ELEVATING CAPACITY WITH INDIVIDUALS WITH SUBSTANCE USE DISORDER: A PROFESSIONAL PRACTICE MODEL TO GUIDE NURSING PRACTICE IN THE CONCURRENT SETTING

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DEDICATION

This work is dedicated to anyone who has walked the path of disordered substance use, is traumatized, marginalized, or stigmatized. To anyone walking the queer path: may we challenge binaries and frustrate societal assumptions and normative discourse. You are seen and honoured.

I also recognize the original peoples to the lands that we walk on and acknowledge the trauma that has been experienced as a cultures, families, and lands were splintered. May our systems attract strong helpers dedicated to walk with you in the healing way as individual and systemic trauma is also decolonized.

To anyone who is walking in trauma and is still rising. You are an inspiration and where you are is sacred space.

May we be kind.

ABSTRACT

There is need for increased knowledge, skill, and capacity for nurses caring for individuals with substance use disorder (SUD) in the dual diagnosis (DD) environment and in other areas of healthcare. SUD is found to be under-addressed, even in DD care environments.

Individuals with SUD have historically been stigmatized in most societal structures, including healthcare which leads to substandard care and outcomes for individuals with SUD. Without a robust body of research, formal education in the area of SUD has also lagged behind other healthcare areas, even mental health. Without this formal education, nurses may resort to stigmatizing societal narratives, rather than evidence-based intervention, for the care for individuals with SUD. This substandard nursing care then diminishes the outcomes for individuals with SUD in the healthcare setting.

After a thorough literature search, implementing project management strategies, and a small pilot evaluation, a professional practice model (PPM) has been created as a practical tool for guiding nursing practice when interacting with individuals with SUD to fill the gap in knowledge for interventions with individuals with SUD. As such, the pilot indicated the PPM was effective in elevating nursing knowledge of caring for individuals with SUD.

PREFACE

When I finished nursing school in 2017, I was 46 years old, bright-eyed, maybe not so fresh-faced, and ready to jump in and make a difference. At the time, permanent nursing positions were not readily available, so after working casually on an Acute Psychiatry unit, I felt fortunate to land my first permanent nursing position on a newly-opening Medical Detox unit. Working there, I quickly came to realize that I was repeatedly asking myself one question as I worked on this dedicated unit meant for people dependent on substances. The introspective question was, "What do these individuals need from me?" I was freshly graduated, with great-distinction, out of a gold-starred nursing education, and I did not know. I came to know this gap in knowledge is common throughout the field of healthcare.

The beauty of the nursing profession, and a credit to my newly-minted, gold-starred nursing education, is that there is a pathway to find evidence-based information to correct knowledge gaps. The more I endeavoured to know, however, the deeper my thirst to get to the bottom of that question became, and the more mysterious the answer was. These clients were so complex, with needs that were significant, yet also elusive—how do we therapeutically meet their needs, helping them into a functional life of recovery? The answer to this question is labyrinthine and I came to know the gaps in research contributed to the enigma.

One aspect remained apparent: we were working with souls that were deeply traumatized, stigmatized, marginalized, and often intersectionalized, that were poor in relationships, finances, skills, resources, motivation, health, and in many other ways that were individual to them. Most people with substance use disorders were deficient in most factors that contribute to a person's health, happiness, peace, and quality of life. I came to understand that the population steeped in substance dependence includes some of the most beautiful souls that ever walked this planet hidden underneath what much of society deems as unworthy of consideration.

I embarked on continuing to answer this question for this master's degree project and this professional practice model is the result.

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To my children and my granddaughters who shared their mother and grandmother with this process. Your patience and understanding have been vital to my success. Education is vitality and there are no limits to what you can do. I love you.

To Silvia, you have re-illuminated my love for learning and rekindled my faith in this educational process from the ashes you found me in. You have shown me an inspiring example of the kind of instructor I want to be. I hope you never underestimate the healing and positive impact you have had on my experience at the University of Lethbridge.

To Aaron, thank you for your endless understanding and support during a time that others would distance and turn away. You have understood how important this has been for me and it became important to you too. I love you.

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LIST OF ABBREVIATIONS

AHS	Alberta Health Services
CCP	Concurrent Capable Practice
CP	Concurrent Practice
CDP	Concurrent Disorders Protocol
DD	Dual Diagnosis
IS	Implementation Science
PPM	Professional Practice Model
SUD(s)	Substance Use Disorder(s)
MHD(s)	Mental Health Disorder(s)

1.0 INTRODUCTION

The rates of substance use disorders (SUDs) and mental health disorders (MHDs) are increasing (Beckerleg & Hudgins, 2022; Czeisler et al., 2021; Gomes et al., 2021). Moreover, with calls for drug decriminalization, SUD will further evolve as a health issue rather than a legal issue. It could be argued that care for and management of MHDs is the future of nursing. If managing MHDs could be the future of nursing, then managing SUDs, also commonly addressed as addictions, is the frontier of nursing. The current knowledge, training, and skillsets that help nurses to care for and manage SUDs in the healthcare setting lag behind other areas of knowledge and skillsets, including mental health (Corrigan et al., 2017).

The deficiency in nursing skillsets for SUDs is problematic for an array of reasons. Both mental health and SUDs are managed under the field of psychiatry (APA, 2013) and are mainly treated in the spaces of addiction and mental health in the healthcare setting. However, in reality, SUDs and MHDs are managed—in some way—in every setting in which nurses practice. Concurrent Capable Practice (CCP) is the term for when SUDs and MHDs are co-located and meaningfully addressed in the same healthcare setting by the same skilled staff (Carreno & Perez-Escobar, 2019; DuPont & Gold, 2007). Currently, often these two conditions are addressed separately, or one takes priority over the other, depending on the care setting (Lopez-Pelayo et al., 2020; Stuebing et al., 2020). Substance use disorders are even under-addressed in concurrent settings (Louie et al., 2019), where MHDs and SUDs are treated together. It has been demonstrated that the integration and co-location of both MHDs & SUDs nursing skillsets offers fewer barriers for the client and saves the system money by having the same practitioners practice with integrated skillsets (Lopez-Pelayo et al., 2020; Stuebing et al., 2020). Concurrent practice results in better outcomes for the client overall (Sumner et al., 2021). One physician appropriately

used the analogy of having a house fire with two fires. We have to put both of them out at the same time for interventions to work (Carreno & Perez-Escobar, 2019).

It is problematic when the treatment of one condition (SUD or MHD) takes priority over the other because, when one treatment is put on hold until the other is resolved, it puts the client at risk and may leave a person untreated (DuPont & Gold, 2007). In addition, one condition might be a mask for the other, or each condition could be making the other condition worse (National Institute on Drug Abuse [NIDA], 2020).

The reason for this lag in nursing skill and knowledge regarding SUD is multi-factored. SUD is under-addressed in formal nursing training compared to the training offered for mental illness (Corrigan et al., 2017; Farrell, 2020; Van Boekel et al., 2013). Under-addressing addiction in formal training could be an outcome of the reality that SUD research has been a low priority (Farrell, 2020; Nusbaum & Farkash, 2022; Rastegar & Fingerhood, 2016; Van Boekel et al., 2013; Wild et al., 2014).

The stakeholder for this project, Alberta Health Services (AHS) Addictions and Mental Health Concurrent Practice Office, asked for the creation of a tool, with supporting information, to help close this clear knowledge gap for nurses. A Professional Practice Model (PPM) was created to elevate nursing care of individuals with SUD. This project was created for nurses who are working in the concurrent addictions and mental health environment, however the PPM could also be generalized to other healthcare environments across the multidisciplinary team in future use.

This PPM, the first of its kind, will contribute to elevating knowledge of interventions and techniques for nurses who interact with individuals with SUD. In turn, this will enhance patient outcomes in the concurrent-practice environment, contributing to further recovery efforts for these clients to present for healthcare services.

2.0 REVIEW OF LITERATURE AND NURSING EVIDENCE

2.1 SCOPE, NATURE, AND IMPACT OF THE PROBLEM

There is no doubt that substance use and misuse and mental illness are correlated with one another. One significantly contributes to the decompensation of the other, and vice versa (NIDA, 2021), which often warrants admission to concurrent practice settings and services. Knowing that SUD is under-addressed in nursing formal education and in concurrent care settings (Corrigan et al., 2017; Farrell, 2020; Van Boekel et al., 2013), increasing nursing capacity and skills with SUD for healthcare clinical staff is necessary.

The definition of SUD was re-engineered in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA]) in 2013 from the previous version to reflect current and improved understanding and approaches to problematic substance use (Hasin et al., 2013). Substance Use Disorder is a pathological condition of impaired control of overusing drugs, cannabis, or alcohol. As the APA diagnostic criteria states in the *DSM-5*, a SUD is achieved if two to three symptoms are present in mild cases, four to five symptoms are noted in moderate cases, and six or more symptoms are featured in severe cases. The outcomes often include social impairment and risky and deleterious lifestyle factors, and there are pharmacological considerations of tolerance and withdrawal (APA, 2013). Table 1 outlines the criteria of pathological features used to define and diagnose SUD (APA, 2013, pp. 483–484).

Table 1

Criteria for Substance Use Disorder – DSM-5

Impaired Control	Social Impairment	Risky Use	Pharmacological Criteria
Substance increases in a longer timeframe or larger amounts than intended	Using results in inability to fulfill role obligations at home, school, or work.	Recurring use which puts the person in hazardous situations or danger.	Tolerance is achieved and requires increased dosing to maintain desired effect.

Impaired Control	Social Impairment	Risky Use	Pharmacological Criteria
Express desire to regulate or cut down use, and may have unsuccessfully achieved same.	Use continues despite ongoing social or relationship problems caused by the effects of using.	Use continues despite knowing of the persistent problems is causes.	Withdrawal is present with reduced use or disuse, often contributing to reuse.
Spends a lot of time obtaining, using, or recovering from the substance.	Social, recreational or vocational activities, or hobbies, may be forfeited, withdrawn from, or reduced due to use.		
Intense cravings or urge for the substance, often not being able to think of anything else.			

Those with dual diagnoses (DD), a more contemporary term for the concept of concurrent disorders, experience greater negative effects than if they just had a single diagnosis (Ruppelt, et al., 2020) because both conditions interact with each other and negatively affect a client's overall prognosis (NIDA, 2020). For instance, individuals with DD have higher rates of dropout from treatment programs (NIDA, 2020). Oftentimes, the issues of their SUD or MHD are treated separately, however, integration and co-location of the two offers the client fewer barriers and better overall outcomes and saves the system money by having the same practitioners practice with integrated skill-sets (Lopez-Pelayo et al., 2020; Stuebing et al., 2020).

In current practice, treatment for mental disorders is commonly separated from addictions in the care setting, or one is overwhelmingly prioritized over the other (Lopez-Pelayo et al., 2020; Stuebing et al., 2020). Treatment for a MHD may be put on hold until the SUD is resolved. Moreover, it may take someone with a SUD multiple attempts to achieve sobriety, and some may never maintain sobriety. This approach puts the client with SUD at risk for continued unaddressed mental health issues if sobriety is not achieved. With these barriers, individuals may try to self-medicate to help their MHD with substances. These kinds of scenarios may leave a person with DD left unsupported and untreated. Dupont & Gold (2007) urge clinicians to treat each pathology as equal and to not prioritize one over the other. SUD is far less addressed than MHD, even in concurrent settings (Corrigan et al., 2017; Louie et al., 2018) This concept needs

to be at the forefront of consideration for policymaking, as well as in each nurse's professional practice.

Both, SUD and the rate of MHD are increasing, and the COVID-19 pandemic has significantly contributed to this (Czeisler et al., 2021; Gomes et al., 2021). Considering this increase, and with repeated calls for drug decriminalization, addressing SUD will further evolve as more of a health issue rather than a legal or political issue.

Nurses are already on the frontlines of addressing SUD (no matter how SUD is categorized) and are perfectly situated to be leaders for change and agents to provide high quality care. Nurses are poised to lead in this effort because of this issue evolving more of a health issue rather than a legal issue with calls for drug decriminalization. Clients with SUD are in every nursing practice environment. Nurses, now and into the future, should be knowledgeable in understanding and caring for people with SUD, provide evidence-based practice, exhibit skills in this area, and should have access to experts in SUD in practice areas, in order to be prepared to meet this demand.

Use disorders are considered to be in the realm of psychiatry; however, mental health issues and SUD, in reality, are in every nursing practice area. DD, also historically termed as Concurrent Disorders (CD), is when a person with a mental illness also uses drugs or alcohol (Centre for Addiction and Mental Health, n.d.). This increased prevalence of co-occurrence between SUD and MHD occurs in three ways: 1) both conditions have shared risk factors to developing SUD or mental illness, 2) SUD can contribute to developing mental illness, and 3) mental illness may support the development of SUD (NIDA, 2020). A concurrent healing environment is when the skillset of meeting both treatment demands, MHD and SUD, is simultaneously employed by the same healthcare provider, unit, or team. It has been demonstrated that the integration and co-location of both treatment modalities, concurrently, has

better outcomes for the affected individual (Sumner et al., 2021). It is imperative that a concurrent capable workforce is providing quality care for individuals with SUDs and MHD at a level equal to the current demand, especially on units meant to address both addiction and mental health.

Substance Use Disorder is under-addressed in formal nursing training compared to the training given for mental illness (Corrigan et al., 2017; Farrell, 2020; Van Boekel et al., 2013). Historically, even researching addiction has been a low priority (Rastegar & Fingerhood, 2016). Stigmatization and judgment are often intertwined into nursing care and workplace culture which negatively affects care outcomes (Corrigan et al., 2017). Given the historical void in adequate formal nursing training for SUD, today's nurses may not have the skillset to adequately address the SUD element of the needs of the concurrent client.

2.2 STATE OF THE EVIDENCE

The last time managing SUD was meaningfully addressed and evaluated by policymakers was 40 years ago during the heroin epidemic (Lopez-Pelayo et al., 2020). Fortunately, there is a current and renewed, international burgeoning interest in researching SUD, further fueled by the decompensating effects of the COVID-19 pandemic. This field is currently re-examining how SUD is addressed, including within the healthcare setting.

2.3 CURRENT STRATEGIES USED

There is currently no existing PPM that could be found, worldwide, for addressing SUD in a concurrent setting or in another clinical setting. The only existing framework for managing SUD in concurrent settings in Lethbridge, Alberta is an older model (see Appendix I) called the Concurrent Disorders Protocol (CDP) that is used on the Acute Psychiatry unit at the Chinook Regional Hospital. This framework was instituted over 13 years ago and is largely punitive and

not consistent with current evidenced-based, client-centred approaches for this population. In informal conversations with staff from this unit with the project lead, the CDP is currently used to flag certain clients so nursing staff know there is a substance issue, but the tasks listed are not enforced. Moreover, there is no direction to what type of use is flagged (e.g., recreational use versus SUD), and no meaningful standard assessment for individuals who use substances beyond asking if they use substances and which ones. There is little to no further unit-directed information on what nursing care the CDP client should have other than what is written in this CDP.

AHS as an organization has basic online learning courses for their staff regarding SUD and DD. These resources are largely up to the clinician to seek out on their own volition for further information.

The Acute Psychiatry unit at the Chinook Regional Hospital has a new manager experienced in working with SUD, who is looking to change to current evidence-based approaches for SUD, and has been following, contributing to, and is supportive of this project. The staff on the Acute Psychiatry unit is an excellent group of caring specialists in psychiatry who also largely see the redundancy of the old model and the need for more education and tools about techniques and interventions for individuals with SUD.

2.4 ELEMENTS OF LITERATURE SEARCH

For this PPM search for evidence, the rapid scoping review method was chosen because it is designed to address the broad purpose of the project and suits newer bodies of research like the emerging and burgeoning nature of the evidence in this field (Corrigan et al., 2017; Temple University, n.d.).

The search characteristics for inclusion are as follows:

- Focus of study: Increasing knowledge that can be applied in addressing SUD and DD in the healthcare setting to elevate nursing practice.
- Participants: People who are experiencing SUD and DD, or healthcare workers interacting with people with SUD and DD. People in various stages of using or recovery. Subject matter experts.
- Accessible in English.
- Study designs: All study designs were potentially included as long as the other categories above were satisfied.
- Setting: Clinical, outreach, public health, or other settings that can be applied to nursing practice areas.

Other search characteristics that were included:

- Recent international peer-reviewed literature, mostly in the last 5 years. Older, more seminal sources or government or organizational reports were also sparingly included if their fit for the population of the research question was appropriate.
- Peer-reviewed research literature and expert-led articles were included.
- Full text availability.
- Textbooks.
- Grey literature, government sources, university publications, subject matter expert sources.

Sources with the following characteristics were excluded:

- Populations that are not individuals with SUD.
- Cannot be applied to nursing practice.
- Interventions that are not applicable to nursing practice in concurrent settings.
- Sources with obvious bias from a funder or researcher.

The following search terms were used:

- Addiction
- Concurrent disorders
- Drug use
- Harm reduction
- Health care
- Inpatient
- Nurses
- Nursing practice
- Psychiatric care
- Recovery
- Recovery oriented care
- Strategies for dual diagnosis
- Substance use
- Substance use disorder

- Substance use disorder assessment

It should be noted that the term harm reduction was included in the search as the concept of harm reduction is seeping into more mainstream use (Szott, 2015) in the context of SUD. Harm reduction as a concept is broad and could include concepts such as moving toward less lethal ways of using street drugs, reducing stigma, providing other basic needs during periods of substance use, or removing barriers to care. Many addiction services, including AHS, the main stakeholder for this project, have adopted aspects of harm reduction in their addictions services, such as overdose prevention sites and through policy (see Appendix H). Harm reduction is an important aspect of AHS's concept of recovery-oriented care. This term was included in the literature search to cast a broader net to find relevant literature for this project.

Search Libraries:

- PsychINFO: This library has been used because addiction and mental health is under the main category of psychology and the medical discipline of psychiatry. This database results in mental health research and interventions.
- CINAHL: This library is a robust nursing literature database, and this project is centred around nursing interventions for SUD.
- Academic Search Complete: This is a broad search library that accesses a wider network to be able to mine information about SUD.
- Google Scholar: This is also a broad search library that results in access to a wider array of source literature.

As mentioned earlier, the body of research for increasing capacity for addressing individuals with SUD for nurses in concurrent settings, as well as addressing SUD overall, is still emerging and maturing. Search terms and inclusion criteria are categorized to pull from the overall body of SUD treatment evidence as well as evidence specifically tailored for the concurrent setting.

Where possible, research from Alberta and Canada has been prioritized, but the research in the broader international context has also been utilized due to the worldwide SUD problems, need for innovation, and international engagement.

A content expert was necessary for this Rapid Scoping Review (Temple University, n.d.). The content expert was the AHS Addiction and Mental Health Concurrent Practice Office to whom this project was presented for feedback on May 16, 2022. Synthesis has been comprised of descriptive categorization of data.

2.5 THEMES

2.5.1 Substance Use Disorder is Less Addressed Overall

Considering mental illness and addictions are often correlated, research informs us that SUD is far less addressed, even in concurrent settings (Corrigan et al., 2017; Louie et al., 2018). The body of research has been robust for mental health practice, but until recently, addressing SUD has been a low priority (Rastegar & Fingerhood, 2016). Low research priority and lack of research may contribute to a knowledge gap in institutions that rely on evidence-based practice, like formal training for nurses or other disciplines in the healthcare team. This likely leaves a gap in important knowledge of the psychobiological effects of addiction, elements of recovery, what policies help or harm, and how to meaningfully help an individual with SUD in the healthcare setting. With this gap in formal training, it may leave the clinician bereft of evidence-based knowledge and skillsets in caring for individuals with SUD and the clinician may, instead, default back to marginalizing societal narratives (Nieweglowski et al., 2019) to inform practice.

