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PREDICTORS OF CLIENT COMPLETION FOR A LONG-TERM
CHRISTIAN-BASED RESIDENTIAL ADDICTION
TREATMENT PROGRAM

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
Of the Requirements for the Degree
Master of Social Work

by
Dena Carol Carey
Marianne Louise Grant

June 2001


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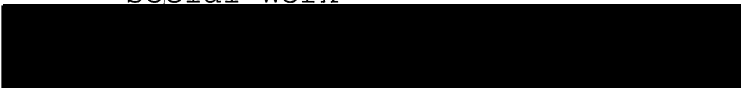
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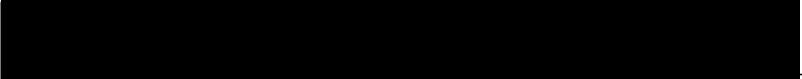
June 2001

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ABSTRACT

Long-term residential drug and alcohol treatment programs can only be effective if the client remains in the program long enough to attain maximum recovery.

Administrators and financial investors of such programs can benefit from understanding the characteristics that may effect a client's decision to follow through. This study looked at former client files from one facility, the Drug Alternative Program (DAP) in Grand Terrace, California, to help determine some factors that can contribute to client completion of the program.

Demographic information, programmatic issues, and some scales from MMPI-2 results were used. Results from the data collection revealed insufficient record keeping on the part of the program to gather a substantial amount of information. However, there were some correlations found that have an interesting basis for further exploration.

ACKNOWLEDGMENTS

We would like to extend a special thank you to Steve Nitch, our adviser, who gave much needed guidance and encouragement that made this project bearable to accomplish. We would also like to thank Timothy Thelander whose expert knowledge of Microsoft Word and last minute willingness to share that knowledge made it possible to meet graduation deadlines. Without either one, we would have remained overwhelmed and unfinished.

DEDICATION

To my children, Ami, Beau and Cori who have been supportive and proud of their mom's accomplishments for the past nine years.

D.C.

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CHAPTER ONE

INTRODUCTION

Problem Statement

Programs designed to assist clients recover from addictions to drugs and alcohol can only be effective if the addicted client remains for the duration of the program. Most addicts enter drug or alcohol treatment facilities stating their full intention of achieving the maximum level of recovery. Unfortunately, this intention is often not realized as many clients choose to leave treatment prematurely without reaching their goal. Leaving the program early interrupts the continuity of the program as well as disrupts the life of the client and all those involved in his life. This study will look at some factors that are correlated with variables common to those clients who have successfully completed treatment in a long-term residential program versus those who have not.

One of the benefits of small residential drug and alcohol treatment programs is that they offer an intensive atmosphere to facilitate recovery. These programs either operate for profit or have a non-profit

status. Generally, programs rely on positive client outcomes to remain in business (Ouimette, Finney, & Moos, 1997). It is often difficult to maintain funding sources without proven success rates. In drug and alcohol treatment, success is measured by program completion, which translates into a higher recovery rate. Most facilities are interested in producing success stories as a means to justify their business. In addition, recovered addicts often act as significant role models for newly recovering individuals.

If administrators could determine guidelines for screening clients who are likely to succeed at completing a recovery program, then it would affect the success of the program as a whole. Likewise, the program may then be able to tailor its services toward a high-risk client population (Alterman, McKay, Mulvaney, & McLellan, 1996). When uninterested or uncommitted clients mix with those who are interested and committed to recovery, there is the possibility that the less serious clients will project negative influences. This inhibits the sense of community necessary to enhance the group process that is inherent to recovery programs (Straussner & Spiegel, 1996). When members of a group have similar goals, the

group is more productive (Yalom, 1995). Uncooperative members can instigate division within the group that will sabotage trust, thereby rendering the group less effective.

Drug and alcohol addiction is an increasing problem that requires sufficient access to recovery opportunities. It would benefit treatment facilities to have a framework to predict a client's likelihood of program success. This would allow administrators, supporters, and funders to use program resources to their fullest potential. Consequently, they would be able to better identify the clients who are truly ready for inpatient recovery versus those who may need a different mode of treatment.

The focus of this study, the Drug Alternative Program (DAP), is a local residential treatment facility servicing men who wish to recover from drug or alcohol addiction. It is a non-profit Christian-based facility that is affiliated with the Seventh-day Adventist religious denomination. The intensive program is designed to house approximately twenty men in three residences who are in various stages of recovery. Most residential programs are structured for the client to complete in six

weeks to six months. In contrast, the potential DAP client is instructed that the length of stay will be between twelve and eighteen months, with an exact graduation date to be determined by staff. Due to the long-term nature of this program, it is the administration's desire to make full use of their resources by providing services to those clients who are fully committed to the recovery process.

The DAP clients are not mandated to enter the program; however, some are admitted as a chosen alternative to a jail sentence. Clients come from various parts of the United States and all have entered the program voluntarily, although some are strongly influenced by family members to participate in the program. Prior to admittance, there is a telephone-screening interview conducted by the director of the program. The intention is to obtain a preliminary substance abuse recovery history log on each client so that the staff can tailor the services to the individual needs of the client. In addition, the client gives a verbal commitment to the terms of the program and confirms his understanding of the program's expectations.

