IJSRM
INTERNATIONAL JOURNAL OF SCIENCE AND RESEARCH METHODOLOGY
An Official Publication of Human Journals

Human Journals
Review Article
April 2020 Vol.:15, Issue:2

Living with a Dual Diagnosis

IJSRM
INTERNATIONAL JOURNAL OF SCIENCE AND RESEARCH METHODOLOGY
An Official Publication of Human Journals

Taylor J. Brown[1], Kelly A. Vaulman[1], Rebecca A. Stierley[1], Samuel P. Abraham[2*]

[1]Bronson School of Nursing, Western Michigan University, Kalamazoo, Michigan, USA

[2]Associate Professor of Nursing, Bethel University School of Nursing, Mishawaka, Indiana, USA*

Submission: 23 March 2020
Accepted: 30 March 2020
Published: 30 April 2020

HUMAN JOURNALS
www.ijsrm.humanjournals.com

Keywords: dual diagnosis, substance use, stigma, victimization, care

ABSTRACT

Background: Dual diagnosis is having one diagnosed mental illness and a comorbid substance use problem. Dual diagnosis treatment is clinically complex and often poorly managed because of poor coordination, resulting in higher rates of victimization and recurring criminalization. The purpose of this review was to investigate living with a dual diagnosis and identify factors that contribute to barriers to treatment, the prevalence of victimization, factors associated with victimization, and the stigma these individuals face. **Method:** A review of the literature was conducted on the concept of patients who are living with a dual diagnosis. The studies were found on PubMed, Elsevier, and library databases. Three specific topics were focused on and those were the stigma associated with dual diagnosis, the victimization of those with dual diagnosis, and the coordination of care for those individuals. **Conclusion:** It was found that improved care along with coordination of care was critical to reducing the stigma and victimization of those living with a dual diagnosis.

INTRODUCTION

Living with a dual diagnosis disorder, also known as a co-occurring disorder is a very complex situation. The National Alliance of Mental Illness [1] describes the disorder as someone who is diagnosed with a mental illness and also suffers from a substance use disorder at the same time (see Figure 1). Either disorder can begin initially, but substance use escalates and intensifies the symptoms of mental illness negatively [1]. Dual diagnosis treatment is clinically complex and often poorly managed because of poor coordination, resulting in higher rates of victimization and reoccurring criminalization. The purpose of this review of the literature was to identify factors that contribute to barriers to treatment, the prevalence of victimization, factors associated with victimization, and the stigma that these individuals face with a dual diagnosis (see Figure 2).

Figure No. 1: Dual diagnosis is a co-occurring disorder.

There is a gap in research of effective ways to coordinate services from both mental health services and substance use because much of the care seems to be fragmented. Given that there are two different diagnoses, patient outcomes are much worse for dual diagnosis rather than patients with only one diagnosis [2]. Many providers and researchers believe that one cannot treat mental illness without first controlling substance use. This method leaves a gap in care as many facilities are split in specializing treatment of mental illness or substance use rather than treating them simultaneously and preventing a recurring cycle.

