, 2002). Scales that have previously been used to develop path models of stigmatising attitudes towards the mentally ill, the SDS (Bogardus, 1928; Link et al., 1987) and the attributions questionnaire (AQ – Corrigan et al., 2002), were also included. The SDS is a seven question single factor questionnaire that is considered as a proxy measure of behaviour related to attitudes. The AQ measures a number of potentially
stigmatising perceptions towards people with mental illness/problematic substance use: fear, dangerousness, anger, pity, willingness to help, want to avoid and person has responsibility for their condition. As level of contact with people with a stigmatised condition has been shown to influence attitudes, the familiarity of participants with people with mental illness/problematic substance use was measured using the level of contact report (LOCR – Holmes, Corrigan, Williams, Canar, & Kubiak, 1999). Each of these scales originally refers purely to mental illness, but the wording of the scales was changed to ask about “people who have a mental illness and heavily use drugs or alcohol”. The altered surveys were trialled on a small group of service clients in the Consumer Advisory Committee at Aftercare.

**Staff and general public survey**

Staff and the “public” completed questionnaires that assess their attitudes towards people with mental health and substance use issues. The scales used for both the staff and public were the SDS, LOCR and AQ questionnaires that were included in the client questionnaire. The staff questionnaire was individually completed on a laptop computer at the usual workplace within normal work hours. All staff at services where client data was collected were approached with only one staff member declining to take part. The public attitudes survey was web-based and conducted by a commercial market research company which was asked to provide age and gender ratios that matched those that had already been collected in the staff survey. Only one response was allowed per person and the age ranges and gender balance were screened to approximate those gained in the staff survey. The study was approved by the Human Research Ethics Committee at the University of New South Wales.

**Statistical analysis**

Statistical analysis was conducted in SPSS 18.02 (SPSS, 2010), and EQS 6.1 (EQS, 2010). \( \chi^2 \) tests were used for determining differences in frequencies. Non-parametric Kruskal–Wallis independent samples test with step-down post hoc analysis was used for determining group differences as there were large differences between group Ns in addition to significant heteroscedasticity. Mean replacement of missing client data was used as the level of missing data was acceptable for that procedure, there being less than 5% missing values on any one variable. As the staff and public data were collected electronically there were no missing data.

**Results**

A total of 82 staff, 333 clients and 545 members of the general public completed surveys. Of the staff, 51 were staff from service 1 and 31 were recruited from service 2, 170 clients were from service 1 and 163 clients from service 2. Data on four age ranges were collected, 18–25, 26–40, 41–60 and over 60. As the numbers in the youngest and oldest age groups of clients and staff were too low for valid statistical comparison, the ranges were collapsed to under 41 and over 40, with less than 30 clients and 20 staff being under 26 or over 60.

Overall, there was no significant difference in the age group proportions of staff, clients and public \( \chi^2 (2, n = 960) = 3.8, p > 0.05 \). In terms of gender, overall there was a difference in the proportions of males and females between the groups \( \chi^2 (2,
Rates of problematic drug and alcohol use of clients in the two mental health NGOs
The overall rates of problematic alcohol, drug, and additionally, a rate for those with combined alcohol/drug use amongst psychosocial support-based mental health NGO clients were 25.5%, 39% and 14.7%, respectively, as defined by the AUDIT and DAST measures. There was a significantly higher rate of problematic alcohol use amongst service 2 clients (33%/19%), $\chi^2(1, n = 333) = 8.2, p < 0.05$. There were no differences between organisations in the rate of problematic drug or combined alcohol and drug use. Younger clients had higher rates of alcohol and drug use 31%/20%, $\chi^2(1, n = 333) = 5.6, p < 0.05$; 46%/32%, $\chi^2(1, n = 333) = 7.2, p < 0.05$, respectively. But there were no gender differences in alcohol or drug use, 29%/21%, $\chi^2(1, n = 331) = 3.2, p > 0.05$; 44%/34%, $\chi^2(1, n = 331) = 3.7, p > 0.05$, respectively.

Comparison of staff, client and general public attitudes
When staff and client attitudes from the two services were combined and compared to the attitudes of the general public using the Kruskal–Wallis independent samples test with step-down post hoc analysis procedure in SPSS, significant differences were found between groups on all attitudinal variables, with the exception of whether people felt that those with both issues were responsible for their condition, $\chi^2(2, n = 958) = 1.72, p > 0.05$.

