Cross-program Strength Profiles of a Culturally-tailored Chemical Health Center

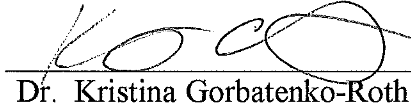
By

Robert Timothy Spencer

A Research Paper
Submitted in Partial Fulfillment of the
Requirements for the
Master of Science Degree
In

Applied Psychology

Approved: 4 Semester Credits



Dr. Kristina Gorbatenko-Roth

The Graduate School

University of Wisconsin-Stout

December, 2009

The Graduate School
University of Wisconsin-Stout
Menomonie, WI

Author: **Spencer, Robert T.**

Title: ***Cross-program Strength Profiles of a Culturally-tailored Chemical Health Center***

Graduate Degree/ Major: MS Applied Psychology

Research Adviser: Kristina Gorbatenko-Roth, Ph.D.

Month/Year: December, 2009

Number of Pages: 101

Style Manual Used: American Psychological Association, 5th edition

ABSTRACT

The present research examines three substance dependence treatment programs that are each tailored tor a unique population. One program focuses on African-American males, one focuses on Mothers and pregnant women, and one focuses on the homeless. The present research is a retrospective re-analysis of quantitative survey data and qualitative focus group data that was previously collected for a formal program evaluation. Statistical testing was used to determine if each program produced statistically and clinically significant changes on outcome indicators, as well as to determine how the programs' outcomes compared to each other. Additionally, qualitative analysis of focus group data yielded strength profiles of each program. Overall, all programs were found to be providing effective, tailored treatment to patients in order to increase their chemical health and life skills. The programs, while tailored to a specific population, share common strengths, such as focusing on patients' individual needs and teaching them to

strengthen their social support networks. Implications of the research are that program administrators should continue to provide effective, individualized treatment and seek out new ways to tailor their programs to the needs of their patients.

The Graduate School

University of Wisconsin Stout

Menomonie, WI

Acknowledgments

For Kiki. Thank you for all the advice, the meetings, the discussions, and the editing. Your guidance throughout the last two years, and especially the last two months, has been invaluable.

For my family. Without your continued support and encouragement through the years, I would not be the person I am today. Thank you for always being there for me.

For ACET, Inc. Thank you for giving me the opportunity to learn and grow, both as a person and as a professional. You have inspired me, and served as wonderful role models.

For Heidi and Gary from the treatment center. Thank you for the opportunity to develop my professional skills by researching your programs.

And for Samantha Langan, who believed in me when I did not believe in myself.

TABLE OF CONTENTS

	Page
ABSTRACT	ii
List of Tables	viii
Chapter I: Introduction	1
Statement of the Problem	2
Purpose of the Study	3
Methodology	4
Definition of Terms	4
Limitations	5
Assumptions of the Study	5
Chapter II: Literature Review	6
Substance Dependence Description	6
Consequences of Substance Dependence	7
Prevalence	7
Traditional Treatment	10
Need for Tailored Treatment	12
Summary of Culturally Sensitive Treatment	15
Program Descriptions	17
Program Evaluation History and Need for Current Research	19
Chapter III: Methodology	21
Participants	21
Design	22

Procedure....23

Measures....24

Data Analysis Plan....26

Chapter IV: Results....28

Q1: Program Entry-to-Exit Analysis....28

Q2: Program Comparison Analysis....35

Q3: Program Process Strengths....41

Chapter V: Discussion....55

Q1: Program Entry-to-Exit Analysis....55

Q2: Program Comparison Analysis....60

Q3: Program Process Strengths....62

Limitations and Recommendations for Future Research....65

Internal Validity....66

External Validity....67

Concluding Remarks....68

References....70

Appendix A: AAP: Logic Model....74

Appendix B: MP Logic Model....75

Appendix C: HP Logic Model....78

Appendix D: AAP Patient Focus Group Script....79

Appendix E: AAP Staff Focus Group Script....81

Appendix F: MP Patient Focus Group Script....83

Appendix G: MP Staff Focus Group Script....85

Appendix H: HP Patient Focus Group Script....87

Appendix I: HP Staff Focus Group Script....89

Appendix J: Data Collection Instrument....91

List of Tables

Table 1: Patient age in years by program........16

Table 2: Patient ethnicity by program........16

Table 3: Patient exit type by program........16

Table 4: Proportion of patients living in agency housing by program........17

Table 5: Patient problem drug by program........17

Table 6: GAF Impact: descriptives and paired samples t-tests results for all programs........28

Table 7: Descriptives and paired samples t-test results for AAP program, Psychosocial Stressors........29

Table 8: Descriptives and paired samples t-test results for MP program, Psychosocial Stressors........30

Table 9: Descriptives and paired samples t-test results for HP program, Psychosocial Stressors........31

Table 10: Descriptives and paired samples t-test results for AAP program, Chemical Health/Recovery........32

Table 11: Descriptives and paired samples t-test results for MP program, Chemical Health/Recovery........33

Table 12: Descriptives and paired samples t-test results for HP program, Chemical Health/Recovery........34

Table 13: Results of MANOVA for Psychosocial Stressors across programs........36

Table 14: Planned comparison of MANOVA results for all programs, Psychosocial Stressors mean changes from program entry to exit........37

Table 15: Results of MANOVA for Chemical Health/Recovery across programs........38

Table 16: Planned comparison of MANOVA results for all programs, Chemical Health/Recovery mean changes from program entry to exit........37

Table 17: Results of MANOVA for Level of Progress across programs........40

Table 18: Planned comparison of MANOVA results for all programs, Level of Progress scores........40

Table 19: Results of one-way ANOVA for Level of Progress item Legal Status........................40

Table 20: Summary of statistical and clinical significance, all programs, Psychosocial Stressors........................56

Table 21: Summary of statistical and clinical significance, all programs, Chemical Health/Recovery........................57

Chapter I: Introduction

Dependence on drugs and alcohol is a major problem in the United States, and is responsible for a variety of personal and public health and safety consequences, including "family disintegration, loss of employment, failure in school, domestic violence, child abuse, and other crimes" (National Institute on Drug Abuse, 2008, p.1). In addition, the annual economic costs are an estimated $185 billion for alcohol (Harwood, 2000), and $181 billion for drugs (Office of National Drug Control Policy, 2004).

The present research focuses on substance dependence for three specific populations: African-Americans, women, and the homeless. Prevalence rates for drugs and alcohol among these populations differ from the general population. For the general population, national studies have shown that between seven and eight percent of all Americans met criteria for alcohol dependence at some point in their lifetime (Nace, 2005). For 1-year point prevalence estimate, almost four million Americans aged 12 or older were classified with illicit drug dependence or abuse in 2008 (National Survey on Drug Use and Health, 2008).

While rates of substance dependence are similar for African-Americans (8.8%) and Caucasians (9.0%) overall, there are differences by age group (SAMHSA, 2009). Specifically, African-Americans' rates of alcoholism are low in the young adult group, then peak at middle-age and decline, whereas the Caucasian rate is higher in the young adult group and then declines from there (Franklin & Markarian, 2005; Nace, 2005). According to the National Survey on Drug Use and Health (SAMHSA, 2009), the rate of binge drinking or heavy alcohol use was 20.4% for African-Americans in 2008 for all age groups compared to 24.0% for Caucasians, and the rate of illicit drug use was 10.1%, compared to 8.2% for Caucasians.

In terms of gender, the overall rate of substance use for men is about twice as high as that for women (11.5% vs. 6.4%) (SAMHSA, 2008). Additionally, the rate of alcohol dependence and abuse is higher for men (32.6%) than women (14.6%) (Blume & Zilberman, 2005). However, for ages 45-54, women show higher lifetime rates of drug dependence than men (3.8% vs. 2.1%) (Blume & Zilberman,

2005). Among pregnant women aged 15-44, estimated alcohol use was 10.4%, binge drinking was 4.5%, and heavy alcohol use was 0.8% (SAMHSA, 2009).

Rates of drug and alcohol dependence among the homeless have been shown to be several times higher than the general population. Studies of the homeless population in Minnesota have found that 28% of homeless males had been diagnosed with an alcohol abuse disorder, and 23% had been diagnosed with a drug abuse disorder (Wilder Research, 2007). In a related study of substance use, Malcolm (2004) found that a staggering 73% of his sample of homeless males had used alcohol in the past 30 days, and almost 90% had used drugs in the past 30 days.

Statement of the Problem

Scientific research over the last four decades has contributed to a body of knowledge about what constitutes effective substance dependence treatment. Typically, a combination of medication and behavioral therapy is the most effective course of treatment (NIDA, 2009; Martens, Neighbors, & Lee, 2008). Patients commonly begin treatment with a detoxification phase, usually in the form of an inpatient treatment using medication to suppress withdrawal symptoms. Some patients continue a medication-only course of treatment, but most move to behavioral treatment, usually provided in an outpatient setting. The goals of behavioral treatment are to modify the patient's attitudes and behaviors toward drug use, help the patient recognize, cope, and avoid relapse situations, and build healthy life skills (NIDA, 2009).

Traditionally, treatment programs are developed in such a way that they do not provide special interventions for patients based on gender, ethnicity, or other factors such as homelessness. Generally speaking, these traditional approaches have been shown to be effective at treating substance dependence (Martens, Neighbors, & Lee, 2008). However, despite the proven success of traditional programs, recent research has presented the need for treatment programs that are specifically tailored by ethnicity, gender, and other factors such as homelessness. Research has further shown that tailored programs can be more successful than traditional approaches (Bass & Jackson, 1997; Blankertz, Cnaan,

& Freedman, 1993; Brown & Smith, 2006; Brown, Hill, & Giroux, 2004; Cosden & Cortez-Ison, 1998; Gil, Wagner, & Tubman, 2004; Jackson & Freitas, 1995; Lev-Wiesel & Shuval, 2006; Malcolm, 2004; Strada, Donohue, & Lefforge, 2006; Sue, 1998).

The present research is a retrospective analysis of previously collected data on three substance abuse treatment programs provided by the same agency in the Minneapolis, Minnesota metropolitan area. All three are tailored for a specific population: one for African-Americans, one for mothers and pregnant women, and one for homeless individuals. Previous program evaluations have determined that each program is effective at treating dependency (K. Rewey, personal communication, 12/17/09). However, program administrators were interested in examining the three programs in relation to each other. Therefore, the present research compared existing program data to identify the process strengths of each program. Specific interest was in determining which process factors were common across programs and which were population unique.

Purpose of Study

The objective of the present research was to re-analyze quantitative and qualitative data collected for a previous program evaluation to perform cross-program analyses. The agency had developed a quantitative survey instrument to record data on patient functioning at program entry and exit, called the Data Collection Instrument. This instrument contains demographic patient and program information, as well as several domains related to treatment-related outcomes. Specifically, patients are given ratings for Global Assessment of Functioning, a commonly used indicator of a patient's overall condition, Psychosocial Stressors (e.g. Problems with primary support group, Occupational problems, Housing problems), Chemical Health and Recovery risk factors (e.g. Acute Intoxication and/or Withdrawal Potential, Relapse/Continued Use Potential), and exit-only Level of Progress ratings (e.g. Increased Recovery Skills, Maintaining Safe Housing).

Program administrators and program evaluators from the firm ACET, Inc. worked together to develop focus group scripts for staff and patients of each program for an evaluation in the summer of

2009. Qualitative data were collected from patients and program personnel regarding which program activities were perceived to be most beneficial to patients, and specific ways in which participation in the programs increased patients' chemical health and life skills.

The research questions for the present study were as follows:

- Question 1 (Q1): Did each program produce significant changes in outcome indicators from program entry to exit within the domains of global functioning, psychosocial stressors, and chemical health/recovery?
- Question 2 (Q2): How did the programs compare to each other on outcome indicator domains of interest (i.e. global functioning, psychosocial stressors, and chemical health/recovery)?
- Question 3 (Q3): What were the process strengths of each program, as determined by separate focus groups for patients and staff?

Methodology

To answer the above questions, a variety of methods were employed. Appropriate statistical tests were performed on the quantitative data to determine if each program showed statistically significant improvement from program entry-to-exit (Q1), and how the programs compared statistically on their changes for the various domains (Q2). Additionally, qualitative focus group data were analyzed by the researcher to determine process strengths of each program, as well as which strengths were common across programs and which were unique to a specific program (Q3).

Definition of Terms

To protect confidentiality, anonymous names and acronyms will be used throughout this report for the organization and the specific programs:

The agency: the parent organization that administers the programs.

AAP: a culturally sensitive substance dependence treatment program specifically designed for African-Americans.

MP: a substance dependence treatment program specifically designed for pregnant women and Mothers.

HP: a substance dependence treatment program specifically designed for homeless individuals.

Limitations

There are several limitations to the present research. First, the quantitative data for patients was collected via program staff. Therefore, the study relied on subjective, second-hand accounts of patient behavior. Second, as a retrospective analysis of previously collected data, the researcher was not able to set methodological parameters such as comparison groups, random assignment of patients, etc. Third, a convenience sample of patients was used for focus groups, which may limit generalizability to other cohorts. Finally, the qualitative analysis was performed 'long-hand' by only one individual; without the use of qualitative data analysis software or a second person, no estimates on qualitative data 'reliability' can be assessed.

Assumptions of the Study

There are two main assumptions of the study, both pertaining to the nature of the data collection. First, as the quantitative data was collected subjectively through a second party (program staff,) it is assumed that staff perceptions are unbiased and accurate representations of patients' true functioning and behavior. Second, as a convenience sample was used for patient focus groups, it is assumed that the sample patients in the focus groups are representative of the overall program, and that their perceptions of the program are unbiased and accurate representations of others in the program.

Chapter II: Literature Review

The following chapter presents a review of the current literature on substance dependence and treatment, for the general population and three sub-populations of interest: African-American males, mothers, and the homeless. A definition of substance dependence will be provided, followed by a listing of the negative consequences of alcohol and drug dependence. Prevalence data will be provided, for the general population as well as the three sub-populations of interest. A description of methods for traditional substance dependence treatment will also be provided, followed by efficacy data for those methods. A justification for treatments that are tailored to specific populations will follow, based in part on the unique causal and treatment factors identified for the three subpopulations of interest.

The present research is a process and outcome evaluation of three such substance dependence treatment programs, each tailored to specific population: one for African-Americans, one for mothers, and one for the homeless. All three programs are provided by the same agency in the Minneapolis, Minnesota area. A program description and evaluation history of each program follows. The chapter concludes with a discussion of the need for the present research.

Substance Dependence Description

The Diagnostic and Statistical Manual of Mental Disorders (4th edition) describes substance dependence as "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems" (American Psychiatric Association, DSM-IV-TR, 2000, p. 192). According to the DSM, three or more of the following criteria must be present at the same time over a twelve-month period to be classified as substance dependent: tolerance—a need for increased amounts of the substance to achieve intoxication or diminished effects with continued use; withdrawal—a series of negative effects resulting from cessation of the substance; taking the substance in larger quantities than intended; unsuccessful efforts to decrease or discontinue use; spending a great deal of time obtaining, using, or recovering from the

effects of the substance; reduced social, occupational, or recreational activities due to use of the substance; or continued use of the substance despite recognizing a problem (American Psychiatric Association, DSM-IV-TR, 2000).

Consequences of Substance Dependence

Consequences of Alcohol Dependence.

Alcohol dependence continues to be one of the most costly health care problems in America. The yearly dollar cost for alcoholism is more than $185 billion, which incorporates health- and crime-related costs, as well as lost productivity (Harwood, 2000). Negative social consequences of alcohol dependence include alcohol-related crime, traffic crashes, and violence associated with alcohol use (Nace, 2005). According to the American Psychiatric Association, 60% of American males and 30% of American females have experienced some kind of adverse alcohol-related event in their lives (American Psychiatric Association, DSM-IV-TR, 2000).

Consequences of Drug Dependence.

Economic costs of drug abuse and dependence have been calculated to be nearly $181 billion annually, and increasing at a rate of over five percent per year (Office of National Drug Control Policy, 2004). Drug dependence is responsible for numerous additional personal and public health and safety consequences, including "family disintegration, loss of employment, failure in school, domestic violence, child abuse, and other crimes" (National Institute on Drug Abuse, 2008, p. 1).

Prevalence

Alcohol Use Prevalence.

General population prevalence.

National studies have found that 25% of Americans will meet DSM criterion for alcohol abuse in their lives, and 10% will meet criterion for alcohol dependence (McDowell & Spitz, 1999, in Hansell & Damour, 2005). According to the National Survey on Drug Use and Health (SAMHSA, 2009), an

estimated 18.3 million Americans aged 12 and older (7.3%) were classified with dependence on alcohol in 2008.

Prevalence for African-Americans.

Lifetime prevalence rates for alcohol dependence are similar for whites and African-Americans (Nace, 2005). However, African-Americans' rates of alcoholism are low in the young adult group, then peak at middle-age and decline, whereas whites' rates are higher in the young adult group and then decline from there (Franklin & Markarian, 2005; Nace, 2005). According to the National Survey on Drug Use and Health (SAMHSA, 2009), the rate of binge drinking or heavy alcohol use was 20.4% for African-Americans, and the rate of substance dependence or abuse (including alcohol and drugs) was 8.8%.

Prevalence and gender differences.

