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DUAL DIAGNOSED CLIENTS AND RATE OF RELAPSE

By
Michele Fredericks

A Thesis

Submitted in partial fulfillment of the requirements of the
Masters of Arts Degree
of
The Graduate School
at
Rowan University
2002

Approved by _____

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ABSTRACT

Michele Fredericks
DUAL DIAGNOED CLIENTS AND RATE OF RELAPSE
2002
Dr. J. Klanderaman
Seminar in School Psychology

The objective of this study was to gather information on dual diagnosed client's level of social support in the environment and to assess the degree to which this has an impact on the rate of relapse or rehospitalization. The sample for the study consisted of 46 clients with an Axis I diagnosis of schizophrenia or a chronic mood disorder according to the DSM IV criteria along with poly substance abuse. The age of the clients ranged from 19- 59 with a mean of 38.8. All clients used in the study were enrolled in a nonprofit intensive case management program (ICMS) for at least six months post discharge from a state or county psychiatric hospital.

The design of the study was conducted to establish that dual diagnosed clients level of social support is directly correlated to the level of stability the client is able to maintain in the community. It is hypothesized that a positive relationship would exist between level of social support and rate of relapse or rehospitalization.

MINI-ABSTRACT

Michele Fredericks

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Dr. J. Klanderman

Seminar in School Psychology

The objective of the study was to gather information on the level of social support dual diagnosed clients received, and to assess the effects on the rate of relapse or rehospitalization. It was hypothesized that a positive relationship would exist between the level of social support and the rate of relapse or rehospitalization. The data collected confirmed that researchers hypothesis that a positive relationship exists between social support and rate of relapse.

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Chapter One

Need

Caring for the mentally ill has been a serious and controversial issue for many years in the United States. More than 5.5 million adults in the United States have been diagnosed with a serious mental illness such as Schizophrenia, Bipolar disorder or depression (Rhoades 2000). The criteria for a mental illness diagnosis is a display of symptoms for at least a year with an inability to perform self care and undertake community living on their own (Rhoades 2000). The question of treatment has been a long-standing question in the mental health field and different methods have come under great controversy.

Treatment of the mentally ill has changed significantly throughout the past thirty years. In the 1960's and 1970's national mental health policies shifted and alternate methods of caring for people with mental illness was found to be more effective (Rhoades 2000). In 1963 the community mental health centers construction act and its amendments made in 1965 and 1975 made it clear that long term institutionalization of individuals with a mental disorder was a violation of their human rights, and this resulted in a decline in population of state hospitals (Rhoades 2000).

Providing a therapeutic base for clients in the community where individuals can give back and gain through vocational means from their surroundings give clients a better quality of life and adds a humanistic quality that has been missing in the past.

Community based agencies have been set in place to provide a more therapeutic environment for clients. It has become the role of Community based programs to help with the transition from hospital to the community, in the hopes of decreasing the rate of client relapse.

A discharge plan is made for clients prior to leaving the hospital, and linkages are made to services in order to assist in aftercare and adjustment in the environment. At present publicly funded community mental health agencies located throughout the counties are mandated to provide aftercare services for the discharged mentally ill client. Services may include prescribing and monitoring medications, offering group, individual, and family therapy, and linking to other community agencies for additional needed services.

In principle a newly discharged client from a state or county hospital is linked to an intensive case management service where the individual is followed for a minimum of eighteen months. The hope is that by providing these needed services the client will adjust to his or her environment and this in turn will prevent re-hospitalization or relapse.

The concept of decreased hospitalization and linkages to community based agencies has been successful for the most part with mentally ill clients with a single diagnosis, however, there is a widespread comorbidity of psychiatric disorders and substance use disorder clients who have not benefited. The term dual diagnosed arose in the early 1980's and identifies individuals who have a dual disorder of severe and persistent mental illness and substance abuse dependence (Smith 2001).

Statistical research done by Mental Health Weekly (2001) noted that dual diagnosed clients have higher rate of hospitalizations, 456 are hospitalized per 1,000 clients across three states, this is more than five times the rate of mental health only clients and they are twenty times more likely to be hospitalized. Dually diagnosed clients exhibit greater symptomatology, are difficult to treat, and are more often than not treatment noncompliant.

Purpose

Dually diagnosed client continues to have high rate of relapse despite the many treatment programs, and services set into place to assist with the transition. The dually diagnosed client appears to have the most difficulty adjusting in the community. A better understanding of what causes this poor adjustment is needed as well as more effective treatment methods in order to properly service this population.

The purpose of this study is to examine the factors involved in the high rate of relapse of dual diagnosed clients, and by doing this it is the hope that more effective treatment methods will be found and implemented to assist clients.

Hypothesis

The study will compare psychiatric severity and social support and assess its role in the rate of relapse. It is the hope that a positive relation exists between the lack of social support for dual diagnosed client and the high rate of relapse.

