

**University of St. Thomas, Minnesota**  
**St. Catherine University**

---

Social Work Master's Clinical Research Papers

School of Social Work

---

2017

# Factors Contributing to Success in Treatment for Individuals with a Dual Diagnosis

Logan Evenson

University of St. Thomas, Minnesota, [evens167@d.umn.edu](mailto:evens167@d.umn.edu)

Follow this and additional works at: [https://ir.stthomas.edu/ssw\\_mstrp](https://ir.stthomas.edu/ssw_mstrp)

Part of the [Clinical and Medical Social Work Commons](#), and the [Social Work Commons](#)

---

## Recommended Citation

Evenson, Logan, "Factors Contributing to Success in Treatment for Individuals with a Dual Diagnosis" (2017). *Social Work Master's Clinical Research Papers*. 725.

[https://ir.stthomas.edu/ssw\\_mstrp/725](https://ir.stthomas.edu/ssw_mstrp/725)

This Clinical research paper is brought to you for free and open access by the School of Social Work at UST Research Online. It has been accepted for inclusion in Social Work Master's Clinical Research Papers by an authorized administrator of UST Research Online. For more information, please contact [libroadmin@stthomas.edu](mailto:libroadmin@stthomas.edu).

Factors Contributing to Success in Treatment for Individuals with a Dual  
Diagnosis

By

Logan C. Evenson, B.A.

MSW Clinical Research Paper

Presented to the Faculty of the  
School of Social Work  
St. Catherine University and the University of St. Thomas  
St. Paul, Minnesota  
In Partial fulfillment of the Requirements for the Degree of  
Master of Social Work

Committee Members  
Lisa Kiesel, Ph.D., LICSW (Chair)  
Bethany Broman, LICSW  
McKena Martin, LICSW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University - University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

### **Abstract**

This clinical research project investigates factors that contribute to success in substance abuse treatment for individuals with a dual diagnosis through the perspective of licensed social workers in the State of Minnesota. This research looked at possible associations between different individual client factors, respondent's demographic background, and treatment model effectiveness as they relate to clients success in treatment. A quantitative study was conducted by administering a survey to a randomly generated email list in which 146 respondents completed the survey. The respondents were all licensed social workers in the state of Minnesota and identified themselves as having experience working with clients who had a dual diagnosis or a mental illness and substance use disorder. The results show that many of the respondents have mixed beliefs in what determines a client's success in treatment. Many of the hypothesized demographic factors that were believed to effect social workers perspective, such as respondents years practicing, level of licensure, and geographic location of practice, were found to not have a significant statistical association between responses. The perception of the factors that contribute to success in treatment is notable, and has implications for future social work research.

## Table of Contents

<b>Introduction</b> .....	Error! Bookmark not defined.
<b>Literature Review</b> .....	<b>5</b>
<b>Individual Factors for Success in Treatment</b> .....	<b>5</b>
Psychosocial Factors.....	5
Gender.....	6
Relationship between mental health stability and chemical health.....	7
<b>Issues Integrating Substance Abuse and Mental Health Treatment</b> .....	<b>8</b>
Geographic limitations .....	8
Program limitations.....	9
<b>Co-Occurring Disorder Treatment Models</b> .....	<b>11</b>
Disease Concept Model .....	11
Solution-Focused Therapy.....	11
Cognitive Behavioral Model.....	12
<b>Conceptual Framework</b> .....	<b>13</b>
<b>Biopsychosocial Model</b> .....	<b>13</b>
<b>Harm Reduction Model</b> .....	<b>13</b>
<b>Methods</b> .....	<b>14</b>
<b>Research Design</b> .....	<b>14</b>
<b>Sample</b> .....	<b>14</b>
<b>Protection of Human Subjects</b> .....	<b>15</b>
<b>Data Collection Instrument and Process</b> .....	<b>15</b>
<b>Proposed Data Analysis Plan</b> .....	<b>16</b>
<b>Findings</b> .....	<b>21</b>
<b>Descriptive Statistic</b> .....	<b>21</b>
Frequency Distribution of Respondents Gender.....	22
Frequency Distribution of Respondents Race .....	22
Frequency Distribution of Respondents Social Work Licensure.....	23
Frequency Distribution of Respondents Years Practicing Social Work.....	25
Frequency Distribution of Location of Respondents Clients Served.....	26
Frequency Distribution of Belief in Effectiveness of Treatment Types.....	27
Frequency Distribution of Belief of Importance of Causes for Success in Treatment .....	28
Frequency Distribution of Percentage Based Responses.....	30
<b>Inferential Statistic</b> .....	<b>31</b>
<b>Discussion</b> .....	<b>44</b>
<b>Strengths and Limitations</b> .....	<b>48</b>
<b>Strengths</b> .....	<b>50</b>
<b>Limitations</b> .....	<b>50</b>
<b>Contribution to Social Work Practice</b> .....	<b>48</b>
<b>Implications for Future Research</b> .....	<b>48</b>
<b>References</b> .....	<b>52</b>
<b>Appendix A</b> .....	<b>57</b>
<b>Appendix B</b> .....	<b>61</b>

Individuals with a dual-diagnosis of a substance use and mental health disorder have shorter stays in addiction treatment programs, poorer treatment outcomes, and higher treatment cost compared to those with one disorder (Grella, 2003). The presence of a serious mental illness increases the chances for that individual to develop a substance use disorder (Minkoff, K., Zweben, J., Rosenthal, R., & Riesv, R., 2003). According to the DSM 5 “Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home” (American Psychiatric Association, 2013). These individuals are uniquely difficult to treat due to the symptomology that presents as a barrier to treatment. These barriers can include paranoia, depression, anxiety, cognitive deficits, hallucinations, poor social skills, unstable social support, stigma, and others depending on the diagnosis. This presents clinicians with a difficult challenge when working with these clients to achieve success in treatment. Success in treatment is defined in this study as the completion of all programming requirements in the treatment program. The treatment of mental health and substance use disorders has been a core issue facing social workers and clinicians for decades. These two disorders have become the focus in an attempt to create improved integrated treatment for patients with dual-diagnosis. The treatment of co-occurring disorders has many barriers that are both internal and external. Clients with a dual diagnosis often have complex psychosocial issues that interfere with treatment and effect participation. These clients can also have various cognitive deficits and active symptoms that treatment needs to account for in order to implement long-term change. Social workers offer a unique perspective into the factors that contribute to success in treatment for clients with a dual diagnosis.

### **Literature Review**

The literature available for co-occurring disorders focus on a variety of different topics that address the diverse challenges facing these individuals. In order to understand the factors that contribute to success in treatment it is important to understand the barriers preventing the implementation of effective treatment. These barriers relate to both micro and macro issues relating to social work. The micro issues are psychosocial factors, gender, and the effect mental health stability interrelates. The macro issues consist of systemic barriers such as demographic, geographic, and program limitations. These issues are similar to other social service barriers, but our focus will look specifically at their relation to substance use and mental health services.

### **Individual Factors for Success in Treatment**

**Psychosocial factors.** The literature relating to success factors has had a heavy emphasis on psychosocial contributing factors for treatment. The pathway to recovery can vary depending on the individual and severity of addiction. These different forms of recovery include formal treatment, self-help groups, peer support, independent recovery (without formal treatment), and continued but controlled or limited substance use (Green, Yarborough, Polen, Janoff, & Yarborough, 2015). Patients who are recovering from a serious mental illnesses and substance use disorders share consistent themes in their experiences as reiterated by several studies. These themes include learning about the effects of substance abuse, education promoting motivation, and building a foundation for sobriety (Green, Yarborough, Polen, Janoff, & Yarborough, 2015).

The factors that contribute to the decision to terminate drug use can be from an external source but manifest itself as an internal drive. In a study by Cohen and Rabinovitch they looked at the contributing factors for quitting drugs and found that experiencing a traumatic event can be

a major predictor for terminating drug abuse (2005). Another important component to the decision to quit is that the individual believes that a “life after drugs” is possible and that they have a plan (Cohen & Rabinovitch, 2005). This study is consistent with the cognitive model for treating drug abuse. It believes that the individual needs to take time to rediscover effective coping skills that can be implemented in times of crisis, when the desire to use is the strongest.

**Gender.** Among the many factors that can affect the success of treatment is the gender of a client. Treatment programs often utilize individual programs for each gender. The study of the effects of gender on treatment success for clients with dual diagnosis has identified several factors that are affected by gender. According to a study by Jerrell and Ridgely treatment availability, service utilization, and related clinical issues affected women with dual disorder more than men (1995). At the end of the study the women had higher functioning scores, presented with higher psychiatric symptomatology, and had a greater decrease in 24-hour acute treatment services in the first six months of using the specialized intervention programs (Jerrell & Ridgely, 1995). Women are faced with additional barriers preventing them from entering substance abuse treatment compared to men. The barriers to women include a lack of childcare, fear of stigma, lack of family support, financial instability, and a denial of needing treatment (Taylor, 2010).

Stigma is defined as an attribute that is deeply discrediting and consists of traits that set the bearer apart from others in society, which can cause feelings of isolation and shame (Goffman, 1986). Stigma is an issue that affects both those seeking mental health and substance use treatment. The stigma associated with these issues can vary depending on gender and this can have negative effects of stigma. According to a study by Sanders, women from different socially disadvantaged backgrounds are equally likely to experience stigma related to substance

abuse (2012). This study also found that the longer an individual spends involved in a mutual support groups, such as Narcotics Anonymous, the less likely they will negatively experience stigma (Sanders, 2012). Mental health disorders have been shown to have specific masculine and feminine stereotypes and stigmas depending on the disorder (Boysen, Ebersole, Casner, & Coston, 2014). The more feminine stereotypes included eating disorders, histrionic personality disorder, body dysmorphia and antisocial personality disorder, addiction, and pedophilia were seen as masculine (Boysen, Ebersole, Casner, & Coston, 2014). Stigma can have many negative effects on an individual and these effects can continue for years. Stigma can have strong and enduring effects on well-being that continues to complicate the lives of an individual even after treatment has improved their symptoms and functioning (Link, Struening, Rahav, Phelan, & Nuttbrock, 1997). The potential for stigma has a significant effect on individual wellbeing and effect their treatment.