Men have higher rates of lifetime alcohol abuse and dependence than women (32.6% vs. 14.6%) as well as higher 12-month rates of abuse/dependence than women (14.1% vs. 5.3%) (Blume & Zilberman, 2005). Alcohol problems among women are age-dependent. Women aged 21-34 have been shown to have the highest rates of problem drinking than any other age group (Blume & Zilberman, 2005). According to the National Survey on Drug Use and Health (SAMHSA, 2009), the rate of binge drinking among non-pregnant women was 24.0% and the rate of heavy alcohol use was 5.5%. Among pregnant women aged 15-44, estimated alcohol use was 10.4%, binge drinking was 4.5%, and heavy alcohol use was 0.8% (SAMHSA, 2009).

Prevalence for homeless males.

Population rates of alcohol use and dependence are difficult to obtain for the homeless population due to specific characteristics of that population. Homeless individuals are likely to suffer with disaffiliation, have a mistrust of institutions, have psychological, psychiatric, or personality disorders, and are highly mobile (see Malcolm, 2004). According to a recent study of the homeless population in Minnesota, 28% of homeless males had been diagnosed with an alcohol abuse disorder

(Wilder Research, 2007). Malcom (2004) found that 73% of a sample of homeless males had used alcohol in the past 30 days, and the mean lifetime alcohol use was 11.15 years.

Drug Use Prevalence.

General population prevalence.

According to the National Survey on Drug Use and Health (SAMHSA, 2009), 3.9 million Americans aged 12 or older were classified with illicit drug dependence or abuse in 2008. Lifetime dependence rates among users for specific drugs have been found to be as follows: 23.1% for heroin, 16.7% for cocaine, 9.2% for sedatives, 9.1% for marijuana, and 4.9% for hallucinogens (Kessler et. al, 1994, in Hansell & Damour, 2005).Regarding drug use, the 2008 overall rate of lifetime illicit drug use among young adults aged 18-25 was 19.6%, with specific past-month prevalence rates per drug as follows: 16.5% for marijuana, 5.9% for prescription drugs, 1.7% for hallucinogens, and 1.5% for cocaine. Not surprisingly, the rates of drug use among adults aged 26 or older was less than for adults aged 18-25 For this age group, the overall rate of illicit drug use in 2008 was 5.9%. Past-month prevalence for drug use among that group was 4.2% for marijuana, 1.9% for prescription drugs, and less than one percent for cocaine (0.7%), hallucinogens (0.1%), heroin (0.1%), and inhalants (0.1%) (SAMHSA, 2009). Among adults aged 50-59, rates of drug use has increased from 2.7% to 4.6% between 2002 and 2008, reflecting the aging of the baby boom cohort, whose rates of drug use are higher than those of older cohorts (SAMHSA, 2009).

Prevalence for African-Americans.

African-Americans have been shown to have a higher overall use of illicit drugs compared to whites (10.1% vs. 8.2%), as well as a higher specific prevalence rates for marijuana (6.6% vs. 5.0%) and cocaine (1.3% vs. 0.7%) (SAMHSA, 2008; Franklin & Markarian, 2005. In addition, past month use of any illicit drug has been shown to be higher for whites aged 12-25, but higher for blacks aged 26 and above (Franklin & Markarian, 2005). However, rates of substance dependence or abuse are similar

for blacks and whites (8.8% and 9.0%, respectively) (SAMHSA, 2009). Rates of substance dependence were not separated by alcohol and illicit drugs.

Prevalence and gender differences.

The lifetime rate of substance abuse and dependence for men is about twice as high as that for women (11.5% vs. 6.4%) (SAMHSA, 2009). Men have also shown higher 12-month rates of abuse/dependence (5.1% vs. 2.2%) (Blume & Zilberman, 2005). However, women have higher lifetime prevalence of drug dependence in the 45-54 age group (3.8% vs. 2.1%) (Blume & Zilberman, 2005).

Prevalence for homeless males.

As mentioned previously, population estimates of drug use for the homeless are difficult to obtain. However, the data that have been collected are staggering. A recent study of the homeless population in Minnesota, 23% of homeless men had been diagnosed with drug abuse disorder; 48% of homeless men had been in an inpatient drug or alcohol treatment facility; 19% of homeless adults had received outpatient alcohol or drug treatment in the previous two years, and 30% of homeless adults had been admitted to a detoxification center at least once in their life (Wilder Research, 2007). Malcolm (2004) found that among his sample of homeless drug users, 89% had used cocaine in the past 30 days, 37% had used marijuana, 30% had used heroin, and 82% had used some combination of alcohol and drugs. Mean lifetime drug use among the sample was 12.25 years.

Traditional Treatment

Traditional Approaches to Substance Dependence.

Scientific research over the last 40 years has contributed to a body of knowledge about what constitutes effective treatment approaches. Treatment programs aim to help the patient stop using substances, maintain a healthy lifestyle, and develop appropriate coping skills to function in society (NIDA, 2009). Generally speaking, a combination of medication and behavioral therapy has been shown to be an effective course of treating substance dependence (NIDA, 2009; Martens, Neighbors, & Lee, 2008). First, a patient goes through detoxification, usually in the form of an inpatient program and

assisted by medications to suppress withdrawal symptoms. Some patients continue a medication-only course of treatment, and others move to behavioral treatment to "... help patients engage in the treatment process, modify their attitudes and behaviors related to drug use, and increase healthy life skills" (NIDA, 2009, p. 4). Behavioral therapy can increase the effectiveness of medication and help patients stay in treatment longer (NIDA, 2009).

Behavioral treatments are often (but not always) in the form of an outpatient service, where patients visit a clinic at regular intervals. Most behavioral treatments include individual or group counseling and other forms of treatment, such as "... cognitive-behavioral therapy, which seeks to help patients recognize, avoid, and cope with the situations in which they are most likely to abuse drugs...[and] Motivational interviewing, which capitalizes on the readiness of individuals to change their behavior" (NIDA, 2009, p. 4). Programs aimed at treating more severe problems often take the form of residential treatment, wherein patients live and receive treatment at a facility, typically for a period of time between six and twelve months (NIDA, 2009).

Effectiveness of Traditional Approaches.

Martens, Neighbors, and Lee (2008) conducted a review of extant literature on treatment programs using the above described approaches. Overall, they found that "In general, substance abuse treatment works" (p. 561).

A recent meta-analysis of 15 alcohol and four drug treatment programs based on motivational interviewing found that when compared with no-treatment and placebo controls, motivational interviewing approaches yielded effect sizes (*d*) ranging from .25 and .56 (Burke et al., 2003, reviewed in Martens, Neighbors, & Lee, 2008). Another recent motivational interviewing-based, multisite trial that focused on marijuana dependence yielded effect sizes of $d = .33$ and .60 for dependence symptoms and marijuana use per day, respectively (Marijuana Treatment Project Research Group, 2004, reviewed in Martens, Neighbors, & Lee, 2008).

Cognitive Behavioral Therapy (CBT) programs have also been found to be an effective treatment option. Two reviews of literature on alcohol treatment found CBT programs to be effective at improving social skills, developing positive relationships, and establishing coping skills (Finney & Moos, 1998; Miller et al., 1998, both reviewed in Martens, Neighbors, & Lee, 2008). CBT has also been found to be effective at treating cannabis and cocaine dependence (Marijuana Treatment Project Research Group, 2004; Carroll et al., 2004, both reviewed in Martens, Neighbors, & Lee, 2004).

Need for Tailored Treatments

Despite the proven success of traditional treatment approaches, a growing body of literature presents the need for treatment programs that are specifically tailored by ethnicity and gender, or other factors such as homelessness (Bass & Jackson, 1997; Blankertz, Cnaan, & Freedman, 1993; Brown & Smith, 2006; Brown, Hill, & Giroux, 2004; Cosden & Cortez-Ison, 1999; Gil, Wagner, & Tubman, 2004; Jackson & Freitas, 1995; Lev-Wiesel & Shuval, 2006; Malcolm, 2004; Strada, Donohue, & Lefforge, 2006; Sue, 1998). Although traditional approaches have been shown to be successful, the literature has identified a number of specific causal and treatment factors unique to these groups, suggesting that tailored treatment programs could be even more effective than traditional models that do not account for unique populations.

Factors for African-Americans.

The literature on African-American drug and alcohol use tends to focus on specific subgroups of that population—adolescents, males or females, urban vs. rural African-Americans, et cetera. (Bass & Jackson, 1997; Brown & Smith, 2006; Gil, Wagner, & Tubman, 2004). Therefore, it is difficult to generalize on causal factors for all African-Americans. However, causal factors that have been identified across groups include socioeconomic status (SES), urbanization, discrimination, cultural mistrust, and level of ethnic orientation. Each of these factors are discussed briefly in the paragraphs below.

Lifetime residence in an urban area, as well as residence in a 'wet' area (versus a 'dry' area where alcohol is not available) has been shown to associate with increased drinking among African-Americans (Herd, 1995, reviewed in Brown & Smith, 2006). Specifically, increased bar attendance and drinking norms are associated with males who live in an urban or 'wet' area.

Discrimination and cultural mistrust have also been identified as causal factors for substance abuse for African-Americans (Gil, Wagner, & Tubman, 2004; Franklin & Markarian, 2005). Furthermore, a link has been identified between socioeconomic status (SES) and discrimination. Those of low SES may experience more forms of overt discrimination and are more likely to reside in communities with more police surveillance, which leads to mistrust of the majority society (see Franklin & Markarian, 2005). Other SES factors that have been identified as substance abuse causal factors include low education level, poor employment history, and legal problems including incarceration (Franklin & Markarian, 2005).

Conversely, protective factors against drug use have been identified specific to African-Americans. Researchers have found that ethnic pride and ethnic orientation (i.e., ethnic group membership, pride for one's heritage, friendships within one's ethnic group, etc.) have been shown to be protective factors for both drug and alcohol use among African-Americans (Gil, Wagner, & Tubman, 2004).

Studies have found that African-American patients express a strong desire for culturally-appropriate treatment. Patients have described how their decision to participate in a program is influenced by the degree to which the program is tailored to their unique needs. In California, a program that was designed by and for African-Americans has been shown to be effective, and patients have said they chose to participate in the program based on its culturally and ethnically sensitive services (Jackson & Freitas, 1995, in Bass & Jackson, 1997). Other research has confirmed that male African-American patients express a strong "need to relate to other African American men in recovery" (Brown, Hill, & Giroux, 2004, in Brown & Smith, 2006, p. 194-195).

In addition to a culturally sensitive program design, patients have identified the importance of having program staff members of their same ethnicity. Culturally sensitive staff members are better able to relate to patients, build trust, and provide resources and treatment that will most benefit patients (Bass & Jackson, 1997). Research has shown that patients of all ethnicities (including Caucasian) stay in treatment longer when matched with a therapist of their same race/ethnicity, which in turn leads to better treatment outcomes (Sue, 1998, reviewed in Strada, Donohue, & Lefforge, 2006).

Factors for Women.

Research has identified different perceived causal factors of drug use between men and women. Lev-Wiesel and Shuval (2006) found that women were more affected by spousal drug addiction than men. That is, a male spouse's drug use is likely to influence drug behavior of the female.

The literature further reflects that a history of child abuse and domestic violence is a strong causal factor to women's initiation of drug use (Cosden & Cortez-Ison, 1999; Lev-Wiesel & Schuval, 2006; Blume & Zilberman, 2005). Lev-Wiesel and Schuval (2006) found a higher correlation among age of initiation of drug use and history of domestic violence than parent addiction history, suggesting that violent parents may have more of an impact on drug use than parent addiction.

Women in treatment have identified that their children and families are important factors for successful treatment. Women with children may avoid seeking treatment for their substance abuse if they know their children will be placed in foster care (Bass & Jackson, 1997; Cosden & Cortez-Ison, 1999). Women have also reported self-terminating treatment because of the loneliness associated with being separated from their children. Programs that do not separate mother and child have been identified as more attractive options for substance abusing mothers, and graduation rates have been shown to be higher (Bass & Jackson, 1997; Cosden & Cortez-Ison, 1999). Programs that do not separate mothers from their children also tend to focus on incorporating other family members and significant others into the treatment, which has shown to be effective in developing support networks

and strengthening positive relationships with children and significant others (Bass & Jackson, 1997; Cosden & Cortez-Ison, 1999; Strada, Donahue, & Lefforge, 2006).

Factors for Homeless Men.

As mentioned previously, the homeless population is more likely to have psychological, psychiatric or personality problems (Malcolm, 2004). Additionally, this population is typically poor, commonly suffer from a co-morbidity of substance use and mental disorder, have lower self-esteem, self-worth, and self-confidence, and underdeveloped personal skills (Malcolm, 2004). Blankertz, Cnaan, and Freedman (1993) found that their homeless sample were frequently exposed to common adverse events in childhood, such as physical and/or sexual abuse, living with substance abusing and/or mentally ill parents, and out-of-home placement. Research on the adult male homeless population has indicated that interventions should seek to understand patients' childhood maltreatments and seek to develop patients' self image in order to implement a successful treatment (Malcolm, 2004; Blankertz, Cnaan, & Freedman, 1993).

Summary on Culturally Sensitive Treatment.

Overall, culturally sensitive programs are more attractive to potential patients, making them more likely to seek treatment. Once patients are in treatment, there are a variety of advantages to culturally appropriate treatment and staff of similar ethnicity. These include better outcomes, graduation rates, and success indicators.

The present research is focused on three culturally sensitive treatment programs provided in the Minneapolis, Minnesota area. Tables 1 through 5 provide demographic information for each program, including patient age, ethnicity, 'problem drug,' proportion of patients residing in agency housing, and exit status of patients. The following sections will describe these programs and outline previous evaluation findings on them, followed by a description of the need for the present research.

Table 1
Patient age in years by program

	Minimum Age	Maximum Age	Mean Age
AAP Program	19	56	38
MP Program	20	52	34
HP Program	19	57	42

Table 2
Patient ethnicity by program

	AAP	MP	HP
African/African American	88	40	37
American Indian/Alaskan Native	0	4	5
Hispanic/Latino	0	0	1
Caucasian	0	19	21
Somalian	1	0	0
Israelite	1	0	0
Brazilian	0	1	0
Mixed Ethnicity	0	1	2

Table 3
Patient exit type by program

	Completed	Patient Left	Staff Request	Other	Total	Completion Percent
AAP Program	61	16	8	5	90	67.7%
MP Program	37	22	7	0	66	56.1%
HP Program	48	13	3	2	66	72.7%

Table 4
Proportion of patients living in agency housing by program

	Percent living in agency housing
AAP Program	78%
MP Program	100%
HP Program	98%

Table 5
Patient problem drug by program

	AAP Program	MP Program	HP Program
Alcohol	24	16	26
Heroin	7	11	4
Marijuana	29	15	6
Cocaine/Crack	28	18	28
Non-prescription Methadone/Opiates	1	1	0
Methamphetamine	0	4	2
Other	1	0	0

Program Descriptions

African-American Program (AAP).

A copy of the AAP Logic Model can be found in Appendix A. The stated goal of the AAP program is "To provide culturally appropriate chemical health treatment access, treatment support, and recovery maintenance services to the Twin Cities chemically-dependent African American community using evidenced-based practices." The AAP program believes that provision of culturally appropriate services will cause recipients to remain in the program, thereby increasing their recovery maintenance skills. Program activities include individual and group counseling with motivational interviewing, peer-to-peer recovery and support, violence prevention, cultural celebration, and recovery incentives. Program activities are structured around the idea that if participants receive comprehensive, individualized services, they are more likely to increase their chemical health and quality of life.

The program is unique in that it is specifically tailored to the African-American population. All recipients and staff members are African-American, and the program puts specific emphasis on ethnic pride, cultural celebrations, and specific considerations unique to African-Americans. Another unique factor of the AAP program is its use of peer mentoring. The program uses different levels of peer mentors, including patients who are near completion of the program, others who are recent graduates, and local successful African-Americans. Peer mentors participate in certain program activities and

provide unique motivation for patients that they would not receive in other programs. In short, the AAP program is designed by African-Americans, for African-Americans.

Mothers Program (MP).

A copy of the MP Logic Model can be found in Appendix B. The MP program is specifically tailored to substance abusing pregnant women and women with dependent children. The stated goals of the program are to reduce barriers to recovery by providing sober housing and sobriety maintenance services; to increase recipients' self-sufficiency by stabilizing their living environment, helping them gain financial stability, and reducing their involvement in government systems; and to increase recipients' quality of life by improving their mental and physical health, fostering development of social networks, and developing life management skills. The program believes that receipt of comprehensive, tailored, individualized, evidence-based treatment will help patients increase their self-sufficiency, chemical health, and quality of life. Program activities include: case management activities such as one-on-one advocacy, assessment, goal planning, services/resources coordination, referrals and individual counseling; employment and job-seeking services such as resume development, networking, and dealing with a long history of unemployment; and therapeutic and behavioral support groups on life skills, relapse prevention, nutrition education, parenting skills, child development education, HIV/AIDS prevention, prostitution recovery, and family programming.

