TYPES OF TREATMENT AND EFFECTS OF TREATMENT

FOR DUAL DIAGNOSES CLIENTS:

A SURVEY OF COMMUNITY SUPPORT PROFESSIONALS

BY

DIANE L. OLSON

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Dr. Charles Barnard

**THE GRADUATE COLLEGE
UNIVERSITY OF WISCONSIN-STOUT
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The Graduate College
University of Wisconsin-Stout
Menomonie, Wisconsin 54751

ABSTRACT

Olson	Diane	L.
(Writer) (Last Name)	(First)	(Initial)

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A literature review of the topic dual diagnoses and the treatment options available to community support professionals was conducted.

The survey explored the treatment options available to clinical coordinators and case managers who work for community support programs within the State of Wisconsin.

This study was conducted to gather information using a numerical and multiple choice scale of measurement. The Likert scale of measurement was used to afford subjects the opportunity to offer opinions about services they used.

Limitations of this project were discussed, as well as review of the instruments used in the study. The conclusion examined results and significant questions and summarized the data obtained during the study.

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CHAPTER I

Introduction

The nature of the human body with all the complex systems is a wonder to researchers, doctors, and people in general. The systems within the body are intertwined so that each organ, cell, and vessel work in conjunction one with the other. Practitioners have the knowledge to work with and treat each individual who seeks their services. Over time, the body and the systems can change and create more complicated illnesses and disease. "There exists a list of those people who are categorized as ill: 1. Persons displaying overt or hidden signs of a bodily abnormality. 2. Persons complaining of being ill. 3. Persons complaining of troubling condition or propensity. 4. Persons complaining of insufficient self-control. 5. Persons committing shocking crimes" (Szasz, 1987, p.13). With these changing and evolving diseases, more and more research has evolved. Technology has evolved to allow researchers to narrow their scope and discover how and why disease happened.

Statement of the Problem

The purpose of this research was to survey clinicians and direct care staff in regards to treatment options available to them and practices with individuals who were dual diagnosed with chemical dependence and schizophrenia. The research asked the subjects to evaluate the types of treatments available to them and the effectiveness of those treatments.

The subjects of the survey were clinicians and direct care staff (Community Support Workers) within the State of Wisconsin Community Support Programs. Each clinician is responsible for coordinating mental health services in their respective county in Wisconsin. There are 72 counties. Each area of the state of Wisconsin is made up of different urban and rural settings which offer a different avenue for treatment of

these individuals. Some areas had more than one community support program which are in the directory.

Community support workers are responsible for direct contact with mental health clients who have accessed the community support program in their respective county. Each Clinician had a minimum of a master's degree. Each direct care worker had a bachelor's degree.

The survey was done at the state wide Community Support Conference which was held in Middleton in June of 2000. During the conference, each category of staff met in their respective groups for round table discussions. Each member of those groups was given the opportunity to complete a survey. They were all given an explanation about the survey and informed that participation was voluntary. A staff assistant collected the completed surveys. Each person identified themselves in their job capacity, age, degree level, further education beyond the masters, area of service and number of consumers they treat. Each person was asked to identify the types of treatment they had used and to give an opinion of the effectiveness of those treatments.

Objectives

Objectives to be addressed by this study were:

1) Do professionals have different levels of awareness?
2) Does level of education influence their opinion of how effective treatment is?
3) Are there more treatment options in urban settings verses rural settings?
4) Do rural Community Support Program staff collaborate regularly for services for their clients?

CHAPTER II

Review of the Literature

Mental Illness

One group of diseases which continue to test researchers is mental illness. Mental illness appears to be related to a breakdown in brain chemicals. The brain, a complex organ, has many parts which can become sick. "Mental illness is defined as a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life. Related to mental illness is chronic mental illness. Chronic mental illness is a disease which is severe in degree and persistent in duration, which causes a diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, and which may lead to an inability to maintain stable adjustment and independent functioning without long term treatment and support" (Szasz, 1987, p. 51).

