2009

Seriously mentally ill clients' perspectives on substance use and treatment

Ann LaVerne Jankowski

SERIOUSLY MENTALLY ILL CLIENTS' PERSPECTIVES ON SUBSTANCE USE AND TREATMENT

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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ABSTRACT

Individuals with co-occurring disorders of serious mental illness and substance use suffer from two daunting illnesses, each complicating recovery from the other. They are at a greater risk of negative consequences such as hunger, homelessness, frequent hospitalizations and suicide, and face barriers and challenges to treatment, such as denial, lack of motivation and hopelessness.

The purpose of this study was to interview individuals with co-occurring disorders, who attend Dual Diagnosis Anonymous groups, to obtain their perspectives on the consequences and effects of substance use on their mental illness and their lives; their participation in and evaluation of treatment, and their willingness to stop, reduce, or continue to abstain from substance use.

Study findings revealed that 73 percent of the interview participants were in recovery from substance use, experienced most of the negative consequences described above, as well as what they have identified as the benefits of substance use, and are committed to participation in treatment.

ACKNOWLEDGMENTS

To my mother, who has always been "the wind beneath my wings," and who I miss more than I can say.

To my dear husband, Steve, who has been patient and supportive and has had to learn to cook so we wouldn't starve.

To my children, grandchildren, brother, sisters, nieces and nephews, grandnieces and nephews and friends, who have been understanding during these two years, when my absences in their lives have been frequent and regretted.

To the 15 study participants who generously shared their stories and perspectives, and without whom this study would not exist.

To my thesis advisor, Dr. Caroline McAllister, whose guidance, support and encouragement were appreciated and gave impetus to the completion of my thesis.

To Dr. Davis whose class engaged my interest in substance abuse issues to the extent of inspiring my thesis subject.

To Gene Maingot, my field instructor, who has been an excellent role model in teaching me how to be the best possible clinician, which I hope to be some day.

TABLE OF CONTENTS

CHAPTER ONE

INTRODUCTION

Problem Statement

This study explores the perspectives of seriously mentally ill clients on substance use and treatment. Client input is essential to understanding how to best serve a population that suffers from co-occurring disorders of serious mental illness, such as schizophrenia, bipolar disorder and major depression, and substance use. With about 51% of the clients experiencing these co-occurring disorders, this is a social issue that merits the attention of social work practice (Alvidrez, Kaiser, & Havassy, 2004; Brooks, Malfait, Brooke, Gallagher, & Penn, 2007).

Suffering from both serious mental illness and substance abuse, these clients are at a greater risk for negative consequences than if they had only one of the disorders. They also face considerable challenges and barriers to obtaining effective substance abuse treatment (Brooks et al., 2007; Gonzalez, Bradizza, Vincent, Stasiewicz, & Paas, 2007; Laudet, Magura, Vogel, & Knight, 2000).

The negative consequences are many. Seriously mentally ill individuals with a co-occurring substance disorder are at risk of intensified psychiatric symptoms, hunger and homelessness, (Alvidrez et al., 2004; Dumaine, 2003), medication noncompliance, suicide, violence, unemployment, incarceration, and increased risk of HIV and other medical illnesses. They are also more likely to be hospitalized and frequently use emergency rooms (Drake et al., 2001; Klein, Cnaan, & Whitecraft, 1998; Swartz & Lurigio, 2006).

Despite the seriousness of these consequences, which would suggest a need for substance abuse treatment, there are challenges and barriers to treatment. The clients with co-occurring disorders present a number of challenges. The more severe the client's mental illness, the less likely they are to be aware of the need for treatment, and to have the ability to accept and engage in it (DiClemente, Nidecker, & Bellack, 2008). Even with less severe symptoms, clients with co-occurring disorders may deny substance abuse problems because they don't want to stop using, they lack the motivation to address their problems or they feel hopeless (Drake et al., 2001; Mericle, Alvidrez, & Havassy, 2007). Treatment can also

be challenged by the tendency of clients with co-occurring disorders to be noncompliant with medication, to be likely to relapse, to have social and financial problems, and to avoid the daily struggles of recovery (Brooks et al., 2007).

In a study by Brooks et al., (2007), consumers with co-occurring disorders of mental illness and substance abuse provided their perspectives during focus groups on treatment provided by two agencies serving them, one fully integrated and the other partially integrated. At the agency or macro level, consumers identified system barriers, which included poor therapeutic environments, system navigation difficulties, lack of treatment integration, and medication issues. Their view of the staff at the micro level was that they failed to establish rapport or trust, there were frequent case manager changes, and the major focus was on substance abuse which detracted from mental health issues.

In treating clients with co-occurring disorders, it is not only the clients who may be frustrated with treatment limitations. Providers, at the micro level, also feel a sense of frustration, and sometimes hopelessness related to both the clients' behavior,

specifically denial of substance abuse and lack of motivation, and system and environmental barriers. Diminished resources from the State and federal governments often result in limited access and short term, poor quality treatment, when the seriously mentally ill clients with substance abuse disorders require long term, integrated treatment (Drake et al., 2001; Mericle et al., 2007).

Environmental barriers also hinder substance abuse treatment. Clients frequently live in poverty and drug-infested neighborhoods, surrounded by drug users and dealers. Providers would like to offer quality services, but the barriers are stacked against them, and they end up feeling burned out (Brooks et al., 2007; Mericle et al., 2007).

Ideally, treatment for clients with co-occurring disorders would be fully integrated, providing both mental health and substance abuse treatments by therapists, who are trained in integrated treatment interventions (Center for Substance Abuse Treatment, 2005). These interventions could include, but would not be limited to assertive outreach, motivational interviewing, group counseling, intensive case

management, and residential treatment. The clients' goals and treatment preferences would be incorporated to the extent possible (Brooks et al., 2007; Drake et al., 2001; Sacks, Chandler, & Gonzales, 2008).

Purpose of the Study

The purpose of this study was to obtain knowledge from the clients' perspectives on their co-occurring disorders of serious mental illness and substance abuse, and their treatment experiences. It provides valuable data on clients' perceptions of the positive and negative aspects of drug use, the extent to which they believe substance use is a problem in their lives, acceptability of substance use, positive and negative treatment experiences, and willingness to stop, reduce or continue to abstain from substance use.

This information is of particular importance because, although much has been written on co-occurring disorders in the last few decades, there has been less of a focus on seriously mentally ill clients with co-occurring substance abuse disorders. This has been a difficult population to treat, due to more challenges and barriers and poor treatment outcomes, if treatment is

received at all (Alvidrez et al., 2004). Studies have speculated as to the reasons that individuals with serious mental illness use substances. Some indicate that it is a means of self-medication. Others report that these clients use substances for some of the same reasons as the general population, which include anxiety, boredom, loneliness and insomnia (Drake & Mueser, 2000).

Much is still to be learned about why those with serious mental illness use substances, which is one of the issues addressed in this study. Acquisition of knowledge in this area contributes to developing or adapting treatments, which may be effective in addressing co-occurring disorders.

To achieve this end, a qualitative study of clients with co-occurring disorders of serious mental illness and substance abuse, using an interview guide adapted from a similar study by Alvidrez et al. (2004) has been completed. This guide includes demographics and questions related to the effects of substance use on the mental illness and the lives of the clients, and their treatment experiences. Four interview questions were added which are related to why the clients use substances, the types of substances used, the effects of substance use on their

medications and whether they are willing to engage in treatment or are currently engaged in treatment to stop, reduce or continue to abstain from substance use.

A convenience sample of 15 clients was used for this study. Volunteers were solicited from Dual Diagnosis Anonymous (DDA) meetings held in Los Angeles, Orange and Riverside counties. DDA is a 12-step program for clients with co-occurring disorders of serious mental illness and substance use.

