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Evaluating integrated treatment of co-occurring disorders throughout San Bernardino and Riverside County

Joseph Hugo Bermudez

EVALUATING INTEGRATED TREATMENT OF CO-OCCURRING DISORDERS THROUGHOUT SAN BERNARDINO AND RIVERSIDE COUNTY

A Project

Presented to the

Faculty of

California State University,

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In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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ABSTRACT

It has been reported that between seven and ten million people in the U.S. have a co-occurring mental health and substance use disorders. Integrated treatment models are seen as an improvement over traditional models of treatment, providing clients with coordinated substance use and mental health services in the same treatment setting. The purpose of this study was to evaluate dual diagnosis programs currently available throughout San Bernardino and Riverside County. A questionnaire was given to 10 practitioners from 10 different treatment agencies (6 = San Bernardino County and 4 = Riverside County) for the purpose of obtaining information regarding treatment outcomes and to determine which program currently utilizes the eight essential components of integrated treatment associated with evidence-based practice. Study findings revealed that traditional models of treatment are no longer effective as many treatment agencies throughout San Bernardino and Riverside County are moving towards an integrated treatment approach. It was also revealed that eight treatment agencies were utilizing six out of eight essential components of an effective treatment program.

These treatment agencies did not provide Assertive Outreach and Long-term treatment services. Only two agencies utilized all eight essential components. In terms of treatment outcomes, the eight treatment programs that incorporated only six essential components were just as effective as the two treatment programs that incorporated all eight components. Unfortunately, treatment agencies face drastic budget cuts in the next few years due to California's economic recession. Therefore, agencies must seek additional revenue and utilize community-based resources.

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I would like to acknowledge my mother and father for all their love and support. I would also like to acknowledge Vaneshia, Christian, Tony, and Julie for putting up with my insanity throughout the MSW program. And last but not least, I would like to acknowledge my class cohort...you are all wonderful and intelligent in your own way. You were like a great dysfunctional family to me. I will never forget you.

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CHAPTER ONE

INTRODUCTION

Problem Statement

The problem discussed in this paper will focus on the effectiveness of integrated treatment of co-occurring mental health and substance use disorders. In the field of addiction counseling, substance abuse counselors often discover that drugs and alcohol are only a small piece to a larger puzzle. During a counseling session, a counselor will address many issues that are both directly and indirectly related to a client's substance use, issues concerning physical health, legal concerns, employment problems, financial difficulties, family dysfunction, and most importantly, issues regarding mental health. If a client has a mental health concern, such as major depression or anxiety, substance abuse counselors will typically refer them to another treatment agency because it is often outside their scope of practice. Unfortunately, this separation of services often becomes a hardship for clients with a co-occurring disorder, resulting in higher relapse or drop-out rates. This type of agency represents the vast majority of treatment

facilities throughout the U.S. who do not provide integrated treatment services, which many feel would be beneficial to this client population and would produce more successful treatment outcomes.

The purpose of an integrated treatment model is to provide coordinated substance use and mental health services by a single clinician or group of clinicians in the same treatment setting. Professionals work together to provide the client with a single diagnosis and prescription for treatment, as opposed to conflicting messages given by two or more service providers. Overall, the focus of integrated treatment is to remove the obstacle of managing two treatment programs, eliminate the financial burden associated with multiple providers, and provide consistent services that meet the special needs for individuals with co-occurring disorders (Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998, p. 590).

It has been reported that between seven and ten million people in the U.S. have a co-occurring mental health and substance use disorder. It is also reported that nearly half of all people with a lifetime substance abuse diagnosis also have a least one psychiatric diagnosis and 51% of all people with a lifetime

psychiatric diagnosis also have at least one substance abuse diagnosis (DHHS, 1999). Throughout the psychiatric community, individuals with depressive disorders (30%), bipolar disorders (50%), and psychotic disorders (50%) have a co-occurring substance use disorder (Bride, MacMaster, & Webb-Robins, 2006, p. 43).

Individuals with co-occurring disorders often experience poorer treatment outcomes than individuals diagnosed with a single disorder. According to Johnson (2000) these individuals

> (a) have worse psychiatric symptoms, treatment compliance, and prognosis; (b) use more treatment and service resources; (c) show a greater propensity toward suicide and self-destructive behaviors and generally poor physical health habits; (d) have few social supports or financial resources with which to seek treatment other than treatment on an outpatient basis from public sector community providers; and (e) exhibit the highest rates of expensive public psychiatric hospital admissions and criminal justice system involvement. (p. 119)

According to Worley, Trim, Tate, Hall, and Brown (2010), the price for treating individuals with a

co-occurring disorders can become quite costly. For individuals receiving treatment for a substance use disorder alone, the average cost is $1,246 per year. For individuals receiving treatment for a comorbid substance use disorder and depression, the average cost can increase to $5,318 per year (p. 124). In addition to cost, people with co-occurring disorders often engage in sexual and drug risk behaviors and have a greater chance of contracting infectious illnesses such as HIV and hepatitis. They also have a higher probability of displaying "violent or aggressive behavior" during periods of intoxication (Donald, Kower, & Kavanagh, 2005, p. 1372).

Individuals with co-occurring disorders often find it difficult to locate appropriate treatment services. When they are being treated for a single disorder, whether it is concerning mental health or substance use, they often do not meet the criteria for "treatment priority" for the other disorder. In many cases, the second disorder is not seen as being "sufficiently severe" for treatment. In other instances, the mere existence of a co-occurring disorder will automatically

disqualify patients from receiving services (Donald et al., 2005, p. 1373).

Public sector community-based mental health providers are more likely to treat the co-occurring population because these individuals often lack the resources to seek private treatment. Among counties throughout California, it is reported that "less than half" provided integrated mental health and substance abuse treatment within the public sector. It is also reported that "one-third" of integrated treatment is provided among the private sector, many of whom referred co-occurring individuals to outside providers. In addition, it was noted that patients with severe and persistent mental illness were at high risk of being referred to other treatment facilities (Ducharme et al., 2006, p. 365).

The reason why many treatment facilities do not treat individuals with co-occurring disorders is because these people often require "medication, treatment, housing and occupational support, case management, and other social services" and many facilities lack the services required to meet these special needs. Among the small number of facilities that provided dual diagnosis

programs, 43.4% did not provide "prescription medications," 37.8% did not provide "psychiatric or psychological assessment or diagnostic services," and 26.7% did not provide "case management." Only a small portion of treatment centers provided "transitional housing or employment assistance, HIV or domestic violence education, or health screening." Without these critical services, many of these dual diagnosis programs may not be effective to treat this client population (Mojtabai, 2004).

In the context of practice, the development of an integrated treatment program will be beneficial to social workers in many practice settings. At the present time, when a social worker encounters a client who displays symptoms of a co-occurring disorder or self discloses a co-morbid condition, they typically refer these individuals to multiple treatment providers. However, a referral to a treatment facility that provides integrated services will allow social workers the opportunity to provide their clients with appropriate services that will treat both disorders simultaneously.

Purpose of the Study

The purpose of this study is to explore the effectiveness of integrated treatment of co-occurring disorders by examining the dual diagnosis programs currently available throughout San Bernardino and Riverside County. In the past ten years, there has been a wealth of research conducted on integrated treatment. As a result, many psychosocial interventions have been developed such as cognitive-behavioral therapy, motivational interviewing, and twelve-step facilitation therapy. Although many researchers have demonstrated that integrated treatment is an effective method for treating individuals with co-occurring disorders, treatment is still not widely available to consumers. There is still a need for more research in order to find empirical support for this treatment approach.

