1-2014

Treatment of Co-Ocurring Psychiatric and Substance Use Disorders

Kady Wiliams

Treatment of Co-Occurring Psychiatric and Substance Use Disorders

Kady Williams

University of North Dakota

Title Treatment of Co-occurring Psychiatric and Substance Use Disorders

Department Nursing

Degree Master of Science

In presenting this independent study in partial fulfillment of the requirements for a graduate degree from the University of North Dakota, I agree that the College of Nursing of this University shall make it freely available for inspection. I further agree that permission for extensive copying or electronic access for scholarly purposes may be granted by the professor who supervised my independent study work or, in her absence, by the chairperson of the department or the dean of the Graduate School. It is understood that any copying or publication or other use of this independent study or part thereof for financial gain shall not be allowed without my written permission. It is also understood that due recognition shall be given to me and to the University of North Dakota in any scholarly use which may be made of any material in my independent study.

Signature Kady Williams

Date 1-31-2014

Abstract

The National Institute on Drug Abuse [NIDA] (2007) reports that six out of ten people with substance use disorder also suffer from another form of mental illness. In the majority of cases, addiction and mental health disorders co-occur, with one influencing the other. Frequently, in many mental health treatment facilities or facilities that focus on treating addictions, the treatment focus is relatively narrow, with emphasis placed on one or the other, but not both. Very few substance abuse treatment programs are equipped to provide services for both psychiatric and substance use disorders. This project involved a review of literature in order find evidence to support the need for identifying and treating co-occurring substance use and psychiatric disorders concurrently. The information obtained from the literature was presented to licensed staff members at a dual diagnosis enhanced residential treatment program. After the presentation a discussion was held, with the staff members viewing the presentation. There was some reluctance from staff regarding concerns with over diagnosis and prescribing unnecessary medication. Despite these concerns, changes were made to the intake and discharge planning process.

Treatment of Co-occurring Psychiatric and Substance Use Disorders

Purpose

The purpose of this project is to raise awareness of the significance, both in frequency and magnitude, of co-occurring disorders among those individuals with addictions and mental health ailments, and to emphasize the importance of treating the disorders simultaneously as opposed to a piece-meal intervention, or treating one with the hope the other will simply subside. Frequently, in many mental health treatment facilities or facilities that focus on treating addictions, the treatment focus is relatively narrow, with emphasis placed on one or the other, but not both. To affect clinical practice, clinicians have to ask themselves if they have the training and resources to provide the necessary interventions, and if not, how they will go about enhancing their ability to deliver the appropriate services. This project will provide those clinicians with the evidence they need to support the expansion of clinical assessments and the changes in practice necessary to address both addiction and co-occurring mental health disorders simultaneously.

The reality for many patients being treated for addiction or a psychiatric disorder is that they don't have one or the other, but instead experience both simultaneously. The National Institute on Drug Abuse [NIDA] (2007) reports that six out of ten people with a substance use disorder also suffer from another form of mental illness. In the majority of cases, addiction and mental health disorders co-occur, with one influencing the other. When considering the source of comorbidity, the practitioner should consider at least three factors. The first factor is that drug abuse can cause a mental illness; the second is that mental illness can lead to drug abuse; and the third, drug abuse and mental disorders can both be caused by other common risk factors. In

reality, all three scenarios can contribute, in varying degrees, to the establishment of specific comorbid mental disorders and addiction (NIDA, 2011b).

Recognizing that co-occurring disorders are likely to exist among a large segment of the patient base is but the first step. It is also important to explore evidence-based practices that support a holistic treatment approach to addiction and mental health therapies. For example, federal, state and private agencies have directed significant attention to the application of evidenced-based practices in substance abuse treatment (Abraham A. J., Knudsen, Rieckmann & Roman, 2011). However, medications that improve cognition and reduce cravings, or those medications used to treat co-occurring psychiatric disorders, remain under prescribed, indicating there may be reluctance, biases, or ideological barriers promoting the gap between evidence and practice. In order to close the gap, it is important for treatment providers to systematically evaluate holistic treatment practices with the patients' unique needs in mind. They also need to identify the barriers to delivering those interventions across addiction treatment and mental health treatment modalities.

Significance

Killeen (2010) noted that rates of mental disorders have skyrocketed in recent history. The growing healthcare issue consists of a broad spectrum of disorders, including depression, anxiety, PTSD, bipolar disorder, schizophrenia, ADHD, autism, Alzheimer's disease and many more. Statistics indicate that individuals are one hundred times more likely to suffer from depression today than they were 100 years ago, and that the number of Americans struggling with three or more mental disorders – nearly one-fifth of the population – has more than tripled for the post WWII generation. Mental disorders – especially depression – are the leading causes of disability in North America (Killeen, 2010, p. 26).

