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# COMORBIDITY OF ALCOHOL AND MENTAL HEALTH: ADDRESSING ACCESS TO DUAL DIAGNOSIS TREATMENT CENTERS AND THE PERCEIVED EFFECTIVENESS

Annmarie M. Scott

*Master of Social Work*, anniez1234@gmail.com

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COMORBIDITY OF ALCOHOL AND MENTAL HEALTH: ADDRESSING  
ACCESS TO DUAL DIAGNOSIS TREATMENT CENTERS  
AND THE PERCEIVED EFFECTIVENESS

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A Project  
Presented to the  
Faculty of  
California State University,  
San Bernardino

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In Partial Fulfillment  
of the Requirements for the Degree  
Master of Social Work

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by  
Anmarie Monroe Scott

June 2017

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Approved by:

Dr. Armando Barragan, Faculty Supervisor, Social Work

Dr. Janet Chang, Research Coordinator

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## ABSTRACT

The purpose of this study was to examine the comorbidity of substance use disorders and mental illness: Addressing access to dual diagnosis treatment centers and the correlation of perceived effectiveness. The research project was conducted in collaboration with California State University, San Bernardino, (CSUSB) and the Master in Social Work Program. The study used a survey designed with items that measured the participant's perception of availability and effectiveness of dual diagnosis treatment centers. A quantitative study was conducted using a fixed choice response and data was analyzed on an interval measurement scale. Frequencies and cross tabulations were used to present participant's answers. 86.7% of respondents perceived that they benefited from a dual diagnosis treatment center. All respondents perceived they were better equipped to manage their alcoholism after treatment, were better equipped to manage their mental illness after treatment, and better equipped to be a contributing member of society after treatment. The findings of this research may contribute to social work's knowledge of treating comorbidity by providing insight into the factors that contribute to individual's effectiveness in regards to post dual diagnosis treatment.

## ACKNOWLEDGEMENTS

A huge thank you to my amazing parents. Thank you for never giving up on me and believing in me when I did not believe in myself.

And to my baby girl, Emma Jo, you are the air I breathe. Words cannot express the love that I have for you. You, my dear, are my motivation to leave this world better than I found it. Always remember, you can accomplish anything you put your mind to. And always strive to “be the change you wish to see in the world.”

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## CHAPTER ONE

### INTRODUCTION

#### Problem Statement

Co-occurring disorders pertaining to substance use disorders (SUD) and mental illness negatively affect thousands of Americans, while contributing heavily to the health burden in the United States. Co-occurring disorders (COD) have become increasingly recognized as prevalent, difficult to treat, and requiring specialized treatment services (Gotham, Claus, Selig, Homer, 2009). There are many consequences of undiagnosed, untreated and/ or under treated co-occurring disorders, these include a higher likelihood that an individual suffering from COD will experience homelessness, incarceration, medical complications, and early death (Substance Abuse and Mental Health Services Administration (SAMSHA),1, 2015).

#### Substance Use Disorder- Alcohol

In 2014, 139.7 million Americans over the age of 12 reported current use of alcohol consumption, 60.9 million reported binge drinking, and 16.3 million reported heavy use of alcohol within the past month (NSDUH, 2015). Alcohol Use Disorders (AUD's) are characterized as the harmful consequences of repeated alcohol use, a pattern of compulsive alcohol use, which can result in physiological dependence on alcohol (NSDUH, 2015). According to the 2015 National Survey on Drug Use and Health (NSDUH), 15.1 million adults ages 18

and older had AUD. Of these 15.1 million adults, only 8.3 % received AUD treatment at a specialized dual diagnosis treatment facility in 2015 (NIAA, 2017). Alcohol abuse is the third leading preventable cause of death in the United States, killing nearly 88,000 people annually and contributes to an array of negative economic, social and health care outcomes (SAMSHA,2, 2015).

### Mental Illness

Mental illness affects how individuals relate to others and their decision making. Mental illness comes in a variety of forms; anxiety, extreme changes in mood or reduced ability to focus and behave properly, auditory and/or visual hallucinations, or false beliefs about reality (SAMSHA,1, 2015). Mental illness is typically diagnosed when a person's ability to function has decreased and these behaviors interfere with their daily functioning (SAMSHA, 1, 2015). According to SAMSHA, serious mental illness is having, at any time throughout the past year, a diagnosable, mental, behavioral, or emotional disorder that has caused serious functional impairment, which has considerably interfered with or limits one or more of the individual's major life activity(s). Serious mental illness includes; major depression, schizophrenia, bipolar disorder, generalized anxiety disorder, as well as other mental disorders that cause an individual serious impairment (SAMSHA,1, 2015). In 2014, there were an estimated 9.8 million adults 18 years old and older who had been diagnosed with a serious mental illness in the past year (SAMSHA,1, 2015). Individuals with serious mental illness are more likely to

encounter homelessness, unemployment, and incarceration compared to those without a mental illness (SAMSHA,1, 2015).