The MP program is unique in that it is specifically tailored toward pregnant women and women with dependent children. All program staff members are female, and the program does not separate women from their children—all patients reside in agency housing with children permitted to live with their mothers. Additionally, the program provides patients with housing that is separated from housing for patients of other programs. Program activities are specifically tailored to helping women find housing and employment, and teaching them the skills to become better parents. Program staff focus on child development, parenting skills, and emphasize the importance of proper support networks.

Homeless Program (HP).

A copy of the HP Logic Model can be found in Appendix C. The stated goal of the HP program is to reduce homelessness and increase access to recovery maintenance services to the Twin Cities chronically chemically dependent and homeless. The program believes that provision of comprehensive, tailored, individualized, evidence-based treatment will help increase recipients' chemical health, reduce homelessness, and increase their quality of life. Program activities include individual and group counseling with motivational interviewing, comprehensive chemical and mental health services, and incentives for program involvement and providing contact information.

The program is unique in that it is specifically tailored to the needs of homeless individuals. Along with standard treatment and recovery maintenance programming, the program provides patients with housing and allows visits from family members. Program activities focus on building patients' self-sufficiency and life skills. It also provides them resources to find/secure housing and employment. Additionally, program staff members are sensitive to the unique mental needs of homeless patients and teach them emotional skills such as anger management, conflict resolution, and emphasize the importance of healthy support networks.

Program Evaluation History and Need for Current Research

The first formal evaluation of these programs was conducted in June, 2009 by the program evaluation firm ACET, Inc. The evaluators used a mixed-method design, using quantitative data already collected by the organization, and qualitative data via a series of focus groups. Detailed descriptions of the methodology of the evaluation, as well as descriptions of the quantitative and qualitative instruments can be found in Chapter III. The objective of the first evaluation was to determine if the programs met their objectives, as stated in a logic model for each program. Logic Models can be found in Appendixes A through C.

Overall, the results of the evaluation indicated that each program was producing desired outcomes. Specifically, the evaluation focused on pre- to-post program outcomes, and found that all

programs showed significant patient improvement from program entry to exit. These results are replicated in Chapter IV.

The organization that operates the programs was pleased with the results of the evaluation. However, as the evaluation only examined each program individually, the organization expressed a desire to compare the programs to each other based on similar quantitative measures and qualitative focus group data. The researcher contacted the organization, expressing a desire to conduct the cross-program analysis. The organization agreed to share data, and the present research was launched.

Chapter III: Method

The present research was a retrospective analysis of existing data from a program evaluation of a substance abuse treatment center in Minneapolis, Minnesota. Three culturally-tailored programs were compared using an asset-based analysis: a program specifically designed for African-Americans (AAP), one for mothers (MP), and one for homeless individuals (HP). A combination of quantitative survey data and qualitative focus group data were examined to determine process strengths of each program, along with commonalities and unique aspects of each program. The main questions to be answered through the present research were:

- Question 1 (Q1): Did each program produce significant changes in outcome indicators from program entry to exit within the domains of global functioning, psychosocial stressors, and chemical health/recovery?
- Question 2 (Q2): How did the programs compare to each other on outcome indicator domains of interest (i.e. global functioning, psychosocial stressors, and chemical health/recovery)?
- Question 3 (Q3): What were the process strengths of each program, as determined by focus groups for patients and staff?

Participants

Population of Interest.

The population of interest for the present research included all patients who completed substance abuse treatment via one of three programs (AAP, MP, HP) at a treatment facility in Minneapolis, Minnesota between the months of July, 2008 and April, 2009. Data was collected for all patients regardless of whether they completed their program, but given the nature of the present research, only data from patients who completed treatment were of interest. As a retrospective analysis of existing data, no new participants were involved in the present research.

Sample Characteristics and Sample Size.

The present research utilized both quantitative and qualitative data. The sample for the quantitative portion consisted of all patients who completed their treatment program between the months of July, 2008 and April, 2009. As the treatment facility maintains quantitative data on all patients, 100% of the population of interest was examined quantitatively.

For the qualitative portion, a convenience sample of patients and staff from each of the three programs of interest was gathered. A total of 43 patients attended focus groups (17 from the AAP program, 16 from the MP program, and 10 from the HP program) out of a population of 222 patients, resulting in a sample of 19.4% of the population of interest. A total of 19 staff members attended the three focus groups: eight each from the AAP and MP programs, and three from the HP program. Staff participating in the focus groups included counselors, case managers, and other various staff. Additional detail on staff positions cannot be provided due to confidentiality protection issues. The total number of staff is unavailable, so the proportion of the population of interest is incalculable.

Tables 1 through 5 can be found in Chapter II, and represent demographic data for participants of each program, including age, ethnicity, patients' self-reported drug of choice (i.e. 'problem drug'), patient housing status, and program completion status. Please note that demographic tables include all patients who entered the program after July, 2008 and left the program before the end of April, 2009, including those that did not *complete* their program. Demographic data was not separated by program completion status when produced by the client.

Design

The present research was a retrospective asset-based analysis of a pre-post, within subjects, quasi-experimental design. The levels of the quasi-independent variable were the different treatment programs (AAP, MP HP) and the dependent variables were a mixture of quantitative survey data (administered both at patients' program entry and program exit) and qualitative focus group data from both patients and staff of the various programs.

Procedure

Data Collection.

As a retrospective analysis of previously collected data, two procedures were used to complete the present research. The first was the procedure for the initial data collection; the second the procedure for the re-analysis of that data. The present research was exempted by the University of Wisconsin-Stout's Institutional Review Board (IRB).

The initial data collection was performed as part of a formal program evaluation conducted by the evaluation firm ACET, Inc. Because the client had the quantitative data collected during the programs as part of their normal record keeping procedure, no new procedure was needed to be developed by ACET, Inc. to collect the quantitative data. Patients' quantitative data were selected for inclusion in the evaluation based on their date of program entry and program exit. That is, only data from patients who entered the program after July, 2008 and left the program before the end of April, 2009 were analyzed.

To collect the qualitative data, the client agreed to host a number of on-site focus groups for each program of interest. The evaluators created unique focus group scripts for each program's staff and clients. These scripts were approved by the client for use in the focus groups, and can be found in Appendixes D through I (see Measures section.) A total of three focus groups were conducted for program staff—one for each program. A total of five patient focus groups were conducted—two each for the AAP and MP programs, and one for the HP program. All patients participating in focus groups were enrolled in their respective program at the time. Participants volunteered to participate in the focus groups, and gift cards for local retailers were offered as incentive to participate.

As a re-analysis of existing data, no new procedure was needed to collect the data reported in this document. The researcher performed a variety of data preparation and data cleaning procedures,

which are outlined in the Data Analysis Plan below. A detailed account of these procedures can be found in Chapter IV, immediately preceding the statistical results.

Program Receipt.

Patients at the agency receive treatment for a variety of reasons. Some are going through the first steps of their treatment or primary care. Treatment for these individuals is very structured to ensure they do not relapse; the focus is on eliminating the patient's physical and psychological addiction. Other patients are enrolled in the program for aftercare. These patients have already completed their primary care, either at the agency or another facility. Programming for individuals in aftercare focuses on continued relapse prevention, developing life skills, and developing a smooth transition into a stable living environment.

Upon entry into their respective program, patients are assessed by a staff member through administration of a standardized single measure, with the staff member acting as the respondent. The measure consists of a number of domains related to physical and mental well-being and chemical health risk factors. For a full description of these domains, see the Measures section below and/or Appendix J. Patients are assessed again by staff members on the same domains when they leave the program—either through successful program completion or other circumstances (e.g. dropping out of the program, being transferred to another program.) Again, the staff member is the measure respondent. In addition, upon exiting the program, patients are also assessed on a post-test only scale measuring overall level of progress.

Measures

Data Collection Instrument.

The agency had developed an instrument for collecting quantitative data on its patients prior to the present research or the formal evaluation. This measure is titled *Data Collection Instrument* (DCI). A copy of DCI can be found in Appendix J. The instrument was developed by the agency for internal record keeping purposes, and is based on guidelines provided for diagnosis of Psychiatric/ mental

health disorders as specified in the text-revision of the fourth edition of the Diagnostic and Statistical Manual (DSM-IV-TR) (American Psychological Association, 2000).

The first section of the instrument consists of general client information such as name, gender, and counselor/case manager. Also recorded are the dates the patient entered and exited the program, the specific program in which the patient is enrolled, and the type of treatment they are receiving.

Next, a series of metrics are recorded pertaining to the patient's mental and chemical health at the time of the assessment. The first is a Global Assessment of Functioning (GAF), which serves as an overall indicator of the patient's condition. Patients are subjectively rated on a scale of 0 to 100, with higher scores representing better overall functioning. Patients are then rated on their problems with Psychosocial Stressors (e.g. Problems with primary support group, Occupational problems, Housing problems.) Next, patients are assessed on a variety of risk factors pertaining to Chemical Health and Recovery (e.g. Acute Intoxication and/or Withdrawal Potential, Relapse/Continued Use Potential.)

The DCI also contains a few program-exit relevant items. First, the organization developed a general Level of Progress scale for the patient to be assessed at program exit only. This scale reflects a patient's progress on specific life skills (e.g. Increased Recovery Skills, Maintaining Safe Housing.) Second, the patient's status at program exit is recorded; options consist of Completed, Patient Left/AWOL, Staff Request, and Other. Lastly, an open-ended section allows staff to provide any other comments relevant to the patient's treatment.

Focus Group Scripts.

Copies of scripts used for focus groups can be found in Appendixes D through J. Each script contains common elements, yet each is specific to staff or patients of one program. First, an Introduction section provides notes for the focus group facilitators when beginning the session to establish a sense of trust among the group. These notes help ensure that participants will provide honest and frank discussion about the elements of the program. Some specific topics covered in the

introduction section include a statement of purpose, a guarantee of confidentiality, a notification that the focus group was to be recorded digitally, and an opportunity for participants to ask questions.

Next, a section called Opening Questions served as an icebreaker for the group. Each person was asked to share their first name, and to list a few words or phrases that came to their mind when thinking about their specific treatment program. This tactic is preferred by ACET, Inc. to build participant comfort levels.

Each script then listed the key evaluation questions for both outcomes and processes in a numbered list. Following the evaluation questions were the specific focus group items/questions to be asked by the facilitators. Each item referred back to the specific evaluation question(s) it was designed to answer. Where appropriate, probe questions were listed in the event that participants were not able to answer the question as listed.

Finally, a Closing section provided notes for the facilitator when wrapping up the focus group. Specific topics covered in this section were a reminder to thank participants for their time, a re-assurance of confidentiality, and another opportunity for participants to ask questions about the use or dissemination of focus group results.

Data Analysis Plan

Q1: To answer the first question, paired-samples t-tests were performed for each item on the Data Collection Instrument for which patients were given pre- and post-test scores (i.e. all domains save Level of Progress) using the patient's entry and exit input as the paired scores. Mean changes from entry to exit were analyzed to determine if each program produced statistically significant entry-to-exit improvement on GAF, Psychosocial Stressors, and Chemical Health/Recovery. For each comparison, a .05 significance level was used

Q2: To answer the second question, multiple statistical tests were employed. A one-way analysis of variance (ANOVA) was conducted to assess if the programs produced different changes in Global Assessment of Functioning from entry to exit. A series of multiple analyses of variance

(MANOVA) were conducted to determine if the programs differed significantly on their changes in entry-to-exit scores for the domains of Psychosocial Stressors, Chemical Health/Recovery, and Level of Progress. Planned comparison testing was also conducted when programs produced significant differences in ANOVA and MANOVA tests, to determine which programs differed from each other. For each planned comparison, a .05 significance level was used. In addition to statistical significance testing, an examination of clinical significance was conducted, using criterion determined via conversations with a research adviser. The criterion for clinical significance for Psychosocial Stressors and Chemical Health/Recovery risk factors was one full point on each scale.

Q3: To answer the third question, focus group data from all patient and staff focus groups were analyzed using Krueger's (2000) method. Focus group data were examined by the researcher using a combination of firsthand notes and audio recordings of the groups. The data were compiled and examined to identify process themes, using the quantitative results for guidance. After all focus groups were analyzed, the researcher identified process strengths for each program, in order to identify which processes the programs have in common and what unique processes each program utilizes.

Chapter IV: Results

The following chapter contains the results of the data analysis as described in Chapter III Statistical test results will be discussed, followed by a discussion of clinical significance. It should be noted that all values presented hereafter represent average changes, aggregated across program participants in any given program, from program entry to exit.

Based on logic and discussions with a research adviser, the researcher determined that clinical significance for the following results would be established using a benchmark of one point on each scale. That is, given that the response ranges on the Data Collection Instrument are four- or five-point scales (0 = No Problem to 5 = Severe Problem; 0 = No Risk to 4 = Severe Risk), a change in the desired direction of one full point would be deemed clinically meaningful.

Q1: Did each program produce significant changes in outcome indicators from program entry to exit within the domains of global functioning, psychosocial stressors, and chemical health/recovery?

Global Assessment of Functioning.

Table 6 represents entry (pre) and exit (post) Global Assessment of Functioning (GAF) scores for each program, as well as the results of paired samples t-tests using program entry and exit scores as the paired dependent variables. All programs produced a significant pre-to-post program increase in GAF, all *p's* < .05.

Table 6
GAF Impact: descriptives and paired samples t-tests results for all programs

Program	GAF Entry	GAF Exit	GAF Change	t	sig.
AAP	56.41	67.17	10.76	-17.23*	.000
MP	54.09	63.00	8.91	-5.19*	.000
HP	64.71	72.00	7.29	-14.24*	.000

NOTE: * represents significant change from program entry to exit.

Psychosocial Stressors.

Tables 7 through 9 represent Psychosocial Stressor results for each program. Included are entry and exit descriptives and results of paired samples t-tests using program entry and exit scores as the paired dependent variables.

As can be seen in table 7, the AAP program produced statistically significant decreases in entry-to-exit scores for all items, all *p's* < .05. Additionally, the program produced clinically significant decreases on five out of eight items, showing decreases ranging between 1.05 points (Economic problems) and 1.36 points (Problems with primary support group). Two items approached clinical significance: Educational problems showed a decrease of 0.89 points, and Occupational problems showed a decrease of 0.86 points. Only one item, Legal problems, did not approach clinical significance, showing a decrease of 0.61 points from program entry to exit.

Table 7
Descriptives and paired samples t-test results for AAP program, Psychosocial Stressors

Item	Entry M	Entry SD	Exit M	Exit SD	Difference	t	sig.
Problems with primary support system	2.67	0.80	1.31	0.78	-1.36[a, b]	13.98	.00
Social problems related to the social environment	2.81	0.63	1.48	0.73	-1.33[a, b]	16.00	.00
Educational problems	2.61	1.01	1.72	0.98	-0.89[a]	90.2	.00
Occupational problems	2.83	0.80	1.97	0.96	-0.86[a]	8.40	.00
Housing problems	2.64	1.07	1.50	0.84	-1.14[a, b]	11.77	.00
Economic problems	2.68	0.75	1.64	0.81	-1.05[a]	9.96	.00

Problems with access to health care services	2.41	1.08	1.26	0.78	-1.15[a, b]	10.55	.00
Problems related to interaction with the legal system/crime	2.09	1.74	1.48	1.30	-0.62[a]	4.73	.00

NOTE: [a] represents statistically significant change from program entry to exit. [b] represents clinical significance.

As can be seen in table 8, the MP program also produced statistically significant decreases in entry-to-exit scores for all items, all *p's* < .05. Yet, only one item showed a clinically significant decrease: Housing problems decreased 1.68 points. All other items did not approach clinical significance: decreases in entry-to-exit scores ranged from 0.78 points (Problems with primary support group) to 0.35 points (Legal problems). It should be noted that patients' entry scores for Educational and Healthcare problems ($M = 1.35$ and $M = 1.34$, respectively) were low to begin with, making it difficult to show clinical significance due to range restriction.

Table 8
Descriptives and paired samples t-test results for MP program, Psychosocial Stressors

Item	Entry M	Entry SD	Exit M	Exit SD	Difference	t	sig.
Problems with primary support system	2.78	1.13	2.00	1.05	-0.78[a]	6.71	.00
Social problems related to the social environment	2.81	1.00	2.13	1.10	-0.68[a]	5.61	.00
Educational problems	1.35	1.54	1.03	1.36	-0.32[a]	3.00	.01
Occupational problems	3.19	0.90	2.47	1.39	-0.72[a]	4.10	.00
Housing problems	3.59	1.13	1.91	1.86	-1.68[a, b]	5.19	.00
Economic problems	3.41	0.84	2.72	1.33	-0.69[a]	3.67	.00

Problems with access to health care services	1.34	1.26	0.84	0.95	-0.50[a]	4.55	.00
Problems related to interaction with the legal system/crime	1.61	1.41	1.26	1.37	-0.35[a]	3.25	.00

NOTE: [a] represents statistically significant change from program entry to exit. [b] represents clinical significance.

As can be seen in table 9, the HP program produced statistically significant decreases in entry-to-exit scores for six out of eight items. The item Educational problems was not statistically significant, $p = .16$, and the item Healthcare problems was marginally significant, $p = .06$. All other items produced significant decreases in entry-to-exit scores, $p < .05$. The program produced clinically significant decreases on four out of eight items, ranging from a decrease of 2.17 points (Housing problems) to 1.05 points (Problems with primary support group). One item approached clinical significance: Social problems decreased 0.92 points. The remaining three items did not approach clinical significance: Legal problems decreased 0.60 points, Healthcare problems decreased 0.23 points, and Educational problems decreased 0.08 points. It should be noted that patients' scores for Educational and Healthcare problems ($M = 0.79$ and $M = 0.48$, respectively) were low to begin with, making it difficult to show either statistical or clinical significance.

