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Substance abuse: A chronic care perspective

Michael James Sweitzer

SUBSTANCE ABUSE: A CHRONIC CARE PERSPECTIVE

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

Since its beginning substance abuse treatment has undergone many changes. This study provides an examination of the Chronic Care Model and its application to the treatment of substance abuse disorders. The hypothesis of the study was that elements of the Chronic Care Model are not being utilized within San Bernardino County's system of care. The study was conducted by having Alcohol and Other Drug Counselors throughout San Bernardino County complete the study's 24-question quantitative survey. The study utilized Pearson's r for statistical analysis and found at least two important correlations. Results showed a significant, positive, and large correlation between client involvement in treatment planning and professional monitoring of 12-step attendance. Analysis also revealed a significant, positive, and medium correlation between client involvement in treatment planning and counselor collaboration with referring agencies. These results showed that certain elements of the Chronic Care Model are being utilized, and that client involvement in treatment planning may have a positive effect on how professionals interact on behalf of the client. It is

important for social work professionals to continue with substance abuse treatment research because they interact with substance abusers on many fronts and need to be aware of the most up to date treatment approaches. Finally, this study's findings also revealed that improvements need to be made to bring San Bernardino County in line with the concepts outlined by the Chronic Care Model.

ACKNOWLEDGMENTS

At this time, I would like to acknowledge all those that were instrumental in assuring this project was completed. First, I would like to acknowledge my academic advisor Thomas Davis, PH.D. who walked me through the process and provided me with insight, especially at those times when I was unsure how to proceed. Second, I want to thank all those that participated in the project's survey, and the administrators that opened their facilities doors. It would not have been possible without you! Next, I want to acknowledge all my friends that provided feedback as I traveled on this journey. Finally, I want to acknowledge my cohort and all the professors in the program that have put up with me, allowed me to be myself, and supported me throughout the last three years. Thank you all!

DEDICATION

This project and the work put into it are dedicated to my daughter Rachel and niece Kimberlee. I know the two of you will be able to reach any of the educational endeavors you aspire to achieve. It is also dedicated to my mother. She has stood by me, been the one constant in my life, and has helped me in every way possible to pursue my educational goals. I love you mom!

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CHAPTER ONE

INTRODUCTION

Problem Statement

The topic addressed in this project is the need of a system change in the treatment of substance abuse by implementation of the Chronic Care Model. Although substance abuse is widely viewed as a chronic disease it is mainly treated with acute interventions (Clark, 2008). Clark's briefing (2008) went on to suggest that these types of interventions place the field and those serviced by the system in a position for failure. This perspective is also supported by the work conducted by McLellan (2002).

McLellan (2002) suggested those who are addicted are prone to suffer multiple relapse or recurrence of symptoms much like other chronic illnesses. White (1998) pointed out how the field has transformed from long-term recovery to one expecting the same results from the least expensive acute interventions. This acute care model is now under scrutiny and the field is looking toward a model that utilizes strategies similar to treatments for other chronic conditions (Clark, 2008).

This issue is currently of great concern within New York, New Jersey, Connecticut, California, and even closer, San Bernardino County. For instance, the county of San Bernardino is working with the state of California to implement the Chronic Care Model (CCM), and New Jersey, as well as other states is looking to the CCM as a way of treating those affected by substance abuse. For the purposes of this project the work being conducted in California and San Bernardino County will be of central focus.

It is important to understand this problem because agencies both in the public and private sector serving those addicted should offer the most up to date, evidenced based, and cost effective services to their clientele. As cited in the Institute for Research, Education and Training in Addictions' (Flaherty, 2006) report clients in the healthcare system often do not receive, appropriate, evidenced based services (p. 2).

The overall goal of the Chronic Care Model is to have a system of care where a client enters the door for treatment and can access all services within the system of care from that site. This model would also provide longitudinal services to clients and linkages to other

needed services. San Bernardino County has already begun to move Alcohol and Other Drug (AOD) Counselors into mental health clinics and has AOD Counselors in most of the county Department of Children's Services offices. This change in the system will not only affect the Department of Behavioral Health, but will change the way other agencies deal with their substance abusing clients. It will also change the nature of the providers being utilized to provide services within the county by increasing client centeredness, collaboration, and bringing together a united system aimed at providing the most appropriate services to those entering the system for treatment services.

This will also change the face of social work practice in many fields. It is quite likely this model is going to be the next breakthrough in the AOD field (as with healthcare), changing the nature of services provided, and the systems of operation utilized. In this time of shrinking budgets, social workers need to utilize the most advanced systems giving affected clients the best chances at recovery.

Purpose of the Study

The purpose of this study is to add to the sparse literature related to the Chronic Care Model and its application to the alcohol and other drug (AOD) field. At this time the AOD field utilizes an acute care model which is ineffective for those treated for addiction (Clark, 2008).

This study seeks to increase awareness, and gather input from professionals as to the importance of the implementation of the Chronic Care Model. For example, should a central assessment center be created enabling individuals to enter the system at the proper level of care, or should focus be given to a data system allowing professionals to maintain a more comprehensive longitudinal view of the client and their treatment progress? The hope is the information gained from this study will be utilized by agencies and professionals in the field, and begin to bridge the gap between evidence and practice.

Since this model is still in the early implementation phase within San Bernardino County it made sense to gather feedback from professionals in the field. The data collected may be used as an informal needs

assessment addressing both staff needs and those of the client.

The study design utilized a questionnaire and followed a quantitative research approach. Some of the questions asked were: To what extent does the client participate in the actual creation of treatment planning, to what extent do you conduct client follow-up post treatment at your agency, does your agency utilize a comprehensive evidenced based curriculum, and have you had any training in the use of the Chronic Care Model? The questionnaire was comprised of 24 questions and was administered to 59 professionals from the AOD field across San Bernardino County.

Significance of the Project for Social Work

This study may have helped add to the limited research conducted on the application of the Chronic Care Model to the alcohol and other drug field. It may have assisted in gaining insights from professionals in the field that would help develop an applicable plan and move the process from theory to practice. It is possible this study could be used to give leaders insight into areas of the Chronic Care Model that might be implemented in

practice within the current system, with the least additional funding required.

This study fits into the implementation phase of the generalist model of social work. The implementation process of the Chronic Care Model into the California alcohol and other drug system has already begun. It is also underway in San Bernardino County. Knowledge brought forth from the study may be used to better equip leaders and more importantly professionals in the field.

Based on the literature reviewed chronic care is a better model because it provides longitudinal support for a chronic disease. The hypothesis was that elements of the Chronic Care Model are not being utilized within San Bernardino County.

CHAPTER TWO

LITERATURE REVIEW

Introduction

In this chapter evidence will be provided which supports addiction as a chronic relapsing disease. It will then move into a literature review of the Chronic Care Model and its application to the alcohol and other drug field. There will then be a brief discussion of systems theory as the guiding theoretical framework for the study. The chapter will end by providing support for further study of the subject matter and will indicate some differences from previous research.

Addiction as a Disease

It became evident early on that any discussion of the treatment of alcohol and other drugs (AOD) should include at least a brief overview of the history and science related to addiction as a disease. Page (1997) cited that E. M. Jellinek was the first to bring forward the disease model using the scientific method and paved the way for future advances in the field. Savva and Edwards (2001) reported that Jellinek's concepts are now

being proven by brain imaging and other research in the field of addictions (p. 1523).