2.5.2 Effects of Stigma Related to Concurrent Disorders

Stigma, judgment, and moralization against individuals with SUDs is present in care settings by healthcare staff and can be reinforced within a workplace culture (Corrigan et al., 2017). Unfortunately, judgment and stigma towards people with SUDs has a strong historical

presence in most societal systems, including healthcare (Brahim et al., 2020; Corrigan et al., 2017; Milligan et al., 2017). Stigma towards individuals with SUD in healthcare delivery, in and out of the concurrent setting, results in substandard outcomes (Van Boekel et al., 2013).

2.5.3 Nurses' Ethical Responsibility to Elevate Nursing Practice with Substance Use Disorder

Nurses have the ethical responsibility to provide a healing environment for all patients (Canadian Nurses Association, 2017). Nursing staff is the intended end-user for the model that will be developed in this project. As nurses, we are perfectly poised to engage tools for leadership, endorse full scope of practice, and endorse high-value education and interventions (Garrod et al., 2020; Pinderup, 2018) as we elevate our own practices. Nurses are appropriate for this intervention because as SUD continues to become a health issue, nurses are found in most places where health is addressed.

In the hands of our sizeable nursing body, we can fortify our knowledge and skill with evidence-based modalities (Cleveland & Bonugli, 2014; Russell et al., 2017), challenge our own biases (Brener et al., 2019; Cleveland & Bonugli, 2014; Hutchison, 2015; Van Boekel et al., 2014), understand ethical considerations of working with this vulnerable group (Nicolini et al., 2017), challenge stereotypes (Matthews et al., 2017; Rastegar & Fingerhood, 2016), provide knowledgeable and affirming care by protecting the therapeutic relationship with the patient (Alexander, 2017; Espinet et al., 2016), guard against stigma and coercion (Barry et al., 2014; Johansson & Wiklund-Gustin, 2016), remove barriers and increase quality of care (Garrod et al., 2020; Raistrik et al., 2015), understand how SUD affects populations differently, and be the voice of advocacy. Nurses are recognizing the scope of this problem and asking for knowledge and tools to meaningfully help clients with SUD (Alexander, 2017).

Nurses can elevate their practice, show collective macro-level leadership in this emerging focused care area, and benefit our patients by providing high-value care, creating a responsive system, and being helping hands to potentially guide patients with SUD forward into recovery.

2.5.4 Importance of Evidenced Interventions and Expert Led Teams

Recent literature is extending calls for service teams to reflect neoteric evidenced intervention, and to have expert leadership in the form of clinical nurse specialists at points of care in all environments where addictions are addressed (Bauer & Kirchner, 2019; Bonnie, 2017; Garrod et al., 2020; Hughes et al., 2007; Mahmoud et al., 2020; Mendell, 2021; National Institute for Health and Care Excellence, 2016; Pinderup, 2018). Some healthcare systems are creating hospital-based intervention teams who provide substance use consultation to staff and interventions for patients on-site (Tran et al., 2021). These two elements—current evidence-based intervention implementation in nursing practice and expert-led teams readily available to each setting—should be policy-driven, and/or accreditation-mandated, but they are largely absent in most systems-level mandates and policies.

With the blossoming current body of literature with SUD (Rastergar & Fingerhood, 2016), an expert-led team will need to stay abreast of the new evidence and leading the changing of policies and practices accordingly.

2.5.5 Addressing the Disconnect in Services and Nursing Care

Disordered substance use has long since been misunderstood, underserviced, and underfunded (Wild et al., 2014). There are also systems-level considerations that affect the nursing practice environment. As societal systems, we have not yet uncovered the overarching answer to solving this complex issue. The field of addictions research is also trying to address the disconnect between policies and services provided and what the population experiencing SUD need. Oftentimes, the voices of those experiencing SUD do not reach the policymaking level

(King et al., 2021; Strach et al., 2020), so policymakers create services that do not meaningfully address the need. We could have services with beds to fill, but there are varying reasons why the individuals experiencing SUD are turned away or cannot access services, leaving empty beds (Strach et al., 2020). Strach et al. (2020) calls this the "illusion of services" (p. 342).

Strach et al. (2020) assert that this illusion of services exists for a number of reasons: 1) Service providers may not possess a correct understanding of the problem, or policies that are implemented fill another type of gain that is not correlated to why the system has been created; 2) The policies, the organization, the socio-political realm, or the staff overseeing the program may be responsible for unsuccessful programming; 3) Oftentimes restrictive policies are implemented, like not accepting individuals currently on opiate replacement therapy, or people with mental disorders; 4) Detox centres may turn people away unless an appropriate level of active withdrawal is expected, though individuals in need of help may be unaware the level of service they may need; 5) Some organizations may only take people within certain business hours, when the need for service extends through all hours of the day; 6) There are issues with staffing shortages, or lack of staff with sufficient SUD expertise; 7) There is a stigma that comes with working in the field of addictions, so healthcare workers may not choose to work in this area; and 8) Individuals in certain life situations may not find the flexibility needed in services; for example, mothers with children who do not have the supports available at home to manage their absence while they get help. These barriers are frustrating to the individuals they are trying to serve and undermines trust in the system set up to help them.

2.5.6 Concurrent Practice Post COVID-19

Due to the global COVID-19 pandemic and the difficulties people around the world have endured, including isolation and financial hardships, there has been an increase in stigma and marginalization toward people with SUD (Jenkins et al., 2021; King et al., 2021). Moreover,

resources to address mental health and addictions may be further stressed or deprioritized in favour of other vulnerable groups, which now include healthcare workers (Czeisler et al., 2021; Johnson, 2021; Lopez-Pelayo et al, 2020; Mendell, 2021; Mochari-Greenberger & Pande, 2021; Sumner et al., 2021). Through the pandemic, clients with SUD were additionally marginalized, unsupported, and services were more uncertain as a result of changing system policies (King et al., 2021). A recent report from Public Health Ontario states that opioid overdose deaths increased 79% between the latter 11 months in 2020 and the same period in the previous year (Gomes et al., 2022). As statistics emerge that show the enormity of the impact of the COVID-19 pandemic on people with SUD, we will get a better idea of what we are facing as clinicians. This puts the added responsibility on healthcare systems to build skilled responsiveness into policies.

2.5.7 Opportunities in this Field

The negative effects of disordered use have recently reached the realms where SUD can no longer be systemically or functionally ignored. As this literature review and project development has taken place before and through the COVID-19 pandemic, an observable increase of literature that reflects medical issues with disordered use, an examination of the systems set up to try to help, and what this vulnerable population needs from helpers in order to address this worldwide problem has been noted. This current global effort to solve this growing problem is an opportunity to educate and support the professional helpers to know how to assist the population with SUD.

2.6 GAPS IN THE LITERATURE

As this body of research is maturing, there are gaps. One article could be found on meaningful interventions for the inpatient, dual diagnosis client on a compulsory concurrent unit. There is little evidence for interventions specifically for the concurrent practice environment. This gap is vital to note because it leaves concurrent practice to inform itself from two

interrelated—but separate—disciplines of addiction and mental health, rather than informing itself from integrated addiction and mental health literature. What was found will be incorporated into the model for nursing practice. This demonstrates the need for this PPM.

It is important to note that there is also a gap in the research that reflects patient perspectives in concurrent settings. One of the barriers to researching this population could be access to people with SUD, and their adherence to the process of research. Many of these individuals with SUD can also be transient. There are also ethical barriers to researching vulnerable populations. If there were more articles addressing the needs and voices of the SUD or concurrent client, it would help further robustly support and refine evidence-based nursing practice with regards to SUD as well as DD care.

Another important aspect of SUD research is that the majority is based on the medical model of addiction recovery that centres around the notion that the brain is compromised. While this is evidenced, there are some emerging voices who are forwarding reconceptualized, holistic, and individualized approaches to SUD. There are efforts to find solutions that will work for recovery that is not based in the medical model (Carreno & Perez-Escobar, 2019).

More longitudinal studies are needed; significant challenges exist in this regard when researching clients with SUD. Those with SUD can be physically, mentally, and psychosocially transient with varying levels of the characteristic of responsibilization and responsiveness. For instance, Hjemsaeter et al. (2019), in their 18-year longitudinal study, found roughly half of the participants were no longer in disordered use. Of the half that continued disordered use, depression was the most common mental health diagnosis that was present. Longitudinal studies like the one by Hjemsaeter and colleagues give us an evidenced-based roadmap and increased understanding of what to do in the present to help motivate individuals with SUD into recovery. More of these types of studies would be beneficial to reinforce the overall body of evidence.

Research that meaningfully investigates the disconnect between services offered and people with SUD who need the services shows a gap as well. As clinicians, advocates, thought leaders, decision-makers, and policy-drivers, we need to ensure our services are accessible to those who need them. There was one article found on this subject, but more needs to be done in this area to be able to provide high value, accessible services and avoid barriers to care.

A final identified gap in the research is regarding nursing assessment specific to SUD. With SUD, assessment skills need to be accurate without assuming, and not stigmatizing in order to know how to proceed with the care of the client. There is no nursing assessment research or tool for SUD that could be found in the parameters of the search terms.

3.0 PROJECT DETAILS

3.1 PROJECT GOALS

This is a Quality Improvement (QI) project that is asking how addressing SUD in the concurrent setting can be elevated if a defined evidence-based tool and approach were incorporated into nursing practice in concurrent practice areas. The goal for this project was to provide a tool that can be used to elevate nursing care of clients experiencing SUD, to ultimately enhance quality of outcomes for people with SUD who present for services.

3.2 THEORETICAL UNDERPINNING

This PPM project utilizes the concepts from Bandura's Social Cognitive Theory (SCT) (Heydari et al., 2014), which emphasizes the connective, interactive, and social aspects of learning with significance on external and internal analysis and reinforcement for behavioural change. This theory is congruent with this project because of the under-addressed and highly stigmatized nature of SUD in the healthcare setting, there is an element of individual and systemic behavioural change that is necessary. Elevating care for individuals with SUD needs to be an interactive and social effort which includes lifting the culture on the unit on a whole, as education and change are implemented.

A second theory that underpins this project is Jean Watson's (2013) Theory of Caring, which is widely known in the nursing field. This theory forwards the concept of holistic and authentic relationships in nursing care for better health outcomes. Individuals with SUD is a population that is stigmatized and marginalized in society, and they present to healthcare environments with complex biopsychosocial needs. Holistic and compassionate care of these individuals is necessary, and Watson's theory reflects this. As the model for nursing practice was synthesized, the SCT and Watson's theory guided the inclusion of evidence and the creation of the model.

This project also includes the Recovery Oriented Care approach (AHS, 2019), espoused by AHS, which emphasizes building on the concurrent client's own strengths and skills, including shared decision-making, to care for the client in the concurrent setting. See Appendix H for information about the AHS approach. This approach is also congruent with current research and congruent with the two theories on which the project is based.

3.3 PPM STRUCTURE: SLATYER'S 6 STEPS

The development of the PPM (see Appendix A) was created from the review of literature (see data tables in Appendix F) and grouping of key components related to nursing care of SUD, guided by the concept forwarded by Fantuzzi & Mezzina (2020), and structured into a PPM in a manner posited by the work of Slatyer et al. (2015). The concept of shared governance allows nurses to control their own practice and PPMs are considered to be empowering to nurses (Slatyer et al., 2015). As per Slatyer et al. (2015), the core values of AHS will also be considered as a key component of the PPM. Professional practice models help nurses shape, define and measure their own evidence-based practice (Slatyer et al., 2015).

According to Slatyer et al. (2015), there are six components to consider when developing a PPM to help provide a structure to enhanced nursing practice. These components are:

1) leadership—nurses are considered leaders, and each define their own clinical practice;

2) independent and collaborative practice, professional authority and communication, autonomy, and accountability;

3) environment—a respectful and healing environment contributes to quality patient care and therapeutic patient relationships;

4) research/innovation—genuine and evidence-based clinical inquiry and effective translation of knowledge;

5) nurse development and rewards & expertise in clinical area—when this occurs there are improved patient outcomes;

6) quality patient outcomes—professional practice models with the aforementioned five elements create resourced nurses that influence and contribute to a practice environment with enhanced patient outcomes.

At times, the PPM was a structure which informed future hiring as well. These aspects were considered when the model was created.

Successful professional practice models, according to Slatyer et al. (2015), consist of a visual model with accessible concepts and language. Strategies were employed to ensure efficient communication, education, creation of committees to increase engagement and knowledge translation, and use of unit champions, who help integrate the new intervention into the practice area at the point of patient contact. Consultation is necessary to ensure it is accessible and easy to understand.

For this project, the consultation was provided by the main stakeholder; the education team for addictions and mental health in Lethbridge, Alberta; the manager of acute psychiatry; an addictions counsellor in outreach; and the Assistant Head Nurse (AHN) of medically supported detox. Consultation was also provided by nurses, and two addictions counsellors in three different concurrent settings in Lethbridge, Alberta: 1) clinicians that work on medically supported detox, 2) clinicians that work in outreach, and 3) nurses that work on acute psychiatry. A peer support worker who also has six years of experience with severe SUD and a street lifestyle who is now sober has also been consulted to try to fill the gap in the absence of voices of those with lived experience with dependence.

The deliverable is all the content in Appendix A. For the process of the third wave of feedback, the deliverable was printed and collated into folders.

When this project was conceptualized, the implementability of this intervention was considered. Klaic et al. (2022) forward the concepts of fidelity, feasibility, and acceptability which lead to sustainability and scalability in a quality improvement program. These aspects were considered during the creation of this model. The implementation of this PPM beyond the small pilot effort and evaluation that was completed is beyond the scope of this project. The implementation past the scope of this project will be discussed in the recommendations.

3.4 PROJECT LOGIC MODEL

The inputs and outputs and goals have been listed in the logic model (Appendix D), as well as the expected outcomes of the project. The short-term outcomes are expected to achieve better understanding of SUD, reduce stigma in the healthcare environment, and provide systems support for elevated care by considering making this tool policy-driven. The expected medium-term outcomes are improved quality of individual nursing care with individuals with SUD and continued systemic support. The anticipated long-term outcomes are improved health in the lives of concurrent clients and that the tool will continue to sustain improved care through protecting from program drift. Since the PPM had a small pilot evaluation, the outcome is congruent with the outcomes the logic model outlines.

3.5 ETHICS REVIEW

The ARECCI screening tool, created by Alberta Innovates (2021), helped determine for the level of risk a project carries, the kinds of potential ethical risks, where risk mitigation strategies need to be employed, and elucidates the measures of ethics review the project requires. Appendix G contains the ARECCI results for this project.

The risk score is 10 for this project, which is considered “somewhat more than minimal” (Alberta Innovates, 2021) (See Appendix G). This score was achieved because the project lead is a graduate student. As suggested by the ARECCI process, this risk is mitigated by having a

supervisor attached to the project and the stakeholder, AHS, as a reviewer. Both of these requirements were completed in this project.

3.6 PROJECT MANAGEMENT

3.6.1 Stakeholder Engagement

A Stakeholder Engagement Plan was also completed (see Appendix E). This document outlined the different roles and stages of stakeholder engagement. Due to the three waves of feedback, including various stakeholders, this was necessary. A stakeholder priority matrix and stakeholder engagement plan were also implemented. This plan was able to formulate the hierarchies of engagement as was defined in the outset of the project.

3.6.2 Project Management Strategy and Timeline

A Project Management Strategy was also created (see Appendix J). This project used the Critical Path Project Management Method. This method was chosen, as per Levy et al. (2014), because: 1) the tasks are well-defined that have an eventual end to the project, 2) the tasks are independent of one another, and 3) the sequenced tasks need to be done in a certain order.

A timeline for the project and was created (see Appendix C) to elucidate and outline the project calendar structure and goals. It should be noted that this project, including stakeholder engagement, has been underway for over two years rather than the time span of the University of Lethbridge Spring and Summer terms of 2022 that is reflected in the timeline in Appendix C. The project lead has been ardently combing through the evidence for this subject prior to and through the Covid-19 pandemic and has witnessed increased amount and increased fervour in the research about SUD during the pandemic to now from worldwide sources. The proposed timeline was adhered to throughout the completion of the project between the Spring and Summer of 2022.

3.7 PROJECT DELIVERABLE

This project provides a professional practice model and supporting information to guide nursing practice to elevate capacity with addressing SUD in the concurrent setting. This model for nursing practice is based on the strategy as outlined by Slatyer et al. (2015), following a review of current evidence to answer this broad question: How can we elevate nursing capacity to care for individuals with substance use disorder in the concurrent practice setting?

This model is based on Bandura's Social Cognitive Theory (Heydari et al., 2014) and Jean Watson's Theory of Caring (Watson, 2013) because the enhancement of nursing care for individuals with SUD is indivisible with the concepts of autonomy of the nurse's own practice (Slatyer et al, 2015), the staff supporting the changes, and caring about the client with SUD who has been historically stigmatized in nearly all societal systems. The components that Slatyer et al (2015) have postulated of nurse development, translation of knowledge through clinical inquiry, leadership, accountability, shared governance, and providing a healing environment for clients can all be found within this model. The outcome, as Slayter et al (2015) has delineated, of better client outcomes, is also expected as the pilot effort for this project has shown.

AHS Addiction and Mental Health Concurrent Practice Office is the main stakeholder. The deliverables are: 1) an oral Zoom presentation of the PPM which took place on May 16, 2022, 2) a written report outlining the evidence, and 3) the PPM itself with supporting information and evidence with relevant feedback from the stakeholders implemented. This document is the report includes the report and the PPM can be found in Appendix A.

After reviewing the literature on SUD recovery, interventions and treatment for this project, it was clear that in order to serve such a complex population that two approaches needed to be simultaneously addressed (see Appendix A). The first approach is shown in the blue petals

in the diagram which elucidate areas of competencies, skills, and knowledge necessary to enhance a nurse's capacity to care for individuals in SUD. These are the "Tools":

1) Systems-level Competencies: These are the areas that the organization is responsible for to provide educational resources, materials, and low-barrier, nimble systems that stand poised to help. In Appendix A, the evidence is listed under "System's Level Competencies."
2) Individual Practitioner's Competencies: This section lists the competencies, skills, and knowledge for which an individual practitioner is responsible. The evidence is listed under "Individual Level Competencies" in Appendix A.
3) Understanding Components & Science of Substance Use Disorder: To be an effective concurrent clinician, understanding the science of SUD, the trauma, and experiences that usually come with dependence is important. This information is also under Evidence in Appendix A.
4) Understanding Components and Science of Recovery: Understanding recovery is important to help direct conversations and help a client motivate themselves and understand the tasks that are usually necessary to embark or continue into a state of recovery. Extra information about the journey of recovery is also included to help guide those potentially motivating conversations. A four-by-six inch card with distilled information about the tasks of recovery was also part of the package that was meant to be for the clinician and the client. This information is also included in Appendix A under Evidence.