Though most clients have learned about the program through the Seventh-day Adventist Church, potential clients are reminded during the interview that DAP is a Christian-based program with a specific Seventh-day Adventist focus. All clients are accepted with the understanding that they will attend religious services and study lessons in the Seventh-day Adventist tradition. However, no one is required to be baptized in, or convert to, this specific denomination. The client is also informed that DAP is a work program in which the client will be expected to perform certain duties. This includes working on the lawn crew Monday through Friday as well as doing minor construction or clean up jobs. This serves as a source of income for the program as well as another opportunity for cooperative existence and building of a community atmosphere. Along with the phone interview conducted by the director, there are various other assessment tools that have been utilized by the program in the recent past. For instance, the Minnesota Multiphasic Personality Inventory, 2nd Edition (MMPI-2) has recently been used to help staff accumulate pertinent information about the client in order to further personalize his treatment.

As previously stated, most DAP clients enter the program willingly and cooperate with program curriculum. However, there are a minority of clients who are accepted in the program but subsequently do not cooperate with the program curriculum. This population deserves research attention to determine underlying causes of treatment failure. Further knowledge in this area stands to strengthen the recovery program as a whole, prevent resources from being used ineffectively, and improve the overall quality of services.

Problem Focus

There are a number of clients who appear willing to commit to the long-term recovery process, yet become resistant to treatment after a short time. The majority of these clients voluntarily leave the program before completion. In addition, small portions of clients are terminated by the mutual agreement of staff for the purpose of maintaining a positive recovery atmosphere for the remaining clients. The administrators and staff do not advocate terminating addicts who are in the midst of recovery; however, uncooperative clients can taint the success of the rest of the program by sabotaging the

recovery program of others. They can set a negative example for their fellow clients who are struggling with their own recovery issues. Upon recommendation of staff, those who stay within the parameters of the recovery program at DAP are celebrated with an elaborate graduation ceremony.

This ceremony is highly regarded by the residents and those who graduate leave with a sense of pride of accomplishment.

In this study, a comparison of successful and unsuccessful cases has been undertaken. Issues that were addressed include demographic variables as well as the client's attitudes about recovery as indicated by MMPI-2 results. In addition, data collection and administrative record keeping issues have been analyzed. In order to include child welfare issues, the literature review and discussion will briefly address how family of origin influences precipitate substance abuse.

In general, this study will be useful in differentiating the potential of success for recovery in a long-term inpatient treatment facility. This can influence the development of different types of programs for those who are interested in a similar treatment

philosophy, but who are unable to complete a long-term residential recovery program. The intent of this study is not to filter out the "bad" clients. Rather, it is meant to identify those addicts who are likely to fully benefit from a long-term treatment program and those who need a different type of recovery model. The results of this study, although specifically directed at the DAP program, will be useful for other similarly designed addiction treatment programs. Therefore, this study will address the following research question: What factors influence successful outcomes as defined as the completion of the Drug Alternative Program?

CHAPTER TWO

LITERATURE REVIEW

Popular belief maintains that addiction is a social problem that takes hold of bad people (Leshner, 1997). However, according to recent studies, "addiction is actually a chronic, relapsing illness, characterized by compulsive drug seeking and use" (p. 45). Other research suggests, "biological aspects must...be considered...for working with the chemically dependent" (Wade, 1994, p. 415). Studies also reveal that addiction can be effectively treated (Marwick, 1998; Leshner, 1997). For instance, Alcoholics Anonymous (A.A.) is known for utilizing a 12-step approach for recovery from addiction to alcohol (Straussner & Spiegel, 1996). Likewise, most other drug programs "adopt some 12-step techniques in treatment" (Winzelberg & Humphreys, 1999, p. 790).

The 12-step method used by A.A. has earned a reputation for having a higher recovery rate than any other recognized program (Galaif & Sussman, 1995). Here, the 12-step approach is used exclusively on an outpatient basis with minimal requirements for admission. One must want to stop using drugs and/or alcohol, attend meetings,

and consider himself or herself a member (Winzelberg & Humphreys, 1999; Denzin, 1987). These types of programs encourage a sense of community where peer support and accountability is crucial (Straussner & Spiegel, 1996).

In-patient, non-hospital based programs have the advantage of a controlled climate for recovery; yet they often adapt some of the outpatient 12-step strategies as well. The program used for this study covertly uses universal 12-step principles; however, it denies using a direct 12-step approach preferring instead to acknowledge the One-Step process of a relationship with God. The goal is to facilitate a long enough stay for the client to make a full recovery. Studies show that the longer a client receives treatment, the better the outcome in terms of relapse rate (Ouimette, Moos, & Finney, 1998; Lash & Dillard, 1996). These successful outcomes then positively influence the client's ability to function in his or her social environment after discharge (Timko & Moos, 1998).

Another important aspect of the recovery process in most outpatient based programs, including A.A. and Narcotics Anonymous (N.A.), is the need for the client to incorporate a spiritual concept in his daily life

(Winzelburg & Humphreys, 1999). According to the Alcoholics Anonymous Book, reliance on a power greater than oneself is essential for recovery. "The spiritual life is not a theory. We have to live it" (Alcoholics Anonymous, 1996, p. 83). Although DAP does not require a denominational affiliation, it does emphasize a reliance upon God and incorporates biblical teachings.