A review conducted by Yucel and Lubman (2007) reported addictive drugs have been found to contribute to deficits in attention, memory, and other key functions of the brain (p. 33). Leshner (1997) also reported addiction is a disease that damages the mesolimbic system. Leshner cited work conducted by Koob (1992) which suggested this is one of the reasons users keep taking the drugs despite negative consequences (p. 3).

McLellan (2002) described addiction with many relapses and the need for continuing follow-up or care to ensure on-going recovery. One of the major problems with this approach is that most modalities and funding streams of treatment do not support this design (Boult, Karm, & Groves, 2008). Boult, Karm, and Groves (2008) suggested there is a growing mismatch between the needs of those suffering from addiction and the acute services offered to treat them. A report written by the Committee on Crossing the Quality Chasm described this as a situation with serious consequences for individuals, their loved ones, and society as a whole (Improving the Quality of Health Care, 2006).

McLellan, Lewis, O'Brien, Hoffman, and Kleber (n.d.) cited a study conducted by Rice, Kelman, and Miller (1991) which "estimated that drug dependence costs American society approximately $67 billion each year" (p. 4). In a report entitled Improving the Quality of Health Care for Mental and Substance-Use Conditions, the Institute Of Medicine cited that each year over 33 million Americans enter the health care system for mental illness, "or conditions resulting from their use of alcohol, inappropriate use of prescription medications, or less often illegal drugs" (Improving the Quality of Health Care, 2006, p. 3).

There is no particular way to identify those that are caught in the grip of this disease, or even those struggling with use of an addictive substance. The Institute Of Medicine's report explained these are people we know. They are our friends, neighbors, loved ones, and even our children (Improving the Quality of Health Care, 2006).

Leshner (2001) explained that although addiction begins voluntarily with use, "it is essential to understand when dealing with addicts that we are dealing with individuals whose brains have been altered by drug

use" (p. 78). McCabe, Page, and Daniels (2007) suggested the stigma attached to substance abuse, both social and in policy, need to be addressed in order to better serve this population and advance the alcohol and other drug treatment field.

The Chronic Care Model

One of the major themes found in the literature was that addiction is a chronic disease (Watkins, Pincus, Tanielian, & Llyod, 2003). It is obvious there is a need for change with the system of care that is provided; this stands true in the light of articles similar to the one in the New York Times cited by McLellean, Lewis, O'Brien, Hoffmann, and Kleber (n.d.) that suggested considering addictive disorders as medical relieves the individual of responsibility, and may negatively impact the public's health (p. 5). Dennis and Scott (2007) described a very different scenario; in their version it is time for the acute system of care to be transformed to what research and clinical experience confirm to be true: the need to treat addiction from a chronic care standpoint that will respond appropriately to a client's need for continued services. For this reason, the literature review focused

on the elements of the Chronic Care Model as a way to advance the treatment of, and improve outcomes for, those that find themselves within the alcohol and other drug (AOD) system of care.

The Chronic Care Model is an evidenced based practice set forth by Wagner et al. and is comprised of six basic elements to be used when treating those with chronic illnesses. The major tenets of the model are: multidisciplinary care, patient self-management, coordinated care, delivery system redesign, clinical information systems, and evidenced based care (Scott, 2008, p. 427, 428).

In a study published by Nutting et al. (2007) it was found that utilization of the Chronic Care Model in small rural practices improved the outcomes for patients being treated for diabetes without implementing major changes in programming (p. 14). Additionally, in a similar study conducted with diabetic patients by Dorr, Wilcox, Burns, Brunker, Narus, and Clayton (2006) the Chronic Care Model was found to be cost effective at the provider level (p. 13). Recently, these strategies have been applied to the alcohol and other drug (AOD) field and are the focus of this literature review.

The California Department of Drug and Alcohol Programs (ADP) recently created a task force to address the needs of the state with regard to the AOD system of care. ADP utilized the elements of the Chronic Care Model and sculpted them to fit a re-engineering of the current AOD system, with hopes of increased "outcomes for prevention, treatment, and recovery for those in the communities served by the AOD field" (California Department of Alcohol and Drug Programs, n.d., p. 3).

The Phase II report (California Department of Alcohol and Drug Programs, n.d.) outlined the Chronic Care Model as it relates to the alcohol and other drug field. It proposed a "System Improvement Model" adapted from the Chronic Care Model. The Phase II report outlined its six elements as: "System of Service Design, Leadership & Administrative Support, Resources & Policies, Community Partnerships, Prevention and Recovery Support Services, and Workforce Development" (p. 11). These are all areas supported by Staskon, Kopera and Wilson (2007) in their work which described the foundations for the implementation of the Institute Of Medicine's Chronic Care Model.

In the "System of Services Design" (California Department of Alcohol and Drug Programs, n.d.) the taskforce envisioned a system of care that is proactive rather than reactive to the needs of the community, a system which is gender responsive and that embodies all the elements of "prevention, treatment and continued recovery support" (p. 15). It also focused on the need for collaborations and client linkages to other resources in the community. Additionally, it aimed to incorporate harm reduction approaches and include court-mandated clients into the Continuum of Services (p. 14).

The Phase II report's "Leadership & Administrative Support" laid out a leadership style that recognized improvement in care as essential to the AOD's success. It recognized the need to develop a data system that provides up to date tracking and enables the responsible sharing of information among collaborative agencies. It also discussed the need to reduce the stigma attached to addiction and make sure all addictive substances are addressed within the system of care (California Department of Alcohol and Drug Programs, n.d., p. 17).

In the Phase II report, "Policies & Resources" were aimed at bridging the gap in knowledge pertaining to

"prevention, treatment and recovery" (p. 18). One of the goals described was to establish the California Department of Alcohol and Drug Programs as the sole agency in the state responsible for the funding, implementation, and policy related to the alcohol and other drug system of care. Additionally, the taskforce sought to address and change if necessary, the laws and regulations that hinder or create barriers to the re-engineering of the system (California Department of Alcohol and Drug Programs, n.d., p. 18).

The "Community Partnership Committee" recognized in the Phase II report (California Department of Alcohol and Drug Programs, n.d.) that community collaboration is essential. It followed the work by McCabe, Page and Daniels (2007) which suggested all parties must be involved in the building of the "infrastructure and clinical practices necessary for ongoing quality improvement" (p. 70). The system must build collaborations that go beyond the alcohol and other drug (AOD) field. This model seeks to build new allies with other service agencies such as mental health, the community, businesses, criminal justice, as well as

individuals and families (California Department of Alcohol and Drug Programs, n.d., p. 19).

Liang (2007) suggested in the past there has been too much focus on the clinician's part of the treatment equation and little attention given to the client's role as a part of the recovery process. The "Prevention and Recovery Support Services" element of the taskforce's report described the need to enhance the strengths of the client and promote a system where the community and individual play leadership roles in aftercare services. There was also added attention to prevention services throughout the continuum, including outreach services to "at risk" populations, and increased environmental prevention strategies aimed at keeping children and communities safe (California Alcohol and Drug Programs, n.d., p. 20).

The taskforce also recognized the need to have a trained workforce providing services throughout the system. "Workforce Development" addressed these issues by insuring best practices and evidenced based standards. They will also seek to establish a single certifying body and link salaries to levels of competency and/or licensure (California Alcohol and Drug Programs, n.d.,

p. 22). Additionally, there will be the need to educate the work force on the Chronic Care Model itself.