The second approach is represented by the purple petals that have been reversed to also look like butterfly wings. The purple petals show the "Techniques" of nursing care of individuals with SUD. As is postulated by Fantuzzi & Mezzina (2020), these two themes, tools and

techniques, must be integrated into care because the tools are not effective without the techniques and vice versa. In effect, one must have the evidenced and scientific knowledge and the holistic understanding and caring together to be an effective clinician for individuals with SUD. The evidence is also listed in Appendix A for this second approach as well. These four techniques are:

1) Practitioner Evidence-based Skill-building: This may seem similar to individual practitioners' competencies; however, this is the learning side of the same coin. A clinician must increase in skill and knowledge and when the skills and knowledge are acquired, then the skills shift into the competencies category. It is important to guard against complacency and understand this is still a burgeoning area of research.
2) Offer Hope, Acceptance, & Compassion: Understanding that people can recover and offering hope is important to build confidence.
3) Use Person-first & Stages of Change Language: This is important to be respectful and dignifying to the clientele. Alberta Health Services also forwards the use of this strategy as well.
4) Leadership in Recovery-oriented Care & Guarding Against Stigma: This is a main focus of the techniques of care. The evidence shows that healthcare systems are historically stigmatizing to this population, which can decompensate clients with SUD further into relapse or more use. Leadership in guarding against stigma is something that is repeatedly mentioned in research. Oftentimes, nurses resort to societal narratives in an absence of knowing what evidence is telling us. Please refer to the list of evidence in this category under Appendix A.

The rings around the PPM reflect AHS vision elements because this project was created in the context of the AHS health system. The CARES model of "Compassion,

Accountability, Respect, Excellence, and Safety" that AHS espouses is on the blue ring. Recovery-oriented care and harm reduction are reflected on the purple ring.

3.8 EVALUATION METHOD

The project was evaluated by three waves of feedback. The first wave was a Province-wide Zoom meeting with an unknown number of participants. Waves 2 and 3 received feedback from a total of 21 clinicians and 1 peer support worker. The final wave included a soft pilot where nurses and two addictions counsellors working in concurrent environments gave feedback. The final source of feedback was from an individual with lived experience with six years of severe substance dependence, including a street-involved lifestyle, who is now sober and has been rebuilding his life working in the peer recovery space. Considering the gap in research from voices of people with lived experience with SUD, it is important to receive feedback from a person who can speak to the experiences of the population the PPM will be ultimately serving. This is why the peer support worker was included in this evaluation.

The first wave of feedback was from the community of practice online meeting that was attended by concurrent clinicians throughout the province on May 16, 2022. The presentation of the model was given to the AHS Addictions and Mental Health Concurrent Practice Office via an online community of practice Zoom meeting format. During the presentation, comments and feedback were written down by the project lead (See Appendix B) and the few suggestions for changes were incorporated. There was a typographical suggestion by a psychiatrist which was incorporated (exchanging a '&' for a '+' in the centre of the model). The rest of the feedback was congratulatory and positive. Feedback from one of the meeting participants even resulted in adoption of the PPM tagline "recovery from many places." The feedback from this meeting is included in Appendix B.

The second wave of feedback was from leaders in the local concurrent disorders/dual diagnosis practice areas. A printed version of the PPM was given in a folder with the PPM on the front, with supporting information including the evidence as shown in Appendix A. The Acute Psychiatry manager from Chinook Regional Hospital, the Assistant Head Nurse (AHN) from the Medically-supported Detox unit at the Chinook Regional Hospital, one of the two clinical educators for AHS Addiction and Mental Health South Zone, and an experienced Addictions Counsellor from AHS Addiction and Mental Health were asked for their feedback and comments. These were given either face to face (then written down by writer) or in e-mail format. This wave of feedback resulted in positive feedback with some small suggestions for change, which were incorporated, if appropriate (see Appendix B).

The third, and final wave was feedback from nurses and several addictions counsellors, (one from Detox, and one who had worked in several areas, with varying acuity), with addictions in the Lethbridge, Alberta area. The feedback of the peer support worker, which was acquired in a one-on one unstructured conversation, is included in Appendix B.

This is considered an informal pilot of the PPM. The feedback from the two addictions counsellors was accepted because the scope of an Addictions Counsellor and the scope of a concurrent-practicing nurse are similar in approach. The managers of the Acute Psychiatry unit and Medically-supported Detox were aware and supportive of this action.

Nurses from Detox, Acute Psychiatry, and the Addictions and Mental Health Outreach Team gave feedback. A package was made with the PPM on the front of a folder and supporting information inside. Pens were made available with the PPM logo on them for recognition, engagement, and ease of filling out the survey.

A quantitative survey was created. This survey and the responses can be found in Appendix B. The packages, surveys, and pens were left in staff areas on Detox and Acute

Psychiatry. Packages were personally given to two nurses in the outreach team for feedback. It should be mentioned that the project lead currently works in all three areas alongside all respondents, so the project manager is known to all respondents.

A total of 13 surveys were returned, of which the feedback can be seen in Appendix B. Several instances of in-person and informal qualitative focus groups gave further feedback to the project lead that occurred outside of the survey format. The remarks from the informal focus groups were written down during the feedback or directly after the conversations. When in the informal conversation, some nurses remarked that there was so much information in the package to read but they did not have time to fill out the survey too.

In the two areas where addiction is routinely functionally addressed in practice (e.g., on Detox and Outreach), the staff seemed to have an easier time understanding the information in the package and gave glowing feedback regarding its completeness and usefulness. The feedback from Acute Psychiatry, where SUD is less functionally addressed, was valuable because there were indications that some found the information harder to follow. There was one respondent who had all negative responses and did not see the point of the PPM. This one piece of all negative feedback points to the need for more clarity in the presentation of the PPM, and there could also be inherent bias in the respondent toward the subject matter which is also relevant to the evaluation. The surveys were received anonymously, so there was no clarification as to why the clinician gave the negative feedback.

Feedback from all three areas mentioned the information-dense nature of the information. The wave three feedback was incorporated, as appropriate, into the PPM and the final deliverable can be found in Appendix A. The main changes were to bring more simplicity to the information and its delivery. This will be further discussed in the reflection.

The feedback from the peer support worker was valuable. He liked the card with the butterfly picture on the back and said that it "sums up recovery very well; it's not missing anything." He also said it was validating that healthcare "might really understand what this journey of recovery is like. This will make a big difference."

4.0 REFLECTION

This reflection will use Driscoll's (2007) reflective process. The learning that has taken place will be discussed, and proposed recommended actions will follow.

Over the course of four years in this graduate degree program, two of which I actively worked on this project, there have been plenty of opportunities to reflect on this process and move forward in growth. First and foremost, over the last four years, I have learned the undeniable difference that an organized course structure, instructor dependability, humility, openness, and kindness make in an environment that nurtures learning as opposed to an environment that is disorganized, callous, abrupt, and abstruse. As nursing scholars, the ability to be organized, reflexively and effectively translate knowledge as teachers, and support a learner is an indispensable and indivisible skill to our leadership roles in which a graduate education automatically positions us. This concept speaks to the Master of Nursing competency number six: leadership. I want to acknowledge the instructors that were exemplars and positively transformative to my learning and my development as a future project manager, instructor, and leader in the nursing field moving forward with this education. I will always remember and apply this particular lesson above all. As a nursing leader and scholar, it does not matter how much I know if I do not have the skills to effectively, and kindly, transfer knowledge.

My underlying core value of advocacy is what drove this project to completion. There were times that I felt the concept of courtesy stigma (Neville & Roan, 2014) as a project manager who was creating this PPM about addressing SUD. Courtesy stigma is when a clinician is going counter-culture and advocating for an individual who is usually stigmatized in the working environment or system, and because of this advocacy, the clinician, manager, or researcher can be stigmatized by peers. When I entertained the notion of discontinuing in this program because I was unsupported, the course process became cruel, and the stress was unsustainable, I knew that

a voiceless population, as well as nurses looking for answers, could be helped by this project. Stopping was not an option. This project needed to be birthed, no matter what.

Due to this value of advocacy, when I sat down for the conversation with the peer support worker, his approval of the project became the most important evaluation piece for me, personally. It was like four years of arduous work and stress became validated and justified in one conversation. The conversation with him meant the last four years have been meaningfully spent. In subsequent conversations after the feedback stage was closed, other now-sober clients, through informal conversations, have also validated the integrity of the information as being congruent to their experiences and also said they could see widespread implementation of this PPM as beneficial.

The second lesson that I learned was at the end of my program, after two years of earnestly engaging in learning the depth and breadth of what the research is telling us about how to elevate our skill in caring for individuals with SUD. Breaking the information down into bite-sized, easily digestible, and clear nuggets of information for nurses serving this complex client population was a significant challenge. I did not know what to leave out. This is reflected in the information-dense nature of the version of the deliverable that the nurses reviewed in the third wave of feedback. After the nurses' feedback, the deliverable was pared down even more so it was concise. All this knowledge is not useful if I cannot communicate it properly. This also reflects the leadership and substantive understanding of an aspect of nursing practice and awareness of complex problems as elucidated in domains one and six of the Master of Nursing Competencies (Canadian Association of Schools of Nursing Graduate Education Framework, 2015).

Considering the audience is another aspect of reflection. In the waves of feedback, the individuals with more prior knowledge about SUD and dual diagnosis were readily able to

understand and see the need for the model and appreciate the dense supporting information. Generally, the less prior SUD literacy my readers had, the less engaged they were in reviewing and providing feedback. This tells me that different levels of SUD literacy already present makes a difference in the reception of the audience which should also alter the approach upon implementation of the PPM. Some healthcare areas are ready for the density of information and some others may not be. From the unit the least familiar with SUD concepts, Acute Psychiatry, there was still overall interest in learning the subject matter, but would need education delivered in a more digestible way. One respondent recommended this information be available online for ease of access, which is valid, progressive feedback but is beyond the scope of this current project. The recommendation of online content should be considered in future implementation.

One nurse from Acute Psychiatry told me after the surveys were collected and analyzed, that she appreciated the information because she has been having better conversations with her clients since reviewing the package and she even used that information to effectively answer some questions in a job interview she recently had. She asked for more copies of the card with the distilled recovery information on it to hand out to her patients, which were given. This satisfies domain four of the Master of Nursing competencies (Canadian Association of Schools of Nursing, 2015) by demonstrating an ability to use advanced communication, consultation, collaboration, and lead in the field of nursing.

Another important realization learned was I had to learn when to stop diving into the research and understand that I had taken the project this far; it is enough, and it is time to wrap it up and wind it down and prepare for it to go to the stakeholders. There will always be new research and the model was created to be able to absorb new research as it becomes available. I understand that in a more realistic situation outside of a graduate degree process, a project like this has more people working on it that are responsible for more pieces. There was value in

learning what all those pieces were by doing them all in this process. There was also value in learning a systemic way to conduct a project to completion. Learning how to apply theories, strategies, frameworks, and models added reliable structure, validity, and organization to complete this project. These actions have satisfied the guiding principle of systematic inquiry, knowledge elevation and translation, and scholarship from domains two and three of the Master of Nursing competencies (Canadian Association of Schools of Nursing, 2015).

Through this consultive process and small pilot action, the PPM and accompanying information could be considered as completing the goal at the outset of the project asked by the main stakeholder: to create a tool to elevate nursing knowledge of caring for individuals with SUD.

This information could also be generalizable to the larger healthcare community. As one of the respondents in the community of practice meeting said, the model should be used for the whole multidisciplinary team. This information can help anyone who is a helper to those in SUD. To illustrate this, one security guard read it and told me that he will be using it to guide his interactions with not only patients in the hospital, but also with family members who are experiencing SUD.

4.1 RECOMMENDATIONS

The goal of this project was to provide a PPM and accompanying information to help nurses increase knowledge and capacity with concepts related to SUD into their nursing practice. This has been achieved.

These recommendations will include implementation science concepts for improved uptake, sustainability, and longevity of implementation cycles. The recommendations will centre on evidence-based, high-value interventions that focus on individual client contexts to care that

reflect the fragility that dual diagnosis clients may experience (National Institute of Health and Care Excellence, 2016).

Implementing this professional practice model onto concurrent units is beyond the scope of this project; however, the following recommendations are of note. Implementation Science (IS) principles would be key in the success of implementation. Implementation Science, a method still in its infancy (Albers et al., 2020), is rooted in the science of behavioural change. It takes 17 years to adapt 14 percent of research into evidence-based practice (Balas & Boren, 2000). It is realistic to plan for multiple improvement cycles with the goal of increasing knowledge with each cycle (Nelson-Brantley & Chipps, 2021). On a systems level, employing an implementation scientist familiar with IS principles and theories who is skilled at leading change through assessing organizational climates, absorptive capacity, readiness determination, and to help the adoption and implementation of this PPM would be advantageous to preparing a workforce that is IS-ready (Albers et al., 2020) to sustain this innovation. Before interventions are implemented with their strategies, there should be an analysis to find the most effective, feasible, and acceptable way to incorporate this PPM into the system of healthcare delivery (Zuzelo, 2022).

Training should include the voices of those with lived experience with SUD (Knaak et al., 2022), like the peer support worker who provided feedback on this project deliverable. Narratives of lived experience in training reduce stigma and increase knowledge uptake.

Hospitals and care areas should have access to expert-led resources and teams. Many big hospitals have hospital-wide teams that help with individuals with SUD and support the staff as they work with individuals with SUD, but Chinook Regional Hospital in Lethbridge does not have such a team. Considering the opiate crisis that has plagued this region, it would be an advantageous step forward.

Considering the stigmatized nature of the population with SUD who present for healthcare services, instituting unit champions (clinicians who are in a position to be influential on a nursing unit who have been previously trained in the use of this PPM) to help influence and example the use of the model to their fellow nurse-colleagues as this model is implemented in point of care areas would be advantageous (Luz, Drach, & Shadmi, 2021). Understanding and guarding against courtesy stigma is also important when implementing this program.

It is recommended to have printed material and tools on the unit about SUD and recovery for clients and clinicians to help guide conversations and formulate goals, and help to create elements of a change plan (Antai-Otong, Theis & Patrick, 2016). As the mind could be clearing from SUD, accessible printed materials help to clarify concepts for the client.

It is this project manager's experience that widespread training on proper nursing assessment of the individual situation and needs of a client with SUD is necessary. This is another use where this PPM could be helpful. There is a gap in research and tools about proper assessment, and is worth mentioning as a recommendation. Without accurate and psychologically-safe, skilled assessment, and understanding of the stages of change, nurses may miss the presence of a SUD, may not be able to help identify core issues about the client's individual experience to help propel them into recovery, and/or may resort to inaccurately assuming a SUD is occurring when the client is reporting sobriety. The latter situation can frustrate the genuine and hard-won efforts of sobriety, trigger relapse, could destroy any therapeutic rapport being built between the client and the clinician, and reduce trust in the system. We want change from our clients, and accurate assessment without assumptions of continued use or relapse from clinicians is key to help elicit recovery-oriented nursing care. This is another situation where a clinical nurse specialist available to nursing units would be

beneficial. This is a nuanced skill that comes with experience with working with clients with SUD.

4.2 FUTURE DIRECTION

This report will be submitted to the AHS's Addictions and Mental Health Concurrent Capable Practice Office, as the main stakeholder. This report will also be made available to the other stakeholders who provided evaluation feedback. This project has provided a model to guide nursing practice in the concurrent practice setting. This model can be utilized to guide recommendations, tools, and policies, and as a guide for evidence-based practice.

This PPM has been designed for nursing practice, but for future uptake, it should be noted that all levels of leadership and front-line managers will also need to be supportive of, engaged in, and familiar with the concepts of the model if any changes are implemented in their care areas as a result of the model according to implementation science principles (Garrod et al., 2020; Mochari-Greenberger & Pande, 2021).

The model itself can also help to shape policy, hiring, and impact sustainability and longevity of future programming or education. It can serve to prevent program drift, as well as enhance the ability for the information to be repackaged for forward movement into other relevant nursing practice environments and settings.

4.3 CONCLUSION

In conclusion, the evidence is clear that there is need for increased knowledge, skill, and capacity for nurses caring for individuals with SUD. The research has been historically thin and even working with addiction has been stigmatized, which are likely reasons why the body of research has been under-resourced and sluggish. Moreover, without a robust body of research, formal education in the area of SUD has also lagged behind other medical areas, even other stigmatized areas like mental health. As this research area works to mature, there are noticeable

gaps that should be rectified. The most noticeable gap is giving a voice to this mostly-voiceless and overlooked population of individuals experiencing SUD and increasing capacity in knowledge and skill in practitioners. Closing the distance between service providing and meaningfully addressing the needs of this marginalized population is also a significant gap in knowledge.

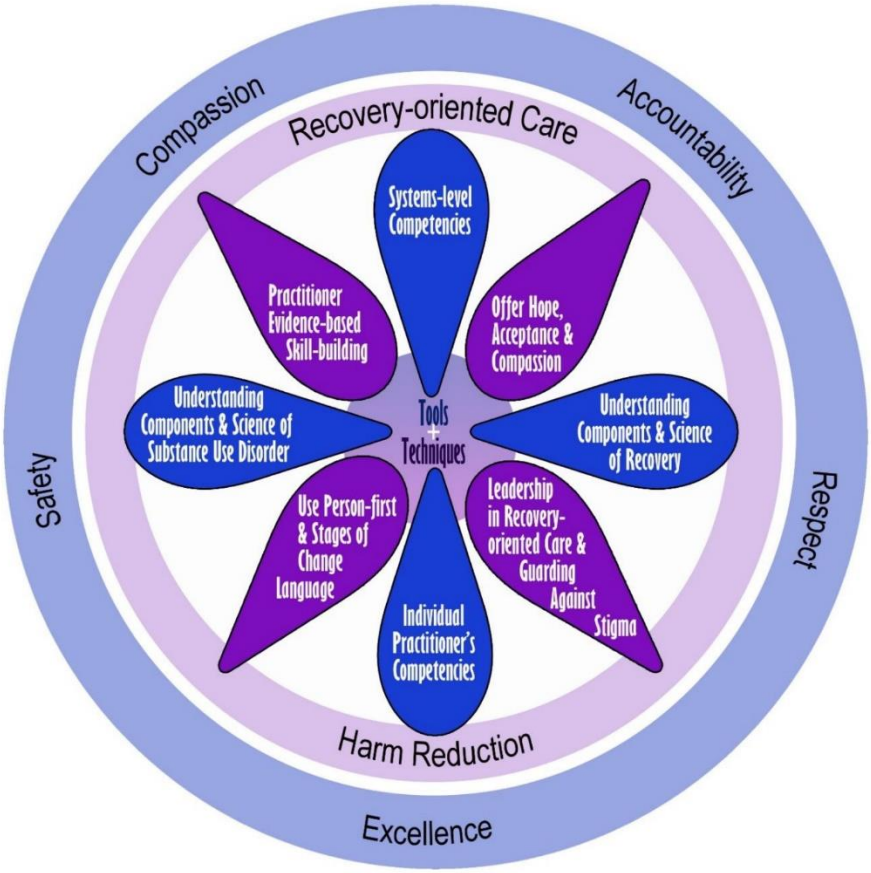
This project could be an important contribution to the field of concurrent practice nursing by providing a practical tool for guiding nursing practice when interacting with individuals with SUD. The stakeholder will decide its potential use within the organization. This has been designed to help elevate the capacity of the SUD component of working with these complex concurrent patients that could increase the mastery of skill for nurses in the concurrent practice environment. The elevation of nursing knowledge and skill could eventually translate to a higher level of patient care when addressing substance use disorder in concurrent environments.

The evaluation process and small pilot survey achieved an initial indication that the PPM was useful and valuable in achieving the goal of elevating nursing knowledge when interacting with individuals with SUD. The project has reflected breadth, depth, and quality application of evidence on this topic and usability of the model in the practice setting as determined by the stakeholder. This project has fulfilled all of the requirements of the Master of Nursing Competencies that the program has required for completion (Canadian Association of Schools of Nursing, 2015).