Schizophrenia

One category of mental illness is schizophrenia. Schizophrenia is a leading public health problem. "Two thirds of chronic mental illnesses are diagnosed as schizophrenia. Forty percent of the nation's hospital beds are occupied by persons with schizophrenia. One to two percent of the general population will have a schizophrenic episode in their lifetime" (Szasz, 1987, p. 51). Anderson and Carpenter (1993) discuss the impact of schizophrenia on society

> Schizophrenia often begins relatively early in life, frequently leads to social and economic impairment, and typically leaves traces on its victims for the remainder of their lives. Schizophrenia results in great suffering for both the patients and their families. Its cost to society is also great, exceeding the financial burden of cancer. (p. 25)

Diagnostic criteria are present in the DSM IV. "A person must have at least two of the following, each present for a significant portion of time during a 1-month period. These include: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, or negative symptoms" (Anderson and Carpenter, 1993 p. 30). Szasz (1987) believes that

> individuals with schizophrenia do not intent on having this disease. The belief that the mentally ill person cannot form intent-that his behavior is unintended, like a reflex-plays an important part in the idea of mental illness, especially in its legal applications. The belief that the mentally ill person is a passive victim of compulsions, irresistible impulses or unconscious forces is a closely related notion. (p. 54)

"Schizophrenia is best understood as a group of brain disorders which interfere with the ability to think clearly, know what is real, manage emotions, make decisions and reality to others" (Geberal, 1996, p. 51). These individuals face daily challenges to understand the world around them. Many are unable to think clearly to make personal decisions, have meaningful relationships, work at gainful employment and practice good self-care. Daley, Moss and Campbell (1987) discuss the five subtypes of schizophrenia

> 1) Paranoid type, persecutory or grandiose delusions and hallucinations are dominant. . . . 2) disorganized type, speech and behavior problems, silly affect 3) catatonic type, catalepsy or stupor, extreme agitation, extreme negativism; 4) undifferentiated type, no single clinical presentation predominates; and 5) residual type, prominent psychotic symptoms are no longer predominate. (p. 154)

<u>Treatments</u>

Individuals diagnosed with schizophrenia are treated with psychotropic medications. These medication included Clozaril, Haladol, Risperdal, or Risperidone. These are used on individuals who are being seen and monitored clinically. However, there are individuals who have symptoms and are not seen clinically. They have yet be diagnosed or have choosen not to take their medication. These individuals tend to self-medicate with over-the-counter medications, street or illegal drugs or use alcohol to treat or mask their symptoms.

<u>Societial use of Alcohol</u>

Alcohol has been around for centuries. Stone pots dating from the Old Stone Age have been found that once contained beer or wine. Many stories of history report the use of alcohol at celebrations and for convivial uses. Fermentation is a natural process which occurs when yeast combines with another substance. This process may have happened by accident, but coincidentally, alcohol was born. Almost everyone was exposed to alcohol in some capacity when they grew up, sipping on Dad's beer or tasting some at a family celebration. People produced their own product at home and used it for personal enjoyment. During prohibition in 1919, Congress made it illegal to manufacture or sell alcohol. Prohibition remained in effect from 1920 to 1933. This was not a deterrent for those who made and consumed the product. When prohibition was repealed, the problem of abuse was still there and those dependent continued to use.

As the use of alcohol became legal and increased in consumption, society began to see the first problems in regard to the use of alcohol. There were social drinkers who just had a few. Others began to lose jobs, struggle with family functions, and use the product for other purposes than recreational use.

Alcoholism

"E.M. Jellinek, a pioneer in the study of alcoholism defined alcoholism as any use of alcoholic beverages that causes any damage to the individual or society or both" (Kinney, 1995, p. 58). Alcoholism became a household word. "Alcoholism is a complex chronic psychological disorder associated with excessive and unusually compulsive drinking of alcohol often accompanied by life management breakdown" (Holder, 1995, p. 10). Alcohol is costly to society. Statistics available indicate "68 % of men and 47% of women are drinkers. They comprise about 60% of the adult population. Per capita comsumption during the 1960's rose 32%. In the 1970's, despite some ups and downs, comsumption basically leveled off" (Kinney, 1995, p.19).

"Thus 70% of the drinking population consumes about 20% of all the alcohol" (Kinney, 1995, p. 20). Use of alcohol in society is the norm. Based on this norm, this is a costly practice. "The cost of $136.3 billion in 1990 and a rise to $150 billion by 1995" (Kinney, 1995, p. 22). Included in that calculation was loss of work, health care costs, motor accidents, crime, reduced production at home and alcohol treatment. Alcoholism, as does schizophrenia, creates situations of life management breakdown. Some individuals enrolled in treatment and maintain recovery and others continued with active usage.