Clients and public indicated that they would be less likely than staff to help or pity someone with both issues, $\chi^2(2, n = 958) = 84.03, p < 0.05$; and $\chi^2(2, n = 958) = 8.96, p < 0.05$, respectively. They were also more angry with, $\chi^2(2, n = 958) = 61.2, p < 0.05$, afraid of, $\chi^2(2, n = 958) = 78.80, p < 0.05$, likely to avoid, $\chi^2(2, n = 958) = 45.14, p < 0.05$ and thought that those with both issues were more dangerous $\chi^2(2, n = 958) = 70.79, p < 0.05$. The public were less likely than clients, who were in turn less likely than staff, to have had contact with people with both issues $\chi^2(2, n = 958) = 135.02, p < 0.05$, and wanted more social distance from them compared to clients, who, again, also desired more social distance than staff $\chi^2(2, n = 958) = 35.93, p < 0.05$ (Table 2).

Factor model of service clients’ attitudes
Using questions adapted from Corrigan et al. (2002) to be applicable to co-occurring substance use and mental illness stigma resulted in a statistically valid model of stigma, though it is only of moderate strength (Figure 1, Table 3). In the course of the development of the model, personal responsibility was included as a variable.

Table 1. Gender and age balance between client, staff and public participants.

<table>
<thead>
<tr>
<th></th>
<th>Male (%)</th>
<th>Female (%)</th>
<th>Aged 18–40 (%)</th>
<th>Aged over 40 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client</td>
<td>53.5</td>
<td>46.5</td>
<td>48.9</td>
<td>51.1</td>
</tr>
<tr>
<td>Staff</td>
<td>37.8</td>
<td>62.2</td>
<td>61.0</td>
<td>39.0</td>
</tr>
<tr>
<td>Public</td>
<td>34.5</td>
<td>65.5</td>
<td>51.2</td>
<td>48.8</td>
</tr>
</tbody>
</table>
Table 2. Comparison of median scores of staff, client and public attitudes towards, and experience of people with comorbidity.

<table>
<thead>
<tr>
<th></th>
<th>Helping behaviour</th>
<th>Pity</th>
<th>Anger</th>
<th>Danger</th>
<th>Fear</th>
<th>Responsible for condition</th>
<th>Avoid</th>
<th>Social distance</th>
<th>Level of contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum*</td>
<td>15</td>
<td>15</td>
<td>10</td>
<td>10</td>
<td>20</td>
<td>10</td>
<td>11</td>
<td>29</td>
<td>69</td>
</tr>
<tr>
<td>Client</td>
<td>7</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>11</td>
<td>6</td>
<td>9</td>
<td>23</td>
<td>16</td>
</tr>
<tr>
<td>Public</td>
<td>7</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>12</td>
<td>6</td>
<td>9</td>
<td>23</td>
<td>9</td>
</tr>
<tr>
<td>Staff</td>
<td>4</td>
<td>8</td>
<td>8</td>
<td>7</td>
<td>16</td>
<td>6</td>
<td>10</td>
<td>20</td>
<td>35</td>
</tr>
</tbody>
</table>

Note: *Ranges = 0–Maximum.

Figure 1. Factor model of client comorbidity stigma.

Table 3. Questions relating to each factor in client model of comorbidity stigma.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Label</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pity</td>
<td>1 I feel pity for persons with a mental illness who abuse drugs or alcohol</td>
<td>2 How much sympathy would you feel for a person with a mental illness who abuses drugs or alcohol</td>
</tr>
<tr>
<td></td>
<td>3 How sorry do you feel for persons with a mental illness who abuses drugs or alcohol</td>
<td></td>
</tr>
<tr>
<td>Fear</td>
<td>4 Persons with mental illness who abuse drugs or alcohol terrify me</td>
<td>5 I would feel threatened by a person with a mental illness who abuses drugs or alcohol</td>
</tr>
<tr>
<td></td>
<td>6 How scared of a person with a mental illness who abuses drugs or alcohol would you feel</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7 How frightened of a person with mental illness who abuses drugs or alcohol would you feel</td>
<td></td>
</tr>
<tr>
<td>Danger</td>
<td>8 I would feel unsafe around persons with a mental illness who abuse drugs or alcohol</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9 How dangerous do you feel a person with a mental illness who abuses drugs or alcohol is</td>
<td></td>
</tr>
<tr>
<td>Avoidance</td>
<td>10 If I were a landlord I would probably rent a house or flat to a person with a mental illness who abuses drugs or alcohol</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11 I think persons with a mental illness who abuse drugs or alcohol pose a risk to other people unless they are hospitalised</td>
<td></td>
</tr>
</tbody>
</table>
Personal responsibility was expected to have more relevance for this model as it related to substance use in addition to mental illness and prior work has suggested that personal responsibility is a factor in the stigma surrounding substance use (Niv et al., 2007). Personal responsibility, however, was not found to be a factor in the stigma surrounding co-occurring substance use and mental illness.