One of the pioneers of this movement toward integrated treatment is Robert Drake, M.D., Ph.D., who has devoted a significant part of his career to developing effective treatments for people with co-occurring mental health and substance use disorders. After thirty years of integrated research, Drake and colleagues have published many journal articles and books

including, "Integrated treatment for dual disorders: A guide to effective practice," which described eight essential components in integrated treatment programs that are associated with evidence-based practice. These components include staged intervention, assertive outreach, motivational interventions, counseling, social support interventions, long-term perspective, comprehensiveness, and cultural sensitivity and competence (Mueser et al., 2003).

In order to determine the effectiveness of integrated treatment, the current research study will distribute a questionnaire to practitioners from every dual diagnosis treatment facility throughout San Bernardino and Riverside County. The questionnaire will use a qualitative design in order to obtain treatment information along with professional opinions from practitioners. The questionnaire will determine which facilities currently utilize the eight essential components of integrated treatment. The questionnaire will also obtain information regarding total number of clients who dropped out of treatment, successfully completed the program, were terminated by the facility and referred to another agency. The questionnaire will

also incorporate the practitioners' personal feelings toward treatment, including benefits and limitations of the program and areas for improvement.

Significance of the Project for Social Work

The proposed study is needed because of the high rate of individuals with co-occurring disorders throughout the United States and the lack of effective treatment services available to this client population. The results of this study will potentially contribute to social work practice by providing further support for an integrated treatment model which will eliminate the client's burden of managing two treatment programs and remove the financial costs related to multiple providers.

The phase of the macro generalist intervention process that will be informed by the study will be the assessment phase. The purpose of an assessment is to gather information on the client and to establish the presence or absence of a co-occurring disorder. It is also used to determine the client's readiness for change and to identify client strengths or weaknesses that may affect treatment and recovery. The study will focus on the issue of co-occurring disorders and the integrated

treatment that can potentially minimize or resolve the problem. Although there have been many studies on integrated treatment utilizing many different psychosocial interventions, there is still a need for empirical support regarding the effectiveness of current dual diagnosis programs. Therefore, the study will pose the question: Which treatment agencies are currently utilizing the eight essential components of integrated treatment and what are the treatment outcomes of these programs?

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter will discuss early traditional models of treatment, which led to the need for an integrated treatment approach to best serve the needs of individuals with co-occurring disorders. The chapter will also provide a history of integrated treatment programs, which led to the development of Congress-approved state grants in order to develop integrated treatment programs. The last section of the chapter will discuss the different psychosocial interventions that are currently used in dual diagnosis programs.

Before an integrated treatment model was introduced there were traditionally two approaches to treating mental health and substance use disorders: The serial (or sequential) treatment model and the parallel treatment model. In the serial treatment model, the client is first treated by one service system, focusing on either the substance use or mental health disorder. Once treatment is complete, the client is transferred to the other service system. In the parallel treatment model, mental

health and substance abuse services are provided simultaneously. However, treatment usually takes place in different agencies and by different treatment staff (Bride et al., 2006, p. 44).

The relationship between psychiatric and addiction services has previously been a source of conflict. Most of these problems stem from philosophical differences regarding treatment approach. The recovery or addiction model has traditionally relied on "peer counselors, spiritual recovery, and a self-help approach." The medical or psychiatric model has traditionally relied on "medications, scientifically based treatment approaches, and continuous case management." Therefore, there is often a lack of communication or collaboration between agencies treating each disorder. In some instances, both groups may be "mutually antagonistic" toward one another. In addition, the treatment staff from one service system may lack the knowledge or skills of the other service system. As a result, the client may potentially receive conflicting messages, producing treatment that is both inconsistent and disjointed (Bride et al., 2006, p. 44).

The most common approach to treating co-occurring disorders has been the serial (or sequential) treatment

model. However, there has been some debate regarding proper sequence of treatment. Some clinicians believe that clients should first receive addiction treatment to establish proper stability before receiving psychiatric treatment. Other clinicians believe that clients should receive psychiatric treatment before focusing on their substance use disorders. There are also clinicians who believe that the severity of the client's addictive or psychiatric symptoms should dictate the sequence of treatment (Woody, 1996).

Due to the limitations of both serial and parallel treatment models, many researchers began developing an integrated treatment approach for individuals with co-occurring disorders. Drake, Mercer-McFadden, Mueser, McHugo, and Bond (1998) offer a comprehensive examination of the history of integrated treatment programs. One of the earliest efforts to address the issue of co-occurring disorders began with the addition of a substance abuse group to a standard mental health treatment program. Unfortunately, many of these studies were inadequate due to the selection of "motivated patients, small study groups, brief follow-ups, high dropout rates, lack of control subjects, and reliance on self-report" (p. 593).

Another early method of integrated treatment consisted of an intensive treatment program with the purpose of achieving immediate and prolonged abstinence from alcohol and/or drugs. These interventions took place in inpatient, residential and day treatment settings and consisted of numerous interventions per day for a period of a few weeks to several months. Unfortunately, these studies were limited by high dropout rates because many patients were unprepared to undergo an intensive treatment program. Those patients who remained in treatment were able to maintain sobriety due to their limited access to alcohol and drugs. However, relapse rates were high once they were discharged from the program (Drake et al., 1998, p. 595).

In 1987, the Community Support Program (CSP) funded 13 dual diagnosis demonstrations projects which examined the effectiveness of integrated treatment programs on high-risk populations such as homeless people, migrant workers, and inner-city residents. A total of 1,157 patients participated in these demonstrations, which included dual diagnosis treatment groups, case management services, and family interventions. Unfortunately, many of these studies were hampered by "small study groups,

changing program models, lack of controls, nonstandard measures, minimal statistical analysis, and use of clinicians as evaluators" (Drake et al., 1998, p. 596).

Despite these limitations, the demonstration projects provided significant findings on integrated treatment. They revealed that integrated services can be applied to different treatment settings. They showed that high-risk populations can be drawn into treatment services. They discovered that many co-occurring clients did not respond to traditional substance abuse treatment. Therefore, stage-wise, motivational interventions were developed for clients at different stages of recovery. They also found that substance abuse assessment tools, such as the Addiction Severity Index (ASI) were not appropriate for clients with severe mental illness (Drake et al., 1998, p. 596).

Later studies on integrated treatment provided more encouraging results, incorporating components of current psychosocial interventions such as case management, assertive outreach and motivational interventions. Despite some research limitations (i.e., lack of control groups), results indicated that patients who participated in integrated treatment for 18 months or longer

experienced remission of substance use disorders and a decrease in hospitalization. Overall, these studies provided encouraging evidence for long-term integrated treatment compared to traditional programs for individuals with co-occurring disorders (Drake et al., 1998).

The increasing focus on co-occurring disorders led the Substance Abuse and Mental Health Services Administration (SAMHSA) to submit a report to the U.S. Congress on December 2002, outlining the need for integrated services for individuals with substance use and mental health disorders. As a result, Congress announced the availability of funds to develop Co-occurring State Incentive Grants (COSIG). In 2003, the COSIG program distributed grants to seven states in order to provide "accessible, effective, comprehensive, integrated and evidence-based treatment services to persons with co-occurring disorders" within a five-year period. For the first three years, grantees received an annual amount of one million dollars. For the fourth year, grantees received half of their third year amount and 10,000 dollars for the fifth year (Dausey, Pincus, Herrell, & Rickards, 2007, p. 903).

During the first two years of funding, SAMHSA conducted a process evaluation in order to monitor which of the seven states had reached their interim project goals. Results indicated that two states had a "few delays" in reaching their goals, three states had "moderate delays" in reaching their goals and two states had "significant delays" in reaching their goals. The states that had the most success in achieving project goals were able to plan carefully based on previous experience, had the ability to anticipate bureaucratic challenges, and gained early consensus from committees which facilitated progress. As of 2006, the number of states that have received the Co-occurring State Incentive Grant (COSIG) has risen to seventeen (Dausey et al., 2007).