**Relationship between mental health stability and chemical health.** The mental health and chemical health of an individual can have a profound impact on their ability to engage in treatment. There is an abundance of research that has studied the effects sobriety can have on mental health and the effects of mental stability on the success in treatment. Sobriety can help people to begin their mental health recovery processes along with achieving and maintaining sobriety (Green, Yarborough, Polen, Janoff, & Yarborough, 2015). Mental health stability also increased patient's self-efficacy, self-confidence, and improved overall functioning (Green, Yarborough, Polen, Janoff, & Yarborough, 2015). These are core components to many of the addiction models discussed later in this paper and are equally important to managing mental health symptoms. The treatment of mental health and substance abuse can have positive effects for the recovery, maintenance, and treatment of the other. Psycho-education for



substance use builds a foundation for the education of mental health symptomology and provides self-confidence (Green, Yarborough, Polen, Janoff, & Yarborough, 2015). Integrated services have been proven to be effective for dual diagnosed clients in improving substance dependence, anxiety, depression, and impairment in social functioning (Hogan, Elison, Ward, & Davies, 2015). Research has also suggested that the use of modified treatment programs have been shown to reduce criminal behavior and recidivism (Sullivan, Sacks, Mckendrick, Banks, Sacks, & Stommel, 2007). These findings were associated with offenders and measured their recidivism along a 12-month post prison study. This research argues that substance abuse success is closely related to mental health stability and skills learned to manage symptoms can be used as a foundation for substance use treatment.

The treatment of trauma has had increased focus over the years in regards to the treatment of both substance use and mental health. Individuals with a severe mental illness are at a higher risk for trauma and are more vulnerable to the effects of trauma (Grubaugh, Zinzow, Paul, Egede, & Frueh, 2011). Substance use has been found to partially mediate the relationship between sexual abuse and mental health outcomes (Ulibarri, Ulloa, Salazar, 2015). Findings also suggest that mental health and substance use services should include treatment for trauma, which has a strong association with mental health and substance use disorders (Ulibarri, Ulloa, Salazar, 2015). Trauma has also been found to correlate with symptom severity among individuals with severe mental illness (Lu, Yanos, Silverstein, Mueser, Rosenberg, Gottlieb, & Giacobbe, 2013).

### **Issues Integrating Substance Abuse and Mental Health Treatment**

**Geographic limitations.** The factors that contribute to success in treatment have primarily focused on the individual, but it is important to focus on the programs being utilized in terms of addressing the specific needs of individuals with co-occurring conditions. Factors such

as long travel distance to treatment, higher crime rate in patient's neighborhood, and the requirement to travel to a higher crime neighborhood all reduce treatment continuity (Mennis, Stahler, & Baron, 2012). These researchers also found that white patients are more likely to be effected by higher travel time and African Americans treatment attendance reduced due to having to travel to higher crime areas (Mennis, Stahler, & Baron, 2012).

Structural barriers have also been found to prevent programs from delivering care for dual diagnosed clients. These barriers are often associated with funding given to providers. Studies have shown that programs are able to function as "nearly capable" to treat dual diagnosis, but they are still limited by structural barriers associated with funding to adequately support these programs (Padwa, Larkins, Crevecoeur-Macphail, Desiree, and Grella, 2013). Many programs have not yet explored their potential for delivering services for co-occurring conditions, which would require enhancing their program structure, treatment services, and continuity of care services (Padwa et al., 2013).

**Program limitations.** Increasing research has suggested the use of an integrated approach to treating co-occurring conditions, but many programs have not yet adopted these models. Research has suggested several barriers to the implementation of an integrated approach including systemic and professional barriers (Blakey & Bower, 2014). The factors that reduce success in treatment differ depending on the specific diagnosis. Several factors can affect treatment success based on the symptomology of the illness. Clients with ADHD and substance abuse face barriers that include a lack of accurate information from the family members, potential abuse of ADHD medication, and a pressure for an ADHD diagnosis by both the patient and caregiver. (Matthys, Soyez, van den Brink, Joostens, Tremmery, & Sabbe, 2014). Family focused child mental health services have also identified similar treatment barriers and

dissatisfaction with parents and providers. According to a study by Baker-Ericzén, Jenkins, and Haine-Schlagel providers and parent of dually diagnosed adolescence reported several specific barriers that included inadequate service support systems, a lack of family involvement, and an overwhelming demands relating to the complexities of families' needs (2013). This study also found different opinions among the therapists who highly endorse using family-focused therapy and desire parent participation, and the parents who felt unsupported by the therapist (Baker-Ericzén, Jenkins, & Haine-Schlagel, 2013).

Research has also suggested that a main barrier to effective treatment for clients with a co-occurring condition is the staff involved in the treatment. In order to effectively care for people with comorbidity mental health providers need to identify “gaps in their knowledge, skills, and attitudes” in regards to training (Wheeler, Crozier, Robinson, Pawlow, & Mihala, 2014). Research also calls for supervisors and administrators to play a key role in identifying these barriers and implementing training for staff (Wheeler, Crozier, Robinson, Pawlow, & Mihala, 2014). The presence of competent staff that is available to help implement specific clinical programs addressing dual-diagnosis has been proven to be key to success. According to Harris and Cormier found that evidence-based integrated treatment is best implemented with the help of a practitioner who can also contribute to research on the effectiveness of a program (2013). Staff at these facilities has a desire and motivation to learn the skills needed to effectively treat both mental illness and substance abuse. The ability to handle issues such as brief intervention, assessment, motivation, and treatment goal setting are all seen as manageable by mental health staff (Wheeler, Crozier, Robinson, Pawlow, & Mihala, 2014).

### **Co-Occurring Disorder Treatment Models**

**Disease concept model.** In this model disease addiction is viewed as the primary disease rather than a secondary condition and was originally applied to alcoholism in the early 1930's and 1940's. This model believes that the disease of addiction is chronic, incurable, and that there is no treatment that will allow the person to use again without reverting back to their problematic use of the drug (Stein & Foltz, 2009). In this model the primary form of treatment is utilizing community and culturally appropriate treatment groups that use the 12-step treatment model (Capuzzi & Stauffer, 2016). A few examples of programs that use this model are Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, Food Addicts Anonymous, and Gamblers Anonymous. These groups utilize the self-help method for treating addiction by allowing the person to participate in a community, engaging in psychoeducation, learning treatment goals, obtaining a sponsor, and encouraging socialization. This is the model that most abstinence-based programs are modeled after due to their view that addiction is a disease that cannot be cured. This model believes that the only true form of treatment for substance use disorders is to support and maintain abstinence.

**Solution-Focused therapy.** This model originated out of critiques for the disease model that uses a "one size fits all" approach to treating addiction. According to Whittinghill and Loesch, addiction often falls on a continuum of use that range from sporadic detrimental use to relentless addiction (2000). They disagree with the abstinence-based model of the 12-step program model when the severity of addiction is minimal. In the solution focused approach counselors focus of client strengths, successes, and resources available (Kim-Berg & Miller, 1992). This model is intended to be simple rather than complex, focus on natural changes to find solutions, collaborate with the client, and focus on the present (Kim-Berg & Miller, 1992). They

emphasis a client focused approach to treatment that is intended on being simple in order to allow individuals with cognitive or intellectual deficits to engage in treatment. The overall goal for each client is individualized and can range from abstinence to substance use reduction depending on the severity of abuse and needs of the client.

**Cognitive behavioral model.** Cognitive-behavioral therapy is one of the most empirically supported forms of therapy and has been widely used to the treatment of substance use disorders (Hides, Samet, & Lubman, 2010). The research has also found that this approach reduces the likelihood an individual will relapse after treatment (McHugh, Hearon, & Otto, 2010). Cognitive behavioral therapy is a form of talk therapy that encourages self-awareness of inaccurate or negative thinking. This approach is designed so that the individual will eventually reduce the negative behaviors that are associated with the inaccurate or negative thinking (Beck, 2011). The model is designed to change cognitive distortions that cause maladaptive behaviors such as substance abuse. The goal is to reduce or end this behavior, but the overall goal is to change the cognition associated with the behavior.

## **Conceptual Framework**

### **Biopsychosocial Model**

The biopsychosocial model was created in response to the medical model that had been the dominant model for the medical community. This model attributes the disease outcomes to interactions between biological factors, psychological factors, and sociological factors (Engel, 1992). The treatment of co-occurring conditions has multiple components that need to be addressed for each individual patient. Due to the nature of mental illness and substance use these clients will often have biological factors that have contributed to their addiction and mental illness including genetics, biophysiology, and neurobiology (Inaba & Cohen, 2014). These factors are combined with psychological factors (mood, personality, psychopathology, behavior) and social factors (culture, socioeconomic status, family structure) (Engel, 1992). This model takes a holistic approach to view the individual as a whole and consider all of the components that contribute to addiction and mental illness.

### **Harm Reduction Model**

The harm reduction model is an approach that views addiction in terms of public health instead of the traditional disease model. This model views abstinence as the “ideal” outcome, but recognizes alternatives that reduce harm and that “prevention” should target the harmful effects of use instead of use itself (Marlatt & Witkiewitz, 2002). The low-threshold access to service is a key component of harm reduction, which also focuses on the individuals managing of their daily functions rather than moralistic idealism (Capuzzi & Stauffer, 2016). The low-threshold approach uses the client’s definition of the problem as a basis for intervention and uses this base to facilitate a treatment alliance (Tatarsky, 2003). Witkiewitz (2002) outlined three

main objectives for harm reduction which is to reduce harmful consequences associated with use, provides alternatives to abstinence only approach, and promote access to services by embracing low-threshold approaches.

## **Methods**

### **Research Design**

The purpose of this research was to measure and record social workers attitudes and attributions regarding the treatment of substance use and mental health of individuals with a dual diagnosis. The research was designed to measure whether there were connections between internal or external factors and dually diagnosed individual's success in treatment and which of these factors contributed the most to successful maintenance of symptoms and decreased substance use. In order to further investigate these relationships a "Social Workers Attitudes regarding the Treatment of Dual-diagnosis Clients" survey was created. The variables that this survey collected consisted of cognitive attitudes towards internal and external factors that effected individual's treatment resulting in mental health stability and decreased substance abuse. This study used the survey software Qualtrics to collect the data and the software SPSS to do a secondary analysis of the data collected from this survey.

### **Sample**

The survey was conducted during the winter of 2017 and the early spring of 2017 to a total of 146 social workers. The survey was administered through email from a mailing list purchased from the Minnesota Board of Social Work. This influenced the results of the survey in several ways. The individuals surveyed had already agreed to receive emails from students for

the purpose of research. This would mean that their responses might have differed from that of social workers who had not preapproved to participate in research.

### **Protection of Human Subjects**

The social workers in the study were all given an online prompt that required them to give Consent to participate in the survey. They were also given an opportunity to email questions to the researcher administering the survey prior to taking the survey. After consent was given the respondent was allowed access to the online survey through the Qualtrics software. The survey software Qualtrics provided anonymity and prevented coercion. All of the respondents were given the opportunity to refrain from taking the survey and to skip any questions they did not want to answer. After the respondents completed their survey they were instructed to close the window, which would log them out of the Qualtrics system. The online consent prompt informed the respondents that there is no potential risk for harm and that there is no benefit for taking the survey. The Institutional Review Board approved the survey and administration process.

