An exploratory study of the relationship between client satisfaction and length of stay in a residential substance abuse treatment facility

Kamesha D. Milline-Cardenas
CLARK ATLANTA UNIVERSITY

Follow this and additional works at: http://digitalcommons.auctr.edu/dissertations

Recommended Citation
http://digitalcommons.auctr.edu/dissertations/3483

This Thesis is brought to you for free and open access by DigitalCommons@Robert W. Woodruff Library, Atlanta University Center. It has been accepted for inclusion in ETD Collection for AUC Robert W. Woodruff Library by an authorized editor of DigitalCommons@Robert W. Woodruff Library, Atlanta University Center. For more information, please contact cwiseman@auctr.edu.
THESIS TRANSMITTAL FORM

Name of Student  KAMESHA D. MILLINE-CARDENAS

Title of Thesis  AN EXPLORATORY STUDY OF THE RELATIONSHIP BETWEEN  
CLIENT SATISFACTION AND LENGTH OF STAY IN A RESIDENTIAL  
SUBSTANCE ABUSE TREATMENT FACILITY

We the undersigned members of the Committee advising this thesis/dissertation  
have ascertained that in every respect it acceptably fulfills the final requirement for the  
degree of  M.S.W. in the Whitney M. Young, Jr., School of Social Work.

Hattie M. Mitchell  
Major Advisor

Social Work  
Department

Date

Name  
Date

Name  
Date

As Chair of the Department of the Master’s Program in Social Work I have  
verified that this manuscript meets the School’s/Department’s standards of form and  
content governing thesis or dissertations for the degree sought.

Bernice W. Liddie-Hamilton  
Chair

Date

As Dean of the School of the Whitney M. Young, Jr., School of Social Work I  
have verified that this manuscript meets the School’s regulations governing the content  
and form of thesis or dissertations.

Doreas D. Bowles  
Dean

Date

As Dean of Graduate Studies I have verified that this manuscript meets the  
University’s regulations governing the content and form of thesis.

William H. Beall  
Dean of Graduate Studies

Date
ABSTRACT

SOCIAL WORK

MILLINE-CARDENAS, KAMESHA D.  B.A., UNIVERSITY OF GEORGIA, 1993

AN EXPLORATORY STUDY OF THE RELATIONSHIP BETWEEN CLIENT SATISFACTION AND LENGTH OF STAY IN A RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY

Advisor: Hattie M. Mitchell, M.S.W.

Thesis dated May, 2002

The overall objective of this study was to examine if there was a direct correlation between client satisfaction with substance abuse treatment received and length of stay in the program. To obtain this objective, sixty clients in an all female nine month residential treatment facility were administered a standardized Likert-scale consumer satisfaction survey. From January 2001 to January 2002, clients at the NIA Project with one month, three months, six months, and nine months length of stay were tested utilizing a sample of convenience. The variables were measured using descriptive statistics, frequency distribution, Chi-Square and cross-tabulation analysis. The study was an attempt to ascertain if patient satisfaction with service delivery affected retention and completion rates. It was determined that there was no statistically significant relationship between client satisfaction with services received and length of stay in treatment.

Supportive information also provided to determine correlation between consumer satisfaction and length of stay included: defining treatment success, reviewing
precipitation factors to treatment failure, and defining what constitutes treatment satisfaction. Due to the multifaceted problems presented by this particular population all other contributable factors could not be controlled for. Additional limitations and implications for social work practice also considered.
AN EXPLORATORY STUDY OF THE RELATIONSHIP BETWEEN CLIENT
SATISFACTION AND LENGTH OF STAY IN A RESIDENTIAL
SUBSTANCE ABUSE TREATMENT FACILITY

A THESIS
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY
KAMESHA D. MILLINE-CARDENAS

WHITNEY M. YOUNG, JR., SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA
MAY 2002
CLARK ATLANTA UNIVERSITY THESIS
DEPOSITED IN THE ROBERT W. WOODRUFF LIBRARY

STATEMENT OF UNDERSTANDING
In presenting this thesis as a partial fulfillment of the requirements for an advanced degree from Clark Atlanta University, I agree that the Robert W. Woodruff Library shall make it available for inspection and circulation in accordance with its regulations governing materials of this type. I agree that permission to quote from, to copy from, or to publish this thesis may be granted by the author or, in his/her absence the Dean of the Whitney M. Young, Jr., School of Social Work at Clark Atlanta University. Such quoting, copying or publication must be solely for scholarly purposes and must not involve potential financial gain. It is understood that any copying from or publication of this thesis, which involves potential financial gain, will not be allowed without permission of the author.

Signature of Author

4/18/02
Date
NOTICE TO BORROWERS

All theses deposited in the Robert W. Woodruff Library must be used only in accordance with the stipulations prescribed by the author in the preceding statement.

The author of this thesis is:

Name: Kamesha D. Milline-Cardenas
Street Address: 2447 Hillboro Circle
City, State and Zip: Marietta, GA 30064-5421

The director of this thesis is:

Professor: Hattie M. Mitchell
Department: Social Work
School: Whitney M. Young, Jr., School of Social Work Clark Atlanta University
Office Telephone: (404) 889-6616

Users of this thesis not regularly enrolled as students of the Atlanta University Center are required to attest acceptance of the preceding stipulations by signing below. Libraries borrowing this thesis for use of patrons are required to see that each user records here the information requested.

<table>
<thead>
<tr>
<th>NAME OF USER</th>
<th>ADDRESS</th>
<th>DATE</th>
<th>TYPE OF USE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>ACKNOWLEDGEMENTS</th>
<th>ii</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIST OF TABLES</td>
<td>v</td>
</tr>
<tr>
<td><strong>CHAPTER</strong></td>
<td></td>
</tr>
<tr>
<td>I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>2</td>
</tr>
<tr>
<td>Significance of the Study</td>
<td>2</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>3</td>
</tr>
<tr>
<td>II. REVIEW OF THE LITERATURE</td>
<td>4</td>
</tr>
<tr>
<td>Related Research</td>
<td>4</td>
</tr>
<tr>
<td>Theoretical Framework</td>
<td>20</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>23</td>
</tr>
<tr>
<td>Hypothesis</td>
<td>25</td>
</tr>
<tr>
<td>III. METHODOLOGY</td>
<td>26</td>
</tr>
<tr>
<td>Research Design</td>
<td>26</td>
</tr>
<tr>
<td>Site and Setting</td>
<td>26</td>
</tr>
<tr>
<td>Sample</td>
<td>26</td>
</tr>
<tr>
<td>Data Collection Procedure/Instrumentation</td>
<td>27</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>28</td>
</tr>
<tr>
<td>IV. PRESENTATION OF RESULTS</td>
<td>29</td>
</tr>
<tr>
<td>Overview of Research Questions and Hypothesis</td>
<td>41</td>
</tr>
<tr>
<td>V. SUMMARY AND CONCLUSION</td>
<td>46</td>
</tr>
<tr>
<td>Limitations of Study</td>
<td>49</td>
</tr>
<tr>
<td>Suggested Research Direction</td>
<td>50</td>
</tr>
<tr>
<td>VI. IMPLICATIONS FOR SOCIAL WORK PRACTICE</td>
<td>51</td>
</tr>
</tbody>
</table>
Table of Contents (Continued)

APPENDICES .................................................................................................................. 53

Appendix A Letter Requesting Permission to Conduct Study ...................................... 54
Appendix B Participant Consent Form ......................................................................... 55
Appendix C Questionnaire ............................................................................................ 56

REFERENCES .................................................................................................................. 60
LIST OF TABLES

TABLE

<table>
<thead>
<tr>
<th></th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Percent Distribution of Demographic Profile</td>
<td>30</td>
</tr>
<tr>
<td>2. Percent Distribution of Quality of Service</td>
<td>32</td>
</tr>
<tr>
<td>3. Percent Distribution of Desired Service</td>
<td>33</td>
</tr>
<tr>
<td>4. Percent Distribution of Needs Met</td>
<td>34</td>
</tr>
<tr>
<td>5. Percent Distribution of Refer Friend</td>
<td>35</td>
</tr>
<tr>
<td>6. Percent Distribution of Service Satisfied</td>
<td>36</td>
</tr>
<tr>
<td>7. Percent Distribution of Problem Improved</td>
<td>37</td>
</tr>
<tr>
<td>8. Percent Distribution of Overall Satisfied</td>
<td>38</td>
</tr>
<tr>
<td>9. Percent Distribution of Return If Needed</td>
<td>39</td>
</tr>
<tr>
<td>10. Percent Distribution of Length of Stay</td>
<td>40</td>
</tr>
<tr>
<td>11. Cross Tabulation of Problem Improvement by Length of Stay</td>
<td>42</td>
</tr>
<tr>
<td>12. Cross Tabulation of Overall Satisfaction by Length of Stay</td>
<td>44</td>
</tr>
</tbody>
</table>
CHAPTER ONE

INTRODUCTION

Although drug and alcohol abuse and relapse following treatment are recognized as major health and economic problems, surprisingly little research has attempted to identify predictors to relapse other than demographic variables, personality traits, and using history. Moreover, minimal focus has been directed toward the extent to which varying levels of micro-stressors faced by consumers are adequately addressed by treatment facilities.