Theories Guiding Conceptualization

Theoretical perspectives that will guide the study include an assortment of psychosocial interventions that are currently used in dual diagnosis programs. Some of these interventions include cognitive-behavioral therapy, twelve-step facilitation therapy, motivational interviewing, contingency management, and assertive

community treatment. Cognitive behavioral therapy (CBT) is designed to restructure the maladaptive thoughts and feelings that lead to distressing negative emotions. The strategies of CBT often include "1) identifying intrapersonal and interpersonal triggers for relapse, (2) coping-skills training, (3) drug-refusal skills training, (4) functional analysis of substance use, and (5) increasing nonuse-related activities" (Magill & Ray, 2009, p. 516).

Twelve-step facilitation therapy consists of hour-long group sessions emphasizing the four core topics of treatment: "acceptance of the addiction problem, surrender of control, and active participation in 12-step meetings and a program of recovery" (Hayes et al., 2004, p. 668). Motivational interviewing (MI) is a brief intervention designed to help clients develop "intrinsic motivation" to change addictive behaviors. The four principles of MI include "expressing empathy, developing discrepancy, supporting self-efficacy and rolling with resistance" (Cleary et al., 2009, p. 241) and the five stages of change involve "precontemplation, contemplation, preparation, action and maintenance" (Cleary et al., 2009, p. 241).

Contingency management is an intervention designed to provide clients with cash, vouchers, or privileges when they engage in positive behaviors, such as drug abstinence or medication adherence. When clients engage in undesired behaviors, they receive negative consequences such as withholding incentives or a negative report to a parole officer (Higgins & Petry, 1999). Assertive Community Treatment (ACT) utilizes a multidisciplinary team of clinicians who provide 24-hour treatment services for clients with severe mental illness. The ACT team maintains a low clinician-to-client caseload ratio (1:10) and provides services in the client's natural living settings, as opposed to a treatment facility (Manuel et al., 2011).

The psychosocial intervention that has received the most attention has been cognitive-behavioral therapy (CBT). It has been shown that cognitive behavioral therapy can reduce depressive symptoms for individuals at-risk for major depression. CBT has also been shown to decrease substance use for individuals with an addictive disorder. Since CBT has been used to treat both depression and substance use independently, many theorize that it can be useful for treating co-occurring disorders

in a substance abuse treatment facility (Osilla et al. 2009).

In one study, the authors developed an integrated cognitive-behavioral treatment program for depression and substance use disorders that could be carried out by counselors in a substance abuse treatment facility. Afterwards, the program was assessed for its "feasibility and acceptability" to administrators, counselors, and clients. The results indicated that the CBT model was favorably received by the clients, counselors, and administrators. Clients stated that the treatment program gave them the cognitive-behavioral skills to manage their depression and substance use. They also felt that CBT provided more "solutions" than a twelve-step program. Counselors and administrators supported the treatment because it provided clients with the tools to identify and modify maladaptive thoughts and behaviors (Osilla et al., 2009).

In another study, the authors conducted a randomized controlled trial to determine whether an integrated cognitive behavioral treatment (ICBT) for veterans with substance use disorders and major depression receiving standard pharmacotherapy would produce greater treatment

results over twelve-step facilitation therapy. Results indicated that both interventions produced decreased levels in depression and substance use in veterans during treatment. However, reductions in depression and substance use were more consistent through six months post treatment among participants in the ICBT group compared to the twelve-step facilitation group, which displayed a steady increase in symptoms following treatment (Brown et al., 2006).

One study compared costly treatment services for co-occurring substance use and depression used by 236 veterans within an 18-month period. These individuals were randomly assigned to a cognitive behavioral therapy (CBT) or a twelve-step facilitation group. Results indicated that the CBT group showed reduced utilization of inpatient services in comparison to the twelve-step group after 1-year posttreatment. The CBT group also made use of additional medication services in the first few months following treatment. However, the number of visits had reduced within the first year, resulting in levels comparable to the twelve-step group (Worley, 2010). Although there is research that supports a 12-step based treatment approach, some therapists have expressed

concern over referring co-occurring clients to AA or other twelve-step meetings, especially those with severe mental illness and poor social skills (Jarrell & Ridgely, 1995).

Although CBT has been provided some positive results, there are other psychosocial interventions that have been shown to be effective with individuals with co-occurring disorders. Motivational interviewing (MI) is considered most beneficial to clients in the early stages of treatment, especially when they are not aware that their substance use has caused significant impairment in their everyday living. They often need assistance moving from one stage of change to another, especially the precontemplation to contemplation stage, in which clients are aware of the existence of a problem but have not taken action to resolve it (Horsfall, Cleary, Hunt, & Walter, 2009).

One study has shown a decrease in drug-taking behavior after three hours of MI. Another study spread three hours of MI over six to nine sessions. As a result, there was a decline in substance use that was maintained for an entire year. One study reported that clients were able to refrain from alcohol for six months after three

one-hour sessions of MI (Horsfall, Cleary, Hunt, & Walter, 2009). Another study found that MI caused a reduction in substance use over a short period of time. However, these periods were extended when MI was combined with CBT (Cleary et al., 2009).

Motivational interviewing is useful with co-occurring clients because they exhibit more problems with treatment adherence than any other group of clients. Research studies utilizing motivational interviewing have shown positive results in increasing "treatment engagement and adherence" with this client population. In a sample of 100 psychiatric clients with co-occurring disorders from a large university hospital, one study found that participants who received one MI session prior to hospital discharge were more likely to attend an initial outpatient treatment session than participants who did not receive a MI session, an increase from 36 percent to 67 percent (Miller & Rollnick, 2002).

Contingency management and its use of rewards and incentives have been shown to be an effective means of reducing substance use. One study assessed the value of including "enhanced incentives" to vocational rehabilitation in the Veterans' Administration's

compensated work therapy (CWT) program. Nineteen dually diagnosed veterans participated in the study. Eleven veterans received CWT with incentives and 8 veterans received CWT without incentives. Results indicated that veterans who received added incentives were more likely to abstain from substances, participated in more job-related activities, and received 68% more in job earnings (Drebing et al., 2005).

Another study focused on the use of contingency management to encourage marijuana abstinence among 18 adult males with schizophrenia or other serious mental illness. Participants were given varying amounts of monetary incentives ($25, $50, and $100) if they provided researchers with a negative marijuana urinalysis test. Results showed decreased marijuana use during the intervention phase. However, there was no evidence indicating that larger incentives had influenced abstinence results (Stacey et al., 2000).

Assertive community treatment (ACT) has been shown to be an effective intervention with co-occurring individuals with severe mental illness, especially those with poor medication adherence. One study compared assertive community treatment against standard clinical

case management. Results indicated that the ACT patients reported greater medication adherence compared to patients receiving standard case management (Manuel, 2011).

Tsai et al., (2009) assessed a pilot program which incorporated integrated dual diagnosis treatment, supported housing services, and assertive community treatment (ACT). Collaboration was developed between a state hospital, a community mental health center and a housing provider in an effort to help homeless clients re-enter the community after being discharged from a state hospital. During the course of a 2-year period, 12 clients were enrolled in the program and received substance abuse treatment and housing assistance. Results of the study demonstrated significant reductions in hospitalization and increased participation in the active and maintenance stages of substance abuse treatment. In addition, results indicated an increase in employment rates and a steady decrease in homelessness.