### Comorbidity

According to SAMHSA (2016), a co-occurring disorder (COD) is the coexistence of both a mental health and substance use disorder. Comorbidity is also referred to as a co-occurring disorder (COD), and/ or dual diagnosis (SAMSHA,1, 2015). There is not one specific combination of substance use disorder in combination with mental illness that uniquely specifies a co-occurring disorder (SAMSHA,1, 2015). Co-occurring disorders may include any combination of two or more substance use disorders and mental illness that are recognized in the Diagnostic and Statistical Manual of Mental Disorders, Fifth edition (SAMSHA,1, 2015). People with mental illness are more likely to experience a substance use disorder than individuals not affected by a mental disorder (SAMSHA,1, 2015). According to SAMSHA, approximately 7.9 million adults, had a co-occurring disorder in 2014. Co-occurring disorders can be difficult to treat due to the complexity of the overlapping symptoms (SAMSHA, 1, 2015). It may be difficult to distinguish whether an individual's mental illness is the byproduct of a substance use disorder or whether it was present before. According to SAMSHA, it is common for one disorder, either mental illness or substance use disorder to be addressed while the other is left untreated.

According to Ronald C. Kessler, primary mental illness disorders strongly predict later substance use disorder. Mental illness and substance use disorders

co-occur much higher than at chance levels (Kessler, 2004). With the number of people who suffer from substance use disorders and the number of patients struggling with mental illness, it would be quite impossible for these numbers not to overlap. It must be taken into consideration that there are many people who would benefit from a dual diagnosis treatment but never receive the opportunity due to lack of available treatments centers and resources. According to the National Survey of Substance Abuse Treatment Services (N-SSATS) there is an alarming rate of individuals suffering from co-occurring disorders, approximately 45% of Americans seeking SUD treatment have been diagnosed with a co-occurring mental illness (SAMHSA, 1, 2015). Only about 50% of all patients who need help for both issues ever get the treatment they need (SAMHSA, 1, 2015).

Currently, there is extensive research on the benefits of co-occurring treatment centers. However, there is still little research on individual's access to dual- diagnosis treatment centers and the perceived effectiveness. This area of research is currently understudied, and this study will contribute in increasing knowledge in this area of social work.

#### Purpose of the Study

The purpose of the research study was to address individual's access to dual- diagnosis treatment centers and the perceived effectiveness. In looking at the field of comorbidity in mental health and substance use, there is a significant problem, a lack of dual- diagnosis treatment centers. Studies of diagnostic patterns sampled in the general population carried out in recent years in the

United States as well as elsewhere in the world, have consistently concluded that mental illness and substance use disorders co-occur much higher than at chance levels (Kessler, 2004). Individuals suffering from a mental illness are more likely to experience a substance use disorder and individuals with a substance use disorder are more likely to have a mental illness when compared to the general population (SAMHSA, 1, 2015).

Derived from knowledge that there are not sufficient dual-diagnosis treatment centers, it is important to understand this problem further if our society is to be successful at providing adequate services to those suffering from comorbidity. Research needs to be utilized to guide professionals in how to best address the most effective treatment for individuals with dually diagnosed disorders.

The overall research method implemented in this research study was quantitative. This research design was selected to ensure anonymity in the survey. The survey was self-administered through an online survey service.

### Significance of the Project for Social Work

The need for this study arose from the researcher's desire to create more awareness for the need of dual diagnosis treatment centers. The findings of this research may contribute to change in social work practice by creating an awareness of the critical importance of having an integrated treatment approach when treating COD patients. Integrated treatment requires collaboration from various disciplines. Integrated treatment planning addresses both mental health

and substance abuse problems. Integrated treatment is associated with lower costs and better outcomes which can be seen through reduced substance abuse, decrease in psychiatric symptoms, fewer hospitalizations, increased housing stability, fewer arrests, and improved quality of life (SAMSHA,1, 2015). There is a growing recognition within the mental health, medical and psychosocial treatment community of the importance of identifying comorbidity simultaneously in both mental health and substance abuse disorders.

## CHAPTER TWO

### LITERATURE REVIEW

#### Introduction

Throughout the various fields in social work, social workers will find themselves encountering clients with co-occurring disorders. The Epidemiologic Catchment Area study (Regier et al., 1990) found that the prevalence of substance abuse in individuals with a severe mental illness was between 30% and 60%. Given the high prevalence of co-occurring substance abuse and mental disorders, most social workers will at some point in their career work with an individual who is suffering from a COD. There is lack of education and training regarding treating individuals with COD, as a whole, the majority of social workers are ill-prepared to adequately assess and treat individuals with COD despite the high prevalence of clients diagnosed with a COD.

Considering social workers are on the front lines in many treatment and service settings, it is imperative that they be prepared adequately assist clients who are suffering COD. Because the high prevalence of COD among the populations social workers predominantly serve, it is in poor practice to be unprepared in identifying, treating, and/or referring clients with co-occurring disorders. While not all social workers need to be experts in co-occurring disorders, it would be ethical to prepare and educate social work students in this area.

