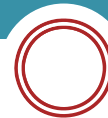
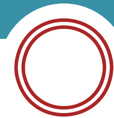
Dual Diagnosis Nursing Care: Treating the Patient with Co-Occurring Addiction & Mental Health Disorders.

Deborah Koivula R.N.



Webinar Overview & Objectives



I. Review current trends in co-occurring disorders

II. Identify the most common mental health issues among addicted patients

III. Review screening and assessment tools used in dual diagnosis settings and discuss strategies for working with the dual diagnosed population

IV. Identify consequences of undiagnosed, untreated or undertreated co-occurring disorders

V. Identify positive outcomes for patients who have co-occurring disorders treated simultaneously

“Every form of addiction is bad, no matter whether the narcotic be alcohol or morphine or idealism”.

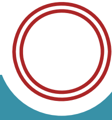
-*Carl Jung*

“Disorders Relating to the Use of Alcohol and/or Other Drugs of Abuse”

Substance Abuse & Dependence

- **Clusters of behaviors and physiological effects occurring within a specific time frame**
- **Dependence always takes precedence over that of abuse, e.g., a diagnosis of abuse is made only if DSM-IV criteria for dependence have never been met.**

Definitions



Substance Abuse

(1 or more in a 12-month period)

Symptoms must never have met criteria for substance dependence for this class of substance.

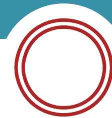
- Recurrent use resulting in failure to fulfill major role obligation at work, home or school
- Recurrent use in physically hazardous situations
- Recurrent substance related legal problems
- Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by substance

Substance Dependence

(3 or more in a 12-month period)

- Tolerance (marked increase in amount; marked decrease in effect)
- Characteristic withdrawal symptoms; substance taken to relieve withdrawal
- Substance taken in larger amount and for longer period than intended
- Persistent desire or repeated unsuccessful attempt to quit
- Much time/activity to obtain, use, recover
- Important social, occupational, or recreational activities given up or reduced
- Use continues despite knowledge of adverse consequences (e.g., failure to fulfill role obligation, use when physically hazardous)

Substance Dependence



In using the DSM-IV criteria, specify whether substance dependence is:

*** *with* physiologic dependence**
(i.e., there is evidence of tolerance or withdrawal)

Or

- ***without* physiologic dependence**
(i.e., no evidence of tolerance or withdrawal).

Substance Dependence

Current	Remission
• Currently manifesting a pattern of abuse or dependence i.e.; "alcohol dependence, current"	• Or as in remission i.e.; "alcohol dependence, full sustained remission"

Those in remission can be divided into four subtypes....

*** on the basis of whether any of the criteria for abuse or dependence have been met**

***and over what time frame.**

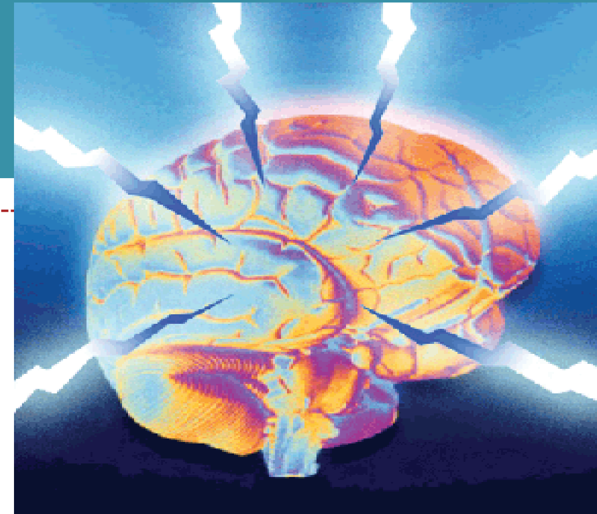
- Full
- Early partial
- Sustained
- Sustained partial

A diagnosis of C.O.D. can be made when:

- At least one disorder of each type (substance use and mental health d/o) can be established independent of the other, and is not simply a cluster of symptoms resulting from one disorder.

- C.O.D.'s may include alcohol, other drugs, and non-substance related DSM-IV-TR Axis I & II mental disorders. (Substance Abuse and Mental Health Services Administration, 2005 TIP 42)

What is Comorbidity?

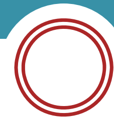


When two disorders or illnesses occur in the same person, simultaneously or sequentially, they are described as comorbid.

Comorbidity also implies interactions between the illnesses that affect the course and prognosis of both.

(U.S. Department of Health and Human Services-National Institute of Health, September 2010).

Current Trends in Co-Occurring Disorders



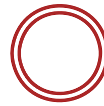
Mental and substance use conditions often *co-occur.*

In other words,

individuals with substance use conditions often have a mental health condition at the same time and visa versus.