Significance of the Project for Social Work

The study obtained qualitative data from seriously mentally ill clients regarding reasons for substance use; its effects on mental illness, medication compliance and quality of life; treatment experiences, and motivation to stop, reduce or continue to abstain from substance use. It was important to obtain this information, because co-occurring disorders of serious mental illness and substance abuse are prevalent, and more data is needed on this population to develop effective treatment interventions.

The study findings provide social work practice with a better understanding of the clients' perspective of

their co-occurring disorders. Direct knowledge of the challenges and barriers facing these clients, and their attitudes toward substance use and treatment, can assist social workers in finding or adapting treatments for this population that will meet their specific needs, and achieve better treatment outcomes. Client input could also potentially result in policy changes that will improve treatment services.

On a macro level, and in the generalist phase of advocacy, the data could be used by social workers to advocate for the development of a workable plan to integrate mental health and substance abuse treatment services. This plan could better meet the treatment needs and improve outcomes for clients with co-occurring serious mental illness and substance abuse disorders. The findings from this study may also have the potential to inform micro social workers in the generalist phases of engagement and assessment, planning and implementation for these clients.

The research questions addressed are: 1) do severely mentally ill clients recognize the negative consequences of substance use on their mental health and lives, 2) do they have a history of treatment and 3) are they willing

to stop, reduce or continue to abstain from substance use?

CHAPTER TWO

LITERATURE REVIEW

Introduction

Co-occurring disorders of serious mental illness and substance abuse, also referred to as dual diagnoses, began to be recognized in the 1970s (Center for Substance Abuse Treatment [CSAT], 2005). For the last two decades, research on co-occurring disorders has been significant in size, and has focused mainly on prevalence, the problems and challenges, and the effectiveness of treatments. However, research of co-occurring disorders is still considered somewhat new, and more research is needed to build on existing literature to further understanding of co-occurring disorders of severe mental illness and substance abuse, and to improve treatment for those who suffer from these disorders (Sacks, Chandler, & Gonzales, 2008).

For the purposes of this study, there was sufficient literature in the areas of consequences and treatments of co-occurring disorders. However, there was less research on the perspectives of the clients on their co-occurring disorders, which further supports the purpose and need

for this study (Drake, O'Neal, & Wallach, 2008; Sacks et al., 2008).

Consequences of Substance Use by the Seriously Mentally Ill

The literature reflects a consensus of the dire consequences of co-occurring disorders. Those with co-occurring disorders are more likely to be homeless (Alvidrez et al., 2004; Bradizza & Stasiewicz, 2003; Drake & Mueser, 2000; Dumaine, (2003); Klein, Cnaan, & Whitecraft, 1998). A meta-analysis by Dumaine (2003), of 15 studies of individuals with serious mental illness and a substance disorder, found that almost 80% of the clients were homeless. Not only are clients with these co-occurring disorders more likely to be homeless, they are homeless longer, have the highest levels of victimization, and the lowest level of income. They suffer from more chronic and acute medical conditions and are less likely to get treatment. They are more likely to go hungry. It is difficult for them to meet even their most basic needs (Brooks et al., 2007; Burt, Aron, Lee, & Valente, 2001; Dumaine, 2003).

Similar to the higher frequency and more severe impacts of homelessness, clients with co-occurring

disorders experience more serious consequences in many other areas of their lives than those with only one of the disorders. These include the intensification of psychiatric symptoms, which can result in frequent hospitalizations, incarcerations, violent behavior or even suicide, and the impairment or severing of family and social relationships. The consequences extend to unemployment, medication noncompliance and HIV and other sexually transmitted diseases (Drake & Mueser, 2000; Dumaine, 2003; Gonzalez, 2007; Klein et al., 1998). Most aspects of the lives of those with severe mental illness are adversely impacted by a co-occurring disorder of substance abuse.

Client Perspectives on Co-Occurring Disorders

Although there is value in the clients' perspectives to better understand the complexities of their co-occurring disorders of serious mental illness and substance abuse, there is a scarcity of recent studies in this area. However, there are five studies which focus on aspects of clients' views of co-occurring disorders.

A study by Alvidrez et al., (2004) queries clients about their attitudes on drug and alcohol use, and how it

impacts their mental illnesses and their lives. Although the interview instrument includes questions related to treatment, the findings did not address this area, other than to list the treatments in which the respondents participated. Research by Bradizza and Stasiewicz (2003) focuses solely on the triggers identified by the severely mentally ill that lead to substance abuse. Brooks et al., (2007) obtained consumer perspectives on their treatment experiences as they relate to system barriers, and consumer challenges and needs. Laudet, Magura, Vogel, and Knight (2000) discuss interview results from individuals with dual diagnoses of mental illness and substance abuse, who attend Double Trouble in Recovery (DTR) meetings. The findings relate to drug and alcohol use, mental health, the relationship between substance abuse and mental health, and treatment. Quimby (1995) reports on the views of homeless clients, with dual diagnoses of severe mental illness and substance abuse, regarding their recovery experiences in one of two integrated treatment programs.

Among the five studies, similarities were apparent in the findings related to client recognition of the consequences of substance use, socioeconomic issues in

recovery and the effectiveness of treatment. No obvious differences were identified.

There was some agreement among the participants in three of the studies that substance abuse negatively impacted their mental illness. Most of the respondents in the study by Alvidrez et al. (2004), agreed that substance abuse made psychological symptoms worse, particularly for those with bipolar disorder and schizophrenia. However, somewhat contradictorily, they believed that marijuana was helpful in addressing such symptoms as anxiety, depression and lack of motivation. Participants in the Bradizza et al. (2003) study were divided with some never using drugs or alcohol when experiencing psychiatric symptoms, because they became worse, contrasted by others who were more likely to use substances when encountering symptoms related to their mental illness. The extent of the difference is unknown, as the study did not include numbers or percentages. In the Laudet et al., (2000) study, 69% of the participants reported that symptoms related to their mental illness became worse when they used drugs or alcohol, while 44% had a greater urge to use substances when they were experiencing symptoms.

Socioeconomic issues were mentioned in three studies as barriers to recovery. Participants in the Brooks et al. (2007) study described the hopelessness they sometimes feel in trying to recover from substance abuse, because they are faced with so many other negative factors such as poverty, social isolation, lack of housing and transportation, and other resources. Subjects in the Laudet et al., (2000) study shared similar frustrations, citing isolation, lack of housing, work and money problems as contributing to their relapses. The Quimby (1995) study identifies social forces such as housing issues, deteriorating communities, broken families and relationships, and a lack of resources as contributing to substance abuse among the homeless mentally ill.

In the two studies that focused on treatment, clients expressed their views on the effectiveness of the treatment. The most frequently client-cited treatment problems in the Brooks et al., (2007) study included: poor service coordination; lack of understanding of the difficulties of mental illness that the clients face, and which can interfere with treatment; pressure to achieve abstinence and non-acceptance of relapse, and failure to

integrate mental health and substance abuse services. Participants also felt the case managers were negative. Similar comments were made by participants in the Quimby (1995) study. They felt they were "infantilized" and "depersonalized" by treatment staff, and that their case managers were disrespectful, untrusting, unsupportive, too controlling and did not effectively link them to services.

As this was a three year project, client relationships with their case managers improved in the second and third years, when trust was established and clients felt more respected and valued. Staff and clients both experienced positive growth as the project progressed (Quimby, 1995).

Treatment Issues for Co-Occurring Disorders

The issues related to effective treatment for the clients with co-occurring disorders are client challenges, the effectiveness of treatment interventions and the availability of integrated treatment. Treating this population is a challenge, because they have two serious primary diagnoses, are often non-compliant with their medication, and experience the socio-economic

stressors described above (Alvidrez et al., 2004; Brooks et al., 2007; DiClemente et al., 2008).