The drug most frequently involved in emergency room visits according to the Drug Abuse Warning Network (DAWN), is cocaine. This drug is currently ranked third, behind heroin and alcohol-drug combinations, as one of the leading causes of drug-related deaths. As cited by McBride (1989), according to the Emergency Medicine reports, March 14, 1988, traffic and trade of cocaine and crack has also contributed substantially to trauma and violent deaths, especially in urban areas.

From previous research (McBride, 1989), it was projected by the National Institute on Drug Abuse, Prevention Networks, that 5,000 Americans would use cocaine for the first time today, based on national surveys of that time. For some their curiosity would be satisfied and would never use the drug again (The National Institute on Drug Abuse, Prevention Network, 1986) and one in five of those 5,000 would become
occasional users. But for some, this seemingly innocuous experimentation will be the first step into a living nightmare of drug dependence. It will be more important than their careers, their families and friends, and their possessions. They will steal, they will prostitute, they will “deal” to support what has become an all-consuming habit. Some will end up in jail, many in hospitals, others in the morgue (Prevention Network, 1989).

Statement of the Problem

Many qualitative studies have provided insight into the perceptions of clients in substance use treatment and have identified several specific issues which are related to satisfaction with treatment services, including: therapeutic relationships with staff; personal treatment goals; the operation of treatment services; and having enough time in treatment to deal with problems. However, minimal studies exist to show how level of satisfaction in meeting these needs relate to retention in treatment and ultimate abstinence upon discharge.

Significance of Study

In a review and study of public and private facilities success and recidivism rates, it appears that problems of drug users were not being accurately or effectively addressed. There are very few public-funded treatment providers with any type of consistent protocol for drug treatment. Most public and private sites appear to address drug dependence by providing referral sources, no treatment at all, or the most convenient treatment available as opposed to treating the addiction.
Mark W. Parrino (1987) in his study proposal for the Georgia Department of Human Resources Division of Mental Health, Mental Retardation, and Substance Abuse, conceded that the most frequent consumers of state supported services are: "individuals from lower socioeconomic backgrounds, who experience or have higher rates of substance abuse problems" (Jester, 1989). The consumers of state-supported services lack the mechanisms that insured consumers have as critical resources for long-term rehabilitation. Private sector consumers, while perhaps not as chronic, have individual issues as well that are failing to be addressed adequately based on their relapse rates.

Purpose of the Study

The researcher has identified and observed many cases where drug dependent individuals have received treatment only to relapse in short periods of time. Another phenomena has evolved where these consumers have received several treatment modalities only to continuously relapse several times. There seems to be a direct correlation between "effective satisfactory treatment" and relapse upon substance dependent individuals.

The writer delineates what constitutes effective, how client satisfaction is defined, and historical impediments to treatment success. Specific concerns deal with the failure of many drug treatment facilities to (1) property match the consumer with the treatment that recognized the special issues of that individual; (2) to develop a standard protocol for treating drug dependence; and, (3) provide viable services to target populations, all in an effort to increase patient satisfaction and therefore prevent relapse.
CHAPTER TWO

REVIEW OF LITERATURE

Related Research

According to the Diagnostic and Statistical Manual of Mental Disorders (1998) prevalence rate for most used drugs by adult population are 13 percent, 0.2 percent, and 2 percent for alcohol, cocaine, and marijuana, respectively. Note that these statistics are based on data obtained between 1981-1983 and as a result will not adequately reflect increases in cocaine dependence due to the “crack” cocaine epidemic of the mid-1980s. Past research (Joong, Benson, Ramussen, & Zuehkle, 1993) has shown that in 1992 there were a reported 1.8 million heavy cocaine users and 600,000 – one million hard core heroin addicts. The Rand Corporation reports that only 13 percent of heavy cocaine users avoid heavy use after treatment. Of those, not all stay off permanently. About fifty percent of alcoholics relapse within three months of entering treatment. Although it is accepted that drug addiction is a result of genetic, biological, behavioral, and environmental factors, no treatment method in the United States has been successfully developed that can produce effectiveness in addressing these issues. Nevertheless, in the treatment of addiction, there is a consensus that the reduction of drug use, increases in personal health and social functions, and reduction in threats to public health is the goal. However, there is such inconsistency across treatment systems that this goal seems unattainable. Historically, Americans have alternated between viewing addiction as a
medical problem, social ill, or self-inflicted personal problem. As a result, treatment of addiction has passed through varied cycles of medical care followed by punitive crackdowns.

Pilot studies (Siegal, Rapp, Li, Saha, & Kirk, 1997) have also exploring alternative treatment subsystems. The National Institute on Drug Abuse (NIDA), funded the strengths-based case management method as an enhancement to the conventional, disease-oriented substance-abuse treatment program. This project was specifically designed to determine the effectiveness of case management in improving retention in treatment and resulting outcomes among substance abusers. The strengths-based perceptive of case management developed from earlier efforts that offered clients a variety of needed resources and the opportunity of selecting the services they received. This case management practice model is “community oriented and emphasizes client autonomy and skills development” (Siegel, Rapp, Li, Saha, & Kirk, 1997, p. 822). It begins with the identification of client strengths and assets, allows the client to determine all goals and actions to be taken, calls for the use of informal helping networks, offers assertive community involvement by case managers, and teaches creativity in utilizing community resources. Using this perspective enables case managers to assist clients in any or all of nine life-domains: basic life skills, finances, relationships, leisure, internal resources, occupation or education, living situation, and recovery (Siegel, Rapp, Li, Saha, & Kirk, 1997). In this particular pilot project the case management enhancement improved outcomes for clients suggesting that case management services may also be a useful alternative to conventional models.
From a social standpoint there are also many special interest groups who fail to receive effective treatment or any treatment at all. Furthermore, negative views and failure to recognize the special needs specific to these groups perpetuate the low success rate in maintaining abstinence. Low success rates are typical among drug programs particularly those treating addicts toward the bottom of the socioeconomic ladder. Drug treatment for the people who started drug use in their teens, never worked, dropped out of school and never learned to cope with adversities in a drug free way has proven successful only 20 to 40 percent of the time (Sterling, Gottheil, Weinstein, & Shannon, 1994). Generally, treatment success rates depend on the addict’s social station (Glazer, 1995). Most addicts make repeated attempts at treatment, but only a minority eventually cease drug use for good.

Other drug experts contend that drug treatment is successful for those whom it has worked best for in the past: the educated, white collar professionals with strong support from family and friends. According to Glazer (1995), “what we are left with is a population less likely to give up frequent drug use: those who are poorer, less educated, and more prone to support their habits through crime.” If one evaluates a program with pregnant women sent by welfare, who do not want to stop using, treatment success is questionable at best. Inner city cocaine addicts tend to have lower recovery rates, where abstinence is only 30 to 40 percent in the first three to six months after treatment (Taylor, Chitwood, McElrath, & Belgrave, 1994). Pregnant welfare mothers and drug users convicted to crimes generally need more than drug rehabilitation to have a normal working life. Frequently they need help with the daily stressors of life without drugs.
The Child Welfare League of America, representing 800 public and private child welfare agencies, also paints a pessimistic view about treating addiction. "Relapse of drug addicts is the rule, not the exception. Although there has been some success in treating heroin addicts and alcoholics, most treatment programs report breaking the pattern of crack cocaine use only temporarily" (Taylor, Chitwood, McElrath, & Belgrave, 1994).

Weinberg and Koegel (1995) researched impediments to recovery for dually diagnosed homeless adults: "Individuals who have been dually diagnosed as suffering from both psychiatric problems and substance abuse problems are known to be particularly disadvantaged subgroup among the homeless population in the United States . . ." (p. 193). Until very recently most were either taken back and forth between the substance abuse and mental health systems (often receiving conflicting assessments and treatments from them) or fell through the cracks of the service delivery system altogether (Weinberg & Koegel, 1995). The consumers were placed in one of three conditions: (1) a hybrid residential program; (2) a nonresidential program; and (3) no treatment except for what dually diagnosed homeless individual themselves obtained through available systems of care. The implementation of these programs, the nature of services delivered, and the costs associated with different approaches were evaluated. In addition, data were collected in order to determine treatment approaches were evaluated. In addition, data were collected in order to determine how the programs operated in practice and how they were experienced by those who participated in them.
Research (Weinberg & Koegel, 1995) found three practical conflicts which consistently interfered with many clients' ability to participate in these programs: (1) the antithetical demands placed on people by social life in the programs and social life as a homeless person on the streets; (2) the challenge of participating in treatment while struggling to meet immediate sustenance needs; and (3) the difficulties that arose for homeless dually diagnosed individuals as they came to recognize that many of their problems could not be resolved through participation in treatment. In comparing residential treatment and day treatment, Weinberg & Koegel (1995) concluded that “[W]hile some features may make one treatment modality the preferred choice over the other for a given individual, other features of that modality may carry costs that complicate the ability to sustain participation in such treatment. There are clearly no easy answers to the question of which is better, and perhaps no easy answers even to the question of which is better for whom” (p. 231). They did suggest that the best alternative is to maximize treatment options and help prospective clients become involved in the modality or combination thereof which is most suitable to their current needs.