Those statistics become even more relevant when they are related to addiction. Compared with the general population, NIDA (2007) reports that patients with mood or anxiety disorders are about twice as likely to suffer from a substance use disorder, and patients with a substance use disorder are roughly twice as likely to be diagnosed with mood or anxiety disorders. Studies indicate that the rates of specific comorbidities also vary by gender. For example, among individuals in drug treatment, antisocial personality disorder is more common among men, while women have higher rates of major depression, posttraumatic stress disorder, and other anxiety disorders.

The Substance Abuse & Mental Health Services Administration (SAMHSA) (2010) estimates that approximately 8.9 million adults suffer from co-occurring psychiatric and substance abuse disorders. Most of those individuals receive no treatment at all – only a small percentage receives treatment for both disorders. Therefore, healthcare professionals and society actually have a two-fold problem. One is to increase access to treatment so that a greater percentage of those needing treatment receive it, while the second is to improve the quality of treatment that results from a more holistic approach to problem solving across multiple systems.

Specialized addiction or mental health support services may be difficult to access, specifically in rural or underserved communities. General medical providers often have the first opportunity to identify a psychiatric or substance use disorder, as these conditions often accompany medical illness. Some general practitioners are reluctant to treat this population due to lack of training, "inadequate clinical tools, time constraints, ignorance of treatment resources, and issues of professional jurisdiction" (Sterling, Chi, & Hinman, 2011, p. 341). Therefore, it is important for addiction treatment providers, mental health providers and general medical providers to have a broad understanding of scope of the problem, the resources necessary to

provide effective treatment, and the desire to collaborate with others to deliver holistic interventions.

Theoretical Framework

The theoretical framework utilized to organize, describe, predict and control the combining of pharmacological and counseling therapies to treat mental health and addiction issues is encompassed within General System Theory. General Systems Theory provides the basis for breaking "systems" into component parts and determining how those parts work together. Although General Systems Theory grew out of the field of thermodynamics, today it is utilized to study various systems, from political, to economic, to healthcare, by suggesting the world is made up of interconnected systems which influence each other. By affecting one element within a system, the entire system is changed. By altering one system, interacting systems are also influenced.

The human body, comprising one system, consists of several subsystems. The subsystems are physiological, which refers to the physiochemical structure and function of the body. The psychological subsystem refers to mental processes and capacities, emotions and attitudes. The socio-cultural subsystem includes an individual's relationships, social/cultural expectations, activities and the influence of society on the individual. The spiritual subsystem refers to the influence, or lack thereof, of spiritual beliefs. While in theory, the functioning of the human body can be considered comprised of even smaller or additional subsystems, for the purpose of this paper I am limiting my perspective to these.

The importance of the systems approach resides in its potential for evaluating information to help individuals and their families' progress toward the goal of healthy living. From a very narrow perspective, "health" can be considered a state of homeostasis, where the system is in a

state of equilibrium. Equilibrium can be metabolically within a cell or organism, or socially or psychologically within a group or individual. Illness and problems lie in wait when those systems become out of balance. It is the nurse's responsibility to assess the extent, to which all parts of the patient's system are in balance and working properly, and to identify and address actual or potential threats to system homeostasis.

Addiction and mental health issues are at the root of problems that can affect many of the subsystems that comprise the human body. The problems that affect one subsystem typically influence the performance of others, and certainly affect the larger system. Addiction is a chronic illness that alters the chemistry in the brain, thereby affecting thoughts, behaviors, actions, relationships, etc. The psychological subsystem and its mental processes are obviously altered. However, General Systems Theory allows us to examine the impact beyond the psychological subsystem to that of the physiological, the socio-cultural and the spiritual, and recognize the effect on the overall human system. Addiction and/or mental health issues cross subsystems creating a tangled web of issues. For example, addictioleads to systematic problems, including difficulty with relationships, employment, legal, financial, psychological, as well as eventual problems with the individual's physical health. Beginning with the relatively small problem of addictive behavior affecting the psychological subsystem, the consequences grow and spread until they affect other subsystems and eventually the larger human system.

The same can be said of co-occurring disorders. Statistics indicate that many individuals suffering from mental illness are also addicted, and conversely, many individuals with addictions suffer from mental illness. Viewing this problem through the lens of General Systems Theory allows practitioners to view the dimension of the problem in its entirety.

The first challenge is diagnosis. Practitioners, understanding the issue from a systems perspective, can view interventions as needing to span subsystems. For many specialists in addiction or mental health, that will require the need to seek counsel that goes beyond their field of expertise, and/or refer patients for additional treatment or services. A narrow diagnosis that does not identify the breadth of the problems will not lead to the necessary treatment interventions.

Once the connection is made between addiction and mental health, more appropriate interventions can be developed. Healthcare economics of the future will probably not allow problems to be addressed independent of one another. Instead, addiction and mental health issues will need to be treated concurrently, recognizing the disorders affect the same systems and that the best treatment results cannot be achieved without addressing all subsystem issues simultaneously.

