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TREATMENT FOR PATIENTS WITH DUAL DIAGNOSIS OF BIPOLAR AND SUBSTANCE DEPENDENCE

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by

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This paper researched publications and articles to understand the treatment options for persons diagnosed with bipolar disorder and substance use disorders. Upon gaining information regarding treatment options for both conditions, the author of this paper sought to provide knowledge of counseling techniques to be used by professional in the rehabilitation field as well as other counseling professionals in combining some overlapping treatment requirements when treating clients with a dual diagnosis of bipolar and substance use disorder. Many people diagnosed with a dual diagnosis find themselves overwhelmed with treatment requirements and as a result the either go without the services they need or self-medicate with substances of abuse. By exploring effective treatments for both disorders, this author hopes to share information that can be used to integrate the treatment requirements for both conditions. By integrating care, it will improve the outcomes for people with a dual diagnosis. April 2017.

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CHAPTER 1

STATEMENT OF THE PROBLEM

Introduction

For several years, individuals with a dual diagnosis of bipolar and substance abuse disorder have been overwhelmed when it comes to treatment. Even though there has been research on individualized treatment, the issue of integrating care for both disorders has become of extreme importance. Previously, patients were treated by various doctors like mental health therapist as well as substance abuse counselors. As such, separate treatment for each condition implied two different treatment schemes with steps and obligations to fulfill both. In this respect, patients were usually overwhelmed, and this led to patients giving up seeking services for the two cases.

Dual diagnosis is a term used to refer to situations when an individual diagnosed with a mood disorder also has a problem with substance abuse. Some of the most common mood disorders include bipolar disorder and depression. Both mood disorders and a substance abuse require separate treatment plans that may often need different interventions to help the patient recover (Fisher et al., 2009). Patients with dual diagnosis of the substance dependence and bipolar disorder have problems adhering to the two treatment plans administered for these conditions, especially when the plans bring in different therapists and health facilities. As a result, researchers' attention has been drawn to the conditions affecting these individuals with the aim of ensuring that the treatment procedures are improved to fit in the physical, mental, and financial capabilities of the patients (Bellenir, 2005). This goes a long way in helping them adapt and enhance the effectiveness of the procedures. One of the factors that have been widely considered in these researches is the quality of life (QOL) of the patients (Jay & Boriskin, 2007).

Statistics show that at least half of the people diagnosed with bipolar disorder also drug dependency issues (Cardoso et al., 2016). This means that such individuals must be enrolled in interventions for both conditions. These diagnoses have different effects on various aspects of life of the patient and can have a negative impact on their social wellbeing, employment, and general health. Entities involved in the treatment of these conditions often come up with different but conflicting guidelines and plans. While patients tend to struggle to meet the expectations of both entities, they often give up, thus, resulting in the deterioration of their quality of life (Whitley et al., 2015).

Conducting research is appropriate in coming up with plans and recommendations to ensure that both treatments remain effective for the relevant conditions. This can be done by integrating the two treatment plans or having proper coordination of the healthcare facilities and healthcare professions in charge of the two treatment plans. This is aimed at making the treatment more patient centered, thus, increasing its achievability and appeal to the patient and their relatives. Some of the interventions used on both conditions include medications, community program participation, psychotherapies, and education (Whitley et al., 2015). Because these interventions overlap integrating aspects common to both interventions can help reduce the time and energy spent by the patient to adhere.

Treatment of bipolar disorder has been given vast attention in the US healthcare system (Bush et al., 2015). The costs emanating from treating this condition have been skyrocketing. Nonetheless, the accumulation of treatment of substance abuse cases has led to further escalation of these costs. As such, there must be an integration of the two. Non-treatment of either or both conditions due to various reasons has led to decreased productivity of the human resources, escalating costs of care, loss of employment and income by the individuals who are diagnosed

(Bush et al., 2015). This research aims at coming up with a proposal that will see the effectiveness and success of the treatment process of patients with dual diagnosis enhanced. The researcher will delve on how the reduction in the hours spend on treatment and the costs emanating from the whole process will provide patients an incentive to follow up the treatment procedure and collaborate with the appropriate facilities and personnel for quality outcomes.

Background

Bipolar disorder was initially referred to as the manic depression. This term was made in reference to an individual that experienced alternating hypomania and depression. Hypomania refers to high mood conditions where an individual feels elated. Again, this person may be easy to interact with anyone. However, the excitement may be blown out of proportion and as such, the individual may be exposed to self-harm by their willingness to take risks (Cook et al., 2015). On the other hand, depression refers to the low moods where an individual may often escape company or generally feel demotivated to carry out certain tasks that may include daily activities. Individuals, who suffer from these conditions, may also experience hallucinations and delusions. Similarly, individuals, who suffer from drug dependence, are likely to experience high and low alternating moods depending on the rate at which they consume the addictive substance (Larsen, 2014).