Although each of these psychosocial interventions appeared to be associated with a certain level of treatment success (some more successful than others), there is no clear evidence supporting one type of

intervention over another. Nevertheless, Robert Drake and colleagues utilized thirty years of research on integrated treatment to publish a book titled, "Integrated treatment for dual disorders: A guide to effective practice" which described the eight essential components of integrated treatment. They stated that these components were associated with evidenced-based practice because they were frequently included in programs that have produced successful treatment outcomes. They also stated that the absence of these components were associated with "predictable failures." The first three components incorporated familiar treatment interventions such as cognitive-behavioral therapy, motivational interventions, and assertive outreach. The remaining five components included components such as staged interventions, social support interventions, a long-term perspective, comprehensiveness, and cultural sensitivity and competence (Mueser et al., 2003).

Staged interventions consist of four stages of treatment: Engagement, Persuasion, Active treatment, and Relapse Prevention. The purpose of engagement is to establish a trusting therapeutic relationship between

client and counselor. The purpose of persuasion is to establish proper motivation for the client to participate in the treatment of their co-occurring disorders. The goal of active treatment is to provide the client with the skills and tools for controlling their illness, decreasing their substance use and achieving personal goals. Relapse prevention helps the client develop strategies to maintain sobriety for a sustained period of time (Mueser et al., 2003).

The purpose of social support interventions is to provide clients with the appropriate skills for meeting their interpersonal needs and managing social situations involving alcohol and drugs. A long-term perspective was included because clients experience treatment differently and recover at their own pace. Clients need adequate time to utilize new skills learned during treatment and to establish a positive support system. In order to eliminate substance abuse, a comprehensive perspective was developed in order to examine many aspects of an addict's life, which include family/social relationships, housing, employment, personal activities, and managing stressful situations. Cultural sensitivity and competence is an essential component in dual diagnosis treatment

because it acknowledges the importance of a client's culture, values, beliefs, and traditions (Mueser et al., 2003).

These theories guided the current research study with the construction of a questionnaire that determined what type of psychosocial interventions are being used in current dual diagnosis programs throughout San Bernardino and Riverside County. In addition, the questionnaire determined which treatment facilities utilized all eight essential components of integrated treatment associated with evidence-based practice. This study determined the importance of integrated treatment programs for individuals with co-occurring disorders and to provide continued support for the research theories proposed by Mueser et al. (2003). This type of study was necessary because there is a lack of public information regarding dual diagnosis treatment programs throughout San Bernardino and Riverside County and the overall success (or failure) of these integrated programs.

CHAPTER THREE

METHODS

Introduction

In this chapter, the study design, sampling method, data collection and instruments, procedures, protection of human subjects and data analysis will be covered. Preliminary plans on ways to obtain samples and levels of measurement for both independent and dependent variables will be discussed. Limitations to this specific study will also be discussed.

Study Design

The purpose of this study was to explore the effectiveness of integrated treatment of co-occurring disorders by examining the different dual diagnosis programs currently available throughout San Bernardino and Riverside County.

According the book, "Integrated treatment for dual disorders: A guide to effective practice" (Mueser et al., 2003), there are eight essential features in integrated treatment programs that are associated with evidence-based practice because they are frequently present in programs that have produced successful

treatment outcomes. These features include staged intervention, assertive outreach, motivational interventions, counseling, social support interventions, a long-term perspective, comprehensiveness, and cultural sensitivity and competence. A questionnaire (See Appendix A) was created for the purpose of obtaining information regarding treatment data and to determine which program currently utilizes the eight essential components of integrated treatment.

The questionnaire was given to treatment professionals throughout San Bernardino and Riverside County who either supervise or perform integrated treatment of substance use and mental health disorders. The questionnaire was divided into four sections using a qualitative design. This research method was chosen because these individuals can provide valuable insight in the area of dual diagnosis and what they perceive to be effective treatment for this client population based on professional experience.

The first section asked the treatment professional to provide an overview of the treatment facility such as length of dual diagnosis program, whether or not clients are attending treatment voluntarily or mandated by the

courts, and the severity of client co-occurring mental illness. The second section asked treatment information to determine which programs have utilized all eight essential components of integrated treatment according to Mueser et al. (2003). The treatment professional was given a description of each of these components and asked whether it is included in their dual diagnosis program.

The third section asked the treatment professional to provide demographic information concerning the dual diagnosis program, including the total number of clients who dropped out of treatment, successfully completed the program, were terminated by the facility, and referred to another agency since the program was implemented. The fourth section asked each treatment professional to provide the overall benefits and limitations of their dual diagnosis program. They were also asked to offer any suggestions that might improve the treatment program.

One of the limitations of the study was that the research data was solely dependent on the cooperation from each treatment agency. Without sufficient data from an assortment of treatment facilities, the study would only generate limited results. The main hypothesis for this study stated that dual diagnosis programs which

incorporate all eight essential features of integrated treatment will generate more successful treatment outcomes than duals diagnosis programs that do not contain all eight essential features of integrated treatment.

Sampling

The sample for the study included data from treatment professionals throughout San Bernardino and Riverside County who either supervise or perform integrated treatment of substance use and mental health disorders. This population was the main focus of study because these individuals have the professional experience to determine the effectiveness of the dual diagnosis program implemented within their agency. In terms of sample size, the study obtained data from treatment facilities throughout San Bernardino and Riverside County. According to the Rainbow Resource Directory, there are eight facilities in San Bernardino County and ten facilities in Riverside country that provide dual-diagnosis services. A sample size of ten to twelve treatment professionals was preferred in order to obtain a representative sample of treatment facilities

throughout San Bernardino and Riverside County. Data collection was conducted from August through December 2011.

Data Collection and Instruments

In this qualitative study, data was collected through questionnaires given to each treatment professional from different dual diagnosis programs throughout San Bernardino and Riverside County. The questionnaire began by asking the treatment professional to provide an overview of the treatment facility: 1) What is the length of your dual diagnosis program? 2) Is your program an outpatient or residential facility? 3) What is the severity of the client co-occurring mental illness?

The questionnaire gathered data regarding the number of programs that currently utilize the eight essential components of integrated treatment. The treatment professional was given a description of each of these components and asked whether it is included in their dual diagnosis program:

Component #1 (Staged interventions): Does your program abide by the four stages of treatment? The

four stages include engagement, persuasion, active treatment and relapse prevention.

Component #2 (Assertive outreach): Does your program provide assertive outreach services?

Component #3 (Motivational interventions): Does your program provide motivational interventions?

Component #4 (Counseling): Does your program provide counseling services in the form of cognitive-behavioral skills?

Component #5 (Social support interventions): Does your program provide social support interventions?

Component #6 (Long-term perspective): Does your program view treatment as a long-term process?

Component #7 (Comprehensiveness): Does your program view treatment as comprehensive?

Component #8 (Cultural sensitivity and competence): Does your program practice cultural sensitivity and competence?

The questionnaire also asked treatment professionals to provide demographic information related to their treatment program. Since the program's inception, how many clients have: 1) Dropped out of the program?

2) Successfully completed the program? 3) Were terminated from the program? 4) Were referred to another agency?

In addition, the questionnaire incorporated the treatment professionals' personal feelings toward their treatment program: 1) What do you feel are the overall benefits of the treatment program? 2) What do you feel are the limitations of the treatment program? 3) Can you offer any suggestions that might improve on the treatment program?

The questionnaire was created for the study because there was not an instrument currently available that assessed the effectiveness of dual diagnosis programs which utilized the eight essential features of integrated treatment according to Mueser et al. (2003). It was difficult to determine the likely strength of this instrument because it was created for the sole purpose of this study. This was also the main limitation of the instrument. It was not proven to be either valid or reliable. The list of general topics that was addressed throughout the study included staged interventions, assertive outreach, motivational interventions, counseling, social support interventions, long-term

perspective, comprehensiveness, and cultural sensitivity and competence.