For the purpose of this study, psychoactive drug abuse is defined as presenting the physiological, behavioral, and environmental affectations manifested by the drug dependence. Addiction is seen as a chronic relapsing disorder since 50-90 percent of alcoholics and drug addicts will use again after treatment. Since it is a chronic relapsing disease it requires maintenance, just like hypertension, diabetes, or asthma. Relapse may also be an integral part of recovery because it stresses the fact that addicts no longer have control over the substance they use. In comparing treatment experience with relapse rates
the cyclic nature of the disease is reinforced; many tries have to be made before it is successful. As a result, lifelong abstinence on the first attempt is not considered attainable and should not be a measure of treatment success (Wallace, 1991). In fact, the expectation that treatment will yield total abstinence forever is an unreasonable expectation stemming from a false understanding of addiction. This chronic disorder requires medication, education, and counseling for a number of years.

Meanwhile, detoxification can only be a temporary “stopgap” measure without offering the benefits of treatment. Addicting drugs produce changes in the brain pathways that endure long after the person stops using them. Furthermore, research (Schafer & Fals-Stewart, 1996) has shown that associated medical, social, and occupational difficulties that develop during the course of addiction do not disappear when the patient is detoxified. Failure to therapeutically address these brain changes and related personal and social difficulties increases the likelihood that the individual will relapse.

Despite the perception of drug addiction as a voluntary, self-afflicted problem, there are many involuntary components in the addictive process. Although the choice in trying the drug the first time is voluntary, whether the drug is taken can be influenced by external factors such as price, availability, and peer pressure. However, most people exposed to drugs do not become addicts. Heredity most likely influences the effects of the initial drug sampling, and these effects are in turn likely to be influential in affecting continued use. According to O’Brien and McLellan (1996), “Individuals for whom the initial psychological responses to drug are extremely pleasurable may be more likely to
repeat the drug use and some them will develop an addiction.” At some point after this continued voluntary drug use, the drug “user” loses the ability to control its use. At that point, the “drug misuser” becomes “drug addicted” and there is a compulsive, overwhelming involuntary aspect to continuing drug use and to relapse after a period of abstinence.

Reissman and Carroll (1996) expound on the complexities of addiction, distinguishing between simple addiction and complex addiction. Simple addiction is superficial. Although it involves physical craving and withdrawal symptoms when the substance is removed, it can be overcome without resorting to in-depth approaches or professional rehabilitation programs. It is reversible by means of will power and individual effort.

Complex addiction has four basic qualities: (1) good feelings – the addictive product generates profoundly pleasurable physical and/or mental sensations while also eliminating unpleasant sensations; (2) loss of control over the addiction – inability to feel ordinary human emotions or to monitor behavior no matter how harmful or self-destructive it may be; (3) compulsion to continue despite the consequences – the addictive behavior persists despite the problems it produces for the user and others; and (4) denial – the addict denies that he or she has a problem (Reissman & Carroll, 1996, p. 38). In addition to pleasure, craving, and compulsion, the driving force behind complex addiction is an attempt to use the external addictive product as a means of altering or repressing an inner psychological mood.
Despite the extensive knowledge concerning drug addiction etiology and impediments to successful treatment, drug dependence continues to be a prevalent problem in this country. A predominant theory of its causation relates to inappropriate use of treatment modalities. Some limitations of drug abuse treatment are a direct result of inadequate resources – too few programs and slots for the number of clients seeking treatment, let alone the number in need of treatment. Additional limitations result from an insufficient range of program types of employing different strategies and from insufficient knowledge about how best to match available programs and services to clients with different degrees of dependence, at different periods of their addiction career, and with different social, psychological, and ethnic characteristics (Wellisch, Prendergast & Anglin, 1995). Research has established that no single treatment approach is effective for all clients with drug addiction issues and that a range of alternatives needs to be available to suit individual needs. According to Yih-Ing Hser (1995), “Optimum treatment involves the selection of the most appropriate treatment or treatments that we most likely to facilitate a positive outcome in a particular individual – or effective matching.” Platt, Widman, et al. (1998) assert that “comprehensive services, including employment/vocational interventions, family therapy, medical care, and case management, have been shown by the literature to be critical elements of programs that provide effective treatment for substance abusers.” However, despite clear research findings, clients are often unable to obtain needed services at their clinic. Other studies examining the organization of care show that integrated services provide better access for
clients, greater continuity of care, higher rates of service use, and more client satisfaction (Bickman, 1996; Soman, Brindis, & Dunn-Malhotra, 1996).

Despite the obvious need for professional referral, there are currently no commonly accepted guidelines for standardized diagnostic assessment and program selection. A systematic process for matching drug users’ needs with treatment program and services does not exist at this time. In spite of this lack, clients are referred to treatment; furthermore, selection of the treatment is contingent on clinical judgment, federal guidelines, legal structors governing hospitals/clinic practices, and client preferences. However, current practices need to be amended to enable effective matching of the client to the most appropriate treatment. This is necessary since most referral sources provide contact information about programs within their area and provide only one major therapeutic option. As a result, the placement of clients is mainly determined by the availability of a treatment slot, not the specific needs of the individual. Past research Hser (1995) shows that since the majority of drug abusers most in need of treatment are likely to be those without financial resources, the need for flexible referral with effective matching is vital. Variables considered in treatment matching in the past, included sex, age, race, socioeconomic status, IQ, martial status, problem severity, social supports, history, and numerous other psychological and demographic dimensions. However, problems with these variables are that their relationships to treatment outcome have been weak and inconsistent. In fact, many experts believe that the highest priority in dealing with an individual seeking treatment is to immediately engage him or her into any kind of treatment, however minimal, rather that to wait for the “right” program. This
creates major problems for communities that are recipients of publicly funded treatment with long waiting lists; “matching may become contingent upon whether one should wait for availability of the most suitable program or accepts placement in the most convenient one. Despite the cost savings and benefits of treatment, the number of people who actually receive treatment is far below the number who need or want treatment.

There have been hundreds of empirical studies initiated in an effort to address problems and effects of treatment. One such study, (Bell, Williams, Nelson, & Spence, 1994) did an experimental test on the retention in residential and outpatient programs. They worked with the premise that the length of stay in treatment predicts successful treatment outcomes. This applies if treatment is effective based on diminishing returns or readmissions. This study compared a 28-day residential program and a 28-day outpatient program. Both programs were conducted by the same organization and had similar basic philosophies and daily schedules. Both programs involved at least eight hours of educational and therapeutic activities per day. This included chemical dependency education, group therapy, and vocational and educational counseling. Twelve-Step support groups like Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous were also provided. The outpatient treatment was a five-day per week program and the residential treatment was a seven-day per week program. This study found a significant relationship between program assignment (residential) and education, homelessness (residential), and previous drug treatment (residential). Retention rates based on program completion were higher in residential treatment than outpatient treatment. However, the researchers caution that outpatient and inpatient are not
comparable, either in rate of treatment or curriculum. Therefore, one cannot determine if observed differences were due to inherent differences between residential and outpatient programs, content of particular programs studied, or differences in the kinds of clients attracted to each type of program.

Other studies are concerned about the treatment received by special groups like the homeless, pregnant mothers, and African Americans. One qualitative study (Shahler, Cohen, Greene, Shipley, & Bartelt, 1995) was initiated about treatment success among homeless, crack cocaine addicted men. Service providers in a Philadelphia treatment demonstration project were interviewed and they selected 18 clients who were deemed as "successes." Both staff and clients defined success in terms of sobriety and abstinence rather than program completion. In addition, the clients reported that being able to deal with feelings and life circumstances better was considered a degree of success.