General System Theory allows the practitioner to understand the connections between addiction and mental health treatment, and how those individually and collectively affect the subsystems of the human body. As a result, the practitioner is able to use that understanding to organize the relationship among the issues to explain, illustrate and control practice.

Definitions

The following definitions are provided in order to assist the reader in understanding the terms utilized in this paper.

Substance-Use Disorder:

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by 2 (or more) of the following, occurring within a 12-month period:

1. recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)

2. recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)

3. continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

4. tolerance, as defined by either of the following:

a. a need for markedly increased amounts of the substance to achieve intoxication or desired effect

b. markedly diminished effect with continued use of the same amount of the substance (Note: Tolerance is not counted for those taking medications under medical supervision such as analgesics, antidepressants, ant-anxiety medications or beta-blockers.)

5. withdrawal, as manifested by either of the following:

a. the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)

b. the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms (Note: Withdrawal is not counted for those taking

O'Brien, & Dundon, 2013, p. 24). Research indicates that an integrated treatment approach in which addiction treatment providers and clinicians trained to address the mental health needs of the patient through pharmaceutical and therapeutic interventions is more advantageous as opposed to having multiple providers in various treatment venues (Sterling, Chi, & Hinman, 2011, Murthy & Chand, 2012 Straubing, Harden, Callihan, & Gold, 2013,). However, few substance abuse treatment programs are equipped to provide services for both psychiatric and substance use disorders. Generally, addiction treatment programs are run by individuals who are exclusively trained to diagnose or assess for the presence of a substance use disorder. Consequently, the patient is required to navigate through "two separate service delivery systems" (Ducharme, Knudsen, & Roman, 2006, p. 364) in order to access psychiatric care. As a result, the care provided is suboptimal and patients become frustrated, eventually dropping out of treatment completely (Straubing et al, 2013). Additionally, when care is provided in separate systems valuable healthcare resources are are wasted and the implementation of crucial interventions are delayed (Murthy & Chand, 2012).

Chan, Huang, Bradley, & Unutzer (2013) explored the connection between involvment in a substance abuse treatment program and improvement in depressive symptoms among individuals with a co-occurring substance use disorder and depression in a state-wide integrated behavioral health program. This study had a rather large sample size, involving 2,373 participants. Of those, 1,095 were referred for substance abuse treatment. In total, 780 accepted substance abuse treatment, while 315 refuse. Participants with a diagnosis of depression and a substance use disorder, who had received substance abuse treatment services had greater improvement in their depressive symtpoms as compared to those who had refused substance abuse treatment. They also found that depression was more severe and there was a greater risk

for suicidality among participants who refused substance abuse treatment. Additionally, Chan, Huang, Bradley, & Unutzer (2013) noted that once a substance use disorder was identified, every week that referral to substance abuse treatment was delayed, was corelated with a decreased improvement in depressive symptoms.

While the findings of this the studyindicates that concurrent treatment for co-occurring psychiatric and substance use disorders improves patient outcomes it is not without limitations. Although the design of the study is replicable; it is unlikely that results in an identical study would be consistent as there are a number of variables that cannot be accounted for in observation. The nine question, Patient Health Questionairre was utilized to measure depression. This is a standardized screening tool that is utilized in many practice settings. However, the rating scale is based on the patients' self disclosure, and there are factors that can effect the reporting of symptoms such as the dynamic of the relationship between the provider or the patients' level of insight. Additional variables that may produce different results based on the theoretical approach utilized in the treatment of substance use disorders, severity of participants depression at baseline and overall readiness to change.

As part of a county wide initiative, mental health and substance abuse treatment programs teamed up to enhance the delivery of services to individuals with co-occurring psychiatric and substance use disorders (Grella & Stein, 2006). Subsequently, they conducted a study that involved 11 publicly funded residential substance abuse treatment programs for adults located in Los Angeles County. The focus of the study was to determine if on-site verses collaboration with other providers impacted service use. They conducted baseline assessments of 351 patients who were similar in regards to their "treatment history, perceived quality of life, motivation for treatment and socioeconomic status" (p.1013). Assessments were completed at

the time of admission and 6 months following treatment. Participating programs were a minimum of 90 days in length, and based on the 12 step recovery principles. In addition, program administrators were surveyed in order to identify specific program characteristics including services provided on site, staff training and qualifications, and therapeutic approach. A higher rate of mental health service utilization was associated with programs that provided on-site mental health services. However this was also associated with longer lengths of stay, which may have affected study outcomes. Researchers also found greater service utilization in programs that had more clinicians trained in the treatment of co-occurring disorders. They predicted that this service use would be associated with improved outcomes, and found this to be true for all substances. The majority of participants had lower Brief Symptom Inventory Scales and RAND, (a 36 item health survey) scores at follow up, and the attrition rate was relatively low. In total, 90% of the 351 participants were located for follow up and only 2% did not complete the study. There were variations in the environments of care, staff qualifications, and levels of counseling and rehabilitation services provided (Grella & Stein, 2006). These differences are likely an accurate representation of the varying models of treatment that exist among dual diagnosis programs. However, these differences also suggest concurrent treatment for co-occurring psychiatric co-morbidities may be of more importance than the treatment model itself or specific program characteristics.