Table 9
Descriptives and paired samples t-test results for HP program, Psychosocial Stressors

Item	Entry M	Entry SD	Exit M	Exit SD	Difference	t	sig.
Problems with primary support system	2.90	1.02	1.85	1.01	-1.05[a, b]	8.50	.00
Social problems related to the social environment	2.98	0.91	2.06	1.00	-0.92[a]	7.29	.00
Educational problems	0.79	1.13	0.71	0.99	-0.08	1.43	.16

Occupational problems	3.38	0.97	2.26	1.19	-1.12[a, b]	7.97	.00
Housing problems	3.71	0.77	1.54	1.18	-2.17[a, b]	14.75	.00
Economic problems	3.29	0.94	2.04	0.89	-1.25[a, b]	10.04	.00
Problems with access to health care services	0.48	0.90	0.25	0.60	-0.23	1.97	.06
Problems related to interaction with the legal system/crime	1.79	0.14	1.19	0.87	-0.60[a]	4.69	.00

NOTE: [a] represents statistically significant change from program entry to exit. [b] represents clinical significance.

Chemical Health/ Recovery.

Tables 10 through 12 represent Chemical Health/Recovery results for each program. Included are entry and exit descriptive values and results of paired samples t-tests using program entry and exit scores as the paired dependent variables.

As can be seen in table 10, the AAP program produced statistically significant decreases in entry-to-exit scores for all items, all p's < .05. However, the program did not produce clinically significant decreases for any of the items. Three items approached clinical significance: Readiness to Change decreased 0.90 points, while Relapse Potential and Emotional, Behavioral, or Cognitive Conditions both decreased 0.84 points. The remaining items ranged from a decrease of 0.76 points (Recovery Environment) to 0.69 points (Biomedical Conditions).

Table 10
Descriptives and paired samples t-test results for AAP program, Chemical Health/Recovery

Item	Entry M	Entry SD	Exit M	Exit SD	Difference	t	sig.
Acute Intoxication and/or Withdrawal Potential	1.52	1.06	0.81	0.63	-0.71[a]	10.16	.00
Biomedical Conditions and Complications	1.50	0.90	0.81	0.51	-0.69[a]	8.37	.00

Emotional, Behavioral or Cognitive Conditions	2.12	0.56	1.28	0.62	-0.84[a]	14.26	.00
Readiness to Change	2.02	0.61	1.12	0.42	-0.90[a]	14.09	.00
Relapse/Continued Use Potential	1.91	0.76	1.07	0.41	-0.84[a]	10.45	.00
Recovery Environment	1.90	0.64	1.14	0.58	-0.76[a]	11.41	.00

NOTE: [a] represents statistically significant change from program entry to exit.

As can be seen in table 11, the MP program produced statistically significant decreases in entry-to-exit scores for only one item, Biomedical Conditions, $p < .05$. Additionally, no items approached clinical significance. Biomedical Conditions showed a decrease of 0.44 points, and Relapse Potential showed a decrease of 0.41 points. All other items showed decreases of less than 0.20 points. It should be noted that patients' program entry scores on this domain were low, making it difficult to show either statistical or clinical significance.

Table 11
Descriptives and paired samples t-test results for MP program, Chemical Health/Recovery

Item	Entry M	Entry SD	Exit M	Exit SD	Difference	t	sig.
Acute Intoxication and/or Withdrawal Potential	0.38	0.71	0.41	0.80	0.03	-0.18	.86
Biomedical Conditions and Complications	1.03	0.78	0.59	0.71	-0.44[a]	2.61	.01
Emotional, Behavioral or Cognitive Conditions	1.47	0.80	1.59	0.88	0.12	-0.56	.58
Readiness to Change	1.16	0.95	0.97	0.82	-0.19	0.90	.37
Relapse/Continued Use Potential	1.66	1.07	1.25	0.95	-0.41	1.63	.11

Recovery Environment	1.44	1.11	1.25	1.14	-0.19	0.71	.48

NOTE: [a] represents statistically significant change from program entry to exit.

As can be seen in table 12, the HP program produced statistically significant decreases in entry-to-exit scores for all items but one, $p < .05$. The only item that did not show statistical significance was Withdrawal Potential, but patients' entry scores were extremely low ($M = 0.13$) and all patients received a score of zero upon program completion. The program produced clinically significant decreases on three items out of six: Readiness to Change (1.09 points), Relapse Potential (1.02 points), and Recovery Environment (1.00 points). One item approached clinical significance, Emotional, Behavioral, or Cognitive Conditions (0.87 points). The other two items did not approach clinical significance, Biomedical Conditions (0.40 points) and Withdrawal Potential (0.13 points). However, it should be noted patients' entry scores on both of these items were very low ($M = 1.00$ and $M = 0.13$, respectively), making it difficult to show clinical or statistical significance.

Table 12
Descriptives and paired samples t-test results for HP program, Chemical Health/Recovery

Item	Entry M	Entry SD	Exit M	Exit SD	Difference	t	sig.
Acute Intoxication and/or Withdrawal Potential	0.13	0.61	0.00	0.00	-0.13	1.43	.16
Biomedical Conditions and Complications	1.00	0.95	0.60	0.57	-0.40[a]	3.73	.00
Emotional, Behavioral or Cognitive Conditions	1.75	0.81	0.88	0.44	-0.87[a]	8.62	.00
Readiness to Change	1.67	0.78	0.58	0.58	-1.09[a, b]	9.78	.00
Relapse/Continued Use Potential	1.75	0.70	0.73	0.49	-1.02[a, b]	10.12	.00

Recovery Environment	1.77	0.63	0.77	0.59	-1.00[a, b]	9.70	.00

NOTE: [a] represents statistically significant change from program entry to exit. [b] represents clinical significance.

Q2: How did the programs compare to each other on outcome indicator domains of interest (i.e. global functioning, psychosocial stressors, and chemical health/recovery)?

Global Assessment of Functioning.

A one-way analysis of variance determined that the programs differed significantly on change in GAF from program entry to exit, $F(2, 135) = 4.47, p < .05$. Specifically, the AAP program produced significantly more of an increase ($M = 10.76$) than did the MP program ($M = 7.29$). The HP program ($M = 8.91$) did not differ statistically from the AAP or MP program.

Psychosocial Stressors.

A Multiple Analysis of Variance (MANOVA) determined that the programs differed significantly on groups of scores on Psychosocial Stressors, $F(16, 248) = 8.79, p < .05$. Table 13 represents the results of a MANOVA conducted using the three programs as levels of the independent variable and the groups of scores on the Psychosocial Stressors domain as the dependent variable. As can be seen in the table, the programs differed in the average amount of change on all but two stressors, Occupational stressors ($p = .15$) and Legal stressors ($p = .42$). All other items were statistically significant, $p < .05$.

Planned comparison testing revealed which programs differed statistically from each other. As can be seen in Table 14, the AAP program produced a significantly greater decrease than both other programs for three Psychosocial Stressors (Social Environment, Educational Problems, and Healthcare Problems); and produced significantly greater decrease than the MP program but not the HP program for one Psychosocial Stressor (Problems with Primary Support Group). The HP program produced significantly greater decrease than the AAP program but not the MP program for one Psychosocial Stressor (Housing Problems); and produced significantly greater decrease than the MP program but not

the AAP program for one Psychosocial Stressor (Economic Problems). The MP program did not produce a significantly greater decrease than any other program on any Psychosocial Stressor.

Table 13
Results of MANOVA for Psychosocial Stressors across programs

Item	Type III Sum of Squares	df	Mean Square	F	sig.
Problems with primary support system	6.87	2	3.43	5.77	.00
Social problems related to the social environment	9.82	2	4.91	9.06	.00
Educational problems	18.90	2	9.45	25.52	.00
Occupational problems	3.15	2	1.58	1.92	.15
Housing problems	26.57	2	13.28	9.74	.00
Economic problems	6.37	2	3.18	3.99	.02
Problems with access to health care services	24.28	2	12.14	19.84	.00
Problems related to interaction with the legal system/crime	1.34	2	0.67	0.86	.42

Table 14
Planned comparison of MANOVA results for all programs, Psychosocial Stressors mean changes from program entry to exit

Item	AAP	MP	HP
Problems with primary support system	-1.37[a]	-0.80[a]	-1.04
Social problems related to the social environment	-1.33[a,b]	-0.67[a]	-1.04[b]
Educational problems	-0.89[a,b]	-0.30[a]	-0.06[b]
Occupational problems	-0.88	-0.73	-1.13
Housing problems	-1.16[b]	-1.70	-2.17[b]
Economic problems	-1.05	-0.67[c]	-1.26[c]
Problems with access to health care services	-1.18[a,b]	-0.50[a]	-0.23[b]
Problems related to interaction with the legal system/crime	-0.60	-0.37	-0.62

NOTE: a = AAP is significantly different than MP, all p's < .05. b = AAP is significantly different than HP, all p's < .05. c = MP is significantly different than HP, all p's < .05

Chemical Health/Recovery.

A multiple analysis of variance determined that the programs differed significantly on groups of scores on Chemical Health/Recovery risk factors, $F(12, 260) = 7.79, p < .05$ Table 15 represents the outcome of a MANOVA conducted using the three programs as levels of the independent variable and the groups of scores on the Chemical Health/Recovery domain as the dependent variable. As can be seen in the table, the programs differed somewhere for all but one item, Biomedical Conditions ($p = .10$). All other items were statistically significant, $p < .05$.

Planned comparison testing revealed which programs differed statistically from each other. As can be seen in Table 16, the AAP program produced significantly greater decrease than both other programs for one Chemical Health/Recovery risk factor (Withdrawal Potential); and produced

significantly greater decrease than the MP program but not the HP program for three risk factors (Emotional, Behavioral, and Cognitive Conditions; Readiness to Change; and Recovery Environment). The HP program produced significantly greater decrease than the MP program but not the AAP program for four risk factors (Emotional, Behavioral, and Cognitive Conditions; Readiness to Change; Relapse Potential; and Recovery Environment); and did not produce significantly greater decrease than both other programs on any risk factor. The MP program did not produce significantly greater decrease than any other program on any risk factor.

Table 15
Results of MANOVA for Chemical Health/Recovery across programs

Item	Type III Sum of Squares	df	Mean Square	F	sig.
Acute Intoxication and/or Withdrawal Potential	14.43	2	7.22	15.65	.00
Biomedical Conditions and Complications	2.62	2	1.31	2.33	.10
Emotional, Behavioral or Cognitive Conditions	23.80	2	11.90	19.04	.00
Readiness to Change	16.40	2	8.20	13.19	.00
Relapse/Continued Use Potential	7.42	2	3.71	4.71	.01
Recovery Environment	12.91	2	6.46	8.11	.00

Table 16
Planned comparison of MANOVA results for all programs, Chemical Health/Recovery mean changes from program entry to exit

Item	AAP	MP	HP
Acute Intoxication and/or Withdrawal Potential	-0.71[a,b]	0.03[a]	-0.33[b]

Biomedical Conditions and Complications	-0.69	-0.44	-0.53
Emotional, Behavioral or Cognitive Conditions	-0.84[a]	0.13[a,c]	-0.88[c]
Readiness to Change	-0.90[a]	-0.19[a,c]	-1.08[c]
Relapse/Continued Use Potential	-0.84	-0.41[c]	-1.02[c]
Recovery Environment	-0.76[a]	-0.19[a,c]	-1.00[c]

NOTE: a = AAP is significantly different than MP, all p's < .05. b = AAP is significantly different than HP, all p's < .05. c = MP is significantly different than HP, all p's < .05

Levels of Progress.

A multiple analysis of variance determined that the programs differed significantly on groups of scores on Level of Progress, $F(12, 254) = 4.29, p < .05$. Table 17 represents the outcome of a MANOVA conducted using the three programs as levels of the independent variable and the groups of scores on the post-test only Level of Progress domain as the dependent variable. As can be seen in Table 17, the programs differed somewhere on all but one item, Increased Recovery Skills ($p = .21$). All other items were statistically significant, $p < .05$.

Planned comparison testing revealed which programs differed statistically from each other. As can be seen in Table 18, the AAP program did not produce significantly greater Level of Progress than both other programs on any item; and produced significantly greater Level of Progress than the MP program but not the HP program for one item (Improved Relationships with Primary Support System). The HP program produced significantly greater Level of Progress than both other programs for one item (Increased Sobriety); produced significantly greater Level of Progress than the MP program but not the AAP program for three items (Improved Mental Health; Improved Relationships with Primary

Support Network; and Developing and Maintaining Support Network). The MP program did not produce significantly greater Level of Progress than any other program for ay item.

One item from the Level of Progress domain, Improved Legal Status, was excluded from the MANOVA due to a large quantity of patients with scores of 'Not Applicable'. Improved Legal Status was instead analyzed using a one-way ANOVA. Table 19 represents the results of the one-way ANOVA conducted on the Improved Legal Status item. As can be seen in the table, there were no significant differences across programs on this item, $p = .22$.

Table 17
Results of MANOVA for Level of Progress across programs

Item	Type III Sum of Squares	df	Mean Square	F	sig.
Increased Sobriety/Chemical Health	9.58	2	4.79	13.77	.00
Increased Recovery Skills	1.23	2	0.62	1.58	.21
Improved Mental Health	3.51	2	1.76	3.77	.03
Maintaining Safe Housing	3.95	2	1.98	3.10	.05
Improved Relationships with primary support system	4.37	2	2.19	4.66	.01
Developing/maintaining support network	6.37	2	3.18	5.43	.01

Table 18
Planned comparison of MANOVA results for all programs, Level of Progress scores

Item	AAP	MP	HP
Increased Sobriety/Chemical Health	2.31[b]	2.41[c]	2.90[b,c]
Increased Recovery Skills	2.24	2.16	2.40

Improved Mental Health	2.18	1.91[c]	2.33[c]
Maintaining Safe Housing	2.20	1.81	2.23
Improved Relationships with primary support system	2.13[a]	1.75[a,c]	2.29[c]
Developing/maintaining support network	2.02	1.72[c]	2.29[c]

NOTE: a = AAP is significantly different than MP, all p's < .05. b = AAP is significantly different than HP, all p's < .05. c = MP is significantly different than HP, all p's < .05

Table 19
Results of one-way ANOVA for Level of Progress item Legal Status

	Sum of Squares	df	Mean Square	F	sig.
Between Groups	2.15	2	1.08	1.54	.22
Within Groups	79.71	114	0.70		
Total	81.86	116			

Q3: What were the process strengths of each program, as identified by qualitative results of staff and patient focus groups?

The following sections summarize the strengths of each program. Strengths are based on qualitative data gathered from multiple focus groups. For each program, separate focus groups were held for staff and patients. For each program, comments from the staff and patient focus groups were reviewed separately, and then compared to establish process strengths. Data was thus analyzed separately for each program. Distinctions were made between staff or client findings as appropriate.

AAP Strength Profile.

This section provides a description of program strengths, as determined by examining the data from a focus group conducted with AAP staff (N = 8) and two separate focus groups with AAP patients

(N = 10 and N = 7). Many different program strengths were identified by staff and patients, including a culturally tailored, individualized treatment; a sense of community and increased communication skills; patient buy-in; staff that are invested in client success; and development of sober support networks and relationships.

Culturally Tailored, Individualized Treatment.

Patients recognized and greatly appreciated that the program is geared specifically toward African-Americans, and mentioned many times how the program's emphasis on their specific culture aided their recovery and sobriety. Many patients had been through other treatment programs, and when asked about differences between programs, patients recognized that the AAP program *"is geared toward us."* They mentioned how specific other programs in the area *"are not geared toward anyone but people with drug problems."* Patients offered many stories and examples of how a culturally-specific treatment program was one of the main factors in the success of their recovery. As one man succinctly said, *"Culturally specific is essential."*

In addition to providing culturally sensitive treatment, AAP staff strive to provide individualized treatment for patients, citing the importance of *"meeting the client where the client is at."* Staff talked about how the individual counseling and motivational interviewing processes allowed them to effectively help clients on a one-to-one basis. Specifically, staff described how these processes help them avoid *"talking at"* the clients, but rather *"listen and support them."* Other specific advantages of these processes that were mentioned by staff were confidentiality, privacy, *"more freedom to explore and trust,"* and *"more depth than a group setting."* Staff also talked about how their attention to the individual discouraged them from simply *"telling the client what to do,"* and instead encouraged clients to *"become part of the change,"* and *"do it for themselves instead of doing it because someone told them to."* Patients recognized and appreciated the individualized treatment. One man shared a powerful story about how he was in prison for twenty years with no one to talk to, and how grateful he was for AAP staff that were willing to simply sit down and listen to him. Another

man cited individualized treatment as something that set the program apart from others, saying, *"They ask you what you want. Other places don't ask you, especially a black man, 'What do you want out of life?'"* Overall, the individualized treatment fostered patient buy-in with the program, which appears to have been a major contributor to all aspects of program success. This topic will be discussed in further detail (see Patient Buy-in section below).