Theory

The problem of comorbid mental illness and substance abuse is a pervasive and far reaching in the United States (Smith 2001). Since the de-institutionalization of the mentally ill in the 1980's there has been a large percentage of mentally ill clients who are homeless, living on the streets in the cities and in and out of short term care mental hospitals. Smith (2001) reports, "a significant association exists between homelessness and dual diagnosis; two thirds homeless adults are substance dependent, 22% have chronic mental illness and 77% have both"(3).

Homeless mentally ill clients largely represent the population who have minimal to no support in the community whether it be family, friends, religious organizations or programs set up to assist clients. This population is difficult to deal with and as a result they are often faced with alienation from family and friends due to lack of understanding of the illness or stigmatism.

The stress involved in dealing with a persistent mental illness, and having no support network has been the topic of many research theorists. One such study was done by Gomez et al. (2000) where it was reported that "the probability of an individual engaging in drug and alcohol use is linked with stress level and the degree to which it is buffered by stress modifiers such as social networks, social competence, and resources"(2).

There have been several social support theories that believe that a stronger support network is the key to decrease in rate of relapse in dual diagnosed clients. Other theories believe that is not the level of support necessarily, but the perceived level of support that has more of an impact on the ability of clients to function in the community. Weinberg

(1996) social model theory stressed the self-help principles and traditional psychotherapeutic techniques when applied were affective in the stability process (2).

Psychiatric severity and the inability of the client to cope with symptoms is another theory that the researcher discusses. Clients use alcohol and or drugs as a way of self-medicating in the attempt to cope.

Motivation or readiness to change is another theory that is held by many researchers and practitioners (Carey et al.2001). Clients are unable to process cognitive self-help measures, because of the debilitating effects of their illness.

A study will be conducted in a mental health outpatient setting with forty-six dual diagnosed clients, and by doing this to investigate the relationship between social support and self-esteem and the rate of relapse. This study will demonstrate that social support and feelings of belonging diminish stress, which in turn can decrease the affects of physical and psychological symptoms that causes client to relapse.

Assumptions

For this study the researcher assumes that the clients in the study are appropriately diagnosed post discharge from state or county hospital. The information for the study was gathered from the assessment addendum done at intake and the researcher also makes the assumption that the information is accurate and applicable to clients at this time.

Limitations

The sample size is limited to a particular treatment sector that might affect the results of the study; this will only be minimal and will not have a significant affect on the results of the study.

Terms

Dual diagnosed client—A client that has more than one Axis I diagnosis in the mental health DSM IV manual. A dual diagnosed client can have an Axis I diagnosis of Bipolar disorder, and drug and alcohol abuse.

Comorbidity—Use in mental health to refer to disease that has two parts “co” meaning to be accompanied by another word to mean dual diagnosed. Will be used interchangeable in paper.

Baseline—Mentally ill clients have a level of stability to which they are considered to be functioning at their best given their illness. Some clients’ baseline is better than others.

Overview

Chapter two will provide a broader view of the dually diagnosed client, and the researcher will examine the extensive literature that is significant to the topic of the thesis. In chapter three, the researcher will present the design of the study. Finally in chapter four and five the researcher will analyze and discuss the findings and results of the study.

Chapter Two

Literature Review

Introduction

In this chapter the researcher reviews the array of literature that has contributed pertinent information to the area of dual diagnosis and the rate of relapse. The beginning of the chapter presents the reader with some statistics regarding the history and prevalence of dual diagnosis. Initial studies done on the topic and outcomes of these studies will be discussed. By giving the history and prevalence of dual diagnosis, it is the researchers hope to provide the reader with a better understanding of the illness. The body of chapter two covers several categories of research that contribute significant information on the topic of the researcher's thesis.

The literature that the researcher reviews for this thesis will consist of contributing factors in high rate of relapse, and more effective treatment methods to reduce rate of relapse. Since the researcher chose to look at the literature in-depth, the researcher establishes several sections, so that the reader may develop a clear understanding of the themes that contribute significantly to the thesis. The following areas are covered in some depth in this chapter: *primary Axis I diagnosis; psychiatric severity, and the Transtheoretical model; perceptions of social support*. The researcher begins with the literature that is most general to the purpose of this thesis, and proceeds to focus on the

specific areas of research that contributes the most significant information to the thesis. Finally, chapter two concludes with a summary in which the researcher discusses the implications of all of the previous work in this area. The researcher then provides the reader with a direction for chapter three.

History of Dual Diagnosis

Research on clients with dual diagnosis has been extensive within the past ten years mainly due to the increase in severity of illness and the difficult challenge it is to provide effective treatment for this population. The researcher identifies a dual diagnosed client as an individual who has a dual disorder of persistent mental illness and substance abuse or dependence (Smith, 2001). Smith (2001) states that the term dual diagnosis arose in the early 1980's when a consistent and pervasive relationship between a psychiatric disorder and alcohol and drug abuse was recognized (p.2). "As many as ten million Americans have dual diagnosis; One possible explanation for this number is the widespread de-institutionalization of the mentally ill in the 1980's, which exposed mentally ill fragile people to the rising availability for acceptability to alcohol and other drugs"(Smith, 2001).