Due to the severity of their illnesses, they have difficulty meeting even their basic needs. Often they are in denial of their substance abuse problems and lack motivation to address them. Given these obstacles, it is not surprising that engaging and retaining these clients in treatment is frequently unsuccessful (Brooks et al., 2007; California Department of Alcohol and Drug Programs [ADP], 2006; Dumaine, 2003).

Another issue is that despite an increasing number of research studies of comprehensive, integrated dual diagnosis treatment programs, there is no consensus on the effectiveness of these programs for clients with co-occurring disorders of severe mental illness and substance abuse (Alvidrez et al., 2004; Brooks et al., 2007; DiClemente et al., 2008).

Drake et al., (2008) completed a systematic review of 45 controlled studies of psychosocial dual diagnosis interventions, which were grouped into eight categories. It was concluded that three of these categories might work for the dually diagnosed: group counseling, contingency management and long-term residential

treatment. However, while most of these three integrated interventions help decrease substance use to some degree, for the most part they do not show results on mental health outcomes (Drake et al., 2008).

The final issue is the availability of integrated treatment for clients with co-occurring disorders of serious mental illness and substance abuse. Few programs which address both disorders are available. Successful programs for this population are costly, as these individuals can take months or years to recover (Drake & Mueser, 2000).

Due to the cost, the time required, the unresponsive of this population to treatment, and competition for limited funding, advocacy is needed to access funding and to make a case to the mental health and substance abuse departments to move toward integrating their services. (Drake et al., 2001; Drake & Mueser, 2000; Drake et al., 2008; Dumaine, 2003; Mericle et al., 2007).

12-Step Programs as an Alternative Treatment

As the interview participants in this study are all members of Dual Diagnosis Anonymous, a review of this type of 12-step group is in order. The systematic review

by Drake et al. (2008) did not focus specifically on 12-step groups as a potential treatment for individuals with co-occurring disorders. Yet, there is support for these types of groups, particularly those that integrate mental illness and substance abuse, such as Double Trouble in Recovery (DTR) and Dual Diagnosis Anonymous.

A study by Laudet, Magura, Vogel, and Knight (2000) of DTR participants concluded: "Persons with higher levels of support and greater participation in dual-recovery mutual aid reported less substance use and mental health distress and higher levels of well-being" (p. 457). However, the impact on mental health was less apparent, as is the case with other similar research studies

A study by Magura et al. (2003) of a similar population focused on four factors related to DTR, internal locus of control, sociability, spirituality and hope. The findings identified a positive correlation between locus of control and sociability, and abstinence and healthy behavior. Spirituality and hope only correlated with healthy behavior, which very importantly includes medication compliance.

Two additional studies also support the use of 12-Step programs which include a dual diagnosis focus. The first is a two-year longitudinal study by Laudet et al. (2004) that found attending DTR meetings is positively correlated with abstinence, and that attending AA or NA meetings along with DTR produces an even higher level of abstinence. The baseline abstinence rate was 54 percent. It increased to 72 percent after one year, and 74 percent after two years.

The second study is a consumer evaluation of DTR meetings by Magura, Villano, Rosenblum, Vogel, and Betzler (2008). On a 10 point scale, participants rated the value of their participation in DTR at a mean of 7.8. Survey results indicated that participants also improved significantly in the areas of self-esteem and self-efficacy. Another important contributor to recovery from co-occurring disorders was the support of peers.

Theories Guiding Conceptualization

The recovery model, systems theory and the biopsychosocial perspective guide this study. The recovery model is appropriate for individuals with co-occurring disorders of severe mental illness and

substance abuse. It offers recovery even if the disorders are not cured. It replaces hopelessness with hope and optimism that the individual can lead a satisfying and meaningful life, even with the limitations of mental illness and substance abuse (Ramon, Healy, & Renouf, 2007). The recovery model offers the security of stable and safe housing, employment, sufficient income and access to health, mental health and substance abuse treatment. It assists in recovering a sense of self in a way that is safe and nurturing. Although recovery is a unique and personal journey, family, friends and community can support and encourage the individual's quest for recovery. Along the journey, which may not be easy or fast, the sense of empowerment and self-determination are achieved and coping strategies are developed, resulting in a new purpose to life (Repper & Perkins, 2003).

Systems theory can guide the study by providing a framework that allows a comprehensive understanding of all of the barriers, challenges and stressors that face those with co-occurring disorders (Mattaini & Meyer, n.d.). Many times clients with co-occurring disorders experience disconnects with other systems in their

environment, such as families, employment and community. Repeated interactions are more likely with emergency rooms, psychiatric hospitals, prisons and shelters. The lives of individuals with co-occurring disorders are complex and having a clear and accurate picture of their interactions with the various systems can assist the client in improving interactions with these systems (Zastrow & Kirst-Ashman, 2007).

The biopsychosocial perspective recognizes the interaction between biological, psychological and sociocultural factors. The biological relates to the genetic links to mental illness and substance abuse disorders experienced by individuals with co-occurring disorders. The psychological refers to the traumatic life experiences common to those with co-occurring disorders and the distorted perceptions and faulty thinking of their mental illness. The sociocultural describes the problems in relationships which are common to individuals with co-occurring disorders (Halgin & Whitbourne, 2007). The biopsychosocial perspective also recognizes that there are "multiple types of personalities, with multiple combinations of adverse consequences, with multiple

prognoses, that may require different types of treatment interventions" (Fisher & Harrison, 2008, p. 7).

Summary

The literature presents a picture of individuals who suffer grievously from two daunting disorders, one further complicating recovery from the other. Considerable research has focused on developing treatment models that will meet the needs of this vulnerable population, but a gap exists between research and practice (Brooks et al., 2007; Sacks et al., 2008). Further research on the perspectives of those experiencing the co-occurring disorders of severe mental illness and substance abuse could help bridge this gap. This was the reason and purpose of this study.

CHAPTER THREE

METHODS

Introduction

This study sought to gain knowledge from clients' perspectives on their co-occurring disorders of serious mental illness and substance use, so that this information can be used to develop treatments that more closely meet their needs. Chapter three describes how this information was obtained. It explains the study methods and design, sampling, data collection, procedures, protection of human subjects and data analysis.

Study Design

The purpose of this study is to examine the clients' perspectives on their co-occurring disorders of serious mental illness and substance abuse, and their treatment experiences. The research method used to accomplish this purpose was a qualitative study, which utilized a semistructured interview with open and closed-ended questions. A qualitative approach was used as it provided an opportunity for the individuals experiencing these

co-occurring disorders to express their perspectives and their realities (Grinnell & Unrau, 2008).

Using a qualitative approach limited the generalizability of study findings. However, although the findings cannot be applied to the general population of clients with co-occurring disorders, this study offers new insights. Gaining more knowledge can result in more effective treatments (Alvidrez, 2003; Brooks, 2007).

The research questions for this study are:

1. do severely mentally ill clients recognize the consequences of substance use on their mental health and their lives, and
2. do they have a history of treatment, and
3. are they willing to stop, reduce or continue to abstain from substance use?

Sampling

A convenience sampling method was used for this study. Volunteers were solicited from the Dual Diagnosis Anonymous (DDA) meetings held in the Los Angeles, Orange and Riverside counties. DDA is a 12 step recovery peer support program for people with mental illness and substance abuse problems. It is unique because it

includes five steps designed to aid in mental health recovery. These five steps are: (1) acknowledging and accepting a dual diagnosis of mental illness, (2) accepting help for both disorders, (3) accepting the need for both mental health treatment and abstinence from non-prescription drugs and alcohol, (4) believing recovery can be achieved by joining own efforts with those of God and others, and (5) acknowledging that recovery can be achieved by adhering to the 12 steps of recovery and 5 steps of Dual Diagnosis Anonymous (Dual Diagnosis Anonymous Worldwide Services, Inc. [DDA], 2008.