In order to determine characteristics of alcohol and drug addicted clients who are most likely to complete a long-term treatment program, one must have an understanding of the dynamics of addiction as well as an understanding of people who are addicted to drugs or alcohol. There is an abundance of literature devoted to the study of alcohol and drug addiction causalities, typologies, and treatments that give a picture of addiction. According to Wade (1994), social stressors such as unemployment, financial distress, and/or homelessness are to be considered as catalysts for substance abuse among minority men. Both Ball (1996) and Babor (1996) each divide drug and alcohol addicts into two groups. The addict who has an onset of addiction late in life with little or no family history of addiction is classified as type A or type I. The type B or type II

addict is someone who has an early history of drug or alcohol addiction and has evidence of intergenerational patterns as well.

Typologies are useful in the development of treatments (Babor, 1996) and may be significant in determining client program completion. In addition, cultural considerations such as reactions to experiences of racism and other environmental issues should also be remembered when determining an effective treatment strategy (Wade, 1994). Due to its deep-seeded etiology, either learned or biologic, the category of type B or type II alcoholics may include more resistant clients who are more likely to terminate prior to completing a long-term program. On the other hand, type A or type I addicts who typically have other factors that have contributed to their addiction, may be predicted to have a higher likelihood of program completion. Understanding typology may also be helpful in predicting which addicts are likely to seek help in the first place.

The results of a longitudinal study of help-seeking predictors concluded that men are more likely to seek help than women for addiction recovery (Kaskutas, Weisner, & Caetano, 1997). The men in the study sought

treatment because of experiences of repeated social consequences rather than acknowledgment of symptomatic problems. Therefore, readiness for change can be considered a factor that may influence program completion. According to Isenhardt (1997), action oriented clients and those who have pretreatment support are likely to finish a recovery program. Isenhardt's study found no correlation between pretreatment readiness and the amount or frequency of alcohol consumption. As a result, one cannot assume that readiness follows a lengthy time of active addiction. He did find, however, that successful recovery as well as recidivism is both influenced by external factors such as family and work related issues.

Readiness for treatment begins with acknowledgment of an addiction problem. If a client is forced into treatment by family members or is merely avoiding jail, acknowledgment may be absent and consequently have a negative effect on program completion. Grant (1997) found that many addicts who resist treatment perceive their addiction as not severe enough to warrant seeking help, which, in recovery terminology, translates into denial. Another impediment to readiness for treatment has to do

with the client's perception of the stigmatization due to participation in the treatment program (Grant, 1997). As a result, more functional addicts are not as likely to acknowledge the need for change, which causes them to avoid treatment or leave a recovery program early.

Another issue that can inhibit the success of treatment is the client's perception that his needs are being met. Farr, Bordieri, Benschhoff, Taricone, and Patrick (1996) suggest that assessment of individual client needs is helpful in enhancing the likelihood of program success. The climate of the treatment program is therefore very influential in patient satisfaction and dropout rates (Moos, 1997). The literature reveals that those who engage in the program services and activities have a higher overall success rate (Timko & Moos, 1998). In recognition of this, the DAP program puts an "emphasis on supportive relationships, the sharing of personal histories, and practically oriented tasks" which "encourages patients' active use of facility and community resources and services" (Timko & Moos, 1998, p. 1147). As a result of this practice, clients are more likely to fully benefit from the program.

The Minnesota Multiphasic Personality Inventory, Second Edition (MMPI-2) is used by many programs to evaluate psychopathology and psychological distress in order to assess mental status and treatment goals (Austin, 1994; Gallagher & Ben-Porath, 1997). The client "may be motivated to distort their self-presentation" on this test "because they are fearful or misunderstand the actual purpose of the psychological testing" (Gallagher & Ben-Porath, 1997, p. 361). As a result, the built-in validity scales of the MMPI-2 must be carefully regarded and further assessment of the client's response tendencies must be conducted. For instance, the L, F, and K scales of validity are effective measures of false presentation that should be carefully considered (Gallagher & Ben-Porath, 1997; Cloak & Kirklen, 1997).

The DAP program began to utilize the MMPI-2 in 1996; however, administrators and staff have not been able take full advantage of the results. On the surface, administrators have seen a correlation between those who have completed the MMPI-2 honestly and those who successfully complete the program. In addition, low scores on the Addiction Acknowledgment Scale (AAS) are indicative of potential denial (intentional or

unintentional) of substance abuse problems (Butcher & Graham, 1994). Butcher and Graham suggest that the AAS questions are easy to detect so it is important to be aware of the client's test-taking attitude when interpreting the final scores.

A t-score above 65 or 70 on most MMPI-2 scales denotes the possibility of a psychological disorder that can negatively affect recovery attempts (Patalano, 1998; Scafidi, Field, & Abrams, 1999). Research shows that there is typically more of a variety of psychopathological signals in the scores for substance abusers, which demonstrates the need for "differential treatment planning" (Patalano, 1998, p. 506). Another study indicates that a client's personality style affects his report of satisfaction in a program that, as discussed above, can have an influence on successful completion (Cernovsky, O'Reilly, & Pennington, 1997).

Predisposition factors should also be considered when looking at adult addicts and/or alcoholics. The data available for this study were insufficient to include familial influences in the correlation analysis. In this study, the majority of addicts started using drugs or drinking during adolescence. The literature offers

several factors that may predict likelihood of substance abuse before adulthood. For instance, Jacob and Johnson (1997) found that children of alcohol and drug addicts are more likely to repeat the addictive behaviors of their parents.