Research for some of the best interventions on the various mental conditions affecting humanity has been aimed at dealing with the most common factors between these disorders such as depression. Therefore, most of the attention of the researcher was given to the symptoms rather than the underlying factors. There was neither motivational nor out-reach interventions that sought to look at the underlying factors that affect the patients. Therefore, a drug addict was only treated of the effects of the drug on their mental wellbeing while ignoring other factors,

such as family, societal influences, and economic factors that would have led to their drug dependence (Cardoso et al., 2016).

During the 20th century, most of the mental conditions affecting humanity were generalized, and similar plans were availed for detection and control (Bush et al., 2015). It is important to note that most of the treatments applied on these conditions were traditional. Therefore, the interventions used for bipolar disorder and drug dependence were similar. This means that an individual suffering from either or both conditions would be put on a single treatment plan without considering the differences in their needs (Daley et al., 2006).

The latest developments in research on mental health have seen practitioners distinguish the interventions for different conditions. Researchers and practitioners have come up with different treatments to handle clinical depression, dementia, anxiety disorders, bipolar disorder, and schizophrenia among other mental conditions. Further, these individuals have come up with alternatives for different patients depending on the conditions surrounding their disorder. These include therapies, family intervention, coping and social skills and training programs (Bush et al., 2015). The interventions have also been divided further to respond to the specific needs of the patient. For instance, a patient who requires therapies for recovery and adaptation may either be put on cognitive remediation therapy or cognitive behavioral therapies with each having its own purposes (Fisher et al., 2009).

Purpose of Study

This study aims at helping practitioners to integrate the treatment plans for patients with dual diagnosis that involves substance dependence and bipolar disorder (Maremmani et al., 2015). Advancement in mental health research discovered that different factors were behind various conditions experienced by mental health patients with more than one disorder. This

necessitated that different interventions be put in place considering the contribution of the factors towards the symptoms rather than dealing with the symptoms themselves. However, it is important to note that individuals with mental disorders have problems carrying out normal activities often due to impaired reasoning, memory, or other factors associated with mental functioning. As a result, having these individuals adhere to the demands of multiple treatment plans can prove tedious and unachievable. This means that the multiplicity of treatment plans impairs their effectiveness, especially when the patients fail to comply with their demands (Cardoso et al., 2016).

Some of the common interventions applied by practitioners on patients suffering from both bipolar disorder and substance addiction include therapies, family and community interventions, social skills and psychoeducation or prophylactic interventions.. However, under extreme cases these interventions may lead to more problems in terms of drug and substance dependence. Subsequently, these interventions are applied in response to the conditions behind the symptoms experienced by the patient (Maremmani et al., 2015). An individual put on separate medications with some overlapping aspects may find the treatment plans repetitive and uninteresting and thus may withdraw from one or both or simply skip some of these aspects without considering their benefits and the likely effects of their actions. As a result, it becomes necessary that the two plans be integrated and the patient be allowed to take active part in the harmonized plan. However, this integration takes into account the different needs of the patient and conditions tied to each disorder that surround the various symptoms experienced by the patient

There are different treatments for individuals with bipolar and substance use disorders. One of the widely used drugs is lithium since it is effective in controlling obsession when it

comes to stabilizing mood (Malhi, 2015). Other effective medications include carbamazepine, lamotrizine, valproate, and asenapine (Marchand, 2012), but they have to be used throughout a person's lifetime. Once an individual's mood is stabilized, anti-anxiety, antipsychotics and antidepressants are prescribed so as to complement mood stabilizers (Otto, 2011). Complementing additional drugs with mood stabilizers is a balancing act for medical practitioners since antidepressants can trigger mania while anti-anxiety could lead to relapse which in turn leads to depression. Nonetheless, under certain conditions particularly in severe depression, electroconvulsive therapy is an effective management intervention (Miklowitz, 2011). After achieving mood stabilization, it is necessary for patients to continue with medication. Other treatment strategies for these disorders include psychotherapy and psychoeducation especially, family therapy, cognitive behavioural therapy, interpersonal and rhythm therapy (Marchand, 2012).

Again, all these therapies require active involvement of patients. Furthermore, cognitive therapy is a temporary measure that assists patients with bipolar and substance use disorders to alter the way they think by strengthening desired behaviors and by eliminating unnecessary ones. Conversely, family therapy takes about nine months and it involves patients and respective families to educate them on substance use and bipolar disorders, prevention of relapse, communication and drug management (Marchand, 2012). Interpersonal and social rhythm therapy is the most effective treatment intervention for managing depression and involves strategies for stress management; enhancing personal relationships, approaches of maintaining regular schedules and adherence to daily prescriptions (Caponigro, 2012). When it comes to psychoeducation it is all about educating patients and their families on bipolar and substance abuse disorders.

Definition of Terms

Substance abuse disorders. Substance abuse disorders occur when an individual, after repeated administration of certain drugs, becomes adapted to them to the extent that withdrawal from administration may result in changes in the functioning of their body. Therefore, an individual makes consumption of certain drugs a habit which develops as a normal occurrence to his bodily and mental functions (Bush et al., 2015).