Robust measures of fit were used due to multivariate non-normal distribution of the data (Mardia’s Normalised Coefficient > 3). The Satorra–Bentler scaled $\chi^2$ was significant $\chi^2 (38, n = 333) = 109.88, p < 0.05$, which indicates less than perfect fit, but does not rule out the model having an acceptable fit to the data, and thereby validly describing the results. The Bentler–Bonett Normed Comparative Fit Index (0.954) suggests good fit was achieved by the model and Aikake’s information criterion (AIC) also indicates the model was more parsimonious than the null model (Null AIC = 1508.31, Model AIC = 33.885). Each of those indices suggests that the proposed relationships between the factors are a better description of the results than simply allowing all the factors to vary independently. The root mean square error of approximation (RMSEA), however, suggests that the result may only apply reasonably well (RMSEA = 0.075, 90% confidence interval 0.59–0.91). The statistics thus support the contention that the model is a valid way of describing data. In addition to the statistical analysis, the model is also supported by its close match to the model previously applied to mental illness (Corrigan et al., 2002).

No combination of factors was able to adequately describe the attitudes of the general public towards those with co-occurring mental illness and problematic substance use. However, the weak and unreliable models that were tested did suggest that personal responsibility was only very weakly, if at all, related to any combination of factors in the current analysis.

Discussion

Reported rates of problematic alcohol and drug use were far higher than had previously been estimated using entry data obtained by the participant NGOs. This suggests that there are difficulties gaining accurate data at intake to the services. It is possible that clients are not disclosing the true extent of their substance use at intake. Perhaps they are reticent for fear that they will be refused a mental health service on the basis of drug and alcohol use or perhaps they themselves are unaware that their level of use may be problematic. Initial entry into the service is an opportunity for staff to screen for these problems using tools such as those used in this study so that any problems may be identified earlier and appropriate referrals and support can be given. Staff are currently focused on developing rapport with their clients as a part of providing recovery-based psychosocial support, but what may be lacking is a focus on the number of their clients with problematic substance use and of a willingness to approach an issue that is usually not within the mental health domain and which may require specialist intervention. Substance use and appropriate referral pathways should be more of a focus for these services.

Though there is no definitive answer to what type of contact between a marginalised/stigmatised group or person and those who are not a part of that group. It has been clearly shown that the type of contact is important and that a positive and co-operative interaction may be a factor in promoting attitude change via contact (Alexander & Link, 2003; Couture & Penn, 2003). The theoretical orientation of the participant organisations are recovery based and predicated on the idea that an
individual can recover at least to some degree from their difficulties and provision of collaborative support will aid that process. Thus, the staff may experience both the disconfirmation of negative stereotypes of people with co-occurring substance use and mental health issues during the process of recovery and via the organisational mindset that recovery through a collaborative process is an appropriate strategy.

Further, though it has previously been reported that health professionals might distance themselves from their clients and find them more dangerous (Servais & Saunders, 2007; Wahl & Aroesty-Cohen, 2010), the scores on the SDS show that support staff of the organisations in this study did not distance themselves from their clients compared with the general public and clients. Previous work has also found that a higher level of knowledge amongst mental health professionals predicted improved attitudes (Peris et al., 2008), and a large Australian study found that health professionals had more negative attitudes than the general public (Jorm et al., 1999), but the support workers in the current study are relatively untrained in comparison to the psychiatrists, mental health nurses and psychologists who have been surveyed in previous studies yet they had clearly positive attitudes. The participant organisations operate with a recovery orientation that explicitly emphasises the possibility that every client can improve their quality of life and personal wellbeing and that the best way of assisting this is to collaborate with the client in a more or less equal partnership (Oades et al., 2005). Cooperation and equality have been identified as possible preconditions for contact to be effective in changing attitudes (Couture & Penn, 2003) and thus may explain the positive staff attitudes found in the current study. It is also possible that the types of people that work for community-based mental health organisations hold less stigmatising attitudes than others in the community, irrespective of contact level. Further research, using the specific measures used in this study in addition to other measures, is needed to identify the causes of the positive staff attitudes found in the present study, and to directly compare these attitudes with other health professions.

