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AN EVALUATION OF TWO DRUG ABUSE
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IN
LANSING, MICHIGAN

By

William Robert Ives

A DISSERTATION

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ABSTRACT

AN EVALUATION OF TWO DRUG ABUSE TREATMENT PROGRAMS IN LANSING, MICHIGAN

By

WILLIAM ROBERT IVES

The major problem in the treatment of addiction has been the relative inability to find an effective treatment (i.e. one that reduces the probability of the addict returning to crime, institutional care, and the abuse of addicting drugs). In addition, there have been very few studies seeking to evaluate the effectiveness of alternative treatment approaches. Because of the lack of such data the present study has undertaken an evaluation of the relative treatment efficacy of two disparate treatment approaches; a traditional halfway house and an innovative program, the lodge. The halfway house provided a highly structured living environment designed to provide a gradual transition between addiction and normal community life. Conversely, the lodge was designed as a loosely structured, member-governed, residential community. The operation of a lodge business was intended to provide both employment and a source of support for the lodge program. A series of problems though, occurred in the implementation of the lodge program. Because of these problems, the lodge program was modified such that it was actually run as less-authoritarian halfway house.

Drug abusers from the local community who voluntarily sought treatment were randomly assigned to one of the two programs at intake. During this initial interview information was collected on personal characteristics, treatment expectations and drug attitudes. At the end of 90 days in a given program follow-up information is collected on a number of new arrests, reinstitutionalizations, length of stay in the program, and use of drugs while in the program. Chi square analysis of the outcome variables revealed no significant differences between the halfway house and lodge. The finding of no differences between the two approaches seriously weakens the arguments for the need for highly structured programs for the treatment of chronic drug abusers. Data on personal characteristics of addicts was cluster analyzed. The factors that were found to be related to outcome generally supported the hypothesis that increased assimilation into the "drug culture" (i.e. longer time spent mainlining heroin, greater habit cost, illegal support of the habit, and more time spent in jail after beginning illegal drug use) leads to unfavorable treatment outcomes. No evidence was found that related treatment outcomes to social class, age, education, employment history, marital status, or drug use history, as had been reported by several other investigators. Three critical elements were also discussed which are necessary for the implementation of community research: 1.) Written administrative agreements; 2.) Researcher control of treatment programs; and 3.) The necessity to leave unwilling programs out of the research design.

ACKNOWLEDGMENTS

I had originally intended to create a pool-pah but better judgment has overcome my social motives. Thank you Lou for all your support.

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CHAPTER I

INTRODUCTION

A Brief History of Opiate Use

The problem of narcotic addiction is not a new one. The use of opium was known to the Sumerians, where mention of the collection of opium from poppies (Papaver somniferum) was made in the seventh century B.C. Opium was used in remedies by the early Egyptians, Persians, and later by the Greeks and Romans (Hess, 1971). Hippocrates (460-357 B.C.) recommended a preparation of opium for the treatment of leukorhea. The writer Virgil (70-19 B.C.) mentions the sleep-inducing properties of opium in two of his works. Galen (130-200 B.C.), the Greek physician, saw opium as a virtual panacea and recommended its use for the cure of diseases such as epilepsy and melancholy (Terry and Pellens, 1928).

Opium was introduced into Europe during the Middle Ages by the Chinese, where its use grew rapidly.

"The famous physician . . . Paracelsus (1490-1540) owed much of his success to the bold way in which he administered opium to his patients. He is said to have carried opium in the pommel of his saddle and called it the 'stone of immortality.' His followers were as enthusiastic as himself over the virtue of opium. Platerus of Basle in 1600 strongly recommended it and Sylvius de la Boe, a famous Dutch physician declared that without opium he could not

practice. The celebrated chemist and physician, Van Helmont, about 1640, used it so frequently that he was called Dr. Opiatus, and Sydenham about 1640 writes that among the remedies which it has pleased Almighty God to give to man to relieve his sufferings, none is so universal and so efficacious as opium" (Terry and Pellens, 1928, p. 57).