Although there is little research to test this design, it is possible clients may go into remission after completing several episodes of treatment (Merrill & Menza, 2002). The Chronic Care Model is not set up to be considered separate treatment episodes but would serve clients that need more treatment and utilize a continuum of care allowing for re-entry into the system if needed (McLellan, 2002). The Chronic Care Model will have to integrate current systems, combine services, bring together stakeholders, and address policy in order to be successful (Flaherty, 2006).

Theories Guiding Conceptualization

Based on the literature reviewed, using a systems approach appeared to fit most appropriately to the work being conducted in regard to the Chronic Care Model, and its implementation within the alcohol and other drug field. For example, Payne (2005) described *open systems* that occur when energy and resources are allowed to cross the boundaries of a system, while the system itself is allowed to stay intact. This concept fit well with the

idea of building collaborations, sharing information with other fields, and outside agencies, while at the same time maintaining central guidance of treatment, policy, and funding within the alcohol and other drug system (California Alcohol and Drug Programs, n.d.).

Bruggemann (2006) described a systems approach as "a process of inputs, maintenance, outputs, and feedback" (p. 347). This was applied to the innovations of the Chronic Care Model as evidenced in the literature review of the subject. For instance, the Chronic Care Model is premised on the idea that improving the system's parts will increase successful outcomes for those served by the system.

Another basic tenet to systems theory is that the individual has to be part of the system. There is also a strong emphasis on building supports through social networks (Payne, 2005). In the Chronic Care Model (CCM) this is of major focus for both the professional and the client. For example, basic elements of the CCM are to increase social/prevention supports in order to decrease the likelihood of individuals entering the AOD system of care. There is also a strong emphasis for the professional to expand their relationships within the

helping profession in order to better serve the client (California Alcohol and Drug Programs, n.d.).

Finally, implementation of the Chronic Care Model must incorporate the individual into the system as both a stakeholder and expert on their needs. This would allow for the individual to be a part of the *feedback loop* which Payne (2005) suggested is a way the system receives feedback and measures the results of the system's output.

Support of the Study

After conducting a literature review of the Chronic Care Model (CCM) and its application to the alcohol and other drug (AOD) field, it became evident there is need for further study into the implementation and efficacy of the CCM being adapted to the AOD field. This study sought to gather information from professionals in the AOD field and assist with the implementation process. For example, a task of this study was to ask AOD professionals which elements of the CCM they already practice, and which elements could be applied most easily.

The study was different from others by the fact that it was based on information gathered from the alcohol and other drug field and not healthcare. This project

attempted to identify gaps in the system needing to be improved and trusted in the knowledge of those working in the field.

Summary

This chapter provided a brief discussion of addiction as a brain disease and chronic illness. It then focused on a literature review of the Chronic Care Model and its application to the alcohol and other drug field. Next, it provided a short discussion of the guiding theory. Finally, support for the project, and differences of this project from other research were provided.

CHAPTER THREE

METHODS

Introduction

In this chapter an overview of the purpose of the study will be provided. There will be a discussion of the study design and an explanation of the sampling methods. Next, information pertaining to the survey tool and independent and dependent variables will be discussed. Finally, there will be an explanation of the procedures for data collection and general data analysis techniques.

Study Design

The purpose of this study was to evaluate components of the Chronic Care Model currently being utilized by professionals in the treatment of substance abuse within San Bernardino County. This study incorporated a quantitative approach to information gathering. The design of the study aimed to gather input from alcohol and other drug (AOD) professionals throughout San Bernardino County's system of care. This was accomplished by targeting professionals at treatment facilities throughout the various geographic regions that represent the system as a whole.

The implications of the study design would be that the information gathered was representative of professionals' experience within the field, and that the results can be extrapolated to AOD professionals within San Bernardino County's entire system. At least one limitation of this study was that there is a dearth of knowledge related to the Chronic Care Model and its use in substance abuse treatment. This means there were no other studies to directly compare the findings.

The hypothesis was the elements of the Chronic Care Model are not being utilized within San Bernardino County's system of care. The expectations of findings were that more elements of the Chronic Care Model may be practiced by residential and drug court programs than with outpatient programs.

Sampling

The sample for this study was drawn from alcohol and other drug (AOD) professionals at contract agencies throughout San Bernardino County. The goal was to gather information from a wide array of professionals in the field. The survey was conducted with 59 AOD professionals involved in direct client service. Stratified random

sampling was utilized as a way to ensure the sample was representative of the system as a whole. For example, outpatient, residential, and drug court facilities were identified and then the sample was randomly drawn from professionals working at these various organizations.

Direct service professionals were chosen to ensure the data collected came from those actually involved in the day-to-day care of the client. The justification for this approach was that these professionals are expert in the services provided to clients within the system of care. These are also the professionals most aware of what is working and what is not. This sample was also utilized to gain information representative of current AOD treatment practices within San Bernardino County.

Data Collection and Instruments

First, data were collected on Alcohol and Other Drug Counselors and treatment services offered. Information such as certification status, highest level of education, length of work in the AOD field, type of treatment provided, length of treatment and educational discipline were gathered. These were all measured at the nominal

level, except for length of work in the field which was measured at the ordinal level.

Fifteen of the questions on the survey sought to gain data regarding to what extent professionals utilized certain practices and policies. The independent variables were the specific practices and policies such as collaboration with other agencies, client involvement in treatment planning, medication assisted treatment, etc. The dependent variables were the professionals' utilization or answer to these certain criteria. These were all measured at the ordinal level using a Likert scale giving respondents a range from always to never. The data were collected by using a survey questionnaire (Appendix A) created for this study. The survey was created because no similar tool was found capturing the information sought in this study.

The survey tool was pretested by continued utilization of an academic advisor and input from other professionals on the Chronic Care Task Force in San Bernardino County. Additionally, the survey was given to certain professionals' representative of the sample and was updated for clarity and content as a way of eliminating possible errors and irrelevant questions.

These techniques were used in order to reduce the possibility of bias such as social desirability and response set bias in the survey.

Procedures

The data were gathered from alcohol & other drug professionals in various contract agencies throughout San Bernardino County. The goal was to obtain survey data from the Desert-Mountain, West Valley, Central Valley, and Morongo Basin Regions. The data were gathered by traveling to these various sites and passing out the survey to AOD professionals willing to participate in the research project. Participants signed informed consents and were given a printed debriefing statement. The surveys were collected before leaving from each agency location.

Participation in this research project was solicited by contacting the administrators of these various agencies, gaining approval, and setting appropriate dates and times to conduct the survey with various staff. Agencies were also recruited to participate in the study by giving a brief presentation at an Association of Community Based Organizations meeting and a San

Bernardino County Substance Abuse Provider Network meeting. Additionally, a recruitment flier was sent to the administrators to be passed out to staff. For the purposes of this study the Institutional Review Board (IRB) process was followed at the California State University, San Bernardino. The data collection for this study took approximately six to eight weeks.

Protection of Human Subjects

The confidentiality of those surveyed was protected in several ways. First, there was no identifying information on the survey tool. Second, all data were held in confidence and the information was not shared outside of the study parameters. Third, each participant signed an informed consent, was given a debriefing statement (Appendices C, B), and was provided knowledge of their rights regarding participation. Additionally, none of the agencies that agreed to allow staff involvement were specifically identified in any of the findings.