Individuals with dual disorders presented a challenge to the existing mental health providers and there began an increase in studies to better understand this population. Smith (2001) discusses a study done in the early 1980's of 20,000 people in the United States, involving institutionalized and homeless people. The National Institute of Mental Health commissioned the Epidemiological Catchments Area (ECA) to conduct this study

of the general population. This study was done with the intent of documenting for the first time what was already commonly believed by mental Health and substance abuse professionals—that comorbidity of substance use and psychiatric illness was becoming increasingly prevalent and common in the general population (p. 2). Smith further reports that of the 20,000 people surveyed, approximately 45% of those individuals had an alcohol use problem and 72% a drug abuse or dependence also had some type of psychiatric disorder (p.2).

Smith (2001) reports on another survey done in 1991 was done by the National Comorbidity Survey (NCS), where the risk factors associated with comorbid mental illness and substance abuse was investigated in greater depth. The study revealed that roughly one sixth of the total population had a serious psychotic disorder and that a high level of comorbidity exists among these individuals (p.2).

It is believed that mental illness precedes substance abuse somewhere in the preteen age and later in teen and early twenties substance abuse disorders manifest itself (Smith, 2001). Later in the chapter the researcher will go into depth as to the reasoning behind the theory of mental illness preceding substance abuse better known as self-medicating.

Primary Axis I Diagnosis

In this section of the chapter, the researcher reviews some research material related to prevalence of certain Axis I diagnosis and substance abuse. Clients diagnosed with Schizophrenia are thought to be more susceptible to substance use. The October 2000

edition of the Harvard Mental Health Letter published an article titled “What Is The Relationship Between Schizophrenia And Substance Abuse?” Questions were asked of Alan I Green MD about his perceptions of the relation between Schizophrenia and substance abuse, and he states that “about 50% of people with schizophrenia also have a history of substance abuse or dependence, including alcoholism—a rate three times higher than average”(p.1).

Within the mental health field and among mental health professionals there is a term known as self-medicating and Green (2000) uses this term as an explanation for substance abuse among schizophrenics. Green (2000) states that Schizophrenics may be trying to override the neurological side effects of the anti-psychotic medications, which can cause client to become uncoordinated (p.1). Another explanation given by Green (2000) is that clients may be attempting to medicate themselves in order to decrease symptoms, such as lack of motivation and an inability to experience pleasure.

Schizophrenic patients are unable to experience pleasure out of every day life due to inadequate functioning in certain brain circuits. Dopamine, which is a neurotransmitter in the brain, promotes feelings of well being and pleasure and the malfunctioning of this circuit causes positive symptoms (hallucination and delusions) and negative symptoms in schizophrenics (p.1).

Substance use is prevalent in Schizophrenic because Green (2000) states that it helps to facilitate dopamine transmission in the brain circuits and produces in schizophrenics a short-lived sense of will being. This sense of well-being is false; drug and alcohol use in all dual diagnosed clients produces a long-term deterioration in functioning (p.1). This deterioration in functioning results in “ a very high rehospitalization rate, notorious non-

compliance and a poor prognosis have consistently been shown... high incidence of homelessness, more positive and less negative symptoms compared to other schizophrenics, more affective disturbance, ...and an increased suicide rate..."(Soyka, 2000, p.3).

Therapeutic interventions for the dual diagnosed client is challenging due to the inability of mental health professional to administer the traditional treatment methods. Certain self-help groups, because of their confrontational and abstract spiritual approach, may not work for many psychotic patients (Soya, 2000, p.4). Green (2000) states that certain anti-psychotic drugs such as Clozapine seems to lower the amount of substance use, however more studies are needed in this area (p.2).

Virgo, Bennett, Higgins, Bennett, and Thomas (2001) conducted a study on inpatient, day patient and out patient dual diagnosed clients in Eastern Dorset United Kingdom. In the study it was found that of the 510 patients more than half were schizophrenic, with depression second at 17% and a close third was Bipolar disorder, and Schizoaffective disorder (p.4). This statistical outcome mirrors other research done on the North American population. The clients in Virgo, Bennett, Higgins, Bennett, and Thomas (2001) study tended to be younger than the general mental health population and most often male (p.6).

Dual diagnosed clients have a high rate of substance use, however "the most problematic substance use in patients of the mental health services was abuse rather than dependence" (Virgo, Bennett, Higgins, Bennett, Thomas, 2001, p.7). It would lead the researcher to the idea that dual diagnosed clients use substances as a coping mechanism for symptoms, rather than from addiction. Virgo, Bennett, Higgins, Bennett, and Thomas

(2001) who concluded that dual diagnosed clients would benefit more from treatment mainly for mental health rather than addiction services (p.7) further support this.