Because each system of treatment has traditionally been separate from each other, it has been extremely difficult for people who have a COD to receive the appropriate care they need because historically these two treatment programs have been addressed separately, rather than simultaneously. It is imperative that individuals with COD receive treatment from a treatment program that has expertise in both areas. Recently there has been an increasing number of substance use disorder treatment programs that are equipped to treat COD, however there are still not enough treatment centers available to individuals suffering from COD.

It is important to implement integrated treatment services, as well as to expand integrated services that address both issues of addictive behaviors and psychiatric disorders (Petrakis et al., 2002). Petrakis, Gonzalez, Rosenheck, and Krystal (2002) suggest that many individuals entering mental health or substance abuse treatment programs have other psychosocial issues that need to be addressed but that many of these individuals with comorbid disorders do not receive the integrated services they need. The increasing rates of comorbidity combined with low rates of appropriate treatment facilities available for individuals, provides substantial evidence that integrated treatment services for COD clients are direly needed (Petrakis et al., 2002).



## Psychiatric Conditions

Social workers working with alcohol use dependent patients are frequently faced with the difficult task of assessing their patient's psychiatric conditions. Professionals must be cognizant when assessing the patient's psychiatric conditions, as heavy drinking associated with alcoholism can coexist with, contribute to, or result in the form of several different psychiatric syndromes (Shivani, et al., 2002). There are common diagnostic difficulties associated with comorbidity of alcoholism and other psychiatric disorders. The psychiatric conditions observed in the context of excessive alcohol consumption are divided into three sub categories; alcohol-related symptoms and signs, alcohol-induced psychiatric syndromes, and individual psychiatric disorders that co-occur with alcoholism (Shivani, et al., 2002). These psychiatric conditions often make it difficult to identify whether a client is suffering from an alcohol-related psychiatric symptom or an alcohol-induced psychiatric symptom, as opposed to those who are suffering from a primary, independent psychiatric disorder (Shivani, et al., 2002). These diagnostic difficulties transpire due to the obscuring of alcohol related symptoms or alcohol-induced psychiatric syndromes that are initially indistinguishable from the independent psychiatric disorders they mimic (Shivani, et al., 2002). Alcohol abuse can cause signs and symptoms that mimic psychiatric disorders both during intoxication as well as during withdrawal. These mimicking symptoms can last for weeks, and can lead to the premature labeling and misdiagnosing of a patient's primary problem (Shivani, et al., 2002). Shivani,

Goldsmith and Anthenelli (2002) discuss the implementation of a diagnostic algorithm when evaluating a patient's psychiatric complaints, to be aware that alcoholism may be a contributing factor. This may be difficult because there tends to be a lack of honesty from patients regarding their alcohol consumption. Many patients tend to deny, minimize, and seldom volunteer information about their alcohol use and associated problems when presenting their psychiatric complaints (Shivani, et al., 2002)

### Treatment Program Models

Leading up into the 1980's, there were two general approaches to the treatment of co-occurring disorders that dominated the treatment setting. The first approach, the sequential treatment, directs clients to access specific treatment in one system before entering treatment in another (Drake & Mueser, 2000). The second approach, the parallel treatment approach, directs clients to pursue independent treatments in each of the separate systems, mental health and substance use (Drake & Mueser, 2000). Both approaches place the burden of integrating services solely on the clients rather than on the providers, while ignoring the need to correct the broken system (Drake & Mueser, 2000). In the mid 1980's there was a shift from these traditional dual- diagnosis treatment services to the formation of integrated treatment; combining mental health and substance abuse services. At the core of integrated treatment is the concept that the same team of clinicians, who work in one setting, provide both mental health and substance abuse treatment (Drake & Mueser, 2000). In this setting,

clinicians are responsible for tailoring and combining treatment for the co-occurring client (Drake & Mueser, 2000).

According to Drake and Mueser (2000), more than 100 studies indicate that clients with COD are more likely to be associated with higher rates of negative outcomes, such as; severe financial problems, unstable housing and homelessness, medication noncompliance, relapse, re-hospitalization, violence, legal problems, incarceration, depression, familial problems and high rates of sexually transmitted diseases.

The establishment in 1992 of the Center for Substance Abuse Treatment (CSAT), an agency of the United States government, a part of the Substance Abuse and Mental Health Services Administration (SAMHSA), within the United States Department of Health and Human Services (DHHS) was established in an effort to expand the availability of effective treatment and recovery services for individuals suffering from substance use disorders (SAMHSA 3, 2016). The CSAT mission is to promote high quality, effective treatment and recovery services (SAMHSA 3, 2016). CSAT is funded by the Substance Abuse Prevention and Treatment Block Grant Program. CSAT supports SAMHSA's free treatment referral service which links people to community-based substance abuse treatment services. Despite the CSAT block grant funding for community-based treatment, there continues to be limited funds. The CSAT block grant is the county's primary source of monetary allowance for these services. This single block grant is intended to provide detox, hospitalization, inpatient and outpatient