Bipolar disorder. Bipolar disorder is a mental condition characterized by extreme and often sudden changes in the amount of energy, moods, level of activity and the ability to carry out daily tasks by individuals. The main symptoms for this condition are alternating hypomania and depression and the rest of the symptoms stem from these two conditions (Malhi, 2015).

Dual diagnosis. This term refers to a situation where medical tests indicate that an individual is suffering from both drug dependences that leads to substance dependence disorders and a mental illness such as dementia or bipolar disorder (Murthy & Chand, 2012; Hill & Charura, 2015). In this paper, this term exclusively refers to co-occurring substance abuse disorders and bipolar disorder in an individual.

Hypothesis and Research Questions

Combining overlapping aspects of treatment of bipolar disorder and substance abuse can help reduce the time and resources spent on treating patients with dual diagnosis and increase the effectiveness of the procedure. So, research questions to support the hypothesis are the following:

1. What treatment processes are common to both bipolar disorder and substance dependence?

2. Can procedures that make up both treatments of bipolar disorder and substance dependence be integrated to reduce the number of times they are carried out?
3. How can common treatments be applied to both disorders?

CHAPTER 2

OVERVIEW OF THE LITERATURE

Current Research and Practice on Dual Diagnosis

Bipolar disorder, also known as Manic Depression, is a chronic psychiatric condition that has been associated with many co-occurring conditions. Individuals with characteristics of such state primarily experience many mental complications ranging from normal mood swings to extreme high and lows. Individuals with dual diagnosis have both mental disorders and a drug problem, which involves alcohol in most cases (Hill & Charura, 2015). Both conditions have overlapping characteristics and are often associated with other situations such as anxiety disorders, depression, personality disorders and schizophrenia. One of the problems that policymakers in the health sector face is that some of the substance dependency issues are associated with legalized substances such as alcohol and medications (Cardoso et al., 2016). Therefore, individuals are likely to get back to them because of their availability.

In some cases, mental problems may occur first. These motivate the people into drug and substance abuse in the hope of getting a remedy. However, such steps usually worsen the condition. In other cases, drug abuse may come before the mental problems. As an individual gets more enveloped in substance abuse, they develop emotional and mental problems (Murthy & Chand, 2012). Both factors interplay to contribute into the worsening of the other if early interventions are not put in place. It is important that an individual who raises concerns of having either of these conditions is tested for both. Once both conditions have been diagnosed, appropriate interventions should be put in place to aid their recovery. Neglecting one of either condition may act as a barrier to the treatment of the other due to the effects that each has on the mental, physical and social wellbeing of the patient (Larsen, 2014).

Dual diagnosis refers to a broad array of conditions where an individual experiences both a substance abuse problem and a mental illness simultaneously. The multiplicity of the conditions has made it necessary for researchers and practitioners to divide them into various subcategories to apply appropriate interventions. The conditions referred to by the term, could range from developing minor depression to symptoms of schizophrenia. A case involving alcohol abuse may not require the same attention as that involving alcohol abuse and bipolar disorder (Cardoso, 2016). This means that researchers must apply different interventions for each patient.

Currently, alcohol and other forms of substance abuse are characterized as psychiatric disorders in the US. (Geddes, & Miklowitz, 2013) noted that most individuals who are found to be abusing other substances also abuse alcohol. This is due to the fact that alcohol is one of the cheapest, easily available drugs and many individuals with tendencies of drug abuse first become addicted to alcohol. Research in the past 30 years has shown that disorders from alcohol use are often accompanied by anxiety and mood disorders (Cardoso et al., 2016). Research has indicated that substance abuse changes an individual's priorities and desires. Statistics released by the National Institute of Mental Health in 2014 showed that 20.2 million adults across the United States had a substance use disorder. Out of this population, 7.9 million had both a substance use disorder and another mental illness (National Institute of Mental Health, 2014). Bipolar disorder accounts for more than half of this population.

A dual diagnosis for bipolar is related to high rates of substance use, however, according to recent studies, approximately 50% of individuals diagnosed with bipolar meet the DSM-5 criteria for a substance related disorder as well (National Institute of Mental Health, 2014). If these disorders are not treated, the dual diagnosis can adversely impact on all aspects of life. In

addition, if these disorders are not treated, they can adversely affect their families, ability to maintain employment and health care structure. According to SAMHSA, the treatment of co-occurring disorders presents the health experts and addiction counselor the ability to work with patients diagnosed with substance use and bipolar. Therefore, SAMHSA presents the necessary material for increasing the treatment of these disorders while helping health practitioners with a comprehensive understanding of how to advise patients with these disorders (Sacks & Ries, 2005). The occurrence of co-occurring substance use and bipolar disorder is high.

Having multiple illnesses at the same time is usually referred to as comorbidity and the prevalence of one has devastating effects on the treatment of the other. The process of dealing with these conditions involve diagnosing both disorders then coming up with appropriate treatments for both to run concurrently (Hill & Charura, 2015). Most people who seek treatment for bipolar disease are put on a combination of psychotherapy and medication. Even in cases when bipolar disorder exists alone, it becomes challenging for both the therapists and the individual to adhere to the appropriate schedules (Caponigro, 2012). The initial symptoms of bipolar disorder often lead to denial by the individuals. This results in attempts to alleviate the symptoms through self-medication. This leads to problems in the diagnosis and thus many cases go undetected. Individuals do not also seek professional health services due to denial (Cook et al., 2015).