Concerning the key elements they considered responsible for their progress in treatment, clients focused on the important roles that self-motivation, 12-Step meetings, the structured environment of the treatment setting, support from staff and fellow clients, and encouragement from family and friends all played in their recovery efforts. Implications for the findings of this study were that there is a need to develop effective programs for homeless substance abusers where other institutions can and should be called upon to help reintegrate them back into a non-substance-using structure. However, researchers warned that there were limitations to the generalizability of their findings due to the specific population chosen as the focus of research.
Another study (Wellisch, Prendergast, & Anglin, 1995) evaluated current treatment methods in an effort to develop a more integrated, coherent drug treatment system. These researchers sought to bring about a significant improvement in the number of drug abusers who receive treatment and in the effectiveness of the treatment they received. Their contention was that it could only be accomplished by replacing the current fragmented approach with a more comprehensive, integrated, and coherent system of drug treatment. More specifically, they felt this could be best accomplished by utilizing the health care and criminal justice systems as locations to identify persons in need of drug treatment, and matching clients with appropriate services to improve treatment effectiveness. The optimum drug treatment system should be able to identify drug dependent people, deliver appropriate services, monitor progress, and provide a continuum of care matched to the needs of the client.

"The role of the federal and state governments should be to establish standards, set guidelines, provide technical aid, contribute financial support to local systems, and aggressively support research to improve the organizational structure of local systems and enhance the development of treatment strategies" (Wellisch, Prendergast, & Aglin, 1995). Federal government will encourage closer cooperation among agencies involved with substance abuse in order to better identify people in need of treatment to place and keep them in treatment, to develop effective treatment programs, to support research efforts, and to promote short and long-term planning toward agreed upon goals.

Considering the multitude of advances made in this society, why drug addiction continues to be such a prevalent problem remains confounding. Despite the numerous
treatment options available, drug dependence continues to proliferate. However, there are many special treatment issues which contribute to this problem. Overall, it can be assumed in part, that continued relapse for those who seek treatment may be a result of treatment modalities failing to recognize inherent differences in the individual addict and treating those differences accordingly. Clients bring to treatment different characteristics, including their addiction and treatment histories, goals for treatment, motivations, cognitive styles, social and economic statuses, support systems, and vocational and coping skills (Wellisch, et al., 1995). By the same token, therapists and drug counselors differ in their treatment philosophies, cognitive styles, flexibility, expectations for treatment, skill, training, and experience. Due to those differences, some form of matching between client and treatment program is vital in order to improve treatment effectiveness and to make better use of treatment resources. At a more generalized level, experience has shown that potential clients often have already decided about what type of treatment they need and will accept. When the program fails to meet the preference and needs of the client compliance with the program treatment is low (McKay, Rutherford, & Alterman, 1996).

Recognition and acceptance of treatment as a complex process will also be instrumental in treating addiction successfully. While some improvement can result from matching procedures at the client and program level, the most improvement can be obtained by maintaining clients under long-term management in a drug treatment that acknowledges the chronic, relapsing nature of addiction and that has a variety of
integrated programs and services available for clients at different stages of their treatment career and life status (McKay, Rutherford, & Alterman, 1996).

There is also a need to revamp criteria implemented in a given treatment program. In other words, specification of treatment programs should be determined along a consistent set of descriptive dimensions. In addition, this information should be readily available for effective referral. "Dimension consideration should include the philosophy and orientation of the program, the stage of the drug problem at which the treatment is directed, the setting of the program, the services and components, the criteria for admission, program goals, the target population, program length and intensity, staffing and staff qualifications" (Hser, 1995, p. 215).

Another important consideration for substance abuse treatment is client satisfaction with services received. Specifically it is important to measure the patient's attitudes about the specific treatment received from the program and not their attitudes about treatment in general or treatment they might have received in the past. Moreover, mental health practitioners are increasingly being called on to evaluate the effectiveness of the treatment they provide. Hoge, Garrell, Strauss, et al. (1987) studied subjects in a partial hospital program and found a significantly positive treatment effect in lessening acute symptoms, improving patient demoralization, and decreasing the difficulty associated with readjusting to the community after discharge. In the mental health field, a sizable body of research has investigated clients' satisfaction at the extent to which a program is perceived to have met an individual's treatment needs and wants. A range of issues have been examined including the accessibility, adequacy, content and impact of
services received. In addition to serving a simple monitoring function for treatment service providers and funders, treatment satisfaction is argued to be a valuable indicator of treatment experience. Treatment satisfaction can act as a moderator of treatment outcome since it is reasonable to assume that less satisfied clients may have prematurely or have different responses to interventions (Atkisson & Pascoe, 1983).

In assessing whether a substance abuse treatment program has been “successful” or not generally abstinence or reduced levels of drinking substance use, or treatment graduation rates have served as measures (Stahler, et al., 1995). Other studies have viewed improvements of various areas of life functioning, including behavioral and emotional areas, as additional criteria for judging the effectiveness of substance abuse treatment (Rawson, et al., 1991). Stahler studied how “successful clients” perceived reasons for their own personal outcomes. From the client perspective, success revolved around “the ability to deal better with feelings and emotions, developing healthy relationships, handling money, feeling better about oneself, being able to take responsibility for one’s life, having the ability to handle stress, developing and pursuing goals, and obtaining and maintaining a job and place to live” (Stahler et al., 1995).

Concerning the key elements they considered responsible for their progress in treatment, clients focused on the important roles that self-motivation, 12 Step-meetings, the structured environment of the treatment setting, support from staff and fellow clients, and encouragement from family and friends all played in their recovery efforts.

Another study (Bell et al., 1994), found that length of stay in a treatment program predicts successful treatment outcomes. “This is to be expected when treatment is
effective: exposure to more treatment should produce better outcomes up to some point of diminishing returns. Logically, it follows that to improve treatment outcomes, programs must increase time in treatment (Bell et al., 1994). It was also noted that connection variables (such as caring, trust, empathy, responsibility, and nurturance), variables that can change during treatment and are often the direct focus of treatment, will be important in understanding those aspects of the treatment process that lead to retention.

Siegal, et al. (1997) also contend that “the search for reasons for treatment retention differences should center on what happened during treatment period” (p. 827) rather than the demographics of clients. In this study, a positive relationship between treatment retention and better outcomes was found. Other research has shown that length of time spent in treatment has been found to be an important prediction of outcome (Mejta, Bokos, Mickenberg, Maslar, & Senay, 1997). It has also been shown that further improvement occurs in direct proportion to amount of time spent in treatment (Hubbard, Marsden, Rachal, Harwood, Cavanaugh, & Ginzburg, 1989).

From a programmatic perspective, Dansky (1996), concluded that quality improvement in healthcare organizations requires effective measurement of patient satisfaction. Dansky (1996) also notes that “satisfying the customer is a fundamental principle of quality management (p. 508).” Patient satisfaction is important for several reasons. First, satisfied patients are more likely to maintain their relationship with a specific provider. Second, high levels of patient satisfaction are associated with direct financial benefits to the organization such as improved risk management and improved
employed productivity. Finally, patient satisfaction information identifies areas of strength and weaknesses in the organization, thereby improving the quality improvement process. Moreover, Dansky reports how the focus on cost containment and competition has forced healthcare providers to adopt strategies that are targeted to client’s needs and interest. As a result, quality has become a critical issue, with clients playing a major role as evaluators of quality. In addition, in order to be truly meaningful, patient satisfaction indicators must be compared to other measures, such as perceptions of overall quality.

Siegel, et al. (1997) evaluated patient satisfaction and treatment outcome. Demographic data, measures of psychosocial functioning, and measures for treatment motivation were used as a baseline parameters. Researchers found that subjects who participated in both case management and aftercare showed improved functioning on six of nine measures, including decreased substance abuse and increased self-help group attendance. The case management group reported the leased illegal activities and fewer incarcerations following treatment. Consistent with previous research, a positive relationship between treatment retention and better outcomes was found in this study.

Theoretical Framework

As cited by Rhodes and Johnson (1996), despite the fact that alcohol and drug treatment centers focus on the addiction itself, the reliance on the medical model in these settings directs attention to the presenting problem while failing to account for the extraneous contributing factors. With the medical model, addiction is perceived as a disease in part to decrease the moral condemnation directed towards addicts. In other words, the disease concept states that one does not develop addiction but is predisposed
to addiction. A major tenet of the medical model of powerlessness, which stipulates that the addict is out of control and unable to exercise any restraint over his or her behavior (Rhodes & Johnson, 1996).

However, although this model provides a non-judgmental interpretation for describing drug use it only presents a linear causation (genetic predisposition yields addiction) that fails to account for other contributory factors to addiction (Rhodes & Johnson, 1996). In other words, the role of the environment in the perpetuation of addiction is not addressed because such aspects cannot be explained by this model which relies heavily on predisposition.

The ecological model focuses on the transactions between the person and the environment, stressing environmental causation of addiction instead of internal defects (Rhodes & Johnson, 1996; Longbaugh & Beattie, 1985). By placing the focus of addiction as a result of environment, the ecological perspective yields a more comprehensive view of human behavior than does the medical model alone. Personal issues such as deprivation, sexism, poverty, racism, and discrimination, which are accepted as barriers to treatment by the ecological model are dismissed as internal resistance by the medical model.