Data Analysis

The data gathered from this study was analyzed using the computer program SPSS. There were tests run to

identify frequencies, cross tabulations, and correlations regarding participant responses. For example, what is the relationship between outpatient programs and termination from treatment for relapsing? Overall the study sought to gain insight into professional practices in certain areas with clients and to tie these back to recommended practices of the Chronic Care Model as evidenced in the literature review section of this study. The results will then be discussed from a Chronic Care perspective in hopes of finding areas that need to be improved in current practices within the field of substance abuse treatment.

Summary

This chapter provided a brief description of the study design and methods used to gather data from substance abuse professionals. A brief description of the independent and dependent variables of the study was also discussed. Additionally, there was an explanation of how informed consent was conducted and the assurance of participant confidentiality. Finally, informed consent, debriefing statement, and the survey tool were provided in Appendices A, B, C.

CHAPTER FOUR

RESULTS

Introduction

In this chapter there will be a presentation of the demographic information collected from counselors that participated in the study as well as a listing of all the evidenced based curriculums respondents reported utilizing at their agencies. The chapter will also include frequencies of counselors' responses to the survey questionnaire. In addition, a presentation of correlations and cross tabulations related to study results will be provided.

Presentation of the Findings

Table 1. Respondents' Demographics

Characteristics	N	%
Certification status		
Registered with certifying body	25	42.4
Certified	33	55.9
Missing data	1	1.7

Characteristics	N	%
How many years have you worked in the alcohol & drug field?		
1-5 years	27	45.8
6-10 years	21	35.6
11-15 years	6	10.2
16-20 years	2	3.4
21 years and above	1	1.7
Missing data	2	3.4
Highest level of education		
Highschool/GED	6	10.2
Substance abuse counseling certificate	28	47.5
Associate of Arts	9	15.3
Bachelor of Arts	9	15.3
Masters	3	5.1
Missing data	4	6.8
Educational discipline		
Substance abuse	42	71.2
Mental health	1	1.7
Sociology	4	6.8
Social work	1	1.7
Other	5	8.5
Missing data	6	10.2
Do you believe addiction is a chronic relapsing disease?		
Yes	50	84.7
No	7	11.9
Missing data	2	3.4
Have you had training in the use of the chronic care model?		
Yes	30	50.8
No	28	47.5
Missing data	1	1.7
Does you agency use an evidenced based model?		
Yes	58	98.3
No	1	1.7

Characteristics	N	%
What is the average length of treatment at your agency?		
1-3 months	23	39.0
4-6 months	27	45.8
7-9 months	3	5.1
10 and above	5	8.5
Missing data	1	1.7

Table 1 provides a description of the demographics collected from the survey. In total 59 substance abuse counselors participated in the study. Of the respondents 42.4% reported being registered with a certifying body for substance abuse counselors, 55.9% were certified, and there was one instance of missing data to this survey question.

Respondents reported a wide range of years working in the field of substance abuse. In total 45.8% reported working in the field for 1-5 years, 35.6% 6-10 years, 10.2% 11-15 years, 3.4% 16-20 years, and 1.7% reported working in the field for more than 21 years. There were two instances of missing data equaling 3.4%.

In regard to highest level of education 10.2% reported having a high school diploma or GED, 47.5% reported attaining a certificate in substance abuse

counseling. There were also 15.3% that had an Associate of Arts degree and a respective 15.3% a Bachelors degree. Of the respondents 5.1% had an education at the Masters level. The survey had 6.8% missing data for highest level of education.

Respondents reported a slight variance in educational discipline. Of those participating in the survey 71.2% reported substance abuse as their educational discipline, 1.7% mental health, 6.8% sociology, 1.7% social work, and 8.5% reported "other" as their education discipline. Missing data equaled 6.8%.

It was found that 87.4% of respondents believe that substance abuse is a chronic relapsing disease. An additional 11.9% of those surveyed did not believe addiction is a chronic relapsing disease, and 3.4% chose not to answer this question.

When asked if they had training in the use of the Chronic Care Model 50.8% reported yes, and 47.5% reported they had not had training in the Chronic Care Model. There was 1.7% missing data to this question of the survey. Of those surveyed 98.3% responded that their agency utilized an evidenced based curriculum for treating their clients, and 1.7% does not.

Length of treatment was also included in the demographics for this survey and 39.0% reported the average length of treatment was 1-3 months. Of the additional respondents 45.8% reported 4-6 months, 5.1% 7-9 months, and 8.5% reported the average length of treatment to be above 10 months. Missing data accounted for 1.7%.

Table 2. Questionnaire Responses

	N	%
To what extent is the client involved in the actual creation of treatment planning at your agency?		
Occasionally	1	1.7
Usually	2	3.4
Always	56	94.9
To what extent do you monitor participation in 12-step or other self-management activities?		
Rarely	1	1.7
Occasionally	1	1.7
Usually	8	13.6
Always	49	83.1
To what extent are alumni used as a resource in your agency?		
Never	2	3.4
Rarely	2	3.4
Occasionally	25	42.4
Usually	18	30.5
Always	12	20.3

	N	%
To what extent do you provide client case management services such as resource & referrals to outside agencies?		
Occasionally	3	5.1
Usually	15	25.4
Always	41	69.5
To what extent do you collaborate with referring agencies?		
Occasionally	4	6.8
Usually	14	23.7
Always	41	69.5
To what extent do you conduct client follow-up post treatment at your agency?		
Never	2	3.4
Rarely	8	13.6
Occasionally	9	15.3
Usually	11	18.6
Always	29	49.2
To what extent do you have access to electronic medical charts at your agency?		
Never	42	71.2
Rarely	1	1.7
Occasionally	2	3.4
Usually	2	3.4
Always	10	16.9
Missing data	2	3.4
To what extent does your agency utilize medication assisted treatment?		
Never	27	45.8
Rarely	8	13.6
Occasionally	6	10.2
Usually	3	5.1
Always	14	23.7
Missing data	1	1.7

	N	%
To what extent do you participate in treatment team meetings regarding your clients?		
Never	2	3.4
Rarely	2	3.4
Occasionally	5	8.5
Usually	4	6.8
Always	46	78.0
To what extent does funding limit your ability to provide appropriate services to your client?		
Never	2	3.4
Rarely	4	6.8
Occasionally	21	35.6
Usually	14	23.7
Always	18	30.5
To what extent are clients terminated for relapsing at your treatment facility?		
Never	4	6.8
Rarely	12	20.3
Occasionally	22	37.3
Usually	3	5.1
Always	18	30.5
To what extent are you allowed to share information with outside agencies that would benefit your client?		
Never	19	32.2
Rarely	15	25.4
Occasionally	15	25.4
Usually	6	10.2
Always	4	6.8

Table 2 describes respondents' answers to questions that were a part of the chronic care survey conducted across San Bernardino County at various agencies

providing substance abuse treatment. The survey included aspects of the Chronic Care Model as they might be applied in the area of substance abuse treatment.