Procedures

Before this research study was conducted, the dual diagnosis treatment agency was contacted. In order to obtain approval to conduct the study, an informed consent document was sent, outlining the identification of the researcher, contact information, the nature and purpose of the study, how confidentiality will be preserved, the voluntary nature of the study, and an approval statement from the Institutional Review Board. In addition, a copy of the questionnaire to be utilized for the study was attached. Once the study was approved, a face-to-face interview with a treatment professional was requested. If a physical interview was not possible, then a phone conference was suggested. If these two methods posed a hardship for the treatment professional, the questionnaire was sent via mailbox or email attachment. If the treatment professional chose the mailbox method, a self-addressed, stamped return envelope was sent to the treatment facility.

Once the treatment professional completed the questionnaire, they simply dropped the envelope in the mailbox. If the treatment professional chose the email attachment method, they only needed to open the attachment, complete the questionnaire, then resend the questionnaire to the original email address. Afterwards, each treatment professional received a debriefing statement (See Appendix B) describing the study they just participated in. They also received information regarding when and where they can obtain the results of the study. The timetable of the activities was August through December 2011.

Protection of Human Subjects

All data was collected from treatment questionnaires. However, the identity of the individuals completing these questionnaires remained confidential and non-identifying information was used in the research findings. In addition, specific information such as treatment facility was not included in the research findings. All information obtained throughout the study was stored in a locked cabinet and disposed of after the appropriate specified amount of time (See Appendix C).

Data Analysis

Qualitative procedures used to answer the research question was through questionnaire responses given by each treatment professional regarding the overall benefits and limitations of the treatment program and suggestions to improve the dual diagnosis program. Treatment professionals provided the study with valuable insight in terms of the strengths and weaknesses of dual diagnosis programs and what type of treatment is beneficial for this specific client population.

Summary

In this chapter, the preliminary study design was discussed, as well as the means from which the data will be collected. Procedures for which the data will be collected were specified and the provisions of confidentiality were outlined. Data analysis was conceptualized and preliminary thoughts on statistical tests were discussed.

CHAPTER FOUR

RESULTS

Introduction

In this chapter, research data including the type of treatment professionals who participated in the study, length of dual diagnosis program, treatment facilities involving voluntary versus court mandated clients and severity of client co-occurring mental illness are revealed and the presentation of the research findings will be covered.

The main hypothesis for this study stated that dual diagnosis programs which incorporate all eight essential features of integrated treatment will generate more successful treatment outcomes than dual diagnosis programs that do not contain all eight essential features of integrated treatment.

Participants of the Study

The sample for the study included data gathered from ten different professionals from ten different agencies throughout San Bernardino and Riverside County who either supervise or perform integrated treatment of substance use and mental health disorders. This population was the

main focus of study because these individuals have the professional experience to determine the effectiveness of the dual diagnosis program implemented within their agency. The treatment professionals who participated in the study included one clinic supervisor, two program managers, two clinical therapists, and five substance abuse counselors. A deliberate attempt was made to interview different treatment professionals throughout San Bernardino and Riverside County in order to obtain an array of professional opinions concerning dual diagnosis treatment.

Treatment Information

The treatment facilities that participated in the study included five outpatient treatment facilities and one residential facility in San Bernardino County. In addition, three outpatient treatment facilities and one residential facility in Riverside County participated in the study. The length of dual diagnosis programs were varied throughout San Bernardino and Riverside County. The shortest dual diagnosis program was a voluntary three month program and no aftercare at the end of treatment (Agency #4). Another three month dual diagnosis program

was used in the research study. However, clients from this treatment program were allowed to continue treatment after the three-month period as long as they attended group sessions on a consistent basis (Agency #3). This program involved a mixture of voluntary and court-mandated clients.

The next two treatment facilities included a four-month treatment program and 12 weeks of aftercare (Agency #2) and a five-month treatment program and no aftercare (Agency #1). Both treatment programs involved a mixture of voluntary and court-mandated clients. The next treatment facility included a six-month treatment program and three additional months if clients choose to extend their treatment (Agency #7). The longest dual diagnosis program lasted for one year and had no aftercare (Agency #6). It is possible to allow clients to continue treatment for an additional three months, but it is often done on a case-by-case basis. Only two treatment facilities allowed clients to continue treatment without a time limit. One treatment professional stated that clients can attend treatment "for as long as they need or until we feel that they have met their recovery goals" (Agency #5, Personal Interview, December 2011). Another

treatment professional stated that "clients can see the therapist as long as they need to" (Agency #9, Personal Interview, December 2011).

The first residential facility that was used for the study included a 60-day treatment program for a Kaiser-funded clients or a 45-day treatment program for County-funded clients (Agency #10). The second residential facility that was used for the study included a 90-day treatment program and an aftercare component at the end of treatment (Agency #8). Both residential facilities included a mixture of voluntary and court-mandated clients.

In terms of the severity of client co-occurring mental illness, seven out of ten treatment facilities used in the research study stated that their dual diagnosis clients had a "moderate" severity of mental illness (Agencies #1, 2, 3, 4, 6, 7, and 8). Some of the mental health diagnoses provided by treatment professionals included a mixture of Major Depressive disorder, Bipolar disorder with and without psychotic features, and "high functioning" schizophrenics. Both residential facilities were included among the agencies that treated clients with a "moderate" severity of mental

illness. Residential facilities often accept dual diagnosis clients with a "moderate" severity of mental illness because clients are required to follow directions given by treatment staff and abide by the rules of the treatment program.

One out of ten treatment facilities (agency #10) used in the research study stated that their clients had "moderate to severe" co-occurring mental illness, with a mixture of depression, anxiety, and schizophrenia. The last two treatment facilities (Agency #5 and #9) used in the research study stated that their clients had "severe" co-occurring mental illness, most notably, schizophrenia. These are the same two agencies who allow clients to continue treatment without a time limit. Many clients who participated in dual diagnosis treatment, whether it is outpatient or residential, moderate or severe, came into treatment with medication on-hand or receive medication after an examination from a medical doctor.

Research Findings

Research findings indicated that all ten treatment agencies participated in staged interventions (Component #1) which included Engagement, Persuasion, Active

treatment and Relapse Prevention. Only two treatment agencies (Agency #5 and #9) stated that they provided assertive outreach (Component #2), which is due to the fact that both agencies receive their funding sources through California's Mental Health Services Act (MHSA). The purpose and intent of the MHSA is

> to reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness...to insure that all funds are expended in the most cost effective manner...to ensure accountability to taxpayers and to the public. (MHSA, 2004. p. 3)

The two agencies who participated in the study treated the underserved population (i.e., homeless) who present a severe mental illness (i.e., schizophrenia) and indicate recent hospitalization or multiple hospitalizations within a twelve-month period.

All ten treatment agencies indicated that they participated in motivational interventions (Component #3). All ten treatment agencies stated that they participated in cognitive-behavioral counseling (Component #4). All ten treatment agencies stated that they participated in social support interventions

(Component #5), including dealing with substance use situations, ability to engage in conversation and friendship, assertiveness and conflict management, and problem-solving skills. Only three treatment agencies (Agency #3, #5, and #9) stated that they participated in a program with a long-term perspective (Component #6). Treatment agencies #5 and #9 both receive funding sources through the Mental Health Services Act (MHSA). Treatment professionals from both agencies indicate that their programs are open-ended, no real time limit. Clients continue to see a therapist or attend group sessions for as long as they need to, or until treatment staff feels that they have met their recovery goals.

Treatment agency #3 has a treatment program with a duration of 16-weeks. However, the treatment professional indicated that their program allows clients to continue attending group sessions after the initial 16 weeks because they view treatment as a long-term perspective. They feel that 16 weeks may not be sufficient time to treat their co-occurring clients. They also feel that these clients often develop close, almost "familial" bonds with one another which promote healthy social support. If clients choose to continue their treatment,

they are asked to attend group sessions on a consistent basis.