(SAMHSA.GOV 2012)

Current Trends in Co-Occurring Disorders: Statistics



45 million adults in the U.S. report having any type of mental illness in the past year —

SAMHSA Office of Applied Studies, National Survey on Drug Use and Health from 2008 and 2009:

Current Trends in Co-Occurring Disorders: Statistics

According to SAMSHA'S Office of Applied Studies, National Survey on Drug Use and Health from 2008 and 2009:

8.9 million adults in the United States

have co-occurring disorders;

that is they have both a mental and substance use disorder.

- Only 7.4 %

receive treatment for both conditions

- 55.8 % receiving no treatment at all.

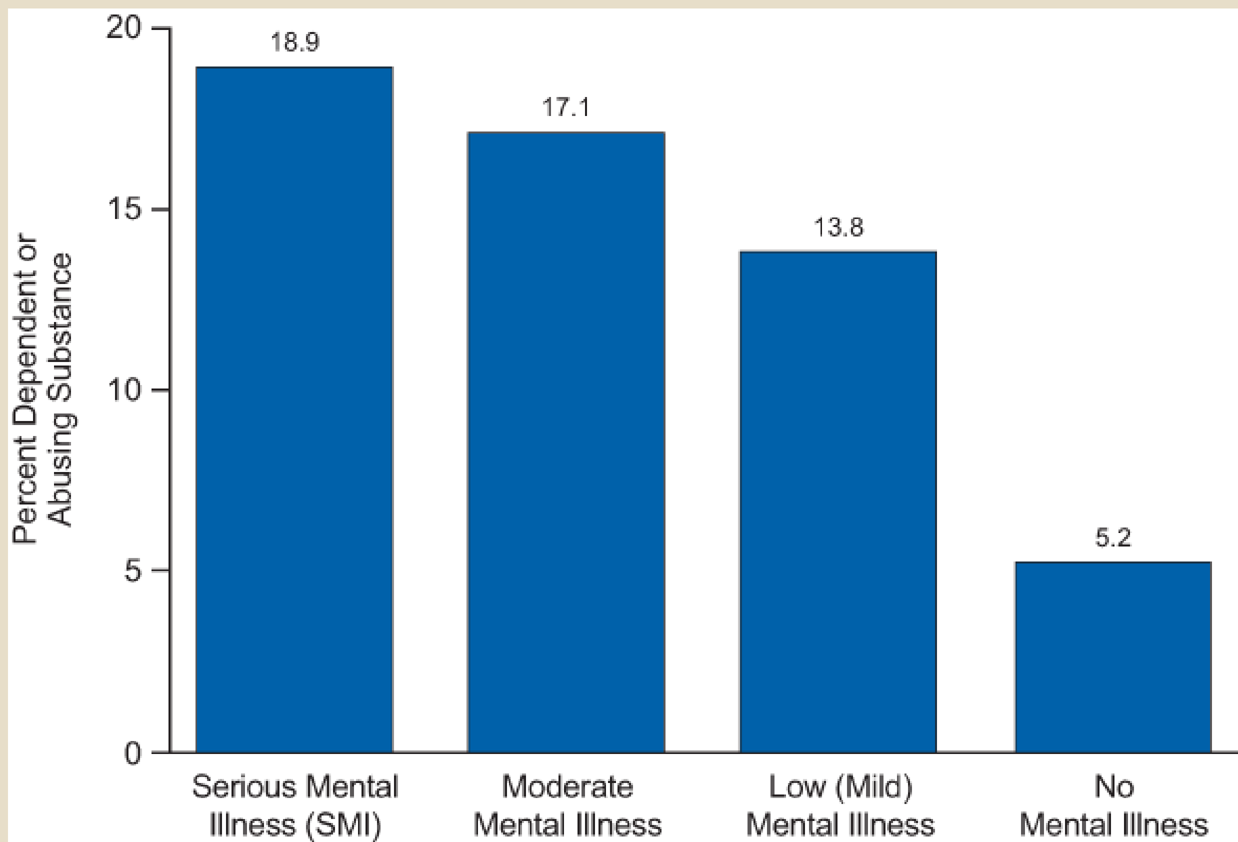
Current Trends in Co-Occurring Disorders: Statistics

According to SAMSHA'S Office of Applied Studies, National Survey on Drug Use and Health from 2008 and 2009:

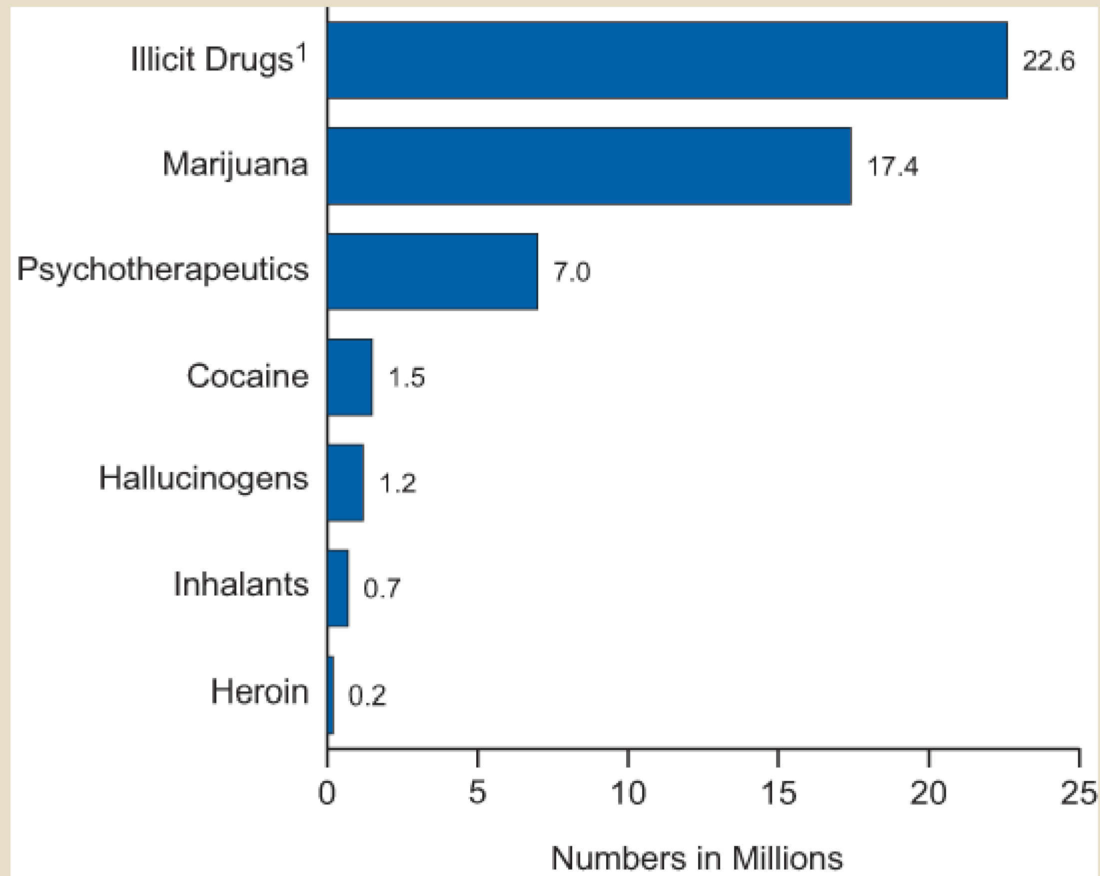
Adults with
serious mental illness
(SMI)
& substance use dependence
= 2.8 million in the U.S.

- 62 % received substance use or mental health treatment
- 38 % did not receive any treatment.

Substance Abuse and Mental Health Services Administration, Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings



Current Trends in Co-Occurring Disorders: Statistics



What drugs are our patients using?

Figure shows Past Month Illicit Drug Use among Persons Aged 12 or Older: 2011

Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings SAMHSA.gov

What About Alcohol?
Frequency of Overlap Between Mental Illness and Alcohol:

- Overall, the prevalence of alcohol dependence is almost twice as high in those with psychiatric disorders as in the general population:

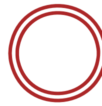
One US study found that 19.9% of the general population had one or more psychiatric disorders, but in those with alcohol abuse or dependence the figure rose to 36.6%

(Institute of Alcohol Studies, 2012)

Current Trends in Co-Occurring Disorders

How do these statistics impact the addiction nurse?

Current Trends in Co-Occurring Disorders:

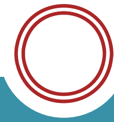


Nurses who are knowledgeable of Addiction Nursing and current trends in the field of addiction are more likely to facilitate *evidence based strategies* when caring for the dual diagnosis patient.

This is applicable:

- In addictions settings such as rehab, detox, outpatient
- As well as other areas of nursing care i.e.; ER, Critical Care, Med Surg, OBGYN, Public Health Settings and Home Care

How knowledgeable are nurses to treat the addiction client?



Journal of Emergency Nursing , August 2000

305 emergency nurses' questionnaires were given to determine nursing knowledge of substance dependence.