In regard to the question "To what extent is the client involved in the actual creation of treatment planning at your agency?" 1.7% reported clients are occasionally involved, 3.4% usually involved, and the remaining 94.9% responded that clients are always involved in treatment planning. To the question "To what extent do you monitor participation in 12-step or other self management activities?" 1.7% responded rarely, with a respective 1.7% occasionally, 13.6% usually, and the remaining 83.1% declared they monitor 12-step or other self management activities. In answering the question, "To what extent are alumni used as a resource in your agency?" 3.4% stated client alumni are never used, 3.4% rarely, 42.4% occasionally, 30.5% usually, and 20.3% stated that client alumni are always used as a resource at their agency.

When asked "To what extent do you provide client case management services such as resource & referrals to outside agencies?" 5.1% stated they occasionally provide resource & referrals, 25.4% usually, and 69.5 % reported

they always provide resource & referrals to outside agencies. To the question "To what extent do you collaborate with referring agencies?" 6.8% responded they occasionally collaborate with referring agencies, 23.7% usually, and 69.5% reported always collaborating with referring agencies. To the survey question "To what extent do you conduct client follow-up post treatment at your agency?" 3.4% stated never, 13.6% rarely, 15.3% occasionally, 18.6% usually, and 49.2% reported they always conduct client follow-up post treatment.

To the question "To what extent do you have access to electronic medical charts at your agency?" 71.2% declared they never have access to electronic records at their agency, 1.7% rarely, 3.4% occasionally and 3.4% usually with 16.9% reporting they always have access to electronic medical records. Missing data accounted for 3.4%. In regard to the question "To what extent does your agency utilize medication assisted treatment?" 45.8% reported never, 13.6% rarely, 10.2% occasionally, 5.1% usually, and 23.7% stated they always utilize medication assisted treatment at their agency. There was 1.7% missing data to this question.

When asked "To what extent do you participate in treatment team meetings regarding your clients?" 3.4% stated never, 3.4% rarely, 8.5% occasionally, 6.8% usually, and 78% reporting always participating in treatment team meetings regarding their clients. To the question "To what extent does funding limit your ability to provide appropriate services to your client?" 3.4% declared never, 6.8% rarely, 35.6% occasionally, 23.7% usually, and 30.5% responded that funding always limits their ability to provide appropriate services. To the question "To what extent are clients terminated for relapsing at your treatment facility?" 6.8% stated never, 20.3% rarely, 37.3% occasionally, 5.1% usually, and 30.5% reported clients are always terminated for relapsing. Finally, the table shows that when participants were asked "To what extent are you allowed to share information with outside agencies that would benefit your client?" 32.2% responded never, 25.4% rarely, 25.4% occasionally, 10.2% usually, and 6.8% reported always being allowed to share client information with outside agencies.

Table 3. Evidenced Based Curriculums

If your agency uses an evidenced based model please specify which one in the space provided.	N
Matrix Model	29
Social Model	4
Therapeutic Community	2
Living in Balance	3
Living in Balance/Matrix Model	4
Hazelden	2
12-step	2
Alcoholics Anonymous Big Book	1
Framework for Recovery	2
Matrix, Anger management, parenting, relapse prevention, Living in Balance, Framework for Recovery	4
Missing Data	8

Table 3 represents a listing of all the evidenced based models counselors reported using at their respective agencies. SPSS was not used to analyze these results.

Table 4. Treatment Planning and Self Management

		client involvement in treatment planning	to what extent do you monitor 12 step or other self management activities
client involvement in treatment planning	Pearson Correlation	1	.698**
	Sig. (2-tailed)		.000
	N	59	59
to what extent do you monitor 12 step or other self management activities	Pearson Correlation	.698**	1
	Sig. (2-tailed)	.000	
	N	59	59

**. Correlation is significant at the 0.01 level (2-tailed).

Table 4 indicates the correlation between the variables "To what extent is the client involved in the actual creation of treatment planning at your agency?' and "To what extent do you monitor 12-step or other self management activities?" The correlation is ($r = .698$, $n = 59$, $P < 0.01$). The correlation of these two variables is significant, positive and large.

Table 5. Treatment Planning and Collaboration

		client involvement in treatment planning	to what extent do you collaborate with referring agencies
client involvement in treatment planning	Pearson Correlation	1	.314*
	Sig. (2-tailed)		.015
	N	59	59
to what extent do you collaborate with referring agencies	Pearson Correlation	.314*	1
	Sig. (2-tailed)	.015	
	N	59	59

*. Correlation is significant at the 0.05 level (2-tailed).

Table 5 shows the correlation between "To what extent is the client involved in the actual creation of treatment planning at your agency?" and "To what extent do you collaborate with referring agencies?" The correlation is ($r = .314$, $n = 59$, $P < 0.05$). The correlation of these variables is significant, positive, and medium.

Table 6. Termination and Sharing Information

		to what extent are clients terminated for relapsing at your treatment facility	allowed to share information with outside agencies to benefit client
to what extent are clients terminated for relapsing at your treatment facility	Pearson Correlation	1	-.375**
	Sig. (2-tailed)		.003
	N	59	59
allowed to share information with outside agencies to benefit client	Pearson Correlation	-.375**	1
	Sig. (2-tailed)	.003	
	N	59	59

**. Correlation is significant at the 0.01 level (2-tailed).

Table 6 shows the correlation between "To what extent are clients terminated for relapsing at your treatment facility?" and "To what extent are you allowed to share information with outside agencies that would benefit your client?" The correlation is ($r = -.375$, $n = 59$, $P < 0.01$). The correlation of these two variables is significant, negative, and medium.

Table 7. Termination and Referral

		to what extent are clients terminated for relapsing at your treatment facility	to what extent do you provide client case management services such as resource & referrals to outside agencies
to what extent are clients terminated for relapsing at your treatment facility	Pearson Correlation	1	.431**
	Sig. (2-tailed)		.001
	N	59	59
to what extent do you provide client case management services such as resource & referrals to outside agencies	Pearson Correlation	.431**	1
	Sig. (2-tailed)	.001	
	N	59	59

**. Correlation is significant at the 0.01 level (2-tailed).

Table 7 reveals the correlation between the variables "To what extent are clients terminated for relapsing at your treatment facility?" and "To what extent do you provide client case management services such as resource & referrals to outside agencies?" The correlation is ($r = .431$, $n = 59$, $P < 0.01$). The correlation of these two variables is significant, positive, and medium.

Table 8. Funding and Termination

		to what extent does funding limit your ability to provide appropriate services to clients	to what extent are clients terminated for relapsing at your treatment facility
to what extent does funding limit your ability to provide appropriate services to clients	Pearson Correlation	1	-.302*
	Sig. (2-tailed)		.020
	N	59	59
to what extent are clients terminated for relapsing at your treatment facility	Pearson Correlation	-.302*	1
	Sig. (2-tailed)	.020	
	N	59	59

*. Correlation is significant at the 0.05 level (2-tailed).

Table 8 provides the correlation between the variables "To what extent does funding limit your ability to provide appropriate services to your client?" and "To what extent are clients terminated for relapsing at your treatment facility?" The correlation is ($r = -.302$, $n = 59$, $P < 0.05$). The correlation is significant, negative, and medium.

Table 9. Self Management and Follow-Up

		to what extent do you monitor 12 step or other self management activities	to what extent do you conduct client follow up at your agency
to what exetent do you monitor 12 step or other self management activities	Pearson Correlation	1	.289*
	Sig. (2-tailed)		.026
	N	59	59
to what extent do you conduct client follow up at your agency	Pearson Correlation	.289*	1
	Sig. (2-tailed)	.026	
	N	59	59

*. Correlation is significant at the 0.05 level (2-tailed).