It has been suggested that both family environment and family structure have an influence on a child's risk for developing alcoholism or other drug abuse problems (Jacob & Johnson, 1997). The most crucial of family influences is the relationship between the parent and the child. Consequently, positive parental involvement "promote[s] prosocial behavior and reduce[s] the major family risk factors for alcohol, tobacco, and other drug (ATOD) use" (Hahn, Hall, & Simpson, 1998, p. 327). Once a child or teen is in need of treatment, long-term inpatient programs produce the best overall change in addictive behaviors (Dobkin, Chabot, Maliantovitch, & Craig, 1998). A support network, especially from parents, is crucial for an adolescent's recovery that can be facilitated in a long-term recovery program (Olsen, Allen & Azzi-Lessing, 1996).

This study hopes to find some variables that will help the DAP program screen those who are highly motivated for treatment success versus those who are not.

CHAPTER THREE

RESEARCH DESIGN AND METHODS

Study Design

The purpose of this study was to explore commonalities between successful graduates of the Drug Alternative Program (DAP) located in Grand Terrace, California. The study also explored differences between successful graduates and those clients who, for various reasons, did not successfully complete the program. The results of this study will help determine potential clients' goodness of fit for the program, which increases the likelihood of the client remaining at the facility for the appropriate length of time to maintain recovery.

The method used for data collection involved extraction of information from case files of former clients. For reasons related to patient confidentiality, no files of current clients were included. A preliminary review of case files was conducted to determine potential information that might be gathered. A checklist was then devised to gather demographic information and other variables of interest. This review indicated that outside of minimal demographic information, the files contained

inconsistent and missing data on the intake face sheets. As a result of this, it was not possible to collect client data related to family history, addictive habits, and personal medical and psychological histories.

Variables that were found in the majority of case files and analyzed to determine predictors of program completion included demographics such as age of client at admittance, ethnicity, marital status, drug of choice, age when substance abuse began, and length of time clients used their substance of choice. The number of disciplinary actions during the client's stay at DAP, the inclusion of contact notes in the file, and whether the client was discharged through graduation or early withdrawal were the variables chosen to address administrative issues. The main outcome variable of interest was discharge status defined as either successful graduation or unsuccessful completion by voluntary early withdrawal or staff termination.

Information was also taken from the MMPI-2 test administered to twenty-eight clients immediately after their admittance to DAP. The variables analyzed included the t-scores obtained by clients on the three traditional validity indices (L, F, K), the ten basic clinical

scales, and various supplementary scales. These scales measure constructs such as social introversion (Si), hypochondriasis (Hs), depression (D), hysteria (Hy), psychopathic deviate (Pd), masculinity-femininity (Mf), paranoia (Pa), psychasthenia (Pt), schizophrenia (Sc), hypomania (Ma), anxiety (A), repression (R), ego strength (ES), MacAndrew alcoholism scale-revised (MAC-R), addiction acknowledgment (AAS), addiction potential (APS), over controlled hostility (O-H), and dominance (Do).

Sampling

The DAP directors and financial supporters expressed an interest in finding predictors for success in their all male addiction recovery program. Consequently, the research received full cooperation from the facility administrators. Fifty-seven case files, which comprise the entire past client base, were available for examination. Confidentiality was maintained by gathering data in the administrative office of the facility. Files were kept isolated from any potential examination from either current clients or other outside contacts. The data collection checklist did not include the names of

the clients in order to protect their confidentiality at all times. In addition, to alleviate any potential bias, the data collector who is employed by the facility refrained from examining case files of those clients who she had counseled in the past. Many client files were found to be missing some data on the checklist; however, no file was excluded in the final results.

The average age of subjects was about 35.5 years with ages ranging from 18 to 52 years. There was an equal distribution of 45% African-American and 45% Caucasian subjects. The remaining 10% were a combination of Latino (6%), Asian (2%), and other ethnic backgrounds (2%).

More than half of the subjects had no statement as to religious affiliation; however, of those who did indicate a denominational preference, 87% belonged to the Seventh-day Adventist faith. The majority of subjects had graduated from high school (58%), while few had a college background (29%), and even fewer had not finished high school (13%). Forty-three percent did not have any children while 43% of the subjects had one or two children only.

Data Collection and Instruments

A three-page checklist was used in collecting data from past case files. Most of the checklist items were formulated after data collectors reviewed random files in order to determine what information the files contained. The remainder of checklist items were added in the hope that further investigation into each file would reveal other variables of interest.

Eight categories of demographic information were gathered in the first section. These included age, ethnicity, religious affiliation, years of education, marital status, number of times married, and number and ages of children. The next section had seventeen items related to the client's addiction. This section included drug of choice, treatment history, age when substance and/or alcohol use began, how long and how many times the client reported being clean and/or sober, and any legal ramifications of his addiction.

A short health history checklist was included to determine if any physical or mental illnesses had been diagnosed. Family history was included to investigate any environmental factors that could be related to the

clients' addiction. This section included four items that recorded parental use of alcohol, history of physical abuse, and parental marital status.

The program issues addressed included the number of disciplinary actions the client received during treatment at DAP, inclusion of contact notes in the file, and discharge status.