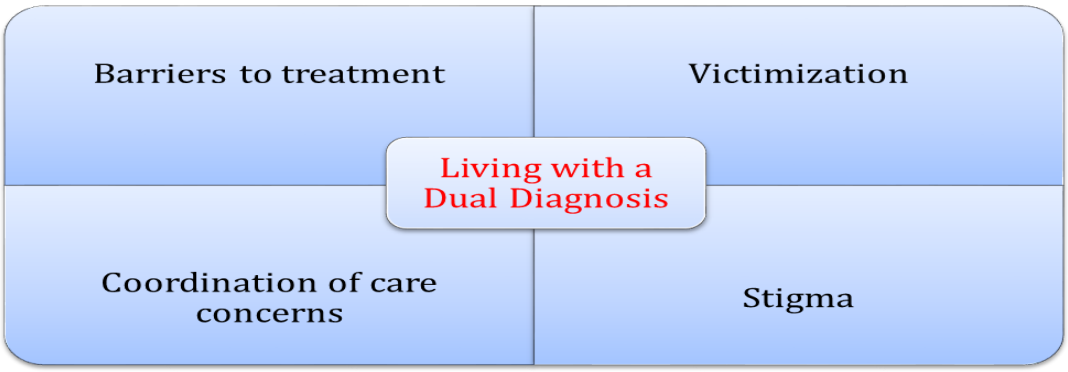


Figure No. 2: Associated factors for individuals living with a dual diagnosis

Case Study

This case involves an individual (female patient A) who was attempting to inflict self-harm by running into traffic under the influence of alcohol. Her diagnosis was bipolar II, post-traumatic stress disorder (PTSD), and substance use disorder (SUD). With both a mental illness and substance use disorder, she was categorized with a dual diagnosis. She reported not taking any medications to manage her diagnosis.

She has been homeless for a few years. She experienced suffering in her life including childhood trauma from a physically abusive father who also used substances in her presence. As well as, a recent miscarriage with an abusive significant other who also suffers from mental illness and SUD. She reported suffering many bruises on her entire body from that relationship. She has also been incarcerated multiple times for crimes varying from petty thefts to possession of drugs. Due to her behaviors, habits, and lifestyle, treatment plans have never worked out after she was released from jail or the psychiatric unit. This is because of the lack of coordinated care and follow-up after she is released from jail or the psychiatric unit.

She acknowledged that she had a problem with her mind that needed to be treated along with her substance use. It appears that substance use started because of the mental illness because she stated, “it made me feel more normal.” She was self-medicating because of the way the medications made her feel and the stigma with asking for help for mental illness. It was evident that she just needed someone to listen to her. She claimed, she had been ignored, stigmatized, and unheard of in the system for so long. She wanted a change, which allowed her to be open to participating in therapy, focused on herself, and improving one day at a

time. The medication regimen she was on was not to her liking because she "felt too tired to participate in daily tasks." Coordination of care would be beneficial to her.

LITERATURE REVIEW

This literature review was focused on victimization, stigma, and coordination of care for patients with co-occurring disorders. These individuals have more severe and persistent symptoms, as well as, more likely to be homeless, face treatment barriers, and victimized [3]. Considering this, studies incorporating these themes were analyzed to identify methods to improve coordination of care so that individuals with a dual diagnosis have improved outcomes, reduced stigma, and less victimization. Sources were compiled from PubMed, Elsevier, and the library database.

Victimization

People living with a dual diagnosis are prone to be victimized [3]. This means they are more likely to be victims of a crime. These crimes include violence, threats of violence, sexual assault, physical assault, and property theft. For instance, those with a dual diagnosis are 14.8 times more likely to be victims of physical assault and 5.8 times more likely to be victims of sexual assault than the general population [3]. Within these victimizations, gender plays a role as to the prevalence as well. The prevalence amongst men and women varied slightly with 47% of the women in the study being physically assaulted compared to 35% of the men. The study showed that men were more likely to be physically assaulted by an individual unknown to them whereas the women were more likely to be abused by a partner or former partner. Only 4% of the men in the study were sexually assaulted compared to 29% of the women [4]. These studies show a disturbing truth that those who are struggling with a dual diagnosis are significantly more likely to be victims of a crime. A staggering number shows that 60% of these participants reported violent victimization and 58% reported property victimization. Similar studies that focused on those with only a mental illness or those with only a substance use disorder resulted in fewer victimizations. For example, using the same measuring instrument, the study showed 23% of violent victimization and 22% property victimization in severe mental illness patients. For those with only a substance use disorder, reported 42% violent victimizations and 48% property victimization [4].

An additional study focused on the factors associated with victimization for those with a dual diagnosis [5]. The aim was to identify factors such as demographics, gender, age, behavior,

and socioeconomic status. The results were then sorted out based on gender. It's male patients with a dual diagnosis, violent victimization was independently associated with younger age, self-sacrificing behavior, and an overly accommodating personality. For the women, violent victimization was independently associated with younger age, homelessness, and a dominant and controlling personality. Violent victimization was not associated with a distant personality or being socially inhibited [5]. All of this is valuable information because there are not many studies on patients with a dual diagnosis. This helps guide literature and focus further research on the coordination of care, treatments, interventions, and reducing stigma.