Table 9 shows the correlation between the variables "To what extent do you monitor 12-step or other self management activities?" and "To what extent do you conduct client follow-up post treatment at your agency?" The correlation is ($r = .289$, $n = 59$, $P < 0.05$). The correlation of these two variables is significant, positive, and small.

Table 10. Length of Treatment and Alumni

		average length of treatment	to what extent are alumni used as a resource in your agency
average length of treatment	Pearson Correlation	1	-.378**
	Sig. (2-tailed)		.003
	N	58	58
to what extent are alumni used as a resource in your agency	Pearson Correlation	-.378**	1
	Sig. (2-tailed)	.003	
	N	58	59

**. Correlation is significant at the 0.01 level (2-tailed).

Table 10 reveals the correlation between "What is the average length of treatment at your agency?" and "To what extent are client alumni used as a resource in your agency?" The correlation is ($r = -.378$, $n = 59$, $P < 0.01$). The correlation of these two variables is significant, negative, and medium.

Table 11. Evidenced Based and Medication

		does your agency use an evidenced based model		Total
			no	
to what extent does your agency utilize medication assisted	never	26	1	27
	rarely	8	0	8
	occasionally	6	0	6
	usually	3	0	3
	always	14	0	14
Total		57	1	58

Table 11 depicts a cross tabulation between "Does your agency use an evidenced based model?" and "To what extent does your agency utilize medication assisted treatment?" The table reveals that of the respondents reporting utilizing an evidenced based model for treating their clients nearly half stated they never (26) or rarely (8) use medication assisted treatment at their facility. Six respondents reported they occasionally utilize medication, three usually, and 14 reported their agency always utilizes medication assisted treatment.

Table 12. Training and Termination

		Have you had training in the use of the Chronic Care model		Total
		yes	no	
to what extent are clients terminated for relapsing at your treatment facility	never	1	3	4
	rarely	8	4	12
	occasionally	12	10	22
	usually	1	2	3
	always	8	9	17
Total		30	28	58

Table 12 depicts a cross tabulation between "Have you had training in the use of the Chronic Care Model?" and "To what extent are clients terminated for relapsing at your treatment facility. The table shows that of the

sample reporting training in the use of the Chronic Care Model there was not significant differences overall in responses from those that reported having training in the Chronic Care Model to those that had not.

Table 13. Training and Collaboration

Count		Have you had training in the use of the Chronic Care model		Total
		yes	no	
to what extent do you collaborate with referring agencies	occasionally	2	2	4
	usually	6	7	13
	always	22	19	41
Total		30	28	58

Table 13 depicts the cross tabulation between "Have you had training in the use of the Chronic Care Model?" and "To what extent do you collaborate with referring agencies?" There is not a significant difference in responses regarding collaboration between those that reported having training in the Chronic Care Model from those that had not.

Summary

This chapter presented the demographics of the survey respondents. It also provided tables and

explanations of the frequencies of respondents' answers to the survey questions. Finally, it presented important correlations and cross tabulations relevant to the discussion that will be provided in chapter five.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter will provide a more in depth discussion of the data that were collected. It will return to the literature of the Chronic Care Model in order to provide this analysis and discussion. It then presents limitations of the study and provides recommendations to the social work profession. It will end with final thoughts related to this project and the Chronic Care Model being implemented into the alcohol and other drug field.

Discussion

Treatment Planning

The Institute for Research, Education and Training in Addictions' (2006) report described the need to have client involvement in the process of treatment planning. The survey results showed of the AOD counselors that participated in the study 94.9 % reported clients are always involved in the creation of their treatment plans. An additional 3.4% reported clients are usually involved and the remaining 1.7% reported clients are occasionally

involved in the creation of their treatment plans (see table 2).

Often times, the discussion of client involvement in treatment planning centers around increasing clients' participation in the treatment process. This survey looked at it from a different perspective seeking to find if it affected other aspects of the counselors' interactions on behalf of the client. The correlation between "To what extent is the client involved in the actual creation of treatment planning at your agency?" and "To what extent do you monitor 12-step or other self-management activities?" was positive and large (see table 4). This correlation reveals the more clients are involved in treatment planning the more counselors monitor client participation in 12-step and other self-management activities. The survey also showed that 83.1% of respondents reported monitoring client participation in 12-step/self-management activities and 13.6% reported they usually monitor attendance. Hopefully, increased counselor monitoring of client self-management activities will impact client attendance and help the client engage in the recovery process.

Another correlation between "To what extent is the client involved in the actual creation of treatment planning at your agency?" and "To what extent do you collaborate with referring agencies?" revealed a positive and medium correlation (see table 5). This means the more clients are involved in treatment planning the more counselors collaborate with referring agencies. It was also found that 69.5% of counselors reported always collaborating with referring agencies and 23.7% usually collaborate. The two examples above show client involvement in treatment planning may not only benefit the client by engaging them in the process, but it may also help with how the counselors then advocate with the client while in treatment.

The correlation between "To what extent do you monitor 12-step or other self-management activities?" and "To what extent do you conduct follow-up post treatment at your agency?" was positive and small (see table 9). This suggests that the more 12-step or other self-management activities are monitored the more counselors conduct client follow-up post treatment. This is also an important factor because it shows the more the counselor engages with the client the more likely it will

be that follow-up will be provided which is shown to improve client outcomes McLellan (2002).

Alumni

One of the main goals of the California Department of Alcohol & Drug Programs (N.D.) was to create a system of care that provides recovery support services in which the client can engage in safe self-management activities.. The correlation between "What is the average length of treatment at your agency?" and "To what extent are alumni used as a resource at your agency was negative and medium (see table 10). This means the shorter the length of treatment the more alumni are utilized as a resource. This is a very important topic for discussion.

The agencies offering these shorter modalities of treatment are often connected to recovery centers that are a key part of San Bernardino County's system of care, and set the system apart from other counties within California. The recovery centers provide clients, alumni, and the general public a clean, free, and safe environment to participate in recovery activities. The various recovery centers throughout the county offer relapse prevention, smoking cessation classes, 12-step

meetings, parenting, anger management, and a number of other services at little or no cost to the public.

Another important component of the recovery centers is that they allow clients, alumni and others to engage in safe activities, teaching there is fun in recovery. Many of the recovery centers have pool tables, video games, safe lounges with big screen televisions, and one even has a client/alumni run coffee shop. Alumni also participate in planning social activities like beach trips, bowling, barbeques and other activities. These recovery centers have been found to be a very crucial and cost effective way to provide people in recovery a safe place to gather in the community. These recovery centers have even received special recognition from the University of California, Los Angeles and the state of California.

It was found that only 20.3% of counselors reported always using alumni, 30.5% usually, and 42.4% reported they occasionally utilize alumni in their agency. This shows some improvement needs to be made to connect clients to other resources where they can participate in safe, recovery focused activities in the community. The recovery centers provide an excellent opportunity to

utilize alumni and the public in creating safe and healthy communities.

Relapse/Termination

The survey found that 30.5% of clients are always terminated for relapsing, 5.1% usually, 37.3% occasionally, 20.3% rarely, and 6.8% reported clients are never terminated from treatment for relapsing. The correlation between "To what extent are clients terminated for relapsing at your agency?" and "To what extent does funding limit your ability to provide appropriate services to clients?" was negative and medium (see table 8). This suggests if agencies do not have enough funding more clients are terminated for relapsing.