Sense of Community & Increased Communication.

Patients described many times how the culturally specific and individualized treatment enabled them to identify with each other and develop a sense of community within the program, thus resulting in increased communication. When explaining the difference between AAP and other programs, one man listed a benefit of, *"Being around people I can relate to. I can't learn from people I have nothing in common with."* As a result, patients were more willing to communicate and share intimate thoughts and feelings with each other. One patient talked about how he recognized that the other men in the program come from *"different walks of life,"* but he said, *"I can relate with the things he's going through because I have been there, done that."* Another client said, *"Just to see other faces that I know from my community, it makes me more open to speak about things that bother me, which can help me get to the next level. If you're around people you don't know, you're going to sit back and let them speak."* For some of the patients, it was the first time they had been around a group of other African-Americans willing to share their problems with each other. One patient described how this fostered a sense of *"brotherhood"* within the group, saying the men *"inspire each other."* Another patient described an incident where a person from a different program tried to get an AAP patient in trouble for something he didn't do, but a staff member stepped in and dismissed the accusation. This patient talked about how encouraged he was to see a group of African Americans working together (patients and staff alike) and who *"got each other's back."* He talked about how this incident had a powerful impact on him, and how it brought the group closer together as a community.

Patient Buy-in.

A common theme across the staff focus group and both patient focus groups was that the patients really *"buy-in"* to the recovery process, due in large part to specific efforts from staff. Patients can easily recognize staff emphasis on this aspect of their recovery. In one of the focus groups, patients described how staff members confront them with the question of whether they are ready to change. Patients describe how, in as many words, staff ask them, *"Are you willing to change? Do you want us to help you change or just let you do your time here?"* This process forces the patients to examine whether they really are ready to change, and if they decide they are, they become much more engaged and motivated. The main contributing factors to client buy-in are seeing and interacting with staff and peer mentors who have dealt with their own drug issues and act as positive role models. Patients recognize that staff members have been through drug issues of their own, and list them as inspirations to their own recovery, saying they can trust and relate to them better. Staff use their drug histories as motivators, inspiring patients by saying *"If I can do it, so can you."*

In addition to staff members, the AAP program makes a point to incorporate peer mentors into the recovery process. There are three levels of peer mentors: level one are still in the program, but are close to graduating. Their role is to serve a "big brother" role to other patients. Patients see these mentors as successful, yet not far removed from their drug problems. Level two mentors are out of the program and at least one year sober. They are invited back to speak with current patients and describe how they are *"doing positive things in the community,"* and still *"incorporating tools from treatment into their daily life."* Level three mentors are at least three years sober, and come back to the program to facilitate groups and classes. It is important to note that staff see themselves as mentors to the peer mentors, which provides benefits across all stages.

Patients and staff alike mentioned many times how the peer mentoring process is beneficial to the program. It is helpful for patients to see successful black men who have themselves come out of recovery. One staff member described how patients are *"exposed to a different side of what they see*

every day [on the streets.] That contributes to retention and makes them feel inclusive." Patients who see other individuals very similar to themselves who have been successful are more motivated to continue their treatment and strive for positive results. Staff also mentioned that there may be some issues or topics that patients may not want to discuss with *"authority figures,"* but peer mentors can serve as a *"buffer"* or *"go-between"* so that patients can *"confide in mentors things they may not be able to confide in staff."* Staff recognize that, especially in the early stages of recovery, it may be easier for a patient to trust a peer mentor than a staff member, thus highlighting the importance of the mentors to get patients engaged in the recovery process early on.

Staff are Invested in Patient Recovery.

Apart from the benefits already mentioned regarding staff members, patients gave a number of other examples how staff help them through their recovery. In general, patients recognize that staff are genuinely interested in seeing them overcome their drug problems. Patients perceive that in other recovery programs, staff *"look down their nose"* at patients or are not really interested in helping them. However, patients can see that AAP staff really do want to help them. Patients said many times in focus groups how the program and staff are *"out to help me,"* and are not adversarial. In addition to the example listed previously of staff *"sticking up"* for clients, one man shared how a staff member went out of his way to write a letter of recommendation to a judge, saying, *"That made me feel open to the people I was living with because he was willing to put in a couple good words for a brother."* Based on the patient and staff focus groups, there is a tremendous amount of respect between staff and clients, which in turn helps patients through all stages of recovery.

Support Networks & Relationships.

Finally, a main strength of the program is an emphasis on *"sober networks"* and support groups. As a result, patients describe how they have been able to develop better *"people skills"* and *"learn to deal with people"* in new ways. Patients also talked about how they learn coping mechanisms not involving substances. As one man said, *"drugs and alcohol were a way to deal with life. [I*

learned] to develop other ways to deal with life other than drugs and alcohol." He went on to talk about how the program taught him to *"Deal with life on life's terms"* without falling back to substance use. The program heavily encourages patients to surround themselves with people who are *"not involved in drug life."* Patients describe how doing so helps them to *"learn to identify 'real' relationships"* with friends and significant others. The communication strength mentioned previously carries over to this topic, in that patients describe how they take their learned communication skills from the program and apply them to their new, sober support networks. One man described how he is better able to communicate and resolve conflicts peacefully with his girlfriend, and how their relationship had gotten much better as a result.

One way the agency encourages this process is to demonstrate a sober environment for celebrations and social activities. The organization holds regular "sober parties" for participants, to show them that it is possible to have a good time in a social setting without using drugs and alcohol. Participants that attend these parties talk about how they can see firsthand that it is possible to have a good time in a sober setting, and learn how to interact with others in a sober environment.

MP Strength Profile

This section provides a description of MP program process strengths, as determined by examining the data from a focus group conducted with MP staff (N = 8) and two separate focus groups with MP patients (N = 9 and N = 7). There are a number of different strengths of this program, including individualized treatment; motivation to complete treatment due to having their children present; involvement of children in recovery; an emphasis on non-familial relationships and support networks, self-sufficiency and life skills; and proper mental health and medication.

Individualized Treatment.

Patients perceive the individualized treatment they received to be very beneficial to their recovery and maintenance. Program staff *"focus on what each client needs"* by providing *"individual*

service" and *"individual meeting times."* Staff cite their ability to *"assess unique needs of different clients and meet those needs with different services"* as beneficial services, and patients recognize and appreciate that staff *"meet you where you're at."* Staff also singled out the motivational interviewing process, saying it allows them to better *"deal with clients with critical issues, and take more time to explore what is really going on, how they [really] feel."*

Patients appreciate the individualized treatment, saying it is *"easier to be motivated"* and helps them *"feel like [we] are accomplishing something."* They added that their quality of life has improved, and that they are *"more dependable, accountable, and responsible."*

As an extension of the individualized treatment, staff and patients both brought up the fact that the program continues to serve patients after their time in the program is done. Staff talked about how patients *"can still utilize services after leaving housing,"* and patients appreciated that *"alumni are welcome back at any point."*

Children Provide Increased Motivation.

MP patients commonly mentioned being on their *"last chance"* at recovery before losing custody of their children—an obvious motivating factor. The women talked at length about how they wanted to be responsible and do right by their children. When asked how having their children with them helped with their recovery, patients specifically mentioned that they were *"more motivated"* to change. One woman specifically talked about how the *"threat of losing [my] kids"* and the *"guilt of disappointing them"* prevented her from relapsing. Other women mirrored this point, and all the women appreciated the ability to have their children with them while they were in the program. As a result, patients' children became directly involved in their recovery, which fostered an increased sense of motivation.

Children Become Involved in Recovery.

As a result of the MP program allowing children to live with their mothers or visit regularly while in treatment, the children become directly involved in the recovery process. This in turn was

perceived by the patients as beneficial. The women frequently expressed how the program allowed them to rebuild their relationships with their children. For many of the women, their relationships with their children were greatly strained (or in some cases, nonexistent) when they were regularly using drugs or alcohol. However, as a result of children staying with their mothers during recovery, patients said they became *"closer with the children,"* and had *"better communication"* and *"better bonding"* with them. One woman talked about her child with attention deficit disorder, saying that when she was using substances, she didn't have any patience with the child. However, during her time in the program, she learned how to have more patience, and said their relationship had greatly improved.

Patients described *"talking more openly"* with their children about their recovery, and how the kids became more directly involved in the recovery process. Patients talked about how open and honest discussion helped kids *"regain trust"* in their moms. When the relationship between mother and child had been re-established, patients talked about how their kids would *"ask how my treatment was going."* It was discussed earlier how simply having children around would motivate mothers to successfully complete their recovery, but when children showed a direct interest in the recovery process, the motivation was that much greater. One woman described how her children became more engaged in her recovery, saying, *"[they] have more faith in their Mom."* She went on to talk about how she became more motivated to successfully complete her recovery because her children were directly involved in the process.

Staff mirror these sentiments, clients, citing patients' increased *"patience," "consistency,"* and *"stability"* with regard to their parenting. Staff also said patients were *"more attentive to their families"* and had *"increased confidence in their parenting skills."*

Non-Familial Relationships & Support Networks.

The MP program's emphasis on relationship building extends beyond parent-child and familial relationships, and as a result, patients reported better support networks and relationships in general. Program staff emphasize the importance of healthy relationships and support networks in a woman's

life, and strive to *"give [them] skills to deal with people."* One staff member talked about how she stresses *"relationship building"* with patients, adding that *"relationships are huge in women's lives. With children, with a partner, and relationships in general."* Staff recognize that a key first step is to get the patients to *"detach from their old [support] network"* and distance themselves from people who may not be supportive of their recovery. Staff also stress that *"women were not using the support groups they already had in place in the past, but are now using them."* One staff member described how she encourages patients to start small and work up from there, saying, *"Just to open up and try to trust* someone *is big. Just one outside person, then two..."*

Often, patients begin by building trusting relationships with each other, and then applying the skills they learned in the program to their outside relationships. MP staff describe how *"between client networks"* develop in the program, as a starting point for the women to develop their relationships and support networks. One staff member described how one of the patients who was comparatively older *"acted as a mother figure to the younger [patients],"* and how this process benefited both groups in their recovery. Staff reported that the bonding and relationship building that occurred provided the start of a powerful support network to help the women through their recovery. The patients themselves talked about the benefits of network building with other patients. As mentioned previously, patients described the importance of a *"safe environment with other females"* and being *"able to connect with other females"* to their recovery and overall quality of life. Some patients talked about how in their previous lives, they were not able to meaningfully connect with other women, but through the program learned to develop proper support networks.

Patients elaborated on the program's benefits, saying it *"teaches us how connect with people"* and *"seek out a different type of friendship in a sober environment."* One woman described how her involvement in the program has *"kept me out of bad relationships."* She added that if she had not joined the program, she would have gone back to one of her previous partners and rejoined a harmful relationship. Other women talked about how being provided housing with roommates helped their

recovery. One patient said that *"just having others around, not being alone in a house by myself"* helped her to progress through the program. Another talked about how establishing a positive relationship with her roommate helped her *"learn to be trustful."*

Self-Sufficiency & Life skills.

One of the most important processes of all three programs (see below for HP program) mentioned in this report is that patients are provided housing, but at the same time are given a great deal of freedom. Specifically, patients must *"cook on their own, clean on their own, and take care of an apartment."* This combination of increased freedom and the responsibility associated with it is an extremely important factor for patients. Simply learning these *"basic living skills"* helps patients stabilize their living environment, which in turn allows them to focus on their recovery and maintenance. Patients mention many times how much they appreciate the freedom and responsibility associated with learning how to become self-sufficient. They recognize that they are expected to develop the skills to *"do all the things we will need to do when we get out"* of the program. They appreciate that the program *"prepares you for life after treatment"* and helps them develop a *"healthy schedule."* Patients also say that these skills help them develop *"self esteem," "patience," "tolerance," "confidence,"* and *"balance in recovery."*

Apart from simple cooking and cleaning skills, program staff stress other life skills, including a *"daily emphasis on time management, housing, jobs, school, and budgeting."* Staff members develop budget plans with the women, and *"talk about managing money regarding food,"* adding that *"women must stretch their income to cover their children."* One staff member talked about how many patients *"have not been taught about budgeting or clipping coupons."* Staff and patients both reported that the program's emphasis on self-sufficiency and life skills allows patients to take control over their own recovery, and teaches them valuable skills that they can take with them after they have completed their treatment.

Mental Health & Medications.

MP staff talked about how they emphasize that patients take care of their *"mental health needs"* and stabilize their medication. In addition, staff educate patients about *"how to deal with their mental health and continue their recovery"* effectively.

Patients appreciate the program's emphasis on mental health. One patient explained that before her time in the program, she was aware she had problems with depression, but wouldn't see a doctor and did not take her medication. She went on to say that from being in the program, she learned the importance of taking care of her mental health and taking her medications. Another patient talked about how she appreciated that the program was able to *"provide money to get prescriptions."*

HP Strength Profile

This section provides a description of process strengths of the HP program, as determined by examining the data from a focus group conducted with HP staff (N = 3) and a focus groups with HP patients (N = 10). There are a number of different strengths of the program, including individual attention, motivational interviewing, a focus on mental health and emotional growth which led to increased familial relationships, and an emphasis on development of life skills.

Individual Attention

HP staff report striving to focus on each patient as an individual and provide resources and services that will most benefit that individual. Staff describe making efforts to *"meet the [patients] where they're at"* in order to *"teach the [patient] to challenge their assumptions and views of the world."* One staff member used an analogy of a *"go-kart,"* saying that often, patients simply *"need a push to get them started"* in the right direction, *"and they can go from there."* Staff do their best to seek out specific resources that will benefit each patient. Patients, in turn, recognize that staff are tailoring to them as individuals, and as a result are more receptive to the treatment. Patients greatly

appreciate the individual treatment they receive, saying staff *"are all on the same page. They provide a variety of help, and are always available."*

Motivational Interviewing.

A main tool used by program staff to help patients progress through their recovery is motivational interviewing. Staff report valuing this tool because it allows them to provide an *"installation of hope"* in patients and *"shift their perspective"* to see that *"the best things in life aren't things."* Motivational interviewing is used to *"empower the client to make their own choices"* and let them *"choose the direction"* of the interview. As one staff member said, *"it's about what* they *want"* to discuss in the interview. Patients, in turn, value the relationship that is developed with staff, and are *"more willing to disclose,"* which helps foster their treatment. Staff sense that patients appreciate being *"genuinely heard and not judged, sometimes for the first time in their lives."* HP staff use motivational interviews as a tool to develop patients' *"self-sufficiency"* and *"help the [patient] identify examples of positive things he's done."*

Focus on Mental Health & Emotional Growth.

HP staff report a strong emphasis on teaching patients about the importance of proper mental health and emotional growth, which allows patients to better progress through their recovery. Staff reported that many patients have unresolved mental health conditions upon entry to the program, such as *"undiagnosed mental health issues," "wrong medication,"* and emotional problems such as *"low frustration tolerance," "anger management"* problems, and overall problems *"managing emotions."* Staff also identify emotional barriers to patients' recovery, such as a *"locus of control [that is] too external,"* a sense of *"learned helplessness,"* and *"many layers of [emotional] defenses."*

Due to the above, staff report making concerted efforts to remedy mental health issues early in the program. Staff described providing *"lots of mental health work"* to clients in order to *"change their views on anger and frustration."* They report striving to educate patients on the physiological effects of their addiction.

Staff help patients with their mental and emotional issues by encouraging a free *"expression of feelings"* and reinforcing simply *"talking about daily life."* For example, one staff member described a patient seeking him out to talk to him about a recent job interview. By promoting simple emotional expression and acting as outlets for patients to express themselves, they are teaching patients valuable ways to grow emotionally.

Staff also talked about infrastructure that is in place that provide valuable help to patients that need to *"get mental health help,"* such as an *"in-house nurse"* and nearby facilities that provide *"walk-in treatment."* Staff report that this infrastructure allows patients to better focus on their recovery and maintenance process.

Patients appear to recognize and appreciate the attention paid to their mental health and emotional growth needs. They said it is *"hard to ask for help"* with issues such as *"depression"* and even *"everyday situations,"* but when they did reach out for help, they reported a myriad of benefits. Patients said as a result of the program, they *"get angry less,"* have more *"patience and clarity,"* and interact *"more rationally"* with others. One man said he has been helped *"big time"* by the program, saying he is *"more honest, up-front, [and] less judgmental,"* adding that he *"no longer just reacts"* to situations, but *"sees things more clearly."*

Emotional Growth Improves Familial Relationships.

When describing the gains they made in their mental and emotional health, patients talked at length about how their relationships with their family and significant others improved as a result. Patients talked specifically about how their relationships with their kids and grandkids have improved due to their ability to control their emotions. Patients say they are *"more honest"* and *"more reliable"* with their children, and are grateful that they are rebuilding their relationships as a result. Patients were also very appreciative of the fact that the program allows their children to visit them and stay with them. One man in particular was extremely thankful that his young son was allowed to stay with him on weekends, and added that other programs would not allow children to stay with their fathers, only

their mothers. He elaborated that he was re-establishing a warm relationship with his son, and added that it was an extremely motivating factor for him to continue his recovery maintenance. Other patients described how their relationships with partners and significant others were improved as a result of the program's emphasis on mental and emotional health. Patients talked about being *"more honest"* with their significant others, leading to stronger relationships with them. One man talked about how he was using the skills he learned in the program to help his partner stay sober, and another described that as a result of his time in the program, he decided to *"look for a steady relationship"* with one woman instead of spending time with multiple partners.