APPENDIX A: PROFESSIONAL PRACTICE MODEL

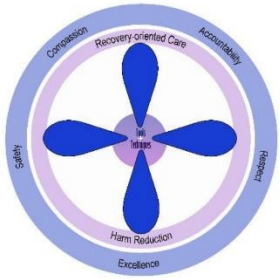
Elevating Nursing Care of Individuals with Substance Use Disorder:

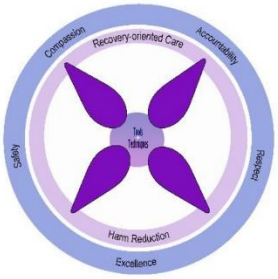
A Professional Practice Model



Tools

The competencies, skills, and knowledge about understanding and addressing substance use disorder in the practice setting.





Techniques

The "how". Delivering quality and kind care to clients with substance overuse or dependence.

These purple petals also look like a butterfly's wings, suggestive of a change, or metamorphosis.

The tools are not effective without the techniques and the techniques are not effective without the tools.

Why a Professional Practice Model?

- Professional Practice Models are indicated for foundations of high value nursing care,
- They are empowering to nurses,
- They help nurses define and measure their own evidence-based practice,
- They can also inform for future hiring for managers,
- They help to create resourced nurses that can enhance patient outcomes, and
- They can prevent program drift.
  Slatyer, S., Coventry, L. L., Twigg, D., & Davis, S. (2016)

What is Recovery-oriented Care?

- Care prioritizes well-being and quality of life of clientele,
- It is trauma-informed care,
- It is culturally-safe care,
- It is psychologically safe experience,
- It is person-centered,
- It is conducted with empathetic detachment,
- Ensures universal access, and
- It is strengths-based.

Concurrent Capable Practice is:

- Mental illness and substance use disorder often go together. The co-location of services for these two related conditions is termed concurrent practice. (also known as “dual diagnosis”),
- One can make the other worse,
- One can mask the symptoms of the other, and
- Concurrently-affected clients have increased, or more severe results of:
    - Legal outcomes,
    - Relational outcomes,
    - Emergency/medical outcomes,
    - Suicide & self-harm,
    - Drop-out rates for youth,
    - Housing limitations, and
    - Socioeconomic outcomes.

Key Concepts

- The Rate of Substance Use Disorders (SUD) and mental disorders are increasing.
- Utilization of emergency departments for concurrent disorders are increasing.
- SUD will further evolve as health issue rather than legal or political issue.
- Nurses are already addressing SUD in nearly all healthcare environments.
- Skill and knowledge to address SUD in the healthcare setting lags.
- Stigma toward individuals with SUD in the clinical setting is well-evidenced in the literature and negatively impacts quality of care.
- SUD is under-addressed in concurrent healthcare settings and formal healthcare education environments. There is a lack of training overall.
- Nurses have asked for more training in the area of use disorders.
- Co-locating and Integration of care by the same team to address SUD and mental disorders is clinically effective and cost effective.
- Nurses have an ethical responsibility to provide a healing environment.
- The "Illusion of Services" (services created, but still inaccessible to the population intended to use the services) needs to be systemically addressed.
- Recent international interest in researching SUD has resulted in increased knowledge in this field. The effects of the COVID-19 Pandemic on mental health and addictions has fueled this effort further.
- Particular attention and psychologically-safe care to mother/baby dyad in the context of SUD is important.

Explanation of model

The two rings on the outside show Alberta Health Services (AHS) CARES model, and their adopted evidence-based elements of recovery-oriented care and harm reduction. The blue petals of the diagram represent competencies, skills, and knowledge about understanding and addressing SUD in the practice setting. There are systems-level responsibilities and individual-level responsibilities, and enhancing the clinician's knowledge set of SUD and recovery. These are the tools. In this genre of healthcare, we also need sound technique of delivering quality and kind care to clients with substance overuse or dependence. The purple petals represent the techniques of nursing care to those with use disorders who are in our care. These purple petals also look like a butterfly's wings, suggestive of a change, or metamorphosis.

It should be noted that the two categories of Individual Practitioner's Competencies and Practitioner Evidence-based Skill-building are similar. The difference is that once the skill-building is achieved, those new skills become competencies moving forward.

Information about recovery

It is important to understand what substance use disorder (SUD) is and what the trajectory of recovery usually consists of in order to help guide individuals with SUD toward a more functional, intact, and more peaceful future when they are ready. If they aren't ready when we interact with them, at the very least, maybe our interactions will help them be ready in the future. In this package is information about recovery to help the clinical guide their practice as important conversations take place.

Helping someone in recovery is a client-centred, individual effort rather than a broad-stroked concurrent policy alone. Skillful, nimble, and responsive attention to their needs with detached empathy helps their recovery journey. This is the intended outcome of this professional practice model.

Further Knowledge about Use and Recovery from the DSM-5 (2013) and the Life in Recovery Survey (2017): There are usually significant experiences of trauma associated with active substance use disorder. The experience of recovery can be in stark contrast to the experiences of active use.

Criterion for Substance Use Disorder (SUD) according to the *DSM-5*: SUD is present, if 2-3 symptoms are present in mild cases, 4-5 symptoms are noted in moderate cases, and 6 or more symptoms are featured in severe cases.

Impaired Control	Social Impairment	Risky Use	Pharmacological Criteria
Substance increases in a longer timeframe or larger amounts than intended	Using results in inability to fulfill role obligations at home, school, or work.	Recurring use which puts the person in hazardous situations or danger.	Tolerance is achieved and requires increased dosing to maintain desired effect.
Express desire to regulate or cut down use, and may have unsuccessfully achieved same.	Use continues despite ongoing social or relationship problems caused by the effects of using.		
Spends a lot of time obtaining, using, or recovering from the substance.	Social, recreational or vocational activities, or hobbies, may be forfeited, withdrawn from, or reduced due to use.	Use continues despite knowing of the persistent problems it causes.	Withdrawal is present with reduced use or disuse, often contributing to reuse.
Intense cravings or urge for the substance, often not being able to think of anything else.			

American Psychiatric Association. (2013). DSM V: Diagnostic and statistical manual of mental disorders. Washington, D.C.: American Psychiatric Publishing.

Top 10 professional or formal supports:		**Most important informal supports:**	
1) 12-Step/mutual support groups	91.8%	1) Relationships with friends	96.8%
2) Residential treatment programs	60.6%	2) Relationships with family	95.4%
3) Group or individual counselling by a psychologist or psychiatrist not specializing in addiction	56.8%	3) Religion or spirituality	87.4%
4) Group or individual counselling by an addiction Professional	56.5%	4) Meditation or mindfulness	85.6%
5) Outpatient addiction treatment program	41.4%	5) Regular recovery reading practice	85.5%
6) In-patient detoxification program	35.1%	6) Regular exercise program	84.8%
7) Therapeutic community	34.9%	7) Relationship with animals or pets	71.8%
8) Concurrent-specific program	31.8%	8) Recovery nutritional plan or diet	69.9%
9) Recovery supportive housing	30.3%	9) Art, poetry, or writing (expressive arts therapy)	68.0%
10) Employee assistance addiction programs	26.1%	10) Relationship to land or natural environment	66.8%
		11) Recovery websites	64.4%
		12) Social media recovery supports	56.1%
		13) Cultural values and traditions	51.7%
		14) Yoga	41.6%
		15) Smartphone Apps for recovery	39.3%
Additional themes from the comments from respondents included:		**Relapse Statistics:**	
• More options needed than 12-step/mutual support groups. • Programs always need to be no-cost • Faith-based premises may not be sufficient for mental and emotional needs that arise post-addiction • Some groups may still experience discrimination in mutual support groups • More accessibility for youth. "Finding treatment next to impossible". • Access to harm-reduction services and harm reduction workers is essential. • No waits from one stage of recovery to the next. • More emphasis in the First Nation, holistic approach to recovery.		51.2% had no relapses back into active addiction once in recovery 14.3% had 1 relapse 19.4% had 2-5 relapses 4.5% had 6-9 relapses 4.9% had 10-13 relapses 2.9% had 14 or more relapses	

Active Use:

- Discrimination and stigma contributes to life disfunction. People in active use are often treated like they are unfavourable and ostracized. This contributes to self-stigma, shame, guilt, and embarrassment. They are often treated with contempt. They can be banned from services, housing, employment or other necessary functions. Discrimination and judgment from healthcare system, unfortunately, remains problematic. As a relic of this stigma, even in recovery, people can be considered as untrustworthy.
- As addiction continues, the person often finds themselves isolated from natural supports. Their relationships become heavily strained or irreparably fractured. The paradoxical issue is that the individual in recovery is usually more successful because of their natural supports. Violence often is experienced in the lifestyle of active addiction. Family/friend violence, stranger violence, sexual violence. The ignoring of non-consent is common and sexual assault is common.
- Some embraced criminal lifestyles, or would drink and drive losing their licenses and/or killing others.
- Physical and psychological impacts of using can be severe, including cardiovascular concerns, organ failure, incurable diseases, malnutrition, substance overdoses/poisonings, mental health concerns, and suicidal behaviours.

Recovery:

- When people in recovery start piecing their lives together again, repair relationships, restore life functioning, and heal from severity and trauma of use, they report their quality of life has improved.
- People in recovery understand the ongoing mental health concerns they have and they understand they need to work through them, rather than run from them by using. PTSD is common.
- Depression is something most people in recovery experience as the brain chemistry is returning to appropriate functioning and they are healing multiple aspects of their life functioning, but they eventually to get to a point where it lifts.
- They understand triggers and may need extra support through stressful life events.
- Relationship, educational and vocational pursuits provide financial opportunities and security. These steps are often celebrated in the context of how far they have come since using
- One respondent summed it up, "My [worst] day in recovery has been better [than] my best day using."

McQuaid, R.J., Malik, A., Moussouni, K., Baydack, N., Stargardter, M., & Morrisey, M. (2017)

Further Knowledge

The importance of concurrent practice

There is no doubt that substance use and misuse significantly contribute to decompensating mental illness which warrants admission to concurrent practice settings and services. Knowing that SUD is under-addressed in concurrent settings (Louie et al., 2019), elevating capacity with SUD for healthcare workers is vital.

Currently, treatment for mental disorders is commonly separated from addictions in the care setting. Treatment for mental illness may be put on-hold until the SUD is resolved. It may take someone multiple tries to achieve sobriety, and some may never maintain sobriety. At times, it could be argued the substance use itself, is an act of resilience to self medicate, to self-nurture, and to self-manage a person's own mental disorder, but often with increasingly destructive effects to the person. These kinds of scenarios may leave a person with dual diagnoses left untreated.

Substance use disorder is less addressed

Considering mental illness and addictions are often correlated, research informs us that SUD is far less addressed, even in concurrent settings (Louie et al., 2019). The body of research has been robust for mental health practice, but until recently, addressing addiction has been a low priority (Rastegar & Fingerhood, 2016). Low research priority and lack of research also extends to other spheres like gaps in formal training areas for nurses or other disciplines in the health care team. This leaves a gap in knowledge of the psychobiological effects of addiction, elements of recovery, what policies help or harm, and how to meaningfully help an individual with SUD in the health care setting.

Effects of stigma related to concurrent disorders

Literature about SUD addresses stigma in care settings. The literature tells us that stigma by health care staff, toward people with SUD in the health care setting is a known phenomenon and can be reinforced within a workplace culture. Moralization, stigma, and judgment towards SUD are often elements that contribute to relapse, increasing use, or refusal to access services. Unfortunately, judgment and stigma towards SUD has a strong historical presence in most societal systems, including healthcare (Brahim, Hanganu & Gros, 2020; Corrigan et al., 2017; Milligan, Usher & Urbanoski, 2017).

Nurses' ethical responsibility to elevate nursing practice with substance use disorder

Nurses have the ethical responsibility to provide a healing environment for all patients (Canadian Nurses Association, 2017). Nursing staff is the intended end-user for the model that will be developed in this project. Nurses are perfectly poised to engage tools for leadership, endorse full scope of practice, and endorse high-value education and interventions (Garrod, Jenkins, Currie, McGuiness & Bonnie, 2020; Pinderup, 2018) as we elevate our own practices.

Importance of evidenced interventions and expert led teams

Recent literature is extending calls for service teams to reflect neoteric evidenced intervention, and to have expert-leadership in the form of clinical nurse specialists at points of care in all environments where addictions are addressed (Garrod et al., 2020; Hughes, Robertson, Kipping, Lynch, 2007; Bauer & Kirchner, 2019; Bonnie, 2017; Mendell, 2021; Mahmoud, Kameg, & Germack, 2020; National Institute for Health and Care Excellence, 2016; Pinderup, 2018). Some healthcare systems are creating hospital-based intervention teams who provide substance use consultation to staff and interventions for patients on-site (Tran, Swoboda, Perticone, Ramsey, Thompson, Hill, & Karnik, 2021). These two elements: neoteric evidence-based intervention implementation, and expert-led teams readily available to each setting, should be policy-driven, and/or accreditation-mandated.

Addressing the disconnect

Disordered substance use has long-since been misunderstood, underserviced, and underfunded (Wild, Wolfe, Wang, Ohinmaa, 2014). There are also systems-level considerations. The field of addictions research is also trying to address the issue of the disconnect between policies and services provided and what the population experiencing SUD need. Oftentimes the voices of those in SUD do not reach the policymaking level (King et al., 2021; Strach, Zuber & Perez-Chiques, 2020), so policymakers create services that don't meaningfully address the need. We could have services with empty beds to fill, but

there are varying reasons why the users of service are turned away, leaving empty beds (Strach, Zuber & Perez-Chiques, 2020). Strach, Zuber, & Perez-Chiques (2020) calls this the “illusion of services”.

Nurses are also in leadership, decision-making, and policy-driving roles. If nurses fully understand how to address SUD, they could be poised to influence policy. It is important to understand differing perspectives, and the disconnects and barriers to care in order to action inclusivity and responsivity with services.

The Professional Practice Model

The synthesis of the findings of literature review were used to inform the model to guide nursing practice in the concurrent setting. The findings are classified under two themes and eight categories as shown in the model. The two themes are Tools and Techniques for approaching providing addictions nursing care. These themes are also reflected by the technical and behavioural competencies that the Canadian Centre on Substance Abuse (2014) has also linked together in their competencies.

Tools are systems and individual competencies, and the knowledge base to be able to effectively understand the problem that is being faced. Understanding the nature of addiction and the trajectory of recovery is important in order to know how to counsel and guide the concurrent client using the client-centred approach and using evidence-based modalities like Cognitive Behavioural Therapy, Shared Decision Making, and Motivational Interviewing (Antai-Otong, Theis & Patrick, 2016; Szerman & Peris, 2019). There are systems-level competencies and individual competencies to enhance the experience of patients with SUD.

The techniques for approaching the care of the concurrent client are the evidenced soft skills, the “how”, the style, or the tone that is brought with the knowledge and interventions. These techniques are continued practitioner skill-building, leadership in recovery-oriented approaches and guarding against stigma; offer hope, acceptance and compassion; and use affirming language and proper terms with the client and in documentation and shift reporting.

It is evident in the research that these two themes must be addressed together with patients, and when elevating the capacity of the managers and nursing staff with respect to interacting with addictions in concurrent practice (Fantuzzi & Mezzina, 2020). The tools are not effective without the techniques and the techniques are not effective without the tools.

“Recovery from Many Places”

The Evidence

Systems-Level Competencies

- Cultivate policies and protocols supportive of evidence and non-stigmatization. (Garrod et al., 2020)
- Provide training and promote positive staff attitudes (Szerman et al., 2017)
- Remove barriers for care and ameliorate negative repercussions for opiate-exposed mother-baby dyads (Kameg, 2021)
- Implement programming for care, including groups and flexibility for individual needs (Antai-Otong et al., 2016; Canadian Centre on Substance Abuse, 2014; Green et al., 2020; Morales et al., 2018)
- Provide barrier-free, nimble systems (Canadian Centre of Substance Abuse, 2014; De Ruysscher et al., 2017; Garood et al., 2020; Raistrik et al., 2015)
- Provide relevant and high-value education to staff. Managers also need to be involved in training. (Garrod et al., 2020; National Institute for Health and Care Excellence, 2016; Russel et al., 2017; Pinderup, 2018)
- Provide written materials for staff and clients on the unit. (Antai-Otong et al., 2016)
- Youth addictions and mental health services need to be specific to the age group and co-located. Early intervention can decrease SUD. Therapeutic rapport particularly important with this age group. (Brahim et al., 2020; Deady et al, 2016; Hollen & Ortiz, 2015; Public Health Agency of Canada, 2018).
- Profound need for addictions-trained nursing staff. Promote or hire specialist roles. Ensure clinical expertise available on units. Teams need to be expert-led. (Bonnie, 2017; Garrod et al., 2020; Hughes et al., 2018; Mahmoud et al., 2020; Petrakis et al., 2018; Pinderup, 2018)
- Inpatient settings can provide 24-hour access to CBT, motivational interviewing, education empowerment, active engagement and support with treatment concepts when it is needed.
  Provide manualized protocols for groups. (Canadian Centre on Substance Abuse, 2014; Clarke et al., 2012)
- Greater personalization of care plans (Fantuzzi & Mezzina, 2020).
- Greater understanding of withdrawal processes. Provide simulations as they help elevate knowledge base (Snow & Wynn, 2018).
- Create systems that are more equity-aware and trauma-informed (Purkey & Mackenzie, 2019)
- Treatment should be co-located with effective collaboration from multi-disciplinary team, increasing doses of verbal therapies (Louie et al., 2018; Rastergar & Fingerhood, 2016)
- Allow for full-scope nursing as it enhances patient care experiences (Garrod et al., 2020).
- Improve the quality, inclusivity and scope of guidelines for integrated, dual-diagnosis care (Alsuhaibani et al., 2021).
- There is no significant statistical difference in long-term recovery between voluntary and involuntary substance detox and treatment. Any efforts toward discontinuation are warranted (Pilarinos et al., 2020).
- It is necessary to implement the concept of harm reduction in nursing practice (Iammarino & Pauly, 2020).
- Re-define policies. If there are ambiguous policies, nurses can get stuck between evidence-informed care and seemingly conflicting organizational policy (Immarino & Pauly, 2020).
- Integrate personal stories with established curriculum or professional training to improve perceptions toward individuals with SUD (Knaak et al., 2022).
- Clinical guidelines are severely limited for improving the quality of integrated care and need evidenced-based updates. (Alsuhaibani et al., 2021).
- Standardized assessment tools are necessary (Halladay et al, 2021).

Individual Practitioner's Competencies

- Work in full-scope as it enhances patient care experiences (Garrod et al., 2020).
- Know what a teachable moment is and how to use client-centred approaches (Graham et al., 2016)
- Portray SUD as treatable (McGinty et al., 2018).
- Celebrate recovery efforts and post-use growth (Best & Colman, 2019; Haroosh & Freedman, 2017).
- Help client see discrepancies in use and negative consequences of use. Focus on positive aspects of client, accomplishments, autonomy and self efficacy (Nicolini et al., 2017).
- Teach life skills (Canadian Centre on Substance Abuse, 2014; Precin, 2016).
- Promote health and vitality, engage in active listening, don't rely on PRNs (Brahim, Hanganu & Gros, 2020).
- Address addiction once psychiatric acute phase is over after admission (Graham et al., 2016).
- Understand the ethics involved with potential coercion in the compulsory care setting (Hughes et al., 2018; Johansson & Wiklund-Gustin, 2016; Nicolini et al., 2017).