The correlation between "To what extent are clients terminated for relapsing at your agency?" and "To what extent do you provide client case management services such as resource & referrals to outside agencies?" was positive and medium (see table 7). The correlation indicates the more clients are terminated for relapsing the more they receive resource & referrals to outside agencies. This leaves the question: Where do they go? Was the client terminated and told to get into residential treatment or was placement secured? The Chronic Care

Model suggests a tracking system should be in place to follow a client while in the system (McLellan, 2002). Currently a client is terminated and then the receiving agency has to open the client up, but this leaves holes in any comprehensive tracking of the client. The idea behind the CCM is longitudinal tracking/treatment of clients that are in the system.

It was also found that counselors' ability to share information with outside agencies had some affect on client termination. Of those responding to the survey 32.2% stated they are never allowed to share information with outside agencies, 25.4% rarely, 25.4% occasionally, 10.2% usually, and only 6.8% reported always being able to share information (see table 2). It will be very important to find how these 6.8% manage to find ways to share important information beneficial to the client.

The correlation between "To what extent are clients terminated for relapsing at your agency?" and "To what extent are you allowed to share information with outside agencies that would benefit your client?" was negative and medium (see table 6). This correlation suggests the less counselors are allowed to share information with outside agencies the more clients are terminated for

relapsing. This shows it is important for staff to be able to speak with other agencies that play a pivotal role in the life of the client.

In part, this problem can be addressed by ensuring proper releases are signed by the client as part of the intake process. It is not that information cannot be shared; it is that the client needs to approve it, and then staff needs to follow through with advocating on the part of the client. Finally, table 12 shows there was no significant differences in termination practices between those reporting training in the use of the Chronic Care Model and those which did not (see table 12). This topic will be discussed further later in this paper.

Follow-Up

McLellan (2002) reported that even brief client follow-up can be instrumental in preventing client relapse. It should be noted that 49.2% of respondents declared they conduct follow-up with clients post treatment, 18.6% usually, and 15.3% reported occasionally conducting follow-up with clients. Currently there is no tracking method to monitor client follow-up within San Bernardino County. This is an area needing to be addressed in any system redesign. If counselors are

conducting follow-up at the above rates a tracking method has to be put in place to capture these contacts. This is also a key way to monitor and improve client outcomes. As funding becomes outcomes driven this is going to be a crucial piece of data to compile.

Funding

There is no doubt funding is having a massive impact on the AOD system of care. Over the last several years funding streams crucial to its survival have steadily decreased and in some cases disappeared altogether. It also appears to have an effect on client termination as mentioned above (see table 8). Results from the survey showed that 30.5% of respondents reported funding always limits their ability to provide appropriate services to their clients, 23.7 % usually, and 35.6% reported occasionally funding limits their ability to provide appropriate services.

While out in the field conducting the survey at various agencies the impact of reduced funding was evident. Almost all of the agencies have been dealing with layoffs and trying to find innovative ways to keep staff employed while at the same time providing appropriate services to the public. If this question was

asked of agency administrators the response would likely be much higher in those reporting funding is affecting the ability to provide client care.

Evidenced Based Practice

The survey results show 98.3% of respondents reported using an evidenced based model for treating their clients. Only 1.7% of respondents reported not using an evidenced based model. Of those responding 29 reported utilizing the Matrix Model, 4 Social Model, 2 Therapeutic Community Model, 3 Living in Balance, 2 Hazelden, 2 12-step, 1 Alcoholics Anonymous Big Book, 2 Framework for Recovery, and 4 reported a variety of models (see table 3). This reveals evidenced based curriculums will have to be addressed in a system redesign.

This study does not attempt to pose an opinion of what works and what doesn't in the treatment of those suffering from addiction. An issue found was that there does not appear to be continuity in the models counselors reported using at their agencies. In some cases it may be counselor preference versus applied evidenced based practice. There is no doubt 12-step and the Alcoholics Anonymous Big Book are important factors in ongoing

recovery, but they are not evidenced based treatment models or curriculums.

Another important aspect was found by use of a cross tabulation of "Does your agency use an evidenced based model?" and "To what extent does your agency utilize medication assisted treatment?" Of those reporting using evidenced based models 26 counselors reported never using medication assisted treatment, 8 rarely, 6 occasionally, 3 usually, and only 14 of the 59 respondents reported using medication assisted treatment (see table 11). McLellan, Lewis, O'Brien, Hoffmann, and Kleber (N.D.) reported on the development of many new drugs to assist in the treatment of those addicted to a variety of drugs. It will be important to include medication assisted treatment into evidenced based practice as the system moves forward and finds innovative methods for treating substance abuse.

Training

Training is going to be an important aspect to address in the implementation of the Chronic Care Model into the alcohol and other drug field. Of those surveyed 84.7% reported they believe addiction is a chronic disease, only 11.9% reported they do not. Additionally,

50.8% reported having training in the use of the Chronic Care Model. There may be some discrepancy in this number because there have not been many trainings in the use of the CCM locally or at the state level. The two trainings provided since 2008 have simply been overviews and discussion of a system change, not specific methods for how to practice in a redesigned system of care.

It should also be noted cross tabulations were conducted on Chronic Care Model training and collaboration (see table 13) as well as Chronic Care Model training and client termination for relapsing (see table 12). The results from both of these cross tabulations revealed no significant differences in practice between those reporting to have had CCM training and those which had not. This provides brief insight into the fact that a system redesign has to actually allow counselors to practice the CCM, and not just be trained in it.

Limitations

The main limitation related to this study was found when it came time to analyze the data gathered by conducting the survey. It was found a key question on the

survey related to type of treatment modality was unclear and contained unusable responses. When the survey was created, and tested, it was not taken into account some of the contract agencies provide services under more than one modality and this would be reflected in respondents' answers. This made it impossible to explore differences in practice among the treatment modalities as was initially intended.

Another limitation to the study is the results may not be representative to the alcohol and other drug field outside of San Bernardino County. Although the survey was conducted with a large percentage of AOD counselors within San Bernardino County there may be many differences setting results from this system apart from others.

Finally, the study is limited by the fact that it did not address outcomes for clients in relationship to the practice of elements of the Chronic Care Model. For example, the study design did not have any way in finding if client involvement in treatment planning actually lead to better outcomes for the client. It did not gather information to find if those not involved in treatment planning fared badly in their treatment experience.

Additionally, the study had no way to find if agency collaboration, tracking client self management activities, medication assisted treatment or client follow-up in any way increased client success in treatment and ongoing recovery.

Recommendations for Social Work Practice, Policy and Research

As implementation of the Chronic Model moves forward there will be an increasing need to have trained social work professionals involved in the process. Social workers have crucial training in systems theory placing them in a position to assist in the advancement of this process. Social workers also have advanced training in implementing and conducting collaborations which will be a crucial component in working with other fields of practice. Additionally, social workers interact with this population in many different fields, and would be wise to have specific knowledge into the current treatments for those suffering from substance abuse.

It should also be noted more advanced research on the Chronic Care Model will be forth coming. The Chronic Care Model is not only being applied to substance abuse, but has also taken hold in many areas of healthcare.

Social workers will be involved in the future of the Chronic Care Model! Hopefully, social workers will be important catalysis's to ensuring ongoing client centered practice, research, and an empowerment approach.