### **Data Collection Instrument and Process**

The survey utilized a series of demographic questions to measure the demographics of the sample being surveyed. These demographic questions measured variables including age, gender, race, social work licensure, location of clients served, and major area of work. Questions D1-D7 contain the demographic questions for the survey and were the first questions presented to respondents. The next series of questions focused on the effectiveness of known treatment models. This consisted of questions T1-T8. Respondents were instructed to refrain from answering the question if they were not aware of the treatment model or its perceived effectiveness. The factors that contribute to success in treatment were measured with questions



C1-C6 and included cognitive, structural, and external causes that contribute to success in treatment.

The sample was of social works that were on the mailing list of the Board of Social Work in Minnesota. The survey was sent to respondents who agreed to complete the survey along with a Letter of Informed Consent.

### **Proposed Data Analysis Plan**

**Descriptive Statistics.** A series of descriptive statistics will be run for the following statistics D1-D7 in order to understand the sample demographics of respondents surveyed. Descriptive statistics will also be run for both T1-T8 and C1-C6 in order to understand the sample's response to these questions.

**Research Question.** In order to measure factors that contribute to success in treatment a series of research questions are asked based on the review of literature regarding treatment for clients with a dual diagnosis. In order to answer these questions a series of inferential statistics will be completed. The relationship between these statistics will be analyzed using the Statistical Package for the Social Sciences (SPSS) software.

**Research question 1.** The research question is: "Is there a relationship between social workers who believe that competency of treatment staff are very important factor to successful treatment, and the primary location of their clients served?". The research hypothesis is: "There is a relationship between social workers who believe that competency of treatment staff are very important factor to successful treatment, and the primary location of the clients that they serve". A chi-square will be used to answer this question and analyze the relationship between the two nominal variables. The nominal independent variable D8 "How would you describe the primary location of the clients that you serve?", will be compared to the ordinal dependent variable

“Please indicate how important you think each statement is as a cause for dual-diagnosis client’s success in treatment” and will specifically look at the statement “Competency of treatment facility staff”, which uses the likert scale as a measure of response.

This research question is designed to identify if the location of the clients that the respondents primarily serves influences their opinion of the importance of competency in treatment facility staff. The research hypothesis states that the research will find that respondents who serve primarily rural clients will view the importance of staff competency at treatment facilities at a higher rate.

**Research question 2.** The research question is: “Is there a relationship between social workers who believe that mental health should be addressed first and their level of social work licensure?”. The research hypothesis is: “There is an association between social workers who believe that mental health should be addressed first and their level of social work licensure”. A chi-square will be used to answer this question and analyze the relationship between the two nominal variables. The nominal independent variable D4 “Which level of social work licensure are you?”, will be compared to the ordinal dependent variable P5 “Which disorder do you believe should be addressed first for individuals with a dual diagnosis”. The respondents were given two options, which included “mental health”, and “substance use disorder” and these answers were later coded for analysis.

This research question is designed to identify if a social workers level of licensure influences their opinion of which treatment should be pursued first for individuals with a dual diagnosis. The research hypothesis states that the research will find that respondents with higher licensure levels will view mental health as the disorder that should be addressed first for individuals with a dual diagnosis.

**Research question 3.** The research question is: “Is there a relationship between social workers belief in the percentage of individuals with co-occurring disorders that successfully complete substance use disorder treatment programs and the primary location of their clients served?”. The research hypothesis is: “There is an association between location of respondents clients served and their belief in the percentage of individuals with co-occurring disorders that successfully complete substance use disorder treatment programs?”. This inferential statistic utilized an ANOVA test to measure if there is an association between the primary location of the clients that the respondent serves and their belief of percentage of individuals with co-occurring disorders successfully complete substance use disorder treatment programs. The nominal variable in this study measures the primary location of the clients that the respondent serves, which is operationalized with the item “How would you describe the primary location of the clients that you serve?”. The three geographic locations are recoded into either a 1, 2, or 3 with 1 meaning that the respondents clients are located in a “Rural or small town” or “Medium size rural town”, 2 meaning that they are located in a “suburban area near major metro” or “medium size urban area, not a suburb”, and 3 meaning that their clients are located in a “major metropolitan area”. The ordinal variable measures the respondent’s belief in the percentage of individuals with a co-occurring disorder successfully complete substance use disorder treatment program, which is operationalized with the item “What percentage of individuals with co-occurring disorders do you believe successfully complete substance use disorder treatment programs?”, which gives four options that indicate different interval levels for a percentage. The respondent is given four options that correspond to percentages that they believe individuals with a co-occurring disorder successfully complete substance use disorder treatment program with the

possible responses being “0-25%” (1), “25-50%” (2), “50-75%” (3), and “75-100%” (4). The analysis used an ANOVA test to determine an association.

This research question is designed to identify if a social workers experience working in different geographic locations has an influences on their opinion of the percentage of individuals with co-occurring disorders that complete substance use disorder treatment. The research hypothesis states that the research will find that respondents who work in more populated areas will believe that a lowered percentage of clients with a co-occurring disorder complete treatment for substance use disorder.

**Research question 4.** The research question is: “Is there a relationship between social workers belief in the importance of pre-existing coping skills for dual diagnosis clients success in treatment and the amount of years they have been practicing social work?”. The research hypothesis is: “There is a relationship between social workers belief in the importance of pre-existing coping skills for dual diagnosis clients success in treatment and the amount of years they have been practicing social work”. This research question will be answered using an inferential statistic. This inferential statistic utilized a t-test to measure if there is an association between respondents years practicing social work and their belief in the importance of pre-existing coping skills for dual diagnosis clients success in treatment. The nominal variable was the dependent variable and the ordinal was the independent. The dependent ratio variable is operationalized with the question: “The following statements reflect possible causes for success in treatment. Please indicate how important you think each statement is as a cause for dual-diagnosis client’s success in treatment.” And was asked to rate the importance of “Pre-existing coping skills” as a cause for success in treatment. The respondent were given a likert scale of 1-5 with 1 being “Not important”, 3 being “Somewhat important”, and 5 being “Very important”. The nominal

variable was the length of time a respondent has been practicing social work. This is operationalized with the item: "How long have you been practicing social work?". The nominal variable measured the length of time a respondent has been practicing social work and provided five potential responses. These options being "Less than 1 year", "1-2 years", "3-5 years", "5-10 years", and "More than 10 years" as potential responses. The analysis used a t-test to test for an association.

This research question is designed to identify if a social workers years as practicing as a social worker influences their belief in the importance of pre-existing coping skills for dual diagnosis client's success in treatment. The research hypothesis states that the research will find that respondents who have been practicing longer will believe that the presence of pre-existing coping skills is more important to clients success in treatment.

**Research question 5.** The research question is: "Is there a relationship between social workers who work as case managers and their belief in the percentage of treatment facilities that are capable of effectively treating individuals with a dual diagnosis?". The research hypothesis is: "There is a relationship between social workers who work as case managers and their belief in the percentage of treatment facilities that are capable of effectively treating individuals with a dual diagnosis". This inferential statistic utilized a t-test to measure if there is an association between respondents experience working as a case manager and their belief of percentage of treatment facilities that are capable of effectively treating individuals with a dual diagnosis. The ratio variable was the dependent variable and the nominal was the independent. The dependent ratio variable is operationalized with the question: "What percentage of treatment facilities, that you are aware of, are capable of effectively treating individuals with a dual diagnosis?". The respondent is asked to write a percentage that corresponds to a percentage that they believe

treatment facilities are capable of effectively treating individuals with a dual diagnosis with the possible responses ranging from 0% to 100%. The nominal variable was the respondent's major area of work and whether they selected case management. This is operationalized with the item: "Please indicate your major areas of work (check all that apply):". The nominal variable measured individual's major area of work with multiple options. This nominal variable will specifically include respondents that chose "case management" as their major area of work. The analysis used a t-test to test for an association.

This research question is designed to identify if a social workers experience working as a case manger influences their opinion of the percentage of treatment facilities that are capable of effectively treating individuals with a dual diagnosis. The research hypothesis states that the research will find that respondents who are working in case management believe that a lowered percentage of treatment facilities that are capable of effectively treating individuals with a dual diagnosis.

## **Findings**

### **Descriptive Statistic**

Descriptive statistics for the Survey are presented in four sections. Section one summarizes the responses for demographic information for all of the respondents participating in the survey. Section two summarizes the responses that describe the respondent's area and geographic location of practice. Section three summarizes the responses that focus on the effectiveness of treatment programs, causes for success in treatment, and perspective of treatment outcomes for dually diagnosed clients. Section four summarizes respondent's

perspective by using open-ended questions. All survey questions and corresponding question numbers are presented in Appendix D.

**Frequency distribution of respondents gender.** The total number of respondents for the survey was 146 (N=146). The first descriptive statistic analyzes the respondent's gender. The statistical analysis showing a frequency distribution is shown below in Table 1, which displays the number of respondents who answered male (1), female (2), and transgender (3).

Table 1. *Distribution of Respondents Gender*

	Frequency	Percentage	Valid Percentage
<b>Male</b>	22	15.1	15.4
<b>Female</b>	121	82.6	84.6
<b>Missing</b>	3	2.1	
<b>Total</b>	146	100.0	100.0

In Table 1 the frequency distribution shows us that there was a total of 146 respondents for this question and that 3 individuals did not answer this question. Out of the 146 respondents 82.9%, or 121 respondents, answered female (2) meaning that they identify as female. Respondent's answered male (1) 15.1%, or 22 respondents said that they identify as male. This distribution tells us that the majority of respondents identified as female and that none of the respondents identified as transgender.

**Frequency distribution of respondents race.** The second descriptive statistic analyzes the respondent's identified race. This is operationalized with the item: "How do you identify your race?".

Table 2. *Distribution of Respondents Race*

	Frequency	Percentage	Valid Percentage	Cumulative Percentage
<b>Asian</b>	3	2.1	2.1	2.1
<b>Native Hawaiian or Pacific Islander</b>	1	.7	.7	2.8
<b>White</b>	139	95.2	97.2	100.0
<b>Missing</b>	3	2.1		
<b>Total</b>	146	100.0		

In Table 2 the frequency distribution shows us that there was a total of 143 respondents for this question and that 3 individuals did not answer this question. Out of the 143 respondents 95.2%, or 139 respondents, answered white (6) meaning that they identify as white. The remaining respondent's answered Asian (3) 2.1% or 3 respondents and Native Hawaiian or Pacific Islander (5) .7% or 1 respondent meaning that they identified as that race. This distribution tells us that the majority of respondents identified as white and a small percentage identifying as Asian or Native Hawaiian or Pacific Islander.

**Frequency distribution of respondents social work licensure.** The third descriptive statistic analyzes the respondent's social work and other type of licensure. The statistical analysis showing a frequency distribution is shown below in Table 3, which displays the number of respondents who identified their level of licensure.