The research done by Virgo, Bennett, Higgins, Bennett, and Thomas (2001) has shown that Axis I Diagnosis is a determinant of substance abuse rather than dependence, it was found that 'addiction patients were significantly less likely to suffer from schizophrenia (although some did), and more likely to suffer from depression. This study lends to support that Axis I diagnosis does play a role in severity of substance uses and gives implications for treatment.

Psychiatric Severity and Transtheoretical Model

There have been several studies done on psychiatric severity and how it affects rate of relapse. Jordan, Luke (1996) did a study addressing this issue and found that persons experiencing acute psychotic symptoms such a delusions and paranoia were more likely to abuse substances, which increased the likelihood of rehospitalization (p.5). Jordan, Luke (1996) further supported the theory that severity of psychotic symptoms was a stronger predictor of functioning than actual psychotic diagnosis (p.5).

Velasquez, Carbonari, and DiClemente (1999) believed that dual diagnosis treatment could be enhanced by employing techniques that focuses on change process variables that are strongly related to psychiatric distress (p.1). Velasquez, Carbonari, and DiClemente (1999) performed a study involving 132 alcoholic dependent subjects in an out patient dual diagnosis program, where J.O. Prochaska and C. DiClemente's Transtheoretical

Model (TTM) was used (p.1). J.O. Prochaska and C. DiClemente's Transtheoretical model of change is one that is used with addiction patients and consist of five stages of intentional thought and behavior change (Brady et al., 1996, p.2). The stages of TTM are "precontemplation, when the person may be in denial of his or her problem and is unmotivated for treatment; Contemplation, when the individual acknowledges having a problem but not ready to make concrete behavioral changes; Preparation, when planning for change takes place; Action, when the person modifies his or her behavior, experiences, or environment to overcome their problems, and; Maintenance, in which the person works to prevent relapse and consolidated the changes made during action" (Brady et al, 1996,p.2).

In Velasquez, Carbonari, and Diclement's (1999) study psychiatric severity and the TTM constructs of stages and processes of change were measured, and the results were that client's scores were strongly related to psychiatric severity. The more an individual was experiencing psychiatric distress the more he or she was tempted to drink, and changes in the TTM reflected this (p.1).

Carey, Maistro, and Carey (2001) studied readiness-to-change substance misuse among psychiatric outpatients in further depth. The authors felt that there were some concerns regarding the degree to which diagnostic status, cognitive function, or psychotic symptoms may influence the accuracy of a readiness-to-change assessment (p.2). Carey, Maistro, and Carey (2001) felt that "deficits in self awareness or abstract thinking seen in persons with schizophrenia may compromise their ability to self report interest in and intentions to change. Also, the presence of negative symptoms... may interfere with the assessment of such motivational constructs as readiness-to-change (p.2). The authors felt

that it was important to determine empirically whether readiness to change could be assessed reliably and validly in dually diagnosed persons (p.2).

Perception of Social Support

A considerable amount of research has been done on the mechanism through which social support promotes physical and mental health and helps decrease psychological stresses. Support, whether it is from a family member, program or a community network has been positively linked to increased health and longevity. To have a feeling of belonging and support can decrease stress and promote feelings of well being. Hotz (2001) preformed a study, which examined the relation between esteem support and rates of hospitalization in dual diagnosed clients. The results from this study showed that the belief or perception of being supported could decrease psychological symptoms and encourage sobriety (p.1).

For the dually diagnosed client support is very important, especially when dealing with the stress of change” compounded by many other obstacles including stigma, discrimination, low self-esteem, inadequate education, limited vocational skills, housing and financial resources, as well as possible cognitive impairment, emotional liability and side effects from prescribed medications” (Laudet, Magura, Vogel, Knight, 2000, p.1).

A study was done by Ludet, Magura, Vogel, and Knight (2000) who investigated the “the association among support (including mutual aid), recovery status and personal well being in a sample of dually diagnosed persons” (p.2). The study hypothesized that the higher the level of perceived support and the more frequent attendance in mutual aid groups such as AA and NA, the fewer rates of relapse clients will have, as well as higher levels of personal well being (p.2). Participants of the study were from a mutual aid group called Double Trouble in Recovery (DTR). The total number of participant were 310 clients who were interviewed and several questions such as perceptions of social support, partner support, spiritual support, DTR participation, as well as mental health, and substance abuse (p.3-4). Results from the study reflected a “significant correlation between social support and substance use such that subjects who perceived high levels of support and more sources of support were less likely to report having used drugs and/or alcohol in the past year and past month. Longer more frequent attendance at DTR... were significantly associated with less substance use in the past year” (Laudet, Magura, Vogel, Knight, 2000, p.6).