Research has been conducted to determine whether there is a connection between bipolar disorder and substance abuse. Research conducted by Nunes (2010) found out that individuals who suffer from bipolar disorder are predisposed to substance abuse and vice versa. There is no absoluteness on what condition among these two leads to the other, however, approximately 60% of individuals with bipolar disorder in the US also suffer from dependence on drugs and other

substances (National Institute of Mental Health, 2014). The presence of both conditions leads to problems in the diagnosis of bipolar disease. This is due to the fact that substance dependence often resembles the symptoms of bipolar disorder such as high and low moods. Therefore, the clinicians are likely to diagnose the substance part and go on with treatment while ignoring the possibility of bipolar disease. In addition, the treatment of substance abuse has been noted as having a negative effect on the effectiveness of the interventions applied for bipolar disorder (Hill & Charura, 2015; Larsen, 2014).

The diagnosis and treatment process of both bipolar disorder and substance dependence is done with evidence-based practice that has taken clinicians about half a century to research in order to provide the information that is available for practitioners to date (Ketter, 2015). The effectiveness of the diagnosis process combines interventions of both substance abuse concepts and mental health. This is due to the complexity of the needs of clients with comorbid disorders. The doctors, clinicians and other stakeholders must ensure that there is a long-term approach that is comprehensive and geared towards the recovery of the individual. It is important to note that the effects of one condition and the side-effects that result from its intervention such as the use of therapies and drugs are likely to affect the progress of the other treatment plan (Murthy & Chand, 2012). The programs must consider the competence of the therapists involved, the functional goals towards the improvement of the quality of life of the client while at the same time being sensitive to the cultural factors affecting the life of the patient and the community in which they exist. It is the responsibility of the clinicians and service providers in charge to forecast the various barriers that may exist in the course of the treatment plan and ensure that strategies are put in place to help the counselors and the patients adapt to changes that take place in their lives (McKenzie, Pinger & Kotecki, 2008). It is also important to consider the financial

burden that the condition tends to place on the patients and their families and bring in relevant policies and advice to these families to help them cater for the needs of the patient. This requires the involvement of the society through creating awareness and education of the clinicians and community workers involved who offer active support to the patients and their families (Murthy & Chand, 2012).

Past Research on Dual Diagnosis

In many countries around the world, public finances allocated to the health departments and insurance meets the costs of treating and supporting patients with various mental illnesses. Most of these conditions are dealt with as a community rather than a personal issue (Whitley et al., 2015). This is because mental illness has an equally devastating effect on a society just as to an individual. As a result, many policymakers have resorted to community support programs as a way of dealing with patients with dual diagnosis. Before the vast research on the condition in the 1980s, most of the steps taken in applying treatment for dual diagnosis were based on traditional drug abuse treatment plans (Johnson et al., 2016). For instance, common treatment plans involved the twelve steps where both conditions were treated as a similar disease due to the overlapping symptoms without considering the differences.

Murthy & Chand (2012) stated that results on early research on dual diagnosis were often disappointing due to a number of reasons. For instance, researchers and practitioners did not take into account the complex needs of the clients. This can be attributed to the underdeveloped methodologies used in scientific research that were being applied. As a result, the programs that were created from this research did not take into account motivational and outreach interventions that are broadly utilized today to help practitioners familiarize with the needs of the patients. In addition, the topic on substance abuse was not well covered during this period and most of the

time; it was in the same class as other mental conditions.

As scientific research methods developed, long-term interventions supported studies and discoveries that helped researchers formulate the current treatment plans. During the 1990s, outreach and motivational approaches were incorporated into treatment plans for both patients with bipolar disorder and drug dependence (Murthy & Chand, 2012). The plans were also expanded and made multidisciplinary, especially bringing together the clinicians, psychologists, community workers and other professions such as teachers whose services people with these conditions required close collaboration with. (Murthy & Chand, 2012). Up to this time, most of the research carried out on the subject was uncontrolled but certain measures and milestones were brought in to show positive outcomes, which included remission of drug abuse. Pilot studies were required to further refine the interventions proposed. Later, controlled investigations were brought in to help researchers evaluate the proposals by comparison and determine what could be tried out in evidence-based practice (Hill & Charura, 2015). Experimental and quasi-experimental researches have been designed to help the academia prove the authenticity of a number of interventions utilized for dual diagnosis patients. Despite variations in the types of dual diagnoses, a thorough review of the common aspects of these two conditions reveals the needs of the patients that can be covered through similar interventions. For instance, the therapists can apply interventions to improve the quality of life for both conditions. They can also come up with suggestions on the modifications that need to be done on an individual's housing to help them adapt to the changes inflicted by the disorders and avoid accidents that occur from their reduced memory or rationality (Cardoso et al., 2016).