In another study researching criminalization of those with a dual diagnosis, they also found that those with a dual diagnosis have an elevated risk to perpetrate a crime [6]. In those who perpetrate a crime, their risk to be victimized is extremely elevated as there are many major mental health consequences for the victim to face [6]. This study was conducted with 243 patients with a dual diagnosis who were seeking treatment. The main goal was "to identify demographic and clinical factors that were associated with crime perpetration in dual diagnosis patients" [6]. The study focused on factors associated with the perpetration of violent crimes, expression of threat, and property crimes. There was an overlap in the factors that were expressed in all three areas; one of the main factors being, the severity of alcohol and drug use problems. The results also concluded a diagnosis of a personality disorder was highly associated with criminal behavior as they found that 60-70% of the population in this prison facility had a diagnosis of one or more personality disorders [6]. Other factors they found to be associated were lifetime trauma exposure and younger age. Identifying these factors leads to further steps in creating specific prevention programs for reducing crime and victimization in patients with dual diagnoses [6].

There were some limitations to these studies considering that they were done in the Netherlands. Their statistics may be different than those in other countries. Also, their factors that are associated with victimization for those with a dual diagnosis may differ as well. The biggest problem was that the prevalence of victimization was likely to be more severe than what was found [6]. These studies were based on the self-reporting of participants who have a severe mental illness and substance use disorder co-occurring at the same time. These individuals are highly stigmatized because having a mental illness or a substance use disorder are already stigmatized, now they are co-occurring. This means the individual may not want

to report that they have been victimized. Also, if they are partaking in illegal substance use, they may be reluctant to report due to the stigma and potential repercussions. As far as the increased likelihood to commit a crime could be related to the self-fulfilling prophecy of being stigmatized as lower-class citizens due to their illness. It could also be due to the nature of substance use and the need to fill that substance need [6].

Standing Stigma

Patients with dual diagnosis face a number of problems in the medical field and within the legal system. Lack of proper treatment, lack of resources, and improperly educated professionals leads to barriers of care with patients diagnosed with a dual diagnosis. Nicholas et al. [7] conducted a study using interviews structured with open-ended questions to find the most common issues faced by patients with dual diagnosis. Many patients reported they experienced being misunderstood and stigmatized. These patients face difficulty accessing health care and are subject to stigma, abuse, and a poor quality of life [7]. This study, along with others, assessed the treatment patients with dual diagnosis receive. Many times, services are generic and follow specific guidelines. Mainstream psychiatric care does not always fit patients with dual diagnosis because it focuses on one aspect and not the whole patient. When the patient does not respond to treatment they face "negativity and belittlement" from staff and caregivers [7]. The most-reported challenge faced by these patients was a misunderstanding and an insufficient care plan. Many times, these patients felt stereotyped and as if their provider had a lack of knowledge to care for their situation. This study found that many patient's providers gave single attention to only one component of their range of issues [7].

Along with having trouble in inpatient settings, patients with dual diagnosis also face many troubles receiving proper care when discharged. The patients reported having difficulty with gaps in an uncoordinated system and lack of supportive care. When patients with a dual diagnosis were placed in a long-term facility, they faced troubles with proper care due to insufficient resources to meet the needs of complex conditions [7]. Many times, places such as this also have long waiting lists which can be a deterrent or barrier to treatment. The typical standard of practice does not reach the demands of a dual diagnosis patient.

To expand on the idea of treating patients, one study focused on examining the challenges of working with a dual diagnosis patient [8]. The study reports indicated that 50% of individuals

with a mental health disorder have at least one substance use disorder [8]. Dual diagnosis was associated with more instances of relapse, higher numbers of the homeless population, a higher number of psychiatric symptoms as compared to those with one diagnosis, and more suicidal ideations and attempts [8]. Physicians have insufficient knowledge and skills for treatment associated with patients who have a dual diagnosis. Current practice for mental illness is a standardized treatment plan based on diagnostic criteria. If a patient has two diagnoses they will not fit into a standardized plan. One main problem that repeatedly occurs is that treatment plans focus on treating the patient's mental illness and not their comorbid condition simultaneously [8]. This can potentially lead to relapses and a lack of treatment of the substance use disorder due to not recognizing all of the underlying issues. Another major problem dual diagnosis patients face is that professionals have insufficient knowledge and counterproductive attitudes toward these patients. This is a theme that repeatedly occurs in several studies. A reason for this is the lack of research conducted on dual diagnosis and insufficient guidelines in place for treating such patients. Providers often blame the lack of patient compliance for improper treatment. They struggle with patients not showing up for treatment, not taking their medications, or not following the instructions regarding substance use and treatment [8].