Active alcoholics were also some of the same individuals who had mental illness. They began to use alcohol to self medicate, decrease the symptoms they were experiencing, or

became so addicted that they could not stop. These individuals were dually diagnosed. They had both chemical dependence (alcohol) and mental illness (schizophrenia).

Dual Diagnoses

The DSM-III-R generally defines a mental disorder as a "clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with a painful symptom or impairment in one or more important areas of functioning" (Evans, 1990, p. 1). As stated previous, mental illness is complex.
" Substance abuse is a maladaptive pattern of use not meeting the criteria for dependence that has persisted for at least 1 month or has occurred repeatedly over a longer time period" (Evans, 1990, p. 1). This is double trouble. Professionals find this combination of disorders very difficult to treat. These two disorders exacerbate each other. Alcoholics often do not admit that they have a problem; they minimize their involvement with alcohol. People with psychotic symptoms are often unable to identify that they need help. " The two disorders together, and dual diagnosis persons often show double denial and even less willingness or ability to participate in treatment than the individual with a single diagnosis" (Evans, 1990. p. 4). The confused person becomes even more confused. The person who is unable to work has a more difficult time maintaining employment. "Understanding lectures on the negative effects of drugs is difficult for those people with impaired concentration. Attending self-help groups is hard for persons who are seriously depressed and find it difficult to get out of bed or for the persons who are paranoid and are convinced others are talking about them" (Evans, 1990. p. 4). Working with people can be draining on professionals. The intensity of their symptoms and inability to work closely with others is a deterent for treatment. Symptoms of coexisting disorders tend to mask each other and a complete assessment is difficult to

obtain. In order to treat the entire person, the professional must start with a good assessment. This is the beginning stage of treatment.

Assessment

As previously stated, the symptoms of alcohol abuse and schizophrenia mask each other. Part of the treatment process is to get a good assessment. This assessment should be done in a hospital so that the person is clear of alcohol use and the true symptoms of the illness may come out. The problem with this approach is money. Long hospital admissions and stays are a thing of the past. Most hospital stays are now no longer than one week which does not allow the clinician a fair and accurate view of the symptoms. The other problem is professionals in the chemical dependence area come from a different mind set for treatment than that of mental health workers. "Philosophical conflicts and a fragmented service system can further compound the difficulties facing providers, dually diagnosed persons, and their families. Society has tended to view alcoholism and addiction as moral and legal issues. . . . mental health professionals have historically taken a different tack, preferring to see mental disorders as illness and reframing the psychiatric patient as sick and not 'bad' "(Evan, 1990. p. 5). Many professionals continue to be part of the problem and are unable to view the entire picture in order to treat the whole person. If a long stay is allowed, the assessment may involve using self report tools such as the Michigan Alcoholism Screening Test or the Minnesota Multiphasic Personality Inventory (MMPI). Psychiatric assessment is done mostly through interviews with the individual and members of their world such as parents, employer, friends. Brophy (1983) indicated that

> part of the mental status examination includes: 1) appearance: note bizarre or unusual modes of dress, makeup, etc. 2) activity and behavior: gait, gestures, coordination of bodily movements, etc. 3) affect: outward manifestation of emotion such as depression, anger, elation, fear, resentment, or lack of emo-

> tional response, 4) mood: inward feelings, sum of statements, and observable emotional manifestations, 5) speech: coherence, spontaneity, articulation, latency of response (pause before answering), and duration of utterance, 6) content of thought: associations, preoccupation, obsessions, depersonalization, delusions, hallucinations, paranoid ideation, anger, fear, or unusual experiences, 7) sensorium: (a) orientation to person, place, time and circumstances; (b) remote and recent memory and recall; (c) calculations, digit retention . . . (d) general fund of knowledge (presidents, states, distances, events) (e) abstracting ability, often tested with common proverbs or with analogies and differences, 8) judgment regarding common sense problems such as what to do when one runs out of medicine, 9) insight into the nature and extent of the current difficulty and its ramifications in the patient's daily life. (p. 610)

The final component of the assessment is the physical exam. This includes general blood work, medical history, and other special tests deemed necessary.
"Physical illness may frequently present as psychiatric disease and vice versa" (Brophy, 1983, p. 610).