All ten treatment agencies stated that they participated in a treatment program that is comprehensive (Component #7) and addresses all areas of functioning that are frequently impaired in clients with dual disorders, such as housing, vocational functioning, ability to manage the psychiatric illness, and family/social relationships. All ten-treatment agencies stated that they participated in a treatment program that participates in cultural sensitivity and competence (Component #8).

Treatment Outcomes

Of all the dual diagnosis treatment agencies used for the study, only three agencies were able to provide numerical data in terms of clients who successfully completed the program, dropped out of the program, were terminated by the facility, and were referred to another agency (Agency #1, #4, and #6). Agency #1 stated that their dual diagnosis program has only been active for six months and they recently had their first graduate who successfully completed the program. Agency #4 stated that

215 clients successfully completed the program, 306 clients dropped out or were terminated by the facility, and 188 clients were referred to another agency. Agency #6 stated that 316 clients successfully completed the program, 551 clients left the program or terminated by the facility and 230 clients were referred to another facility.

The remainder of treatment agencies provided this study with percentages of clients who successfully completed the program, dropped out of the program, were terminated by the facility, and was referred to another agency. Agency #2 stated that their success rate was 80% and only a small percentage either dropped out of the program or transferred to a higher level of care. Agency #3 stated that most of their clients do well in the program, with only 5-10% getting referred out to a residential facility.

Agency #5 stated that treatment success rates are as high as 80-90%, with a dropout rate of 5%. The treatment professional reported that in his dual diagnosis group, five people have successfully completed the program, but there are 10 clients who are considered successes, and continue to attend group sessions. In addition, the

treatment professional stated that he only had to terminate one person because the client's illness was disruptive to the rest of the group.

Agency #7 stated that 60 % of their clients successfully completed the program, 10 % were referred to a higher level of care and the rest were dropped or terminated from the program. Agency #8 stated that 40 to 50% of clients completed the program. The remainder of clients either walked away from the program or were terminated for not adhering to treatment rules or due to medical, psychiatric or legal reasons.

Agency #9 indicated that they have a success rate as high as 90%. The treatment professional reported that his agency has never terminated anyone from the program. If necessary, they will refer them to another treatment agency. The treatment professional stated that within the last year, he had to refer three or four clients to a higher level of care. Agency #10 stated that they have a 96% success rate of clients who have successfully completed the program.

Summary

In the qualitative research study of dual diagnosis treatment facilities throughout San Bernardino and Riverside County, it was discovered that eight treatment agencies (Agency #1, #2, #3, #4, #6, #7, #8, and #10) were only utilizing six out of eight essential components of an effective treatment program. These treatment programs did not provide Assertive Outreach and Long-term treatment services. However, only two agencies (Agency #5 and #9) were able to utilize all eight essential components because they both received their funding sources through California's Mental Health Services Act (MHSA) and treat the underserved population (i.e., homeless) who present a severe mental illness (i.e., schizophrenia) and indicate recent hospitalization or multiple hospitalizations within a twelve-month period.

CHAPTER FIVE

DISCUSSION

Introduction

In this chapter, a discussion of the research findings will be covered. Professional suggestions to improve or expand dual diagnosis treatment are also included. In addition, there is a brief discussion on how the California recession has negatively impacted County programs and recommendations for social work practice, policy, and research.

Discussion

In the qualitative research study of dual diagnosis treatment facilities throughout San Bernardino and Riverside County, it was discovered that eight treatment agencies were only utilizing six out of eight essential components of an effective treatment program. These treatment programs did not provide Assertive Outreach and Long-term treatment services. Only two agencies were able to utilize all eight essential components because they both received their funding sources through California's Mental Health Services Act (MHSA) and treat the underserved population (i.e., homeless) who present a

severe mental illness (i.e., schizophrenia) and indicate recent hospitalization or multiple hospitalizations within a twelve-month period.

The results of this study indicate that the parallel or serial treatment model for treating co-occurring disorders is no longer in effect as many treatment agencies throughout San Bernardino and Riverside County are moving towards an integrated treatment approach. In addition, the study did not support the hypothesis that dual diagnosis programs which incorporate all eight essential components of integrated treatment will generate more successful treatment outcomes than dual diagnosis programs that do not contain all eight essential components of integrated treatment. The eight treatment programs that incorporated only six essential components were just as effective as the two treatment programs that incorporated all eight components.

Although integrated treatment programs appear to be an effective means to treat individuals with co-occurring disorders, many professionals were able to provide suggestions to improve or expand their treatment programs. More than half of the treatment professionals interviewed for the study suggested that more money

distributed into the agency would provide better treatment outcomes, especially in terms of offering more treatment services to clients. The two agencies that provide assertive outreach stated that their program would be improved if they had access to more vehicles to conduct further outreach services. They also stated that it would be beneficial to provide clients with monthly bus passes if they have transportation issues. Attending group sessions is particularly difficult for clients who live in the high desert region and must travel several miles away to reach the treatment facility.

One residential facility recommended increased funding to expand treatment facilities and hiring more licensed professionals to assist clients. They also suggested more "appropriate" housing for clients seeking a sober living environment at the end of treatment. One treatment professional stated that clients often find themselves going to sober living facilities in drug-infested neighborhoods, further increasing the likelihood of a drug relapse.

In addition to more funds for treatment programs, more than half of treatment professionals suggested that an extended treatment period would improve outcomes for

co-occurring clients. Four agencies suggested that the duration of treatment should be between six and 12 months. One agency did not provide a specific time period for treatment. However, the treatment professional stated that he would like to give clients sufficient time to make use of community-based resources (12-step meetings, sponsorship, etc.) because recovery takes place within an individual's home environment. Another agency also wanted to give clients more time to acclimate themselves into the 12-step community, extending their residential treatment program from 60 to 90 days.

Only one program suggested a shorter period for treatment due to the high drop-out rate of clients. This agency currently has a one-year dual diagnosis treatment program, with an additional three months, if necessary. The treatment professional felt that it is difficult for the dual diagnosis population to remain in treatment for a long period of time and that each day they remain sober is a success. She suggested that four months of treatment would be satisfactory for this client population.

Although many agencies view money and time as a way to improve their treatment program, other treatment professionals provided different suggestions. Two

treatment agencies suggested the inclusion of family groups for dual diagnosis treatment. The purpose of these family groups is to educate the family on co-occurring disorders, developing healthy communication and coping skills, providing social support, and recognizing signs of relapse. One treatment agency suggested more cultural sensitivity trainings, especially towards individuals with co-occurring substance use and psychiatric disorders. According to one treatment professional, staff members often seek guidance from her on the appropriate ways to treat this client population.

California Recession Affects Treatment Services

The latest news from the Substance Abuse and Mental Health Services Administration (SAMHSA) has indicated that less money will be utilized for Mental Health and Substance Abuse treatment services. On February 13, 2012, President Obama's Budget Request for SAMHSA Fiscal Year 2013 was released. This Budget Request was divided among four appropriations: Mental Health, Substance Abuse Prevention, Substance Abuse Treatment, and Health Surveillance and Program Support. For Fiscal Year 2013, the President's Budget Request for the Total Program Level of

SAMHSA appropriations are as follows: Mental Health appropriation was $951.9 million (-$47 million from last year), Substance Abuse Prevention appropriation was $470.4 million (-59.8 million from last year), and Substance Abuse Treatment appropriation was $1.8 billion (-$68.6 million from last year). The only increased SAMHSA appropriation was Health Surveillance and Program Support, which was $187.7 million (+$33.4 million from last year).

It appears that agencies that provide strictly alcohol and drug services are the ones being hit the hardest by these budget cuts. According to one treatment professional, the budget for alcohol and drug services within San Bernardino County has decreased from 47 million to 22 million within the last five years. Perinatal and Addiction Treatment Services, which provided substance abuse treatment to pregnant and postpartum women, was one of the programs affected by decreasing budgets.