In another randomized controlled study, researchers compared 1 year outcomes in individuals who completed an integrated treatment program compared to those who completed a program in which psychiatric services were treated separate from addiction. The results revealed that individuals who received integrated treatment services reported an improvement in quaility of life, had fewer psychiatric hospitalizations, fewer arrests and less involvement in the legal

system when compared to individuals who received non-integrated treatment services. Kendall (2004), found evidence that integrated treatment improves treatment outcomes and are more effective that non-integrated programs in eight studies. Although there were study limitations, "integrated programs are considered as evidence-based practices" because "they are almost always" present in programs that have positive outcomes (Kendall, 2004, p. 184).

Missed Diagnosis in Primary Mental Health Care Settings

Substance use disorders are often undiagnosed in individuals seeking primary mental health care. A 2008 study involved 117 primarily masters level mental health professionals. The participants were asked to read vignettes that contained subtle indications that the patient may have a substance use disorder. The majority of respondents reported that they routinely screen for substance use disorders. While 38.5% asked additional questions after reading the vignettes, 23.9% did not ask questions about substance use at all. Maintaining the belief that patients are dishonest about their substance use, concern about questioning the patient's integrity, and being unable to determine if the pattern of use is problematic were among the reasons cited for not routinely assessing substance use. The study was modeled after the National Center on Addiction & Substance abuse Missed Opportunity Survey conducted with primary care providers in 2002. The vignettes were randomly distributed and the analyzed by blinded graduate students. Participants were however, recruited through graduate students employment and respondents responses may have been biased due to the personal connection.

Data concerning the detection of substance use disorders was obtained from 8 Norwegian Community Mental Health Centers for a study developed to assess the National Plan for Mental Health in Norway (Wüsthoff LE, Waal H, Ruud T, Røislien J, & R.W., 2011). There were a total of 2154 participants in the study. All clinicians were trained to use the "Health of the

Nation Outcome Scale", "Alcohol Use Scale" and "Drug Use Scale" to measure psychiatric and substance use severity (Wüsthoff LE, Waal H, Ruud T, Røislien J, & R.W., 2011). Clinical assessments were completed; however structured interviews were not conducted to substantiate a diagnosis, which is acknowledged as a limitation of the study. Researchers found even with additional training, use of standardized, validated screening tools the diagnosis of substance abuse is inconsistent among clinicians. Interestingly, some patients were not diagnosed with a substance use disorder even when their scores were elevated on the respective scales. Straubing et. al (2013) suggests the limitations of our mental health treatment systems hinders the diagnosis of co-occurring disorders. Generally, mental health providers have more education, however, Straubing et. al (2013) points out that "some providers of mental health services may be inadequately trained in substance abuse treatment and have little knowledge of, or access to those that are" (p. 26). Whats more, is that individuals may be more compelled to enter treatment based on what they see as the primary problem (Primm, et al., 2000). Lembke (2012), states that "many patients with substance use problems present in nonaddiction treatment settings with symptoms of anxiety, depression, insomnia, and chronic pain, to name a few and do not self-identify as having a substance use problem" (p.527). For this reason, Freimuth (2008) suggests that clinicians at all levels should refine their skills to recognize the signs and symptoms of a substance use disorder.

An exploratory study conducted on two programs affiliated with the Johns Hopkins Hospital Community Psychiatric Program examined characteristics of 65 individuals voluntarily admitted for substance abuse treatment and 64 individuals voluntarily admitted to a psychiatric treatment program. The average age in both groups was 36 and predominantly African American. In both groups the majority of individuals had a diagnosis of a polysubstance

disorder. Although this was a smaller study limited to two associated programs, it does reinforce the need for treatment programs to be arranged to provide treatment to individuals with psychiatric disorders of varying degrees and very different diagnostic profiles. Moreover, there are a number of possible combinations of diagnosis', which is one of the greatest challenges of treating individuals with co-occurring psychiatric and substance use disorders (Baigent, 2012).