RESULTS:

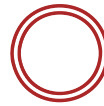
Significant deficits were noted in understanding the terms:

"addiction,"
"tolerance," and
"dependence“

Primary health care nurses' and physicians' attitudes, knowledge and beliefs regarding brief intervention for heavy drinkers. *Addiction (February 2001)*

- ONLY 18% OF RESPONDENTS REPORTED HAVING ENOUGH KNOWLEDGE TO PROVIDE COMPETENT BRIEF INTERVENTIONS

Current Trends in Co-Occurring Disorders:



Understanding statistical trends supports the implementation of best practices including:

•Integration of Care

•Screening and Assessment

•Nursing Interventions

•Training

Section II:
Most Common Co-Occurring Mental Illnesses

- **Mood Disorders**: Depression, Dysthymia, Bipolar Disorder and other Mood Disorders
- **Anxiety Disorders**: social anxiety, claustrophobia, agoraphobia, obsessive-compulsive disorders
- **Post Traumatic Stress Disorder**
- **Psychotic Disorders**: Schizophrenia, Schizoaffective
- **Personality Disorders/Axis II:** Anti-social, Borderline

Mood Disorders: Depression (DSM IV)

Major Depressive Disorder requires two or more major depressive episodes.

Diagnostic criteria for depressive episode:

- Depressed mood and/or loss of interest or pleasure in life activities **for at least 2 weeks and at least five of the following symptoms** that cause clinically significant impairment in social, work, or other important areas of functioning **almost every day**

1. Depressed mood most of the day.
2. Diminished interest or pleasure in all or most activities.
3. Significant unintentional weight loss or gain.
4. Insomnia or sleeping too much.
5. Agitation or psychomotor retardation noticed by others.
6. Fatigue or loss of energy.
7. Feelings of worthlessness or excessive guilt.
8. Diminished ability to think or concentrate, or indecisiveness.
9. Recurrent thoughts of death

Mood Disorders: Dysthymia (DSM IV)

Diagnostic criteria for Dysthymia:

- Depressed mood most of the day for more days than not, for at least 2 years, and the presence of two or more of the following symptoms that cause clinically significant impairment in social, work, or other important areas of functioning:

  1. Poor appetite or overeating.
  2. Insomnia or sleeping too much.
  3. Low energy or fatigue.
  4. Low self-esteem.
  5. Poor concentration or difficulty making decisions.
  6. Feelings of hopelessness

Mood Disorders: Bipolar (DSM-IV)

Bipolar disorder is characterized by more than one bipolar episode. There are three types of bipolar disorder:

- **Bipolar 1** Disorder, in which the primary symptom presentation is manic, or rapid (daily) cycling episodes of mania and depression.
- **Bipolar 2** Disorder, in which the primary symptom presentation is recurrent depression accompanied by hypo manic episodes (a milder state of mania in which the symptoms are not severe enough to cause marked impairment in social or occupational functioning or need for hospitalization, but are sufficient to be observable by others).
- **Cyclothymic Disorder**, a chronic state of cycling between hypo manic and depressive episodes that do not reach the diagnostic standard for bipolar disorder

Manic episodes are characterized by:

- A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary)
- B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (4 if the mood is only irritable) and have been present to a significant degree:

(1) increased self-esteem or grandiosity

(2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)

(3) more talkative than usual or pressure to keep talking

(4) flight of ideas or subjective experience that thoughts are racing

(5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)

(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation

(7)excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

Other Mood Disorders:

Substance-Induced Mood Disorder

- A common depressive illness of clients in substance abuse treatment. It is defined in DSM-IV-TR as "a prominent and persistent disturbance of mood that is judged to be due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication, or somatic treatment for depression, or toxin exposure)

- The mood can manifest as manic (expansive, grandiose, irritable), depressed, or a mixture of mania and depression.

- Generally, substance-induced mood disorders will only present either during intoxication from the substance or on withdrawal from the substance and therefore do not have as lengthy a course as other depressive illnesses.

Other Mood Disorders:

Mood Disorder Due to General Medical Condition

- It is not as common to find depression due to a general medical condition in substance-abuse treatment settings, but it is important to note that depression can be a result of a medical condition, such as hypothyroidism or Parkinson's disease.

- The criteria for diagnosis are similar to Major Depressive Episode or a manic episode; however, the full criteria for these diagnoses need not be met.
- It is important in diagnosis to **establish that the depressive symptoms are a direct physiological result of the medical condition**, not just a psychological response to a medical problem.

Other Mood Disorders:

Adjustment Disorder With Depressed Mood

- Adjustment disorder is a psychological reaction to overwhelming emotional or psychological stress, resulting in depression or other symptoms.
- Some situations in which an adjustment disorder can occur include divorce, imprisonment of self or a significant other, business or employment failures, or a significant family disturbance.
- The stressor may be a one-time event or a recurring situation.
- Because of the turmoil that often occurs around a crisis in substance use patterns, clients in substance abuse treatment may be particularly susceptible to Adjustment Disorders. Some of the common depressive symptoms of an adjustment disorder include tearfulness, depressed mood, and feelings of hopelessness.
- The **symptoms of an adjustment disorder normally do not reach the proportions of a Major Depressive Disorder**, nor do they last as long as a Dysthymic Disorder. An acute adjustment disorder normally **lasts only a few months**, while a **chronic adjustment disorder may be ongoing after the termination of the stressor**.