Convenience sampling was used to select the fifteen individuals from DDA meetings who were interviewed. This sampling method was used because these individuals were readily available and easy to find (Grinnell & Unrau, 2008). They each met the selection criteria of being at least 18 years of age, having a serious mental illness (schizophrenia, schizoaffective disorder, delusional disorder, major depression or bipolar disorder) and were currently using, or were in recovery from alcohol or drug use.

Data Collection and Instruments

Data was collected by asking the participants semistructured quantitative and qualitative interview questions. The dependent variable is clients with co-occurring disorders, and the independent variables are substance use and treatment. As this is a qualitative study, the effects of the variables will be observed rather than measured (Grinnell & Unrau, 2008).

The first set of interview questions (Appendix A) was related to demographic information of age, gender, marital status, ethnicity, education level, and employment status. The second set of questions (Appendix B) asked the participants about their mental health diagnosis and substances used; effects of substance use on mental health problems, symptoms, mental health medications and life problems; and experiences and recommendations regarding substance abuse treatment. The measurement used was nominal level, except for age, which is ratio level.

The interview questions are based on the demographics and interview guide developed by Alvidrez, et al., 2004 for their journal article entitled "Severely Mentally Ill Consumers' Perspectives on Drug Use." It was

e-mailed from Dr. Alvidrez on November 8, 2008 (Appendix C). Some revisions were made to the instrument to better reflect the purposes of this study. Questions were added on why clients use substances, the types of substances used, the impact of substances on mental health medications and whether clients are willing to stop or reduce substance use. Questions deleted were related to how many people with mental health problems use substances, and those related to research projects.

Although no information on the validity and reliability of the instrument is available, the interview guide was effective in providing information to support the Alvidrez et al. (2004) study.

Use of a semistructured interview has some limitations. The disadvantages of this approach include interviewer inexperience and bias, since the interviewer has formulated the research questions. However, these limitations are balanced by the advantages. This interview method is generally used to interview clients, who have shared common experiences, which was the case in this study. The interviewer is knowledgeable of the subject, and the brevity of the instrument will minimize confusion (Grinnell & Unrau, 2008).

Procedures

The data was gathered by the author of the study via face to face or telephone interviews, based on client preference and convenience. Seven clients opted for face to face interviews, and eight for telephone interviews. For those who were interviewed by telephone, the interviewer had face to face contact with them at the DDA meetings prior to the interview. The interviews were recorded in handwriting by the interviewer, and include direct quotations. Participation was solicited by a flyer (Appendix D), which was distributed and discussed at the end of DDA meetings. The interviewer attended the meetings by invitation from the members. Ten dollar gift cards were given to compensate the participants who completed the interview. The interview data was transported in a locked box that is stored in the researcher's home office.

Protection of Human Subjects

There are a number of safeguards that were used to protect the participants in this study. Confidentiality was maintained by coding interview instruments with numbers instead of names. Participants have remained

anonymous. Their names were not used in any aspect of the study. For face to face interviews, each participant was given an informed consent form (Appendix E) to read, discuss and check. For telephone interviews, the informed consent form was reviewed with the participant, and their agreement obtained, before the interview began. The form provided the participants with information on the study. It also advised them that participation was voluntary, that they could stop the interview at any time or decline to answer questions. Following the interview, each participant was given a debriefing statement (Appendix F) to thank them, provide them with the name and contact number of the advisor, and include a place and time when they can view the completed study. For those interviewed by telephone, the interviewer hand delivered the debriefing statement at the next DDA meeting. When quotations are used in this study, the client's name has been altered to protect his or her identity.

Data Analysis

The data from this qualitative study was coded by the researcher using the constant comparison method (Grinnell & Unrau, 2008). The constructs include: reasons

for substance use, the consequences of substance use, beneficial effects of substance use on mental health, negative effects of substance use on mental health, effects of substance use on mental health medications, acceptance of substance use for individuals with mental illness, client treatment experiences, client-identified substance abuse treatment improvements, and decisions to reduce, stop or continue substance use.

Summary

This chapter summarizes the methods used for this study. It is a qualitative study, which included some quantitative questions, and utilized semistructured interviews to elicit the clients' perspectives on their co-occurring disorders. A convenience sample was used to solicit 15 participants, who met the selection criteria. Protection of human subjects was strictly observed. Data was analyzed by the interviewer using the qualitative data analysis process in Grinnell and Unrau (2008).

CHAPTER FOUR

RESULTS

Introduction

This chapter presents the results obtained from this qualitative research study. It provides demographic information, and presents the responses of the 15 interview participants on their perceptions of the consequences and effects of substance use on their mental illness, their participation in and evaluation of treatment, and their intentions to continue with treatment. It also answers the three research questions: 1) whether clients recognize the consequences of substance use on their mental health and lives; 2) whether they have a history of treatment, and 3) if they are willing to continue treatment to stop/reduce substance use.

Presentation of the Findings

Demographic Characteristics

The characteristics of the 15 interview participants are summarized in Table 1. The majority of the research sample is diagnosed with bipolar disorder (66%), with the remainder diagnosed with schizophrenia (20%),

schizoaffective disorder (7%) and major depression (7%). There are more males (60%) than females. The mean age is 46 years old with a range from 26 to 64 years. Most of the participants are White/Non-Hispanic (60%), followed by Latino/Hispanic (26%) and African American (14%). Related to marital status, there is an equal percentage of single (47%) and divorced/separated (47%) participants with six percent married. The education level is almost equally distributed among some high school (20%), high school/GED (27%), some college (27%) and college graduate (27%). The employment status of the sample reflects most not working/disabled (47%), and the remainder working full-time (32%) or looking for work (20%).

Substances Used and Reasons for Use

The questions related to substance use elicited information which was not anticipated. When participants were asked what substances they used, many related that they were in recovery and no longer were using substances. Seventy-three percent were in recovery for periods of time that ranged from six months to 25 years. This is contrary to the literature on co-occurring disorders, which focuses on the many challenges and barriers to achieving abstinence or even a reduction in

substance use. Possible reasons for this relatively high level of abstinence will be addressed in the next chapter.

As recovery from substance use can be viewed as a continuous, lifelong process, which requires active engagement, and can result in relapse (Fisher & Harrison, 2009), the interviewees in recovery answered questions based on their experiences prior to their recovery, as appropriate.

Interview participants reported alcohol (39%), methamphetamines (22%), and marijuana (16%) as the most frequently used substances. Less used were cocaine (13%) and other drugs (10%). Sixty-six percent of the participants used two or more substances.

One example of the five statements made regarding using substances for self-medication is from "Tom," who stated:

> I have always been manic and hyper, and alcohol calms me down. I feel relaxed and that I am fit socially. I was really self-medicating, because for years I didn't know what was wrong with me. I tried alcohol and all kinds of drugs.

Five of the responses identified escape from reality or pain as the reason for using substances, like "David," who remarked:

> If I couldn't deal with something, if I was upset, if I was happy, I would want to drink. It was an escape from reality.

Another five participants gave answers that did not fit into a particular category, such as "Julie's" response:

> I drank for anxiety. It made me feel better. If I drank I could drive. Otherwise, I had too much anxiety to drive.

Consequences of Substance Use

Many journal articles note that individuals with co-occurring disorder are at greater risk for negative consequences and list many of them (Gonzalez, Bradizza, Vincent, Stasiewicz, & Paas, 2007; Brooks et al., 2007; Laudet, Magura, Vogel, & Knight, 2000). The study participants each experienced one or more of these consequences, including losing custody of a child, homelessness, incarceration, hospitalization, intensified psychiatric symptoms, unemployment, suicide attempts, medication noncompliance, serious medical problems,

depression, self-destructive behavior and frequently hearing voices. Responses included:

> When I was taking drugs I wanted to be on the streets and do drugs and not worry about anyone bothering me. Drugs have caused me to be homeless and in and out of jail for many years ("Alberto").
>
> I feel like a failure in life. I have not accomplished what I need to do. I don't have a house. I am not married. I have rationalized using alcohol, but it isn't okay. I have been blacked out for so many years. I'm afraid it is too late to change ("Tom").
>
> I lost custody of my son due to using meth. Using meth also affects my finances ("Lily").