Kavanagh & Connolly's (2009) research on co-occurring disorders produced several recommendations for interventions to improve the efficacy of treatment of both disorders. Their first recommendation is to routinely screen and initiate brief interventions (Kavanagh & Connolly, 2009). Next, they suggest that interventions should accommodate individuals with multiple comorbidities as well as adolescents and young adults, who are considered to be a high risk group. Additionally, the authors assert that "all problematic substance use should be addressed including smoking" (p. 839). Emphasis is placed on the the importance of utilizing a treatment model that takes into account the the reciprical relationship between substance use and psychiatric disorders, understanding the risk factors that influence the development of both disorders, and recognizing that one disorder may impact the other (p.840-841). Furthermore, "services should be coherent, accessible and seamless" and clinicians should possess skills necessary to treat both disorders (p.841). Moreover, sustained motivation can be problematic for individuals with a psychiatric disorder, and in people with a substance use disorder it "....is often fragile at best" so incentives for change should be addressed. (Kavanagh & Connolly, 2009, p. 843). Finally, the authors bring to mind that social and environmental stressors can increase the risk of relapse and ongoing support may be necessary until the patient is stable.

Medication in Substance Abuse Treatment

Kelly, Daley, & Douaihy (2012) reviewed twenty-four research reviews and 43 research trials regarding pharmacologic and psychotherapeutic treatments of co-occurring psychiatric and substance use disorders. The authors concluded that treatment of co-occurring psychiatric and substance use disorders is most effective when the the length of treatment is adequate , and pharmacotherapy and behavioral treatments are combined. Kelly, Daley, & Douaihy (2012), also point out that it is important for the cycle of substance use to be arrested in order to be able to appropriately assess for a psychiatric disorder. For instance, anxiety cannot be accurately diagnosed until withdrawal symptoms resolve. While this is true, it is important that clinicians continue to monitor for persistant symptoms of anxiety. Evidence suggests that when left untreated, anxiety can lead to major depression (Simon,2009 as cited by Lembke, 2012).

Some substance abuse treatment providers are against the use of medication, even if it is being used to treat a mental disorder (National Institute on Drug Abuse, 2010). On the other hand, some mental health providers tend to maintain the ideology that substance use disorder is a symptom of the psychiatric disorder and if the underlying psychiatric disorder is treated, the substance use disorder will no longer be problematic (Sterling, Chi, & Hinman, 2011).

Regardless of the treatment venue, "the intensity of treatment must be matched based on "substances being abused and the severity of the comorbidity" (Kelly, Daley, & Douaihy, 2012, p. 20). Individuals with co-occurring substance use and psychiatric disorders require higher intensity services and more frequent follow up, with medication dosage adjustments to enhance the effectiveness of medications (Malat & Kahn, 2011). As an example, individuals with a co-occurring substance use and bipolar disorder can be challenging to engage in substance abuse treatment due to fluctuation in moods. Acheiveing mood stability may require trialing mood

stabilizers and adding antidepressants if necessary, in order to establish an effective medication regimen.

Ziedonis, et al., (2005) offers direction for the pharmacologic treatment of co-occurring substance use and pychiatric conditions. The authors endorse the treatment of symptoms rather than vague complaints. "Treating non-specific complaints in patients with co-occurring disorders may not be helpful and can reinforce self-medication behavior (Ziedonis, et al., 2005, p. 326). Caution is advised when prescribing medications with powerful anticholinergic or orthostatic risks. Medications with abuse potential or high risk of overdose is discouraged, and awareness of interactions between psychotropic medications and substances of abuse is advised (p.325). For example, benzodiazepines have been shown to be effective for individuals with anxiety disorders, but the risk of abuse in patients with a substance use disorder is very high (Murthy & Chand, 2012). Further, Ziedonis and collegues suggest using injectable or longer acting medications to promote medication adherence and advise that providers "use every appointment as an opportunity to ask patients about how they take their medication, to review proper use of medications, to promote medication adherence, and to provide medication education" (p.326).

Findings from two separate studies indicate the use of medications, including those approved for the treatment of addiction is highly dependent on the programs funding source. Addiction treatment programs were randomly sampled and in person interviews were conducted with program administerators in both studies. Correctional facilities and programs within the Veterans Health Administration were excluded from both studies as they are not open for public access. Detoxification, methadone maintenance programs, and physicians in private practice were excluded from the analysis of private sector programs. A majority of public programs surveyed were small, privately owned agencies, receiving non-Medicaid public funding. The

private sector programs examined, received at least half of their reimbursement from Medicaid or commercial insurance. A majority of the public programs had no medical or nursing personnel on staff and had adopted no pharmaceutical interventions, while private sector programs had greater access to physicians and had more counselors with master's level training on staff (Abraham, Knudsen, & Roman 2011). The rate psychiatric medication was prescribed was just over 70% in private sector treatment programs, while in public programs use of psychiatric medication was less than 30% (Knudsen, Roman, & Oser, 2010,Abraham, Knudsen, & Roman, 2011). Because the data was obtained via interviews with program administrators, responses may have been biased. Furthermore, neither study accounted for the mid-level prescriber, which compromises the external validity of the studies. Nonetheless, these studies indicate that even with access to physicians, the use of psychiatric medications has not become a routine practice in a significant proportion of addiction treatment programs. Furthermore, these findings suggest that the standard of care and application of evidence based practice is highly dependent on access to resources.