The use of opium during the eighteenth and nineteenth centuries followed a similar course. De Quincie's description of his personal use of opium in Confessions of an English Opium Eater (1821) did much to popularize the use of opium. In 1803 the chemist, Serturmer, isolated morphine from opium and with the development of the hypodermic method of injection by Wood in 1843, the addiction problem increased in severity. The hypodermic method had two influences; 1.) It provided a more efficacious means of administration of drugs and 2.) It led to the belief that hypodermic injection of morphine was a cure for opium addiction and non-addicting. Unfortunately the first victim of an overdose was Wood's own wife.

The American Civil War provided the first opportunity for physicians to use the hypodermic method of injection of morphine on a large scale. The disastrous consequences of this wide spread morphine use were reflected in the large number of addicts seen after the hostilities were concluded.

Opium based preparations found their way into the consumer market during the late 1800's and early 1900's as tonics, elixirs, cough syrups, and pain killers. Opium smoking was introduced in the 1850's by the Chinese immigrants to the U. S. It is instructive to note that while

the dangers of opium addiction had been known since 1563, the use of opium had been widespread. It wasn't until gamblers, prostitutes, and underworld figures began to smoke opium that the public was aroused.

"It was due to the shady character of the first white opium smokers that first the smoking habit, and later all narcotics use became to be considered as disreputable and associated in popular opinion with crime This new spirit (i.e. regarding opium use as criminal) is aptly expressed by the new, specifically American term 'dope fiend' the first known usage of which occurred in the New York Sun in 1896 (Hess, 1971, p. 593)."

At the same time as public awareness was increasing with respect to the problems of opiate addiction heroin was synthesized from morphine by the German chemist Dresser. The Bayer Company took over the development of this derivative terming their new product heroin and placed it on the market as a cure for morphine addiction. In commenting on the use of heroin Terry and Pellens (1928) state:

"In reviewing the very remarkable history of the rapid increase in the use of this drug, its wide popularity as a therapeutic agent, the acclaim with which it was received by the medical profession, and the persistence with which manufacturers advertised its virtues in both technical and lay publications, it is astonishing that physicians were so slow to recognize its dangers and that for the first six or eight years of its employment there were only a few among the large number who proposed its employment in an ever increasing number of conditions who appreciated the harm that was being done. One wonders why during this period members of the profession, to whom cases of chronic heroin intoxication must have appealed for treatment and who scarcely could be unaware of the growing popularity of the drug among the laity, did not come forward in greater numbers with appropriate warnings. The fact remains however that for 12 or

14 years after its introduction current medical literature included constant references to its value as a therapeutic agent in almost every variety of complaint Heroin was quickly seized upon by the underground market subsequent to the passage of state regulatory laws and the Harrison Act (because it was particularly adapted) to the purposes of vendors of illicit drugs inasmuch as its morphology permitted easily of adulteration with sugar of milk (i.e. lactose) or certain coal tar products (i.e. quinnine) while morphin (sic) could be so treated only with great difficulty (p. 86)."

Legal History

Increase in the public's awareness of addiction consequent to opium smoking and the use of over-the-counter preparations containing opium or opiates (e.g. heroin) resulted in the Pure Food and Drug Act of 1906, the banning of the importation of opium for smoking in 1909, and the Harrison Act of 1914. The passage of this latter act signalled the beginning of the increasing criminalization of the addict status. Its passage represented a tacit admission of the failure of the medical community to find an effective cure for addiction. The Harrison Act and subsequent Supreme Court decisions engendered by its enforcement effectively removed the problem of addiction from the medical profession and gave it over to the law enforcement officials.

The Harrison Act was passed, ostensibly as a revenue measure, imposing a tax of one cent per ounce on opiates and making trade in opium a matter of public record. The act stated nothing about treatment of addicts. Several subsequent Supreme Court decisions effectively altered the intent of this act. In Webb vs. U. S. (1919) the court ruled that

prescription of drugs for the treatment of an addict "not in the course of professional treatment in the attempted cure of the habit but being issued for the purpose of providing the user with morphine sufficient to keep him comfortable by maintaining his customary use" was not a legal prescription under the act (Lindsmith, 1965). In the U. S. vs. Behrman (1922) the court ruled that prescriptions for morphine given to addicts were illegal regardless of the purpose.