According to Rhodes and Johnson (1996) “the ecological model, with its dynamic interplay of causation, implies change in the person, the environment, and the way the client interacts with the environment. [Moreover], environmental services are critical to the ongoing support of recovery” (p. 183). Research (Rhodes & Johnson, 1996) also shows that interventions to help clients acquire basic needs such as food, shelter, health
care, child care, and transportation contribute to the overall functioning of recovering clients. In essence, the ecological perspective contends that such services are “as important to the promotion of sobriety and positive social functioning as are traditional therapeutic and group interventions” (Sullivan et al., 1992, p. 200).

The assumption that substance abuse is related to treatment received stems from belief that if the client receives treatment, ideally abstinence from drug abuse or improvement in life circumstances should result. Moreover, if treatment addresses client needs comprehensively then it stands to reason that the client will have satisfaction that there particular issues are being addressed and therefore more likely to stay in treatment. As reinforced by Rhodes and Johnson (1996) “the ecological focus is consistent with a strengths perspective and collaborative problem solving, whereby clients need to become actively involved both in the way the problem is defined and in the formulation of interventions.”

According to Urie Bronfenbrenner (Vander Zander, 1993, p. 8), with the ecological approach “the study of influences... must include the person’s interaction with the environment, the person’s changing physical and social settings, the relationship among those settings, and how the entire process is affected by the society in which the settings are embedded.” In addition, Bronfenbrenner delineates the ecological system into four levels of environmental influences: the microsystem, the mesosystem, the exosystem, and the macrosystem. The microsystem consists of the network of social relationships and the physical settings in which a person is involved each day. The mesosystem consists of the interrelationships among the various settings in which the
person is involved. The exosystem consists of the social structures that directly or indirectly affect a person’s life. The macrosystem consists of the overarching cultural patterns of a society that is expressed in family, educational, economic, political, and religious institutions (Vander Zander, 1993, pp. 9-10).

In applying the ecological model of treatment, one expects that the environmental conflicts and problems with overall life functioning play a major role in relapse. As a result, the systems in which the chemically dependent client is involved must be considered in order to determine interventions needed.

According to Rhodes and Johnson (1996), “from the ecological perspective, substance abusing behaviors are not the sole criterion in addressing improved social functioning, and initial episode of use is addressed and evaluated along with other behaviors toward the achievement of goals” (p. 184). The ecological model offers the possibility of growth on a continuum of social functioning and therefore recognized incremental growth in all aspects of the client’s life.

Definition of Terms

In terms of classification with the DSM-IV-R (1998), both alcohol and cocaine dependence are considered psychoactive substance use disorders. “The essential feature of this disorder is a cluster of cognitive, behavioral, and physiologic symptoms that indicate that the person has impaired control of psychoactive substance use and continues use of the substance despite adverse consequences (DSM-IV-R, 1998). As cited in the DSM-IV-R (1998), there are nine diagnostic criteria used in determining psychoactive substance dependence of an individual:
1. Substance often taken in larger amounts or over a longer period than person intended
2. Persistent desire or one or more unsuccessful efforts to cut down or control substance use.
3. A great deal of time is spent in activities necessary to get the substance (i.e., theft).
4. Frequent intoxication or withdrawal symptoms when expected to fulfill major obligations at work, school, or home or when substance is physically hazardous.
5. Important social, occupational, or recreational activities are given up or reduced because of substance use.
6. Continues substance use despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or exacerbated by use of the substance.
7. Marked tolerance: need for markedly increased amounts of the substance in order to achieve intoxication or desired effect, or noticeably diminished affect with continued use of the same amount.
8. Characteristic withdrawal symptoms
9. Substance taken to relieve or avoid withdrawal symptoms.

Note that not all nine symptoms must be present for the diagnosis of dependence, however, at least three characteristic symptoms must be present to make the diagnosis. In addition, the diagnosis for the syndrome requires that some symptoms have persisted for at least one month, or have occurred repeatedly over a longer period of time.

The DSM-IV-R also presents criteria for the severity of psychoactive substance dependence: mild, moderate, severe, in partial remission, and in full remission. “Mild” diagnosis is when symptoms result in mild impairment in occupational functioning or in usual social activities or relationships with others. “Moderate” presents symptoms or functional impairment falling between “mild” and “severe”. “Severe” presents many symptoms existing in excess of those required to make the diagnosis. These symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others. In partial remission refers to some use of the substance with
some symptoms of dependence, within the last six months. In full remission applies when there has been no use of the substance of use of the substance without symptoms of dependence, with the past six months.

Client Satisfaction is defined as the degree to which a client perceives quality of services received and the extent to which their needs were.

Length of Stay is defined as how long a client has been in treatment. Clients were studied at one, three, six, and nine months into treatment respectively.

Residential Treatment is defined as an intensive level of treatment whereby the client lives on site and receives treatment for an extended period of time.

Hypothesis

The key hypothesis of this study is:

HO: There is no statistically significant relationship between length of stay in treatment and the client satisfaction.
CHAPTER THREE

METHODOLOGY

Research Design

A standardized Likert-scale consumer satisfaction questionnaire was presented to clients at varying stages of treatment to determine if there was a correlation between length of stay and consumer satisfaction. Information was gathered for one year from women with one, three, six, and nine months in treatment.

Site and Setting

The NIA (Nu-Woman Integration Actualization) project is a 35-bed ready-for-work residential substance abuse treatment facility for women located in Decatur, Georgia. Criteria for admission into this nine-month program entail having a primary diagnosis of substance abuse, homelessness prior to treatment, and being a TANF recipient or disabled. The facility also provides treatment for consumers that have dual diagnosis.

Sample

Sixty predominately African-American female clients who received treatment from January 2001 to January 2002 were used in a non-randomized sample of convenience contingent upon their agreement to participate. Clients one, three, six, and nine months into treatment respectively were sampled. Sixteen women per category were
studies who had received nine months of treatment. On average, study participants ranged from 26 to 36 years of age.

Data Collection Procedure/Instrumentation

A person to person interview was employed during the course of the study by the researcher. Data were obtained from clients in treatment with the NIA Project between January 1, 2001 and January 31, 2002. Quarterly, questionnaires were distributed in a group setting to assure anonymity. For those selected, an introduction stating the purpose of the study and requesting the consumer’s participation was presented. Participants were assured confidentiality and were given an opportunity to decline to participate. Consumers were asked to give basic demographic information and length of time in treatment without identifying self.

The Client Satisfaction Questionnaire (CSQ-8) was administered to determine level of satisfaction with treatment and service delivery. The Client Satisfaction Questionnaire (CSQ-8) is an eight-item questionnaire used to measure client satisfaction. It was designed to assess a unitary general satisfaction factor. It consists of eight Likert-type items with four response choices, where 1 indicates the lowest rating of quality or degree of satisfaction and 4 indicates the highest.

A demographic questionnaire was used to obtain a variety of information on the clients in the study including length of time in treatment, race, gender, age, income, marital status, and level of education.
Data Analysis

The data was analyzed using SPSSX System at Clark Atlanta University. Due to the nature of the sample and research questions, the data was analyzed using descriptive statistics, frequency distributions, Chi Square, and cross-tabulation.
CHAPTER FOUR

PRESENTATION OF RESULTS

The major purpose of this study was to determine if there was a statistical relationship between length of stay in residential substance abuse treatment and client satisfaction with services received. This chapter describes the findings of the study and test for the significance of the variables as put forward in the hypothesis of this study. The findings are organized in three sections: demographic data, frequency distributions of the Client Satisfaction Questionnaire-8, and relationship between length of stay and overall satisfaction, and relationship between length of stay and client perception of needs met in treatment.