Zettler [9] examined the treatment of a dual diagnosis patient who was previously incarcerated for a drug charge. Some common risks that dual diagnosis patients face compared to other types of offenders are higher rates of homelessness, which affects their path to distance from crime [9]. Patients with a dual diagnosis have longer incarceration periods with poorer outcomes resulting in increased costs. This may be related to treatment noncompliance. A person with dual diagnosis is significantly more at risk for recidivism following completion or dismissal of a drug court problem. Another finding was that the chance of recidivism wanes over time. This indicates treatment following the drug court program may be helpful such as aftercare follow-up appointments [9].

Coordination of Care

As shown in Figure 3, patients who have received a dual diagnosis have been deemed as one of the most clinically complex groups of people to effectively treat according to the wide difference in their issues, needs, goals, and therapies possible. One study concluded that there were an obvious fragmentation and lack of coordination between specialists who are supposed to provide treatment services [2]. The root of this coordination issue was that care

given in different settings, one for treatment of substance use disorder and the other for mental health treatment. There was a lack of communication between specialists leaving a gap in the care provided and resulting in poorer client outcomes. Throughout the study, interventions to improve this issue were introduced in ways to collaborate care from the beginning. This can be accomplished by providers meeting in teams upon admission to make joint decisions about the best care possible. During these meetings, providers were to identify all present problems, draw conclusions, analyze, and decide on the best possible client outcome. The last step was to agree on an action or treatment to be performed together; this way clients can receive effective care for both diagnoses in an organized fashion [2].

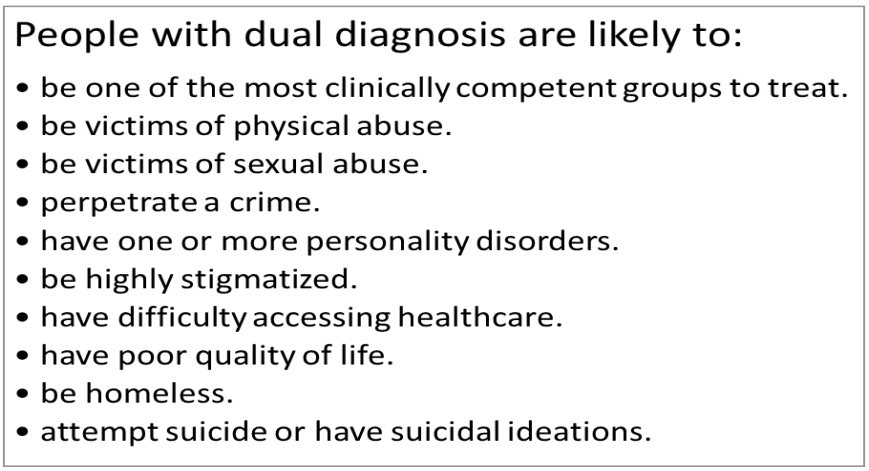


Figure No. 3: Emerging themes related to challenges experienced by patients with a dual diagnosis.

Another study encountered some of the same issues including loss of communication between facilities leading to poor coordination of care. Van Dorn et al. [10] focused on the jail to community treatment continuum and interventions to improve treatment services provided for inmates with co-occurring disorders. Sixty participants were able to enter the study at the beginning of their incarceration. If they fit criteria, they were randomly selected to either motivational interviewing (DDMI) and integrated group therapy (IGT) or the usual protocol treatment already being provided in the facility. This study was aimed at improving both jail and community-based treatment services to improve communication between each facility and provide more effective care when inmates are re-entering the community [10]. The interventions of exchanging treatment of usual protocol with DDMI-IGT helped improve coordination of care and fill in missing gaps of services. The aim was to reduce re-entry into incarceration. Individuals released from prison experience high rates of injury related to dual

diagnosis, therefore, the development of targeted injury prevention programs are needed [11]. McCabe and Parrish [12] argued that including specific content about comorbidities is important for students to be equipped with the levels of knowledge and confidence needed to do their best work, and to make a positive difference with dual diagnosis population.