Anxiety Disorders

- Anxiety Disorders, including Panic Disorder, Agoraphobia, Social Phobias, Generalized Anxiety Disorder and Obsessive Compulsive Disorder:

Symptoms of anxiety disorders are most often on the anxiety spectrum, but the chronic stress faced by individuals with anxiety disorders can produce depressive symptoms including irritability, hopelessness, despair, emptiness, and chronic fatigue.

Post Traumatic Stress Disorder

- Posttraumatic Stress Disorder (PTSD)

Symptoms include episodes of re-experiencing the traumatic event or re-experiencing the emotions attached to the event; nightmares, exaggerated startle responses; and social, interpersonal, and psychological withdrawal. Chronic symptoms may include anxiety and depression. **PTSD is categorized as an anxiety disorder.**

Psychotic Disorders

Schizoaffective Disorder and Schizophrenia

- Individuals with schizoaffective disorder have, in addition to many of the symptoms of schizophrenia, a chronic depression with most of the features of Major Depressive Disorder. Because of the difficulty individuals with schizophrenia have in coping with the daily demands of living, depression is often a symptom. With both schizoaffective disorder and schizophrenia, the depression adds an additional dimension to treatment, specifically in helping the person mobilize in the face of their depression to cope with their illness.

Personality Disorders

Antisocial, Borderline, Narcissistic

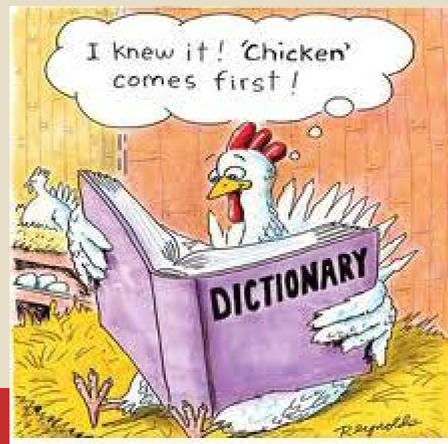
- People with personality disorders are particularly susceptible to depression.
- These individuals are at high risk for substance use disorders.
- As a result, it is not uncommon to find clients in substance abuse treatment with all three diagnoses.
- Because personality disorders are categorized in DSM-IV-TR as Axis II disorders it is common to find their depression diagnosed separately as an adjustment disorder, dysthymia, or major depressive disorder

Chicken or Egg?

Mental health problems may be a cause of problem drug use

OR

Problem drug use may be a cause of mental health problems



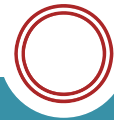
Section III:

A. Screening and Assessment Tools Used in Co-Occurring Treatment

&

B. Strategies for Working with the Co-Occurring Patient

Screening and Assessment Tools Used in Co-Occurring Treatment



Screening –

- The process to determine the ***likelihood*** that a person has a co-occurring disorder and whether there is a need to conduct an in-depth assessment (Substance Abuse and Mental Health Services Administration, 2006a).

*Early identification of true disorders

*Identification of at-risk behaviors

Assessment –

- The process of gathering information and engaging with a client to **establish** (or rule out) the existence of a co-occurring disorder or service need, determine the client's readiness for change, identify the client's strengths and problem areas that may affect treatment and recovery, and work with the client to develop a treatment and service plan

(Substance Abuse and Mental Health Services Administration, 2005b)

How do you know which screen to use?

Depends on the

- Sensitivity and
- Specificity (How true is the result?)

of the instrument and the population being screened.

For example- some screenings are more specific to alcohol use.

TABLE. Screening tools for substance abuse

Screening tool	Sensitivity	Specificity	Sample question(s)
CAGE Cut down Annoyed Guilty Eye opener	76%	90%	• Have you ever felt you ought to Cut down on your drinking? • Have people Annoyed you by criticizing your drinking? • Have you ever felt Guilty about your drinking? • Have you ever had a drink first thing in the morning (Eye opener)?
AUDIT Alcohol Use Disorder Identification Test	84%	90%	How often did you have 6 or more drinks on one occasion in the past year?
ASSIST Alcohol Smoking Substance Involvement Screening Test	90%	78%	Has a friend or relative or anyone else ever expressed concern about your use of (first drug, second drug, etc.)?
DAST Drug Abuse Screening Test	82%-96%	71%-91%	• Have you used drugs other than those required for medical reasons? • Can you get through the week without using drugs?