Methods

A literature search and review was conducted to find supporting evidence for the importance of identifying and treating co-occurring substance use and psychiatric disorders. A search of databases was conducted using the University of North Dakota's Harley French Library website.

In the CINAHL database, CINAHL headings were searched using the terms *integrated treatment* AND *dual diagnosis.* This resulted in 106 citations. Articles were limited to the years 2006-2013, which decreased the amount of citations to 64. After review of abstracts, 4 articles were chosen for inclusion. The PsycINFO data base was searched using the terms *integrated*

treatment AND *dual diagnosis* OR *co-morbidity.* This search yielded 138 results. Citations were limited to those between the years of 2006 -2013, relevant to adults 18 years and older. This resulted in 42 citations. After review of abstracts, 7 articles were chosen for inclusion. Lastly, two relevant articles were obtained from the 11 articles retrieved using the above methods and one article was obtained from a monthly periodical obtained through this authors employer.

The findings of this project were presented to licensed staff members at a dual diagnosis enhanced residential treatment program. The staff members in attendance consisted of the facility case manager, 2 Licensed Independent Clinical Social Workers (LICSW), 3 Licensed Addiction Counselors (LA-C), an Occupational Therapist, a Physician Assistant, and a Family Practice M.D. The power point was utilized and those present were provided with a copy of the presentation (See Appendix A).

Time was allotted for discussion following the presentation regarding how the organization identifies and provides treatment to individuals with co-occurring substance use and psychiatric disorders a treatment program. Through the discussion, it was established that in most addiction treatment programs, including the one who participated in viewing the presentation, each client undergoes a comprehensive biopsychosocial assessment by an LA-C.

The LA-C's in attendance acknowledged that unless the client has obvious symptoms, has previously been diagnosed or treated for a mental health disorder, it is difficult to ascertain if the symptoms reported by a client are due to their use of alcohol or drugs or are related to withdrawal. As a result, they delay making a referral to the LICSW until the client is no longer experiencing symptoms of withdrawal and the symptoms persist. One licensed addiction counselor expressed concern with "jumping the gun", over diagnosis and unnecessarily

medicating clients. Both LICSW's as well as the Physician Assistant shared that often times; a mental health disorder is not identified until the client is 2 or 3 weeks into their treatment process. This delays pharmacological treatment and limits their opportunity to truly benefit from both pharmacological and non-pharmacological treatment.

Results

The existing process in the organization viewing this presentation was discussed. In the current process, the LA-C determines if a referral to an LICSW is warranted after completing the comprehensive biopsychosocial assessment. The staff members viewing presentation agreed that this procedure could be more efficient and elected to modify current processes.

It was determined that each client would be seen by the LICSW as part of the intake process. The LICSW is then responsible for screening for the presence of a co-occurring mental health disorder. In the event that that LICSW identifies symptoms consistent with a mental health disorder, a more comprehensive assessment is conducted in order to confirm, or rule out a diagnosis. If a diagnosis cannot be confirmed, the LICSW will then make make the determination if a referral for psychological testing is indicated.

Moreover, LICSW will determine, based on their clinical judgment the frequency in which they will see the client for individual mental health therapy. In addition, as part of the intake process, the patient is seen by the mid-level practitioner for a routine history and physical to assess overall health, and to rule out medical issues that are either causing or contributing to psychiatric symptoms. Medication, when indicated is prescribed for the treatment of physical or psychiatric conditions. This process was essentially unchanged, with the exception of a adding a weekly between the prescribing practitioner, assigned LA-C and LICSW in order to discuss the client's therapeutic progress and response to medication.

A concern was noted with the existing procedure used for continuing care planning, specifically the communication. At the time of admission, the case manager ascertains from the client where he or she would like to do his or her continuing care. When finalizing discharge plans, the case manager obtains recommendations from the LICSW, the prescribing provider, and the LA-C. Consequently, additional time is spent seeking clarification from the client as well as from providers. In order to make this process more efficient, at the same time ensuring that continuing services are comprehensive, yet not duplicated, as integrated as possible, and patient centered, the interdisciplinary team opted to make adjustments to this process. First, each discipline will dedicate time during one session to discuss continuing care recommendations with the client. This will provide the patient with an additional opportunity to discuss what he or she would like his or her continuing care plan to look like. During the weekly interdisciplinary team meeting, providers can discuss the client's plan. Once continuing care recommendations are established, the case manager will meet with the client, finalize the plan, obtain Releases of Information (ROI) and set up appointments. Finally, the discharge summary outlining the progress the patient made, including current medications, medications tried and the patient response is provided to continuing care providers whom the patient has authorized communication.