Interventions for Better Care

A common theme recurring was that patients with dual diagnosis feel they do not receive adequate care. Their feelings of inadequate care were based on the period of treatments, the methods of treatment, and the knowledge to which health professionals have when caring for these patients. It can be concluded from the studies that patients with a dual diagnosis cannot be treated the same as a patient who is facing a single mental illness or substance use disorder. Patients need interveners such as social workers to provide advocacy [7]. The patients need someone to support them and recognize their true needs. Yes, this happens now, but not for enough patients. This leads to the idea that more education on dual diagnosis is needed for professionals. To better the care of a patient with a dual diagnosis, more education is needed. This will also help to reduce stigma.

The medical treatment team sometimes places blame on the patient when they relapse with drug use or do not comply with medical orders. With a flexible, longer treatment, and collaboration of substance use and mental illness, it will be less difficult to treat patients with dual diagnosis and they will respond better [8]. The hope is for more mental health professionals to recognize the challenges faced by patients who have comorbid conditions [8]. These interventions are also needed for those who have been incarcerated due to drug use. The current standardized programs do not address all aspects of the dually diagnosed patient. These patients need recurrent follow-up care to help prevent recidivism (see Figure 4).

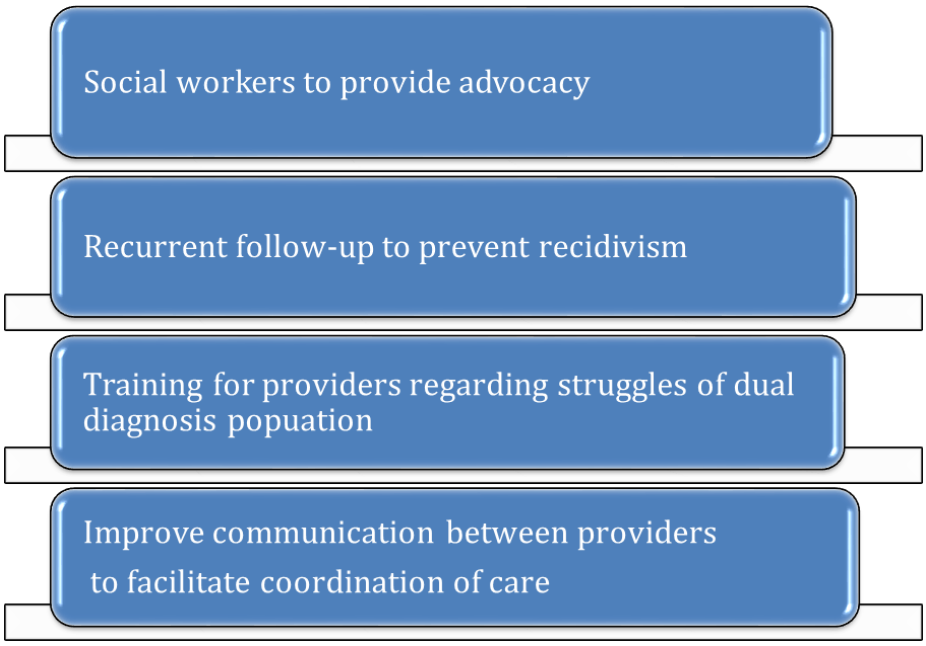


Figure No. 4: Emerging themes regarding the required interventions to treat dual diagnosis.

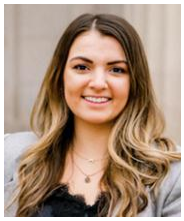
CONCLUSION

Patients who live with dual diagnosis are not the same as those who face mental health and substance use disorders. This class of patients live with two separate diagnoses that require individualized care. People who have co-occurring conditions have more severe symptoms and thus face stigma, judgment, inadequate care, and are victimized. They commonly experience relapse due to a lack of adequate care. Patients living with a dual diagnosis require care differently than a single mental illness. These patients need coordination of care with properly trained professionals who understand what this population faces. With the proper education of health officials, further research, and specialized care for the dual diagnosis, these individuals could be effectively treated for their illnesses. As a result, individuals with a dual diagnosis may live within the community without stigma and are less victimized.