services to all persons seeking services. Due to the lack of available treatment centers, once individuals are screened and assessed, they are placed on a waiting list to receive services. This lack of readily available treatment centers can deter individuals from pursuing help because they do not want to wait, so in turn they decide not to pursue treatment anymore. The National Institute on Drug Abuse (2012) states that addiction treatment is more likely to be pursued if it is readily available when an individual is ready to seek it. When an individual is seeking COD treatment through Riverside and Bernardino Counties, there is typically a 2 to 12 week waiting list. The reason for this long wait stems from a lack of funding for the Departments of Alcohol and Drug Services. This lack of funding restricts the number of beds these counties can purchase from contracted COD treatment centers for Medi-Cal clients to utilize.

### Limitations

The current limitations on research surrounding the comorbidity of alcoholism and psychiatric disorders are staggering. Petrakis et al., (2002) concludes that most research on treating alcohol use disorders has systematically excluded people with comorbid psychiatric disorders, resulting in a gap between research and clinical realities. The history of mental health and substance use treatment services have been separated for years. It is common for different organizations to provide either mental health or substance use services, rarely providing these two services simultaneously (Drake & Mueser, 2000). The design and quality of research procedures and data across dual

diagnosis studies are inconsistent. Dual diagnosis research has studied the clinical enterprise of treatments and programs, with little attention to the policy or system perspective (Drake et al., 2001).

The consensus obtained from these studies supports the idea that there is not enough research or emphasis on the importance of recognizing and treating comorbidity. Interventions differ across studies, manuals, fidelity measures are rare, and there is no consensus that exists on specific approaches to treatment, including, detoxification, inpatient services, outpatient services, individual therapy, group therapy, housing, medication assistance, vocational training, case management and re-entry from controlled environments (Drake et al., 2001). The theme throughout the literature review was that there is relatively low cross training on COD for social workers, as well as little mandate on the implementation of screening and assessment tools. Although social workers encounter relatively high rates of individuals with these disorders in their routine practices, they are clinically limited by policy, training and expertise (McGovern, Xie, Sregal, Siembab, Drake, 2006).

Currently addiction treatment centers, programs, and clinicians are challenged to sift through a variety of federal policy recommendations, clinical guidelines, and financial strains (McGovern et al., 2006). According to McGovern et al., (2006) when it comes to providing services to individuals with COD, addiction treatment providers tend to find themselves lost between the vague and the overly particular, making research- to- practice translations difficult. There are

various implications in the research of COD program's effectiveness and implementation. More research on the longitudinal process of implementation is needed, including the effects of organizational factors on implementation of evidence based practice in COD treatment centers (Gotham, et al., 2009).

In 2004, the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index was developed by McGovern and colleagues. This 35-item rating tool for outpatient, residential and hospital -based treatment programs is the closest thing that is utilized among COD treatment centers in the United States (Gotham, Brown, Comaty, McGovern, Clause, 2013). The DDCAT was developed to provide services for clients with co-occurring mental health disorders (Gotham, et al., 2013). The Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) Index was developed as a parallel instrument to the DDCAT. It was created to assess the capability of mental health programs that are not specifically implementing Integrated Dual Disorder Treatment (IDDT). It is a companion instrument to the DDCAT. Allowing for the comparison in the implementation progress at primary mental health and addictions treatment programs (Gotham, et al., 2013) The DDCMHT is evaluated based on an objective scale. The evaluation is based on a site visit which includes semi-structured interviews with staff members from various positions. This evaluation focuses on program documentation, client charts, and ethnographic observation of the environment and setting. The DDCMHT included 35 items across 7 dimensions. All of the items are scored on a five-point scale using benchmarks tied to mental health

services (Gotham, et al., 2013). Each item has objectively defined anchors for the five-point scale. Items in each dimension are averaged and the total score is used to provide an overall indication of dual diagnosis capability (Gotham, et al., 2013).

There were some limitations to this treatment model. The first limitation was that the tested data was generated in only 6 states and 67 programs. Among those 67 programs almost all of them offer only outpatient services, 3 offer only partial hospital services and only 1 was in an inpatient program (Gotham, et al., 2013). According to Gotham et al. (2013), almost all the programs provided services at the mental health service level but only 1\10 provided services at the dual diagnosis capable level. These findings suggest that there is a great deal of work to be done to implement an appropriate amount of COD programs across the country.

### Theories Guiding Conceptualization

The theoretical framework guiding this project is Biopsychosocial Theory. The Biopsychosocial Model was developed by George L. Engel in 1977 (Turner, 2011). This theory states that interactions between biological, psychological, and social factors determine the cause, manifestation and outcome of an individual's wellness and disease (Turner, 2011). This theory offers a holistic approach with patient- centered care at the core. The biological influences on health and illness include genetics, infections, physical trauma, nutrition, hormones and toxins (Turner, 2011). Many mental disorders have an inherited genetic vulnerability.