During the period from 1919-1921, 44 clinics were operated which dispensed morphine on an outpatient basis to registered addicts. Practices were quite variable from clinic to clinic and the fact that they were generally operated by persons who were naive with respect to the problems of narcotic addiction were probably contributing factors to their closing by the Federal government. Lindsmith (1965) states:

"In view of the wide differences between the clinics and the short period of their operation (some were only open a few months before they were closed) it is inconceivable that the Washington authorities who ordered them closed acted on the basis of knowledge of how the individual clinics were operated (p. 52)."

In 1925 the Supreme Court apparently reversed itself in Linder vs. U. S. by ruling that prescription of drugs to relieve withdrawal distress by physicians acting in good faith and fair medical practices, is not a violation of the law (Lindsmith, 1965). This case notwithstanding, doctors gave up the practice of dealing with addicts because of the

possibility of prosecution. The addict thus had to turn to illegal sources in order to supply his habit. Terry and Pellens (1928) quote a report of the Committee on Traffic in Narcotic Drugs published in June 1919:

"In recent years especially since the enactment of the Harrison Law, the traffic by 'underground' channels has increased enormously and the present time it is believed to be equally as extensive that carried on in a legitimate manner. This traffic is chiefly in the hands of so-called 'dope peddlers' who obtain their supplies by smuggling from Canada, Mexico, and along the Atlantic and Pacific coasts (p. 87)."

Thus by the 1920's the criminalization of the addict status was complete.

History of Treatment

Treatment for addicts was usually accomplished in hospital settings until the 1950's. The Federal government has established two such hospital treatment programs, one in Lexington, Kentucky, and the other in Fort Worth, Texas. These two facilities were developed in the 1930's in the belief that addict prisoners shouldn't be mixed with other types of offenders. Addicts were at first withdrawn through the use of morphine but in 1948 methadone was substituted for morphine. By 1970 these two facilities had treated more than 50,000 addicts with a fairly low degree of success. The results of a number of investigations of addiction status subsequent to treatment at the Lexington facility are quite variable. The results vary from a low of 39.9% relapsed (Pescor, 1943) to a high of 90.1% relapsed (Hunt, 1962). O'Donnel in discussing the variability of the "Lexington

Studies" points out that the disparate findings could be explained by the fact that relapse rates vary considerably depending on the age, volunteer-non-volunteer status, length of stay, and social status of the addicts (1965).

In 1958, Synanon was established in Ocean Park, California by Charles Dederich, an ex-member of Alcoholics Anonymous. For several reasons Synanon has effectively resisted evaluation by outside professionals. One of the reasons is that Synanon has a strong anti-professional bias. Professional people and particularly those who profess to be experts in the area of addiction treatment are therefore not encouraged to undertake an evaluation of the program. Secondly, Dederich believes that if the addict population seeking treatment knew what the success rate was they would use it as an excuse and a rationalization for failure (Yablonsky, 1965). Volkman and Cressey (1966) have come the closest to evaluating Synanon. From May 1958 to May 1961, 263 people were admitted to Synanon. Of these, 190 left without the advice of the program giving an attrition rate of 72%. Ninety percent of the dropouts from the program occurred within the first three months of the program. By the seventh month only 75 out of the original sample of 263 were totally abstinent. Thus, the relapse rate appears to be approximately 71.5%.

Deissler (1972) cites several factors that he feels are important determinants of the success of Synanon:

(1) Environment - Diessler feels that an addict cannot be rehabilitated if he is kept in his usual environment.

Therefore addicts coming to treatment in Synanon are usually moved far away from their original neighborhoods.

(2) Learning from Peers - All work at Synanon is done by ex-addicts who reside there. The author feels that this instills the belief in the if-he-can-do-it-I-can-do-it philosophy.

(3) Interaction with the Community - Synanon encourages its people to interact with the community which fosters something other than "junkie" behavior.

(4) Self-Support - Synanon is almost totally self-supporting deriving most of its support from its advertising business. Diessler feels that this leads to cooperation among participants and therefore fosters group spirit.