Treatment Options

Based on the findings of the above assessment, treatment might involve a mental health clinic with medications, drug or alcohol programs including 12 step and aftercare, long-term medical care and follow up, being involved with the legal systems because when they were drinking or not taking their medication, they committed a crime. Each of these components and treatment agencies has their own agenda. Dual Diagnosis treatment programs are developing and becoming more accepted. "Many chemical dependency treatment programs will now accept individuals who are using psychiatric medications, as long as their condition has been stabilized. Such programs however, may not be

tailored specifically for clients with schizophrenia. Evaluate any such program carefully before referring clients to them" (Daley, 1993, p. 162). Daley discusses the difference between addiction and schizophrenia.

> Addiction clients are well defended-that is, they can protect their egos, often using rigid defenses such as denial and projection. The goal of treatment is to break down these defenses and replace them with healthier ones. . . . People with schizophrenia, however, have more fragile, less defended egos. Treatment approaches must therefore avoid increasing anxiety and instead should support the defenses present. (p. 163)

There is no one treatment approach. However, Kim T. Mueser, Ph D. (1998) of Dartmouth Medical School, has submitted a research report to the Journal of Practical Psychiatry and Behavioral Health titled, "Integrated Mental Health and Substance Abuse Treatment for Severe Psychiatric Disorders" that outlines such essential components of an integrated treatment program as:

> 1) Being comprehensive, because integrated treatment assumes the recovery process occurs longitudinally in the content of making many life changes.
>
> 2) Having a goal of shared decision making among all stakeholders, assuming that more knowledge, greater choice of treatment, increased responsibility, self management, and higher satisfaction with treatment will produce better outcomes and quality of life.
>
> 3) Involving a long-term commitment, because learning to adhere to an abstinent lifestyle requires that one make major life changes over months and years. (p. 2)

CHAPTER III

Methodology

Subjects

The purpose of the study was to survey clincians and direct care staff in order to determine what treatment methods were used and the views of theses professionals as to the effectiveness of those treatments. Objectives included: 1) Do professional have different levels of awareness? 2) Does level of education influence their opinion of how effective treatment is? 3) Are there more treatment options in urban settings verses rural settings? 4) Do rural Community Support Workers collaborate regularly for services for their clients?

Subjects were direct care staff and clinicians who work with Community Support Programs in the state of Wisconsin. These subjects were hired by their respective agencies to carry out the state required services of Community Support. In Wisconsin, some programs are certified and some are not. Certification requires that the program follow a stringent guideline of acceptable services for mental health consumers. Clinicians were the individuals who coordinate the program and follow the state guidelines. Community Support Workers were the staff that incorporated the guidelines into direct care for the clients. Each subject had at least 1000 hours of mental health experience which allows them to collect reimbursement for their job. After the 1000 hours of experience, they are required to be supervised by a clinical coordinator who is required to have a master degree preferably in mental health counseling or other similar degree.

Each year, these individuals convene at the Community Support Conference in a central location in Wisconsin. This annual conference provides inservice training on a variety of topics to the participants, such as controlling angry clients, monitoring psychiatric medication, or working with the reluctant client. This three day conference allowed mental health workers to network and share ideas and gather knowledge about new practices. For the purpose of this study, the subjects were selected based clinical coordinators and direct care staff who attend the round table discussions. The population of mental health professionals, approximently 500 individuals, from the state Community Programs were preregistered for the conference. They were required to register the first day of the conference and receive their packets. The clinical coordinators were chosen and support workers were chosen using the technique of stratified sampling for comparison.

Instruments

The purpose of the instrument was to give the subjects an avenue to express their usage of treatment types and practices and to rate how they felt these treatments worked with mental health consumers they worked with. This study was descriptive research using a self-report instrument with a comparison between clinicians and direct care staff. The questionnaire was numerical and multiple choice in nature. The content of the instrument included a multiple choice scale of measurement to record demographics such as: age, sex, level of education, years of experience post bachelors, and years of experience post masters, area of Wisconsin they work, and how many clients are in their respective program. Another category included questions about types of treatment they use. Using a Likert scale or numerical scale of measurement, they were asked to convey if they referred to an outside agency for counseling, did they have an alcohol and drug professional within their agency, did they use combined mental health and AODA

counseling services. The final area contained in the instrument was the opinion area. Again using a Likert scale of numerical measurement of strongly agree to strongly disagree, they were asked if they saw improvement in clients because of referred therapy, were the AODA services clear about mental illness needs of their clients, and, do they attempt to do individualized programs for mental health clients.