Gomez et al (2000) in a community mental health rehabilitation program in Baltimore, Maryland also studied social support. A self-report study was done on clients perception of support, where questions such as way to deal with stress were asked, On the question of ways to deal with stress the most frequently reported response were using alcohol and or drugs (p.3). Gomez et al (2000) found that “ three quarters of the patients (76%) reported using drugs and alcohol as a way to deal with inadequate support systems...”(p.3). The results of this study also showed a correlation between perceptions of social support and relapse.

An article written by Klein and Cnaan (1998) called "Significance of peer social support with dually diagnosed client: Findings from a pilot study", examined a peer social support program which provides support to high-risk dually diagnosed clients (p1). A Comparison study was done involving two groups, on receiving peer social support and the other not. The results favored the group that received peer social support, as they required fewer crisis interventions during the period of the study (p7.). Klein and Cnaan (1998). Summarized that the study finding supported their hypothesis that "coupling a peer social support person ... with services provided by intensive case managers may positively affect systems outcomes and improve an individuals perceived quality of life" (p.10).

This would be an opportune time for the researcher to bring attention to the difference between perceptions of support verses actual support given to a client. Klein and Cnaan (1998) states that, "perceived support (PSS), the extent to which and individual believes that his or needs for support, information, and feed back are fulfilled, differs from support provided by social networks... the reason is the PSS is influenced by personal factors involving both long-standing traits and temporal changes in attitude or mood" (p.2). The first two studies were client's perceptions of social support and the last a comparison in social support verses not. All three studies resulted in a positive correlation between social support and decrease in relapse.

Summary

All of the articles reviewed in this chapter contribute significant background information and purpose for the researcher's study. Since the closing for mental health institutions in the 1980's there has been questions of how to care for mentally ill clients, particularly dual diagnosis clients who are hard to integrate into normal society. It is the researchers hope that the theories presented will offer some insight into dual diagnosed clients and provide the reader with some contributing factors in the high rate of relapse of these clients. The question of clients using drugs and alcohol to self medicate, and psychiatric severity puts forward treatment methods that could possible decrease the homelessness, and frequent rehospitalization of clients. Looking at the social network of client also can offer some input into the growing problem of instability of this population. It is the researcher's hope that the outcome of this study will prove some of these research theories to be an important factor.

Chapter Three

Sample

The samples for this study consisted of 46 dual diagnosed clients' with a mean age of 38.8. All of the clients in this study have an Axis I diagnosis of schizoaffective disorder, schizophrenia, bipolar disorder, depressive disorder, or dysthymic disorder, according to the DSM-IV diagnosis code. In addition to Axis I diagnosis, all clients in the study carried a substance abuse history of some type. The sample consisted of twenty-three males, and twenty-three females. There were twenty-six Caucasians, eighteen black, one Asian, and one Mexican represented in the sample.

All of the clients used in this study were enrolled in a non-profit intensive case management (ICMS) program for at least 18 months post discharge from a state or county mental hospital in the southern New Jersey area. The researcher chose the forty-six sample population out of a hundred and thirty clients due to their comorbidity and length of admission into the ICMS program. Most of the clients selected for this sample were attending a Mentally ill chemical abuse (MICA) treatment facility, or did at one time during their enrollment in the ICMS program.

The researcher works as a clinical case manager at the ICMS program and has access to all files, and statistical information of the clients in this study. Before proceeding with the study, the researcher notified her supervisor of the topic of research and of materials that would be necessary to carry out the study. The researcher received verbal

permission from her supervisor to use the clients' files for information as long as the client's name and the program name remained anonymous.

Measure

The researcher's study comprised mainly of studying the ICMS program consumer tracking outcome reports. This report is a form completed monthly and tracks the rate of re-hospitalization of clients. The level of support a client receives in the community was studied by the assessment addendum done at intake into the ICMS program. The assessment addendum figure 3.1, and 3.2 is a series of questions asked of the client to access the level of support in the community.

The researcher chose to break the subjects up into three groups. Group one, received no support from family, friends, church or community aside from ICMS. The second group, group two, did not have what the researcher considered adequate support in the community, these clients were most likely estranged from their family, had minimal finances such as general assistance or SSI benefits, and was living in a boarding home or shelter.

Clients in group three received good social support in the community. These clients had adequate place to live, at least one family member that they had contact with and was able to maintain a healthy relationship with this family member and was affiliated with a church or organization who assisted in the stability in the community. Subjects in the third also had such things as finances and treatment programs in place.

Figure 3.1

ASSESSMENT ADDENDUM

Consumer: _____ Date: _____

Consumer ID: _____ Consumer DOB: _____ Program: _____

Staff Completing Form: _____

Spiritual Orientation Beliefs	
Describe the Consumer's religious affiliation and participation (past or present).	
Does the Consumer have spiritual beliefs in a higher power that offers them comfort and support? If so, describe.	
Describe how the Consumer's spiritual orientation and beliefs impact treatment.	