Formulation of integrated programs is often faced with methodological limitations. This is mainly because the effectiveness of these methods can be ascertained by coming up with a

relative comparison of the integrated and non-integrated programs. This means that a researcher will require a sizeable research sample and a control group. Since the experiments involve human subjects where subjects have dual diagnosis, the question of research ethics constricts the options that the researchers have on choosing their samples because of the process that has to be undertaken to avoid ethical issues (Weiss et al., 2011). Despite these difficulties, it has been noted that programs that integrate the common aspects of bipolar disorder and substance abuse interventions are more effective than the non-integrated ones. On the other hand, dual diagnosis clients under programs that do not integrate substance abuse and bipolar disorder integrations end up having poor outcomes.

Time becomes an important factor when applying interventions for individuals with dual diagnosis. Despite having the condition, these individuals are likely to have other obligations such as spending time with family members and work (Yatham et al., 2013). Putting them on multiple treatment plans that require a lot of time tends to strain them to the extent that they cannot effectively perform these duties. Often, therapists will bring in community and family participation in order to help the patient fit the treatment programs into their schedules (Hill & Charura, 2015). Having multiple programs such as psychotherapies or education sessions that are almost synonymous might be viewed by the patient as causing boredom or time-consuming. It is therefore likely that the patient may withdraw from the program under either or both medications to create time to run their errands or simply take rest due to exhaustion. During this withdrawal, the patient might fail to consult the clinicians administering the services. This means that neither the conditions affecting them and the targets of these interventions are considered, nor relevant adjustments made. This puts the patients' chances of recovery at risk (Fisher et al., 2009).

It is important that the therapists involved in the treatment plan consider the limitations of

time for the patients. Besides this, the patients should be helped to understand the requirements of the treatment plans in terms of the time required to complete it (Larsen, 2014). It becomes necessary that psychoeducation be carried out to help the patients understand the necessity of the procedure and both benefits and negative aspects of discontinuing. In addition, the family and the community is brought on board with the assumption that these individuals spend a considerable amount of time around the patient and they help them adhere to treatment requirements. The balance between the activities of the patient and treatment outlines that require a lot of time, such as psychoeducation and psychotherapies, is important in enticing the patient into following them to completion (Hill & Charura, 2015; Murthy & Chand, 2012). However, the ultimate solution to the time problem is reducing the multiplicity of similar or overlapping programs. This reduction and streamlining should be done by the therapists who first consider the objectives and goals of the various aspects of bipolar disorder and drug dependence problem. When integrating treatment, the counselors should be aware that treatment goals are aligned to the needs of the patient. In an effort to ensure that the clients adhere to the treatment schedules and attend all sessions for the plans that consist of meetings with various counselors, researchers have sought to reduce the time spend by the patient on treatment by integrating some of these plans (Yatham et al., 2013).

Resources are an important aspect to consider when developing a treatment plan. Activities such as psychoeducation, engagement of families and communities, psychotherapies and even administration of medications require resources and expertise that may be rare or expensive and out of reach for a good number of individuals (Murthy & Chand, 2012). It is also important to consider that despite the enhanced ability to access medical insurance in the contemporary society, not all provide coverage to meet all the costs of mental conditions (Hill &

Charura, 2015). Therefore, it becomes the role of government, community, family and individuals to ensure that they meet the expenses tied to various interventions. Procuring the services from relevant providers also involves a long registration and initial diagnosis process since many people are in need of similar services. The multiplicity of these procedures may therefore become expensive for some individuals who may withdraw because they cannot meet the costs (Bush et al., 2015). Some patents may also decide to treat one condition and defer the process for the other. However, it is important to treat both conditions concurrently since each affect the other.

Therapists should integrate the treatments for bipolar disorder and drug dependence for dual diagnosis patients with the issue of cost in mind. This aspect can also be used as a marketing strategy for profit-making health organizations by enticing individuals who have dual diagnosis with reduced costs of treatment (Murthy & Chand, 2012). Despite the development in human resource in the medical sector in the country, there still exists a shortage in facilities around the country and in most of the world, especially in the developing countries. Therefore, it becomes necessary that the available human resource and hospital facilities be utilized economically. Integrating the overlapping aspects of treatment plans for individuals with dual diagnosis will help the patients utilize the available resources without straining. Stretching these resources often leads to an increase in treatment costs because they tend to destabilize the forces of demand and supply of healthcare services.

Murthy & Chand, (2012) note that it is important to ensure that individuals diagnosed with drug dependence problem and bipolar disorder are treated concurrently for both conditions. Due to the factors such as cost and time outlined above, an individual may decide to defer either treatments and concentrate on the other. On the other hand, the researcher has noted that these

two conditions often overlap with one leading to the other. An individual suffering from bipolar disorder is likely to abuse drugs while the effects of drugs on the mental and physical health of the individual predispose them to bipolar disorder. It therefore becomes necessary that the treatment of the two conditions be concurrent to deal with developing signs and symptoms. Integrating the two treatment plans after a thorough assessment will ensure that there is success in this situation and that the expected outcomes of the interventions on each condition are achieved (Yatham et al., 2013).