A total of 60 adult, predominately African-American females in residential substance abuse treatment were surveyed. The convenience sample was drawn from a pool of clients in treatment that met criteria of one-month, three-months, six-months, and nine-months length of stay in treatment.
Demographic Data

Table 1

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number</th>
<th>Percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>55</td>
<td>91.7</td>
<td>91.7</td>
</tr>
<tr>
<td>Caucasian</td>
<td>5</td>
<td>8.3</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Female</td>
<td>60</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Age Group</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-25</td>
<td>5</td>
<td>9.3</td>
<td>8.3</td>
</tr>
<tr>
<td>26-33</td>
<td>24</td>
<td>40.0</td>
<td>48.3</td>
</tr>
<tr>
<td>34-41</td>
<td>27</td>
<td>45.0</td>
<td>93.3</td>
</tr>
<tr>
<td>42-49</td>
<td>4</td>
<td>6.7</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Economic Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TANF</td>
<td>8</td>
<td>13.3</td>
<td>13.3</td>
</tr>
<tr>
<td>Non-TANF</td>
<td>39</td>
<td>65.0</td>
<td>78.3</td>
</tr>
<tr>
<td>Disabled</td>
<td>8</td>
<td>13.3</td>
<td>91.7</td>
</tr>
<tr>
<td>Employed</td>
<td>5</td>
<td>8.3</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never Married</td>
<td>50</td>
<td>83.3</td>
<td>83.3</td>
</tr>
<tr>
<td>Divorced</td>
<td>6</td>
<td>10.0</td>
<td>6.7</td>
</tr>
<tr>
<td>Separated</td>
<td>4</td>
<td>6.7</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>College Graduate</td>
<td>2</td>
<td>3.3</td>
<td>3.3</td>
</tr>
<tr>
<td>Some College</td>
<td>5</td>
<td>8.3</td>
<td>11.7</td>
</tr>
<tr>
<td>High School Graduate</td>
<td>30</td>
<td>50.0</td>
<td>61.7</td>
</tr>
<tr>
<td>Less Than 12th Graded</td>
<td>15</td>
<td>25.0</td>
<td>86.7</td>
</tr>
<tr>
<td>Vocational School</td>
<td>8</td>
<td>13.3</td>
<td>100.0</td>
</tr>
</tbody>
</table>

This section provides a profile of study respondents. Descriptive statistics were employed to analyze the variables of the study. Table 1 is a demographic profile of the respondents. It shows the demographic characteristics of the client population.
The typical respondent of the study was never married, African American, between 34-41 years of age, female, non-TANF (Temporary Assistance for Needy Families) recipient and a high school graduate.

As shown in Table 1, the majority of the clients were American. Fifty-five or 91.7 percent were African American and five or 8.3 percent were Caucasian. In terms of gender and age all of the clients were female and the majority were between 34-41 years of age. As indicated, five or 8.3 percent of the clients were between 18-25 years of age. Twenty-five or 40 percent of clients were between 26-33 years of age. Twenty-seven or 45 percent of the clients were between 34-41 years of age. Four or 6.7 percent of clients were between 42-49 years of age.

In terms of employment status the majority of clients were unemployed and non-TANF recipients. As indicated in Table 1, 39 or 65 percent of clients received no government assistance for themselves or their children, therefore, requiring support from the program and/or family to meet their financial needs. Eight or 13.3 percent were disabled and received disability benefits. Five or 8.3 percent were employed.

Marital status was also displayed in Table 1. As indicated, the majority of women had never married. Of the 60 clients questioned, 50 or 83.3 percent indicated that they were never married; six or 10 percent indicated they were divorced; and four or 6.7 percent were separated.

The majority of the clients were high school graduates. Table 1 indicated that two or 3.3 percent were college graduates, five or 8.3 percent had some college, 15 or 25
percent had less than 12th grade education, and eight or 13.3 percent reported vocational or technical school training.

Frequency Distribution of CSQ-8

Table 2

Percent Distribution of Quality of Service

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>1</td>
<td>1.7</td>
<td>1.7</td>
</tr>
<tr>
<td>Fair</td>
<td>7</td>
<td>11.7</td>
<td>13.3</td>
</tr>
<tr>
<td>Good</td>
<td>27</td>
<td>45.0</td>
<td>58.3</td>
</tr>
<tr>
<td>Excellent</td>
<td>25</td>
<td>41.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Mean=3.27 Std dev .73

From a review of data compiled from the Consumer Satisfaction Questionnaire-8, descriptive statistics were utilized to obtain percentages of responses per question.

Table 2 summarized responses to the question “How would you rate the quality of service you received?” Of the 60 respondents, one client or 1.7 percent rated service quality as poor and seven or 11.7 percent rated service quality as fair. Twenty-seven or 48 percent rated quality of service as good and 25 or 41.7 percent rated quality of service as excellent.
Table 3

Percent Distribution of Desired Service

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, Definitely Not</td>
<td>2</td>
<td>3.3</td>
<td>3.3</td>
</tr>
<tr>
<td>No, Not Really</td>
<td>4</td>
<td>6.7</td>
<td>10.0</td>
</tr>
<tr>
<td>Yes, Generally</td>
<td>30</td>
<td>50.0</td>
<td>60.0</td>
</tr>
<tr>
<td>Yes, Definitely</td>
<td>24</td>
<td>40.0</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60</strong></td>
<td><strong>100.0</strong></td>
<td></td>
</tr>
</tbody>
</table>

Mean=3.27  Std dev .73

Table 3 summarized responses to the question “Did you get the kind of service you wanted?” As indicated, two or 3.3 percent of clients reported “no, they definitely did not receive services desired.” Four or 6.7 percent reported “no, they did not really obtain services desired.” Thirty or 50 percent reported “yes they generally received service desired” and 24 or 40 percent said they “definitely received service desired.”
<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only a few have been met</td>
<td>11</td>
<td>18.3</td>
<td>18.3</td>
</tr>
<tr>
<td>Most have been met</td>
<td>29</td>
<td>48.3</td>
<td>66.7</td>
</tr>
<tr>
<td>Almost all have been met</td>
<td>20</td>
<td>33.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Mean=3.15 Std dev .71

Table 4 summarized responses to question “To what extent has our program met your needs?” As indicated, no one reported that no needs were met. Eleven or 18.3 percent reported that only a few of their needs were met. Twenty-nine or 48.3 percent reported that most of their needs were met. Twenty or 33.3 percent reported that almost all of their needs had been met.
Table 5

Percent Distribution of Refer Friend

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, definitely not</td>
<td>1</td>
<td>1.7</td>
<td>1.7</td>
</tr>
<tr>
<td>Yes, I think so</td>
<td>28</td>
<td>46.7</td>
<td>48.3</td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>31</td>
<td>51.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Mean= 3.48  
Std dev .60

Table 5 summarized responses to question “If a friend were in need of similar help, would you recommend our program to her?” One or 1.7 percent reported that “no, she definitely would not refer a friend in need of similar services.” None responded “no, I do not think I would refer a friend.” Twenty-eight or 46.7 percent responded “yes, they think they would refer a friend” and 31 or 51.7 reported “yes, they definitely would refer a friend.”
Table 6

Percent Distribution of Service Satisfied

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indifferent/Mildly Dissatisfied</td>
<td>11</td>
<td>18.3</td>
<td>18.3</td>
</tr>
<tr>
<td>Mostly Satisfied</td>
<td>29</td>
<td>48.3</td>
<td>66.7</td>
</tr>
<tr>
<td>Very Satisfied</td>
<td>20</td>
<td>33.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Mean=3.52 Std dev .54

Table 6 summarized question “How satisfied are you with the amount of help you received?” None reported being quite satisfied with amount of help received. One or 1.7 percent reported being indifferent or mildly dissatisfied with help received.

Twenty-seven or 45 percent reported being mostly satisfied and 32 or 53.3 percent reported being very satisfied with help received.
Table 7

Percent Distribution of Problems Improved

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, they really didn’t help</td>
<td>1</td>
<td>1.7</td>
<td>1.7</td>
</tr>
<tr>
<td>Yes, they helped somewhat</td>
<td>26</td>
<td>43.3</td>
<td>45.0</td>
</tr>
<tr>
<td>Yes, they help a great dean</td>
<td>33</td>
<td>55.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Mean=3.53                                    Std dev .54

Table 7 summarized question “Have the services you received help you to dean more effectively with your problems?” None reported “no, problems were worsened.” One or 1.7 percent reported that “no, they did not help me.” Twenty-six or 43.3 percent reported “yes, they did help me somewhat” and 23 or 55.5 percent reported “yes, they helped me a great deal.”
Table 8

Percent Distribution of Overall Satisfied

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indifferent/Mildly Dissatisfied</td>
<td>1</td>
<td>1.7</td>
<td>1.7</td>
</tr>
<tr>
<td>Mostly Satisfied</td>
<td>28</td>
<td>46.7</td>
<td>48.3</td>
</tr>
<tr>
<td>Very Satisfied</td>
<td>31</td>
<td>51.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Mean=3.50

Std dev .54

Table 8 summarized question “in an overall, general sense, how satisfied are you with the service you have received?” As indicated, none reported being quite dissatisfied with overall services received. One or 1.7 percent reported being indifferent or mildly dissatisfied with overall services. Twenty-eight or 46.7 percent reported being mostly satisfied and 31 or 51.7 percent reported being very satisfied with overall services received.
Table 9

Percent Distribution of Returned if Needed

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, definitely not</td>
<td>3</td>
<td>5.0</td>
<td>5.0</td>
</tr>
<tr>
<td>No, I do not think so</td>
<td>3</td>
<td>50.0</td>
<td>10.0</td>
</tr>
<tr>
<td>Yes, I think so</td>
<td>29</td>
<td>48.3</td>
<td>58.0</td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>25</td>
<td>41.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Mean=3.27  Std dev .78

Table 9 summarized question “If you were to seek help again, would you come back to our program?” Three or 5 percent reported “no, I definitely would not return if needed.” Three or 5 percent reported “no, I don’t think I would return if needed.” Twenty-nine or 48.3 percent reported “yes, I think I would . . .” and 25 or 41.7 percent reported “yes, they would definitely return if needed.”