Sexual History Orientation (12 years of age or older)	
What is the Consumer's sexual orientation?	
Is the Consumer currently involved in a sexual relationship, and if so, are there sexual problems?	
Did the Consumer experience traumatic sexual events in the past?	
Does the Consumer need help resolving current or past sexual issues?	

Cultural Ethnic Assessment	
What is the Consumer's cultural/ethnic background?	
How does that background influence or contribute to the Consumer's current condition?	
How may the Consumer's cultural uniqueness affect treatment?	
Does the Consumer's cultural background impact communication?	

Figure 3.2

Leisure Recreation	
Describe the Consumer's interests, hobbies, sports and leisure activities.	
CHILD/ADOLESCENT	
Describe the Consumer's need to engage in play and other activities as a part of daily living and as a potential medium for therapeutic intervention.	

Social Relationships Peer Interactions	
Identify any significant social or environmental issues related to:	
Family	
Job	
Education	
Friends	
Support Systems	
Describe the family dynamics.	

Learning Needs Assessment	
Are there any physical or cognitive limitations? If so, describe.	
Are there any barriers to communication? If so, describe.	
Are there any other barriers to learning? If so, describe.	

Pain Assessment	
Describe what pain, if any, the Consumer is currently experiencing.	
Describe any pain the Consumer has experienced within the past year.	
Describe any other observed uncontrolled physical symptoms or non-verbal indications of pain.	

Pain Scale (please circle the appropriate response)



Severe pain

Bad pain



Moderate pain

Mild pain



No pain

The rate of rehospitalization according to the three groups was evaluated. The researcher found a study done on social support by Klein, and Cnaan (1998), helpful in the design of the study. In Klein, and Cnaan (1998) there was a coupling of peer social support with intensive case management and the results showed a decrease in the amount of re-hospitalization in clients.

Design

This is a descriptive study conducted to establish the theory that lack of support contributes to more frequent hospitalization in dual diagnosed clients. Information was collected from the forty-six dual diagnosed subjects to support this theory. The sample was controlled as the subjects were specifically selected according to diagnosis and time in ICMS program. The clients progress since admittance into the ICMS program and the amount of support they received was measured. The purpose of the design and the research is to provide support for the research question in chapter one of the researcher's paper.

Procedure

The researcher received approval from her place of employment, which is an ICMS program located in Burlington County. Because the subjects' name will remain anonymous there was no need for any written permission from the clients. The

researcher assumed that all the information in the charts was true and accurate. The researcher collected from the files names of clients that were dually diagnosed and began to review the charts to check if they were appropriate for participation the study.

Testable Hypothesis

The researcher intended to find evidence that supported the most recent findings, on dually diagnosed clients, which identified that social support has a direct affect on decreasing rehospitalizations. It is hypothesized by the researcher that a positive relationship exists between social support and rate of hospitalization. The researcher believed that the data collected from this research would support the existing body of literature on dual diagnosed clients and confirm the need to provide a broader and more effective support base for clients post discharge form hospital.

Analysis

The researcher in this study analyzed the rate of which client relapsed and the amount of support they received post discharge. The researcher identified a correlation between support and relapse, and found that the type of Axis I diagnosis the client received in hospital had a bearing on relapse as well as length of stay in hospital. The researcher used SPSS version 10.0 to analyze the date collected in the study. A frequency distribution was conducted to indicate the prevalence of relapse in certain Axis I diagnosed client.

Summary

The researcher in this study will be seeking a positive correlation between dual diagnosed clients and rate of relapse. The process will be to analyze the rate of re-hospitalization for at a six-month period since entrance into the ICMS program. Support network of clients will also be analyzed to find this correlation. The forty-six subjects were formed into three groups as a way of supporting the researcher's theory. The information for social support was gathered from an Assessment addendum done at intake of the client's entrance into the ICMS program post discharge from state or county hospital. The addendum is designed to assess the client's social situation in order to serve him or her better. Questions such as spiritual orientation, peer interactions, and family dynamics are asked of the client.

Chapter Four

Data Analysis

Introduction

In chapter one the researcher hypothesized that a positive relationship would exist between social supports and rate of relapse between dual diagnosed clients. The data collected clearly supports the theory that a positive relationship exists between perceived social support and rate of relapse. The researcher therefore accepts the hypothesis that a positive relationship exists between lack of social support and rate of client relapse.

Results

The results of this study have been summarized in this section of the thesis. In table 4.1 the data collected for the forty-six clients are represented. The gender, length of time in the ICMS program, level of support reported by the clients at intake and number of hospitalizations since entrance into the program is calculated. In figure 4.1 the researcher identifies the level of significance that was found between social support and rate of hospitalization. The study showed a significance level of .050 between groups. Graph 4.1, and 4.2 is a visual interpretation of the percentage of subjects who are hospitalized according to the level of support.