Table 3. *Distribution of Respondents Social Work License*

	<b>Frequency</b>	<b>Percentage</b>	<b>Valid Percentage</b>
<b>LSW</b>	35	24.0	24.8
<b>LGSW</b>	42	28.8	29.8
<b>LISW</b>	5	3.4	3.5
<b>LICSW</b>	49	33.6	34.8
<b>LGSW and LADC</b>	2	1.4	1.4
<b>LGSW and LADC</b>	5	3.4	3.5
<b>LSW and LADC</b>	3	2.1	2.1
<b>Total</b>	141	96.6	100.0

In Table 3 the frequency distribution shows us that there was a total of 141 respondents for this question and that 5 individuals did not answer this question. Out of the 141 respondents 33.6%, or 49 respondents, answered LICSW –Licensed Independent Clinical Social Worker (4) meaning that they currently have an independent clinical licensure in social work. The remaining two licensures that respondent’s possessed was the LSW –Licensed Social Worker (1) 24.0% or 35 respondents and LGSW –Licensed Graduated Social Worker (2) 28.8% or 42 respondents meaning that they had these licensures. This distribution tells us that the majority of respondents were licensed with a LSW, LGSW, or LICSW and a small percentage possessed a dual license or a LISW.

**Frequency distribution of respondents years practicing social work.** The fourth descriptive statistic analyzes how long the respondent had been practicing social work. The statistical analysis showing a frequency distribution is shown below in Table 4, which displays the number of respondents who identified the amount of years they have been practicing social work.

Table 4. *Distribution of Respondents Years Practicing Social Work*

	<b>Frequency</b>	<b>Percentage</b>	<b>Valid Percentage</b>
<b>Less than 1 year</b>	6	4.1	4.3
<b>1-2 years</b>	16	11.0	11.4
<b>3-5 years</b>	20	13.7	14.3
<b>5-10 years</b>	29	19.9	20.7
<b>More than 10 years</b>	69	47.3	49.3
<b>Total</b>	140	95.9	100.0

In Table 4 the frequency distribution shows us that there was a total of 140 respondents for this question and that 6 individuals did not answer this question. Out of the 140 respondents 47.3%, or 69 respondents, answered “More than 10 years” meaning that they have been practicing social work for over 10 years. The next two highest response rates was for the “5-10 years” category where 19.9% or 29 respondents and “3-5 years” where 13.7% or 20 respondents stated they had been practicing. This distribution tells us that almost half of the respondents had been practicing for over 10 years and that the majority of respondents had been practicing over 3 years. A small percentage had been practicing for either under one year or 1-2 years.

**Frequency distribution of location of respondents clients served.** The fifth descriptive statistic analyzes the location of the clients that the respondent serves. The statistical analysis showing a frequency distribution is shown below in Table 5, which displays the number of respondents who identified the location of their clients served.

Table 5. *Distribution of Location of Respondents Clients Served*

	<b>Frequency</b>	<b>Percentage</b>	<b>Valid Percentage</b>
<b>Rural or small town</b>	8	5.5	5.7
<b>Suburban area near major metro area</b>	32	21.9	22.9
<b>Major Metropolitan area</b>	53	36.3	37.9
<b>Medium size rural town</b>	23	15.8	16.4
<b>Medium size urban area, not a suburb</b>	24	16.4	17.1
<b>Total</b>	140	95.9	100.0

In Table 5 the frequency distribution shows us that there was a total of 140 respondents for this question and that 6 individuals did not answer this question. Out of the 140 respondents 36.3%, or 53 respondents, answered “Major metropolitan area” meaning that the location of their clients served was in an area with a population of 500,000 or more. The next highest area that clients stated was the location of their clients was in a Suburban area near major metro area with 21.9% or 32 respondents. The next two highest response rates was for the “medium size urban area, not

a suburb” category with 16.4% or 24 respondents and “Medium size rural town” where 15.8% or 23 respondents stated was the location of their clients served. This distribution tells us that all but 5.5% of the respondents served clients in a population with more than 1,000 and that a third are serving clients in a major metropolitan area.

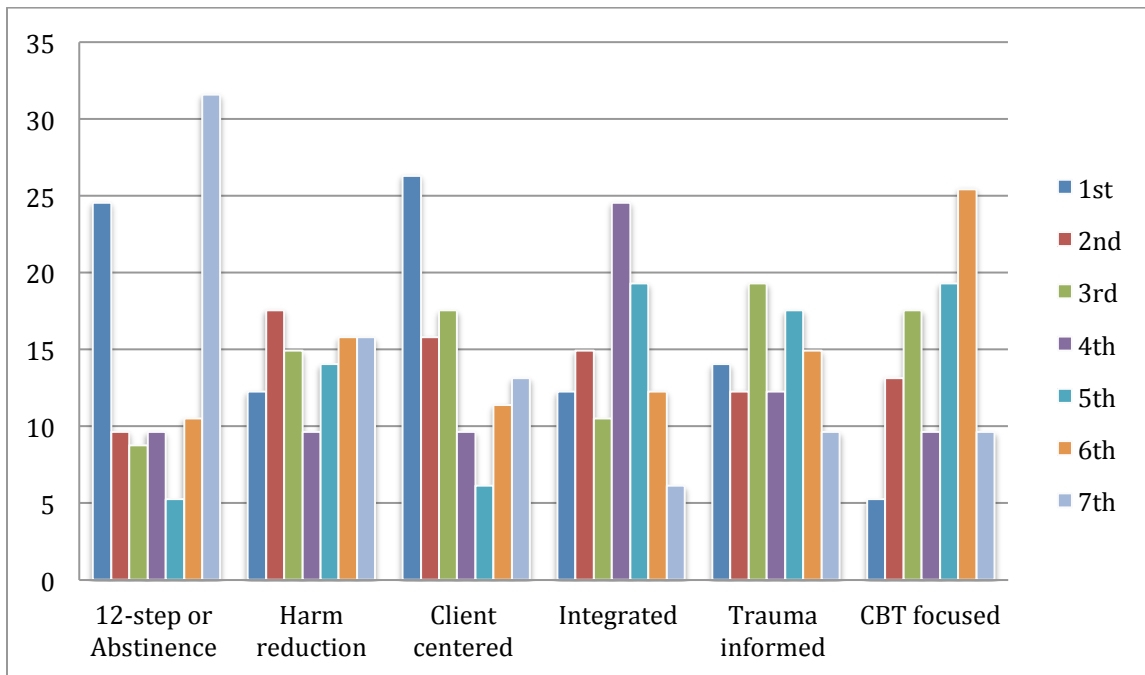
**Frequency distribution of belief in effectiveness of treatment types.** The sixth descriptive statistic analyzes the respondent’s belief in the effectiveness of different types of treatment for client’s success. The statistical analysis showing a frequency distribution is shown below in Table 6, which displays the number of respondents who ranked different treatment types by effectiveness.

Table 6. *Distribution of Respondents Belief in Effectiveness of Treatment Types*

<b>Treatment types</b>	<b>1 (least effective)</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7 (most effective)</b>
<b>12-step or Abstinence</b>	24.56% (28)	9.65% (11)	8.77% (10)	9.65% (11)	5.26% (6)	10.53% (12)	31.58% (36)
<b>Harm reduction</b>	12.28% (14)	17.54% (20)	14.91% (17)	9.65% (11)	14.04% (16)	15.79% (18)	15.79% (18)
<b>Client centered</b>	26.32% (30)	15.79% (18)	17.54% (20)	9.65% (11)	6.14% (7)	11.40% (13)	13.16% (15)
<b>Integrated</b>	12.28% (14)	14.91% (17)	10.53% (12)	24.56% (28)	19.30% (22)	12.28% (14)	6.14% (7)
<b>Trauma informed</b>	14.04% (16)	12.28% (14)	19.30% (22)	12.28% (14)	17.54% (20)	14.91% (17)	9.65% (11)
<b>CBT focused</b>	5.26% (6)	13.16% (15)	17.54% (20)	9.56% (11)	19.30% (22)	25.44% (29)	9.65% (11)
<b>Mental health focused</b>	5.26% (6)	16.67% (19)	11.40% (13)	24.56% (28)	18.42% (21)	9.56% (11)	14.04% (16)

The statistical analysis showing a frequency distribution is shown below in Figure 1, which displays the frequency of how respondents ranked each treatment type in a bar graph.

Figure 1. *Distribution of Respondents Belief in Effectiveness of Treatment Types*



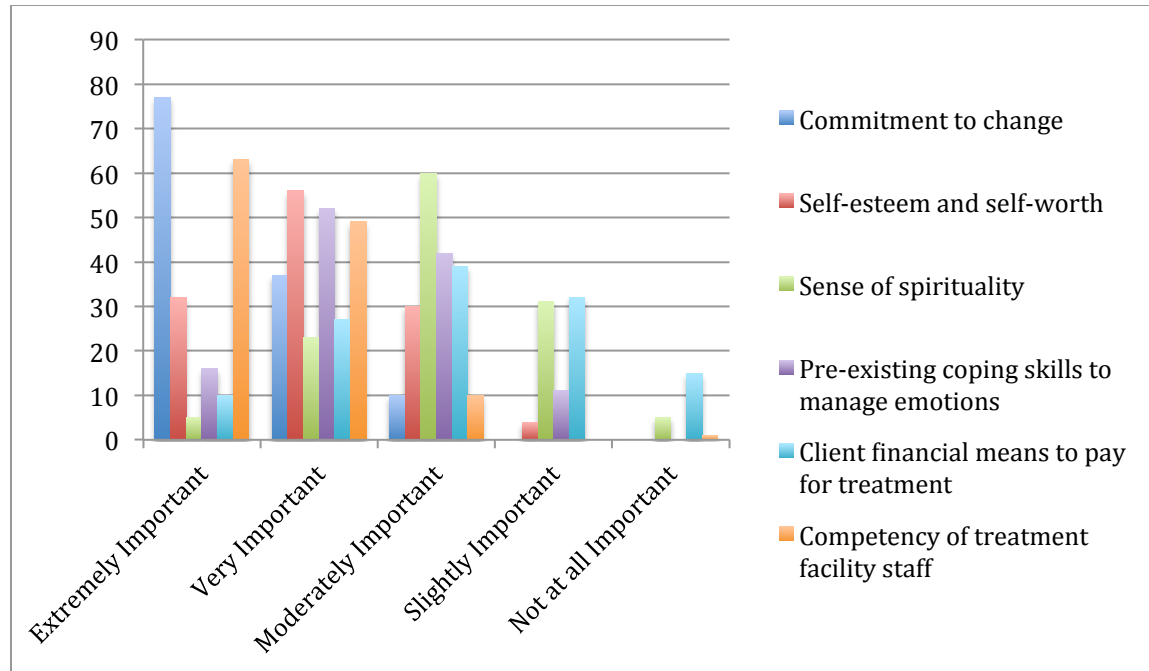
**Frequency distribution of belief of importance of causes for success in treatment.**

The seventh descriptive statistic analyzes the respondent’s belief in the importance of different causes for client’s success in treatment. The statistical analysis showing a frequency distribution is shown below in Table 6, which displays the number of respondents who determined the level of importance for the six different statements.