The psychological component of this theory includes psychological factors that contribute to the development of an individual's health problems (Turner, 2011). These psychological factors include lack of self-control, emotional turmoil, or negative thinking, the social factors of this theory include socioeconomic status, culture and religion (Turner, 2011). The Biopsychosocial Model Theory argues that any one of these factors alone are not sufficient in determining an individual's overall well-being, rather it posits that it is the interplay of all three factors: biological, psychological and social that determine the course of the outcome of an individual's well-being (Turner, 2011). The framework of the Biopsychosocial Model assists in understanding the multiple dynamic components that need to be considered when working with individuals with COD.

### Study Design

Despite widespread endorsement of integrated dual diagnosis services, there continues to be a general failure at the federal and state levels to resolve problems related to organization and financing of dual diagnosis treatment centers. Although there has been emergence of many excellent programs around the country, few, if any large mental health systems have could accomplish the widespread implementation of dual diagnosis services for individuals with COD (Drake et al., 2001). It is important to determine the challenges dually diagnosed clients struggle with at various points in their recovery process, and to address these various issues in an integrated, holistic



way, promoting joint recovery from substance abuse and mental disorders  
(Laudet, et. al., 2000).

## CHAPTER THREE

### METHODS

#### Introduction

The purpose of this chapter is to outline the methods that were administered in this study. The study design, sampling, data collection and instruments, procedures, protection of human subjects and data analysis who were examined. Detailed information on the study provides a purposeful framework that explains the goals of the design and how these goals can be achieved. The overarching goal of this research project was to construct a quantitative assessment of the evaluation of accessible treatment centers and their perceived effectiveness among clients. The rationale for utilizing this methodological approach was based on the lack of previous research in this subject area. The goal of this methodological approach was to lay a foundation for further examination and research in this subject area.

#### Study Design

The purpose of this study was to explore the perceived availability and effectiveness of dual diagnosis treatment centers among adults. Socio-demographic variables included age, education, ethnicity, employment, primary language, marital status and whether client is insured. Clinical variables included mental illness; schizophrenia, mood disorders, anxiety disorders, depression,

personality disorders, delusions and other psychiatric disorders, as well other mental disorders.

The research methodology that was utilized in this research project was quantitative. This research design was selected to ensure anonymity on this self-administered test. The design of the study utilized a set of 20 questions. These questions were formed on existing literature in substance abuse, mental health, dual diagnosis treatment and access to treatment centers. The goal of the research was to collect quantitative data to further explore and examine, identify common themes within the scope of the research topic. Appendix A includes questions that guided this study.

### Sampling

The sample size was 15 adults who identified as having a co-occurring disorder. The sample members represent both men and women, from ages 24-61 years old. The instrument utilized was an online, confidential survey, conducive to the study design and purpose of the study. The sample size as well as the quantitative instrument was sufficient in terms of collecting quantitative data that enables future research. The study used a random purposive sample of individuals suffering from comorbidity of alcoholism and mental illness. The goal of the research was to collect quantitative data that can be further explored and examined to identify common themes, concepts, and ideas within the scope of the research topic.

## Data Collection and Instruments

The data collection in the research project was quantitative. The goal of this data collection was to examine if there are any parallel themes or concepts on comorbidity treatment. Participants were asked to respond to a series of questions regarding this subject area. The implementation of this survey allowed for the use of a fixed choice response, measuring the attitudes or opinions of participants. The construction of the instrument was conducted and based on professional literature which focused on substance abuse, mental illness, and treatment options for comorbid patients.

The instrument used has limitations, based to the fact that the survey scale measurement can be compromised due to social desirability. By offering anonymity on the self-administered questionnaires this should reduce social pressure and may likewise reduce social desirability bias. Questions may be nullified or voided in the future depending on other studies as well as new literature.

## Procedures

A flier was created describing the purpose and goals of the study along with a link to the survey website. A brief summary explaining the study, and instructions on how to access the survey were announced at various Alcoholics Anonymous meetings in the Redlands, California area. This survey was administered through an online survey to ensure participants anonymity. The collection and analyzing of the data was completed in a 2-month time span. The

strengths of this type of data collection in relation to this particular research topic greatly outweigh any of the potential limitations. Firstly, there was no potential risk associated with the nature of the quantitative survey questions. Participants had the right to skip over questions and disclose only what they felt is necessary. Secondly, the quantitative weight and value in terms of implications in the field of social work regarding access to and the treatment outcomes of comorbidity treatment facilities may be beneficial to future research. The data collected was explored and analyzed to understand what types of co-occurring treatment is available and most effective for this population and most importantly, why.

#### Protection of Human Subjects

To protect participants in this study, appropriate precautions took place. Participants were provided an informed consent and confidentiality statement. The informed consent and confidentiality statement provided an in-depth description of the study addressing confidentiality, the purpose of the study, and voluntary participation. The confidentiality statement protected participants from any HIPPA violations. Participants had the ability to skip any questions that they deemed unnecessary or intruding. The statement declared, if at any time the participant did not feel comfortable answering any particular questions within the survey, they had the right to discontinue the survey at any time. This allowed participants to complete the study if desired, but avoid questions they did not want to answer. The consent form provided a designated area for signature. Before the participants could proceed with the study they were required to sign

their name with an X. This provided the participants protection from disclosure of personal information, and agreement to the terms of the study.