Directions for the instrument asked them to answer the first set of demographic questions and then asked them to stop. The directions then asked the subject to think about the last year of practice and consider only the previous year when answering questions in the last two sections. The reason for this was to keep them focused on the most recent treatments they have used and the immediate effect they had on clients.

The reliability of the test was based on a numerical instrument with a causal comparison. Validity will be tested with a particular group at a particular time.   This expert population should determine that the test is valid. The pilot test was conducted with the Dunn County Community Support and the Eau Claire County Community Support Programs during the month of March.   In her book, Dual Diagnosis, Katie Evans referred to types of treatment for the mentally ill and substance abuser and discussed specific models of treatment. She refers to the recovery model as an approach to treating chemical dependency users that views chemical dependency as a disease (Evan and Sullivan, 1990). Evans also refers to the 12 step AA program as a form of treatment. She indicated that the 12 step program enhances the recovery model.

Evans refers to the mental health model in her book. Included in this approach are seven strategies.

1. Correcting physiological deficiencies through such approaches as medication, nutritional supplements, and even exercise.
2. Building social support systems through such things as case management, attendance at special issue support groups and mobilization of friendships.
3. Improving family functioning through such means as education about the disorders, communication skills training, and negotiation of contracts regarding roles, boundaries, and consequences for specified behaviors.
4. Prompting and reinforcing positive behavior through such tools as reminder cards, behavior checklists, and point systems.
5. Increasing the client's functional abilities through the teaching of such skills as assertion, stress management, or activities of daily living such as taking the bus or cooking a meal.
6. Encouraging productive thinking patterns through such things as education about the nature of the disorder, using positive self-talk and imagery, or examining faulty assumptions about self and others.
7. Increasing client awareness of feelings, thoughts and behaviors and their interrelationship through such methods as exploring the relationship between family of origin issues and current behavior, commenting on here-and-now behavior in group therapy and keeping journals.

Evans indicated all of these interventions require close assessment and planning for the support worker and the client. First to think about outside approaches and then to focus internally within the client.

The questionnaire contained questions about many of the areas listed in Evans list of seven strategies. Many of the strategies have a balanced focus between internal and external variable.

Pilot testing was executed with two different community support programs in Dunn County and Eau Claire County. The researcher conducted the pilot test with the Dunn County community support program during their weekly staff meeting during the month of March. Also in March of 2000, the researcher conducted a test with the staff of the Eau Claire County community support program, and administered the instrument. After each administration of the instrument, the researcher asked for verbal feedback. One week following the pilot test, the researcher contacted the programs again for follow up feedback. Each county was informed that the second contact would be made. These two groups were chosen because of location to the researcher and difference in staff size and population size in the counties. Dunn County has a staff of five workers and about 25,000 people in the county. Eau Claire County has a staff of 20 workers and the population of the county is about 75,000. Eau Claire is a larger community with more outside programming available as resources. These two counties offered different levels of feedback for the survey instrument.

Procedures

The data was collected at the annual state conference of the Community Support Programs. Each county is represented at the state convention with one or more staff from their community support programs. Each subject was chosen from the fact that they were clinicial coordinators and direct care workers attending the conference and attending the round table discussions for their respective groups. The researcher attended the breakout sessions of the clinical coordinators and a seperate one for direct care staff and introduced the instrument. The researcher asked each person to voluntarily participate in the survey and if they agreed, they were given a instrument which contained a cover letter and the survey. After they were done completing the survey, the instrument was collected by a moderator of the round table. They were given a verbal thank you and

given the opportunity to put their name and address on a list if they wanted a copy of the survey results.

Unknowns

Rate of response is not something that worried the researcher. People would generally be receptive to this survey. One thing that did concern the researcher was if the conference was not held as scheduled. When writing this portion, the conference was not scheduled and no literature had been received as of yet. Another area of concern was having the survey inclusive of all the treatment options. The researcher came from a small county which does not have extensive resources available. The researcher may not be aware of the options throughout the state.

Limitations

The results of the research could be helpful to all the community support programs in Wisconsin so they were able to see how well other areas compared with them in regards to treatment options. Also, the results could be made available to community task forces and administrations with intentions of future planning with each agency, county, and at the state level. These results could also be used for fiscal agents to determine where money might be allocated in the future. The results could apply to any individual who has an interest in mental health and alcohol and the treatments available as well as those in positions to make program changes within their agency. These results could be used to solicit county boards for more treatment dollars. The previous usage was future oriented. The other use of the results was applied to how services are currently working. Staff who

reviewed the results interpreted them to mean that the programs were doing a very good job overall with treatment of individuals with dual diagnosis.