Life Skills

As with other programs, patients reside in agency housing and are given more freedom to cook for themselves and are expected to be responsible for keeping their apartment clean. This increased freedom and the responsibility associated with that freedom was reported to help clients develop life skills that they can take with them when they leave the program. Patients are appreciative of this freedom, and typically embrace the responsibility, saying it holds them *"accountable."* Staff recognize that patients take responsibility for their life skills, and recognize that they develop *"healthy habits"* and *"disciplinary habits."* Other programmatic activities, for example 'job club', help patients find employment while other activities help them build their life skills and *"deal with life on life's terms."*

Chapter V: Discussion

This chapter presents a summary of the findings of the present research, followed by interpretation of the findings as they apply to each program. Each research question will be discussed, along with possible explanations of the findings and links between process strengths and program outcomes. Program implications will be presented for each research question, followed by a discussion of limitations of the present research, suggestions for future research, internal and external validity, and concluding remarks.

Question 1 (Q1): Did each program produce significant changes in outcome indicators from program entry to exit within the domains of global functioning, psychosocial stressors, and chemical health/recovery?

Global Assessment of Functioning.

All programs showed statistically significant increases in Global Assessment of Functioning from program entry to exit. Given that the GAF is viewed as an overarching measure of patients' wellbeing, this finding dictates that all programs are effective at enriching the overall quality of life of program participants.

Psychosocial Stressors.

Table 20 provides a summary of all programs' statistical and clinical significance for the Psychosocial Stressor domain. Overall, all three programs predominately resulted in statistically significant positive change. Specifically, the AAP and MP programs showed statistically significant improvement in all areas of psychosocial stressors while the HP program did for most.

With the benchmark for determining clinical significance one full-point change on a 5-point scale, the AAP and HP programs showed clinical significance on approximately half of the Psychosocial Stressors, and the MP program showed clinical significance on only one.

Table 20
Summary of statistical and clinical significance, all programs, Psychosocial Stressors

Program	AAP		MP		HP	
Item	Statistical Significance	Clinical Significance	Statistical Significance	Clinical Significance	Statistical Significance	Clinical Significance
Problems with primary support system	Yes	Yes	Yes	No	Yes	Yes
Social problems related to the social environment	Yes	Yes	Yes	No	Yes	No
Educational problems	Yes	No	Yes	No	Yes	No
Occupational problems	Yes	No	Yes	No	Yes	Yes
Housing problems	Yes	Yes	Yes	Yes	Yes	Yes
Economic problems	Yes	Yes	Yes	No	Yes	Yes
Problems with access to health care services	Yes	Yes	Yes	No	No	No
Problems related to interaction with the legal system/crime	Yes	No	Yes	No	Yes	No

Chemical Health/Recovery.

As can be seen in table 21, two programs predominately showed statistically significant positive change in chemical health recovery (AAP and HP). However, the MP program predominately failed to demonstrate statistically significant chemical health change.

With the benchmark for determining clinical significance one full-point change on a 4-point scale, the HP program showed clinical significance on half of the Chemical Health/Recovery risk factors, while the AAP and MP programs did not show clinical significance for any risk factors.

Table 21
Summary of statistical and clinical significance, all programs, Chemical Health/Recovery

Program	AAP		MP		HP	
Item	Statistical Significance	Clinical Significance	Statistical Significance	Clinical Significance	Statistical Significance	Clinical Significance
Acute Intoxication and/or Withdrawal Potential	Yes	No	No	No	No	No
Biomedical Conditions and Complications	Yes	No	Yes	No	Yes	No
Emotional, Behavioral, or Cognitive Conditions	Yes	No	No	No	Yes	No
Readiness to Change	Yes	No	No	No	Yes	Yes
Relapse/Continued Use Potential	Yes	No	No	No	Yes	Yes
Recovery Environment	Yes	No	No	No	Yes	Yes

Synthesis of Statistical and Clinical Significance.

Martens, Neighbors, and Lee (2004) reviewed the literature on efficacy of substance dependence treatment programs and found effect sizes (*d*) ranging from .25 to .60. However, they did not indicate which specific outcomes were measured by the interventions they reviewed. Nevertheless, their research indicates that an expected increase of 25% is not unreasonable as a benchmark. For the present research, a benchmark of one full point was used for clinical significance. The scale of

responses for Psychosocial stressors ranged from 0 (No Problem) to 5 (Severe Problem). Therefore, a change of one full point on any given item represented a 20% improvement. The scale of responses for Chemical Health/Recovery risk factors ranged from 0 (No Risk) to 4 (Severe Risk). Therefore, a change of one full point on any given item represented a 25% improvement. Given the ranges of the scales used to measure Psychosocial Stressor change and Chemical Health/Recovery risk factors, a benchmark of effectively a respective 20% and 25% improvement for establishing clinical significance may have been too ambitious, yet, the literature on other programs suggests that improvements of at least 25% are feasible.

Overall, the rates of statistical and clinical significance reflect very well on these programs. All programs showed positive changes in Psychosocial Stressors, which indicates that the programs are doing an effective job at preparing patients for life after treatment. Patients are equipped with a variety of life skills and coping mechanisms to ensure that they are able to lead a successful life in the "real world" after leaving the program. Improvements in social support networks and social environments show that patients have learned ways of coping with life other than returning to drugs and alcohol. Furthermore, they will draw upon their social networks to maintain their motivation to succeed and lead productive lives free of drugs and alcohol. Improvements in occupational, economic, legal, health, and housing problems indicate that patients will be able to provide for themselves and their families, and are further proof that they will be able to make a successful transition from treatment into leading a normal, healthy life. Furthermore, patients' demonstrated improvements in chemical health risk factors such as relapse potential, intoxication/withdrawal potential, and recovery environment indicate that patients will be able to maintain a high level of chemical health after leaving the program. Finally, improvements in biomedical and emotional conditions show that patients will have the skills to take care of their physical and mental well-being in order to maintain a healthy lifestyle.

Program Implications.

While clinical significance did not result as frequently as statistical significance, the results are still positive for program administrators. All programs were effective at reducing Psychosocial Stressors to some degree, and the AAP program and HP program were effective at reducing Chemical Health/Recovery (CH/R) risk factors.

Yet, to say that the MP program was ineffective at reducing CH/R risk would be erroneous. Specifically, an examination of MP patients' entry scores indicates that statistical and clinical significance were difficult to produce, as patients entered the program with CH/R risk factor ratings in the range of 0.6 to 1.6, reflecting generally initial "Low Risk". These low initial values resulted in range restriction, as final 'improvement' scores had an available range of only 0.6-1.6 score points. As such, both statistical and clinical significance were procedurally difficult to attain. Given the range restriction, the fact that the program generally achieved change in the desired direction is appropriately more interpretable than a lack of significance.

The overwhelmingly positive results of the AAP and HP programs indicate that these programs should 'stay the course'. That is, they should continue to provide excellent treatment tailored for their unique populations.

Two main program implications arise for the MP program. First, it appears that the MP patients involved in this study *already* had low CH/R risk factors. This could be an anomaly, meaning the cohort that provided data for the present research may have had lower risk factors due to chance. If this were the case, the lack of statistically or clinically significant findings would not imply that the program needs to be changed. Rather, future cohorts that did not show the same low CH/R risk factors at program entry may in fact show significant statistical and/or clinical results. Second, if the data were not an anomaly and all MP cohorts tend to show low risk at program entry, the program could shift focus away from chemical health and toward other outcomes such as psychosocial stressors or shift data collection to domains that more accurately reflect expected progress of the women in other domains that may not currently be reflected in the DCI. For the present research, data were not

available on patient program type, and it is possible that the MP patients were in fact in the latter stages of their treatment, such as aftercare or recovery maintenance, in which case they would truly show lower CH/R risk factors.

Further research on this program should examine patients' stage of recovery. Administrators could use this information to adapt their program to more accurately serve their unique populations.

Question 2 (Q2): How did the programs compare to each other on outcome indicator domains of interest (i.e. global functioning, psychosocial stressors, and chemical health/recovery)?

Global Assessment of Functioning.

The AAP program produced a significantly greater increase in patient Global Assessment of Functioning than did the MP program ($M = 10.76$ and $M = 7.29$, respectively). However, it would seem that the finding that all programs produced statistically significant pre-to-post increases in GAF supersedes the finding that the AAP and MP programs statistically differed. This finding highlights the excellent results of the AAP program, but should not take away from the MP program's significant increase of patients' GAF.

Psychosocial Stressors.

Comparatively speaking, the AAP program overall outperformed both of the other programs on alleviating psychosocial stressors. The likely reason for this finding is that the AAP patients reported via focus groups developing very strong bonds with each other and a deep sense of community, whereas patients from other programs did not emphasize those factors.. As a result, AAP patients became involved in each other's recovery process, and inspired each other to successfully complete their treatment. Another likely reason is the AAP program's heavy use of peer mentors and role modeling, both from within and outside the program.

In interpreting these comparative results, it should be noted that each program has a unique areas of focus: the AAP program emphasizes social skill and community development more than the other programs, whereas the HP program emphasizes personal growth in the form of emotional and

mental health, and the MP program focuses primarily on parenting skills and intra-family network building. The fact that the AAP program's main focus is on building a sense of community among African-Americans may be a key reason that program outperformed the other two on Psychosocial Stressors as measured by the DCI. Specifically, a direct link can be made between patients' sense of community and the DCI measured psychosocial stressors related to social support networks and social environments. Given that the other programs' areas of focus were not as well reflected on the DCI psychosocial domains, the current DCI may be less relevant as an outcome measure for the HP and MP. This in turn may explain why although all programs produced statistically significant pre-to-post psychosocial stressor decreases, the AAP program differed from the other two programs on this domain. It may appear 'better' only in that the outcome measure used was a better fit for the AAP.

Chemical Health/Recovery.

For the domain of Chemical Health/Recovery, the AAP program and HP program outperformed the MP program. However, this finding may be more of a statistical artifact than a true reflection of the programs. MP patients entered the program with lower CH/R scores than any other program. While the present research did not test to see if those scores were statistically lower, the fact that MP patients had the lowest CH/R risk factors may explain why the other programs statistically outperformed the MP program. Low entry scores for the CH/R domain prohibit statistical decreases in the amount of change produced. Therefore, the statistical differences in change produced by the AAP and HP programs may have been due simply to the low entry scores of the MP program.

Levels of Progress.

Comparatively speaking, the HP program produced higher Levels of Progress than the other two programs. However, progress scores for all programs ranged from 1.75 to 2.9, reflecting that all programs produced positive change.

Program Implications.

The overall conclusion from these collective findings is that all programs produced good progress in patients. The statistical differences found across programs for this domain are relatively less important than the finding that all programs produced very high levels of progress. Yet, the fact that the AAP program consistently produced the best results suggests that program administrators may look to that program to determine ways to improve the other programs.

For example, administrators could seek to foster a greater sense of community among patients of the other programs, which in turn may lead to better improvement in psychosocial stressors mediated by social support. However, it may be the case that sense of community is most applicable to a homogenous group such as patients in the AAP program. Either way, administrators would benefit from examining the AAP program as an exemplar for other programs, and applying some of the unique processes of that program to the other programs.

Lastly, given that the current DCI psychosocial outcome measure aligns best with the AAP, revisions to the measure incorporating domains pertinent to the other two programs are suggested. Findings from evaluations based on the revised measure would better elucidate if the AAP is truly performing better than the other two programs.

Question 3 (Q3): What were the process strengths of each program, as determined by focus groups for patients and staff?

All three programs were found to have unique strengths. The AAP program fostered a great deal of patient 'buy-in' and patients developed a strong sense of community, which in turn helped motivate patients through their treatment and to inspire each other to successfully complete the program. The MP program allowed patients' children to live with them, which provided a great deal of motivation for patients to successfully complete treatment. The HP program focused on increasing patients' emotional and mental health, which in turn helped patients develop their life skills and maintain chemical health.

However, despite distinctly different populations, there were a striking number of *common* strengths across programs. First, all programs strive to provide individualized treatment that is tailored to the unique needs of patients. Program staff pay very close attention to patient needs in order to *"meet the patient where they are at."* Patients recognize and appreciate the individualized treatment, and often cite it as one of the most important (if not *the most* important) contributing factor to their successful recovery. This finding mirrors that literature that describes how tailored treatments are more effective than traditional approaches (Jackson & Freitas, 1995; Bass & Jackson, 1997; Brown, Hill, & Giroux, 2004; Brown & Smith, 2006; Sue, 1998; Strada, Donohue, & Lefforge, 2006; Cosden & Cortez-Ison, 1999; Malcolm, 2004).

Second, all three programs heavily emphasize the importance of healthy, sober support networks and positive relationships, especially with family members. Patients learn to emphasize healthy social networks, and usually begin by forming networks amongst themselves. This phenomenon is most prominent in the AAP and MP programs. The formation of between-patient networks allows them to develop their interpersonal skills, build trust, and keeps patients invested not only in their own recovery, but the recovery of other patients. Patients described how when they were using substances, their relationships and networks were not supportive and unhealthy. Conversely, networks and relationships built in the program are likely to last beyond the program, and interpersonal skills and relationship-building skills can transfer to familial relationships. The described benefits of this process reflect the literature that deals with unique treatment factors of tailored treatments, and the importance of developing networks between patients with similar characteristics (i.e., race and ethnicity) (Jackson & Freitas, 1995; Bass, Jackson, 1997; Brown, Hill, & Giroux, 2004; Brown & Smith, 2006). Traditional approaches that do not account for unique population characteristics the way these programs do are not as effectively able to encourage personal growth in the form of building support networks, family ties, and healthy peer relationships, which are important steps in the recovery process and contributors to lasting sobriety and chemical health.

Third, similar to the emphasis on networks and relationships, all programs make a concerted effort to build mental and emotional health of patients. While this may be a factor common to both traditional and tailored treatments alike, the effects are perhaps magnified by the individualized treatment provided by these programs. For example, patients in the MP program described being able to better develop their emotional skills in an environment where they are surrounded by other females. This finding was mirrored to a lesser extent in the other programs. Emotional skills are common to all types of behavioral therapy models, but the results of the present research would seem to indicate that catering to specific populations the way these three programs have done enhances the ability of patients to more easily learn those skills when surrounded by other patients who have had similar life experiences (Jackson & Freitas, 1995; Bass, & Jackson, 1997; Brown, Hill, & Giroux, 2004, in Brown & Smith, 2006; Cosden & Cortez-Ison, 1999).

Finally, the agency strives to build self-sufficiency and life skills of all patients by providing patients more freedom than other agencies' programs, but also expecting more responsibility in return. Patients from all three programs embraced the responsibility, and used it to build their self-sufficiency and life skills for when the leave the program. Patients recognized that they were being given an opportunity to develop those skills, such as cooking, cleaning, and time management, and frequently took full advantage. Patients saw that becoming self-sufficient was the first step to leading a clean life, and embraced the challenge of taking charge of their lives again. The literature does not mention whether other programs—tailored or otherwise—allow patients the same combination of freedom and responsibility, so this strength may be entirely unique to this agency and these programs.

Program Implications.

Overall, statistical testing of the programs' outcome indicators revealed that all programs are generally doing well. Qualitative analysis of focus group data confirmed that the programs are providing effective treatment, but also provides program administrators with information regarding the process strengths that are leading to the quantitative results. They reveal the programs' unique areas of

focus, as well as commonalities across programs. Administrators can use these process strengths for future revision and replication planning of these programs. Specifically, they will know which parts of the programs are working most effectively, so as not to take away or hinder those strengths by potential program changes. By nature, qualitative process *strengths* do not directly identify areas where improvement is needed. Rather, the quantitative analysis in this report has identified some future topics that administrators could target to improve their already effective programs.

Limitations & Recommendations for Future Research

A limitation of the current study is that it relied on subjective, second-hand accounts of patient behavior. That is, program staff completed the DCI for patients at program entry and exit. There is no reason to believe that staff would not be able to provide an accurate account of patient functioning, but firsthand data directly from patients would have been preferred. The agency is currently involved in developing a DCI for patients to complete themselves, so future program evaluations and research are recommended to use this data in addition to that of the staff.

Additionally, the present research utilized only subjective data regarding patient attitudes and behaviors. Specific, objective data such as documented patient drug use (i.e. random urinalysis) or withdrawal reactions would have provided a more objective dimension to the research. Future evaluators and researchers are recommended to utilize a combination of subjective data such as that included in this report as well as objective data to provide a more complete representation of the outcomes of the treatment programs.

As a retrospective analysis of previously collected data, the researcher was not able to set methodological parameters. There was no comparison group, no random assignment of participants, and only a convenience sample, as compared to a randomly selected sample, was utilized for patient focus groups. This methodology was appropriate for this initial process evaluation study, but future examinations of these programs might consider a more rigorous approach. Doing so would increase the agency's ability to draw more generalizable conclusions about their programs. Note: the previous

discussion regarding randomly selecting individuals from within each program to participate in the focus group does not apply to selecting individuals for participation in any given treatment program. It should be understood that the nature of treatment programs that are tailored to gender or ethnicity prohibit any kind of random assignment.

