CORA Cork Open Research Archive
Cartlann Taighde Oscailte Chorcaí

Title	The role of trauma in dual diagnosis
Authors	Lambert, Sharon;Murphy, Raegan
Publication date	2019-12-01
Original Citation	Lambert, S. and Murphy, R. (2019) 'The role of trauma in dual diagnosis', Forum: Journal of the Irish College of General Practitioners, December.
Type of publication	Article (non peer-reviewed)
Link to publisher's version	https://www.icgpnews.ie/forum-journal/
Rights	© 2019 ICGP
Download date	2026-11-17 11:32:44
Item downloaded from	https://hdl.handle.net/10468/11435



UCC
University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

Dual Diagnosis and adverse childhood experiences in an adult residential addiction service

Published 2019 – Forum Journal ICGP

Dr Sharon Lambert, Lecturer in Applied Psychology, University College Cork, Ireland (sharon.lambert@ucc.ie)

Dr Raegan Murphy, Lecturer in Applied Psychology, University College Cork, Ireland (raegan.murphy@ucc.ie)

Introduction

Dual Diagnosis (DD) of addiction and mental health is a complex issue and responses in policy and practice to DD in Ireland have been poor. Our findings show that participants identified alcohol as the primary drug of choice (n=46) while poly substance use was the norm rather than the exception. Analysis revealed an objective mental health diagnosis in 44% of cases, which increased to 92 % for self-reported mental health disorders, primarily anxiety and depression. High adverse childhood experiences (ACE) scores (≥ 4), were associated with higher reports of mental health disorders, suicidal ideation and higher levels of imprisonment.

The aim of this exploratory study was to establish the levels of DD and adverse childhood experiences in an Irish adult residential addiction service. Fifty clients (thirty-two male) presenting at an Irish residential treatment programme were screened upon initial assessment and intake during 2016-2017. Data were collected in the form of a questionnaire and completed together by frontline staff and clients.

Dual diagnosis (DD) has proved difficult to define, in that, varying terms have been used interchangeably across the globe. Terms used include 'Mentally Ill Chemical Abusers' (MICA) or 'Chemical Abuse and Mental Illness' (CAMI) and 'dual disorder' [1]. Generally, having a comorbidity of a mental health condition and substance use disorder, or alcohol/ substance

misuse/dependence may result in a dual diagnosis [2]. The prevalence of DD in Ireland is underestimated and under researched according to a study commissioned by the National Advisory Committee on Drugs and Alcohol in Ireland [2]. Equally, policy and healthcare in Ireland does not address these health needs in a collaborative joint approach, rather, they do so in parallel service design.

Addiction and trauma holding a dual diagnosis position is not novel. A 2008 study [3] found that two thirds of people seeking treatment for substance use disorders report one or more traumatic life events while a 2001 study [4] found that up to 75% of clients presenting with addiction have comorbid histories of trauma. More recently, a 2017 study [5] reported that in a sample of people experiencing homelessness and addiction, all had a least one ACE while approximately 78% had more than four ACEs.

McGabhann et al [2] documents a need for the identification of prevalence rates, service user/ patient needs assessments, their views/ perception of the treatment they receive and the role of GPs and primary care received in the treatment of dual diagnosis. Yet, fourteen years on from this report, only one such study has been conducted in Ireland to date [6]. Our study which was conducted with an adolescent sample on substance use and psychiatric disorders found almost half presented with DD and the supporting literature note the high rates of prevalence in the U.S [7, 8]. Our exploratory study of DD and childhood trauma attempts to bridge the gap in knowledge as no study to date on dual diagnosis in Ireland has been investigated. The study will provide evidence that services should provide trauma informed care to best treat and support their clients.

Method

Study design

Clients who self-presented or who were referred onward from general practitioners presented at an Irish residential treatment programme. They were screened upon initial assessment and intake and several questions were asked of consenting clients. Data were collected in the form of a questionnaire and was completed together by frontline staff and clients during 2016-2017. Whilst a sample of 50 clients does not represent the entire population presenting for treatment, there is no reason to consider the sample of 50 clients (38 male) used in these analyses to be any different from the approximate 210 clients who present to the treatment programme on an annual basis

Variables

A number of socio-demographic variables were recorded and included, among others, client age, sex, employment status, total Adverse Childhood Experiences (ACE) score and several mental health items.

Statistical methods

The options open for data analyses are limited to probabilistic modelling of the data. One of the benefits of this data set is that there is no missing data. Φ coefficient and χ^2 runs using likelihood coefficients were used to analyse multi-way contingency tables. Correlations between binary variables was analysed using the Cochran-Mantel-Haenszel test.