Discussion

It is clear that the treatment of addiction must also involve addressing the patients' individual psychiatric needs. Both disorders should be considered primary disorders as treatment for one, cannot be successful without treatment for the other. Currently, treatment for co-occurring psychiatric and substance use disorders simultaneously is the exception, rather than the rule. Programs in which both substance abuse and psychiatric disorders are treated simultaneously are

shown to improve outcomes and lower the rates of drop out. Currently, a majority of addiction treatment programs are not equipped to manage psychiatric conditions. In addition, access to prescribers with medication management for individuals with co-occurring disorders is in short supply.

With the changes to the healthcare environment, providers at all levels are confronted with the challenge of enhancing the quality of services, without additional resources. It is imperative that all clinicians, regardless of their specialty, work together to conserve resources and ensure that care for both disorders is continuous and seamless. Moreover, deserve access to effective behavioral and pharmacological therapies that address the psychiatric and substance use disorder that will improve the chances for recovery and improve their quality of life. Failing to promptly diagnose either disorder delays access to effective treatment, prolongs remission of symptoms and increases the risk for relapse.

Implications for Practice

In all practice settings, nurses will encounter individuals with co-occurring psychiatric and substance use disorders. Therefore nurses must educate themselves, in order to attend to the challenging needs of the patient with a co-occurring psychiatric and substance use disorder. Individuals often seek care for an unrelated health concern and the nurse is often the first to have patient contact. This provides the nurse with an opportunity to screen for psychiatric and substance use disorders as part of the routine assessment.

Nurses also play a significant role in the implementation of evidenced based interventions. This makes the nurse an ideal candidate to facilitate the delivery of integrated care according to the patient's individual needs. Nurses are accustomed to collaborating with other healthcare disciplines, therefore nurses should take an active role in establishing the partnerships that are

needed between agencies in order to refer and coordinate the necessary care. Additionally, nurses should be involved in researching the use of additional interventions in order to add to the growing body of knowledge regarding co-occurring psychiatric and substance use disorders.

It is not uncommon for individuals with co-occurring disorders to have limited insight or awareness regarding their illness. As health educators, the nurse is responsible offering education to enhance the patients understanding of the disorders. Education should be presented according to the patient's learning ability. It is important for patients with co-occurring disorders to understand the importance of adhering to treatment recommendations. This includes medications, medication side effects, as well as the risks of combining medications with mood altering substances. The nurse can reinforce the importance additional therapeutic recommendations and follow up appointments.

Patients should be encouraged to talk openly about their symptoms and substance use and it is up to the nurse to be open minded and understanding. Patients may be reluctant to open up due to fear of being stigmatized, feelings of guilt, shame and embarrassment. Confronting the patient may cause the patient to shut down, and result in further alienation so this approach should be avoided. The nurse should assure the patient that information shared is confidential, maintain a professional demeanor, while at the same time being empathetic and non-judgmental. Motivational interviewing is a helpful skill set for nurses as this can help the patient to identify problematic situations and explore solutions.

Finally, nurses need to be involved in advocating for policy changes that improve the quality and increase access to care for individuals with co-occurring disorders. Nurses can influence policies within organizations, at the local and state levels, as well as the federal level. Nurses can campaign for increased funding and adequate reimbursement for the level of care necessary

to address the complex needs of the individual with a co-occurring psychiatric and substance use disorder.

Conclusion

Co-occurring psychiatric and substance use disorders are of great public health concern and one of the leading causes of death and disability in the United States. It is not a question of which came first or which disorder to treat first, rather both disorders should be equally prioritized and treated concurrently. This paper highlights the importance for medical providers, nurses, and clinicians identify co-occurring disorders in order to implement interventions that are effective in managing both disorders. Evidence indicates that medication is a core component in successfully managing the symptoms of psychiatric disorders and decrease the risk of relapse however, has yet to become a universal standard in substance abuse treatment programs. Thus, it may be important for programs that specialize in the treatment of substance use disorders evaluate their mission and philosophy as it relates individuals with co-occurring disorders and apply evidence based practices. Likewise, it is essential for providers that have become accustomed to exclusively treating psychiatric disorders to recognize the implications of substance use among their patients, implement routine screening, and be prepared to address and coordinate the necessary care for substance use disorders.

References

Abraham, A., Knudsen, H. K., & Oser, C. B. (2011). Barriers to the implementation of medication-assisted treatment for substance use disorders: The importance of funding policies and medical infrastructure. *Evaluation and Program Planning*, 375-381.

Baigent, M. (2012). Managing patients with dual diagnosis in psychiatric practice. *Current Opinions in Psychiatry, 25*, 201-205. doi:10.1097/YCO.0b013e3283523d3d

Chan, Y.-F., Huang, H., Bradley, K., & Unutzer, J. (2013). Referral for substance abuse treatment and depression improvement among patients with co-occurring disorders seeking behavioral health services in primary care. *Journal of Substance Abuse Treatment*, 106-112.