Table 7. *Distribution of Respondents belief of Importance of Causes for Success in Treatment*

	<b>Extremely important</b>	<b>Very important</b>	<b>Moderately important</b>	<b>Slightly important</b>	<b>Not at all important</b>	<b>Total respondents</b>
<b>Commitment to change</b>	62.10% (77)	29.84% (37)	8.06% (10)	0.00% (0)	0.00% (0)	124
<b>Self-esteem and self- worth</b>	26.23% (32)	45.90% (56)	24.59% (30)	3.28% (4)	0.00% (0)	122
<b>Sense of spirituality</b>	4.03% (5)	18.55% (23)	48.39% (60)	25.00% (31)	4.03% (5)	124
<b>Pre-existing coping skills</b>	13.22% (16)	42.98% (52)	34.71% (42)	9.09% (11)	0.00% (0)	121
<b>Financial means to pay for treatment</b>	8.13% (10)	21.95% (27)	31.71% (39)	26.02% (32)	12.20% (15)	123
<b>Competency of treatment staff</b>	51.22% (63)	39.84% (49)	8.13% (10)	0.00% (0)	0.81% (1)	123

The statistical analysis showing a frequency distribution is shown below in Figure 1, which displays the number of respondents who determined the level of importance for the six different statements in a bar graph.

Figure 2. *Distribution of Respondents belief of Importance of Causes for Success in Treatment*

**Frequency distribution of percentage based responses.** The eighth descriptive statistic analyzes the respondent's belief in the percentage of individuals with co-occurring disorders that successfully complete substance abuse treatment programs. The frequency distribution shows that 27.05% or 33 respondents believed that 0-25%, 54.10% or 66 respondents believe 25-50%, and 18.85% or 23 respondents believe that 50-75% of clients with a co-occurring disorder successfully complete treatment.

The ninth descriptive statistic analyzes the respondent's belief in the percentage of individuals with co-occurring disorders that are psychiatrically stable enough to complete treatment. The frequency distribution shows that 22.69% or 27 respondents believed that 0-25% are capable, 44.54% or 53 respondents believe 25-50% are capable, 31.09% or 37 respondents believe that 50-75% are capable, and 1.68% or 2 respondents believe 75-100% of clients are psychiatrically capable of completing treatment.

The tenth descriptive statistic analyzes the respondent's belief in the percentage of treatment facilities that are capable of effectively treating individuals with a dual diagnosis. The frequency distribution shows that 45.83% or 55 respondents believed that 0-25% are capable, 31.67% or 38 respondents believe 25-50% are capable, 21.67% or 26 respondents believe that 50-75% are capable, and .83% or 1 respondents believe 75-100% of treatment facilities are capable of treating clients with a dual diagnosis.

The eleventh descriptive statistic analyzes the respondent's belief in whether mental health or substance abuse should be addressed first. The frequency distribution shows that 64.29% or 72 respondents believed that mental health should be addressed first. The frequency distribution also shows that 35.71% or 40 respondents believed that substance use disorder should be addressed first.

### **Inferential Statistic**

**Chi-square.** A chi-squared analysis was used to analyze the first research question: Is there a relationship between social workers who believe that competency of treatment staff are very important factor to successful treatment, and the primary location of their clients served? This analysis was conducted using SPSS. The nominal variable in this study measures the primary location of the clients that the respondent serves and the other nominal variable measures the respondent's belief in the importance of the competency of treatment facility staff for a client's success in treatment. The hypothesis for this study is: There is an association between location of respondents clients served and their belief in the importance of competency in treatment facility staff. Table 7 below shows the results of the analysis.

In table 4 the top row of numbers have 1 representing an individual believes that the competency of treatment facility staff is either "Extremely important" or "Very important" and 2



meaning that they believe it is “Moderately important”, “Slightly important”, or “Not at all important”. The three geographic locations are recoded into either a 1, 2, or 3 with 1 meaning that the respondents clients are located in a “Rural or small town” or “Medium size rural town”, 2 meaning that they are located in a “suburban area near major metro” or “medium size urban area, not a suburb”, and 3 meaning that their clients are located in a “major metropolitan area”. The cross-tabulation in Figure 4 shows us that in all of the categories respondents identified themselves as believing that the competency of treatment facility staff is either “Extremely important” or “Very important”, which is higher than the expected count of 6.1. The two other group with a higher count than their expected was the 30 and 47 respondents who said that they believed highly in the importance of the competency of treatment facility staff and those that lived in either a medium or rural small town and the group from the major metropolitan area compared to their expected count of 29.8 and 46.6. The remaining respondents 1 reported that they did not believe highly in the importance of treatment facility staff and their clients were located in “suburban area near major metro” or “medium size urban area, not a suburb”. This figure shows that the majority of respondents believed highly in the importance of treatment facility staff regardless of the geographic location of their clients.

Table 8. *Crosstabulation for Location of Clients Served and Importance of Treatment Facility**Staff*

<b>Geographic</b>		<b>Staff Competency</b>		
<b>Location</b>				
		1.00	2.00	Total
<b>Rural, Small, or</b>	Count	30	0	30
<b>Medium Town</b>				
		Expected Count	29.8	2
		% of Total	24.6%	0.0%
<b>Suburban or</b>	Count	44	1	45
<b>Medium Urban</b>				
		Expected Count	44.6	.4
		% of Total	36.1%	0.8%
<b>Major Metro</b>	Count	47	0	47
<b>Area</b>				
		Expected Count	46.6	.4
		% of Total	38.5%	0.0%
<b>Total</b>	Count	121	1	122
		Expected Count	121.0	1.0
		% of Total	99.2%	0.8%

The p-value for the chi-square analysis for location of clients served and importance of competency of treatment facility staff is .422, which is greater than .05 so the analysis fails to reject the null hypothesis. There is not enough evidence to determine an association between location of respondents clients served and belief in the importance of treatment facility staff competence.

**Chi-square.** A chi-squared analysis was used to analyze the second research question: Is there a relationship between social workers who believe that mental health should be addressed first and their level of social work licensure? This analysis was conducted using SPSS. The nominal independent variable D4 “Which level of social work licensure are you?”, will be compared to the ordinal dependent variable P5 “Which disorder do you believe should be addressed first for individuals with a dual diagnosis?”. The hypothesis for this study is: There is an association between respondent’s level of licensure and their view that mental health as a disorder should be addressed first for individuals with a dual diagnosis. Table 8 below shows the results of the analysis.

In table 7 the top row of numbers have ‘Mental Health’ representing respondents that believe mental health should be addressed first in treatment and “Substance use disorder” representing respondents that believe that substance abuse disorder should be addressed first. The three different levels of licensure are recoded as either a 1, 2, or 3 with 1 meaning that the respondents licensure is either a “LSW” or “LGSW”, 2 meaning that they are licensed as either a “LISW” or “LICSW”, and 3 meaning that they have a dual license of either a “LGSW and LADC”, “LICSW and LADC” or “LSW and LADC”. The cross-tabulation in Figure 7 shows us that in categories 1 and 2 the respondents identified that they believe mental health is more important to address first than substance abuse, which is higher than their expected counts of

39.5 and 25.5. The other group with a lower count than the expected was the 1 respondent who had a dual license and said that they believed mental health should be addressed first compared to their expected count of 5.1. The remaining respondents 7 respondents with a dual license reported that they believed that substance abuse should be addressed first before mental health. This figure shows that the majority of respondents without a “LADC” believed highly in the importance of treating mental health before treating substance abuse.

Table 9. *Crosstabulation for Respondents Level of Licensure and Importance of Addressing Mental Health*

		<b>Which disorder should be addressed first?</b>		
<b>License</b>		Mental Health	Substance Use Disorder	Total
<b>LSW or LGSW</b>	Count	43	19	62
	Expected Count	39.5	22.5	62.0
	% of Total	39.1%	17.3%	56.4%
<b>LISW or LICSW</b>	Count	26	14	40
	Expected Count	25.5	14.5	40.0
	% of Total	23.6%	12.7%	36.4%
<b>Dual License with a LADC</b>	Count	1	7	8
	Expected Count	5.1	2.9	8.0

	% of Total	0.9%	6.4%	7.3%
<b>Total</b>	Count	70	40	110
	Expected Count	70.0	40.0	110.0
	% of Total	63.6%	36.4%	100.0%

The p-value for this chi-square analysis of the location of clients served and importance of competency of treatment facility staff is .007, which is less than .05 so the analysis rejects the null hypothesis. There is enough evidence to determine an association between level of respondent's licensure and belief that mental health should be addressed first before substance abuse.

**ANOVA.** An ANOVA analysis was used to analyze the third research question: Is there a relationship between social workers belief in the percentage of individuals with co-occurring disorders that successfully complete substance use disorder treatment programs and the primary location of their clients served? This analysis was conducted using SPSS. The nominal variable in this study measures the primary location of the clients that the respondent serves. The geographic locations are recoded into either a 1, 2, or 3 with 1 meaning that the respondents clients are located in a "Rural or small town" or "Medium size rural town", 2 meaning that they are located in a "suburban area near major metro" or "medium size urban area, not a suburb", and 3 meaning that their clients are located in a "major metropolitan area". The ordinal variable measures the respondent's belief in the percentage of individuals with a co-occurring disorder successfully complete substance use disorder treatment program. The research hypothesis states that the research will find that respondents who work in more populated areas will believe that a lowered percentage of clients with a co-occurring disorder complete treatment for substance use

disorder. The hypothesis for this study is: There is an association between location of respondents clients served and their belief in the percentage of individuals with co-occurring disorders that successfully complete substance use disorder treatment programs. Tables 8 and 9 below show the results of the analysis.

The significant difference between participants with different locations of clients served in the “Between Groups” is .331, which means that the p-value is  $> .001$ . Therefore, we fail to reject the null hypothesis and conclude that there is not a significant difference between location of the clients that the respondent serves and belief in percentage of clients with a dual diagnosis that complete substance abuse treatment.