Table 4.1

	gender	lenght	support	hospital
1	1	.50	3.00	1.00
2	2	1.00	2.00	1.00
3	2	.50	3.00	5.00
4	2	5.00	2.00	13.00
5	1	5.00	1.00	10.00
6	2	4.00	2.00	3.00
7	2	1.00	2.00	3.00
8	1	1.00	2.00	4.00
9	1	4.00	1.00	2.00
10	2	.50	3.00	3.00
11	1	4.00	2.00	5.00
12	2	5.00	1.00	9.00
13	1	5.00	2.00	1.00
14	2	1.00	1.00	2.00
15	2	3.00	1.00	4.00
16	2	1.00	2.00	5.00
17	2	3.00	2.00	5.00
18	1	6.00	2.00	4.00
19	2	5.00	2.00	5.00
20	2	.50	2.00	3.00
21	1	.50	1.00	2.00
22	2	.50	1.00	2.00
23	1	1.00	1.00	9.00
24	1	1.00	2.00	2.00
25	1	1.00	1.00	3.00
26	2	1.00	3.00	1.00
27	2	4.00	1.00	7.00
28	2	3.00	1.00	12.00
29	1	3.00	1.00	5.00
30	1	4.00	2.00	5.00
31	2	2.00	1.00	3.00
32	2	2.00	2.00	5.00
33	2	1.00	2.00	7.00
34	2	3.00	1.00	5.00
35	1	5.00	1.00	5.00
36	1	2.00	2.00	9.00
37	1	4.00	1.00	2.00
38	1	4.00	2.00	7.00
39	1	3.00	3.00	2.00
40	1	1.00	2.00	4.00
41	1	1.00	3.00	1.00
42	2	4.00	3.00	2.00
43	2	1.00	3.00	2.00
44	1	1.00	1.00	6.00
45	1	1.00	2.00	3.00
46	1	2.00	1.00	2.00

The level of support is represented by the numbers one through three, with one being no support and three being good level of support. The results of the graph demonstrate that level one and two clients have the most hospitalizations. The two graphs lend further support of the researches hypothesis.

Discussion

The study revealed clear evidence of a relationship between rate of relapse and perceived social support in clients, which was hypnotized by the researcher. However, the results of the study showed a highest rate of rehospitiliazaiton were the clients with minimal amounts of support. One explanation for this result could be that clients were asked to give their perception of the level of support they received, and as noted in chapter two perception of social support. In clients perceptions of personality characterizes come into play and this was not covered in the researchers study. Another explanation for this result is a few outliers in the study, which is demonstrated in the data in table 4.1.

Psychiatric severity, although not covered in the hypothesis showed some significance in the collection of data. Clients who has an Axis I diagnosis of schizophrenia showed higher rates of relapse regardless of their level of support. This result shows implications for future studies.

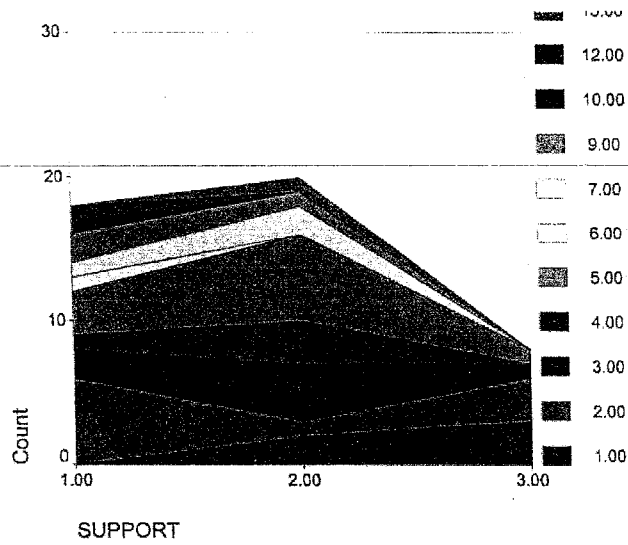
Oneway**ANOVA**

HOSPITAL

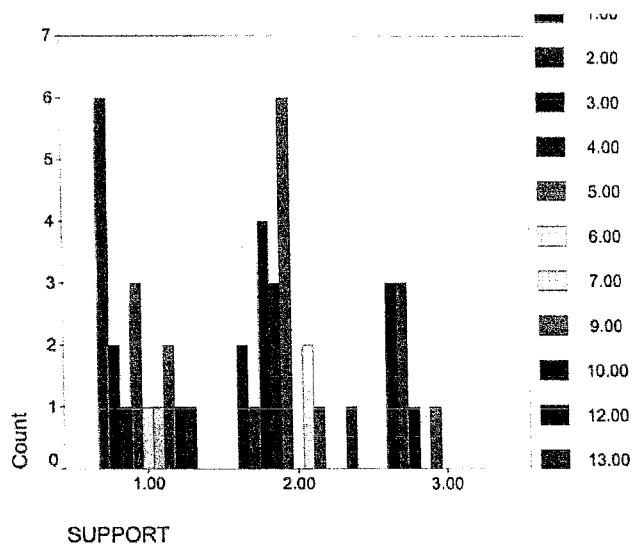
	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	49.642	2	24.821	3.204	.050
Within Groups	333.075	43	7.746		
Total	382.717	45			

Graph 4.1 & 4.2

Graph



Graph



Graph

Summary

The result of this data analysis presented in this chapter supported the hypothesis that a positive relationship exist between a clients lack of social support a rate of relapse. Social support and rate of hospitalization is correlated but psychiatric severity and rate of relapse also showed some level of significance. The group that had the highest percentage of hospitalization however was the group two with minimal level of social support, which could provide implications for future studies.