Finally, data from individual MMPI-2 scores were recorded. Scores on the ten basic scales were recorded. Scale 1 corresponds to hypochondriasis (Hs); Scale 2 corresponds to depression (D); Scale 3 corresponds to hysteria (Hy); Scale 4 corresponds to psychopathic deviance (Pd); Scale 5 corresponds to masculinity/femininity (Mf); Scale 6 corresponds to paranoia (Pa); Scale 7 corresponds to psychasthenia (Pt) (a type of anxiety); Scale 8 corresponds to schizophrenia (Sc); Scale 9 corresponds to hypomania (Ma); and Scale 0 corresponds to social introversion (Si). T-scores above the 65-70 range indicate tendencies for traits in that particular pathology.

Portions of the MMPI-2 supplementary scores were also recorded. Pertinent traits that may be determined to be related to those who suffer from addiction were looked

at. These included anxiety (A), repression (R), ego strength (Es), the MacAndrew alcoholism scale-revised (MAC-R), addiction acknowledgment scale (AAS), addiction potential scale (APS), over-controlled hostility scale (O-H), and dominance scale (Do). In addition, L, F, and K scores from the validity scale were recorded. Other scores from the MMPI-2 results were not considered pertinent to this study.

Procedure

The data took approximately six hours to collect. Two data collectors used the information from entries in client files to gather data corresponding to the checklist. Once all the files had been examined, the checklists were randomly numbered to correspond with data entry into SPSS, the statistical program used to analyze the data.

Protection of Human Subjects

The checklists were used for data extraction purposes only. The files were records of former clients, no longer in the DAP program. Identifying factors were purposefully eliminated so the checklists did not correspond to a particular client file. To ensure further

confidentiality, the data collector who is a current member of the staff of the program did not inspect any files that belonged to clients of whom she may have had prior knowledge. Informed consent was not administered or received from any former clients as the files are the sole property of the DAP administrators. By requesting that the study be done, the administrators gave full permission for use of client files. It will be recommended to the administrators to develop and implement a standardized written release of information at intake for the benefit of future study.

Data Analysis

A correlation analysis was used in this study. In addition, t-tests were used to determine differences between clients who were successful versus unsuccessful in completing the program. A descriptive analysis was used to determine the general characteristics of the sample as a whole.

CHAPTER FOUR

RESULTS

The data collected for this study consisted of file information from 57 former clients of DAP. Half of the subjects' files contained prior treatment history information. Of those who did state treatment history, 39% had participated in some form of recovery at least one time, 22% had entered treatment two times, 28% had done so three or more times, and only 11% had never sought treatment before entering DAP. With two-thirds of subject files containing drug of choice information, 61% listed cocaine as the predominant substance used, 29% admitted to methamphetamine use, while the remaining 10% listed either heroin or pot as their drug of choice. Most of the subjects (74%) admitted to using alcohol as well. Of those who listed a time since onset of substance abuse, 43% had been using for over 15 years, 38% used between five and ten years, and only 20% used drugs for less than five years.

The mean age of subjects when they began using drugs was 20 years old, with the median at age 18, and the mode

at 15 years of age. Similar frequencies were revealed for age when alcohol use began.

An attempt was made to gather other demographic information, but there was an insufficient amount of data contained within the files. For instance, it was impossible to collect data related to types of previous treatment (e.g. A.A. or other 12-step), length of time previously clean and/or sober, motivation for entering treatment (e.g. family pressure, avoiding jail, or self-motivated), and history of legal trouble as a result of addiction. Characteristics of families of origin were also investigated, but again, little information was found in the files. This included the presence of parental addiction, history of domestic violence, and marital status of parents.

All subjects' files were examined for records of disciplinary action during their stay at the facility. Disciplinary action reports are added into the file as a result of a client's disregard for program rules. For instance, inappropriate interactions with co-residents or misuse of privileges are two examples that may prompt the presence of a written discipline report. Fifty-five percent of the subjects had no disciplinary actions while

25% had between one and four records of disciplinary measures. The remaining 23% had more than four disciplinary reports recorded in their file. Discharge status was recorded in nearly three-quarters of the files examined. Sixty-seven percent of those recorded did not successfully complete the program as evidenced by early withdrawal. The remaining 33% were recorded as having successfully graduated from the program.

A little over half ($n = 29$) of the subject files examined included MMPI-2 interpretive reports that indicated the use of this instrument as a means to personalize treatment. The frequencies of scores on the MMPI-2 scales are impertinent to the purpose of this study; however, mean scores on the basic scale are worth noting. The subjects' mean t-score for Scale 1, hypochondriasis (Hs) was 53, which lies in the normal range; Scale 2, depression (D), showed a mean t-score of 59, which falls in the low to moderate level, indicating the possible presence of depression in some clients. Other scores that were found to be in the normal range included those for Scale 3 (hysteria - Hy), with a t-score of 53; Scale 5 (masculinity-femininity - Mf) with

a t-score of 50; and Scale 0 (social introversion - Si) with a t-score of 55.

Other mean t-scores that can be interpreted as being moderately elevated include Scale 6 (paranoia - Pa) with a moderately elevated mean score of 63; Scale 8 (schizophrenia - Sc), which also had a moderately elevated mean score of 64, and Scale 9 (hypomania - Ma) that exhibited a similarly elevated level of 64. The t-score of 65 seen on Scale 7 (psychasthenia - Pt) indicates a marked possibility of positive traits for anxiety. The final basic scale, Scale 4 (psychopathic deviate - Pd), showed a rather high mean score of 71. This is considered to indicate a marked likelihood of psychopathic tendencies and calls for further inspection.