Table 10. *ANOVA for Percentage Successfully Completing Treatment and Location of Clients Served*

	<b>Sum of Squares</b>	<b>df</b>	<b>Mean Square</b>	<b>F</b>	<b>Sig.</b>
<b>Between Groups</b>	1.064	2	.532	1.178	.311
<b>Within Groups</b>	53.267	118	.451		
<b>Total</b>	54.331	120			

The p-value is  $>.001$ , which means that there is not a statistically significant difference between these groups’ location of clients served. Table 10 shows us that the respondents serving clients located in either small, medium, or rural towns (1) had a score of 1.76. The respondents serving clients from either suburban area or medium size urban area (2) and major metropolitan

areas both had an average mean of 1.93. Therefore, we can conclude that there is not statistically significant with the difference between location of respondent's clients and their belief in the percentage of individuals with a dual diagnosis that successfully complete treatment.

Table 11. *Descriptive for Percentage Successfully Completing Treatment and Location of Clients Served*

<b>95% Confidence Interval for Mean</b>								
	N	Mean	Std. Deviation	Std. Error	Lower Bound	Upper Bound	Minimum	Maximum
<b>Small,Medium or Rural</b>	29	1.76	.577	.107	1.54	1.98	1	3
<b>Suburban or MediumUrban</b>	45	1.98	.723	.108	.108	2.19	1	3
<b>Major Metro Area</b>	47	1.98	.675	.099	.099	2.18	1	3
<b>Total</b>	121	1.93	.673	.061	.061	2.05	1	3

**ANOVA.** An ANOVA analysis was used to analyze the fourth research question: Is there a relationship between social workers belief in the importance of pre-existing coping skills for dual diagnosis clients success in treatment and the amount of years they have been practicing social work? This analysis was conducted using SPSS. The nominal variable was the dependent

variable and the ordinal was the independent. The dependent ratio variable is the respondent's belief in the importance of "Pre-existing coping skills" and the nominal variable was the length of time a respondent has been practicing social work. The research hypothesis states that there will be a relationship between social workers belief in the importance of pre-existing coping skills for dual diagnosis clients success in treatment and the amount of years they have been practicing social work. The hypothesis for this study is: There is a relationship between social workers belief in the importance of pre-existing coping skills for dual diagnosis clients success in treatment and the amount of years they have been practicing social work. Tables 10 and 11 below show the results of the analysis.

The significant difference between participants with different locations of clients served in the "Between Groups" is .371, which means that the p-value is  $> .001$ . Therefore, we fail to reject the null hypothesis and conclude that there is not a significant difference between years practicing social work and belief in importance of "coping skills" for successful completion of substance abuse treatment.

Table 12. *ANOVA for Importance of Coping Skills and Years Practicing Social Work*

	<b>Sum of Squares</b>	<b>df</b>	<b>Mean Square</b>	<b>F</b>	<b>Sig.</b>
<b>Between Groups</b>	2.925	4	.731	1.077	.371
<b>Within Groups</b>	78.066	115	.679		
<b>Total</b>	80.992	119			



The p-value is  $>.001$ , which means that there is not a statistically significant difference between these groups' mean scores on the Individual Scale. Table 12 shows us that the respondents with less than 1 year of experience practicing social work had a score of 2.80 and those practicing for 1-2 years had a score of 2.77. The respondents with 3-5 and 5-10 years both had similar means with an average mean of 2.37 and 2.36. The respondents with the most experience of more than 10 years had the lowest average mean score with 2.33. Therefore, we can conclude that there is not statistically significant with the difference between years of experience and their belief in the importance of the existence of "coping skills" for successful completion of treatment.

Table 13. *Descriptive for Importance of Coping Skills and Years Practicing Social Work*

		<b>95% Confidence Interval for Mean</b>							
		N	Mean	Std. Deviation	Std. Error	Lower Bound	Upper Bound	Minimum	Maximum
<b>Less than 1 year</b>		5	2.80	.837	.374	1.76	3.84	2	4
<b>1-2 years</b>		13	2.77	.832	.231	2.27	3.27	2	4
<b>3-5 years</b>		19	2.37	.895	.205	1.94	2.80	1	4
<b>5-10 years</b>		28	2.36	.731	.138	2.07	2.64	1	4

<b>years</b>								
<b>More</b>	55	2.33	.840	.113	2.10	2.55	1	4
<b>than 10</b>								
<b>years</b>								
<b>Total</b>	120	2.41	.825	.075	2.26	2.56	1	4

**ANOVA.** An ANOVA analysis was used to analyze the fifth research question: Is there a relationship between social workers who work as case managers and their belief in the percentage of treatment facilities that are capable of effectively treating individuals with a dual diagnosis? This analysis was conducted using SPSS. The nominal variable was the dependent variable and the ordinal was the independent. The dependent interval variable is the respondent's belief in the percentage of treatment facilities that are capable of effectively treating individuals with a dual diagnosis. The nominal variable was the respondent's major area of work and whether they selected case management. The research hypothesis states that the research will find that respondents who are working in case management believe that a lowered percentage of treatment facilities that are capable of effectively treating individuals with a dual diagnosis. The hypothesis for this study is: There is a relationship between social workers who work as case managers and their belief in the percentage of treatment facilities that are capable of effectively treating individuals with a dual diagnosis. Tables 12 and 13 below show the results of the analysis.

The significant difference between participants with different locations of clients served in the "Between Groups" is .593, which means that the p-value is  $> .001$ . Therefore, we fail to reject the null hypothesis and conclude that there is not a significant difference between social

workers who work as case managers and their belief in the percentage of treatment facilities that are capable of effectively treating individuals with a dual diagnosis.

Table 14. *ANOVA for Experience in Case Management and Percentage of Treatment Capable of Treating a Dual Diagnosis*

	<b>Sum of Squares</b>	<b>df</b>	<b>Mean Square</b>	<b>F</b>	<b>Sig.</b>
<b>Between Groups</b>	.192	1	.192	.288	.592
<b>Within Groups</b>	78.127	117	.668		
<b>Total</b>	78.319	118			

The p-value is  $>.001$ , which means that there is not a statistically significant difference between social workers who work as case managers and their belief in the percentage of treatment facilities that are capable of effectively treating individuals with a dual diagnosis. Table 14 shows us that the respondents who did not have experience working in case management had an average mean score of 1.81. The respondents that did have experience working in case management had an average mean score of 1.73. Therefore, we can conclude that there is not statistically significant with the difference between social workers who work as case managers and their belief in the percentage of treatment facilities that are capable of effectively treating individuals with a dual diagnosis.

Table 15. *Descriptives for Experience in Case Management and Percentage of Treatment Capable of Treating a Dual Diagnosis*

<b>95% Confidence Interval for Mean</b>								
	N	Mean	Std. Deviation	Std. Error	Lower Bound	Upper Bound	Minimum	Maximum
<b>No Experience</b>	79	1.81	.802	.090	1.63	1.99	1	4
<b>Case Management Experience</b>	40	1.73	.847	.134	1.45	2.00	1	3
<b>Total</b>	119	1.78	.815	.075	1.63	1.93	1	4

### **Discussion**

This study analyzed the perspective of social workers views and opinions of the factors that contribute to a person's success in treatment when they suffer from a co-occurring condition. Its main purpose was to analyze the perspective of various social workers from Minnesota and whether specific factors can determine someone's viewpoints or beliefs. The analysis portion of the study focused on finding potential correlations between demographic characteristics and their beliefs about factors that contribute to success. The final results did not yield many correlations between data, but that in itself provides information.

The descriptive statistics from the survey provide a variety of information relating to the perspective of licensed social workers. The respondents were asked to rank different types of substance use treatment programs based on the effectiveness of each model. The treatment type that had the highest percentage of having a (7) ranking, which indicated that they believed was most effective, was the "12-step model or Abstinence" with 31.58%. The next type that was ranked most often as most effective was "Harm reduction" with 15.79% and "Mental health focused" with 14.04%. The treatment types that were ranked most often ranked as the least effective were "Client centered" with 26.32% and "12-step model or Abstinence" with 24.56%. This findings shows a distinct polarization between respondents perspective of the effectiveness of the "12-step model or Abstinence" treatment model. This polarization could be in part due to the changing belief around traditional treatment models such as the 12-step model.

The analysis of descriptive statistics relating to respondents belief in the causes for success looked specifically at individual factors. The findings show that respondents believe that a clients "Commitment to change" has the highest importance out of the other factors listed with

62.10% believing it is extremely and 29.84% believing it is very important. This was followed closely with “competency of treatment staff” with 51.22% believing it is extremely and 39.84% believing it is very important. The “Sense of spirituality” and “Financial means to pay for treatment” was rated lower in importance by respondents. This is significant because in the literature many of the previous studies cited financial means as a main component to client’s success in treatment. The sense of spirituality component is also interesting to note due to the 12-step model have its basis in the belief in a higher power.

The analysis of the effects social workers belief in the competency of treatment staff for success in treatment, and the primary location of their clients served resulted in the findings not being statistically significant. This meant that we were forced to accept the null hypothesis that there was no association between location of respondents clients served and belief in the importance of treatment facility staff competence. It is important to understand this finding in regards to the geographic quality of care throughout the state of Minnesota. Social workers throughout the state of Minnesota believe that the competency of treatment staff is either extremely important (51.22%) or very important (39.84%). This belief does not change regardless of the location of the social workers clients served as this analysis concluded. This finding suggests that a client’s success is in part related to the competency of their treatment staff regardless of their geographic location, such as rural or metropolitan. This could in part be related to the importance that staff has on a clients success when in a treatment program. Future research could further investigate to see if other factors influence the perceived competency of treatment staff. Factors such as level of education, age, training, and income could all effect how a staff is rated on their competency. It is important to know what factor influence the perception of social workers who have experience working with clients who have a dual diagnosis and

participate in treatment. Social workers typically do not directly engage in substance use treatment, unless they have a dual license, but are key components in advocacy and referring clients for these services.

The analysis of the effects social workers level of licensure and their belief in which disorder should be addressed first resulted in the findings that were statistically significant. This meant that we rejected the null hypothesis and that there was an association between level of licensure and belief in the disorder that should be addressed first. In this analysis social workers with a LSW or LGSW had 69.4% believing that mental health and 30.6% believing that substance abuse needed to be addressed first. Social workers with a LISW or LICSW believed that mental health 65.0% should be addressed before substance use 35.0%. The majority of social worker who held a dual license of a LADC believed that substance abuse 87.5% should be addressed before mental health 12.5%. This finding suggests that the presence of a secondary license, primarily a LADC, increases a social workers belief that substance abuse should be the disorder addressed first. It is important to understand how different social workers view the treatment of co-occurring disorder and how one disorder can hinder the treating of the other.

The analysis of the effects social workers location of clients served and their belief in the percentage of dual diagnosed clients that successfully complete treatment was not statistically significant. This meant that we fail to reject the null hypothesis and that there was not an association between location of the clients that the respondent serves and their belief in percentage of clients with a dual diagnosis that complete substance abuse treatment. In this analysis social workers serving in both categorizes of suburban area or medium size urban area (2) and major metropolitan areas both had an average mean of 1.93. The respondents serving clients in either small, rural, or medium towns (1) had a slightly lower average mean of 1.76.