Barriers in the Provision of Integrated Interventions Plans for Dual Diagnosis

A number of barriers have existed for practitioners who wish to integrate aspects of drug dependence and bipolar disorder treatment on patients with dual diagnosis. One of these aspects is policy. Various authorities and facilities that handle mental patients have their organizational structure, licencing and financing stipulated by policies that do not provide for the integration of the two services. Having mental health conditions and drug abuse handled under one facility or promoting the collaboration between various facilities that handle these condition has been proven as a hard task because of the independent development that these institutions has experienced since their separation towards the last quarter of the 20th century (Murthy & Chand, 2012). In many countries and states in the US, these services are provided under facilities handled by different authorities and departments. Combining these services will not only require the intervention of researchers and the academia but also that of the political powers and economic institutions. There must be integration and clear guidelines on the cost coverage and legislations that protect the interests of the patients and the clinicians. Therefore, integrating the two services will require that one brings on board stakeholders on insurance, cost calculation and

that federal insurance programs such as Medicaid and Medicare be updated to help avoid dilemmas and issues that arise from cost coverage (Bush et al., 2015).

Currently, the treatment programs implemented for both bipolar disorder and drug dependence are not homogeneous across all the facilities. Most of the local public, private and community health centers that deal with these disorders lack clear models that can be integrated to facilitate quick recovery of the patients and the effectiveness of the interventions. Therefore, harmonizing these treatment programs may lead to many legal, policy and ethical issues resulting from disruptions in the administrative, quality assurance, incentives and outcome measures procedures that are currently being implemented in the various facilities (Fisher et al., 2009). It is also likely to complicate the process of hiring individuals to carry out the process of diagnosing and intervening on these conditions.

Organizational and occupational culture developed by clinicians also acts as a barrier to the implementation of integrated intervention for patients with dual diagnosis. This explains why the development of an integrated clinical philosophy that can be used to promote the practicability of interventions on dual diagnosis has not been implemented despite being discovered in the 1990s (Murthy & Chand, 2012). This culture has also been integrated into the rest of the population. In America, some therapists may not go ahead to diagnose the individual for drug dependence once they have been diagnosed with bipolar disorder. This is due to the fear that insurance companies and various government funds may cut their funding (Baldessarini et al., 2015). This fear has been transmitted to the rest of the public who will not seek this diagnosis because of the fear of losing their premiums due to the strict terms in the insurance agreements.

It is the role of the researchers and practitioners to explain to stakeholders that despite the fact that the two conditions are independent and one may lead to the other, they are separate and

have to be treated differently and cost sharing can be done in case the policies do not include coverage for drug dependence. Some clinicians also think that once an individual has been diagnosed with either condition, the interventions applied are enough and do not bother advising the patient to go for further diagnosis or treatment (Bush et al., 2015). However, these beliefs and ideological barriers can be alleviated by enabling clinicians with expertise on either drug dependence or bipolar disorder to go for further studies on the other condition to expand their expertise. This will see the integrated interventions applied in one facility coordinated by one treatment team.

The masses remain misinformed or less informed about dual diagnosis and the services available for the treatment of the condition. Limited programs dispense psychoeducational services on both drug dependence and bipolar disorder. However, it is important to note that assistance from families play a central role in the recovery of the patients. Family members should get well informed on drug and substance abuse (Fisher et al., 2009). At the same time, the role of community workers and clinicians should not be ignored as this is important in helping families and patients to shed some popular beliefs like the use of alcohol and marijuana in alleviating stress in patients (Cardoso et al., 2016).

Although no one can determine which came first, bipolar disorder or substance abuse, if a client has one condition they are more likely to have the other. There is no conclusive research to identify why. There is however research that indicated there are evidence based practices that are effective in treating both conditions simultaneously. Cognitive behavior therapy, psychoeducation, family involvement and medication are all important components to treating someone who has a dual diagnosis. However due to program guidelines, insurance coverage and

lack of dual diagnosis training for counselors, clients often are still required to be enrolled into two separate treatment programs.

CHAPTER 3

DISCUSSION AND IMPLICATIONS

The interventions are offered under refined service systems that define the programs under which the patient can be treated. Dual diagnosis tends to combine substance abuse treatment and aspects of intervention programs for mental health. Therefore, integrating treatment for patients with dual diagnosis brings together clinicians who work under one setting or coordination to ensure that the patient receives the appropriate mental and substance abuse interventions concurrently in a manner that takes care of his/her needs and abilities (Larsen, 2014). Though efforts and recommendations have been made to have one or a group of therapists provide these integrated interventions, human resource, policy and feasibility challenges still exist since an individual must get thorough education on both treatments but combining the treatments at this level may also bring up quality assurance issues.

It is the responsibility of the caregivers to ensure that the integrated interventions are well coordinated. To the client, the process becomes smooth and consistent and it becomes easy for them to follow it to the end. The clinicians in charge should consider the circumstances surrounding the patient such as their abilities, support from their family, community and the government and financial endowments. This can only be achieved if there is proper communication of the activities among the clinicians who are coordinating separate programs.