Last, the qualitative analysis of focus group data was conducted singly by the researcher. Future evaluators and researchers are encouraged to analyze qualitative data using more than one person, to maximize the validity of findings.

Internal Validity

Overall, the internal validity for this research project was high. Primarily, this can be said to be due to a lack of plausible alternative explanations. First, the overwhelming majority of patients received inpatient services, and many did not have jobs or other activities that would have influenced the outcomes of the present research. There were few potential confounds to the present research. Patients were required to attend two meetings per week outside treatment provided by the agency—typically Alcoholics Anonymous, Narcotics Anonymous, etc. However, it can be reasonably speculated that since the vast majority of treatment received by patients was from the agency, it was the tailored programming and not the outside programs that influenced the outcomes. Second, although patients' scores on the Readiness to Change item in the Chemical Health/Recovery section of the DCI may indicate that they were highly motivated to increase their chemical health at program entry, and this alone could result in desired changes regardless of program efficacy, one can speculate that even if a patient is highly motivated to change, an efficacious treatment is still required to actually show desired results. One can imagine a patient who is highly motivated to change that enters a poorly run program. Although that patient wants to change, the ineffective treatment would interfere with the patient's recovery. Therefore, good scores at program entry for Readiness to Change are not considered confounds. Rather, the combination of an effective, well-run treatment is complemented and enhanced by patients' readiness to change in order to produce desired results and increased chemical health.

There are several options that could increase internal validity for future research on these programs. A control group or equivalent group would provide a comparison opportunity to see if the results produced by these programs were in fact caused by the programs themselves. However, budgetary constraints may prohibit this design. Additionally, by nature of a tailored treatment program, the recipients of each program are unique, and comparison groups may be difficult to establish. Finally, internal validity would be enhanced if quantitative data were collected from both patients and staff. As mentioned previously, the agency is currently developing a Data Collection Instrument for patients. Therefore, future evaluations and research on these programs will show elevated internal validity. Overall, the lack of plausible alternative explanations and limited potential confounds indicate that the positive results shown by the programs were caused by program activities.

External Validity

As the present research is only focused on these specific programs, no attempt at generalizing to other programs at other locations will be made. However, in terms of generalizing to other cohorts of the same program, the external validity for the present study is high. Based on demographic information of the patients and standard treatment procedures, there is no reason to expect that other cohorts in these programs will show significantly different aggregate scores.

Yet, the nature of the individualized treatment raises several considerations for future cohorts. Individual differences such as age, drug of choice, and referral type all affect a patient's treatment. Given that these programs make a concerted effort to meet each client where they are and provide specific resources and treatment for that individual, it is expected that each future cohort will have unique individuals in it that all require specific attention. Generalizability, even to future cohorts, is thus somewhat limited with programs that are highly specific such as these. However, the tailored nature of the programs is also such that although treatment is individualized, patients will likely have more similarities than differences. Therefore, it is expected that future cohorts of these programs will continue to show positive results and increases in chemical health.

Concluding Remarks

Overall, all three programs were shown to be effective in providing tailored drug abuse treatment. All programs showed significant decreases in patients' psychosocial stressors, and two of the three programs (AAP and HP) showed significant decreases in chemical health risk factors. While the MP program did not show statistically significant decreases in that area, the program generally produced change in the desired direction. All three programs can use the findings from this research to set goals for future interventions, and learn which areas can be targeted for improvement.

Qualitative reports showed that all programs have a unique set of strengths, but also that the programs share many process strengths. The AAP program fosters patient buy-in and a strong sense of community among patients, the MP program teaches patients effective parenting skills and the importance of healthy support networks, and the HP program improves patient emotional and mental health by giving patients tools such as anger management and problem solving skills to increase their emotional health. Common strengths included individualized treatment, staff that are genuinely invested in patients' recovery, an emphasis on family and healthy support networks, and preparing patients for life outside of treatment. These common process factors were perceived by patients and staff as highly salient for providing effective, patent-focused treatment.

The findings from the present research emphasize that substance abuse treatment programs tailored to a specific population are effective and beneficial to patients in a variety of unique ways. Populations such as specific ethnicities, mothers and pregnant women, and homeless individuals all have unique needs that can be better addressed by tailored interventions than traditional approaches.

Extrapolating from this study's findings, it appears that the more tailored the treatment, the more positive the outcomes. Specifically, the AAP program is perhaps the most client-tailored program of the three. That is, the MP and HP programs are comprised of patients of a variety of ethnicities, but the AAP program has only African-American patients. The AAP program also best showed consistent positive results. A causal link cannot be made from these findings, but perhaps future program

evaluations could test this hypothesis. It is known that the agency is currently providing or has plans to provide other, highly specialized programming to specific populations. Such programs can likely be expected to produce very positive outcomes, and are highly encouraged.

Overall, based on the results of the previous program evaluation and this cross-program analysis, the agency appears to be providing beneficial substance dependent treatment services to populations that frequently are underserved. Future programs provided by the agency that serve other populations are anticipated, and the AAP, MP, and HP programs should serve as a model for other agencies seeking to provide tailored substance abuse treatment.

References

* indicates study included in meta-review

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

Bass, L., & Jackson, M. S. (1997). A study of drug-abusing African-American pregnant women. *Journal of Drug Issues, 27*(3), 659-671.

Blankertz, L. E., Cnaan, R. A., & Freedman, E. (1993). Childhood risk factors in dually diagnosed homeless adults. *Social Work, 38*(5), 587-596.

Blume, S., & Zilberman, M. (2005). Addictive disorders in women. In R. Frances, S. Miller, and A. Mack. (Eds.), *Clinical textbook of addictive disorders* (pp. 437-453). New York: The Guilford Press.

Brown, E. J., & Smith, F. B. (2006). Drug (ab)use research among rural African American males: An integrated literature review. *International Journal of Men's Health, 5*(2), 191-206.

*Burke, B. L., Arkowitz, H., & Menchola, M. (2003). The efficacy of motivational interviewing: A meta analysis of controlled clinical trials. *Journal of Consulting and Clinical Psychology, 71,* 843-861.

*Carroll, K. M., Fenton, L. R., Ball, S. A., Nich, C., Frankforter, T. L., Shi, J., et al. (2004). Efficacy of disulfiram and cognitive behavior therapy in cocaine-dependent outpatients. *Archives of General Psychiatry, 61,* 264-272.

Cosden, M., & Cortez-Ison, E. (1999). Sexual abuse, parental bonding, social support, and program retention for women in substance abuse treatment. *Journal of Substance Abuse Treatment, 16*(2), 149-155.

*Finney, J. W., & Moos, R. H. (1998). Psychosocial treatments for alcohol use disorders. In P. E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (pp. 156-166). New York: Oxford University Press.

Franklin, J., & Markarian, M. (2005). Substance abuse in minority populations. In R. Frances, S. Miller, and A. Mack. (Eds.), *Clinical textbook of addictive disorders* (pp. 321-339). New York: The Guilford Press.

Gil, A. G., Wagner, E. F., & Tubman, J. G. (2004). Culturally sensitive substance abuse intervention for Hispanic and African American adolescents: empirical examples from the alcohol treatment targeting adolescents in need (ATTAIN) project. *Addiction, 99*(Suppl. 2), 140-150.

Hansell, J., & Damour, L. (2005). *Abnormal Psychology.* Hoboken, NJ: John Wiley & Sons, Inc.

Harwood, H. (2000). *Updating estimates of the economic costs of alcohol abuse in the United States: Estimates, update methods, and data* [Report prepared by the Lewin Group for the National Institute on Alcohol Abuse and Alcoholism]. Washington, DC: U.S. Department of Health & Human Services.

*Herd, D. (1995). The impact of region and urbanization on African American drinking patterns: Results from a national survey. *Contemporary Drug Problems, 22,* 453-481.

*Jackson, M., & Freitas, F. (1995). Nurturing patent education: A program for African-American families. Fresno: California State University, unpublished master's thesis.

*Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshelman, S., Wittschen, N. U., & Kendler, K S. (1994). Lifetime and 12 month prevalence of DSM-III-TR psychiatric disorders in the United States results from the National Comorbidity Survey. *Archives of General Psychiatry, 51,* 8-19.

Krueger, R. A., & Casey, M. (2000). *Focus groups: A practical guide for applied research, 3rd edition.* Thousand Oaks, CA, Sage Publications

Lev-Wiesel, R., & Shuval, R. (2006). Perceived causal and treatment factors related to substance abuse: Gender differences. *European Addiction Research, 12*, 109-112.

Malcolm, B. P. (2004). Evaluating the effects of self-esteem on substance abuse among homeless men. *Journal of Alcohol & Drug Education, 48*(3), 39-61.

*Marijuana Treatment Project Research Group (2004). Brief treatments for cannabis dependence: Findings from a randomized multisite trial. *Journal of Consulting and Clinical Psychology, 72,* 445-466.

Martens, M. P., Neighbors, C., & Lee, C., Substance abuse prevention and treatment. In S. D. Brown and R. W. Lent (eds.) *Handbook of Counseling Psychology* (4th ed.) (pp. 552-569). Hoboken, NJ: John Wiley & Sons.

*Miller, W.R., Andrews, N. R., Wilbourne, P., & Bennett, M. E. (1998). A wealth of alternatives: Effective treatments for alcohol problems. In W. R. Miller & N. Heather (Eds.), *Treating addictive behaviors* (2nd ed., pp. 203-216). New York: Plenum Press.

Nace, E. (2005). Alcohol. In R. Frances, S. Miller, and A. Mack. (Eds.), *Clinical textbook of addictive disorders* (pp. 75-104). New York: The Guilford Press.

National Institute on Drug Abuse (2008). *Understanding drug abuse and addiction.* Retrieved November 29, 2009 from http://www.nida.nih.gov/PDF/InfoFacts/Understanding08.pdf

National Institute on Drug Abuse. (2009). *Treatment approaches for drug addiction.* Retrieved November 29, 2009 from http://www.nida.nih.gov/PDF/InfoFacts/IF_Treatment_Approaches_2009_to_NIDA_92209.pdf

Office of National Drug Control Policy. (2004). *The economic costs of drug abuse in the United States, 1992-2002.* Washington, DC: Executive Office of the President (Publication no. 207303).

Strada, M. J., Donohue, B., & Lefforge, N. L. (2006). Examination of ethnicity in controlled treatment outcome studies involving adolescent substance abusers: A comprehensive literature review. *Psychology of Addictive Behavior, 20*(1), 11-27.

Substance Abuse and Mental Health Services Administration. (2009). *Results from the 2008 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-36, HHS Publication No. SMA 09-4434). Rockville, MD.

*Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist, 53,* 440-448.

Wilder Research. (2007). Overview of homelessness in Minnesota 2006: Key facts from the statewide survey. Retrieved December 11, 2009 from http://www.wilder.org/download.0.html?report=1963.

Appendix A: AAP Logic Model

Program Goal:
To provide culturally appropriate chemical health treatment access, treatment support, and recovery maintenance services to the Twin Cities chemically –dependent African American community using evidenced-based practices.

Program Theory: *What guides your program? What do you value in your work?*
Recovery Resource Center operates services and guides the recovery process for participants utilizing Stages of Change and Systems Theory.

Values/ Assumptions: *What are the beliefs you have about the program? How and why are program activities expected to lead to the desired outcomes?*

- ✓ *If participants receive recovery maintenance and support services, then participants are more likely to increase their chemical health and quality of life.*
- ✓ *If participants receive evidence-based/ best-practice services (motivational interviewing), then participants will increase their success at recovery maintenance (i.e. achieving their individual goal plans).*
- ✓ *If participants receive services that are culturally specific/ culturally-appropriate, then participants are more likely to remain in services therefore increasing recovery maintenance skills.*
- ✓ *If participants receive individualized, comprehensive services (peer support, domestic violence education, participate in cultural activities, motivational incentives, individual counseling, group counseling, urinalysis, etc), then participants are more likely to increase their chemical health and quality of life.*

Who	Program Goals:	Strategies	Impact
Chemically dependent African American men and women	• Increase treatment access for chemically-dependent, adult African Americans in need of treatment; • Improve retention in chemical health services for chemically-dependent, adult African Americans via culturally-appropriate, evidenced-based services; • Increase treatment completion rates for chemically-dependent, adult African Americans in Minnesota.	• Treatment support & recovery maintenance, including individual and group counseling with motivational interviewing • Peer-to-Peer recovery and support and cultural celebration • Violence prevention and healthy relationships • Recovery incentives	• Clients will receive ongoing, culturally appropriate recovery maintenance and support services; • Clients will reduce their chemical use and increase their sobriety; • Clients will increase their recovery maintenance and life skills; • Clients will develop alternative behaviors and choices to violence and chemical use; • Clients will experience increased peer recovery support.

Appendix B: MP Logic Model

Program Goals:

1. To reduce barriers to recovery by providing sober housing and sobriety maintenance services;
2. To increase the client's self-sufficiency by:
   - Stabilizing their living environment,
   - Helping them gain financial stability and security and,
   - Reducing their involvement with government systems;
3. To increase the client's quality of life by:
   - Improving their mental and physical health,
   - Fostering the development of social networks and,
   - Developing the client's life management skills.

Values: *What guides your program? What do you value in your work?*
Our Mission: "MP empowers people to achieve greater personal, social, and economic success."
Our Commitment: "We are committed to undoing racism and promoting diversity."
Our Promise to participants: "We meet you where you are." "We hear you and understand your needs." "We help you discover your potential and achieve your dreams."
Our qualities: "Welcoming, Dedicated, Visionary, Trusted"
Tagline: "Discover your potential…Achieve your dreams"

Assumptions: *What are the beliefs you have about the program? How and why are program activities expected to lead to the desired outcomes?*

- If the participants receive ongoing, open-ended case management then they will receive more consistent services that will reduce barriers to recovery, and increase self-sufficiency and quality of life.
- If the participants receive employment services then they will be more likely to attain and maintain employment that will lead to an increase in self-sufficiency and reduce barriers to recovery.
- If the participants receive housing services then they will be more likely to obtain stable and sober housing that will lead to an increase in self-sufficiency and reduce barriers to recovery.
- If the participants take part in therapeutic and behavioral groups then they will develop the tools to prevent a relapse in drug use, increase their life skills and develop knowledge of community resources that will increase self-sufficiency, reduce barriers to recovery and increase quality of life.
- If the participants are given increased access to services by being provided transportation, child care and culturally specific services then they will be more likely to remain in the program which will reduce barriers to recovery.
- If the participants receive additional support services such as parent and child development education, prostitution recovery services, and nutritional education then they will be more likely to make changes that will lead to an increase in both self-sufficiency and quality of life.
- If participants take part in family and individual counseling then they will be more likely to report an improvement in mental health status which will lead to an increase in their quality of life.

Who	Process	Outcomes	Impact
Who do you want to impact? *Who will benefit?*	*How do you expect to bring about the intended changes? What are the key activities that will be carried out?*	*What changes do you hope to bring about as a result of the activities? What do you want to achieve?*	*What lasting impact do you hope to have?*
MP participants: **- substance abusing pregnant women & women with dependent children** **- substance abusing women and men offenders & ex-offenders** **- substance abusing women and men with co-occurring mental and chemical health issues**	*Reduce Barriers to Recovery:* - Case management: Provide one-on-one advocacy, assessment, goal planning, services/resources coordination, referrals and individual counseling; - Employment services: Provide job-seeking skills such as resume development, handling questions of long histories of unemployment, and networking; - Housing services: Provide referral and coordination of services, and sober housing; - Increased access to services: Provide transportation, child care, and culturally specific services; - Therapeutic and behavioral support groups: Provide groups on life-skills and relapse prevention, as well as individual or group counseling. *Increase Client's Self-Sufficiency:* - Case management: Provide one-on-one advocacy, assessment, goal planning, services/resources coordination, referrals and individual counseling; - Employment services: Provide job-seeking skills such as resume development, handling questions of long histories of unemployment, and networking; - Housing services: Provide referral and coordination of services, and sober housing; - Therapeutic and behavioral support groups: Provide groups on life-skills and relapse prevention, as well as individual or group counseling; - Additional support services: Provide parenting and child development education, prostitution recovery, and domestic abuse recovery.	✓ **Increased chemical health** ✓ **Increased mental health** ✓ **Increased Accessibility to recovery maintenance services** ✓ **Increased participation in support networks for recovery** ✓ **Improved relationships with significant others & family members** ✓ **Decreased involvement in government systems**	**1. Reduced Barriers to Recovery** **2. Increased Client's Self-Sufficiency** **3. Increased Client's Quality of Life**

Who	Process	Outcomes	Impact
Who do you want to impact? Who will benefit?	*How do you expect to bring about the intended changes? What are the key activities that will be carried out?*	*What changes do you hope to bring about as a result of the activities? What do you want to achieve?*	*What lasting impact do you hope to have?*
	Increase Client's Quality of Life: - Case management: Provide one-on-one advocacy, assessment, goal planning, services/resources coordination, referrals and individual counseling; - Therapeutic and behavioral support groups: Provide groups on life-skills and relapse prevention, as well as individual or group counseling; - Additional support services: Provide nutrition education, parenting, HIV/AIDS prevention, - Family programming.	✓ **Increased access to stable housing**	

Appendix C: HP Logic Model

Program Goal:
The goal of HP is to reduce homelessness and increase access to recovery maintenance services to Twin Cities chronically chemically dependent and homeless.