This finding suggests that the location of the social workers clients does not statistically change their belief in the percentage of clients that complete treatment. It is important to note that there was a slightly decrease in the average score between the individuals who served clients in smaller towns and those serving clients in larger suburban or metro area. Future research could examine whether the location of practice changes perspective on the effectiveness of treatment for people with a dual diagnosis.

The analysis of the effects social workers years practiced and their belief in the importance of preexisting coping skills for client's ability to successfully complete treatment was not statistically significant. This meant that we fail to reject the null hypothesis and that there was not an association between years practicing social work and belief in importance of "coping skills" for successful completion of substance abuse treatment. In this analysis social workers with more years of experience had a higher mean average score indicating that they would be more likely to believe that coping skills were important for success in treatment. The respondents mean average score were 2.80 for less than 1 year, 2.77 for 1-2 years, 2.37 for 3-5 years, 2.36 for 5-10 years, and 2.33 for more than 10 years. This finding suggests that the years a social workers has practiced does not statistically change their belief in the importance of preexisting coping skills. It is important to note that there was a slightly increase in the average score between each category of years of experience. Future research could examine the extent that years of practicing have on perceived importance of coping skills.

The analysis of the effects social workers experience working in case management and their belief in the belief in the percentage of treatment facilities that are capable of effectively treating individuals with a dual diagnosis was not statistically significant. This meant that we fail to reject the null hypothesis and that there was not an association between social workers



who work as case managers and their belief in the percentage of treatment facilities that are capable of effectively treating individuals with a dual diagnosis. In this analysis social workers with experience working in case management had a slightly lower mean average score indicating that they were slightly less likely to believe that treatment facilities were capable of treating people with a dual diagnosis. The respondents mean average score who had experience working in case management was 1.73 compared to 1.81 of those who had did not have experience in case management. This finding suggests that a respondents experience working in case management does not statistically change their belief that treatment facilities were capable of treating people with a dual diagnosis. Although the findings did show a slight decrease in average score of .08 when a respondent had experience in case management it is important to note that based on the analysis this is not statistically significant.

### **Contribution to Social Work Practice**

This study seeks to contribute to the discussion in the professional literature about the factors that contribute to dual diagnosis client's success in treatment. The findings from the survey show that demographic components such as level of licensure or area of practice do not have a statistically significant difference in perception of factors for treatment. The survey reaffirmed many of the beliefs that have existed in addiction treatment literature such as the importance of a client's commitment to change and their overall self esteem. The researcher hopes that this can help to identify specific areas of focus for further research and initiate an increased awareness for the importance of these factors.

### **Implications for Future Research**

The analysis of social workers perspective on the factors that contribute to client's success in treatment found that many of the demographic components were not associated. This

means that if a social worker identifies as being from a specific geographic location or area of specialty this will not affect whether they view a specific factor as important or significant. This helps to further our understanding of social workers experience working with clients with a dual diagnosis and accessing resources in Minnesota. Future research can focus on specific client diagnoses and whether this impacts contributing factors for success. Another potential areas of interest could look for correlation between with one another so that trends in interest can be identified. Graduate programs could use this information to create courses that appealed to these interests and allow them to further their interest in these areas.

The study found several interesting correlations between variables. The study found that those who believe in minimizing state assistance are also more likely to believe that more individuals abuse the welfare system. This is important because it shows the potential reason why individuals believe in minimizing state assistance. The study suggests that a potential factor in individual's belief in minimizing assistance in because they believe individuals abuse the system. Research can further investigate this topic by expanding on which ways individuals perceive others abuse the system. Research could also try to study what individuals believe should be minimized in state assistance.

Our analysis of the different perceptions, attitudes, and attributes social worker students have on poverty has broadened our understanding of the perception of poverty. There are many factors that influence individual's perception of poverty and our current welfare system. Moving forward it is important to expand on this knowledge so that we can work to understand why people view poverty the way they do. Further research can help us do this, but poverty is a complex social issue that is difficult to understand.

### **Strengths and Limitations**

**Strengths.** The strengths of this clinical research project include a high amount of respondents (146 respondents). The survey was exclusively sent to licensed social workers in the state of Minnesota. This study reflects the opinions and perspective of social workers that are or have practiced in the state with this specific population. As part of the criteria to take the survey respondents were asked to only participate if they had experience working with clients who had a dual diagnosis of a mental illness or substance use disorder. This could explain the overall response rate for the survey 7% (146 of 2,000). The recruitment method was a strength and consisted of a randomized list of email addresses that consisted of a variety of respondents with different demographic backgrounds. This research is intended to help further the professions understanding of the important factors that contribute to client's success in treatment. Clients with a dual diagnosis present with numerous challenges and can be difficult to appropriately refer for treatment. Social workers in this survey identified several factors that play an important role in helping clients succeed in treatment. These factors can help further our understanding of this population's specific need.

**Limitations.** This clinical research project has several limitations. The first limitation is that the overall response rate was lower than expected (7%). The number of responses was sufficient to have some generalizable data for the respondents. This could in part be attributed to the method the survey was distributed and how the email addresses were acquired. The analysis of the data was limited in its scope and, due to the researchers time constraints, many of the variables were not analyzed to determine potential correlations. A significant amount of the findings were based on the descriptive statistics from the survey questions. All of the inferential

statistics were predetermined prior to gaining IRB approval and consisted of 5 statistical analyses. Future research would benefit from additional flexibility to look at other variables.

The survey itself was also limited in its scope. This was mainly due to the recruitment and distribution method for the survey. It was determined early in the research that the survey should be limited in length to ensure that respondents had adequate time to complete the survey without being a burden. This resulted in a limited survey that excluded several potential factors, demographic information, and types of treatment. This had a negative effect on the findings and means that this study is not able to be generalizable broadly. The final factor that limited this survey was that it was conducted during a time when other studies are also occurring. This could have decreased the response rate and overall survey completion rate.

### References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Beck, J. (2011). *Cognitive therapy: Basics and beyond, 2<sup>nd</sup> Ed.* NY: Guilford.
- Engel, G. L. (1992). The need for a new medical model: A challenge for biomedicine. *Family Systems Medicine*, 10(3), 317-331. doi:10.1037/h0089260
- Blakey, J. M., & Bowers, P. H. (2014). Barriers to Integrated Treatment of Substance Abuse and Trauma Among Women. *Journal Of Social Work Practice In The Addictions*, 14(3), 250-272. doi:10.1080/1533256X.2014.933731
- Baker-Ericzén, M., Jenkins, M., & Haine-Schlagel, R. (2013). Therapist, Parent, and Youth Perspectives of Treatment Barriers to Family-Focused Community Outpatient Mental Health Services. *Journal Of Child & Family Studies*, 22(6), 854-868. doi:10.1007/s10826-012-9644-7
- Boysen, G., Ebersole, A., Casner, R., & Coston, N. (2014). Gendered Mental Disorders: Masculine and Feminine Stereotypes About Mental Disorders and Their Relation to Stigma. *Journal Of Social Psychology*, 154(6), 546-565. doi:10.1080/00224545.2014.953028
- Capuzzi, D., & Stauffer, M. D. (2016). *Foundations of Addictions Counseling, 3<sup>rd</sup> Ed.* New York: Pearson. ISBN-13: 9780133998641
- Cohen, B., & Rabinovitch, R. V. (2005). Outcomes of the Decision to Terminate Drug Abuse: An Application of Rational Choice Theory. *Journal Of Social Work Practice In The Addictions*, 5(4), 47-62. doi:10.1300/J160v05n0404

- Goffman, E. (1986). Stigma; notes on the management of spoiled identity. *Stigma; Notes On The Management Of Spoiled Identity*,
- Green, C. A., Yarborough, M. T., Polen, M. R., Janoff, S. L., & Yarborough, B. H. (2015). Dual Recovery Among People With Serious Mental Illnesses and Substance Problems: A Qualitative Analysis. *Journal Of Dual Diagnosis, 11(1)*, 33-41.  
doi:10.1080/15504263.2014.975004
- Grella, C. (2003). Contrasting views of substance abuse and mental health treatment providers on treating dually diagnosed. *Substance Use & Misuse, 38(10)*, 1433-1446.
- Grubaugh, A. L., Zinzow, H. M., Paul, L., Egede, L. E., & Frueh, B. C. (2011). Trauma exposure and posttraumatic stress disorder in adults with severe mental illness: A critical review. *Clinical Psychology Review, 31*, 883–899. doi:10.1016/j.cpr.2011.04.003
- Hides, L., Samet, S., & Lubman, D. I. (2010). Cognitive behaviour therapy (CBT) for the treatment of co-occurring depression and substance use: Current evidence and directions for future research. *Drug and Alcohol Review, 29(5)*, 508–517. doi:10.1111/j.1465–3362.2010.00207.x
- Hogan, L., Elison, S., Ward, J., & Davies, G. (2015). Effectiveness of the Pillars of Recovery Group and Key Working Program for Service Users with a Dual Diagnosis of Substance Dependence and Concurrent Mental Health Problems: An Initial Outcomes Evaluation. *Journal Of Groups In Addiction & Recovery, 10(2)*, 125-140.  
doi:10.1080/1556035X.2015.1034821
- Inaba, D. S. & Cohen, W. E. (2014). *Uppers, Downers, All Arounders: Physical & Mental Effects of Psychoactive Drugs* (8<sup>th</sup> ed.). Medford, OR: CNS Productions, Inc. ISBN: 978-0-926544-39-0

- Jerrell, J. M., & Ridgely, M. S. (1995). Gender Differences in the Assessment of Specialized Treatments for Substance Abuse among People with Severe Mental Illness. *Journal Of Psychoactive Drugs*, 27(4), 347-355.
- Kim-Berg, I., & Miller, S. (1992). *Working with the problem drinker*. New York: W.W. Norton & Company.
- Link, B. G., Struening, E. L., Rahav, M., Phelan, J. C., & Nuttbrock, L. (1997). On Stigma and Its Consequences: Evidence from a Longitudinal Study of Men with Dual Diagnoses of Mental Illness and Substance Abuse. *Journal Of Health & Social Behavior*, 38(2), 177-190.
- Lu, W., Yanos, P. T., Silverstein, S. M., Mueser, K. T., Rosenberg, S. D., Gottlieb, J. D., & ... Giacobbe, G. (2013). Public Mental Health Clients with Severe Mental Illness and Probable Posttraumatic Stress Disorder: Trauma Exposure and Correlates of Symptom Severity. *Journal Of Traumatic Stress*, 26(2), 266-273. doi:10.1002/jts.21791
- Marlatt, G. A., & Witkiewitz, K. (n.d). *Harm reduction approaches to alcohol use: Health promotion, prevention, and treatment*. Pergamon Press - An Imprint of Elsevier Science.
- Matthys, F., Soyez, V., van den Brink, W., Joostens, P., Tremmery, S., & Sabbe, B. (2014). Barriers to Implementation of Treatment Guidelines for ADHD in Adults With Substance Use Disorder. *Journal Of Dual Diagnosis*, 10(3), 130-138. doi:10.1080/15504263.2014.926691
- McHugh, R. K., Hearon, B. A., & Otto, M. W. (2010). Cognitive behavioral therapy for substance use disorders. *Psychiatric Clinics of North America*, 33(3), 511–525. doi:10.1016/j.psc.2010.04.012