Integration of the treatment plans does not merely combine the interventions of the conditions in dual diagnosis but also goes farther to modify the traditional interventions on which the plans are based. For instance, the development of social skills has been an important factor in mental health interventions. However, many traditional treatments did not consider that efforts to enhance these skills could also entice people who are abusing substances to abstain, especially if

they are surrounded by individuals with this behavior. Counseling individuals in substance abuse takes into consideration their likely mental impairment as a result of the condition and integrated interventions will seek the support. Family and community interventions will seek to help the individuals around the patient to understand the interplay between the two conditions and their effect on the mental wellbeing of the patient (Baldessarini et al., 2015).

The ultimate target of dual diagnosis is helping the patient suffering from comorbid disorders recover. The process seeks to help the patients adapt to the changes that the condition has brought to their body and mental functions, recover from the extremities caused by this condition and prevent further effects on them (Fisher et al., 2009). This gives the patient the ability to manage both conditions effectively and carry out their activities as normal. It involves community treatment and illness self-management to help the patient gain autonomy or inform those around them about the condition and the interventions that they can apply in case the client fails to manage themselves (Cook et al., 2015).

Important Components of Interventions on Dual Diagnosis

A number of controlled studies have been used to test aspects of integrated programs, especially with their discontinuity or absolute absence acting as predictions for failure of interventions for either substance abuse or bipolar disorder. For instance, social support interventions have seen many programs maintain the clients' health and ability to socialize enabling them go on with important life processes such as work and family commitments (Baldessarini et al., 2015). These interventions are therefore used as a focal point to help stakeholders and clinicians determine what factors of treatment of these conditions can be combined where they exist in comorbidity.

Social support: Social skills are important in helping patients manage the conditions that result from their illness and continue with their activities such as ADL and careers. This support aims at solidifying the patient's position within various social units that they exist in and using this position to give them peace of mind and catalyze their recovery (Fisher et al., 2009). It takes into account the behavior of the patient and other people within this environment. These programs focus on the behavior of both the patient and individuals within this environment. Modification of the behavior considering the wellbeing of the other parties is important and goes a long way in helping them detect the differences in the mental and physical aspects of the patient and offering them help whenever necessary. Once the patient is surrounded by an enabling social environment, it is easy for them to replicate by cooperating with these individuals to manage their illness. This type of intervention places a heavy emphasis on the community networking and the role of the family in helping the patient adhere to schedules and accepting the condition and bracing themselves for the outcomes of the interventions (Baldessarini et al., 2015).

Motivation: Dual diagnosis' patients hardly show any will towards reducing their consumption of substance. This is because they deem the consumption as a remedy for the other conditions affecting the, especially bipolar disorder. These individuals may also show lack of willingness to carry out their daily activities, including ADLs, and achieve other important goals such as education and employment. Therefore, it becomes necessary that the psychiatric conditions be handled appropriately to help them pursue functional goals. Motivational interventions are meant to help the patients brace themselves for programs whose aim is promoting their ability to manage their lives without necessarily having to rely on the support of the medics and the family. Motivations become very significant for patients with addiction to

hard drugs and alcohol (Larsen, 2014). These individuals are of the opinion that the drugs help them handle the conditions that result from bipolar disorder. Such individuals need thorough education on the necessity of medications, interventions and targets of the medics in regard to them. Motivation aligns an individual's goals and aims in life to the treatment program. The clinicians first seek to understand the goals of this individual and also help them recognize them. This process is not always easy and must actively involve the patient who narrates his ambitions or desires on life. The therapist should then determine the effect that the condition has on these goals. This is then followed by education aimed at improving the self-esteem of the patient and making them realize the achievability of these goals (Hill, Penson & Charura, 2015). Integrated interventions should then be brought in and the patient helped to understand its characteristics in regard to saving time, resources and energy that can be utilized in achieving the goals.

Education and counseling: A reasonable proportion of the American population remains less informed on mental health: the various conditions, the signs and symptoms and the available interventions (Baldessarini et al., 2015). In addition, a large proportion of this population holds a number of misconceptions on the condition and clarification should be given through interactive sessions with experts. Education and counseling is meant to help the patients and those around them understand their conditions. As noted above, it is hard to get patients with dual diagnoses to completely abstain from substance abuse. Counseling helps these individuals understand the necessity of abstinence and ensure that they control the symptoms that result from the condition without necessarily bringing in substance abuse. The behavior and cognition of the patients is enhanced at the various levels of counseling. They may involve one affected individual, a group of the family and community at large. In some instances, guiding and counseling is combined with aspects of motivation but this should not allow the profession to veer from the informative

aspect of the process (Larsen, 2014). Combining education and counseling with motivation is one aspect of integrated interventions as it tries to reduce the amount of time and resources spent by the patient on the treatment procedures.