Results

Regarding participants' drug of choice, 46 out of 50 reported alcohol as their drug of choice in general. Participants' second drug of choice was cannabinoid and benzodiazepine with 16 stating this. Third drug of choice was cocaine with 8 participants stating this. Table 1 showcases the descriptive results for this sample.

Table 1 Descriptive results from the residential treatment sample

Variable	Mean (%)	Median	Mode	SD	Information
Age	38	36	33	11.56	Ages ranged from 20 through to 66
Sex					
Male	32(64)	-	-	-	Currently there are more males presenting
Female	18(36)	-	-	-	-
Total ACE score	2.98	3	2		Eight participants scored a zero and twenty-one scored 4 and higher
Mental health diagnosis					
No diagnosis	22(44)	-	-	-	Objective diagnosis
Yes, a diagnosis	28(56)	-	-	-	Objective diagnosis
Depression diagnosis					
No diagnosis	24(48)	-	-	-	Objective diagnosis
Yes, a diagnosis	26(52)	-	-	-	Objective diagnosis
Anxiety diagnosis					
No diagnosis	42(84)	-	-	-	Objective diagnosis
Yes, a diagnosis	8(16)	-	-	-	Objective diagnosis
Self-reported mental health issues					
No self-report	4(8)	-	-	-	Large discrepancy from the official objective diagnosis
Yes, self-report	46(92)	-	-	-	Large discrepancy from the official objective diagnosis
Self-reported depression					
No self-report	14(28)	-	-	-	Large discrepancy from the official objective diagnosis

Yes, self-report	36(72)	-	-	-	Large discrepancy from the official objective diagnosis
			Self-reported anxiety		
No self-report	16(32)	-	-	-	Large discrepancy from the official objective diagnosis
Yes, self-report	34(68)	-	-	-	Large discrepancy from the official objective diagnosis

ACE scores

The ACE questionnaire consists of 10 dichotomously scored items (yes/no) which are totalled to reflect a score out of 10. The total ACE scores from this sample ranged from 0 to 9. Two analytic methods of working with the total ACE score were utilised. The first set of analyses used the total ACE scores which were grouped into a dichotomous score using a score of 4 and higher as a 'high' score and scores between and including 0-3 as 'low' scores. This cut-off score follows on from the ACE literature which concludes that a score of 4 or more is highly indicative of early childhood exposure to trauma [5, 9]. Secondly, total ACE scores were grouped into four categories, with a score of 0 meaning no experience of early childhood trauma, scores between and including 1-3 were considered as low trauma, scores between and including 4-6 were considered high trauma experiences with scores between and including 7-9 were considered as very high early trauma experiences.

Using the dichotomous scoring system, two outcome variables were statistically related to ACE scores. The test statistic used is the Cochran Mantel-Haenszel Common Odds Ratio Estimate (*CMH*) which is a measure of conditional independence among categorical variables. Regarding the relationship between ACE score and the self-report of suicide ideation, the *CMH*

estimate=3.967 [*CI.* 1.07-14.7], p=0.039. This means that high ACE scorers are almost four times more likely to report thinking about suicide when compared to low ACE scorers. Regarding the relationship between ACE score and ever having been incarcerated, the *CMH* estimate=11.2 [*CI.* 1.23-101.88], p=0.032. This means that high ACE scorers are almost eleven times more likely to report being incarcerated when compared to low ACE scorers. Using the second method of using the four-grouping ACE scoring system, having a mental health diagnosis was more likely if the ACE score was higher with a likelihood χ^2 =7.51(3), p=0.05. Being clinically depressed was also more likely if the ACE score was higher with a likelihood χ^2 =7.89(3), p=0.048. Self-reported depressed was also more likely if the ACE score was higher with a likelihood χ^2 =7.93(3), p=0.047. A low cell count for those with very high ACE scores with a concurrent mental health diagnosis and depression means that interpreting this set of results is done so with due caution.

Discussion

The results of this exploratory study indicate the prevalence of mental health diagnosis and exposure to adverse childhood traumatic events are higher in those seeking residential addiction support than that of the general population. Participants in this study reported alcohol as the primary drug of choice, however poly substance use was more likely with cannabis, benzodiazepines and cocaine being the other most commonly reported substances. Analysis revealed an objective mental health diagnosis in 44% of cases, however this increased to 92 % for self-reported mental health disorders. Almost half of clients had received a diagnosis of primarily depression or anxiety from a clinician, however almost all reported that they believed that they had a mental health issue. It is difficult to establish prevalence of DD in Ireland as mental health services in Ireland generally do not work with those in active use. Addiction is treated as the primary issue and referral is to substance dependence services. It is difficult to know whether the mental health issue was present before the onset of the dependence issue or if

it is a response to the addiction. It is being increasingly argued that addiction for many is in fact a self-medicating response to unmet mental health need, with a functional relationship existing between the two issues [10, 11]. Several published studies reveal the impact of ACEs on the development of mental health disorders [12, 13]. Patterson et al. [13] reported that ACEs predict both depressive and anxiety disorders as having a mental health diagnosis for depression and anxiety was more likely if the ACE score was higher.