Values: *What guides your program? What do you value in your work?*
Recovery Resource Center operates services and guides the recovery process for participants utilizing Stages of Change and Systems Theory.

Assumptions: *What are the beliefs you have about the program? How and why are program activities expected to lead to the desired outcomes?*

- ✓ *If participants receive recovery maintenance and support services, then participants are more likely to increase their chemical health, reduce homelessness, and quality of life.*
- ✓ *If participants receive evidence-based/ best-practice services (motivational interviewing), then participants will increase their success at recovery maintenance (i.e. achieving their individual goal plans).*
- ✓ *If participants receive individualized, comprehensive services (peer support, housing, motivational incentives, individual counseling, group counseling, urinalysis, etc), then participants are more likely to increase their chemical health and quality of life.*

Who	Program Goals:	Strategies	Impact
Chemically dependent homeless men and women with previous attempts at recovery	• Reduce chronic homelessness among participants; • Increase accessibility to services for recovery from mental health and chemical health disorders; • Increase participant self-sufficiency (in social and economic functioning; reduced hospitalizations; reduced legal involvement); • Improve the quality of life, and mental and chemical health of the participants.	• Open-ended and individualized services; • Comprehensive chemical and mental health services; • Staff representation of the target population; • Incentives for evaluation participation, follow-up, program involvement, and providing contact information	• Clients will improve their maintenance of stable housing; • Clients will reduce their chemical use and increase their sobriety; • Clients will increase their recovery maintenance and life skills; • Clients will improve their mental health.

Appendix D: AAP Patient Focus Group Script

Introduction

- Thank participants for their willingness to participate in the evaluation.
- Set ground rules (please don't be offended if we have to limit some comments; we want to make sure that everyone gets a chance to be heard)
- The purpose of this discussion is to learn more about their involvement and identify ways to improve the programs at [the agency].
- Assure confidentiality and encourage participants to be as honest as possible.
- Inform them that you will be recording their comments.
- Ask participants if they have any questions.

Opening Questions

- Let's go around the room and have everyone share their first name; I will go first.
- Please give me a few words that come to mind when you think about AAP (these words may be positive, negative, or neutral).

Key Questions

a. How did you learn about AAP?
   - What would your recovery be like if you hadn't been able to access services with [the agency]?
   - How is AAP different than other programs?

b. Which services or topics were the most helpful for you in……
   1. Reducing your chemical use?
   2. Improving your recovery maintenance skills?
   3. Improving life skills?
   4. Developing alternative behaviors for violence and chemical use?
   5. Improving peer support?

c. How has AAP influenced your level of sobriety/ recovery/ abstinence?
   - How have you used what you have learned since leaving the program?
   - What successes have you had? How did the agency program help with that?
   - What challenges did/do you face? How has the agency program supported you though those challenges?

d. What impacts have any the following AP services had on your recovery? Can you give me any examples?
   1. individual counseling
   2. group support/ education
   3. cultural celebration/ education
   4. domestic violence education
   5. incentives
   6. peer mentor program

e. Overall, would you encourage others who could benefit from AAP to come here? What would you tell them about the program?

f. What advice would you give to make the program better? Is there anything that you don't think should be changed?

- Do you have any feedback regarding recovery maintenance? Do you have any advice to make recovery maintenance better? Is there anything that shouldn't be changed?

g. How effective has the AAP program been at meeting the unique needs of African Americans in recovery? Why or why not?

Closing

- Thank participants for their valuable comments.
- Assure participants the information will be used.
- Repeat the issue of confidentiality.
- Ask participants again if they have any questions.

Appendix E: AAP Staff Focus Group Script

Introduction

- Thank staff for their willingness to participate in the evaluation.
- The purpose of this discussion is to learn more about their involvement and identify ways to improve the programs at [the agency].
- Assure confidentiality and encourage staff to be as honest as possible.
- Set ground rules (We have limited time, so please don't be offended if we feel it's time to move on. We want to make sure that all voices are heard during the focus group.)
- Inform staff that you will be recording their comments, but voice recording will be used only to prepare summary and will be destroyed after summary has been completed.
- Ask staff if they have any questions.

Opening Questions

- Let's go around the room and have everyone share their first name and role with these two programs; I will go first.
- Please give me a few words that come to mind when you think about the AAP program (these words may be positive, negative, or neutral).

Key Questions

Context for the Focus Group Questions	
Intended Outcomes (as identified in the Logic Model): To what extent does the program aide in the following: 1. Receipt of culturally appropriate recovery maintenance and support services? 2. Reduced chemical use and increase their sobriety? 3. Increased their recovery maintenance and life skills? 4. Increased development of alternative behaviors and choice to violence and chemical use? 5. Increase peer recovery support? Value Oriented Evaluation 6. Commitment to undoing racism and promoting diversity? Process Evaluation 7. Process Oriented Questions	
Suggested Focus Group Questions	**Outcome**
a. How does the provision of culturally appropriate service to African American men and women with chemical dependency, though the AAP program impact client's recovery?	1
b. How does motivational interviewing contribute to the recovery process?	1
c. How does the program reduce client's chemical use and increase sobriety? If not, why not?	2
d. What impact have any the following AAP services had on the development of recovery maintenances skills for clients? 7. individual counseling 8. group support/ education 9. cultural celebration/ education 10. domestic violence education 11. incentives 12. peer mentor program	2,4,5
e. Does promoting diversity at the agency impact client recovery and abstinence? If so, how? If not, why not?	6
f. In what ways does the AAP program have impact on the client's quality of life? Please share any examples that come to mind.	*

g.	What needs to change within the AAP program to better meet the needs of the clients?	5
h.	Overall, what are the most beneficial parts of the program?	5

Closing

- Thank staff for their valuable comments.
- Assure staff the information will be used.
- Repeat the issue of confidentiality.
- Ask staff again if they have any questions.

Appendix F: MP Patient Focus Group Script

Introduction

- Thank participants for their willingness to participate in the evaluation.
- Set ground rules (please don't be offended if we have to limit some comments; we want to make sure that everyone gets a chance to be heard)
- The purpose of this discussion is to learn more about their involvement and identify ways to improve the programs at [the agency].
- Assure confidentiality and encourage participants to be as honest as possible.
- Inform them that you will be recording their comments.
- Ask participants if they have any questions.

Opening Questions

- Let's go around the room and have everyone share their first name; I will go first.
- Please give me a few words that come to mind when you think about MP (these words may be positive, negative, or neutral).

Key Questions

Outcome Evaluation

As a result of the MP program, did clients experience:

8. Increased Accessibility to Recovery Maintenance Services?
9. Improved Chemical Health?
10. Improved Mental Health?
11. Increased Self-Sufficiency?
12. Increased Quality of Life?

Process Evaluation

13. Process Oriented Questions

Focus Group Questions	Number
h. How did you learn about the agency? How long after you heard about the agency did it take you to access their services? Was it easy for you to access the agency's services?	1, 6
i. Which services or topics are the most helpful for you at the agency?	1, 6
j. Has the MP program influenced your level of abstinence? If so, how?	2
k. Think back to what your relationship was like with your children before you came to MP, what was it like then? What is your relationship with them like now? How have your parenting skills changed since your entered the program (if any change at all)?	4, 5
l. Has the MP program influenced your physical, mental, or chemical well-being? If so, in what way? **Probes**: • Have things gotten better or worse in your personal life since you started the program at MP? • Has the MP program made a difference in your housing status? • Have you been successful in your employment search?	2, 3, 4, 5
m. Overall, would you encourage others who could benefit from MP to come here? What would you tell them about MP?	6
n. What advice would you give to make the program better? Is there anything that you don't think should be changed? • Do you have any feedback regarding recovery maintenance? Do you have any advice to make recovery maintenance better? Is there anything that shouldn't be changed?	6

Closing

- Thank participants for their valuable comments.
- Assure participants the information will be used.
- Repeat the issue of confidentiality.
- Ask participants again if they have any questions.

Appendix G: MP Staff Focus Group Script

Introduction

- Thank staff for their willingness to participate in the evaluation.
- The purpose of this discussion is to learn more about their involvement and identify ways to improve the programs at [the agency].
- Assure confidentiality and encourage staff to be as honest as possible.
- Set ground rules (We have limited time, so please don't be offended if we feel it's time to move on. We want to make sure that all voices are heard during the focus group.)
- Inform staff that you will be recording their comments.
- Ask staff if they have any questions.

Opening Questions

- Let's go around the room and have everyone share their first name and role with these two programs; I will go first.
- Please give me a few words that come to mind when you think about the MP program (these words may be positive, negative, or neutral).

Key Questions

Context for the Focus Group Questions	
Intended Outcomes (as identified in the Logic Model): To what extent do the two programs aide in the following: 14. Reduced barriers to recovery by providing sober housing and sobriety maintenance services? 15. Increased Self-Sufficiency? 16. Increased Quality of Life? Value Oriented Evaluation 17. Commitment to undoing racism and promoting diversity Process Evaluation 5. Process Oriented Questions	
Suggested Focus Group Questions	**Outcome**
i. Does the MP program increase the client's self-sufficiency? If so, how? If not, why not?	2
j. Do you believe that program helped clients to do the following: • Stabilize their living environment? • Gain financial stability and security? • Reduce their involvement with government systems? • If yes, how so? If not, why not?	2
k. Does the program increase the client's quality of life? If so, how? If not, why not?	3
l. Do you believe that the program helped clients to do the following: • Improve their mental and physical health? • Improve their chemical health? • Foster the development of social networks? • Develop their life management skills?	3
m. Does promoting diversity at the agency impact client recovery and abstinence? If so, how? If not, why not?	4
n. What are some of the barriers to recovery (if any) that you perceived among the clients in this program?	1
o. Is providing sober housing and recovery maintenance an effective way to reduce barriers to recovery? Please say why you believe it to either be effective or not effective.	1

p.	Overall, what are the most beneficial parts of the program? What are the least beneficial parts of the program?	5

Closing

- Thank staff for their valuable comments.
- Assure staff the information will be used.
- Repeat the issue of confidentiality.
- Ask staff again if they have any questions.

Appendix H: HP Patient Focus Group Script

<u>Introduction</u>

- Thank participants for their willingness to participate in the evaluation.
- Set ground rules (please don't be offended if we have to limit some comments; we want to make sure that everyone gets a chance to be heard).
- The purpose of this discussion is to learn more about their involvement and identify ways to improve the programs at [the agency].
- Assure confidentiality and encourage participants to be as honest as possible.
- Inform them that you will be recording their comments.
- Ask participants if they have any questions.

Opening Questions

- Let's go around the room and have everyone share their first name; I will go first.
- Please give me a few words that come to mind when you think about HP (these words may be positive, negative, or neutral).

Key Questions

a. How did you learn about HP?
   - What would your recovery be like if you hadn't been able to access services with HP?
   - How is HP different from other programs?

b. Which services or topics had the most positive impact on your....
   1. Ability to maintain stable housing?
   2. Chemical health?
   3. Mental health?
   4. Recovery maintenance skills?
   5. Life skills? (managing finances, family relationships, employment)

c. Please tell me about your housing situation. How has HP helped you maintain stable housing?
   - What has HP taught you to do to help you to maintain your housing?
   - What would you describe to be the biggest contributor in maintaining your housing at HP and/or in the community? Please explain.

d. How has the HP program influenced your recovery/ sobriety?
   - How has the HP program supported you in maintaining your sobriety? Can you give us any examples?
   - Have you maintained your sobriety? What struggles do you have?

e. How has HP influenced your mental health?
   - What has HP taught you about your ability to manage/improve your mental health?

f. How has your <u>quality of life changed</u> since participating in the family program?
   - How as participating in the HP program made a difference in your self-sufficiency?
   - How has participating in the HP program impacted your <u>personal life</u>
   - How has the HP program impacted your <u>employment search</u>? Have you been successful?

g. Overall, would you encourage others who could benefit from HP to come here? What would you tell them about HP?

h. How effective is this program at helping individuals who have a history of chemical dependency and homelessness? Tell us why you feel that way.

<u>Closing</u>

- Thank participants for their valuable comments.

- Assure participants the information will be used.
- Repeat the issue of confidentiality.
- Ask participants again if they have any questions.

Appendix I: HP Staff Focus Group Script

Introduction

- Thank staff for their willingness to participate in the evaluation.
- The purpose of this discussion is to learn more about their involvement and identify ways to improve the HP program.
- Assure confidentiality and encourage staff to be as honest as possible.
- Set ground rules. (We have limited time, so please don't be offended if we feel it's time to move on. We want to make sure that all voices are heard during the focus group.)
- Inform staff that you will be recording their comments, but voice recording will be used only to prepare summary and will be destroyed after summary has been completed.
- Ask staff if they have any questions.

Opening Questions

- Let's go around the room and have everyone share their first name and role with the program; I will go first.
- Please give me a few words that come to mind when you think about the HP program (these words may be positive, negative, or neutral).

Key Questions

Context for the Focus Group Questions	
Intended Outcomes (as identified in the Logic Model): To what extent does the program aide in the following: 18. Improved maintenance of stable housing? 19. Increased chemical and mental health? 20. Increased recovery and life skills? Value Oriented Evaluation 21. Commitment to undoing racism and promoting diversity Process Evaluation 6. Process Oriented Questions	
Suggested Focus Group Questions	**Outcome**
q. How does the HP program reduce chronic chemical dependency? How does the HP program reduce chronic homelessness?	1
r. How does motivational interviewing contribute to the recovery process?	
s. How does the HP program help clients do the following: • Increase accessibility to recovery maintenance services? • Stabilize client living environment? • Increase awareness or utilization of alternatives to chemical use? • Develop their life/ recovery management skills?	2
t. How does the program increase the client's recovery maintenance?	3
u. How does promoting diversity at the agency impact client recovery and abstinence? If not, why not?	4
v. What are some to the barriers to recovery (if any) that you perceived among the clients in this program? How does the HP program address them?	1,2,3
w. In what ways does the HP program have impact on the client's quality of life? Please share any examples that come to mind.	
x. What needs to change within the HP Program to better meet the needs of the clients?	5
y. Overall, what are the most beneficial parts of the program?	5

Closing

- Thank staff for their valuable comments.
- Assure staff the information will be used.
- Repeat the issue of confidentiality.
- Ask staff again if they have any questions.

Appendix J: Data Collection Instrument (Pre-Post Assessment)

(Completed by agency Counselor/ Case Manager)
Client Information
Client: First Name:______________________
Last Name:___________________________

Gender: ____ Male ____ Female ____ Transgender

Counselor/ Case Manager: ________________________________

Program Information
Treatment Recovery Maintenance
_____ Relapse Prevention
_____ Integrated Dual Diagnosis
_____ Drug Court
_____ Family Treatment
_____ AAP
_____ HP
_____ MP
_____ Aftercare Plus
_____ USPO/ BOP
_____ Other(____________________________________)

Length of Involvement
Date of Entry: __ __/ __ __/ __ __ __ __ Date of Exit: : __ __/ __ __/ __ __ __ __

Global Functioning (from DSM-4-TR) Please refer to GAF chart
At Entry____________ At Exit ____________

Psychosocial stressors (from DSM-4-TR) Rate each stressor by the following rating system:
0=No Problem 1=Minimal 2=Some 3=Moderate 4=Significant 5=Severe Problem
AT ENTRY
____Problems with primary support group
____Social problems related to the social environment
____Educational problems
____Occupational problems
____Housing problems
____Economic problems
____Problems with access to health care services
____Problems related to interaction with the legal system/crime
____Other (please list:_____________________)

AT EXIT
____Problems with primary support group
____Social problems related to the social environment
____Educational problems
____Occupational problems
____Housing problems
____Economic problems
____Problems with access to health care services
____Problems related to interaction with the legal system/crime
____Other (please list:______________________)

Chemical Health/ Recovery (from ASAM Criteria)
0=No Risk 1=Low Risk 2=Moderate Risk 3=High Risk 4= Severe Risk
ENTRY EXIT
Dimension 1: Acute Intoxication and/or Withdrawal Potential
Dimension 2: Biomedical Conditions and Complications
Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications
Dimension 4: Readiness to Change
Dimension 5: Relapse/Continued Use Potential
Dimension 6: Recovery Environment

Overall Progress...At Exit from the Program
Discharge Status:
____ Completed
____ Patient Left / AWOL
____ Staff Request
____ Other (____________________________________)

At EXIT, based on clinical impression, rate the client's overall level of progress/ improvement in each of the following areas:
Level of Progress/ Improvement No Progress Low Progress Moderate Progress High Progress Non-Applicable*

Increased Sobriety/ Chemical Health 3 2 1 0 88
Increased Recovery Skills 3 2 1 0 88
Improved Mental Health 3 2 1 0 88
Improved Legal Status (increased compliance with legal system; less legal problems) 3 2 1 0 88
Maintaining Safe Housing 3 2 1 0 88
Improved Relationships with primary support system 3 2 1 0 88
Developing/ Maintaining Support Network 3 2 1 0 88
*Non -Applicable indicates the identified area was NOT an issue for the client.

Comments (add any comments that may relate to the feedback you provided regarding the client)