Data from Lanier D and Ko S,[1] Blondell RD,[9] and Bush K, Kivlahan DR, McDonell MB, et al. The AUDIT alcohol consumption questions (AUDIT-C): an effective brief screening test for problem drinking. *Arch Intern Med.* 1998;158(16):1789-1795.

Most common problems with self reported screening tools:

1- Recall Bias **(can't remember accurately)**

2- Under Reporting

Screening: "D.A.S.T. & C.A.G.E."

The Drug Abuse Screening Test, or D.A.S.T.

Table 1
Pearson Correlations for the Drug Abuse Screening Test–20 (DAST-20) and DAST-10 With Validation Measures

Validation item–score	DAST-20	DAST-10
Days since last drug use	−.59*	−.58*
Days in past month troubled by drug problems	.47*	.43*
Days in past month used more than one drug	.33*	.31
Number of drug types used in last month	.38*	.38*
Number of drug types used in lifetime	.57*	.57
Money spent on drugs in last 30 days	.35*	.30
Number of drug-related treatments	.49*	.45*
ASI-Drug composite score	.42*	.39*
CRS-Drug	.40*	.37*
ASI-Alcohol composite score	.33*	.31*
MAST	.52*	.48*
ASI-Psychiatric composite score	.34*	.40*
SCL-90-R Positive Symptom total	.27	.32*
SCL-90-R Global Symptom Index	.29*	.35*
SCL-90-R Psychoticism subscale	.34*	.40*
SCL-90-R Depression subscale	.27	.32*
SCL-90-R Anxiety subscale	.26	.32*
SCL-90-R Paranoia subscale	.26	.31*
SCL-90-R Phobic Anxiety subscale	.27*	.32*
SCL-90-R Interpersonal Sensitivity subscale	.26	.31*
SCL-90 Obsessive–Compulsive subscale	.23	.29*
SCL-90-R Somatization subscale	.26	.31*
SCL-90 Hostility subscale	.20	.22
Global assessment of functioning (GAF)	−.14	−.14
Previous psychiatric hospitalizations	−.07	−.07

Note. n = 97. SCL–90–R = Symptom Checklist—90—Revised; ASI = Alcohol Severity Index; MAST = Michigan Alcohol Screening Test; CRS = Clinician Rating Scale.
* $p < .003$.

- Example of a standard screening test used to determine if an individual is addicted to or suffering from drug abuse.
- The DAST screening test is a self-test.

C.A.G.E.

- Standard Screening tool for Alcohol Abuse

Table 6. CAGE Screen For Alcohol Abuse.

C = "Have you ever felt you should **C**ut down on your drinking?"

A = "Have people **A**nnoyed you by criticizing your drinking?"

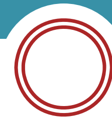
G = "Have you ever felt bad or **G**uilty about your drinking?"

E = "Have you ever had a drink as an **E**ye-opener first thing in the morning to steady your nerves or help a hangover?"

Yes to two or more: probable alcohol abuse

Source: Mayfield D, McLeod G, Hall P. The CAGE questionnaire: validation of a new alcoholism screening instrument. *Am J Psychiatry* 1974 Oct;131(10):1121-1123.

Screening: "S.M.A.S.T."



The Short Michigan Alcoholism Screening Test (SMAST), is a screening test aimed at identifying individuals with drinking problems.

Screening: "S.M.A.S.T."

Short Michigan Alcohol Screening Test*

Instructions: Answer each question with "Yes" or "No".

1. Do you feel that you are a normal drinker? (By "normal" we mean that you drink less than or as much as other people.)

2. Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?

3. Do you ever feel guilty about your drinking?

4. Do friends or relatives think you are a normal drinker?

5. Are you able to stop drinking when you want to?

6. Have you ever attended a meeting of Alcoholics Anonymous?

7. Has drinking ever created problems between you and your wife, husband, a parent, or other near relative?

8. Have you ever gotten into trouble at work because of your drinking?

9. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?

10. Have you ever gone to anyone for help about your drinking?

11. Have you ever been in a hospital because of drinking?

12. Have you ever been arrested for driving under the influence of alcoholic beverages?

13. Have you ever been arrested, even for a few hours, because of other drunken behavior?

Scoring: Each "Yes" answer equals one (1) point.

A score of 1 or 2 indicates there is no alcohol problem.

A score of 3 indicates a borderline alcohol problem.

A score of 4 or more indicates an alcohol problem.

If you scored 3 or more, USC's Staff and Faculty Counseling Center is here to help! We are conveniently located at both the University Park Campus and Health Sciences Campus. Call us at (213) 821-0800.

* Test was developed from the Michigan Alcoholism Screening Test.

Assessing for Substance Use

Diagnostic assessment—classification of a disorder based on a standardized source, such as the Diagnostic and Statistical Manual of Mental Disorders—

Unfortunately, agreement on what else to assess and what to call it may end there.