As found in the literature review, living with a dual diagnosis is associated with barriers to treatment, victimization, stigma, and coordination of care concerns. These individuals are difficult to treat, become victims of crime and sexual abuse, experience homeless, and have difficulty accessing healthcare. Required interventions include recurrent follow-up to prevent recidivism, training for providers regarding struggles of dual diagnosis population, and improved communication between providers to facilitate coordination of care.

REFERENCES

1. National Alliance on Mental Illness. (2017). Dual diagnosis. Retrieved from https://www.nami.org/learn-more/mental-health-conditions/related-conditions/dual-diagnosis
2. Bjørkquist, C., & Hansen, G. (2018). Coordination of services for dual diagnosis clients in the interface between specialist and community care. *Journal of Multidisciplinary Healthcare*, 11, 233-243.
3. de Waal, M. M., Dekker, J. M., & Goudriaan, A. E. (2017). Prevalence of victimization in patients with dual diagnosis. *Journal of Dual Diagnosis, 13*(2), 119-123.
4. de Waal, M. M., Dekker, J. M., Kikkert, M. J., Kleinhesselink, M. D., & Goudriaan, A. E. (2017). Gender differences in characteristics of physical and sexual victimization in patients with dual diagnosis: a cross-sectional study. *BMC Psychiatry*, *17*(270).
5. de Waal, M. M, Christ, C., Dekker, J. M., Kikkert, M. J., Lommerse, N. M., van den Brink, W., & Goudriaan, A. E. (2018). Factors associated with victimization in dual diagnosis patients. *Journal of Substance Abuse Treatment, 84*, 68-77.
6. Eggink, E., de Waal, M., & Goudriaan, A. (2019). Criminal offending and associated factors in dual diagnosis patients. *Psychiatry Research*, 273, 335-362.
7. Nicholas, D. B., Calhoun, A., McLaughlin, A. M., Shankar, J., Kreitzer, L., Uzande, M. (2017). Care experiences of adults with a dual diagnosis and their family caregivers. *Sage Publications Journal, 4*, 1-10.
8. Pinderup, P. (2018). Challenges in working with patients with dual diagnosis. *Advances in Dual Diagnosis, 11*(2), 60-75.
9. Zettler, H. R. (2018). Exploring the relationship between dual diagnosis and recidivism in drug court participants. *Crime & Delinquency, 64*(3), 363–397.
10. Van Dorn, R., Desmarais, S., Rade, C., Burris, E., Cuddeback, G., Johnson, K., . . . Mueser, K. (2017). Jail-to-community treatment continuum for adults with co-occurring substance use and mental disorders: Study protocol for a pilot randomized controlled trial. *Trials, 18*(1), 365.
11. Young, J. T., Heffernan, E., Borschmann, R., Ogloff, J. R. P., Spittal, M. J., Kouyoumdjian, F. G., … & Kinner, S. A. (2018). Dual diagnosis of mental illness and substance use disorder and injury in adults recently released from prison: a prospective cohort study. *The Lancet. Public Health*, *3*(5), e237–e248.
12. McCabe, E., & Parrish, M. A. (2018). A review of the complexities of working effectively with people being prescribed both antipsychotic medications and opioid substitution therapy. *Drugs: Education, Prevention & Policy*, 25(1):1-12.

	Taylor J. Brown *Bronson School of Nursing, Western Michigan University, Kalamazoo, Michigan, USA*
	**Kelly A. Vaulman** *Bronson School of Nursing, Western Michigan University, Kalamazoo, Michigan, USA*
	**Rebecca A. Stierley** *Bronson School of Nursing, Western Michigan University, Kalamazoo, Michigan, USA*
	**Samuel P. Abraham– *Corresponding Author*** *Associate Professor of Nursing, Bethel University, 1001 Bethel Circle, Mishawaka, Indiana,*