The mean score (sum of all scores/total number of participants) of all responses from the Client Questionnaire Survey was 28.83. The following ranges were used to classify overall level of satisfaction:

- 8-14 Quite Dissatisfied
- 15-29 Dissatisfied
- 21-26 Mostly Satisfied
- 27-32 Very Satisfied

Based on scale and mean score value it was determined that clients on average were mostly to very satisfied with services.
Table 10

Percent Distribution of Length of Stay

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>One Month</td>
<td>16</td>
<td>26.7</td>
<td>26.7</td>
</tr>
<tr>
<td>Three Months</td>
<td>16</td>
<td>26.7</td>
<td>53.3</td>
</tr>
<tr>
<td>Six Months</td>
<td>16</td>
<td>26.7</td>
<td>80.0</td>
</tr>
<tr>
<td>Nine Months</td>
<td>12</td>
<td>20.0</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60</strong></td>
<td><strong>100.0</strong></td>
<td></td>
</tr>
</tbody>
</table>

Mean=2.40

Table 10 summarized client length of stay in treatment. Of the 60 clients in the study, 16 or 26.7 percent had one-month length of stay, 16 or 26.7 percent had three months, and 16 or 26.7 percent had six months. Due to limited representation, only 12 or 20 percent had nine-months length of stay.
Overview of Research Questions and Hypothesis

In this study there were two research questions and one Null hypothesis. This section is an analysis of these questions and list of the hypothesis. Phi a symmetric measure of association was used to determine the strength of relationship between variables. The following variables of phi were utilized:

- .00 to .24  "No Relationship"
- .25 to .49  "Weak Relationship"
- .50 to .74  "Moderate Relationship"
- .75 to 1.00 "Strong Relationship"

The two research questions were restated and presented so as to facilitate an analysis of each question. The hypothesis was restated and evidence presented to determine whether or not it was rejected or not rejected.

For the purpose of this study two key questions were used from the Client Satisfaction Questionnaire to analyze the relationship: "Have the services you received helped you to deal more effectively with your problems?" and "In an overall since, how satisfied are you with the service you have received?" These questions were selected from the questionnaire because they appear to address the key focus of this study, namely general satisfaction and improvement in life issues.
Table 11

Cross Tabulation of Problem Improvement by Length of Stay

<table>
<thead>
<tr>
<th>Length of Stay</th>
<th>Problem Improved</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No, they really did not help me</td>
<td>Yes, they helped some</td>
</tr>
<tr>
<td>One Month</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Row %</td>
<td>56.3%</td>
<td>43.8%</td>
</tr>
<tr>
<td>Three Month</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Row %</td>
<td>6.3</td>
<td>18.8</td>
</tr>
<tr>
<td>Six Month</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Row %</td>
<td>62.5%</td>
<td>37.5%</td>
</tr>
<tr>
<td>Nine Month</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Row %</td>
<td>33.3%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>28</td>
</tr>
<tr>
<td>Row %</td>
<td>1.7</td>
<td>43.3%</td>
</tr>
</tbody>
</table>

Phi=.407       df=6        p=.127

Table 11 is a cross tabulation between problem improvement and length of stay. It shows the association between improvement in problems and length of stay. As indicated in Table 11, at one month length of stay, the largest percentage of clients, nine or 56.3% felt that treatment had helped somewhat in improving their problems. Seven or 43.8% felt that treatment "helped a great deal."

At three months length of stay, one client representing 6.3% of this population felt "no, they really did not help me deal with my problems better." Three or 18.8% felt that "yes, they helped somewhat." The largest percentage of clients, 12 or 75% felt that treatment "helped a great deal."
At six months length of stay, the largest percentage of clients, 10 or 62.5% felt that “yes, they helped somewhat.” Six or 37.5% of this population felt that “yes, they helped a great deal.”

At nine months length of stay, four or 33.3% reported “yes, they helped somewhat” and eight or 66.7% reported “yes, they helped a great deal.”

Table 11 further indicates that there was a weak relationship (phi=.407) between length of stay and client perception of improvement with problems. Moreover, when Chi Square test was applied the null hypothesis was not reject (p<.127) indicating that there was no statistically significant relationship between the two variables at the .05 level of significance.
Table 12

Cross Tabulation of Overall Satisfaction by Length of Stay

<table>
<thead>
<tr>
<th>Length of Stay</th>
<th>Indifferent or Mildly Dissatisfied</th>
<th>Mostly Satisfied</th>
<th>Very Satisfied</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>One Month</td>
<td>1</td>
<td>12</td>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td>Row %</td>
<td>6.3%</td>
<td>75.0%</td>
<td>18.8%</td>
<td></td>
</tr>
<tr>
<td>Three Month</td>
<td>6</td>
<td>10</td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>Row %</td>
<td>37.5%</td>
<td>62.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Six Month</td>
<td>7</td>
<td>9</td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>Row %</td>
<td>43.8%</td>
<td>56.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nine Month</td>
<td>3</td>
<td>9</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>Row %</td>
<td>25.0%</td>
<td>75.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>28</td>
<td>31</td>
<td>60</td>
</tr>
<tr>
<td>Row %</td>
<td>1.7%</td>
<td>46.7%</td>
<td>51.7%</td>
<td></td>
</tr>
</tbody>
</table>

Phi=.449 df=6 p=.06

Table 12 is a cross tabulation between overall satisfaction with services and length of stay. It shows the association between perceived overall satisfaction with services and length of stay.

As indicated by Table 12, at one-month length of stay, one or 6.3% of this population reported being “indifferent or mildly dissatisfied” with services. The largest percent, 12 or 75%, reported feeling “mostly satisfied” overall and three or 18.8% reported being “very satisfied” overall.

At three-month length of stay, six or 37.5% reported feeling “mostly satisfied.” The largest percentage of clients in this population, 10 or 62.5%, reported feeling “very satisfied” overall.
At the six-month length of stay, three or 25% reported being “mostly satisfied” whereas nine or 75% reported being “very satisfied” overall with services.

At the nine-month length of stay, three or 25% reported being “mostly satisfied” whereas nine or 75% reported being “very satisfied” overall with services.

Table 12 further indicated that there was a weak relationship (phi = .449) between length of stay and overall satisfaction. When Chi Square test was applied the null hypothesis was accepted (p < .06) indicating that there was no statistical significant relationship between the two variables at the .05 level of significance.
CHAPTER FIVE

SUMMARY AND CONCLUSION

The primary purpose of this study was to determine whether there was a statistical relationship between client satisfaction with services received and length of stay in treatment. The study was based on the premise that the longer clients were in treatment, the more satisfied they would be with services received. In a 12-month time span, 60 clients were evaluated at one month, three months, six months, and nine months respectively. The following demographic variables were also analyzed: gender, race, age, education, income status, and marital status.

This investigation included a review of selective relevant literature. Key components addressed included the following: an overview of substance abuse treatment, contributors to client retention in substance abuse treatment, and effects of client matching.

The theoretical framework was also included. The framework primarily discussed was the Ecological Model, with some reference to the Medical Model. The basic tenet of the Ecological Model is considering the person within the environment. Moreover, this model support the contention that interventions to help clients acquire basic needs such as food shelter, health care, child care, and transportation contribute to the overall functioning of recovering clients. This model validated the researcher’s study.
regarding the importance of client involvement in defining the problem and formulating interventions (Vaillant, Milofsky, Richards, & Vaillant, 1987)

The researcher also identified and elaborated on the following key components: the null hypothesis, research design, population description, method of data collection, and method of data analysis.

The null hypothesis investigate was:

There is no significant relationship between client satisfaction with services received and length of stay in treatment.

The research utilized the Client Satisfaction Questionnaire (Atkinson, 1985) to determine the degree of satisfaction with services received. This standardized questionnaire was distributed in a group setting, every three months, from January 2001 thru January 2002. The sampling technique utilized was the convenience sample. This non-probability sampling technique was required due to the limited number of clients available at the residential treatment site.

Data information was collected, reviewed, and analyzed from primary sources. These primary sources of data were obtained from the satisfaction survey as noted above. The questionnaire consisted of the following two sections: 1) background information, which also included current length of stay in treatment; 2) perception questions on a scale from strongly agree to strongly disagree regarding various aspects of the treatment services provided.
The data was analyzed using frequency distribution, Pearson $r$, and cross tabulation. This statistical analysis was chosen based on the fact that the following test requires nominal and ordinal levels of measurement.