The failure of personal responsibility to add any meaningful information to the model of stigma suggests that personal responsibility may not contribute much to the formation of stigmatising attitudes amongst this group. Two slightly differing models of stigmatising attitudes suggested by Corrigan et al. (2002) and Niv et al. (2007) centre around dangerousness and responsibility, with the Niv et al. (2007) model placing more emphasis on responsibility. The model emerging from the current study was most similar to the Corrigan’s mental illness model and this suggests that, in the perceptions of service clients, the fact that the person has a mental illness removes the perception that they are responsible for their own substance use.

The surveyed attitudes centred on fear, danger, avoidance and a desire for increased social distance. Scores on the SDS and LOCR showed that the public had less contact and wanted more social distance than either clients or staff. Anti-stigma education based around the risks associated with people with mental health/problematic substance use issues and promotion of increased appropriate contact or exposure may reduce these fears and stigmatised attitudes. Overall, the attitudes of the clients of the services were more alike those of the public, and more stigmatising, than those of the mental health workers. This finding suggests that the clients may have internalised public attitudes and as a result may suffer lowered self-esteem and confidence and be less likely to engage in help seeking behaviour due to the stigma involved (Corrigan, 2004; Corrigan et al., 2002; Corrigan & Watson, 2002; Holmes & River, 1998; Link et al., 1987; Room, 2005). Programmes designed to combat both
public and private stigma around people with mental health/problematic substance use issues would, therefore, be expected to encourage help seeking behaviour by people experiencing difficulty.

The present study is a cross-sectional study and has the inherent limitation of such studies in that it cannot directly define the causes of the stigma but can only describe stigma and document substance use rates among this population. Despite the guarantee of confidentiality in this type of research, non-participation will occur in any study involving potentially sensitive topics such as personal drug use. This may have been exacerbated as, to further protect this vulnerable population, the recruitment approach was made by their usual support worker and the priority of the worker is the recovery of the client and not recruiting for research and therefore recruitment may not have achieved maximum effect and there was also no follow up recruitment after the initial approach. However, the sample is large and, though much of the comparison data between the two organisations were not germane to the focus of the issues of focus of this paper and thus not reported, when the findings were compared across the two services the results were remarkably similar. Which suggests the findings may be representative, although it may also be the case that the sampling bias is the same in both organisations. The current study is also unable to definitively identify the reasons for the positive attitudes of staff and it is suggested that further work should involve comparisons across different professional groups and thereby address some of the factors that have been identified in earlier work that may be important in attitude change due to contact; equal status, perceived pleasantness, cooperation, intimacy and voluntary nature of contact (Couture & Penn, 2003).

The mental health NGO sector is a growing part of health service delivery, yet data on co-occurring mental health/problematic substance use is not routinely or reliably collected. As mental health services evolve to more community-based treatment and toward more coordination of mental health and drug and alcohol services, identifying rates of problematic substance use and the utility of using acceptable and appropriate standardised screening tools such as the DAST (Skinner, 1982) and AUDIT (Saunders et al., 1993), which more rigorously define “problem substance use”, can inform programme development for mental health NGOs. Given the high rate of substance use found in this study, routine use of these tools, and more attention to problematic substance use in NGO mental health services can only lead to improved outcomes for those clients affected. Knowledge of the high rate of substance use in these services, the levels of discriminatory attitudes amongst staff, and internalised stigma amongst clients can also assist the development of more targeted anti-stigma training and programmes and support training in the sector.

Acknowledgements
The authors would like to acknowledge the Mental Health Coordinating Council, Network of Alcohol and Drug Agencies and the NSW Ministry of Health for funding the research, and the staff and clients of the services who generously gave their time and effort.

References