Implications

Considering the literature which increasingly argues that addiction cannot be viewed solely in a disease model lens, it could be argued that addiction is a self-medicating response to unmet mental health needs that have their roots in exposure to childhood trauma. There are very clear implications for policy and practice. A national strategy should seek to integrate these services with inter agency shared care planning to increase the outcomes for those impacted by a DDs. Addiction services and mental health services should acknowledge the role of trauma in the onset of clients' disorders and adapt services to support the needs of those presenting. Training all staff on the impact of trauma on health and behaviour and the adoption of Trauma Informed service design reduces the risk of re-traumatising clients and ultimately increases client engagement [14].

Acknowledgements

A sincere thank you to the service users, staff and management of Tabor Group for facilitating the collection of this data at Tabor Lodge Residential Addiction Service.

Financial Support

This research received no specific grant from any funding agency, commercial, or not-for-profit sectors.

Ethical Standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the Psychological Society of Ireland. The study protocol was approved by the ethics committee of each participating institution namely Tabor Lodge Residential Addiction Service, Belgooly, Cork and the School of Applied Psychology, University College Cork, Ireland.

References

1. US Department of Health and Human Services. Assessment and treatment of patients with coexisting mental illness and alcohol and other drug abuse, treatment improvement protocol. 2000; (TIP) Series. US DHHS Publications.
2. MacGabhann L, Scheele A, Dunne T, Gallagher P, MacNeela P, Moore G, Philbin M. Mental health and addiction services and the management of dual diagnosis in Ireland. 2004; Dublin, The Stationery Office.
3. Back SE, Brady KT, Waldrop A, Yeatts SD, McRae AL, Spratt E. Early life trauma and sensitivity to current life stressors in individuals with and without cocaine dependence. Am J of Drug and Alcohol Abuse. 2008; 34,389–396.
4. Jacobsen L K, Southwick S M, Kosten T R. Substance use disorders in patients with posttraumatic stress disorder. A review of the literature. Am J of Psych. 2001; 158(8), 1184-190.
5. Lambert S, Gill-Emerson G. Moving towards trauma-informed care A model of research and practice. Paper presented at the 2017 Trauma-informed care workshop University College Cork Ireland.
6. James PD, Smyth BP, Apantaku-Olajide T.Substance use and psychiatric disorder in Irish adolescents, a cross sectional study of patients attending substance abuse treatment service. Mental Health and Substance Use. 2012; 1, 1-9.
7. Drake RE, Mueser KT. Psychosocial approaches to dual diagnosis. Schizophrenia Bulletin. 2000; 26(1), 105-118.
8. Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. Am J of Preven Med. 1998; 14(4),245-258.

9. Burke NJ, Hellman JL, Scott BG, Weems CF, Carrion VG. The impact of adverse childhood experiences on an urban paediatric population. Child Abuse & Neglect. 2011; 35(6), 408-413.
10. van Dam D, Vedel E, Ehring T, Emmelkamp P M. Psychological treatments for concurrent posttraumatic stress disorder and substance use disorder. A systematic review. Clinical Psychology Review. 2012; 32(3), 202-214.
11. Wall M, Lambert S, Horan A. An Evaluation of Practitioner's Experience of Service Users Seeking Community Detoxification from Benzodiazepines. J of Psychoactive Drugs. 2018; 50(3), 224-230.
12. Dube SR, Anda RF, Felitti VJ, Chapman D, Williamson DF, Giles WH. Childhood abuse household dysfunction and the risk of attempted suicide throughout the life span, Findings from Adverse Childhood Experiences Study. J of the Am Med Ass. 2011;286, 3089-3096.
13. Patterson ML, Moniruzzaman A, Somers JM. Community participation and belonging among formerly homeless adults with mental illness after 12 months of housing first in Vancouver British Columbia, a randomized controlled trial. Community Mental Health J. 2014; 50(5), 604-611.
14. Substance Abuse and Mental Health Services Administration (SAMHSA). Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol. 2014; (TIP) Series 57 HHS Publication No (SMA) 13-4801 Rockville MD, substance Abuse and Mental Health Services Administration.