Effects of Substance Use on Mental Health and Psychiatric Symptoms

As demonstrated by the results, participants have mixed feelings regarding the effects of substance abuse on their mental health symptoms. Three of the interview questions, 4, 5, and 6, are related to the participant's perception of whether substance use makes their mental health symptoms better or worse. The first addresses the effect of substance use on mental health problems and

symptoms. The second asks if substance use makes symptoms worse, and the third question whether substance use makes symptoms better.

The first two questions are combined because they are much the same and elicited similar answers. Fifty-three percent of the participants reported that their substance use made their symptoms worse, including a response from "Elena," who said:

> I hear voices more when taking alcohol and drugs. It makes my paranoia and depression worse.

The 27 percent who answered that substance use made their symptoms better included "Maria," who commented:

> It helped with mental health problems before I started taking psych meds.

A response representative of the 20 percent who identified substance use as a mixture of better and worse is from "Tom," who stated:

> The mania gets better but my depression gets worse. But it is the mania that gets me into trouble, so I need the alcohol sometimes.

The third question focuses on whether substance use makes the mental health symptoms better. Seventy-three percent answered better, including "Joyce," who said:

> I told myself this is better. I was afraid to stop [drinking] because depression got so bad. Alcohol helped with depression. It masked everything. Alcohol was a miracle drug.

An example of the responses from the 27 percent, who felt substance use made their symptoms better and worse, is from "David," who explained:

> Drinking made me feel better. I would feel happy, energetic and funny. Then I would get very depressed. It was like living the movie "Days of Wine and Roses."

To determine the clients' overall perspectives on the effects of substance use on their mental health symptoms, the answers from the three related questions were computed. Overall, 50 percent felt that substance use improved symptoms, while 27 percent believed symptoms became worse and 23 percent concluded they were better and worse. These results tip the scale to substance use having beneficial effects, as perceived by these study participants. However, the "worse" comments were stronger than the "better" comments, as participants identified them as directly impacting their symptoms, such as making depression, mania, and paranoia much worse. The "better"

comments did not refer so much to symptoms getting better, but to "feeling good," "more energetic," and "on top of the world."

Effects of Substance Use on Mental Health Medications

A pattern of choosing alcohol and drugs over mental health medications emerges from the responses to this question.

Fifty-three percent of the participants stopped taking their medication when they are or were using alcohol or drugs. "Joyce," who is in this category, said:

> Never took them at the same time. I would go off meds and relapse. Meds don't provide the high. When you are on this high, you can do anything in the world.

One of the 27 percent, who have used both substances and medications together, is "David," who stated:

> Drinking malt liquor and taking my medication together resulted in a bigger high. Don't do it anymore.

The smallest group at 20 percent stopped using the alcohol and drugs in favor of taking their mental health

medications. A member of this group is "Maria," who commented:

> Once I started taking meds, I stopped taking alcohol and drugs. The meds helped get me off the alcohol and drugs.

Acceptability of Substance Use when an Individual has Mental Illness

All 15 participants were totally opposed to mentally ill individuals using alcohol and drugs, even though their previous responses indicate they are or were more likely to choose substance use over mental health medications. Some of their comments include:

> No, people with mental illness already have screwed up heads, and alcohol and drugs just make it worse. But lots of people with mental illness drink and use meth. I used meth for a year, five years ago ("David").
>
> No, not okay at anytime. Alcohol and drugs are mind altering substances. You already have a chemical imbalance. What makes you think you can do both ("Joyce")?
>
> No, not from what has been told to me and what I have read. Alcohol can greatly reduce the effects of

the medication. Taking both at the same time is self-destructive behavior ("Jack").

Treatment Experiences and Evaluation

Participants in the study have a strong commitment to treatment. Table 2 lists the substance abuse, mental health and dual diagnosis treatments in which the participants are involved. Eighty-seven percent receive treatment in all three categories. Thirteen percent did not engage in mental health treatment, other then to obtain medication, but did attend substance abuse treatment and DDA meetings. However, except for one participant who attends a dual diagnosis program at a county mental health center, and another whose psychologist treats both disorders, everyone else relies on DDA for integrated treatment. The mean, mode and median for treatment activities attended per week are four.

Not only are the study participants committed to treatment, their experiences for the most part have been positive. Participants were given a chance to evaluate their treatment experiences by identifying what they like, what they don't like and what they would change. All liked their treatment. Nine of the 15 specifically

mentioned that they liked groups. Representative of the comments are:

> I like the camaraderie. Group members are all ages and share problems. All are working on recovery together ("Alex").
>
> I like treatment because it gives me structure in my life. Helps with life's journey. Explains how mental and physical health affect each other. Helps with day to day problems ("Kate").

Ten participants expressed comments on what they did not like. The opinions were more varied, such as not liking sober living, not enough time with psychiatrist, and too long and repetitive. Examples of their remarks are:

> It is hard. Nothing works. Anxiety has been debilitating. They say pray, but it doesn't work. The sober living house is too crowded - too many guys ("Tom").
>
> Need more time with psychiatrist. There is lack of participation by the psychiatrist ("Max").

When asked how treatment could be improved, 87 percent said it does not need improvement. The two responses recommending improvement are:

It needs to help me stop hearing voices and not relapse anymore ("Elena").

Getting out the word that substance abuse is a response to an illness that is probably a mental illness. Education - tell what problem really is. Need to stop recommending that [AA] group members not take their psych meds. Could and probably have caused death ("Julie").

Continuing Treatment to Stop or Reduce Substance Use

Not surprisingly, based on their current participation in treatment activities, all 15 participants plan to continue treatment. Some of their reasons are:

Yes, because I am committed to the fact that I am dually diagnosed and that I need to cooperate with treatment the rest of my life. It gives me an opportunity to live a normal life. I can enjoy life and make the best of my life ("Jack").

Yes, it is a change of life and you just can't do it for a week. When I left for a year, I started drinking again ("Max").

Answers to Research Questions

Did clients recognize the consequences of substance use on their mental health and lives? The level of client recognition of the consequences of substance use appears to be low. Of the problems mentioned in their lives, none of the study participants identified substance use itself as a problem, and only one-third recognized substance use as contributing to their most difficult problems. Additionally, as discussed earlier in this chapter, study participants identified more beneficial than negative effects of substance use on their mental health symptoms. Yet, if the answers to study question eight on whether substance use is acceptable for individuals with mental illness are included in the computation, the overall participant opinion is that the negatives exceed the positives. Chapter 5 explains why inclusion makes sense.

Do they have a history of treatment? All of the 15 study participants have a history of treatment and are currently engaged in substance abuse and dual diagnosis treatments. Eighty-seven percent are also participating in mental health treatment.

Are the study participants willing to continue treatment to stop, reduce or continue to abstain from

substance use? Yes, all of the participants are strongly committed to treatment and plan to continue. Participants want to continue treatment because it improves their lives, reduces depression, builds self esteem, helps them to do better, and is necessary to stay in recovery, and to live the best life possible.

Summary

Chapter four provided the demographics of the study participants and the qualitative narrative of the research study. It presented the perceptions of the participants related to the substances that they currently use or have used in the past, and the reasons for using; consequences of their substance use; effects of substance use on their mental health, psychiatric symptoms and medication; acceptability of people with mental illness using substances; their treatment experiences and their evaluation of its effectiveness, and whether they will continue with treatment. It also answered the research questions.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter discusses the significance of the study results. The discussion will include comparing findings to studies cited in the literature review and determining if the study results support the research questions. It identifies unanticipated results and possible explanations; discusses strengths and limitations of the study and suggestions for further research; and presents the implications for social work practice and recommendations for the future.