CHAPTER IV

Data Analysis

The scale of measurement for the instrument was both numerical and multiple choice. In the demographic category, gender was a multiple choice question and one calculated the number in each category and the percentage. The instrument used in the study was an instrument developed by the researcher, which consisted of nine Likert type questions. Each question has a maximum point value of 5 and a minimum value of 1. A more in depth look at the actual statistical data will be discussed later in this chapter in the section titled, Findings. Years of experience post bachelors or years of experience post masters was multiple choice and the scoring was calculated by number in each category and percentage of each. Number of clients on each case load for the entire county is numerical and the mean is then calculated. The final example consisted of an indication by subjects if they possessed a masters degree or bachelors degree. This scoring was based on how many total in each catagory and the percentage of each in relationship to the subject.

Findings

This section will present the findings of the survey completed at the Wisconsin Community Support Conference in Middleton in May of 2000. Results are based on statistical data, demographic information and results from the Likert scale. Descriptive statistics will be used to give an overview of the study's population. The descriptive statistics that will be expressed in this chapter are mean and range of scores obtained from the administration of this survey.

Demographic Data

Participants in the study were asked several questions based on demographics. This information included sex, age, degrees earned, locale of service area, years of mental health experience, time in current position and type of position.

Survey results were based on 60 clinical coordinators being given the survey and 39, or 65% responding. Seventy case managers were given the survey with a response rate of 45, or 64%. Respondents were primarily female, 59 % of clinical coordinators and 73% of case managers. Their ages ranged from 36-55 for clinical coordinators and 25-35 for case managers. All clinical coordinators had master's degrees with no participants having doctoral degrees. Case managers were found to be characterized by 55% with bachelors degrees and 44% a master's degree. Results indicated that 59% of clinical coordinators provided service in a rural county as defined by under 50,000 population. Case managers indicated their service area was about 50% rural and 50% urban. Twenty-nine percent of clinical coordinators had 6-10 years of experience with mental health consumers.
Case mangers were almost evenly divided between the categories. Seventy-one percent of clinical coodinators had been in their current position for 0-5 years. Seventy-four percent of the case managers had been in their current position for 0-5 years.

Each respondent indicated they work with mental health consumers including five clincial coordinators who also work with families. Fifty percent said they had 0-5 clients who use AODA services during one month. Thirty-five percent of case managers have 26-50 clients in their CSP and 33% have over 100 clients in their CSP. Clinical coordinators indicated 49% of them had 26-50 clients. The final question in this catagory asked percent of clients who had a dual diagnosis. Forty-six percent of clinical

coordinators indicated over 20% of their cases were dual diagnosed. Thirty-seven percent of case managers had clients in the same category 20% or more.

A result which was surprising was that over 50% of the programs noted their staff included an AODA specialist. Also, over 56% of clincial coordinators and 66% of case managers had at least 0-5 AODA referral agencies within a 25 mile radius of their CSP. Based on the Likert scale response, rural based clinical coordinators indicated they were slightly more satisfied with the services their clients received from outside agencies. Eighty-two percent of clincial coordinators have between 0-5 referral agencies within 25 miles. All respondents indicated that they refer to inpatient, outpatient, AA clubs, and mental health/AODA programs. Other referral agencies included AA for women, Assessment programs, consumer run dual diagnosis groups, and Star Program.

Significant Questions

In scoring the Likert scale questions, three questions stood out from the others in that they had scores which were signicant to this survey. Each question has a maximum point value of 5, strongly disagree and a minimum value of 1, strongly agree.

These questions were:

3) I am satisfied with the results from my referral.

Item score: 1.97

4) AODA providers understand dual-diagnosis.

Item score: 3.60

9) I will apply for grant money to fund AODA program development.

Item score: 3.2

These questions are addressed in the final chaper of the study titled Conclusion.

CHAPTER V

Conclusion

This chapter will be used to discuss conclusions and recommendations by this writer in regards to the types of treatment for individuals who are dually-diagnosed. There will be results from the respondents of the survey, a overview of the specific questions which were significant from the survey and a final examination of how these results could affect community support programs in the future.