### Data Analysis

This study utilized a quantitative analysis procedure. The instrument was used to measure participant's perceptions by asking the extent to which they agreed or disagreed based on particular questions. The data as analyzed on an interval measurement scale. Five ordered responses were employed; strongly agree, agree, neither agree or disagree, disagree and strongly disagree.

The data collected from the questionnaire was entered into the SPSS program. This study utilized univariate descriptive statistics to describe characteristics of the sample. Descriptive statistics results are presented in tables.

### Summary

This chapter provided the methodology that was implemented in the study. The study provided necessary documentation to participants to protect participants from harm and breach of confidentiality. All data was collected through an online survey with appropriate measures taken to ensure privacy. In this chapter the examination of how individuals with co-occurring disorders view access and effectiveness to dual diagnosis treatment centers was addressed through a study design, sampling, creation of an instrument, data collection analysis.

## CHAPTER FOUR

### RESULTS

#### Introduction

The purpose of this chapter is to outline the results of the statistical analyses conducted. The chapter will include a detailed report of the sample and descriptive statistics. The presentation of the findings will summarize the results for the descriptive statistics which include consent to treatment, gender, age, highest level of education, ethnicity, preferred language, employment, insurance, if the participants identify as having a co-occurring disorder, if the participants know of dual diagnosis treatment centers, if the participants have access to a dual diagnosis treatment centers in their community, if the participants attended dual diagnosis treatment center, which type of treatment they received, how the participants paid for treatment, and how they were referred to treatment. The section will also report data tables and percentages of frequencies for the scales and demographics.

#### Presentation of Findings

In this study, there were a total of 15 participants. 80% of the participants were female, and 20% were male. The mean age for respondents was 47.9 (SD = 13.7) years old. 13.3% of the participants reported not having a high school diploma, 6.7% reported obtaining their Associates degree, 20% reported completing some Associate degree, 46.7% report obtaining their Bachelor's

degree, and 13.3% reported obtaining their Master's degree. 73.3% of participants reported being employed, 26.7% of the participants reported being unemployed (See Table 1, Appendix C).

46.7% of participants strongly agreed, 40% agreed, and 13.3% disagreed to the question: Did you benefit from a dual diagnosis treatment center. 46.7% of participants strongly agreed, and 53.3% agreed to the following question: After treatment, do you feel more equipped to manage your alcoholism. 46.7% strongly agreed, and 53.3% agreed to the following question: After treatment, do you feel more equipped to manage your mental illness. 60% of participants strongly agreed, and 40% agreed to the following question: After treatment, do you feel you are better able to be a contributing member of society. 20% of the participants strongly agreed, 46.7% agreed, 20% disagreed, and 13.3 strongly disagreed to the following question: Do you believe that each of your diagnoses (Substance Abuse and Mental Health Illness) were equally addressed in your treatment (See Table 2, Appendix D).

### Summary

A quantitative study was conducted using a fixed choice response and data was analyzed on an interval measurement scale. Frequencies and cross tabulations were used to present participant's answers. 86.7% of respondents perceived that they benefited from a dual diagnosis treatment center. All respondents perceived they were better equipped to manage their alcoholism after treatment, were better equipped to manage their mental illness after



treatment, and better equipped to be a contributing member of society after treatment. A challenge that was found was that only one-third of the respondents felt that their SUD and mental health treatment were not equally addressed in treatment, indicating that there are still challenges when it comes to addressing an individual's COD simultaneously.

## CHAPTER FIVE

### DISCUSSION

#### Introduction

This chapter will present the major findings of the study and their implications for social work practice, policy, education, training, and future research. This chapter will also present the strengths and limitations of the study. Recommendations for future research will be discussed.

#### Discussion

As seen throughout the literature review section, there is a lack of dual diagnosis treatment centers that effectively treatment both parts of an individual's co-occurring diagnosis simultaneously. Previous studies examined the application of traditional substance use treatment to clients with mental disorders within the mental health system. However, these COD treatment programs based in the mental health system were not able to provide effective treatment regarding the complex needs of COD (Thylstrup, B., & Johansen, K., 2009). This current study indicates that effective COD treatment programs combine mental health and substance use interventions tailored specifically to the complex needs of COD clients. To achieve effective treatment for individuals with COD, it is essential that traditional treatment programs modify their parallel treatment services to simultaneous treatment of mental health and substance use disorders (Thylstrup, B., & Johansen, K., 2009).