The researcher found that there is no significant relationship between client satisfaction and length of stay in treatment.

The Null Hypothesis was accepted based on Pearson $r$ values.

The researcher also concluded the study with a number of recommendations that may assist residential facility administrators in evaluating needs assessments and treatment effectiveness. Emphasis was placed on client matching and applying interventions from an Ecological Perspective.

The demographic data revealed several issues that could possibly be addressed in future research. For instance, all of the participants were female and were predominately African American. It is important for future research to take into consideration three questions:

1) Does gender and race impact survey response rates?
2) To what degree are race and gender considered in treatment interventions?
3) Is there a significant difference in satisfaction levels across race or gender?

Obtaining answers to these questions will enhance the empirical database on the effects of race and gender on client satisfaction. Due to small population studied and time constraints, this researcher was unable to do so.

The majority of the clients were non-TANF or unemployed, with minimal financial support. Initially, all clients were homeless prior to entering treatment and
required supplemental supports for the Department of Family and Children Services. Moreover, although half of the population were high school graduates, 25% had less than a 12\textsuperscript{th} grade education. It is important for future research to address two more questions:

1) To what degree does treatment address multifaceted problems of a target population?

2) Is there sufficient collaboration across systems (i.e. social services, treatment facilities, Department of Human Resources) to assure client integration into society as productive individuals?

The treatment site studied did address these issues, however, the researcher did not study the overall effectiveness of case management services.

Below is a discussion of the Null Hypothesis analyzed.

1) There is no statistically significant relationship between client satisfaction with services received and length of stay in treatment.

The Null Hypothesis was accepted.

In this study the majority of clients reported being mostly satisfied with overall services across all categories of length of stay.

Limitation of the Study

In contrast to the general mental health field, there is a sparse literature on client treatment satisfaction issues in the substance use treatment arena. Outcome research from the United States, which has administered the CSQ-8 and other instruments, has reported high levels of service satisfaction amongst clients in methadone maintenance, therapeutic community and outpatient drug-free programs. However, studies, which have
looked for association between satisfaction ratings and treatment process and outcome, have produced mixed results.

Suggested Research Direction

If we are to be successful in treating addictions of target populations we will have to focus on the more multidimensional examinations of knowing which types of programs in which kinds of environmental contexts are most effective for which types of clients with which types of substance abuse issues and concurrent life concerns. If the client is homeless, HIV positive, presenting with mental illness, or lacking a basic coping skills is it realistic to expect them to process the dynamics addiction when faced with a multitude of other stressors. In other words, high recidivism rates, poor treatment outcomes, and low client satisfaction underscore the need to take a more critical, microscopic look at the correspondence between client characteristics and program elements. One would not merely ask whether Treatment A is more effective than Treatment B; what are the critical processes that produce the beneficial effects; or, what counselor skills and characteristics are associated with favorable outcomes. Otherwise, failure to recognize specific stressors, inconsistency in aiding special populations, and inability to determine efficacy of treatment programs will continue to make drug addiction a prevalent problem for years to come.
CHAPTER SIX

IMPLICATIONS FOR SOCIAL WORK PRACTICE

Based on information presented there are many implications for social work practice. From the case management perspective, when it is determined that a particular drug treatment system has proven effective, social workers may be required to change their counseling methods in order to be compatible with that model. Personal preference cannot take precedence over the growth of the client. There must be an understanding of the variables involved in drug addiction and appropriate interventions necessary to treat the client. Nevertheless, social workers need to also promote the unique perspective of social work, which recognizes that interventions must be directed simultaneously at many relevant systems to improve social functioning. An understanding of intervention that moves beyond a focus on abstinence is a needed corrective for addiction treatment. In other words a literal application of “starting where the client is” is integral to treatment success for that client.

There is substantial variability in effectiveness of substance treatment across different settings, modalities, and programs. As a result, not all treatments prove effective for an individual client. Specifically, in treatment programs there is variation in types and amount of services provided; and therefore variation in treatment success and outcomes. Overall, successful treatment may be more attainable for patients who receive more services specifically targeted to their particular needs. For the social work, there is
a personal responsibility to refer the client to the most appropriate level of care
considering those needs. From a client satisfaction perspective further research on the
nature, experience and response of clients in longer-term treatment programs is
warranted. Specifically, how clients perceive treatment regulations and other factors and
how these perceptions influence treatment and treatment outcomes also warrant closer
investigation.
January 1, 2001

Ms. Davine Sparks
Integrated Life Center
1120 East Ponce de Leon Avenue
Decatur, Georgia 30033

Dear Dr. Sparks:

As discussed previously, I am requesting permission to conduct a research project at your facility for my thesis as a partial requirement for graduation. My thesis is entitled "An Exploratory Study of the Relationship between Client Satisfaction and Length of Stay in a Residential Substance Abuse Treatment Facility."

I am requesting to administer the Consumer Satisfaction Questionnaire to 60 clients in this facility, to determine if client satisfaction relates to length of stay. Due to specific inclusion requirements for this particular study, I request permission to interview clients for a twelve month time period.

I would appreciate your prompt response, so that I may begin my data collection. Thank you in advance for your assistance in this effort.

Sincerely,

[Signature]

Kamesha D. Milline-Cardenas

cc: Professor Hattie Mitchell, Thesis Advisor
223 James P. Brawley Drive, S.W. • Atlanta, Georgia 30314-4391 • (404) 880-8000
I, Kamesha D. Milline-Cardenas, am a Master student in the Social Work program at Clark Atlanta University. I am currently working on a research project as a partial requirement for completing the Master degree. I would like your assistance in completing this project.

You can help me by volunteering to participate in the study. I will ask you to complete a brief satisfaction questionnaire. The questions do not have a right or wrong answer, but knowing your responses would be very valuable to educators. Moreover, your information may contribute to developing future treatment programs to address your specific needs.

The information you give will be kept confidential. I will not use your name on any papers or reports concerning the project. I will share the information given by you only with my thesis advisor.

Thank you for your participate in this project.

I understand the terms above and agree to participate in your project.

Signature ___________________________ Date ____________

225 JAMES P. BRAWLEY DRIVE, S.W. • ATLANTA, GEORGIA 30314-4391 • (404) 880-8000

Formed in 1868 by the consolidation of Atlanta University, 1863, and Clark College, 1869.
APPENDIX C: QUESTIONNAIRE

1. How would you rate the quality of service you have received?
   
   (4) Excellent
   (3) Good
   (2) Fair
   (1) Poor

2. Did you get the kind of service you wanted?
   
   (1) No, Definitely Not
   (2) No, Not Really
   (3) Yes, Generally
   (4) Yes, Definitely

3. To what extent has our program met your needs?
   
   (4) Almost all of my needs have been met
   (3) Most of my needs have been met
   (2) Only a few of my needs have been met
   (1) None of my needs have been met

4. If a friend were in need of similar help, would you recommend our program to her?
   
   (1) No, Definitely Not
   (2) No, I Don't Think So
   (3) Yes, I Think So
   (4) Yes, Definitely

5. How satisfied are you with the amount of help you have received?
   
   (1) Quite Dissatisfied
   (2) Indifferent or Mildly Dissatisfied
   (3) Mostly Satisfied
   (4) Very Satisfied
6. Have the services you received helped you to deal more effectively with your problems?

   (4) Yes, They Helped a Great Deal
   (3) Yes, They Helped Somewhat
   (2) No, The Really Didn’t Help Me
   (1) No, They Seemed To Make Things Worse

7. In an overall, general sense, how satisfied are you with the service you have received?

   (4) Very Satisfied
   (3) Mostly Satisfied
   (2) Indifferent or Dissatisfied
   (1) Quite Dissatisfied

8. If you were to seek help again, would you come back to our program?

   (1) No, Definitely Not
   (2) No, I Don’t Think so
   (3) Yes, I Think So
   (4) Yes, Definitely

9. How long have you been in treatment?

   (4) Nine Months
   (3) Six Months
   (2) Three Months
   (1) One Month

10. What Race do you consider yourself?

    (1) African American
    (2) Caucasian
    (3) Hispanic
    (4) Other

11. What is your Gender?

    (1) Male
    (2) Female
12. What is your age range?
   (1) 18-25
   (2) 26-33
   (3) 34-41
   (4) 42-49

13. What is your income?
   (1) TANF
   (2) Non-TANF
   (3) Disabled
   (4) Employed

14. What is your marital status?
   (1) Married
   (2) Never married
   (3) Divorced
   (4) Separated

15. What is your level of education?
   (1) College Graduate
   (2) Some College
   (3) High School Graduate
   (4) Less Than 12th Grade
   (5) Vocational School
REFERENCES