- Protect therapeutic relationship with the patient, and create safe environment. Avoid retraumatization (Alexander, 2017; Canadian Centre on Substance Abuse, 2014; Espinet et al., 2016; Wason et al., 2021).
- The more staff who provide empathetic care toward patients with SUD, the culture of the unit can change overall (Van Boekel et al., 2014).
- Retain positive regard for client (Sorsa, 2019).
- Help client search for meaning in experiences (Thompson, 2016).
- Disordered use is not necessarily the opposite of resilience. Look for evidence of resilience already in the client (Pilarinos et al., 2020; Rudzinski et al., 2017).
- Understand the outcome of traumatic experiences and mental health conditions that lead to behaviours (Wason et al., 2021).
- Avoid seeing the patient's condition of SUD as self-inflicted that leads to a lessened concern for the clients' welfare which has an outcome of suboptimal care (Johansson & Wiklund-Gustin, 2016).
- Attend to own self-care. Understand what courtesy stigma is (staff who deliver empathetic care for clients with SUD are stigmatized by co-staff) (Neville & Roan, 2014).
- Understand and allow that maturation is often stalled with long-term use (Stecher, 2015).
- Opiate use associated with despair, so prevention needs to also address mental health (Jesmin & Amin, 2020).
- Understand trauma is often the origin of SUD and be able to offer trauma-specific care (Canadian Centre on Substance Abuse, 2014; Evdokia, 2016; Wason et al., 2021).
- Dialectical Behavioural Therapy (DBT) has shown some promising results with SUD (Chapman, 2006).
- Offer flexibility with treatment plans (Wason et al., 2021).
- When working in the family centred environment, nurses in concurrent environments should promote resilience and strengths-based approach for children of parents who use (Anandanbo, Mechling & Ahern, 2020).

Understanding Components and Science of Substance Use Disorder

- Greater understanding of withdrawal processes is needed (Snow & Wynn, 2018)
- Know relapse risks and protective factors (Canadian Centre on Substance Abuse, 2014).
- Understand effects on the brain and why it can be considered a "brain disease" or a "disease of disordered choices" (Conrod & Nikolaou, 2016; Durazzo et al., 2017; Gipson et al., 2021; Kime, 2018; Lappin & Sara, 2019; Ling, 2017; Mercuri et al., 2015; Sanchez et al., 2019; Szerman & Peris, 2018).
- Understand the mechanisms and role of cravings and re-use. Relapse is part of learning to be sober (Ivers et al., 2018; Lewis, 2012).
- Long-term SUD can lead to deficits in executive functions, social cognition, memory, learning, attention and perceptual-motor aspects (American Psychiatric Association, 2013).
- SUD is not just a brain disease, it is also a biopsychosocial pathology as well (Heather et al., 2018).
- Understand how SUD impacts health across the lifespan (increased risk for illness, nutritional deficits, mental disorders, and most of the chronic diseases.) (Mahboub et al., 2020).
- Isolation increases cravings. Reaching out is important (Bonny-Noach & Gold, 2021).

Understanding Components and Science of Recovery

- Abstinence is not the only successful measure of recovery (Kougiali et al., 2017).
- Benefits of gratitude toward recovery (Chen, 2017; Ghalesefidi et al., 2019).
- Understand how internal and external locus of control affects recovery (Rowlands et al., 2020).
- Use Mindfulness and understand feelings and emotions related to use (Esmaeili et al., 2018; Tsavou & Petkari, 2020; Zareban et al., 2017).
- Understand the domains and tasks of recovery:
  1) healing from intensity, pattern and duration of SUD,
  2) reconnection with family and other supportive relationships,
  3) reengage with health and vitality,
  4) work on mental health/self-regulation elevate coping strategies,
  5) increase socialization and connection to community,
  6) taking responsibility/rebuild trust,

7) skill-building/education/occupation,
8) engage in meaningful activities,
9) look for both strengths and gaps to address non-recovery behaviours, &
10) altruism (Best et al., 2021; Canadian Centre on Substance Abuse, 2014; Morton et al., 2016; Semb et al., 2019; Stevens et al., 2020; Watkins, Brown & Courson, 2021; Zhang & Ahu, 2020).

- Help client maintain humility as it is a protective factor against use, reuse, or increased use (Yu et al., 2021).
- Help client identify high risk situations (Melemis, 2015).
- Understand the elements of recovery within the individual context of the clients' needs (Borkman et al., 2016; Kime, 2018; Melemis, 2015).
- Know what enhances or erodes motivation. Use motivational enhancement approaches (Schultz et al., 2018; Senn et al., 2021).
- 12-step, CBT, expressive arts therapy and rational emotive behaviour therapy increase personal investment in recovery (Stuebing et al., 2020).
- Understand that disordered use and suicide are correlated. Knowing this is vital to care (Malhi et al., 2020).
- Social isolation is deleterious to clients with Opiate Use Disorder because it escalates fear and anxiety and can trigger relapse (Ornell et al., 2020).
- Social connectedness and social change increases quality of life in recovery (Bathish et al., 2017).
- Dual Recovery clients say the following is helpful:
  1) Support by family, peers and being active in the community,
  2) Psychologically safe, educational, individualized, holistic treatment,
  3) Foster hope, self-discovery, new identity, self-awareness and self acceptance, making good lifestyle choices to build a positive future, and
  4) Have somewhere to be as evidence of meaningful activities to help with motivation and structure for future orientation (De Ruysscher et al., 2017).
- Motivating and supportive social connections, meaningful peer activities, and separation from relationships that impede recovery are particularly important for emerging adults in recovery. (Bahl et al., 2022).
- The person in later recovery has gone through the process of passively staying safe, exploring/feeling exposed/learning, and self-determined/confidence/authentic. Knowing this helps clinicians help to sustain their recovery (Webb et al., 2022).

Practitioner Evidence-based Skill-building

- Fine-tune own self-awareness and biases (Brener et al., 2019; Cleveland & Bonugli, 2014; Van Boekel et al., 2014).
- Increase in nursing knowledge increases care outcomes (Bonnie, 2017).
- Challenge stereotypes (Matthews et al., 2017; Rastegar & Fingerhood, 2016).
- Increase skills with evidence-based modalities such as CBT, Motivational Interviewing and Shared Decision Making within the context of addiction and mental health (Precin, 2016).
- Advocate for better quality of formal education about SUD. Nurse educators should incorporate SUD education. This education needs to address current attitudes of nursing staff and the array of issues the SUD client presents with (Iammarino & Pauly, 2020).
- Spend time listening to stories and understanding the lived experience to improve attitudes toward people experiencing SUD (Knaak, Besharah, Billett, Kharpal & Patten, 2022)
- Enhance skill and knowledge of addiction and promote evidence-based practice, particularly when working with the mother/child dyad (Renbarger, Phelps, Brand, Broadstreet, 2021).
- Cultivate knowledge in Motivational Interviewing, CBT, DBT, and shared decision making to motivate client (Canadian Centre on Substance Abuse, 2014; Chapman, 2006; Morales et al., 2018; Precin, 2016)

Offer Hope, Acceptance and Compassion

- Maintain psychological safety in nursing practice (Purkey & MacKenzie, 2019).
- Maintain hope, acceptance and compassion (Alexander, 2017; Kemp & Butler, 2014)
- Engage in welcoming characteristics (AHS, 2019).

Use Person-first & Stages of Change Language

- Avoid labeling terms such as “clean”/”dirty”, or “drug abuser”/”Addict”. They are a person who uses substances (Ashford et al., 2019).
- Incorporate Stages of Change (DiClemente & Prochaska, 1998) language in documentation, when describing client, and when reporting to next shift (Canadian Centre on Substance Use, 2014).

Leadership in Recovery-oriented care & Guarding Against Stigma

- Understand aspects to use disorders and intersectionalities (Milligan et al., 2017).
- Knowing that addiction is the most stigmatized condition, orient nursing practice to provide a stigma-free, high-value, non-judgmental, low-barrier, dignified, open-minded aspect to care (Anandan, Cross & Olasoji, 2021; Barry et al., 2014; Brahim et al., 2020; Corrigan et al., 2017; Kameg, 2021; Moore et al., 2020; Purkey & MacKenzie, 2019; Solberg & Naden, 2020; Vatanasin & Dallas, 2022).
- Education reduces bias (Brannock et al., 2020).
- Transmission of stereotypes & stigma occurs when it goes unchallenged (Matthews, Dwyer & Snoek, 2017).
- Stigmatizing health care environments result in a poor quality of care, and is a significant barrier to individuals receiving care. Respectful environments must be maintained and staff must shift focus to patient needs with humanizing interactions, (Iammarino & Pauly, 2020).
- It is important to manage stigma when caring for the mother/child population (Busse et al, 2021; Renbarger, Phelps, Brand & Broadstreet).

Information for nurses & clients in the form of a printed 4”x6” double-sided card as shown below:

A Purpose-Driven Life in Recovery:

1. Get humble, vulnerable, and real with yourself (but actually). Employ “Radical Acceptance" of situation without judgement.
2. Decide to change/stop, set your goals & write them down. Strategize to increase motivation. Set boundaries. Problem solve barriers.
3. Reach out for support, but realize you are the driver. Baby steps are okay.
4. Keep in your life ONLY things, habits and people that support your recovery and wellness. Exercise & eat nutritionally. (These will be big, seismic changes.) Mindfulness is a good strategy for emotion management.
5. You may not feel good, physically & emotionally, as you shift your focus to change/non-use. Become tolerant of turbulent emotions or feeling down as your brain heals. Each healing/sober day is progress, even if you feel like you are going backwards. Exercise self-compassion. Time heals.
6. It is ok to ask for stigma-free interactions. People will judge. It is not okay. You will feel the changes in yourself before others see the changes.
7. Get professional help to process traumas and losses. Journal your journey.
8. Build, invest in, and grow your village and skills. You will need your people.
9. Stay focused and be patient. Rebuilding takes time. Celebrate small things.
10. Get busy, strategize how to stay motivated, vigilant, involved, working, skill-building, connected, creative, and helpful to others.

Believe in yourself. This is your one life, LIVE IT. (But actually)

Image of butterfly (Gwynn, 2006)

APPENDIX B: FEEDBACK AND EVALUATION DATA

Responses from Three Groups of Feedback

First wave of feedback

Community of Practice meeting, May 16, 2022

- Liked butterfly symbol
- The model shows "recovery from many places" and how we can work together from complex systems to help a complex client.
- The model "touches all the places we avoid". It is welcoming and engaging and informs the "how" to do this work
- The model should be used to help inform multi-disciplinary team and train them
- Participant felt this model is timely because it was felt that addictions work has no support from the medical and nursing profession.
- The model is affirming to the work that we do.
- The model needs to go beyond hospital units and can also be used to be pro-active in the community.
- The model will help take inpatient care to a higher standard, beyond safety into a proactive approach
- One participant questioned the 24/7 verbal therapy access.
- One participant felt the model appropriately put emphasis on the psychosocial aspects of addiction, and not just the medical aspects.
- Several visually graphic changes were suggested on the model itself, which were made.

Second wave of feedback

AHN of Detox unit

"There is a dire need for this shift in practice and I'm very pleased to see that you've addressed it so constructively from a top-down approach. It's very well-done and exceptionally thorough. I found it clear and easy-to-follow. I'm most curious to see it implemented practice-wide and look forward to the day we see this shift."

Experienced Addictions Counsellor (AHS):

"Very thorough. I couldn't see anything that was missed, and it brings all the aspects of addictions treatment together in one package."

AHS South Zone Educators:

"Love all of this. Great job! Your passion is obvious and contagious."

(Their feedback included interest in additional steps their team could take and interest in continuing to learn about this, as well as offering strategies for effective training for SUD on their units moving forward.)

Acute Psychiatry Manager

Feedback about the information with the model.

- "Great work!".
- There was also a note offered to include images of hope, as well as include information that "housing, socioeconomic and food outcomes are also more severe" for this population.

Third wave of feedback

13 nurses who responded to this survey and 2 addictions counsellors using Evaluation form. Informal focus group conversations from all three concurrent practice areas also a part of this feedback. The questions and responses are integrated below. The one negatively-responding survey is listed in red.

Evaluation

Package Content and Format

1) **Is this professional practice model immediately useable?** YES 8 NO 3
   a. If no, please explain:
   - some aspects easier than others
   - There is a lot of information in the package. Parts could be used right away, others would take time to learn – the 10 step card/use first person language
   - not sure what you want nurses to learn from this package?

   b. Is there anything missing?
   - MLL education ideas (Referring to Alberta Health Services "my learning link" staff education resources)
   - Role of medication
   - A legend for the model itself, table of contents for the rest of the package. (on the front, simplified version of paragraph 4 from explanation.
   - System barriers, and women in treatment? (i.e., childcare?)
   - just seems like a theoretical model with no practical applicability

2) **Is the format clear?** YES 7 NO 2
   a. If no, please explain:
   - some redundancy, repeats, topics/content

- A lot of information "spliced in" – maybe QR code links to expand online version (more space)
- I think it needs to be smaller and written for everyone
- Information is too dense and overinclusive. I found myself skipping pieces and tuning out

3) **Is the language clear?** YES 6 NO 1

a. If no, please explain:

- some grammatical or some wordy sentences but also has a lot of good information
- Language could be simpler (even though it's a profession, simpler is easier to learn from)
- Yes, but could reach wider audience with simple terms
- Frankly, the language is too 'acedemic' and not easily understood

4) What is the best way for this professional practice model to be presented to nursing staff?

□ In a package like this one for reading. 2
□ In a course format 3 ("Online?")
□ Briefly in an annual training day 3
□ In a small focus group 3
□ Other:

- "Not briefly! Allow for discussion, stories of success will help motivate staff that are feeling helpless in affecting change in this population."
- "Not sure"

5) **Is the accompanying information about recovery helpful for your nursing practice?** YES 8 NO 1

a) If no, please explain

- I am not going to read all these resources. Liked the top 10 most effective recovery resources

6) **Is the accompanying information about the evidence helpful for your nursing practice?** YES 8 NO 1

a) If no, please explain

- well the "evidence" is listed under 5 different categories, so evidence of what?

7) How feasible do you think this project will be to implement on your unit?

- Some areas that I am able to focus on for continued learning
- Easy, we're already doing most of it (detox nurse)
- With time spent it will be beneficial
- Connect with unit educators/managers
- Very feasible
- Very, some aspects easier to implement
- I think it would be feasible with time for in-service/education
- Have these packages/an online version would be easy although relies of staff initiative. Have a course/group may be difficult to do (time/money) – potential increase of retention/initiative.

- I don't understand what exactly you are trying to teach or "emplement"

8) **In what ways do you think this professional practice model can help guide nursing practice?**
   - "Help with stigma"
   - "I love the pie diagram. It is a helpful reminder. I think it would be good to ENGAGE this in poster form to place in an area where nurses congregate. It's a gentle reminder. Love it!!"
   - "Promoting recovery orientated in-patient care"
   - "Person focused/increase evidence-based practice"
   - "Creating knowledge around supporting patients with SUD"
   - Not sure, just seems like another "illusion of services" don't see anything practical in model – It's too dense and wordy.
   - "create awareness of community issues, reduce stigma, standardize understanding and approach to treatment (within nursing field)"

9) **What will be the impact from using this professional practice model?**
   - "Using current evidence to direct practice"
   - "Better/more compassionate/more efficient care/better outcomes"
   - "Compassionate, evidence informed practice"
   - "Consistency, better care for clients, reducing stigma in areas where this is not practiced"
   - "Improved pt care/outcomes – pt focused care"
   - "Improve nursing competency surrounding care for persons with SUD"
   - none
   - "Increased access to supports, reduced barriers, repair ruptured relationships, reduce stigma, humanize the experience and avoid separating or splitting the individual."

10) **What barriers do you perceive to implementing this professional practice model into your nursing practice?**

□ Time to learn the content 8
□ This isn't something I'm interested in
□ Other:
□ Not conducive to practice on the unit 2
□ Personal beliefs about substance use disorders 3

   - "Time to learn is a barrier which is why a course format would be helpful in units where this is not practiced or not the norm. I think it should be mandatory education for nurses, yearly."
   - "Access to programming and wrap-around services, lack of understanding/awareness in the larger community/stigma, funding, "burn out" – easy to feel overwhelmed and hopeless after working with this population. But imagine how they feel living it every single day.

11) **Do you have any other comments or suggestions?**
   - "I like the 10 step card in the front, a good reminder"
   - "I like the picture on the front"
   - "Fantastic job!"
   - "Addiction recovery is a collective approach and takes a community effort to implement. Well done, well researched, and exceptionally presented!"

- "Create language that is user friendly in terms of audience (i.e., instead of "ameliorate" just say to make better). Lots of content – prioritize what is need to know vs nice to know – or diagrams"
- "Great work"
- "LOVE the card, in fact I would love to have 10 of them"
- "This would be a great tool, but needs to be smaller, easier to read/follow. Too much information. Dumb it down some….sorry!"
- "Information was well laid out. Love the rainbow colored text on the cards for recovery!! Very useful package for clinicians. Medical areas may need an inservice or course format to ask questions and to vent about the reasons they feel stigma should stay. Buy in will be easier when nurses feel heard."
- "Great information. Needed to help improve practice. Very well made folder and overall design – just got squished fitting in all the information. Would love to see as online tool with all the information with a simplified version for on the floor reference."
- "I thought this was incredibly well-done and informative. I am thoroughly impressed with the quality, delivery, and presentation of the information included. I can tell this was an exhaustive process to complete

I did want to acknowledge some areas I appreciated you mentioning. I found it valuable to discuss the varying treatment options and the need to keep everything at 'no cost'. Additionally, it is equally as important to address the concepts of new-age recovery models and provide programming that differs from traditional 12 steps models. This could be something like experiential group therapies or a collaboration of individual talk-therapy and progressive support groups. Also, 12 step models are deeply rooted in religion, which can cause upheavals and rupture to progress surrounding any past religious trauma (this can include residential school settings, unhealthy views of sexuality due to religious beliefs, stigmatization and depersonalization of self if individual perceptions don't align with family/church values)

I appreciated your intentional use of appropriate and accepting language throughout. You actively incorporated inclusive and non-judgmental language which highlights the presenting issues or the experiences of the individual but does not label the individual or identify them as their issues. This is a significant problem within healthcare settings and other units as lack of education and personal beliefs can easily be projected to those experiencing the hardships.

I appreciated the information reconnection of self with the Stages of recovery page. It often gets overlooked that though individuals will reconnect with parts of themselves from the past, the growth comes from identifying and connecting with who they can become in recovery.

And lastly, just a side note. When educating other healthcare professionals it is important to address the significance of proper client assessments and history taking

before recommending treatment options. this is to ensure the treatment center/program will be a correct fit for the client, and they will have increased chances of success. I know you are aware of all of these points, just reiterating from my perspective.

Again, I apologise for the delay. I really enjoyed reviewing the literature you prepared and was able to see the importance of this project."

Several focus group discussions with clinicians who chose not to fill out a form, but gave narrative feedback:

- "It is excellent, I can't believe this didn't exist before"
- "It was so helpful! I used the information to answer questions in a job interview, so thank you!"
- "That card is so helpful, can I have some more to give out to clients?"
- "Card is good!"
- "It is a lot of information to read through"
- "Information on recovery is excellent and hopeful"
- "Use more accessible language"
- "I like the diagram, it is easy to see"
- Spelling and grammatical
- "Really helpful"

Discussion with Peer Support Worker

- Regarding the card: "Yes, this sums up recovery very well. It's not missing anything."
- "It is validating to see that clinicians might really understand what this journey of recovery is like."
- "This will make a big difference".