Ducharme, L. J., Knudsen, H. K., & Roman, P. M. (2006, August). Availability of integrated care for co-occuring substance abuse and psychiatric conditions. *Community Mental Health Journal, 42*(4), 364-375. doi:10.1007/s10597-005-9030-7

Freimuth, M. (2008). Another missed opportunity? Recognition of alcohol use problems by mental health providers . *Psychotherapy Theory, Research, Practice, Training*, 405-409.

Grella, C. E., & Stein, J. A. (2006). Impact of program services on treatment outcomes of patients with comorbid mental health and substance use disorders. *Psychiatric Services*, 1007-1015.

Kavanagh, D. J., & Connolly, J. M. (2009). Interventions for co-occurring addictive and other mental disorders (AMDs). *Addictive Behaviors 34* , 838-845.

Kelly, T. M., Daley, D. D., & Douaihy, A. B. (2012). Treatment of substance abusing patients with comorbid psychiatric disorders. *Journal of Addictive Behaviors*, 11-24.

Kendall, C. (2004). Treatment of mental illness and comorbid substance abuse: concepts for evidence-based practice. *Journal of Addictions Nursing*, 183-186.

Kerwin, M. E., Walker-Smith, K., & Kirby, K. C. (2006). Comparative analysis of state requirements for the training of substance abuse and mental health counselors. *Journal Of Substance Abuse Treatment, 30*(3), 173-181. doi:10.1016/j.jsat.2005.11.004

Killeen, P. (2010). *Addiction: The hidden epidemic.* Bloomington, IN: Xlibris Corporation.

Lembke, A. (2012). Time to abandon the self-medication hypothesis in patients with psychiatric disorders. *The American Journal of Drug and Alcohol Abuse*, 524-529.

Levit, K. R., Stranges, E., Coffey, R. M., Kassed, C., Mark, T. L., Buck, J. A., & Vandivort-Warren, R. (2013, June). Current and future funding sources for specialty mental health and substance abuse treatment. *Psychiatric Services, 64*(6), 512-519.

Malat, J., & Kahn, D. A. (2011). Clinical barriers to effective pharmacotherapy in co-occurring psychiatric and substance use disorders. *Journal of Psychiatric Practice*, 360-367. doi:10.1097/01.pra.0000405367.82419.29

Mayo Clinic. (2012, 09 15). *Mental illness: Definition*. Retrieved from Mayo Clinic: http://www.mayoclinic.org/diseases-conditions/mental-illness/basics/definition/con-20033813

Murthy, P., & Chand, P. (2012). Treatment of dual diagnosis disorders. *Current Opinion in Psychiatry 2012*, 194-200. doi:10.1097/YCO.0b013e328351a3e0

National Alliance on Mental Illness. (2010, 04 13). NAMI comments on the APA's draft revision of the DSM-V: Substance use disorders. Arlington, VA, United States of America.

National Institute on Drug Abuse. (2010). *Comorbidity: addiction and other mental illnesses.* Bethesda: U.S. Department of Health and Human services l National Institutes of Health.

Pettinati, H. M., O'Brien, C. P., & Dundon, W. D. (2013). Current status of co-occurring mood and substance use disorders: A new therapeutic target. *American Journal of Psychiatry*, 23-30.

Primm, A. B., Gomez, M. B., Tzolova-Iontchev, I., Perry, W., Thi Vu, H., & Crum, R. M. (2000). Mental health versus substance abuse treatment programs for dually diagnosed patients. *Journal of Substance Abuse Treatment* , 285-290.

Substance Abuse and Mental Health Services Administration (n.d.). *SAMHSA Co-Occurring News*. Retrieved July 7, 2013, from http://www.samhsa.gov/co-occurring/

Sterling, S., Chi, F., & Hinman, A. (2011). Integrating care for people with co-occurring alcohol and other drug, medical, and mental health conditions. *Alcohol Research & Health, 33*(4), 338-349.

Straubing, S. A., Harden, J. R., Callihan, R. R., & Gold, M. (2013). Dual Diagnosis. *Counselor: The magazine for addiction professionals*, 22-28.

Wüsthoff LE, Waal H, Ruud T, Røislien J, & R.W., G. (2011). Identifying co-occurring substance use disorders in community mental health centres. Tailored approaches are needed. *Nordic Journal of Psychiatry*, 58–64.

Wynn, R., Landheim, A., & Hoxmark, E. (2013). Which factors influence psychiatric diagnosing in substance abuse treatment. *International Journal of Mental Health Systems*, 7-17.

Ziedonis, D. M., Smelson, D., Rosenthal, R. N., Batki, S. L., Green, A. I., Henry, R. J., . . . Weiss, R. D. (2005). Improving the care of individuals with schizophrenia and substance use disorders: Consensus recommendations. *Journal of Psychiatric Practice*, 315-339.