According to one clinic supervisor at a co-occurring treatment facility, alcohol and drug services are the first programs to receive budget cuts because they are viewed as voluntary counseling programs where people are making choices to use drugs or not. In order to cut down

on treatment costs, alcohol and drug programs will likely become privatized which offers fewer benefits and takes out the County management portion, which is usually 25% of the cost. The clinic supervisor also stated that dual diagnosis treatment programs will be one of the last programs to be cut because clients with co-occurring substance use and mental health disorders are viewed as having more severe physical, emotional, and social problems compared to clients with only a substance use disorder.

Unfortunately, the current recession in California is not recovering as fast as many had hoped and unemployment rates continue to remain high. Therefore, it is only a matter of time before dual diagnosis programs are negatively affected by the state budget. The clinic supervisor projected two more years before experiencing substantial budget cuts to the treatment program. If this prediction is accurate, dual diagnosis programs throughout San Bernardino and Riverside County will be forced to maintain the quality of client care with fewer agency funds. They will also need to develop new and creative ways to bring about additional revenue.

Recommendations for Social Work Practice, Policy, and Research

In order to assist individuals with co-occurring disorders, especially during these fragile economic times, social workers must utilize more community-based resources, such as specialized 12-step groups for individuals with co-occurring disorders. Four specialized 12-step groups that have gained recognition in the field of dual recovery include Dual Diagnosis Anonymous, Double Trouble in Recovery, Dual Disorders Anonymous, and Dual Recovery Anonymous.

The specialized 12-step group which has received the most attention is Double Trouble in Recovery (DTR) which was co-founded by Howard S. Vogel based on his own experiences in dual recovery (Vogel et al., 1998). In 1998, an evaluation of DTR was conducted by interviewing 310 persons attending 24 DTR meetings in New York City and conducting a follow-up in 1999 and 2000. Ultimately, the results obtained from this evaluation produced 13 articles in 12 peer reviewed journals (Magura, 2008).

Overall, the findings indicated that greater DTR affiliation was associated with increased abstinence from drugs/alcohol (Laudet et al., 2004), better psychiatric

medication adherence (Magura et al., 2002), and improved coping and quality of life (Magura, Cleland, Vogel, Knight, & Laudet, 2007). In addition, it is reported that co-occurring individuals with severe psychiatric symptoms were more likely than others to attend DTR on a regular basis, demonstrating that DTR is available for the most severely impaired individuals (Magura et al., 2003). DTR also appears to be a setting where co-occurring individuals can feel safe discussing issues related to their addiction and other psychiatric disorders, increasing the possibility of personal recovery. In addition, many group members who participate in DTR feel that they can continue attending traditional 12-step groups because they no longer need to depend on the latter for their complete "support network for recovery" (Vogel et al., 1998, p. 361).

Conclusion

It is encouraging news to learn that the integrated treatment of co-occurring disorders has gained acceptance from San Bernardino and Riverside County, especially since mental health disorders often interfere with substance abuse and substance use disorders often interfere with a patient's

mental health. Despite the fact that many researchers have demonstrated the effectiveness of integrated treatment, treatment is still not widely available to consumers. There is still a need for more research in order to find empirical support for this treatment approach. In addition, it is important for social workers to encourage individuals with co-occurring disorders to utilize community-based resources at the completion of treatment in order to maintain dual recovery.

APPENDIX A

QUESTIONNAIRE

DUAL DIAGNOSIS TREATMENT QUESTIONNAIRE

The purpose of this study is to explore the effectiveness of integrated treatment of co-occurring disorders by examining dual diagnosis programs currently available throughout San Bernardino and Riverside County. According the book, "Integrated Treatment for Dual Disorders: A guide to effective practice" (Mueser et al., 2003), there are eight essential components in integrated treatment programs that are associated with evidence-based practice because they are frequently present in programs that have produced successful treatment outcomes. It is also stated that the absence of these components were associated with "predictable failures." The current study will assess the effectiveness of dual diagnosis programs which utilize all eight essential components of integrated treatment.

TREATMENT INFORMATION

- What is the length of your dual diagnosis program?
- Is your program an outpatient or residential facility?
- What is the severity of the client co-occurring mental illness?

COMPONENT #1: STAGED INTERVENTIONS

DOES YOUR PROGRAM ABIDE BY THE FOUR STAGES OF TREATMENT?

1) ENGAGEMENT: The goal is to establish a working alliance between the clinician and the client.

2) PERSUASION: The goal is to develop the client's awareness that substance use is a problem, and increase motivation to change.

3) ACTIVE TREATMENT: The goal is to further reduce substance use and, if possible, attain abstinence.

4) RELAPSE PREVENTION: The goal is to maintain that relapse can happen, and to extend recovery to other areas (e.g., social relationships, work).

COMPONENT #2: ASSERTIVE OUTREACH

The Assertive community treatment model (ACT) was developed to meet the needs of clients with severe mental illness who have histories of very high service utilization. Most services are provided to clients in their natural living settings. There is also a low clinician-to-client caseload ratio (1:10).

DOES YOUR PROGRAM PROVIDE ASSERTIVE OUTREACH SERVICES?

COMPONENT #3: MOTIVATIONAL INTERVENTIONS

The purpose of motivational interviewing is to help clients recognize how their substance abuse interferes with their ability to achieve personally valued goals-rather than the goals of clinicians or of society at large-and become motivated to work on their substance abuse in order to pursue these goals.

DOES YOUR PROGRAM PROVIDE MOTIVATIONAL INTERVENTIONS?

COMPONENT #4: COUNSELING

Cognitive-behavioral counseling consists of teaching clients how to systematically identify and modify the antecedents and consequences of problematic thoughts, feelings, and behaviors.

DOES YOUR PROGRAM PROVIDE COUNSELING SERVICES IN THE FORM OF COGNITIVE-BEHAVIORAL SKILLS?

COMPONENT #5: SOCIAL SUPPORT INTERVENTIONS

Social Skills training groups are aimed at teaching clients specific skills for getting their interpersonal needs met and for handling common situations involving alcohol and drug use. The types of social skills taught are divided into four categories: dealing with substance use situations, conversational and friendship, assertiveness and conflict management, and problem-solving skills.

DOES YOUR PROGRAM PROVIDE SOCIAL SUPPORT INTERVENTIONS?

COMPONENT #6: LONG-TERM PERSPECTIVE

The long-term perspective addresses the need for time-unlimited services: Artificial constraints on the duration of services can prematurely terminate intervention for clients with dual disorders who would otherwise improve with continued treatment.

DOES YOUR PROGRAM VIEW TREATMENT AS A LONG-TERM PROCESS?

COMPONENT #7: COMPREHENSIVENESS

Comprehensiveness addresses the scope of dual-disorder interventions: services are directed not only at the problem of substance abuse, but at the broad array of other areas of functioning that are frequently impaired in clients with dual disorders, such as housing, vocational functioning, ability to manage the psychiatric illness, and family/social relationships.

DOES YOUR PROGRAM VIEW TREATMENT AS COMPREHENSIVE?

COMPONENT #8: CULTURAL SENSITIVITY AND COMPETENCE

Effective integrated treatment programs must contain elements of cultural sensitivity and competence in order to lure consumers. Minority groups such as African-Americans and Hispanics and underserved groups such farm workers, homeless persons, and women with children can benefit from dual diagnosis services as long as it is tailored to their particular racial and cultural needs.

DOES YOUR PROGRAM PRACTICE CULTURAL SENSITIVITY AND COMPETENCE?