APPENDIX C: TIMELINE

Task	March				April				May				June				July				August			
Stakeholders already have draft of the professional practice model. Provide consultive support.																								
Present to the Alberta Health Services Addictions and Mental Health Concurrent Practice Team																								
Receive Feedback from manager, educators and staff from Acute Psychiatry as well as post presentation in May. (Initial evaluative feedback already received from the AHS A& MH concurrent practice office.)																								
Analyze and incorporate feedback																								
Produce final deliverable																								
Produce final report																								
Submit to Faculty of Graduate Studies																								

APPENDIX D: LOGIC MODEL

NAME OF PROGRAM/PROJECT:
Elevating Capacity with Individuals with Substance Use Disorder: A Model to Guide Nursing Practice in the Concurrent Setting.

SITUATION:
Individuals with substance use disorder are in nearly every area that nurses are. This population is often judged and stigmatized by nurses who are known to be insufficiently directed in this area. This stigma can also be reinforced by unit culture. Nurses want more education and direction with regards to this population, but because of the lagging body of research on evidence-based practice for nursing care of individuals with SUD, formal and continuing education in this area has been sparse. Professional practice models are evidenced to help align practice to evidence. This professional practice model will help nurses align their practice to evidence when their client is in, or has a history of, disordered substance use in the concurrent care setting.

OBJECTIVES:
To help nurses who are working in an addiction and mental health concurrent setting to align their practice with evidence. This professional practice model will aim to reduce stigma and elevate the quality of care for those with substance use disorder and mental health issues in the concurrent, addictions and mental health, setting.

INPUTS	OUTPUTS		OUTCOMES		
	Activities	**Participants**	**Short-term**	**Medium-term**	**Long-term**
• Time and Research. • Access to a research library. • Computer and software to organize and write data. • Person to do research. • University of Lethbridge instructor. • Consultive support	• Research, organization, and compilation of professional practice model. • Securing the stakeholders (Acute Psychiatry Unit & AHS Addictions and Mental Health Concurrent Practice Office) • Literature search • Provide professional practice model and supporting information. • Give presentation on May 16, 2022 to the Alberta Health Services Addiction and Mental Health Concurrent Practice team. • Provide consultive support • Engage in the evaluation process for feedback from AHS, and nurses from Acute Psychiatry a concurrent environment. • Integrate feedback from clinicians and stakeholders in an updated version of professional practice model. • Engage patient advocacy group for feedback • Implemented professional practice model in the orientation training on Acute Psychiatry and make it available to the AHS Addiction and Mental Health Concurrent Practice Office for implementation as they see necessary.	• Author of professional practice model, instructor at U of L, School of Graduate Studies at the U of L, Manager of Acute Psychiatry (Lethbridge), and AHS Addictions and Mental Health Concurrent Practice Office. • Patient advocacy group • Nurses providing feedback • My audience is registered nurses in addiction and mental health concurrent settings, specifically, Acute Psychiatry, Chinook Regional Hospital and the Addictions and Mental Health Concurrent Practice Team for AHS	• Achieved better understanding of substance use disorder and reducing stigma in the healthcare environment • Achieved managerial and systemic support for elevated care for individuals with substance use disorder in concurrent settings.	• Improved quality of individual nursing care with concurrent patients in concurrent settings and aligning nursing practice with evidence. • Continued systemic, unit, and managerial support for nurses engaged in improving care for individuals with substance use disorder.	• Improved health in the lives of concurrent clients. • Protected unit practice against program drift

APPENDIX E: STAKEHOLDER ENGAGEMENT PLAN

There are a number of stakeholders are invested in this project. The stakeholders and potential champions for this project are as follows:

- Stakeholder #1: Alberta Health Services Addiction and Mental Health Concurrent Practice Office (AHS A&MH CPO).
    a. This is the main stakeholder from whom the initial request for the project came. They are in a position to recommend and implement the Professional Practice Model (PPM) through AHS, Province-wide.
- Stakeholders #2-4: Manager of Acute Psychiatry; Addictions and Mental Health South Zone nurse educators, and the Assistant Head Nurse (AHN) from Medical Detox.
    a. These are three secondary stakeholders whose feedback is valuable as they are in a position to implement the PPM in working units in AHS South Zone with a "boots on the ground" perspective of feedback.
    b. The AHN from medical detox also has a master's degree in nursing, concentrated in the field of addiction which will also give another layer of valuable and credible perspective.
- Stakeholders & potential champions of the project #5 & 6: Nurses from concurrent settings (from Acute Psychiatry and Medical Detox, Chinook Regional Hospital). Peer Recovery Worker, Lethbridge, Alberta.
    a. The floor nurses and the peer recovery worker will give a tertiary level of feedback and expertise. Once the professional practice model is re-designed from the primary and secondary levels of feedback, it will go to the tertiary levels of feedback. This feedback will serve if the deliverable is clear and useable to those

who are expected to use it. It will also give perspective if the PPM would be helpful to the end users of service, those who have SUD.

b. A second level of tertiary feedback is from a community peer recovery worker in Lethbridge, Alberta who has experience being a system-user from the perspective of someone who was in severe Substance Use Disorder (SUD) and is now three years in focused and successful recovery. Considering the voices of those who are users of concurrent services are almost absent in the wider body of research, this voice is important.

AHS A&MH CPO has been involved with this project for well over a year and has been supportive of this initiative. The initial ask was a tool that could be used for nurses in the concurrent setting to elevate care of individuals with issues related to addiction. The oral presentation on May 16, 2022 was to the Community of Practice group that her office leads. The feedback was positive. They have already expressed interest in implementing this model prior to the meeting.

A stakeholder priority matrix shows the prioritization of the stakeholders in this project. See Figure 2. The AHS Addictions and Mental Health Concurrent Practice Office is considered the priority stakeholder due to their significant provincial influence and the engagement of the initial ask for this project. The secondary stakeholders as outlined above, are considered high influence and low stake because they still hold influence over concurrent environments of this region and are the gatekeepers to be able to allow significant access for feedback from the nurses in their environments of influence. The floor nurses and peer recovery worker are low-influence and high stake. Their feedback is valuable for clarity, and their position to ultimately champion this project into future change on the unit or other

healthcare environments, past the scope of this project, is also in their hands in addition to the main stakeholder and secondary stakeholders. No stakeholders are identified as low influence and low stake.

Figure 2:

Stakeholder Priority Matrix

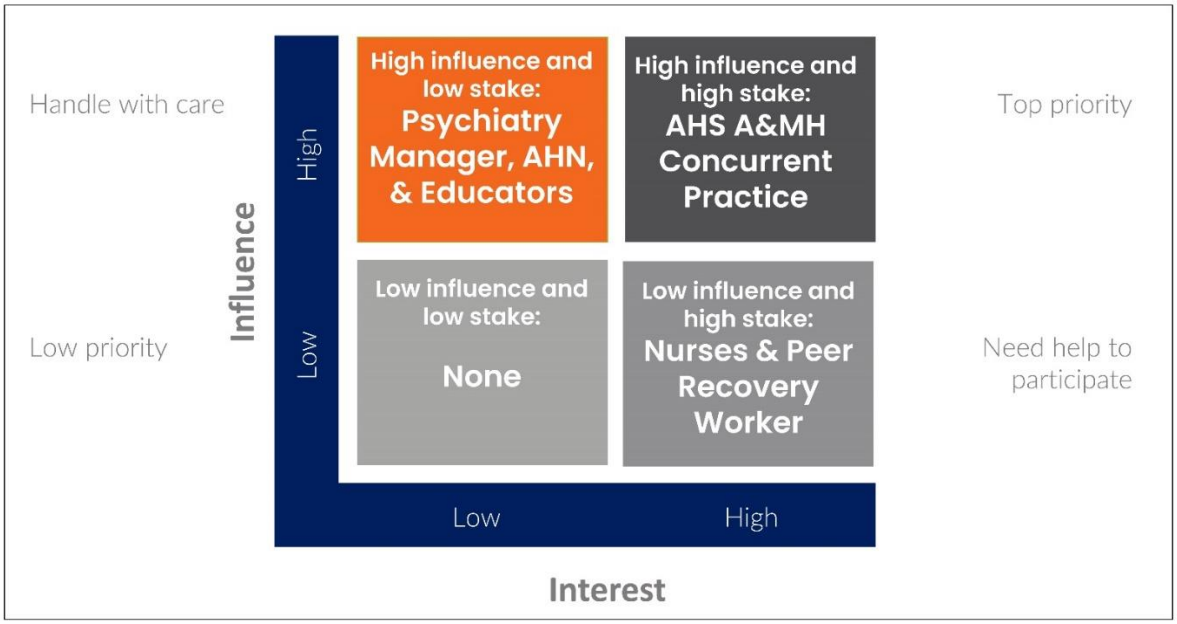


Table 2

Stakeholder Engagement Matrix:

C= current engagement
D= desired engagement

Stakeholders & Champions	Unaware	Resistant	Neutral	Supportive	Leading
Jackie @ AHS A&MH Concurrent Practice Office					C
Manager of Acute Psychiatry				C	D
Site educators for A&MH in South Zone				C	D
AHN for Medical Detox				C	D
Nurses in Acute Psychiatry and Detox	C				D
Peer Recovery Worker				C	D

Stakeholder Engagement Strategy

It is fortunate that the stakeholders are already and regularly well-connected to the principal project manager. The project is currently in the feedback stage of the secondary stakeholders. It has been 7 days since the information was e-mailed to the three secondary stakeholders. I have received feedback from one of the three. I will send a kind reminding e-mail to those who have not returned feedback. That is a challenge with healthcare workers, we are a very busy workforce.

I know I will have the support of the floor nurses when I am at that stage of feedback, as the gatekeepers (the secondary level of stakeholders are open to the tertiary feedback needed). The peer recovery worker is also expecting to see the re-designed PPM and is open to giving feedback.

At the presentation stage, I will make sure to engage my primary stakeholder, and at the final stage, the report and deliverable will be made available to all stakeholders.

APPENDIX F: DATA TABLES

Participants	Author (Year)	Purpose/Background	Strength/Weaknesses	Methods/Study Design	Summary/Limitations
	AHS Policy (Nov 1, 2019)	Policy on residential addictions treatment and detox programs	Does acute psychiatry apply as a residential treatment & detox program?		Pt centred care, safe and welcoming, recovery-oriented, concurrent capable, builds on patient's strengths and increases quality and control in one's life Dignity without stigma or discrimination Harm reduction approach
	Alexander (2017)	Compassionate care		Peer reviewed research paper	Compassionate care for women who use opiates
6 databases, 21 guidelines included in review	Alsuhaibani, Smith, Lowrie, Aljhani & Paudyal (2021)	Explore international guidelines about treatment of co-existing concurrent disorders	Systematic review. Guideline quality: AGREEII tool was used.	Protocol Driven Systematic Review	Improve the quality, inclusivity and scope of guidelines for integrated, dual-diagnosis care. Research and guidelines on integrated care are sparse despite high co-prevalence.
20 studies	Anandan, Cross & Olasoji (2021)	To review literature and evidence regarding attitudes and empathy of mental health nurses with dial diagnoses and identify gaps.	All 20 studies reported original data.	Scoping Review	None of the studies reported empathetic care toward individuals with SUD. Doubt, evasion and distrust from both sides of the therapeutic relationship evident in interactions.
	Antai-Otong, et al, (2016)	Value of integrated care		Peer reviewed research paper	Psychopharmacologic and psychotherapeutic approaches have proven efficacy in the treatment of dual diagnoses
44 adults	Ashford, Brown & Curtis (2019)	Study that explores terminology relating to the population that uses drugs.		Quantitative	The recommended term to substance abuser, (i.e., *person with a substance use disorder)*, was found to also invoke a negative association, however it was less severe than with the term "substance abuser". There is a benefit to using the term "*person with a substance use disorder*", but this benefit does not produce a positive association, just a less negative one.
21 emerging adults in Norway	Bahl, Øversveen, Brodahl, Nafstad, Blakar,,Ness, & Tømmervik,. (2022)	Study that looked at the concept of community and belonging in recovery.	Strength: voices of those who have experienced SUD are being amplified.	collaborative research design, and reflexive thematic deductive analyses	For emerging adults, to aid recovery and prevent substance use, community (e.g., friends, family, system supports, geographical, recovery communities), approaches need to utilize multifactorial and age-specific concepts of belonging.
709 participants of a web based survey. Adults 18+	Barry, McGinty, Pescosolido, & Goldman (2014)			Web based survey	People have low regard for people with addiction, and willing to accept discriminatory behaviour toward them. There is a high desire for social distance from those with SUD. Healthcare needs to engage in stigma reduction.
537 people in recovery who completed a survey	Bathish, Best, Beckwith, Mackenzie, & Lubman (2017)	Explored role of social connection and social identify in recovery			The transition from SUD to recovery had increased social connectedness and social network changes. It was also coupled with a new recovery identity. This can drive further improvements in quality of life.
	Best & Colman (2019)	Characteristics of inclusive, recovery oriented cities.		Peer Reviewed concept paper	Community is important to recovery. Stigma from the community is a barrier to recovery. Recovery-Oriented systems of care characteristics: 1.Person-centred 2. Inclusive of family and other ally involvement 3. Individualized and comprehensive services across the lifespan 4. Systems anchored in the community 5. Connuity of care 6. Partnership-consultant relaonships 7. Strength-based 8. Culturally responsive 9. Responsiveness to personal belief systems 10. Commitment to peer recovery support services 11. Integrated services 12. System-wide educaon and training 13. Inclusion of the voices and experiences of recovering individuals and their families 14. Ongoing monitoring and evaluaon 15. Evidence driven 16. Research based 17. Adequately and flexibly funded Inclusive cities: 1) Connection and social aspects intact 2) Hope about the future 3) Meaning 4) empowerment and strengths based

Participants	Author (Year)	Purpose/Background	Strength/Weaknesses	Methods/Study Design	Summary/Limitations
20 pieces of feedback	Best, Higham, Pickersgill, Higham, Hancock & Critchlow (2021)	Analyses of implementation of model.		outcome data using a standardized measure, qualitative feedback, and standard case management information. Regular research methods are not apparent.	Recovery is contagious. Peer based recovery. 3 elements of recovery: 1) building that relationship of trust with a peer group or community, 2) identifying community assets to engage with and 3) finding ways of effectively linking people in with those community resources. Shows how recovery community can work with complex individuals.
74 Acute Psychiatry nurses.	Bonnie (2017)	Yale nursing thesis for DNP, regarding developing dual diagnosis care curriculum		Survey, Questionnaire Expert Panel Review	Information on this topic is limited as the research is still evolving. Increasing nursing knowledge in dual diagnosis will increase care outcomes.
113 People in recovery	Bonny-Noach & Gold (2021)	To assess level of cravings due to isolation (Pandemic)		Self-reported questionnaire to convenience sample. Hierarchal linear regression analysis	Cravings increased due to stronger feelings of loneliness in one week of isolation. The shorter the time of recovery the stronger the cravings were. The summary suggested for the treatment workers to reach out to those in recovery to help prevent relapse.
Online survey: 238 People in recovery	Borkman, Stunz & Kaskutas (2016)		Voices of people in recovery	Participatory research methods, four step mixed methods, iterative	Consider recovery as ways of being, as learning process involving values, morality and self-awareness. can be used to guide recovery services
Understanding helpful nursing care	Brahim, Hangaru & Gros	To understand what is helpful in nursing care	Canadian reference Patient perspectives	Qualitative descriptive	Montreal source Compassionate care, therapeutic rapport and soft skills are needed especially with young clients, are linked to better outcomes in mental health and maintenance of recovery and reduced feelings of stigma. Promoting health in every-day living (nutrition, hygiene, and mobility) nurse needs to take the time to care and help meet needs Promote psychosocial well-being (resources and experiences offer recreation, relieve boredom) Managing both diagnoses: education about use and mental health Don't just rely on PRNs – skillbuild Build a therapeutic relationship: caring presence, supportive understanding, active listening. Pay attention, know patient spend time with. Treat pt like a person that results in positive self-worth Individualized care.
21 participants in the public and healthcare sector	Brannock, White & Baker (2020)	To assess the ROBIN educational intervention	Low number of participants	Pre-post-test Descriptive Statistics	There is a gap in knowledge with familiarity with opiate use disorder with nurses. Education reduces bias towards those who use opiates
13 clients 8 healthcare workers	Brener, Hippel, Hippel, Resnick & Treloar (2019)	Assessment of clients' perceptions of discrimination		Mixed Methods approach	Perceptions of discrimination were a predictor of treatment completion, with greater discrimination linked to increased dropout.
47 nurses (phase 1) 20 nurses (phase 2)	Busse, Kim, Unite, Kantrowitz-Gordon & Altman (2021)	Teaching nurses to identify areas of need with respect to opiate use disorder when working with peri-partum women and babies		Community-engaged priority setting methods.	Clinicians who work with moms and babies are well-positioned to support the peri-partum mom and babies and should be leading with improving care and engaging in research. Access to services, and standardize and destigmatize care.
	Canadian Centre on Substance Abuse (2014) Competencies for Canada's Substance Abuse Workforce				Technical and behavioural competencies required to perform effectively in the substance abuse field. Outlines Knowledge skills and values.
Report	Canadian Centre on Substance Abuse (2014). Competencies for Canada's substance	To highlight competencies for substance abuse workforce	Written in 2014,	Government Report	Competencies for substance abuse workforce are highlighted as recommendations

Participants	Author (Year)	Purpose/Background	Strength/Weaknesses	Methods/Study Design	Summary/Limitations
	abuse workforce. Ottawa, ON				
Addiction in existential positive psychology from a critique of the brain disease model toward a meaning-centred approach	Carreno & Perez-Escobar (2019)			Academic Research article	This article offers another view of SUD other than the prevalent brain disease model. It is from the purview of psychology and offers alternate insights.
Article	Chapman, 2006	To explain current uses of DBT, one of which is effective for women with SUD and BPD..	The author is PhD prepared and from the Department of Psychology at Simon Fraser University.	Article.	This article is about DBT and its uses.
	Chen (2017)	Value of gratitude in sobriety		Peer reviewed research paper	Gratitude helps person develop strengths to achieve sobriety. May help to include in treatment programs.
Treatment outcomes	Clarke, Young-Mun, Kelly, White, Lynch 2013)			+- tests. Multiple regression analyses	Mixed-gendered interventions may not be trauma-informed for women Participants made significant improvements from admission to discharge Daily structured CBT & support Cost reduction due to shorter stays Empowerment Client involvement in treatment planning Keep building on motivation
	Cleary, Walter, Hung, Clancy, Horsfall (2008) Dr. Cleary is Clinical Associate Professor of Mental Health, Faculty of Nursing and Midwifery, University of Sydney, and Clinical Nurse Consultant, Research Unit, Sydney South West Area Mental Health Service, Dr. Walter is Professor of Child and Adolescent Psychiatry, Discipline of Psychological Medicine, University of Sydney, and Area Clinical Director, Child and Adolescent Mental Health Services, Northern Sydney Central Coast Health, Dr. Hunt is Senior Research Fellow, Discipline of Psychol o g i c a l Medicine, University of Sydney, and Research Unit, Sydney South West Area Mental Health Service,	Promoting Dual Diagnosis awareness	An article in Journal of Psychosocial Nursing & Mental Health Services. It is peer reviewed but it is not a research article.	Article. The authors could be considered subject matter experts, but there is no research design in this literature	Simple, person-centred interventions Person centred, involve client in treatment Treatment aims: minimize harm, educate risks of continued use, and help available Engagement: empathy, accept concerns, stigma, medications (and side effects) optimism Cultivate therapeutic rapport Proper assessment of substances, harm-reduction knowledge and level of motivation Consider previous psych history and personal history Assessments are ongoing Understand withdrawal symptoms Negotiate care plan with client (break down into short and long term Individualized treatment Understand cycles of change MI Don't expect prompt abstinence Avoid blaming, labeling arguing, or confrontation – denial question-answer cycles. Do not think clinician knows best Active treatment not passive Develop strategies to cope with triggers and cravings Clients' environment – are changes needed Increase communication and social skills Address high risk situations that may lead to relapse Safety plan for mental health or substance deerioriation Build on strengths Foster sober friendships