Integrating Aspects of Treatment of Substance Dependence and Bipolar Disorder

Medications: Few researchers have recommended the use of medications on patients with substance abuse disorder before trying out alternative interventions. This is due to the fact that drug dependence rates are high for these individuals and they may eventually fail on its effectiveness in controlling the condition. It becomes necessary that patients with dual diagnosis be monitored closely and medications be cut within the manageable levels. Individuals on different treatment plans for comorbid disorders are likely to be faced with a burden of excess medications if each clinician gives out prescription without consulting the other. It therefore becomes necessary that the therapists in charge of the treatment plans interact and share information on the necessity and applicability of various medications, while examining the alternatives that exist. For instance, there are medications that can be avoided by substituting them with processes such as therapies (Baldessarini et al., 2015). These medications go a long way in helping the patients avoid further addiction tendencies and ensuring that the drugs recommended to them are within ranges that can be effectively handled by their body and mental systems and lead to positive outcomes. Individuals suffering from comorbid mental disorders also have problems with memory. As a result, availing a large number of medications for them is likely to result in overdoses or discontinued medications putting their lives at risk. Integrated interventions will ensure that only medications that are very important with no substitute interventions are utilized. This is mainly those used in detoxification and in easing the patient's withdrawal symptoms by putting them within manageable ranges (Larsen, 2014).

Psychotherapy: Psychotherapies form the largest proportion of treatment plans for dual diagnosis patients. Psychotherapy is largely based on the beliefs and behaviors of the patients and therapists use these two aspects to simulate the patient's mind into the desirable states such as happiness, ease and positive attitude towards life and specifically in regard to their mental condition (Hill, Penson & Charura, 2015). Dual diagnosis intervention broadly applies cognitive behavioral therapy due to its positive effect on changing the patterns of thought and helping individuals cope with new conditions and various circumstances in their lives, for instance, taking up responsibilities in the family that they initially neglected due to alcoholism or other forms of substance dependence (Larsen, 2014).

Certain scientific procedures are used to help the clinicians understand the needs of the patients, compare them with their status and help the patient tend towards meeting their needs. This procedure is usually evidence based and this calls for empiricism (Yatham et al., 2013). The success of psychotherapies in meeting these goals hugely relies on the relationship that exists between the counselor and the patient. Often, problems associated with bipolar disease and substance dependence are related when these two conditions co-occur (Otto, 2011). Therefore, the psychotherapist will be helping the patient reevaluate these conditions and identify problems then help the patient make rational decisions on solving the problems. In other situations, the patients are unable to see the multiple positive aspects that exist in their lives and in the intervention program. It takes the effort of the psychotherapist to help the patient detect these factors and build on them to improve their lives and reduce the time taken to recover (Fisher et al., 2009). The psychotherapist may also bring in other approaches of psychotherapy such as interpersonal, group or other kinds of talk therapies (Weiss et al., 2011).

Psychotherapies are of central importance in the discussion on integrated interventions because of the time and resources spent by the patient, their families and insurance companies on these processes (Otto, 2011). This escalation in the demands of psychotherapy tends to overwhelm the patient and may be seen as a waste of time and resources, especially for individuals with other daily responsibilities. It therefore becomes necessary that the therapists involved be open to integrating the procedures that are helping the patient realize the importance of goals in the treatment plans.

Community program participation and education: Most of these programs are aimed at helping the patients of substance abuse avoid relapse and improving their skills to facilitate maintenance of a good relationship between themselves, family members, colleagues at the workplace or educational institutions or the community at large. Education is aimed at helping the individuals get informed on their diagnosis and the likely experiences that may result from their diagnosis (Cardoso et al., 2016). It helps clients get braced for the changes that will occur in their lives as they continue with the medication. Resilience building in these programs involves preparing oneself emotionally to face the effects of the medications and withdrawal from substance abuse (Jay & Boriskin, 2007). At the same time, the individual is expected to be prepared financially to meet the costs that result from the treatment process. This is both in terms of work hours lost when attending therapy, attending doctors' visits, and paying the costs of treatment either directly or through meeting insurance premiums (Bush et al., 2015). Education is also meant to eliminate the stereotypes that society places on people with substance use disorders. Education of policymakers and insurers would ensure nondiscriminatory coverage for people seeking treatment for a dual diagnosis.

CHAPTER 4

CONCLUSION

Conclusion

Dual diagnosis is a condition that has attracted vast research. As a result, research has been successful in coming up with recommendations on how the treatment programs of bipolar disorder and drug dependence can be combined for better outcomes. However, the barriers still exist to their implementation and most patients are being put on two uncoordinated treatment programs. In addition, some patients diagnosed with either condition are not tested for the other and this bars effective treatment of the diagnosed condition in case the patient suffers from both disorders. Therefore, it is important that patients be tested for both conditions once suspicions arise. The policymakers should also ensure that barriers emanating from weak policies, finances, health organizational structures and misconceptions that exist among the members of the public are eradicated through education and sensitization. This will bring to the forefront effective implementation of integrated treatment procedures that apply methods such as psychotherapies, medications, community programs and education. In addition, these procedures should be modified to ensure that they are in line with the capabilities of the patients and respond to their needs.

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