## Limitations

Due to the anonymity of the participants, several steps had to be taken to protect the identity of all subjects partaking in the survey. This limited the amount of information that could be analyzed due to the inability to explore several correlations on an intrapersonal level. Future research should attempt to include a more diverse sample population in the categories of socioeconomic status, race, ethnicity and gender. Because the sample population was limited to one city meeting, the results found cannot be generalized. A challenge that was found was that only one-third of the respondents felt that their SUD and mental health treatment were not equally addressed in treatment, indicating that there are still challenges when it comes to addressing an individual's COD simultaneously.

## Recommendations for Social Work Practice, Policy and Research

To increase individuals' chances of achieving a full recovery, there are multiple factors that need to be addressed. There are a set of standards that need to be implemented across COD treatment center. Thylstrup & Johansen (2009) recommend the following standards; mental health and substance use disorders need to be regarded simultaneously as primary disorders when they co-exist, each receiving a specific assessment, diagnosis and treatment. Mental health and substance use disorders need to be viewed as chronic, relapsing illnesses addressed from disease and recovery treatment model. The implementation of stage specific treatment for clients is critical to help clients

visualize the stages of treatment they are undergoing. COD treatment should be provided only by individuals, teams, or clinics with expertise in COD. Further research is needed on the longitudinal perspective of dual diagnosis treatment centers, as well as specific components such as admission criteria, continuum of care, simultaneously addressing mental health and substance use disorders, and lastly further research is needed to secure financial support and stability from the state and local counties fiscal and administrative systems.

### Conclusion

The challenge lies in availability and effectiveness of COD treatment. The COD field has been limited by a lack of national, standardized data. There is a need for the development of nationally standardized criteria in the creation of COD treatment centers across the nation. Without standardized treatment criteria, there will continue to be a lack of effective COD treatment centers. There needs to be continuous research on the overall benefits of treatment, as evidenced by client's post-treatment success in regarding to; maintain sobriety, their general health, being able to be contributing members of society, their improved relationships, and other evidence based measurable outcomes.

APPENDIX A  
INFORMED CONSENT

### Informed Consent

The study in which you are asked to participate is designed to examine access to dual diagnosis treatment centers for adults living in the San Bernardino County. The study is being conducted by Annmarie Scott, as a graduate student, under the supervision of Dr. Armando Barragan, Assistant Professor in the School of Social work at California State University, San Bernardino (CSUSB). The study has been approved by the Institutional Review Board Social Work Sub-committee at CSUSB.

**Purpose:** The purpose of the study is to examine the perception of access to dual diagnosis treatment centers in San Bernardino County among adults.

**Description:** If you agree to participate in this study, you will be asked to participate in the survey online via Survey Monkey. You will be asked basic demographic questions and you will be asked to rate your knowledge of access to dual diagnosis treatment centers and your perceived effectiveness of dual diagnosis treatment centers.

**Participation:** This survey is completely voluntary. You can choose to skip questions you do not wish to answer or withdraw from the survey at any time, with no consequences.

**Confidentiality or Anonymity:** Surveys are submitted anonymously through an internet survey provider (Survey Monkey) and IP addresses will not be collected during the survey.

Confidentiality will be maintained to the extent permitted by technology. No guarantee can be made regarding the tracking or interception of responses by any third party. By completing this survey, you are agreeing to the provided informed consent. All survey responses will be kept on an encrypted flash drive in a locked file for three years. After the third year, the researcher will destroy them.

**Duration:** If you decide to participate in this study, you will be given 20 questions over 1 survey. The survey should take no more than 20 minutes to complete

**Risks:** There are no foreseeable risks to the participants.

**Benefits:** There are no direct benefits to you for participating in the research. On a larger scale, information you provide will add to the knowledge base of professional social work.

**Contact:** If you have any questions about this study, please feel free to contact Dr. Barragan at (909) 537-3501

**Results:** Results of the study can be obtained from the Pfau Library ScholarWorks database (<http://scholarworks.lib.csusb.edu/>) at California State University, San Bernardino after July 2017.

This is to certify that I have read the above and I am 18 years or older.

Place an X mark here \_\_\_\_\_

\_\_\_\_\_ Date

California State University, San Bernardino  
Social Work Institutional Review Board Sub-Committee  
APPROVED 6/13/16 VOID AFTER 6/30/17  
IRB CHAIR

909.537.3500

5500 UNIVERSITY PARKWAY, SAN BERNARDINO, CA 92407-2393

APPENDIX B  
DATA COLLECTION INSTRUMENT

## Survey Questions

1. Do you give consent to treatment?
  1. Yes
  2. No
  
2. What is your gender?
  1. Female
  2. Male
  3. Transgender
  
3. How old are you?
  
4. What is your highest level of education?
  1. Received high school diploma
  2. Did not receive high school diploma
  3. Received an associate degree
  4. Completed some associate courses
  5. Received a college diploma
  6. Received a master's degree
  7. Received a doctorate
  
5. What is your ethnicity?
  1. Caucasian
  2. African American/ Black
  3. Mexican/ Latin
  4. Asian
  5. Native American
  6. Middle Eastern
  