Participants	Author (Year)	Purpose/Background	Strength/Weaknesses	Methods/Study Design	Summary/Limitations
	Dr. Horsfall is Research Officer, Research Unit, Sydney South West Area Mental Health Service, Sydney, and Mr. Clancy is Clinical Nurse Consultant, Dual Diagnosis, Hunter New England Mental Health, New Lambton, and Conjoint Lecturer, University of Newcastle, Newcastle, New South Wales, Australia.				
15 mothers, semistructured interviews	Cleveland & Bonugli (2014)	To describe the experiences of mothers who's babies are in the NICU with NAS		Qualitative description	There was a lack of understanding concerning addiction among the nurses. The participants felt judged by nurses which was a barrier to be able to trust the nurses.
	Concurrent Capable toolkit	AHS document	Has clinical decision making model Gives a structure to treatment plan		Create addictions treatment plan with long and short-term goals Health professionals to offer education SMART goals Collaborate with family Create treatment plan with client Patient-first strategy Include all diagnoses & SUD and track progress Individual and appropriate care Improve access and quality care Help to navigate system Blend treatment and supports into one package.
	Conrod & Nikolaou (2016)			Peer reviewed research article Written by well-educated experts in field	neurocognitive and personality/comorbidity-based risk factors for the SUD during adolescence. These risk factors may increased by the use of drugs
Literature review	Corrigan, Schomerus, Shuman, Kraus, Perlick, Harnish, & Smelson (2017)	To understand stigma in the context of mental health to be applied to SUD		Comprehensive review of stigma literature	Education and contact could be used to counteract stigma. Public and self-stigma are barriers to opportunities for those with SUD.
60: 18-25 with depression and hazardous drinking Or 44: attention control group	Deady, Mills, Teesson & Kay-Lambkin (2016)	The DEAL project intervention		4 week intervention and follow up at post intervention and 3 and 6 months. Randomized control trial	Improvement with depression and alcohol use symptoms.
16 Studies	DeRuysscher, Vandevelde, Vanderplasschen, DeMaeyer & Vanheule (2017)	To highlight the voices of the patients in dual diagnosis care	The population in care is highlighted.	Systematic Review	Needs are flexibility in care, future research is necessary. 4 overarching themes discussed
	DuPont & Gold (2007)	Report about self-medicating in dual diagnosis	Gold is the Chief of the department of Psychiatry, University of Florida.	Peer review	Don't prioritize one condition over the other in dual diagnosis treatment.
123 Alcohol dependent individuals	Durazzo, Mon & Gazdzinski & Meyerhoff (2017)	To see the difference between relapsers and abstainers through MRI scans of brain		Quantitative	Those who relapsed showed much smaller bilateral frontal GM volumes than Abstainers
60 participants	Esmaelli, Khodadadi, Norozi & Miri (2018)	8, 1.5 hour intervention of psychotherapy once a week		Quasi experimental design with pre-post test. 2 groups experimental and control. Cognitive	Mindfulness based cognitive based group therapy showed effectiveness for better outcomes.

Participants	Author (Year)	Purpose/Background	Strength/Weaknesses	Methods/Study Design	Summary/Limitations
				emotion regulation questionnaire	
65 mothers with SUD	Espinet, Motz, Jeong, Jenkins & Pepler (2016)	Standard intervention and other intervention with enhanced relationship focus			The group that had mother-child relationships emphasized improved in mental health and relationship capability and supports addiction recovery
	Evdokia (2016)			Peer reviewed Literature review	Mental health workers need deeper understanding of their responses to clients and reduce the risk of secondary trauma. Clinicians to avoid rigid thinking, and to understand vicarious trauma for the clinicians.
Dual Diagnosis: A systematic review of the organization of community health services	Fantuzzi & Mezzina		Community rather than inpatient, but it's a systematic review of this genre of healthcare	Systematic Review	
32 Articles, Scoping Review	Garrod, Jenkins, Currie, McGuiness & Bonnie (2020)	Deliver education to nurses to improve care for dual diagnosis clients		Scoping review	Education decreases negative attitudes
64 SUD patients in an addiction rehabilitation centre	Ghalesefidi, Maghsoudi & Pouragha (2019)	To assess the role of gratitude in recovery	Methods were loosely/not traditionally discussed	Clinical trial	Gratitude improves quality of life and psychological well being while in a treatment centre
	Gipson, Rawls, Scofield, Siemsen, Bondy & Maher (2021)	Effects of SUD on brain		Peer reviewed Literature review	Understanding of altered plasticity with regards to the brain's processes and addiction
Substance misuse brief interventions during psychiatric hospital admissions	Graham, Griffith, Copello (2016)				BIMI program is effective.
	Green, Bratberg, & Finnell (2020)	To ensure patients have seamless and less complex access to care		Peer reviewed Research article	The COVID 19 pandemic is negatively affecting those with SUD
	Halladay, Horricks, Amlung, MacKillop, Munn, Masir, Woock, & Georgiades (2021)				Standardized assessment tools are necessary
104 participants who had recovered from addiction	Haroosh & Freedman (2017)	To highlight post traumatic growth from addiction		Cross sectional study, questionnaires.	Recovery can be associated with growth related to addiction recovery.
Predictors of problematic substance use 18 after treatment 91 participants	Hjemsaeter, Bramness, Drake, Skeie, Monsbakken, Thoreson & Landheim (2019)		Strength: longitudinal cohort study (rare in SUD research)	Longitudinal cohort study of persons with SUD Self-report questionnaire	Concurrent issues. Half of the subjects still had problematic substance use and high mental distress. Depression was the most prevalent mental disorder alongside substance use.
N:9154 Adolescents	Hollen & Ortiz (2015)	Critically view mental health and substance use interventions for youth	Strength, number of participants		Specific Attention needs to be paid to young people's needs Separating interventions of mental health and SUD is not in the best interest of the young patient. Early intervention with the mental health issue can decrease substance use.
98 participants	Hughes, Bressington, Sharratt & Gray (2018)	Insight about the perceptions from mental health clinicians about SUD		Cross sectional survey of mental health clinicians	Mental health clinicians need up to date information on substances and interventions
20 research articles (primary)	Iammarino & Pauly (2021)	Harm reduction in relation to Nursing care	Literature review of harm reduction approach	Using McLeroy's Ecological Model of Health Promotion	Harm reduction is an appropriate guiding philosophy for enhanced quality of nursing care.

Participants	Author (Year)	Purpose/Background	Strength/Weaknesses	Methods/Study Design	Summary/Limitations
10 participants in recovery	Ivers, Larkan & Barry (2018)	To gain an understanding of lived experience of recovery post detoxification		Longitudinal qualitative analysis	Recovery is not linear and reuse was viewed as part of the process. Clients learned into risk factors for reuse. Also shows the role of insight in this growth experience.
	Jenkins, Bolinski, Bresett, VanHam, Fletcher, Walters, Friedman, Ezell, Pho, Schneider & Ouellet (2021)	Outcome of the pandemic on stigma		Peer-Reviewed Research Article	Expert panel commentary
Diseases of Despair 2018 national survey on drug use and health data. 67,791 interviews between the ages of 12-17	Jesmin & Amin 2020		Large number of participants, but through survey data	Survey-based, Binary logistic regressions.	Adolescent Opiate use decreased with supportive family situations. Not knowing students who used/drank decreased risk of use of opioids. Opiate misuse is associated with despair. Mental health strategies need to be present in addressing. Scaling up prevention in high schools and increasing parental awareness and involvement
6 nurses	Johansson & Wiklund-Gustin (2016)	The role of value based care with people with SUD	Low number of participants	Qualitative analysis	Caring and vigilant care is necessary. Vigilance may be a challenge, but can also be an asset.
	Kameg (2021)	To provide recommendations based on public policy about pregnant women who use opioids.		Policy analysis (using the policy analaytical framework) Peer reviewed	To explore policy that impacts women who are pregnant who use opioids.
	Kemp & Butler (2014)		Does not satisfy rigour. Experiential concepts conveyed	Peer reviewed research article by experienced field workers	Love and compassion is the central healing feature of recovery
6 adults who were interviewed with at least 3 years of sustained recovery	Kime (2018)	How people in recovery create meaning from their addiction	Participant number is low	Qualitative interpretive phenomenological analysis	The medical model continues to be a way that those in recovery interpret their experiences. The blend of the medical/spiritual experience is also created in recovery.
Ontario. 50 students	Knaak, Besharah, Billett, Kharpal, & Patten, 2022	To assess the impact of personal stories on the attitudes of nursing students. Showed statistically significant improvement mean scores on stigma	Most of the students were female. Low completion rate with all of the test results. The study surveyed the students at multiple time points. Mixed-methods design.	Single group longitudinal design	Including personal stories with curriculum for nurses is an approach that improves perceptions of nursing students for individuals with SUD.
21 individuals in recovery and active use	Kougliali, Fasulo, Needs & VanLaar (2017)	How recovery is constructed in the lives of those who experience it.		Qualitative narrative analysis	Their stories were constructed in non-linear, interrupted and long lasting patterns of repeated episodes of abstinence and relapse. Relapse was described as an important aspect of learning process as recovery was gradually achieved. Rethink how personal change in recovery is measured and defined
	Lappin & Sara (2019)	To understand the harms of stimulant use.		Peer reviewed Narrative review	The major harms of stimulant use are stroke, cognitive impairment, Parkinson's disease, psychosis, and seizures. Stimulant use can lead to severe long-term impairment
	Louie, Giannopolous, Uribe, Byrne, Morley, Haber, Baillie, Deady, Teesson & Baker (2018)	Focused on nursing education		Concept description of intervention. Research article preliminary to project implementation Peer reviewed article.	
	Mahboub, et al	Comprehensive overview		Peer reviewed article	Effects of drug use on nutrition and health. Elevating nutrition for people in SUD is an underused intervention
	Mahmoud, Kameg & Germack (2020)	Call to action editorial		Peer reviewed Expert-led panel	
	Malhi, Bell, Mannie & Das (2020)	To understand the risk factors and the		Peer reviewed research article	How suicide and addiction are related

Participants	Author (Year)	Purpose/Background	Strength/Weaknesses	Methods/Study Design	Summary/Limitations
		components of suicidal ideation			
	Matthews, Dwyer, & Snoek (2017)	To highlight the role of stigma and self-stigma in addiction		Peer reviewed research article	Stigma is a barrier to care and leads to self-stigma, which is a further barrier to care. Don't lean into stereotypes.
N: 1326	McGinty, Goldman, Pescosolido & Barry (2018)	To assess an education intervention to enhance empathy		Randomized experiment with randomized panel	Exposure to information about barriers to care for marginalized population can increase empathy
	Melemis (2015)	To elucidate aspects of recovery		Peer reviewed research article	1) relapse is a gradual process with distinct stages. 2) recovery is a process of personal growth 3) the main tools of relapse prevention are cognitive therapy and mind-body relaxation 4), most relapses can be explained in terms of a few basic rules. a) change your life (recovery involves creating a new life where it is easier to not use); b) be completely honest; c) ask for help; d) practice self-care; and e) don't bend the rules.
35 individuals with chronic opiate use	Mercuri, Terrett, Henry, Bailey, Curran & Rendell (2015)	To assess this particular change in the brain due to chronic use.		Quantitative	Reduced capacity for episodic foresight. Future orientation may be problematic for this population in recovery and will hamper current recovery efforts.
50 female participants	Milligan, Usher & Urbanoski (2017)	Experiences of pregnant and parenting women with SUD	Adding the voice of the client	Focus groups and questionnaire	To support clients, be nonjudgmental, engage in empathetic listening, show supportive commitment, have crisis support in ER, and instill treatment flexibility.
	Moor, Ali, Burnish-Line, Gonzales, & Stanton (2020)			Peer-Reviewed Research article	Create public health policy that focuses on decreasing unhealthy behaviour and destigmatizing addiction
N:20 DD inpatient clients	Morales, Eiroa-Orosa, et al (2018)	Elements of effective group for DD clients "From feelings of imprisonment to group cohesion"		Qualitative methodology. Hermeneutical triangulation. Descriptive statistics, grounded theory	Group therapy as important tool in psychiatric settings (inpatient). MI with coping skills training for DD clients. Behaviour and self-help formats Take advantage of few sessions and allow feelings to be expressed and allow conflicts within personal story. Establish hope, altruism, universality, expression of feelings and group cohesion. Hope is critical. Verbalization of emotional content. Caretaking: expressions of understanding between group members. Giving help – solving problems through questions Identification: empathy between group members. To support dual-recovery and reintegration Establishment of group norms Talk about psych symptoms Speak of aspects of substance use Change talk/plans for future Reinforce change talk/plans character development Staff interprets and restates feelings of group member Resolve a confusion or refocus group on therapeutic work (redirection) Care for group dynamics/space.
	National Institute for health and Care Excellence (2016)			Government Report	UK dual diagnosis report.
24 nurses completed research questions	Neville & Roan (2014)	To explore nurses attitudes toward patients with SUD		Qualitative inductive	analysis showed negative view toward patients with SUD, need capacity building, Providing high value nursing care for the hospitalized SUD patient with concomitant medical issues is challenging for nurses. Nurses require additional education and professional support in caring for individual with SUD.
	Nicolini, Vandenberghe & Gastmans (2017)	Explored ethical decision making with compulsory dual diagnosis care.		Peer Reviewed research article	A caring and ethical perspective needs to be cultivated for compulsory SUD clients. Increase therapeutic relationships. Patient needs to participate in definition of needs. Feelings of coercion and negative emotions can decrease and an increase in treatment motivation may be an outcome.

Participants	Author (Year)	Purpose/Background	Strength/Weaknesses	Methods/Study Design	Summary/Limitations
99 stakeholders	Nieweglowski, Dubke, Mulfinger, Sheehan & Corrigan (2019)		Exploratory factor analyses. Bartletts test of sphericity and KMO measure of sampling adequacy were used. One-way ANOVA	3 focus groups. To elucidate public stigma of individuals with SUD	Additional insight about stigma of people with SUD to add to the body of research. Familiarity reduces stigma.
414 israeli nurses.	Nusbaum & Farkash (2020)	To assess nurses' knowledge and attitudes about opiate SUD	High number of respondents.	Questionnaire, online survey	Most of the respondents had a positive attitude about caring for individuals with opiate use disorder. Low scores about knowledge and perceived systems support.
	Ornell, Moura, Scherer, Pechansky, Kessler & VonDiemen (2020)	Explored impact of the pandemic on populations with SUD		Peer reviewed research article	SUD interventions must continue rather than be deferred due to the pandemic
9 children (ages 12-17) who's parents have SUD and involved with social services.	Palumbo, Mechling, & Ahern 2021	Explored experiences of children of addicted parents over 8 sessions	Low number of participants. Strength: the voices of children of parents who use are underresearched.	Thematic analysis	When working in the family centred environment, nurses in concurrent environments should promote resilience and strength based approach for children of parents who use.
11 articles found	Petrakis, Robinson, Myers, Kroes, & O'Connor (2018)	To complete a systematic review of staff training in dual diagnoses.		Systematic review	No research into capacity building or dual diagnosis tools. Training and mentoring is needed for practice. Agencies need to be willing to change
3196 community recruited people who use drugs	Pilarinos, Barker, Nosova, Milloy, Hayashi, Wood, Kerr & DeBeck (2020)	To explore coercion in care setting	Canadian study		there appear to be no statistically significant improvements in **substance use** outcomes **among** people coerced into treatment, those who voluntarily went to treatment and those who didn't go to treatment.
102 Questionnaires 85 interviews of workers who work in dual diagnosis treatment	Pinderup (2018)	Intervention is to improve the knowledge, attitudes and practices of mental health professionals regarding DD treatment	Staff self-reports, no patient outcomes	Mixed methods questionnaire, interview, and field operations for 8 centres. 4 champions were trained for each centre	Overall positive change in knowledge
164 individuals with dual diagnoses who are 18+	Precin (2016)			3-year quasi-controlled effectiveness study Pre-and post-test	Living skills recovery curriculum: decreased substance use, improving time and stress management, ADLs and social skills. Uses CBT and psychoeducational approach Skills are taught in relation to relapse and recovery for each client's situation. X4 modules. Found to be effective
Homeless participants: 31 Social service provider informants: 10 Survey of health and social service providers: 136	Purkey & MacKenzie (2019)		Strength: it amplifies the voice of the marginalized homeless population.	Focus groups and in-depth interviews	Ontario. Recommendation is to create a system that is more trauma-informed, equity-aware. It is good the voices of the marginalized population were represented. Move away from one-size-fits-all standard of care. Care to our most vulnerable clients is not adequate and does not meet the professional standards of accessibility, universality, and patient-centredness. Health care services were experienced as stigmatizing and shaming particularly for those with SUD. Could lead to abandonment of care. Healthcare system not accountable to them. Care with dignity, trust and compassion important. Presence of an advocate significantly enhanced care patient received.
	Rastegar & Fingerhood (2016)				Published textbook on addiction medicine
11 qualitative articles using a metasumma ry approach	Renbarger, Phelps, Brand & Broadstreet, 2021	To review healthcare interactions between nurses and women with perinatal substance use disorders.		Descriptive Review	6 types of conflicts: distressing, condemning, inadequate care, rejecting, deficient knowledge, and dissatisfying. Two types of therapeutic interactions: supportive and compassionate. Findings point to the importance of enhancing knowledge of addiction, managing stigma, and promoting

Participants	Author (Year)	Purpose/Background	Strength/Weaknesses	Methods/Study Design	Summary/Limitations
					best practices when caring for mothers and children.
32 participants	Rowlands, Youngs, & Canter (2020)	Agency and communion were explored in the context of recovery		Interviews and analysis	This study suggests the importance of agency and connection in identity change and growth in recovery from SUD.
77 studies	Rudzinski, McDonough, Gartner & Strike (2017)	A review of the literature on resilience in the context of SUD		Scoping literature review	Current ideas of resilience are too narrow to apply to lives of those experiencing SUD.
Increased RN perceived competency with SUD patients (N: 57)	Russell, Ojeda, & Ames (2017)			Pre-class, post-class, Quasi-experimental	Nurses benefit from continuing education on addiction
35 previous individuals who used cocaine and 35 individuals who never used.	Sanchez, Ortega, Arias, Madoz, Miangolarra & Palacios (2019)	To assess fine motor control in individuals with cocaine use in past history		Observational study	Deficits in fine motor control and dexterity found in group with past cocaine use.
12 indigenous mothers living on reserve	Schultz, Teyra, Breiler, Evans-Campbell & Pearson (2018)	To explore indigenous mothers' approaches to recovery		Community based participatory research approach	Requirement of 1) trauma-informed care, 2) culturally-based interventions, including community, 3) more integration of treatment with Child Protective Services, 4) motherhood can be a motivation for recovery
7 young adult service users	Semb, Tjora, & Borg (2019)	Explores what young DD clients find challenging		Qualitative in-depth interviews. Empirical study	Acceptance of one's own life and being caught between conflicting social worlds. fumbling in choices and actions. Community based invalidation occurs when young adults are defined as inadequate which invalidation becomes a barrier to recovery.
99 inpatient for alcohol use disorder	Senn, Odenwald, Sehrig, Haffke, Rockstroh, Pereyra-Kroll, Menning, Wieber, Volken & Rosner (2021)	This study is using the transtheoretical model to explore its efficacy in motivation for change		Observational study	motivation for change contributes to the prediction of treatment outcome using the transtheoretical model for change (predictive value for addiction is inconsistent).
12 nurses	Snow & Wynn (2018)	Nurses were trained through simulation of opiate withdrawal management		Pretest post test	Veterans (with cooccurring PTSD and opiate use disorder) showed decreased concern about their withdrawal management after clinicians were trained.
6 patients	Solberg & Naden (2020)	The meaning of dignity for SUD patients	The patients' point of view	Descriptive and interpretive	Physical dignity was important. Respectful care and attitudes. Treat SUD with understanding and respect. Dignity can be marred through stigmatization and lack of knowledge.
Carriers of Pain: vulnerable meetings between staff & clients with a dual diagnosis	Sorsa (2019)				Approving of clients as people is a way to increase positive regard
	Stecher (2015)	The anatomy of a resentment tool is built for long-term recovery		Peer reviewed Literature review on long-term recovery	Not much literature exists about long-term recovery. The anatomy of backward looking mind states is explored. Work with resentments and encourage cognitive restructuring of self-narrative.
26 participants	Stevens, Hubbard, & Leutwyler (2020)	To evaluate a 12 week fitness and health program collocated with treatment facility		Grounded theory methodology	The program is an aide for recovery, provides physical benefits, and helps the clients feel like they are part of a community. Treatment centers should provide fitness programs and vocational training programs should continue to be looked at.
Why Policies Fail: the illusion of services in	Strach, Zuber & Perez-Cheques (2020)		Strength: this study has the voices of people in SUD as well as policy makers and program deliverers	87 open ended interviews and observed task force meetings	Policy itself does not address the actual underlying problem. Solutions can be misplaced and hide evidence of problem.