Results from the survey

The repondents indicated they were neutral or satisfied, scores ranging from 2.39-2.95, with the results of their referrals to other agencies for services. In the opinion of rural clinical coordinators and case managers, scores of 2.73 and 2.90, services were adequate to meet the needs of the clients and the client was able to recover based on quality of service. Urban clinical coordinators and case managers were neutral in their response to this question, as reflected by scores of 3.00 and 3.06. Most of the respondents did want to look for other services in their area; with scores ranging from 2.21-2.37. However, given their choice, most clinical coordinators, both rural and urban, would not write a grant for additional services to address the client with alcoholism and schizophrenia.

Overview of Specific Questions

Question three, -"I am satisfied with the results from my referral"- produced significant results. Clinical coordinators had an average score of 1.97, expressing their pleasure in

the services their clients received from their referral. Case managers were close to a neutral score for this question, with an average response of 2.62. Clinical coordinators had higher levels of education and more years of experience with mental health referral agencies. They had certain expectations and it appears they believed their expectations were being met. Case managers, by virtue of the title, are very involved with referral agencies and did not believe their needs were being met at the level they were expecting. One element of this may be that case managers work directly with each client and are able to witness the daily stuggles their clients are having with alcohol and mental health recovery. Clinical coordinators on the other hand, have a role of administration and do not have that direct client contact each day. The perception of both groups is different, as reflected in the survey results.

Question four is a different reflection of how the clinical coordinators felt. Their score for this question,-"AODA providers understand dual-diagnosis,"- was 3.60, reflecting between neutral and disagree. It appears that clincial people, as a group, are satisfied with services however, they feel the referral agencies lacks basic knowledge about dual diaganosis. Dual diagnosis is a complex issue for individuals. Professionals in the field differ in how to treat persons with both disorders. Some feel it is imparitive that the mental illness is treated and others believe the addiction should be treated first. Persons in the field do not usually study both areas, they study with focus on one area or the other.
As a result, professionals do not understand the complex issues surrounding an individual with dual diagnosis.

The final question was,-" I will apply for grant money to fund AODA program development." Clinical coordinators, as a group were neutral in this area as reflected by

a score of 3.20. Grant writing is an art and must be driven by desire for change. Clincial Coordinators responded they were comfortable with service delivery and are not interested in changing the current delivery system. Many human service agencies do not write grants for programs because much of the service delivery is an expenditure that is covered under the medical assistance program or private insurance. As a result, grant money is not needed to continue programming for community support programs. More often, grants are written for special programs. Grants are generally not available for ongoing supportive therapy.

Final examination of the statistics

In summary of the data, it should be noted that clinical coordinators, mostly women, were pleased with service delivery to dually-diagnosised clients and would not be interested in changing the current system. There was no area in the survey to describe changes they would like to see however, clinical coordinators did want their referral agencies to have a better knowledge base of dual diagnosis and the special needs of those clients. It appeared that referrals are done to a wide variety of agencies all of which offer different service delivery and address different needs of the clients. Inpatient hospitals are more intensive than outpatient clinics. Outpatient clinics offer the clients the opportunity to continue daily living outside the hospital or treatment center setting. AA clubs are much more informal with their service delivery and those programs are voluntary. These clubs are generally for the recovery period and aftercare. However, this can be a significant area of support for individuals.

Future research conducted with a broader scope of all community support program, or like programs, through out the United States could be of great interest to persons who control national monies and make decisions about future program development.

A larger comparison could be done in regards to where to best treatment programs are and what elements of those programs make them the superlative programs.

In closing, this study attempted to survey the perceptions of providers for dually-diagnosed clients. There are many elements involved with working with this type of client. These results seem to indicate, service delivery is available and staff are finding this service adequate to meet the needs of the clients.

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APPENDIX A

Welcome to the Comunity Support Conference.

The purpose of this letter is to introduce you to the idea of thinking about mental health and AODA services in your county. As we all know, the challenges facing our clients with dual diagnosis are enormous. As I began to look at those challenges, I realized that I was not aware of the extent of services available in the state of Wisconsin. I used that realization to begin my work for my master's degree and subsequently have reached the point of doing this survey.

I am a community support worker with the Dunn County CSP in northwestern Wisconsin. Our program is located in Menomonie. I am currently studying for my master's degree in mental health counseling at the University of Wisconsin Stout in Menomonie.

The purpose of the survey is to use your knowledge to collect information about mental health and AODA services which are used by your community support program. This information could be used to justify more dollars for the state, review how you are doing in comparison to other CSP's and, give you insight into what others are doing and what works. The final area of the survey is your opinion about how these services affect the clients. This is critical information for each of us to think about.