6. What is your primary language?
  1. English
  2. Spanish
  3. Arabic
  4. Cantonese
  
7. Are you employed?
  1. Yes
  2. No
  
8. Do you have insurance?
  1. Yes
  2. No



9. Do you identify as having both a substance abuse disorder and a mental health issue, also known as a dual diagnosis? (Mental Health Illness includes but is not limited to: anxiety, borderline personality, bipolar disorder, depression, PTSD, schizophrenia)
1. Yes
  2. No
10. Do you know about dual diagnosis treatment centers?
1. Yes
  2. No
11. Do you have access to a dual diagnosis treatment center in your community?
1. Yes
  2. No
12. Have you attended a dual diagnosis treatment center?
1. Yes (If you answered Yes, answer questions 13 & 14)
  2. No
13. Was your treatment:
1. Inpatient
  2. Outpatient
  3. Both
14. Did you pay for your treatment with your own money or primarily through insurance?
1. Own money
  2. Insurance
15. Were you referred to a dual diagnosis treatment center? If yes, by whom?
1. Family Member
  2. Friend
  3. Work
  4. Physician/ Health Provider
  5. Court Mandated
16. Did you benefit from a dual diagnosis treatment center?
1. Strongly Agree
  2. Agree
  3. Disagree
  4. Strongly Disagree

17. After treatment do you feel more equipped to manage your alcoholism?

1. Strongly Agree
2. Agree
3. Disagree
4. Strongly Disagree

18. After treatment do you feel more equipped to manage your mental illness?

1. Strongly Agree
2. Agree
3. Disagree
4. Strongly Disagree

19. After treatment, do you feel you are better able to be a contributing member of society?

1. Strongly Agree
2. Agree
3. Disagree
4. Strongly Disagree

20. Do you believe that each of your diagnoses (Substance Abuse and Mental Health Illness) were equally addressed in your treatment?

1. Strongly Agree
2. Agree
3. Disagree
4. Strongly Disagree

Developed by: Annmarie Monroe Scott

APPENDIX C  
DEMOGRAPHICS OF PARTICIPANTS

Table 1. Demographics of Participants

| Variable                            | Frequency | Percentage |
|-------------------------------------|-----------|------------|
| <b>Gender</b>                       |           |            |
| Female                              | 12        | 80%        |
| Male                                | 3         | 20%        |
| <b>Education</b>                    |           |            |
| Did not receive high school diploma | 2         | 13.3%      |
| Received an associate degree        | 1         | 6.7%       |
| Completed some associate courses    | 3         | 20%        |
| Received a college diploma          | 7         | 46.7%      |
| Received a master's degree          | 2         | 12.5%      |
| <b>Employed</b>                     |           |            |
| Yes                                 | 11        | 73.3%      |
| No                                  | 4         | 26.7%      |
| <b>How Treatment was paid for</b>   |           |            |
| Private Pay                         | 4         | 26.7%      |
| Insurance                           | 11        | 73.3%      |
| <b>Source of Treatment</b>          |           |            |
| Inpatient                           | 8         | 53.3%      |
| Outpatient                          | 4         | 26.7%      |
| Both                                | 3         | 20%        |
| <b>Referral</b>                     |           |            |
| Family                              | 8         | 53.3%      |
| Friend                              | 2         | 13.3%      |
| Physician                           | 3         | 20%        |
| Court Mandated                      | 2         | 13.3%      |
| Work                                | 0         | 0%         |

APPENDIX D  
EFFECTIVENESS OF TREATMENT

Table 2. Effectiveness of Treatment

| Variable  | Frequency | Percentage |
|---|-----------|------------|
| <b>Did you benefit from a dual diagnosis treatment center?</b>  |           |            |
| Strongly Agree  | 7         | 46.7%      |
| Agree   | 6         | 40%        |
| Disagree  | 3         | 13.3%      |
| Strongly Disagree   | 0         | 0%         |
| <b>After treatment do you feel more equipped to manage your alcoholism?</b>   |           |            |
| Strongly Agree  | 7         | 46.7%      |
| Agree   | 8         | 53.3%      |
| Disagree  | 0         | 0%         |
| Strongly Disagree   | 0         | 0%         |
| <b>After treatment do you feel more equipped to manage your mental illness?</b>   |           |            |
| Strongly Agree  | 7         | 46.7%      |
| Agree   | 8         | 53.7%      |
| Disagree  | 0         | 0%         |
| Strongly Disagree   | 0         | 0%         |
| <b>After treatment, do you feel you are better able to be a contributing member of society?</b>   |           |            |
| Strongly Agree  | 9         | 60%        |
| Agree   | 6         | 40%        |
| Disagree  | 0         | 0%         |
| Strongly Disagree   | 0         | 0%         |
| <b>Do you believe that each of your diagnoses (Substance Abuse and Mental Health Illness) were equally addressed in your treatment?</b> |           |            |
| Strongly Agree  | 3         | 20%        |
| Agree   | 7         | 46.7%      |
| Disagree  | 3         | 18.8%      |
| Strongly Disagree   | 2         | 13.3%      |

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