A series of t-tests were run with clients grouped according to discharge status. Since the purpose of this study was to find common characteristics between clients who successfully completed the program as opposed to those who did not, the groups were broken down according to those who completed the program through graduating and those clients who were unsuccessful in completing the program evidenced by leaving early either by choice or by termination by staff. The variables used in each t-test

included all MMPI-2 variables previously listed as well as years of education, number of children, times in previous treatment, age when substance abuse began, age when alcohol abuse began, length of time clean and/or sober, and number of disciplinary actions while in the program.

Two significant values were found. There was a significant difference in the number of disciplinary actions obtained while in the program, $t(42) = -3.102$, $p < .05$. Graduates of the program had a higher number of disciplinary actions recorded than those who left the program early. The other significant difference found was on the supplementary scale of the MMPI-2 that measures over-controlled hostility (O-H). For this scale, there was a significant difference between hostility measures for unsuccessful subjects as opposed to graduates $t(23) = -2.277$, $p < .05$). Those clients who did not finish the program scored higher on this scale as compared to those clients who graduated. The other variables tested were found to be insignificant.

One interesting finding was obtained from the analysis of the F scale validity index. The mean score for all subjects was 62.4, which is close to the critical

value of 65 or higher. A high score on this scale indicates the subject is answering the questions in a random manner or deliberately trying to look bad (Scafidi, et al., 1999). The other two validity scales, L and K, had mean scores of 49.9 and 49.1, respectively. This is within the range of normal scores and indicates a lack of defensiveness (K) and predominately honest responses (L) (Scafidi, Field, Prodomidis, & Abrams, 1999). There were no significant differences in scores on the validity indices found between graduates and clients who were unsuccessful in completing the program.

When correlations were run, several significant associations appeared. For instance, there was a strong correlation between the variables "age" and "previous times in treatment," $r(28) = .439, p < .05$. The older the subject, the more times he had been in treatment. Another significant correlation was obtained between "age" and "length of time using drugs," $r(40) = .473, p < .05$. As expected, the older the client, the longer he had used drugs. Likewise, there was a correlation found between "times in previous treatment" and "length of time using drugs" $r(23) = .423, p < .05$. "Age" also had significant positive correlations with the "length of time abusing

alcohol," $r(21) = .743, p < .05$ and "age when substance abuse began" $r(39) = .581, p < .05$. The older the client, the longer he had used alcohol and the older he was when his alcohol use began. There was also a significant correlation between the "age when substance abuse began" and the "age when alcohol abuse began," $r(19) = .668, p < .05$.

In the MMPI-2 categories, only five entries had significant correlations. The F scale for validity had a high correlation with Scale 6 (paranoia -Pa), $r(29) = .804, p < .05$; Scale 7 (psychasthenia -Pt), $r(29) = .592, p < .05$; Scale 8 (schizophrenia -Sc), $r(29) = .644, p < .05$ of the basic scales. The "length of time clean and/or sober" variable had a high correlation with the MMPI-2 supplementary scale measuring ego strength (Es), $r(15) = .529, p < .05$. Other MMPI-2 supplementary scales that were significantly correlated with each other included anxiety (A) and over-controlled hostility (O-H), $r(28) = -.624, p < .05$; ego strength (Es) and over-controlled hostility (O-H), $r(28) = .391, p < .05$; ego strength (Es) and the dominance scale (Do), $r(28) = .706, p < .05$; and the scales measuring addiction acknowledgement (AAS) and addiction potential (APS),

$r(29) = .431, p < .05$. All other correlational analyses were insignificant.

CHAPTER FIVE

DISCUSSION

A significant amount of data collected for this study was found to be unhelpful in answering the research question. For instance, demographic information did not correlate with any program issues such as discharge status. Unfortunately, many items on the checklist could not be gathered from data in the individual files. Some data that would have been interesting to investigate includes family history, prior treatment history, and legal trouble affiliated with addiction. These factors may have led to an indication of predictors for completion. The main conclusion to be drawn is that the available data in the individual files were inconsistent, making it difficult to determine any patterns due to the low sample size.

While most of the data collected did not help answer the research question, several items are worth noting and deserve further investigation. For instance, out of the 29 subjects who had MMPI-2 results in their files, the mean score of 71 on Scale 4 (psychopathic deviate - Pd) indicates the possibility that there may be a relation

between addiction and psychopathic behaviors. In addition, graduates versus non-graduates of the program displayed a negative correlation on the over-controlled hostility (O-H) scale. One interpretation may be that those who enter the program with internalized hostility are more likely to leave early. It is possible that the more one recognizes and expresses his anger, the more compliant he can be to program guidelines. To address this issue, it may be helpful to incorporate an anger management component to the program designed to encourage full participation from those who exhibit underlying hostility.