You were chosen because you work in community support and possess vast experiences to share through this survey. I chose clinicians and direct care staff in order to gain the different perspectives of both administration and direct care.

The intended results of the survey are to determine the extent of comprehensive programs in Wisconsin; the survey should tell me that. Also, it should tell me where the quality programs are and perhaps knowledge can be shared with others in the state to offer better overall services for our clients.

Thank you for participating in this survey. You will have an to opportunity to receive the results if you leave your address with Carol who is assisting with this survey. My hope is that through your efforts, our clients will be better served.

Sincerely,

Diane L. Olson
715-232-1116
Dunn County Community Support
808 Main Street
Menomonie, WI. 54751

APPENDIX B

SURVEY

Please take 10 minutes to complete this survey about mental health consumers who present with alcohol and drug issues. Answer the questions to the best of your knowledge. Thank you for you time and assistance in answering this survey.

I. Demographics

1. Sex M or F

2. Age

18-25 26-35 36-45 46-55 55 and over

3. Most recent degree you have earned.

____ Associate

____ Bachelors

____ Masters

____ Doctoral

____ Other, please be specific

4. Locale of where you work, (rural, a county under 50,000 population and urban, a county over 50,000 population).

____ Rural ____ Urban

5. Years of mental health experience post high school?

0-5 6-10 11-15 16-20 20 and over

6. Length of time in current position?

0-5 6-10 11-15 16-20 20 and over

7. Type of position? (Choose One)

_____Clinical Coordinator ____Case Manager/Direct Care _____Other

II. Type of Clients in your program

1. Type of client which you primarily work with?

    ___ Mental Health Consumer ___ Family ___ Other (Be specific)

2. Number of your clients in the entire program who use AODA services during one month?

    0-5 6-10 11-15 16-20 20 and over

3. Number of clients active in your Community Support Program?

    0-25 26-50 51-75 76-100 100 and over

4. Percentage of those clients who have dual diagnosis in your program?

    0-5 6-10 11-15 16-20 20 and over

III. What is the AODA focus of your community?

1. Do you have an AODA specialist on your staff? YES NO

2. How many AODA referral agencies are within a 25 mile radius of your CSP program? 0-5 6-10 11-15 16 and over

3. Types of AODA services in your area. (Circle all that apply)

    Inpatient Outpatient AA Clubs

    Mental Health/AODA program Other (be specific)

Please rate the items below on a scale of 0 to 5.

Meanings:

0 = Does not apply 1 = Strongly agree 2 = Agree

3 = Neutral 4 = Disagree 5 = Strongly Disagree

IV. Your view point.

1. I refer mental health consumers to AODA services in my service area. 0 1 2 3 4 5

Meanings:

0 = Does not apply   1 = Strongly agree   2 = agree

3 = Neutral   4 = Disagree   5 = Strongly Disagree

2. I feel there are adequate AODA referral options in my service area.	0	1	2	3	4	5
3. I am satisfied with the results from my referrals.	0	1	2	3	4	5
4. AODA providers understand dual-diagnosis.	0	1	2	3	4	5
5. AODA services are accessible to mental health consumers and their families.	0	1	2	3	4	5
6. AODA services have been willing to assist our CSP to develop programs for our clients.	0	1	2	3	4	5
7. My clients have successful recovery because of the AODA services.	0	1	2	3	4	5
8. I will look for new AODA options.	0	1	2	3	4	5
9. I will apply for grant money to fund AODA program development.	0	1	2	3	4	5

Consent Form

I understand that by returning this questionnaire, I am giving my informed consent as a participating volunteer in this study. I understand the basic nature of the study and agree that any potential risks are exceedingly small. I also understand the potential benefits that might be realized from the successful completion of this study. I am aware that the information is being sought in a specific manner so that no identifiers are needed and so that confidentiality is guaranteed. I realize that I have the right to refuse to participate and that my right to withdraw from participation at any time during the study will be respected with no coercion or prejudice.

Note: Questions or concerns about participation in the research or subsequent complaints should be addressed first to the researcher or research advisor and second to Dr. Ted Knous, Chair, UW-Stout Institutional Review Board for the Protection of Human Subjects in Research, 11 HH, UW-Stout, Menomonie, WI. 54751, phone (715) 232-1126.