However, there are a few commonly used assessment methods that nurses should be familiar with.

Comprehensive Longitudinal Assessment

Purpose:

Help the client and clinician understand what psychiatric symptoms were like when substance use was stable, and vice versa,

and

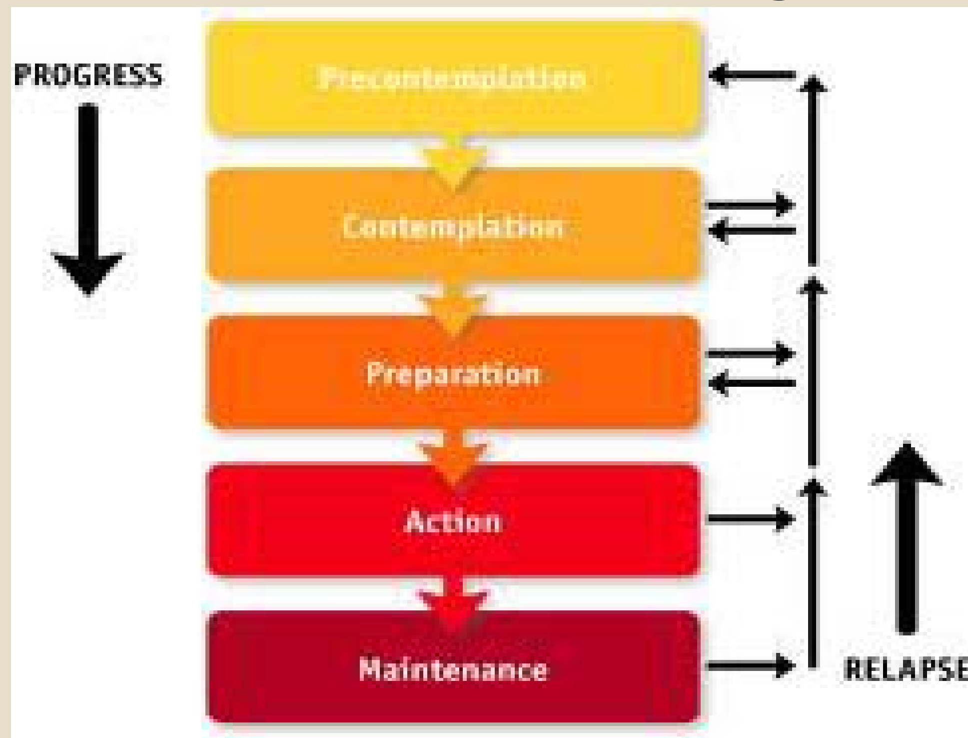
to see how the disorders have interacted during the person's life.

Contextual Assessment

Looks at the recent interaction between substance use and mental health symptoms.

Assessment: Assessing Readiness to Change

Matching treatment strategies to stages of change is an essential component of integrated treatment



Assessing Readiness to Change:

1. On the line below, mark where you are now on this line that measures change in behavior. Are you not prepared to change, already changing or someplace in the middle?

Not prepared to change | Already changing

2. Answer the questions below that apply to you.

- If your mark is on the left side of the line:

  How will you know when it's time to think about changing? . . . .

  What signals will tell you to start thinking about changing? . . . .

  What qualities in yourself are important to you? . . . .

  What connection is there between those qualities and "not considering a change"? . . . .

- If your mark is somewhere in the middle:

  Why did you put your mark there and not further to the left? . . . .

  What might make you put your mark a little further to the right? . . . .

  What are the good things about the way you're currently trying to change? . . . .

  What are the not-so-good things? . . . .

  What would be the good result of changing? . . . .

  What are the barriers to changing? . . . .

- If your mark is on the right side of the line:

  Pick one of the barriers to change and list some things that could help you overcome this barrier. . . . .

  Pick one of those things that could help and decide to do it by ______________________ (write in a specific date).

- If you've taken a serious step in making a change:

  What made you decide on that particular step? . . . .

  What has worked in taking this step? . . . .

  What helped it work? . . . .

  What could help it work even better? . . . .

  What else would help? . . . .

  Can you break that helpful step down into smaller pieces? . . . .

  Pick one of those pieces and decide to do it by ______________________ (write in a specific date).

- If you're changing and trying to maintain that change:

  Congratulations! What's helping you? . . . .

  What else would help? . . . .

  What are your high-risk situations? . . . .

- If you've "fallen off the wagon":

  What worked for a while? . . . .

  Don't kick yourself—long-term change almost always takes a few cycles.

  What did you learn from the experience that will help you when you give it another try? . . . .

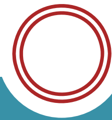
3. The following are stages people go through in making important changes in their health behaviors. All the stages are important. We learn from each stage.