The mean score on the F validity scale indicates a possible trend of client manipulation of test results. According to Scafidi, et al. (1999), this high score can indicate that the subject may have answered randomly or intentionally appeared to be pathological. It is possible that a potential client may be fearful of the purpose of the MMPI-2 or he may not be drug and alcohol free making it impossible to concentrate on the questions resulting in an incongruent pattern of responses. (Butcher & Graham, 1994; Gallagher & Ben-Porath, 1997). Likewise, the client may have the notion that he is "supposed" to

look pathological in order to get the help he needs, thereby intentionally answering questions in a negative manner. It is possible that, to diminish the likelihood of intentional (or unintentional) skewed responses, clear instruction on the purpose and use of the MMPI-2 results should be provided. In addition, test takers should be aware that the test is designed to detect inconsistent patterns of responses.

The other validity scales that serve to measure honesty (L) and defensiveness (K) had normal mean scores, which indicates an open desire for treatment by most clients.

The analyses revealed significant correlations between the variables "age" and "previous times in treatment," "length of time abusing alcohol," "age when alcohol abuse began," and "age when substance abuse began." These correlations were expected. An older person would have more opportunities to seek treatment and would naturally have used drugs or alcohol longer than a younger person. Likewise, the use of drugs and alcohol often go hand in hand; therefore, it is not surprising to find the significant correlation between the ages when substance abuse and alcohol abuse began. Not so obvious

is the correlation between the variables "times in previous treatment" and "length of time using drugs." It could be considered that a person who uses drugs for a long time has attempted to get clean many more times. However, intervening factors, such as life stressors that might precipitate the decision to start using drugs after being clean or underlying issues related to family of origin, must be considered when trying to understand this correlation to its fullest.

The F scale for validity was highly correlated with paranoia (Pa), psychasthenia (Pt), schizophrenia (Sc), and hypomania (Ma). This could be coincidental if the client is randomly answering questions from this scale. On the other hand, these pathologies may have been coincidentally chosen by the client to answer wrong in order to "look bad." However, it is a rather common occurrence for the high correlation between these scales to indicate genuine distress by the subject in one or more of these areas. All these possibilities must be considered when assessing the overall interpretation of the individual results.

On the supplementary scales, anxiety (A) had a negative correlation with over-controlled hostility

(O-H). This could mean those who feel anxious do not hold in hostility. On the other hand, anxiety may be predominant because of the subject's inability to control their level of hostility. However, those who have a strong ego are more likely to control their hostility as well as appear dominant, according to the literature. This study's positive correlation between the variables "length of time clean and/or sober" and the supplementary scale of ego strength (Es) may indicate that the longer a client is clean and/or sober, the stronger his ego becomes. On the other hand, the strong ego may be the precursor for the ability to maintain a longer period of being drug free and/or sober.

As expected, the addiction acknowledgment scale (AAS) was significantly correlated with the addiction potential scale (APS). It is consequently assumed that the subjects answered honestly on the two issues. With a larger sample size, scores on these scales may have some predictive ability regarding who does well in the program and those who do not.

Implications for Social Work

No new knowledge surfaced from the results of this study in terms of social work practice; however, the significant factors illustrate the need for awareness by the test giver of the attitude of the client prior to taking the MMPI-2. For instance, an angry client may deliberately skew his answers in an effort to manipulate his treatment plan. The MMPI-2 should be administered when the client is most likely to answer honestly, such as when he is rested and comfortable in his environment.

Finally, the significant positive correlation between those who graduated and the number of disciplinary actions found in the file has interesting connotations. It may be that, by virtue of longevity, the likelihood of more disciplinary actions is expected. However, as evidenced by observation of the nature of the program, it is more likely that the clients who challenge program routines are given more individual attention by administrators and staff thereby becoming more responsive to the overall goals of recovery as a result.

Recommendations for Further Study

There was a hindrance in collecting sufficient data for this study due to the facility's inconsistent record keeping. As a result of the research undertaken, it is recommended that the DAP program develop useful instruments that would help collect the same information for each client and to be diligent in requiring the paperwork to be completed prior to admission. In order to ensure proper ethical practice, the instrument/s should include a waiver from each client to allow his file to be used for future research purposes. The instruments devised should include family history of drug and/or alcohol abuse, parenting styles and extent of parental involvement as a child and medical and psychological history, in addition to the information that is currently collected.

The limitation of the current study was the lack of consistent information available. Once a consistent pattern of record keeping is established, which may take a period of three to four years due to the length of the program, the study should be repeated. The sample size would be much higher and the available information would

probably be sufficient to determine legitimate associations that could be used as predictive measures to ultimately improve the program.

Conclusion

As a whole, data collected for this study were inconclusive in determining predictors for client completion of the DAP program. The greatest obstacle was the lack of uniform data available in the subject files. Consequently, it has been determined that, in order to answer the research question in the future, DAP administrators must take time to re-evaluate their intake and documentation procedures. Ideas regarding information that should be collected at intake and during recovery have been presented. As soon as accurate and consistent entries into client charts are included as part of the daily operating procedures of DAP, there can be another attempt to find predictors for successful completion of the DAP program in the near future.

Some suggestions for implementing new record keeping procedures include training staff to be familiar with new forms and the importance of accurate data entry. Since there are never more than 18 to 20 residents at one time,

a portion of the weekly staff meetings may be used as a forum to discuss individual file entries as well as to monitor staff compliance to the new routine. Incentives such as small bonuses or special privileges may be established to help staff form new record keeping habits. In all, new record keeping procedures must be implemented and consistently followed to establish sufficient information within client files to conduct a meaningful study in the future.