Discussion of Data Analysis

A review of the significant findings of the study reflects 15 interview participants who are mostly white, single or divorced males, in their mid-forties with a bipolar diagnosis, at least some college and likely to be unemployed. Seventy-three percent are in recovery from substance use, and use or have used mainly alcohol, methamphetamine and marijuana to self-medicate or escape from their problems. They have experienced many of the same consequences attributed to those with co-occurring

disorders. While acknowledging the negative effects of substance use on their mental health and psychiatric symptoms, these participants also identify benefits. When using alcohol and drugs, they are or were more likely to stop using their mental health medications than stopping the substances.

Conversely, they are unanimously opposed to people with mental illness using alcohol or drugs. Unusual for many individuals with co-occurring disorders, they are committed to treatment, and participate in an average of four treatment activities each week. Realizing the benefits, they are determined to continue treatment.

The study findings fully support the research questions related to treatment history and commitment to continuing treatment. The answer to the question on client recognition of the negative consequences of substance use on their mental health is not as clear. Nevertheless, based on the discussion and explanation provided in this chapter, an affirmative answer is supportable.

Literature Comparisons

For the most part, the demographics and research findings of this study are consistent with the studies

cited in the literature review. However, there are three areas that differ from the literature findings: the participant recovery rate from substance use, the effects of substance use, and treatment participation. These differences are compared, discussed and explained.

The first major difference is the high recovery rate of 73 percent in this study, which was unanticipated, as clients with co-occurring disorders frequently struggle to achieve abstinence or even a reduction in substance use. This rate is also significantly higher than those in the two studies from the literature review that addressed recovery rates. The respondents in the Alvidrez et al. (2004) study were all using alcohol or drugs, and the percentage of participants in recovery in the Laudet et al. (2000) study is 53 percent.

There are several explanations for the high recovery rate among the participants in this study. The first is age. With a mean age of 46 years old, this study has older participants, as compared to the Advidrez et al. (2004) study with a mean age of 41, the Bradizza and Stasiewicz (2003) study with a mean age of 37 years, and the Laudet et al. (2000) and Quimby (1995) studies which both have mean ages of 39. Age is an important factor

because clients with diagnoses of bipolar disorders and schizophrenia, which closely mirror the diagnoses of this study, improve in the areas of symptoms, behaviors and substance abuse as they age (Drake et al., 2006).

A second explanation is regular attendance by the study participants in DDA and other 12-step groups. A two-year longitudinal study by Laudet et al. (2004) concluded that attending dual diagnosis 12-step groups was positively correlated with abstinence. In conjunction with traditional 12-step groups, such as AA, the level of abstinence increases, although it is not statistically significant. The abstinence rates in the Laudet study (2004) increased from a base rate of 54 percent to 72 percent after one year and 74 percent after two years. Laudet's (2004) rate is consistent with this study.

The level of motivation and readiness of the study participants is a third explanation. This assessment was completed using the stages of change developed by Procaska and DiClemente (1982). Using this framework, two participants are identified as being in the contemplation stage, thinking their substance use might be a problem but not certain they should consider a change. Another two are in the preparation stage, having determined that

their substance use is a problem, and they are getting ready to change. One is motivated to regain custody of her child and the other is going into residential treatment to help her stop using drugs, and to stop the voices she frequently hears. Eleven participants are in maintenance, having achieved stability and are participating in treatment to maintain it. Two in this stage appear to be more likely to go into relapse. One woman in her sixties has been drinking much of her life and loves the high of a manic episode. The other has been in sober living for several years, and is about to go back into the world on his own, which can be a major adjustment. However, as it stands now, 73 percent of the participants are in recovery.

Treatment participation is a final explanation of the high recovery rate of the study participants. As illustrated in Table 2, eighty-seven percent of the participants engage in substance abuse, mental health and dual diagnosis treatment. The remaining thirteen percent engaged in substance abuse and dual diagnosis treatment, but made no mention of mental health treatment. However, the two participants in this category have been in recovery for 19 years and 25 years, and limit their

mental health treatment to psychiatrists for medication. All 15 are actively engaged in treatment and attend a mean of four treatment activities per week.

Another departure from the literature findings, which is contrary to the high recovery and treatment participation rates in this study, is the perspective of the study participants on the effects of substance abuse on their mental health symptoms. Fifty percent felt that it improved symptoms, 27 percent believed symptoms became worse, and 23 percent concluded they were better and worse. This outcome is not consistent with the first two points in a quote cited by DiClemente et al. (2008):

> Co-dually diagnosed individuals with high motivational readiness to change substance use reported more cons and fewer benefits to using substances, reported more substance abuse problems, took more steps toward changing their behavior, and used substances less than individuals who had lower motivational readiness to change (p. 30).

The study participants' perspectives are also counter to the other literature that was reviewed. Even though the Alvidrez et al. (2004) study respondents were all currently using substances and less than half were in

treatment, only 17 percent stated that drug use could improve mental health symptoms. However, there were also an unspecified number of better and worse answers. In the Laudet et al. (2000) study, 69 percent of the participants reported that substance use made their symptoms worse.

While it is not entirely clear why the participants in this study found substance use as improving their mental health symptoms, they have demonstrated the motivation and readiness to attend treatment and go into recovery at a high rate. It could be that although the negative impacts were fewer, they had more of an impact on their lives and symptoms. A review of participant answers, related to the effects of substances on mental health symptoms, indicated that those who identified substance use as making their symptoms worse were directly impacted in terms of making depression, mania, and paranoia much worse. The answers of those, who indicated that substance use made their symptoms better, were vague and referred less to specific symptoms. Some examples are: "drinking made me feel better," "made me feel good," "and made everything go away."

Additionally, the unanimous and resounding no answers, in response to study question eight related to the acceptability of individuals with mental illness using substances, could be added to the "negatives" of using substances. All of the responses referenced the negative aspects of substance use for someone who has mental illness, such as: "alcohol and drugs just makes it [mental illness] worse," "intensifies problems," "you could die from the interactions," and "now I know better, it is not good."

With question eight added, 51 percent of the participants identify symptoms as getting worse, 33 percent as getting better and 16 percent as better and worse. Including the responses to question eight provides a more accurate and comprehensive picture of the study participants' recognition of both the negative and positive aspects of substance use.

Treatment engagement of the study participants is the final divergence from literature findings. Literature quotes regarding treatment for individuals with co-occurring disorders include: "impaired decision-making skills, and the lack of insight diminish the ability to recognize the need for treatment, as well as individuals'

ability to seek and participate in it" (DiClemente et al., 2008), "most dual diagnosis clients have little readiness for abstinence-oriented treatment" (Drake et al., 2001), "comorbidity is a predictor of negative treatment outcomes" (Laudet et al., 2000), and "they [people with co-occurring disorders] are characterized by nonintegration into and noncompliance with treatment delivery systems (Quimby, 1995).These are only a few of the many quotes describing the challenges and barriers individuals with co-occurring disorders experience related to treatment.

Despite these challenges and barriers, the study participants are committed to treatment as evidenced by their active participation and intent to continue treatment. They are 100 percent engaged. This is not the case with the participants in the Alvidrez et al. (2004) study, in which less than half (42%) of the participants were currently in substance abuse or dual diagnosis treatment. However, the Laudet (2000) and Brooks (2007) studies are consistent with this study. In the Laudet et al. (2000) study, 91 percent of the participants are enrolled in mental health or dual diagnosis treatment, and 71 percent in drug or alcohol treatment.

Participation in traditional 12 step programs is the same as this study - 75 percent. The Brooks et al. (2007) study participants were all attending or had recently attended dual diagnosis programs.