   We go ***from*** "not thinking about it" ***to*** "weighing the pros and cons" ***to*** "making little changes and figuring out how to deal with the real hard parts" ***to*** "doing it!" ***to*** "making it part of our lives."

   Many people "fall off the wagon" and go through all the stages several times before the change really lasts.

Tying It All Together

Section III: B. Strategies for Working with the Co-Occurring Patient



Cognitive Behavioral Therapy

- — A therapeutic approach that targets both thought and behavior change (i.e., thinking differently about substance abuse and coping in ways that do not involve substance use)

Motivational Interviewing

- – A therapeutic approach that helps clients enhance their motivation to reduce substance use or to become abstinent

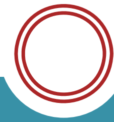
in order to reach their personal goals.

- The approach fosters change by helping clients explore

and clarify their goals, and then make the commitment to change in order to reach their desired goals (Substance Abuse

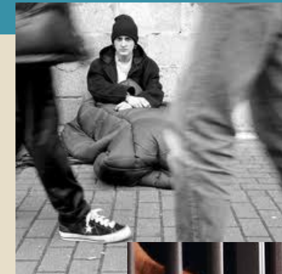
- and Mental Health Services Administration, 2005b, 2008).

Consequences of Co-occurring Disorders



Consequences of undiagnosed, untreated, or undertreated co-occurring disorders

There are several identified consequences of undiagnosed, untreated, or undertreated co-occurring disorders



- Homelessness
- Incarceration
- Early Mortality
- Medical illnesses

  -68 % of adults with mental disorder also have one or more medical conditions

  -29 % of adults with medical conditions have a co morbid mental disorder

  -Medical conditions may lead to mental disorders, or mental disorders may lead to medical conditions.
- Suicide

Current Trends in Co-occurring Disorders

Consequences of undiagnosed, untreated, or undertreated co-occurring disorders

Consequences also include higher likelihood of experiencing:

- *Poverty*- Adults with mental illness/substance use disorders are **twice** as likely to have incomes less than 150% of poverty level as adults without either disorder (SAMHSA.GOVE 2012)
- *Higher rates of relapse*- addiction and mental illness relapses

CDC.GOV

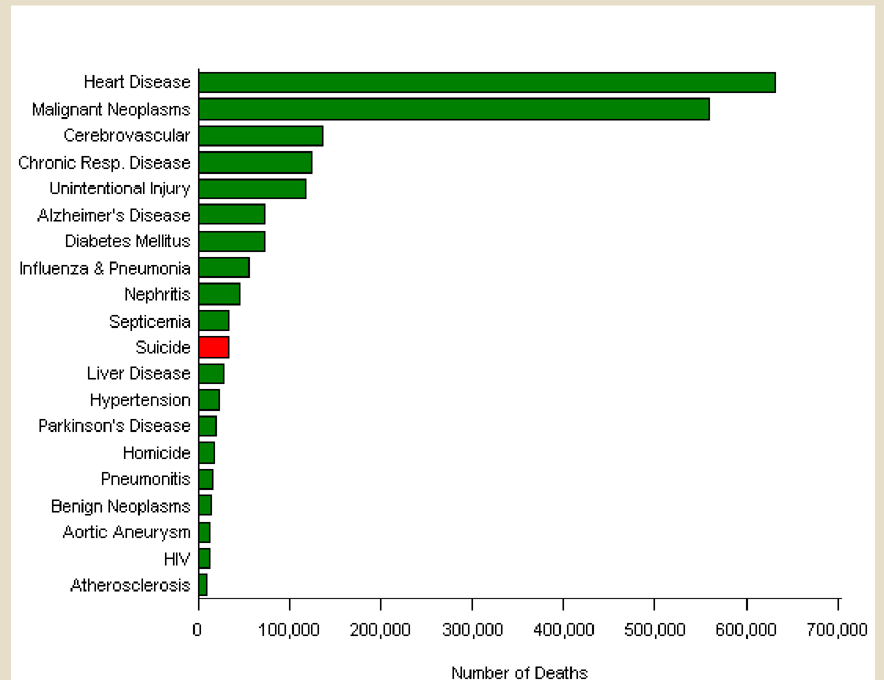
According to the Center for Disease Control,

substance dependence, including use of licit and illicit drugs, alcohol and smoking,

remains a leading preventable cause of morbidity and mortality.

Benefits of Co-Occurring Treatment

- Longer lengths of sobriety
- Increased participation in lifelong recovery
- Decreased rates of recidivism
- Decreased rates of suicide
- Improved housing opportunities
- Improved relationships
- Improved medication compliance
- Better overall outcomes



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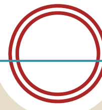

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