Chapter Five

Summary

The purpose to this thesis was to explore effective treatment methods of dual diagnosed clients in order to decrease the rate of relapse. In chapter one the researcher presented the need for more effective treatment. Dual diagnosed clients are reported to be the most difficult to treat, maintain in housing and stabilize in the community. Research on this topic has been increasing throughout the years as the need for effective treatment increases.

In chapter two the researcher discussed several theories that presented contributing factors in the high rate of relapse in the hope of finding alternative treatment methods. One group of researchers conducted a study that showed some significance between the Axis I diagnosis of clients and the rate of relapse. It was found that clients, who are schizophrenia and other psychotic disorders listed in the Axis I DSM IV diagnostic code of 295, were more likely to abuse substance rather than be dependent on it (Green 2000). This was in contrast to clients with an Axis I diagnosis of depressive disorder, dysthmic disorder, or bipolar disorder that were more likely to be substance dependent.

Clients appear to self medicate in order to override the side effects of antipsychotic medication and to decrease symptoms of illness (Green2000). The problem that arises with alcohol and drug use is that it increases the psychotic symptoms and this can result in higher rate of relapse.

Clients experience a temporary feeling of well being with substance use, and stop taking the medications, which increases symptoms of hallucination and delusions.

Psychiatric severity and the transtheoretical model (TTM), presented some light into treatment options in regards to dual diagnosed clients. As mentioned in chapter two the TTM is one of five stages in cognitive process of behavior change to increase the likelihood of maintaining sobriety (Valasques, Carbonari, and Diclement 1991).

The self medication theory presented above and the psychiatric severity theory are very similar in that the main cause of relapse is focused of the mental status of the client instead of the drug and alcohol use. Psychiatric symptoms such as delusions hallucinations, and paranoia cause the client to abuse substances, which increases symptoms.

Valasquez, Carbonari, and Diclement's (1999) study revealed that psychiatric severity resulted in a repositioning of clients in stages of readiness to change. A client who when functioning at his baseline is at the action stage of TTM which is defined as when a person modifies his or her behavior, with increase in psychotic severity might be pushed back to contemplation where they acknowledge having a problem but is not ready, or able to make a concrete behavioral changes (Brady et al. 1996). Dual diagnosed clients were found to be deficient in self awareness or abstract thinking order to achieve the high level necessary to maintain their sobriety and prevent relapse, due to the presence of negative symptoms (Carey 2001).

The final theory discussed by the researcher is social support and its affect on rate of relapse. This theory has had a vast amount of support and is practiced in forms in the

mental health field. There have been numerous studies that show a positive relationship between Social support and rate of relapse. Social support promotes physical and mental health and helps decrease psychological stress (Hotz 2000). Some research theorist holds the theory that actual social support plays a great role in relapse; while other theorist speculates that it is the client's perception of support that is a greater factor in relapse. Both theories have shown a positive relationship in rate of relapse.

Conclusions

The researcher hypothesized that a positive relationship would exist between level of social support of dual diagnosed clients and rate of relapse. The data collected supported that theory of a relationship existing between feeling of esteem and support lowering the rate of relapse or rehospitalization. All of the different theories discussed have one commonality and that is that decrease in substance use can decrease rate of hospitalization by decreasing symptoms in dual diagnosed clients. Understanding the source of the problem is the beginning of finding more effective treatment.

Discussion

The results of the researchers theory showed that there is a positive relationship between lack of social support and rate of relapse. These results are consistent with the findings cited in mental health literature. Given the findings in this study and others done before, it is safe to assume that social support is essential to the stability of dual diagnosed clients in the community.

A larger sample size in this study would have resulted in higher level of significance. There are several other hypotheses that could be formed from this study, one being the psychiatric severity. The researcher and other mental health workers can enhance client improvement and independence by proactively fostering the development of social support systems within the community mental health agencies. Including individualized assessment of available social supports like the assessment addendum, and using it in treatment objectives to assist in self growth and self assurance is a way of taking a proactive role in stabilizing dual diagnosed clients in the community.

Implications for Future Research

Develop a controlled study where there are two groups, one with social support, and one not receiving any support.

Develop a study that test the theory of psychiatric severity in comparison with social support to see which has the most impact on rate of relapse.

Develop a study that has larger number of clients in the sample in order to get a more significant result.

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