TREATMENT DEMOGRAPHICS: SINCE THE PROGRAM'S INCEPTION, HOW MANY CLIENTS HAVE:

1) DROPPED OUT OF THE PROGRAM_____

2) SUCCESSFULLY COMPLETED THE PROGRAM_____

3) WERE TERMINATED BY THE FACILITY_____

4) WERE REFERRED TO ANOTHER AGENCY_____

WHAT DO YOU FEEL ARE THE OVERALL BENEFITS OF THE TREATMENT PROGRAM?

WHAT DO YOU FEEL ARE THE LIMITATIONS OF THE TREATMENT PROGRAM?

CAN YOU OFFER ANY SUGGESTIONS THAT MIGHT IMPROVE ON THE TREATMENT PROGRAM?

Developed by Joseph Bermudez

APPENDIX B

INFORMED CONSENT

INFORMED CONSENT

The study in which you are being asked to participate is designed to investigate the effectiveness of the integrated treatment of substance use and mental health disorders. This study is being conducted by Joseph Bermudez under the supervision of Associate Professor Thomas D. Davis, Ph.D., California State University, San Bernardino. This study has been approved by the School of Social Work Sub-Committee of the Institutional Review Board, California State University, San Bernardino.

The purpose of this study is to examine the effectiveness of current dual diagnosis programs throughout San Bernardino and Riverside County and to determine which facilities utilize all eight essential components of integrated treatment according to the book, "Integrated treatment for dual disorders: A guide to effective practice" (Mueser et al., 2003). Practitioners will be the main focus of study because they will have first-hand knowledge of the effectiveness of the dual diagnosis program implemented within their agency. Practitioners will be given questionnaires requesting information concerning the combined number of essential components incorporated into the program, the total number of clients who dropped out of treatment, successfully completed the program, were terminated by the facility and referred to another agency. The questionnaire will also incorporate the practitioners' professional opinions toward treatment, including benefits and limitations of the program and areas for improvement.

Research participation is completely voluntary. Any treatment providers who refuse to participate will not be penalized in any way. In addition, individuals may choose to discontinue participation at any time during the study without being penalized.

All data will be collected from questionnaires. However, the identity of the individuals participating in these questionnaires will remain confidential and only non-identifying information will be used in the research findings. In addition, specific information such as treatment facility will not be included in the research findings. All information obtained throughout the study will be stored in a locked cabinet and disposed of after the appropriate specified length of time.

The participation for each subject will consist of the completion of a 3-page questionnaire that will take approximately 20 minutes. There is minimal risk for this research study because the main focus will be practitioners who conduct dual diagnosis programs and questionnaires will only request information regarding treatment. Anticipated benefits of the study include further support for the integrated treatment of co-occurring disorders and the eight essential components of integrated treatment associated with evidence-based practice.

To obtain answers to questions concerning the research study, please contact Professor Rosemary McCaslin, Ph.D., M.S.W., California State University, San Bernardino, 909-537-5507 email: rmccasli@csusb.edu. Once the research study is complete, results can be obtained at the CSUSB Pfau library after September 12, 2012.

Your mark below indicates your approval for this study to be conducted at your treatment facility.

Mark: _____ Date: _____

Place a check here if audio recordings are permitted during interviews with practitioners [ ]

APPENDIX C

DEBRIEFING STATEMENT

THE EFFECTIVENESS OF INTEGRATED TREATMENT OF CO-OCCURRING DISORDERS

DEBRIEFING STATEMENT

The research study you have just completed was designed to examine the effectiveness of current dual diagnosis programs by means of questionnaires given to practitioners in different treatment facilities throughout San Bernardino and Riverside County. The study was also designed to assess which facilities currently utilize all eight essential components of integrated treatment according to the book, "Integrated treatment for dual disorders: A guide to effective practice" (Mueser et al., 2003). Although many studies have demonstrated that integrated treatment is an effective method for treating individuals with co-occurring disorders, treatment is still not widely available to consumers. There is still a need for more research in order to find empirical support for this treatment approach.

Thank you for your participation in the study. If you have any questions, please feel free to contact Professor Rosemary McCaslin, Ph.D., M.S.W., California State University, San Bernardino, 909-537-5507 email: rmccasli@csusb.edu. Once the research study is complete, results can be obtained at the CSUSB Pfau library after September 12, 2012.

APPENDIX D

TREATMENT OUTCOMES

Location of agency (SB or Riverside County)	Length of Program	Outpatient or Residential	Voluntary or Court Mandated	Severity of Client mental illness	Comp. Two: Assertive Outreach	Comp. Six: Long Term Perspective	Treatment outcomes
Agency #1 SB County	5 months. No aftercare	Outpatient	50% Voluntary 50% Court mandated	Moderate	No	No	"Our program has only been opened for six months. We currently have 40 clients enrolled with a capacity of 70. We just recently had our first graduate."
Agency #2 Riverside County	4 months of care + 12 weeks of aftercare	Outpatient	Mostly Court mandated, Few cases of voluntary clients	Moderate	No	No	"Success rate of our program is about 80%. A small percentage of our clients dropped out of the program or needed to be transferred to a higher level of care."
Agency #3 Riverside County	16 weeks. "Clients are allowed to continue at group the end of treatment."	Outpatient	A mixture of voluntary and court mandated clients	Moderate	No	Yes	"Most of our clients do well in this program. Only about 5-10% may get referred out to a residential facility."
Agency #4 SB County	3 months No aftercare	Outpatient	Voluntary	Moderate	No	No	"557 clients successfully completed the program, 594 clients voluntarily dropped out, and 329 were terminated by the treatment facility."

Location of agency (SB or Riverside County)	Length of Program	Outpatient or Residential	Voluntary or Court Mandated	Severity of Client mental illness	Comp. Two: Assertive Outreach	Comp. Six: Long Term Perspective	Treatment outcomes
Agency #5 SB County	Open-ended. "Clients continue to attend for as long as they need, or until we feel that they have met their recovery goals."	Outpatient	Voluntary	Severe	Yes	Yes	"Success rates are as high as 80-90%. Dropout rates are low, about 5%. In my group, there are 5 people that have successfully completed the program. But there are 10 that are considered successes, but they are ongoing. I only had to terminate one person because his illness was disruptive to the group."
Agency #6 Riverside County	1 year. No aftercare. "We can keep them 3 extra months but it is done case by case."	Outpatient	Court Mandated	Moderate	No	No	"At this time, 316 clients successfully completed, 551 clients left the program or terminated by the facility & 230 clients were referred to another facility."
Agency #7 SB County	Six months. "It is possible for our clients to extend their treatment for another three months."	Outpatient	Mostly voluntary, some court mandated	Moderate	No	No	"60% of our clients successfully completed the program. 10% were referred to a higher level of care. The rest of our clients dropped or were terminated from the program."

Location of agency (SB or Riverside County)	Length of Program	Outpatient or Residential	Voluntary or Court Mandated	Severity of Client mental illness	Comp. Two: Assertive Outreach	Comp. Six: Long Term Perspective	Treatment outcomes
Agency #8 SB County	90 days + aftercare	Residential	Mostly voluntary, 20% court mandated clients	Moderate	No	No	"40-50% of people who walk through our doors completed the program. The rest didn't make it because of rule violations or fraternizing... or because of medical, psychiatric or legal reasons. And then there are those who just walked away."
Agency #9 SB County	No time limit. "The clients can see the therapist as long as they need to, so it's ongoing."	Outpatient	Voluntary	Severe	Yes	Yes	"We have a good success rate... as high as 90%. We never terminate anyone. We usually try to get them help somewhere else. Last year, I only had to refer 3 or 4 clients to a higher level of care. When they graduate rehab, they usually come back here and do pretty well."
Agency #10 Riverside County	60 day program for Kaiser-funded bed and 45 day program for County-funded bed. "80% of clients have Kaiser."	Residential	Voluntary and Court mandated	Moderate	No	No	"About 96% successfully complete the program. We're really good about working with someone."

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