- McKee, S. A., Harris, G. T., & Cormier, C. A. (2013). Implementing Residential Integrated Treatment for Co-occurring Disorders. *Journal Of Dual Diagnosis, 9*(3), 249-259. doi:10.1080/15504263.2013.807073
- Mennis, J., Stahler, G. J., & Baron, D. A. (2012). Geographic Barriers to Community-Based Psychiatric Treatment for Drug-Dependent Patients. *Annals Of The Association Of American Geographers, 102*(5), 1093-1103. doi:10.1080/00045608.2012.657142
- Minkoff, K., Zweben, J., Rosenthal, R., & Riesv, R. (2003). Development of Service Intensity Criteria and Program Categories for Individuals with Co-Occurring Disorders. *Journal Of Addictive Diseases, 22*113-129. doi:10.1300/J069v22S01\_08
- Padwa, H., Larkins, S., Crevecoeur-Macphail, D. A., & Grella, C. E. (2013). Dual Diagnosis Capability in Mental Health and Substance Use Disorder Treatment Programs. *Journal Of Dual Diagnosis, 9*(2), 179-186. doi:10.1080/15504263.2013.778441
- Renner, J. A. (2007). Training Psychiatrists to Treat Dual Diagnosis Patients. *Journal Of Dual Diagnosis, 3*(2), 125-136. doi:10.1300/J374v03n02-14
- Sanders, J. M. (2012). Use of Mutual Support to Counteract the Effects of Socially Constructed Stigma: Gender and Drug Addiction. *Journal Of Groups In Addiction & Recovery, 7*(2-4), 237-252. doi:10.1080/1556035X.2012.705705
- Stein, D.B. & Foltz, R. (2009). The need to operationally define “disease” in psychiatry and psychology. *Ethical Human Psychology and Psychiatry, 11*, 120-141.
- Sullivan, C. J., Sacks, S., Mckendrick, K., Banks, S., Sacks, J. Y., & Stommel, J. (2007). Modified Therapeutic Community Treatment for Offenders with Co-Occurring Disorders: Mental Health Outcomes. *Journal Of Offender Rehabilitation, 45*(1/2), 227-247. doi:10.1300/J076v45n01-15



- Tatarsky, A. (2003). *Harm reduction psychotherapy: Extending the reach of traditional substance use treatment*. Pergamon Press - An Imprint of Elsevier Science.  
doi:10.1016/S0740-5472(03)00085-0
- Taylor, O. D. (2010). Barriers to Treatment for Women With Substance Use Disorders. *Journal Of Human Behavior In The Social Environment*, 20(3), 393-409.  
doi:10.1080/10911351003673310
- Wheeler, A., Crozier, M., Robinson, G., Pawlow, N., & Mihala, G. (2014). Assessing and responding to hazardous and risky alcohol and other drug use: The practice, knowledge and attitudes of staff working in mental health services. *Drugs: Education, Prevention & Policy*, 21(3), 234-243. doi:10.3109/09687637.2013.864255
- Ulibarri, M. D., Ulloa, E. C., & Salazar, M. (2015). Associations between Mental Health, Substance Use, and Sexual Abuse Experiences among Latinas. *Journal Of Child Sexual Abuse*, 24(1), 35-54. doi:10.1080/10538712.2015.976303
- Whittinghill, D., Whittinghill, L., & Loesch, L. (2000). The benefits of a self-efficacy approach to substance abuse counseling in a era of managed care. *Journal of Addiction & Offender Counseling*, 20(2), 64-74.

**Appendix A****Factors Contributing to Success Survey**

1. (D1) Age: \_\_\_\_\_

2. (D2) Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Transgender

3. (D3) Race:

- \_\_\_\_\_ African American
- \_\_\_\_\_ American Indian or Alaska Native
- \_\_\_\_\_ Asian
- \_\_\_\_\_ Hispanic or Latino
- \_\_\_\_\_ Native Hawaiian or other Pacific Islander
- \_\_\_\_\_ White
- \_\_\_\_\_ Other (please specify) \_\_\_\_\_

4. (D4) Which level of social work licensure are you (check only one):

- \_\_\_\_\_ LSW - Licensed Social Worker
- \_\_\_\_\_ LGSW - Licensed Graduated Social Worker
- \_\_\_\_\_ LISW - Licensed Independent Social Worker
- \_\_\_\_\_ LICSW - Licensed Independent Clinical Social Worker
- \_\_\_\_\_ LGSW and LADC - Licensed Alcohol and Drug Counselor
- \_\_\_\_\_ LICSW and LADC
- \_\_\_\_\_ LSW and LADC

5. (D6) Please indicate your major areas of work (check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> Clinical social work practice with individuals | <input type="checkbox"/> Case management                |
| <input type="checkbox"/> Clinical social work practice with couples     | <input type="checkbox"/> Management/administration      |
| <input type="checkbox"/> Clinical social work practice with families    | <input type="checkbox"/> Intake/discharge               |
| <input type="checkbox"/> Clinical social work practice with groups      | <input type="checkbox"/> Research                       |
| <input type="checkbox"/> Addiction inpatient                            | <input type="checkbox"/> Addiction outpatient           |
| <input type="checkbox"/> Residential care                               | <input type="checkbox"/> Hospital                       |
| <input type="checkbox"/> Mental health outpatient clinic                | <input type="checkbox"/> School based                   |
| <input type="checkbox"/> Children                                       | <input type="checkbox"/> Day treatment                  |
| <input type="checkbox"/> Probation                                      | <input type="checkbox"/> Corrections                    |
| <input type="checkbox"/> Community outreach                             | <input type="checkbox"/>                                |
| Other, specify: _____   | <input type="checkbox"/> Child welfare/child protection |

6. (D7) How long have you been practicing social work?

- Less than 1 year
- 1 – 2 years
- 3 - 5 years
- 5 – 10 years
- More than 10 years

6. (D8) How would you describe the primary location of the clients that you serve? (select only one):

- Rural or small town (less than 1,000)
- Suburban area near major metropolitan area

- \_\_\_\_\_ Major metropolitan area (500,000 or more)
- \_\_\_\_\_ Medium size rural town (1,000 - fewer than 50,000)
- \_\_\_\_\_ Medium size urban area, which is not a suburb of a major metro area (50,000- fewer than 500,000)

Please rank the following substance use treatment types in order of effectiveness (7=most effective, 1= least effective). (T1-T7):

7. \_\_\_ 12-step models or abstinence
8. \_\_\_ Harm reduction
9. \_\_\_ Client centered
11. \_\_\_ Integrated
12. \_\_\_ Trauma informed
13. \_\_\_ CBT focused
14. \_\_\_ Mental Health focused

The following statements reflect possible causes for success in treatment. Please indicate how important you think each statement is as a cause for dual-diagnosis client's success in treatment. (C1-C6)

	Not Important		Somewhat Important		Very Important
15. Clients internalized Commitment to change	1	2	3	4	5
16. Self-esteem and self-worth	1	2	3	4	5
17. Sense of spirituality	1	2	3	4	5
18. Pre-existing coping skills to manage emotions	1	2	3	4	5
19. Clients financial means to pay for treatment	1	2	3	4	5
20. Competency of treatment facility staff	1	2	3	4	5

**Please fill in the exact percentage based on your opinion.**

21. (P1) What percentage of individuals with co-occurring disorders do you believe successfully complete substance use disorder treatment programs?

0-25%            25-50%            50-75%            75-100%

22. (P2) What percentage of individuals with co-occurring disorders do you believe are psychiatrically stable enough to successfully complete substance use disorder treatment?

0-25%            25-50%            50-75%            75-100%

23. (P3) What percentage of treatment facilities, that you are aware of, are capable of effectively treating individuals with a dual diagnosis?

0-25%            25-50%            50-75%            75-100%

25. (P5) Which disorder do you believe should be addressed **first** for individuals with a dual diagnosis?            \_\_\_\_\_ Mental health            \_\_\_\_\_ Substance use disorder

24. (O1) Explain why you answered Q#25 as you did? (Open-ended question)

26. (O2) What do you believe is the biggest contributing factor to successful completion of treatment for SUD? (Open-ended question)

26. (O3) What do you think the biggest barriers to clients seeking substance abuse treatment? (Open-ended question)

## **Appendix B**

### **Consent Form**

St. Catherine University Institutional Review Board

#### **Factors Contributing to Success Survey Email Message**

You are invited to participate in a survey that will contribute to research that is studying factors that contribute to success in treatment for individuals with a dual diagnosis. The purpose of this survey is to research social worker's perspective of factors that contribute to success in substance abuse treatment for clients with a dual diagnosis of mental health and substance abuse disorder. Please only take this survey if you have worked, volunteered, or interned at an agency that works with clients who have a dual diagnosis. If you have any questions please contact the primary researcher, Logan Evenson at [logan.evenson@stthomas.edu](mailto:logan.evenson@stthomas.edu) or the St. Catherine's Institutional Review Board at (651) 690-6204 [irb@stkate.edu](mailto:irb@stkate.edu). Thank you and I appreciate you taking the time to consider participating in this research.

#### **Factors Contributing to Success Survey Consent Form**

You are invited to participate in this project because you are a licensed social worker. The purpose of this survey is to research social worker's perspective of factors that contribute to success in treatment for clients with a dual diagnosis. This project is being conducted by Logan Evenson a MSW student at St. Catherine University. The survey includes items about substance use disorder treatment and dual diagnosis. It will take approximately 10 minutes to complete.

Your responses to this survey will be anonymous and results will be presented in a way that no one will be identifiable. Confidentiality will be maintained to the degree permitted by the technology used. Specifically, no guarantees can be made regarding the interception of data sent via the Internet by any third parties.

Your decision whether or not to participate will not affect your relationships with the researchers or St. Catherine University. If you decided to stop at any time you may do so. You may also skip any item that you do not want to answer. If you have any questions about this project, please contact Logan Evenson at [loganevenson@stthomas.edu](mailto:loganevenson@stthomas.edu). By responding to items on this survey you are giving us your consent to allow us to use your responses for research and educational purposes.