Conclusions

The thesis was that elements of the Chronic Care Model are not being utilized in the alcohol & other drug field. The results of this survey showed some elements are being utilized and some elements need to be improved upon as a part of the implementation process. In looking at the results from a strengths approach the field appears to be sound. Counselors reported high rates of involving the client in treatment planning, counselors are trained in substance abuse treatment, there was call to utilize evidenced based practice, self management is monitored, recovery centers provided, participation in treatment team meetings was high, and the majority of counselors understand addiction as a chronic disease.

The implementation process will have to include improving upon evidenced based curriculums and training in the Chronic Care Model. Attention will need to be given to medication assisted treatments and providing

electronic client files and up to date accurate tracking methods. Finally, increased effort will have to focus on increasing alumni and the public's role as a resource to the system as a whole.

It is with great hope the implementation process includes a strong evaluation component. There must be process evaluation focusing on improving practice and impact evaluation which measures if client outcomes have been improved by implementation of the Chronic Care Model. It will be imperative that the theory behind the Chronic Care Model effects practice and is not just another concept for academia to research.

Finally, as evidenced by recent cuts in all aspects of the healthcare system increased funding will have to be provided to effectively implement the Chronic Care Model. Creating new tracking systems, collaborations, implementing longitudinal care versus acute care, medication assisted approaches to treatment, and all the others efforts required will take both time and money. In its current state the AOD system is in survival mode and in need of an innovative approach to treatment such as that outlined in the Chronic Care Model.

APPENDIX A

QUESTIONNAIRE

QUESTIONNAIRE

Please read the instructions carefully. Check the box next to the appropriate answer that best fits your response to the question.

1. What is your counselor certification status?
   - □ Not registered
   - □ Registered with certifying body
   - □ Certified
   - □ Not applicable

2. How many years have you worked in the Alcohol and Other Drug Field?

   _____

3. What is your highest level of education?
   - □ High School/GED
   - □ Substance Abuse Counseling Certificate
   - □ Associate of Arts
   - □ Bachelor Degree
   - □ Masters
   - □ Doctorate

4. What is your educational discipline?
   - □ Substance Abuse
   - □ Mental Health
   - □ Sociology
   - □ Social Work
   - □ Other

5. Do you believe addiction is a chronic relapsing disease?
   - □ Yes
   - □ No

6. Have you had any training in the use of the Chronic Care Model?
   - □ Yes
   - □ No

7. What type of treatment does your agency provide?
   - □ Outpatient
   - □ Residential
   - □ Drug Court

8. What is the average length of treatment at your agency?
   □ 1-3 months □ 4-6 months □ 7-9 months □ 10 and above

9. Does your agency use a comprehensive evidenced based curriculum?
   - ☐ Yes
   - ☐ No

10. If your agency uses an evidenced based model please specify which one in the space provided? _____

11. To what extent is the client involved in the actual creation of treatment planning at your agency?
   - ☐ Always
   - ☐ Usually
   - ☐ Occasionally
   - ☐ Rarely
   - ☐ Never

12. To what extent do you monitor client participation in 12 step or other self management activities?
   - ☐ Always
   - ☐ Usually
   - ☐ Occasionally
   - ☐ Rarely
   - ☐ Never

13. To what extent are client alumni used as a resource in your agency?
   - ☐ Always
   - ☐ Usually
   - ☐ Occasionally
   - ☐ Rarely
   - ☐ Never

14. To what extent do you provide client case management services such as resource & referrals to outside agencies?
   - ☐ Always
   - ☐ Usually
   - ☐ Occasionally
   - ☐ Rarely
   - ☐ Never

15. To what extent do you collaborate with referring agencies?
   - ☐ Always
   - ☐ Usually
   - ☐ Occasionally
   - ☐ Rarely
   - ☐ Never

16. To what extent do you conduct client follow-up post treatment at your agency?
    - □ Always
    - □ Usually
    - □ Occasionally
    - □ Rarely
    - □ Never

17. To what extent do Policies & Procedures impede you from assessing and entering clients at the proper level of care?
    - □ Always
    - □ Usually
    - □ Occasionally
    - □ Rarely
    - □ Never

18. To what extent do you have access to electronic client medical charts at your agency?
    - □ Always
    - □ Usually
    - □ Occasionally
    - □ Rarely
    - □ Never

19. To what extent does your agency utilize medication assisted Treatment?
    - □ Always
    - □ Usually
    - □ Occasionally
    - □ Rarely
    - □ Never

20. To what extent does your agency utilize technical Assistance offered by San Bernardino Alcohol & Drug Services?
    - □ Always
    - □ Usually
    - □ Occasionally
    - □ Rarely
    - □ Never

21. To what extend do you participate in treatment team meetings regarding your clients?
    - □ Always
    - □ Usually
    - □ Occasionally
    - □ Rarely
    - □ Never

22. To what extent are you allowed to share information with outside agencies that would benefit your client?
    - □ Always
    - □ Usually
    - □ Occasionally
    - □ Rarely
    - □ Never

23. To what extent does funding limit your ability to provide appropriate services to your client?
    - □ Always
    - □ Usually
    - □ Occasionally
    - □ Rarely
    - □ Never

24. To what extent are clients terminated for relapsing at your treatment facility?
    - □ Always
    - □ Usually
    - □ Occasionally
    - □ Rarely
    - □ Never

APPENDIX B

INFORMED CONSENT

INFORMED CONSENT

This study is being conducted by Michael Sweitzer a student at California State University, San Bernardino. The research is being conducted to fulfill the requirements of the Master of Social Work Program.

The purpose of this study is to gather information from professionals in the field of substance abuse treatment regarding client care, client self management, professional collaboration, and client follow-up. The goal is to gain insight into the elements of the Chronic Care Model that can be built upon and assist with its implementation in San Bernardino County.

There are no foreseeable risks as a result of your participation in this study. Participation in this study is completely voluntary and you can withdrawal at any time without consequence. Your participation will include a short survey that will take about 15-20 minutes to complete.

For questions regarding participant's rights or injuries please contact Thomas Davis, Ph.D. (909-537-3839) at the California State University, San Bernardino, School of Social Work. This study has been approved by the School of Social Work's Institutional Review Board Committee at the California State University, San Bernardino. The results of this study will be made available at the John M. Pfau Library at the California State University, San Bernardino after September 2010. Additionally, a copy of the study will be provided to your facility administrator.

Mark _____ Date _____

APPENDIX C

DEBRIEFING STATEMENT

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Thank you for taking the time to participate in this research study conducted by Michael Sweitzer. The purpose of the study is to gain insight into the elements of the Chronic Care Model that are being utilized in the field of substance abuse treatment. As you may or may not know San Bernardino County is in the process of re-engineering the Alcohol and Drug Services system. The information gathered will be used solely for research purposes, is completely confidential, and is in no way a reflection of individual or agency performance. It is solely aimed at identifying areas that can be improved upon and brought into line with the concepts of the Chronic Care Model.

If you have any questions regarding participation in the study, contact Thomas Davis, Ph.D. (909-537-3839) at the School of Social work located at the California State University San Bernardino. For questions regarding the findings and publication contact Michael Sweitzer at 909-421-4601. The findings of this study will be made available at the California State University's Pfau Library, and a copy will be given to your agency after September 2010. Again, thank you for your time and assistance!

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