APPENDIX
DRUG ALTERNATIVE PROGRAM
RESEARCH CHECKLIST

DAP Research Checklist

Demographics

- 1) Age: _____
- 2) Ethnicity: (1) African American (2) Caucasian
(3) Hispanic (4) Native American
(5) Asian (6) Other
- 3) Religious Affiliation: (1) Seventh-day Adventist (2) Catholic
(3) Non-denominational (4) Other
- 4) Years of Education: (1) 9 (2) 10 (3) 11 (4) 12
(5) 13 (6) 14 (7) BA/BS (8) Graduate
- 5) Marital Status: (1) Married (2) Divorced (3) Never Married
- 6) Number of Times Married: (1) 0 (2) 1 (3) 2 (4) 3 (5) More than 3
- 7) Number of Children: (1) 0 (2) 1 (3) 2 (4) 3 (5) 4 (6) More than 4
- 8) Ages of Children: _____
- 9) How Many Times Previously in Inpatient Tx: (1) 0 (2) 1 (3) 2
(4) 3 (5) 4
(6) More than 4
- 10) Previous Types of Tx: (1) A.A./N.A. (2) Other 12-Step (3) Christian based
- 11) Drug of Choice: (1) Cocaine (2) Meth (3) Heroin (4) Pot
- 12) Alcohol Abuse: (1) Yes (2) No
- 13) Length of Time Using Drugs: (1) Under 5 Years (2) 5-10 years
(3) 10 -15 years (4) Over 15 years
- 14) Length of Time Abusing Alcohol: (1) Under 5 Years (2) 5-10 years
(3) 10 -15 years
(4) Over 15 years
- 15) Age When Substance Abuse began: _____
- 16) Age When Alcohol Abuse began: _____

- 17) How Many Times Clean/Sober Since Onset: (1) 0 (2) 1 (3) 2
(4) 3 (5) 4 (6) 5
(7) More than 5
- 18) Length of Time Clean/Sober Prior to Entering DAP?:
(1) 1 week (2) 2 weeks (3) 3 weeks
(4) 1 month (5) 2 months (6) 3 months
(7) More than 3 months
- 19) Reason for Entering Tx: (1) Court mandated (2) Family pressure
(3) Self motivated
- 20) Any Legal Trouble While Using?: (1) Yes (2) No
- 21) What Type of Legal Trouble: (1) Drug Charges (2) DUI
(3) Assault (4) Violence
- 22) Jail Time?: (1) Yes (2) No
- 23) How Long Jail Time: (1) Under 1 year (2) 1-5 years (3) Over 5 years
- 24) How Many Times in Jail: (1) 0 (2) 1 (3) 2
(4) 3 (5) 4 (6) More than 4
- 25) Probationary Status: (1) On Probation (2) Satisfied Current Probation
Commitment

Health

- 26) Medical Condition: (1) Yes (2) No
- 27) Type of Medical Condition: (1) Diabetes (2) Heart Problems
(3) Psychiatric
- 28) Diagnosed Mental Illness/Disorder: (1) Yes (2) No

Family History

- 29) Child of Alcoholic: (1) Yes (2) No
- 30) If Yes, (1) Mother (2) Father (0) Not Applicable
- 31) History of Physical Abuse as Child: (1) Yes (2) No
- 32) Marital Status of Parents: (1) Married (2) Divorced
(3) Separated (4) Never Married

DAP Program Issues

- 33) Number of Disciplinary Actions While in Program:
(1) 0 (2) 1 (3) 2 (4) 3 (5) 4 (6) More than 4
- 34) Contact Notes in File: (1) Yes (2) No
- 35) Discharge: (1) Voluntary (2) Involuntary (3) Graduated

MMPI Data

- 36) (1) Scale 1 _____ Hypochondriasis
(2) Scale 2 _____ Depression
(3) Scale 3 _____ Hysteria
(4) Scale 4 _____ Psychopathic Deviate
(5) Scale 5 _____ Masculinity - Femininity
(6) Scale 6 _____ Paranoia
(7) Scale 7 _____ Psychasthenia (Anxiety)
(8) Scale 8 _____ Schizophrenia
(9) Scale 9 _____ Hypomania
(0) Scale 0 _____ Social Introversion
- 37) Supplementary Scales:
_____ (1) Anxiety (A)
_____ (2) Repression (R)
_____ (3) Ego Strength (Es)
_____ (4) MacAndrew Alcoholism Scale-Revised (MAC-R)
_____ (5) Addiction Acknowledgment (AAS)
_____ (6) Addiction Potential Scale (APS)
_____ (7) Overcontrolled Hostility Scale (O - H)
_____ (8) Dominance Scale (Do)
- 38) Validity Scales:
_____ (1) L
_____ (2) F
_____ (3) K

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ASSIGNED RESPONSIBILITIES

This was a two-person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:

Assigned leader Marianne Grant

Assisted by Dena Carey

2. Data Entry and Analysis:

Assigned leader Dena Carey

Assisted by Marianne Grant

3. Writing Report and Presentation of Findings:

a. Introduction and Literature

Assigned leader Dena Carey

Assisted by Marianne Grant

b. Methods

Assigned leader Dena Carey

Assisted by Marianne Grant

c. Results and Discussion

Assigned leader Dena Carey

Assisted by Marianne Grant