This study, and Brooks, et al. (2007) and the Laudet et al. (2000) studies all recruited their participants from dual diagnosis groups or programs, which could explain the high treatment rates. However, it does not explain why they initially engaged in treatment and why they continued their treatment. Age could once again be an explanation, as the road to abstinence, which older participants are more likely to follow, is treatment (Drake et al., 2006) It should be noted that the Brooks et al. (2007) study did not include age, and the Laudet et al. (2000) study had a younger mean age of 39.

Another possible reason for a high level of treatment engagement for this study is that all of the participants had positive comments about treatment. Eighty-seven percent liked the treatments and did not believe improvements were needed, and all planned to continue treatment. The participants in the Brooks (2007) study had many complaints related to treatment, which included: negative reactions to staff; lack of

understanding of the clients; lack of individualized treatment; lack of trust of staff and frequent staff changes. The Alvidrez et al. (2004) and the Laudet et al. (2000) studies did not address the quality of treatment.

In summary, there were common factors in this study, which contributed to the differences identified in the literature comparisons, in the areas of recovery rate and treatment participation. These factors are the older age of the participants, their motivation and readiness, and participation in dual diagnosis groups and other treatments. With effects of substance use on symptoms, it is concluded when looking at all related study questions, the participants did recognize the consequences of substance use on mental illness symptoms.

Limitations

This study has strengths and limitations. Beginning with strengths, the study findings support existing literature on co-occurring disorders in the areas of reasons for substance use, consequences of substance use, effects of substance use on mental health medications, and acceptability of substance use. Very importantly, this study supports the effectiveness of dual diagnosis

12-step groups in increasing abstinence from alcohol and drugs, as 73 percent of the participants are in recovery and active in dual diagnosis groups supplemented by traditional 12-step programs.

Due to the qualitative nature of the study, the use of convenience sampling and the small sample size, the study findings cannot be generalized to larger populations with co-occurring disorders. An additional limitation, related to and preventing generalization, is that all of the interview participants are members of Dual Diagnosis Anonymous 12-step groups. However, the results may be applicable to the population in dual diagnosis programs.

Another limitation is that although 73 percent of the interview participants related that they were in recovery from substance use, and this information became an important part of the study, they were not asked a specific question on recovery. However, this may not be an issue, as Grinnell and Unrau (2008) cited semistructured interviews as "allowing for unanticipated answers from interview participants."

Additionally, the interview participants in recovery answered questions based on their experiences prior to

recovery, as appropriate. Interviews were conducted by telephone (8) and in person (7), based on client preference and convenience, which did not appear to affect the participant responses, but could possibly have had an effect.

Finally, the data from the interview was done by hand-written recording as some of the participants experience paranoia and expressed concern about a audio-recorded interview, and more than half of the interviews were conducted by telephone. For consistency, all were handwritten-recorded, which still allowed verbatim quotes.

Recommendations for Social Work Practice, Policy and Research

From a social work practice perspective, providing services to clients with co-occurring disorders of serious mental illness and substance use can be a challenge. Having information on the demographics and the perspectives of these clients on their co-occurring disorders, provides a client profile and increases understanding of the consequences experienced, and the challenges faced by this vulnerable population. Very importantly, it informs social work practice of client

strengths, such as motivation, acknowledgement of their co-occurring disorders and the willingness to engage and continue in treatment, which can lead to recovery.

Social work practice has responsibility for a number of roles related to assisting clients with co-occurring disorders to achieve recovery from their substance use. By focusing on the clients' recognition of the negative consequences of substance use on their mental health and their lives, their history of treatment and their motivation to stop, reduce or continue to abstain from substance use, this study provides valuable information for social workers that can be utilized to fulfill many of their roles.

The study participants' conflicting recognition of both the positives and the negatives of substance use on their mental illness and their lives is an indication that they could benefit from psychoeducation on substance use and its consequences. This can be provided by social workers in their role of educator.

As identified by this study, there are also roles for social work advocates, case managers and program developers. In the first chapter of this study an ideal integrated treatment for individuals with co-occurring

disorders was described. Extensive research has resulted in the identification of several treatments which are beneficial to those with co-occurring disorders. They include: group counseling; contingency management, which is a behavioral approach which has been effective in helping clients to stay engaged in treatment and reduce substance use, and long-term residential treatment (Sacks, 2008; Petry, 2002). Social workers can both advocate for and develop such treatment programs.

Unfortunately, due to fiscal realities, the availability of these types of integrated treatment programs are generally limited, as was the case in this study. Only two of the study participants were engaged in integrated treatment programs.

A treatment alternative, which could be considered as a covariate in this study, is participation in dual diagnosis 12-step groups, such as Dual Diagnosis Anonymous and Double Recovery in Treatment. All of the study participants attended Dual Diagnosis Anonymous and were positive about their experience, which may have contributed to their high recovery rate. The findings presented in this and the other studies cited indicate that sustained participation in dual diagnosis 12-step

groups is a viable option for treatment, and can significantly contribute to abstinence from substance use. When supplemented by traditional 12-step groups, such as AA, the effect has been found to be even greater. The traditional 12-step groups alone are not correlated with abstinence for those with co-occurring disorders (Laudet et al., 2004). This approach can also be used to supplement other treatments for better outcomes.

To link clients with co-occurring disorders to dual diagnosis 12-step groups, social workers in their educator, case manager and broker roles can begin by providing psychoeducation to their clients on the background, group format and statistical results that may be experienced with continued participation in these groups. If meetings are not available for referral in the area, there are materials and instructions on line for initiating groups. Although the groups are peer run, social workers can assist their clients in setting up the groups, and act in a consultant role until the group is self-sustaining.

Research is another area of importance for social work practice, since it is a source of evidence based treatments and interventions. As research in the area of

co-occurring disorders is still considered relatively new, more studies are needed to build on existing research, and to expand to unexplored areas. Further understanding of co-occurring disorders and identification of effective treatments that best utilize limited resources can improve the outcomes of these clients in mental health and substance use.

From the perspective of this study, further research could address some of the unanswered research questions related to those with co-occurring disorders, such as: the effect of abstinence from substance use on mental health symptoms, the most effective methods for engaging clients in treatment, the factors contributing to relapses, the effects of socioeconomic factors on recovery, and the effects of recovery from substance use on the quality of life. These are just a few of the many areas that still need to be explored.

Conclusions

The findings of interest in this qualitative study are those that deviated from other similar studies. A high recovery rate of 73 percent from substance use, and 100 percent participation in not just one, but up to four

treatments, is contrary to individuals with co-occurring disorders that face many challenges and barriers. Generally, this population struggles to engage in treatment, much less continue with treatment and achieve recovery. Yet, the majority of the study participants were able to accomplish this, despite some conflicts they experienced related to whether substance use made their mental health symptoms better, worse or a combination of both.

Based on this study, there appears to be a positive correlation between the recovery rate, and treatment adherence and participation in dual diagnosis groups, in particular. Further research is needed to determine if a statistically significant positive correlation exists.

APPENDIX A

DEMOGRAPHICS

Demographics

I would like to ask you some basic questions so I can describe who participates in our interviews.

1. What is your age? _____

2. What is your gender?
   a) male
   b) female

3. What is your marital status?
   a) single
   b) married
   c) widowed
   d) divorced/separated

4. What is your ethnic background?
   a) African-American
   b) Latino/Hispanic-American
   c) Asian American/Pacific Islander
   d) White/Non-Hispanic
   e) Other (specify):_____

5. What is your level of education
   a) Some high school
   b) High school/GED
   c) Some college
   d) Completed college

What is your employment status?
   a) Work full-time
   b) Work part-time
   c) Not in the job market/disabled
   d) Looking for work

APPENDIX B

INTERVIEW GUIDE

Interview Guide

1) What is your mental health diagnosis?

2) What substances do you use (alcohol and/or drugs)?

3) What are the reasons you use alcohol or drugs?