Participants	Author (Year)	Purpose/Background	Strength/Weaknesses	Methods/Study Design	Summary/Limitations
the opioid epidemic. 87 participants					
N: 47 people diagnosed with SUD and a treatment setting	Stuebing Lorenz, & Littlefield, 2020	To critically review the treatment program "Literacy Free 12-Step Expressive Arts Therapy" program	Self-described methodological challenges despite promising results.	Pre-session/Post-session	Few programs offer integrated treatment. 12-step guidelines CBT Rational emotive behaviour therapy and expressive arts therapy increase personal investment in recovery
"State of the Art" review of the last 15 years	Szerman, & Peris (2018)			Peer Reviewed review	Broad overview of this field and vision of the future for addictions treatment. Speaks of precision medicine in mental health and addictions treatment.
11 participants	Thompson (2016)	Case study of meaning-centred therapy practiced at addiction treatment facility		Mixed methods, pre-post test design, researcher field notes, psychiatry reports and participants' stories. Thematic analysis	Measured meaning acquisition and symptom reduction. Therapy influenced developing self-definition, interpersonal relatedness, and intrinsic motivation. Quantitative analysis showed increases meaning and decreases in daily problems. About 6 to 9 months posttreatment, reported sobriety since discharge, fewer negative symptoms and goal achievement.
The substance use intervention team 880 patients were consulted	Tran, Swoboda, Perticone, Ramsey, Thompson, Hill & Karnik (2021)	A hospital based substance use intervention team was implemented and analyzed.		Analysis of Intervention: Implementation of a hospital based SUIT team.	Improved access to SUD treatment for all hospitalized patients. Decreased length of stay. 30-day readmission rate decreased. Reduces barriers to access to care
244 individuals	Tsavou & Petkari (2020)				Emotional Intelligence and personality traits do play a role in SUD, Prevention programs important for people who occasionally use drugs, and therapeutic interventions for people with use disorders, specifically working with levels of neuroticism and enhancing the ability of regulating the negative emotions.
347 healthcare professional	VanBoekel, Brouwers, Weeghel & Garretsen (2014)	To assess attitudes of health care professionals toward individuals who use substances		Linear regression analysis (ANOVA) Questionnaire	More familiarity with SUD, more contact of working with this patients with SUD, and more knowledge in treatment is more positively associated with regard. Addictions specialists showed higher regard. Education might address low regard.
430 participants of youth receiving drug treatment	Vatanasin & Dallas, 2022	To assess the role of self-stigma and those who are in ten treatment centres for drugs	All participants were male and in compulsory treatment.	Cross-sectional study using a predictive correlational design	Nurses should focus on enhancing self-esteem and reducing stigma
	Wason, et al, 2021			Peer reviewed. Literature review and core competencies created	This document forwards Addiction Nursing Competencies due to the lack of formal tools to guide nurses in caring for individuals with SUD.
6 participants	Webb, Clayson, Duda-Mikulin & Cox (2022)	To add to the conversation of growth over recovery	voices from those who have experienced SUD over four years of recovery	Framework analysis from video and audio interviews and diary-style narratives	Provides insight into identity growth in longer-term recovery. This is important to know as clinicians help in maintaining behaviour change. (Early: Passive/Staying safe, Mid: Exploring/Transitional, Later: Self-determined/Agentic)
111 undergraduates	Yu, Tong, Leung, Chin & Lee (2021)	The exploration of the correlation of humility and Substance use		Event sampling and longitudinal study	humility a protective factor against substance use.
268 people 166 were drug dependent 120 had no addiction history	Zareban, Bkhshani, Mohsen, & Bakhshani (2017)	Investigating emotional difficulty in people who are drug dependent		Cross-sectional study	People who use drugs are different in 5 ways 1) nonacceptance of emotional responses, 2) difficulty engaging in goal-directed behaviors, 3) difficulty in impulse control, 4) limited access to emotion regulation strategies, 5) and lack of emotional clarity
38: control group	Zhang & Zhu (2020)	To test the effectiveness of moderate exercise on		Parallel control experiment	Increased the overall sense of health, vitality, and mental health, trait anxiety, and reduced drug craving.

Participants	Author (Year)	Purpose/Background	Strength/Weaknesses	Methods/Study Design	Summary/Limitations
38: exercise group		individuals in substance abuse rehabilitation			

APPENDIX G: ARECCI SCREEN

ALBERTA INNOVATES

arecci

ARECCI Ethics Screening Tool Report

arecci.albertainnovates.ca

Form Submitted: 29/04/2022

This does not constitute / represent a formal ethics ruling. Individuals are advised to additionally follow the policies or consult their local ethics authority. ARECCI helps project leads address and mitigate ethical risks by providing decision support tools, training opportunities, and project ethics consultation. albertainnovates.ca/programs/arecci/

Scoring Explanation

Score Result	Risk & Recommended Ethics Review
47 or Greater	**Definitely greater than minimal:** Organization's recognized review process* using ARECCI Ethics Guidelines for Quality Improvement and Evaluation Projects. *Review by a duly constituted group independent of the project team, that is trained to do project ethics reviews and whose decisions are recognized by the organization.
8 - 46	**Somewhat more than minimal:** Second Opinion Review** using ARECCI Ethics Guidelines for Quality Improvement and Evaluation Projects. **Review by an individual trained to do project ethics reviews who has no vested interest in the outcome of the project.
0 - 7	**Minimal:** Project leader uses ARECCI Ethics Guidelines for Quality Improvement and Evaluation Projects

Project Details

Project Title: Elevating Capacity with Individuals with Substance Use Disorder: A Model to Guide Nursing Practice in the Concurrent Setting

Your score is 10

The project involves Somewhat More Than Minimal Risk and should be reviewed by a Second Opinion Reviewer.

Type of Project

- Quality Improvement

APPENDIX H: ALBERTA HEALTH SERVICES RECOVERY-ORIENTED CARE

Harm Reduction

Recovery-Oriented Care

A recovery-oriented approach uses strategies to empower people to use their strengths and skills to help them lead the life that they choose when experiencing substance use and mental health issues.

Harm reduction is closely linked to recovery-oriented care

Harm reduction is founded on kindness, compassion, and caring. A harm reduction approach includes policies, programs, and practices that aim to reduce the negative consequences of using psychoactive substances, without necessarily reducing substance use itself.

Using a recovery-oriented approach, we empower people experiencing substance use and mental health issues to use their strengths and skills to live the life they choose. Empowering a person often includes a harm reduction approach, where their choices are supported and they are treated with dignity and respect.

Key recovery terms

A **recovery goal** is individually defined. It involves a person living a satisfying, hopeful, and contributing life, even when they may be experiencing ongoing symptoms of mental health illness or substance use. A person's recovery goal may not include abstinence.

Recovery is realized when a person reaches their recovery goal. Recovery is self-defined and looks different from one person to the next. Recovery may not necessarily mean abstaining from substance use.

A **recovery journey** is a process of change on the way to reaching an individual's recovery goal. The person has increasing responsibility and control of their life to improve health and wellness, and move towards hope and a positive identity.

Recovery-oriented care involves healthcare providers working with individuals and their families to reach their chosen recovery goals. Healthcare providers build on personal strengths and skills to enhance health outcomes and quality of life. This includes a broad range of activities that are person-centred and promote resilience.

> Recovery-oriented services do not address addictions and mental health problems sequentially, do not use exclusion criteria or impose treatments.
>
> Recovery-oriented practitioners and providers in both mental health and addictions services **work with people at whatever happens to be their current state** and respect the choices, autonomy, dignity and self-determination of service users.
>
> They see to people's safety and offer support for harm reduction, positive risk-taking and continual personal growth.
>
> **Mental Health Commission of Canada**

Components of recovery

"Components of Recovery Wheel" adapted from the American Psychological Association

For more information, visit www.ahs.ca/harmreduction or contact the Harm Reduction Services Team at harm.reduction@ahs.ca

Alberta Health Services

Harm Reduction

Reducing Stigma

Two key strategies for addressing harmful, high-risk substance use or substance-use disorder include reducing stigma and harm reduction. People will continue to experience harm from substance use if stigma prevents them from seeking help.

What is stigma?

- A complex social process of labeling, stereotyping, devaluing, and discrimination
- Occurs on multiple levels:
  - intrapersonal (self-stigma)
  - interpersonal (relations with others)
  - structural (discriminatory or exclusionary policies, laws, and systems)
- Includes negative attitudes and the negative behaviours that result from those attitudes

> Negative attitudes (prejudice) and negative behaviour (discrimination). These attitudes and judgments can affect how we think about, behave and provide care to clients.
>
> **Alberta Health Services**

The impact of stigma

- Stigma impacts care, treatment, and recovery from a mental health condition or substance use disorder.
- People living with mental illness or substance use say the stigma they face is often worse than the illness itself.
- People are dying alone because of the shame and stigma of substance use.

Stigma prevents people from seeking help.

What does stigma look like?

- Biases
- Distrust, anger, or fear
- Stereotyping
- Labeling
- Avoiding
- Discriminating
- Shaming

The role of healthcare providers

Small things can make a big difference and help a person feel hopeful and supported.

- Listen.
- Show compassion.
- Be understanding.
- Be kind.

Myths that contribute to stigma

- People living with a mental health condition or substance use disorder are dangerous.
- People who use substances are lawbreakers.
- Addiction is just a lack of self-control.
- Addiction is a moral failure.
- Stigma does no harm.

For more information, visit www.ahs.ca/harmreduction or contact the Harm Reduction Services Team at harm.reduction@ahs.ca

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Approaches to reduce stigma

- **Think of the patient as a person first.** Recognize the courage it took for them to seek help. Separate the person from the condition that brought them to you for care.
- **Know the facts.** Educate yourself and others about mental illness and addiction.
- **Be aware of your attitudes and behaviours.** We can change the way we think and act. See people as individuals, not as labels or stereotypes.
- **Focus on the positive.** Recognize and applaud people who are making positive changes despite their challenges.
- **Advocate for patients and their families.** Treat people with dignity and respect.
- **Include everyone.** Ensure people with mental health and substance use problems are given equal opportunities to take part in their own care.

Choose your words carefully

One way to reduce stigma is to change the way we speak about people who use substances and substance use itself.

- **Use people-first language.** Refer to the person before describing their behaviour or condition.
- **Use language that reflects the medical nature of substance use disorders.** Avoid terms that suggest that addiction is a moral or personality failure, rather than a medical issue.
- **Use language that promotes recovery.** Be optimistic, supportive, and respectful of people's autonomy.
- **Avoid slang and idioms.** These terms can have negative meanings and be stigmatizing.

Instead of saying this:	Say this:	Rationale:
• Substance/drug abuse • Problematic use • Misuse	• Substance/drug use • Substance/drug dependence • Substance/drug consumption • Substance use disorder (if diagnosed)	• Does not imply judgment
• Substance/drug user • Addict • Junkie • Druggie • Abuser	• Person who uses substances/drugs • Person with substance use disorder (if diagnosed) • Person with lived/living experience with substance use	• Refer to people as people first, not their use • Literal and neutral terms
• Person who is clean • Person who has been clean • Former addict • Former abuser • Former junkie • Former druggie	• Person in recovery • Person who is sober • Person who is abstinent • Person who has lived experience with substance use • Person no longer using substances	• Literal and neutral terms that do not imply judgment (for example, if someone is "clean" when sober, they must be "dirty" when using)
• Relapse	• Return to use	• Does not imply judgment
• Clean drug screen • Dirty drug screen	• Negative drug screen • Positive drug screen	• Medically accurate and neutral • Avoids slang

For more information, visit www.ahs.ca/harmreduction or contact the Harm Reduction Services Team at harm.reduction@ahs.ca

Alberta Health Services

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APPENDIX I: CURRENT CONCURRENT DISORDERS PROTOCOL (CDP) ON ACUTE PSYCHIATRY, CHINOOK REGIONAL HOSPITAL, LETHBRIDGE, ALBERTA

Care Plan for Patient on Concurrent Disorders Protocol

1. Change of hospital pyjamas and slippers
2. Belongings will be searched
3. Close Observation
4. No visitors for 24 hours
5. Meals will be eaten in the common areas
6. Participate in the completion of the Nursing Data Base and ASSIST assessment of alcohol and substance abuse

Day 1-5

1. Close observation (exactly 120 hours from time of arrival on Psych unit). (Needs a Doctor's Order to be on General Observation after the 1100 hours.
2. Meals will be eaten in the common areas
3. No passes
4. No visitors in patient's room
5. Participate in individual substance abuse counselling with nurses and/or social worker
6. Assessed for and expected to attend and participate in groups

Day 6 Until Discharge

1. Observation level consistent with behaviour and assessment
2. Urine Drug Screen on return from passes
3. Meals will be eaten in the common areas
4. No visitors in patient's room
5. Continue to participate in individual substance abuse counselling with nurses and/or social worker – emphasizing establishing goals and relapse prevention strategies
6. Continue to attend and participate in group therapy
7. Participate in discharge planning and arrangements for follow-up discharge

Care Plan for Patient on Concurrent Disorders Protocol

1. Change into hospital pajamas and slippers.
2. Belongings will be searched.
3. Close Observation/No passes for exactly 120 hrs.
4. No visitors for 24 hrs.
5. Meals will be eaten in the common areas.
6. Participate in the completion of the Nursing Data Base.

Days 1-5

1. Close Observation for 120 hrs starting from the time you arrive on the unit!
2. Urine Drug Screen on return from pass.
3. Meals to be eaten in the common areas.
4. No visitors in the Patient's room.
5. Continue to participate in individual substance abuse counseling - emphasizing establishing goals and relapse prevention strategies.
6. Continue to attend and participate in group therapy.
7. Participate in discharge planning and arrangements for follow-up discharge.

Concurrent Disorders Protocol Checklist

Date	Start	Day 1	Day 2	Day 3	Day 4	Day 5
Exact Time on Unit Hours		24 hrs.	48 hrs.	72 hrs.	96 hrs.	120 hrs.
In hospital attire						
Belongings Searched						
Close Observation						
No Visitors						
Meals in Common Area						
Nursing Data Base Complete						
Fax referral to Addiction Services						
No Passes						
No visitors in Room						
Scheduled Group Attendance						

Day 6 - Until Discharge

Day of Hospital Stay	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11
Group Attendance						
May Request a physician's order for DSU if alcohol or substance use while on pass is suspected						

APPENDIX J: PROJECT MANAGEMENT STRATEGIES

Project Management Strategies

The proposed model to guide nursing practice in the concurrent setting has been synthesized based on the literature review that has been completed. An oral presentation has taken place for the Alberta Health Services Addiction and Mental Health Concurrent Practice Community of Practice. Feedback has been received from that group. The presentation was also given via PowerPoint to the Manager of Acute Psychiatry, and the Educators for AHS Addictions and Mental Health South Zone, including Lethbridge and Medicine Hat. It was also sent to the Assistant Head Nurse for the Medical Detox at Chinook Regional Hospital.

This project is using the Critical Path Project Management Method. This method was chosen, as per Levy, Thompson & Wiest, (1963), because: 1) the tasks are well-defined that have an eventual end to the project, 2) the tasks are independent of one another, and 3) the sequenced tasks need to be done in a certain order. See Table 1 for the sequence of tasks and expected timeline. The Logic Model for this project is also included in this document for reference to prevent program drift (see Table 3). See Figure 1 to see tasks up to the project presentation.

Table 1:

Sequence and Expected Timeline

Job	Description	Immediate Predecessors	Time
A	Continuation of Project		
B	Presentation to Community of Practice Partners on May 16, 2022	A	90 minutes
C	Record feedback from presentation	B	90 minutes
D	Send information from presentation to Manager of Acute Psychiatry, AHN at Medical Detox, and Educators in AHS South Zone for feedback.	B	Allow Feedback until May 27, 2022

Job	Description	Immediate Predecessors	Time
E	Continue implementing received feedback into updated PPM	C & D	Have completed by May 29
F	Update PPM and finalize design for feedback from end-user (nurses in concurrent settings)	E	Have completed by May 31
G	Get it produced (printed)	F	Have deliverable in-hand by June 10
Out of town from June 1-5 while the deliverable is being printed			
H	Develop evaluation form in conjunction with Evaluation plan	E	By June 10
I	Give to nurses in concurrent settings with evaluation form. Give to peer recovery worker for feedback with evaluation form.	H	June 11
J	Feedback Received from Nurses.	I	Ask for feedback by June 20
K	Implement Evaluation Strategies	J	By June 27, 2022
L	Reflection on the project	K	Continuous
M	Develop Project Presentation	L	By July 3, 2022
N	Present Project	M	July 3-9, 2022
O	Paper is written and send paper for review from writing centre, for peer review and peer-review another's paper	N	July 17-July 23
P	Final Paper writing and send for review	O	Send for review from Silvia by July 23
Q	Return of Review and Turning in of Final Draft	P	August 6
R	Be available for further revisions	Q	August 7-29
S	Have all documents submitted, including final draft submitted to Jackie at AHS Addictions and Mental Health Concurrent Practice Office, Manager of Acute Psychiatry, and the AHN of Medical Detox.	R	August 30
T	End of project	S	

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