4) How does using drugs or alcohol affect your mental health problems?

5) Does using alcohol or drugs make symptoms (like depression, anxiety, or paranoia) worse? If yes:
   a) How?

6) Does using alcohol or drugs make symptoms (like depression, anxiety, or paranoia) better? If yes:
   a) How?

7) How does using alcohol or drugs affect your mental health medications?

8) Do you think it is okay to use alcohol or drugs when you have mental health problems?
   a) Why?

9) What would you say are the worst problems in your life right now?

10) Is drug or alcohol use connected to the problems that you just mentioned? If yes:
    a) How?

11) Have you been in substance abuse treatment? If yes:
    a) When?
    b) Where?

12) What did you like about treatment?

13) What didn't you like about treatment?

14) How can substance abuse treatment be improved?

15) Do you want to continue/start treatment to stop or reduce your use of alcohol or drugs?

APPENDIX C

ALVIDREZ INTERVIEW GUIDE

Consumer Perspectives on Substance Abuse and Substance Abuse Treatment

Gender: M F

We would like to ask you some basic questions so we can describe who participates in our interviews.

1. How old are you? _____

2. What is your ethnic background?
   ___ White/Caucasian
   ___ Black/African American
   ___ Latino/Hispanic--Country of origin: _____
   ___ Native American
   ___ Asian/Pacific Islander
   ___ Other: _____
   ___ More than one: _____/_____

3. What is your marital status?
   ___ married
   ___ living with partner
   ___ widowed
   ___ separated
   ___ divorced
   ___ never married

4. How much school have you had?
   ___ Less than 8th grade
   ___ Some high school
   ___ Completed high school/GED
   ___ Some college
   ___ Completed college

5. What is your employment status?
   ___ Not in the job market/Disabled
   ___ Student
   ___ Homemaker
   ___ Looking for work
   ___ Retired
   ___ Volunteer Work
   ___ Work part-time
   ___ Work full-time
   ___ Sheltered Workshop

6. Where have you received mental health treatment?

7. Have you ever received substance abuse treatment? If yes, where?

Interview Guide

1. How many people with mental health problems use drugs or alcohol?
2. Does using drugs or alcohol cause problems for people with mental health problems?
3. Do drugs make symptoms (like depression, anxiety, or paranoia) worse?
4. Do drugs make symptoms (like depression, anxiety, or paranoia) better?
5. Do you think it's ok to use some drugs when you have mental health problems? (If yes, how much would be ok to use?)
6. What would you say the worst problems in your life right now? Do your friends have similar problems?
7. Is drug use connected to any of those problems you just mentioned?
8. What do they do at (ask about each service where they got mental health treatment) to help people with their drug use?
9. What kind of drug treatment is available in San Francisco?
10. Is drug treatment helpful?
11. How can drug treatment be improved?
12. One way to improve drug treatment is to do research. Have you ever been in a research study?
13. What are good ways to let people know that research projects are going on?
14. What are good ways to get people interested in research projects?
15. Do you have any ideas about why people wouldn't want to be in research studies about drug treatment?

APPENDIX D

FLYER

STUDY ON CLIENTS' VIEWS OF DUAL DIAGNOSIS
VOLUNTEERS NEEDED FOR INTERVIEWS

PURPOSE OF RESEARCH: To gain knowledge of the perspectives of mentally ill clients on substance use and treatment.

ELIGIBILITY CRITERIA: Individuals who are at least 18 years of age, with a mental illness of schizophrenia, schizoaffective disorder, delusional disorder, major depression or bipolar disorder, and who use alcohol or other drugs.

INTERVIEW/TIME COMMITMENT: The interview will take from 30 to 45 minutes. Participants will be asked questions regarding the effects of substance use on mental health symptoms, medications and life, and their experience with substance abuse treatment.

CONFIDENTIALITY: All responses will be held in strictest confidence by the researcher. No names will be requested or used in the study. All data will be reported in group form only.

Participants are free not to answer questions and can withdraw from the interview at any time.

COMPENSATION: Those completing the interviews will receive a $10 gift card.

Researcher is Ann Jankowski, a Masters in Social Work Student at California State University San Bernardino

Contact No. – (909) 964-6459

APPENDIX E

INFORMED CONSENT

Informed Consent

The study in which you are being asked to participate in is designed to explore severely mentally ill clients' perspectives on substance use and treatment This study is being conducted by Ann Jankowski under the supervision of Dr. Carolyn McAllister, Assistant Professor of Social Work. This study has been approved by the Department of Social Work Subcommittee of the Institutional Review Board, California State University, San Bernardino.

In this study you will be asked to respond to questions regarding the effects of substance use on your mental health symptoms, medications and life, and your experiences with substance abuse treatment. The interview should take 30 to 45 minutes to complete. All of your responses will be held in the strictest of confidence by the researcher. Your name will not be reported with your responses. All the data will be reported in group form only. You may receive the group results of this study upon completion after September, 2009, at the Pfau Library, California State University, San Bernardino.

Your participation in this study is totally voluntary. You are free not to answer any questions and withdraw at any time during this study without penalty. When you have completed the interview, you will receive a debriefing statement describing the study in more detail. There are no foreseeable risks or benefits related to participating in this study. In order to ensure validity of the study, we ask that you not discuss this study with other participants.

If you have any questions or concerns about this study, please feel free to contact Dr. Carolyn McAllister at (909) 537-5559.

By placing a check mark in the box below, I acknowledge that I have been informed of, and that I understand, the nature and purpose of this study, and I freely consent to participate. I also acknowledge that I am at least 18 years of age.

Place a check mark here [ ] Today's Date _____

APPENDIX F

DEBRIEFING STATEMENT

Seriously Mentally Ill Clients' Perspectives on Substance Use and Treatment Debriefing Statement

The research study you have just completed was designed to examine seriously mentally ill clients' perspectives on substance use and treatment. The interview questions are designed to capture client views on the effects of substance use on their mental illness and their lives, and to obtain information on their treatment experiences. The questions can result in an unlimited number of meanings that are anticipated and expected. The researcher is particularly interested in the recognition of the consequences of substance use on clients' mental illnesses and lives, and the willingness to continue/start treatment to stop or reduce substance use.

Thank you for your participation and for not discussing the contents of the survey with other participants. If you have any questions about the study, please feel free to contact Professor Carolyn McAllister at (909) 537-5559 If you would like to obtain a copy of the group results of this study, please contact Professor Carolyn McAllister at (909) 537-5559 at the end of June, 2009.

APPENDIX G

TABLES

Table1. Demographic Data (N = 15)

Variable	Number	Percent
Diagnosis		
Bipolar	10	66
Major Depression	1	7
Schizoaffective	1	7
Schizophrenic	3	20
Gender		
Male	9	60
Female	6	40
Age		
18-29	2	14
30-39	2	14
40-49	4	26
50-59	5	32
60+	2	14
Ethnicity		
White/Non-Hispanic	9	60
Latino/Hispanic	4	26
African American	2	14
Marital Status		
Single	7	47
Married	1	6
Divorced/Separated	7	47
Education		
Some High School	3	20
High School/GED	4	27
Some College	4	27
Completed College	4	27
Employment Status		
Full-time Work	5	32
Not working/disabled	7	47
Looking for Work	3	20

Table 2. Current Treatment (N = 15)

Variable	Number	Percent
Substance Abuse Treatment		
Alcoholics Anonymous	12	45
Cocaine Anonymous	1	4
Narcotics Anonymous	7	26
Chemical Dependency Groups	2	7
Residential	2	7
Sober Living	3	11
Mental Health Treatment		
Inpatient Treatment	2	7
Outpatient Treatment	13	43
Case Management	3	10
Psychologist	7	23
Self-Help Groups	5	17
Dual Diagnosis Treatment		
Dual Diagnosis Program	2	12
Dual Diagnosis Anonymous	15	88

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