(5) The Synanon Game - Neissler and most other advocates of the Synanon treatment approach usually place the greatest emphasis on this aspect of Synanon. The "game" amounts to a no-holds-barred, confrontative encounter group. Neissler feels that this "game" allows the addict to grow personally and emotionally.

To most Synanon detractors this latter aspect of Synanon is the most offensive. Many feel that the game is inhumane treatment for an addict and that it does more damage than good. Perhaps what the critics are reacting to is the fact that Synanon does not pretend to be a non-directive program interested only in keeping the addict off heroin. The employment of a non-directive approach would be in direct contradiction to their values.

Synanon has given rise to several similar programs in other parts of the country. A few of the more well known are DAYTOP Village (an acronym for Drug Addicts Treated On Parole), Phoenix House in New York City, and Gaudenzia House, in Philadelphia. Most of these therapeutic communities have lacked evaluative research, although DAYTOP has been studied in a survey by Glasscote, et al. (1972). In terms of outcome the authors state that out of approximately 1000 participants (records were rarely kept in the early years) over a period of six years only 137 participants have reached "graduate status." For these 137, 14 had returned to drug use, 29 were on the staff of DAYTOP, 61 were on the staff of other drug treatment programs, and 32 were employed at other jobs. It should be noted that this information was gained on hearsay rather than through more reliable methods of data collection.

Treatment of narcotic addicts has also been accomplished by use of the halfway house concept. The basic idea of the halfway house is borrowed from the area of corrections where it was first originated by William Roscoe in 1819. Roscoe contended that prisoners leaving the Massachusetts State Prison should be returned via a transitional residential program:

"The convicts who are discharged are often entirely destitute. The natural prejudice against them is so strong that they find great difficulty in obtaining employment. They are forced to seek shelter in the lowest receptacles if they wish to lead a new course of life are easily persuaded out of it, and perhaps driven by necessity to the commission of fresh crimes. It is intended to

afford a temporary shelter in this building, if they choose to accept it, to such discharged convicts as may have conducted themselves well in prison, subject to such regulations as the directors may see fit to provide. They will have here a lodging, rations from the prison at a cheap rate, and a chance to occupy themselves where they can gain an honest livelihood in society. A refuge of this kind to this destitute class, would be found perhaps, humane and politic (Roscoe, 1819 quoted in Geis, 1966, p. 165)."

Evaluations have been reported in the literature on three such facilities. Geiss (1966) randomly assigned felons with a previous record of narcotics use to one of two conditions: either a halfway house or regular parole. The house population (24) turned over about every four months. Commenting on this high turnover rate Geis (1966) states:

"The rapid shift of residential population was seen by the treatment staff as seriously inhibiting any continuity in attempts to establish a certain ethos in the house and vitiating therapeutic advances by rapidly removing centers of stability from the house and intruding a large number of uninitiated entrants each month. The aim of this rapid turnover was to determine whether a facility such as the East Los Angeles Halfway House could in fact produce a positive result without the rather high cost associated with long-term residence in the facility and without the allegedly debilitating influence of extended dependence upon the house (p. 129)."

Follow-up was conducted at 12 months. There were no statistically significant differences found between experimental and control conditions in terms of return to use of narcotics, drug free weeks, and number of new criminal convictions.

Berecochea and Sing (1972) report on an evaluation of a halfway house similar to that described by Geis (1966). Subjects were civilly committed addicts assigned to the

halfway house as a part of their treatment, following inpatient detoxification at the California Rehabilitation Center. A sample of 44 clients turned away because of overcrowding served as the control group. Follow-up was conducted at 12 months after an individual was released from the house. The authors reported no significant differences between experimental and control programs, with respect to new convictions and detected drug use during a follow-up period.

Kaplan and Meyerowitz (1969) studied a halfway house facility designed as a transitional residence for narcotic addicts coming out of prisons and hospitals. Subjects were randomly assigned to the treatment condition. One hundred seventy-seven individuals who were institutionalized and scheduled for release served as the control group. Follow-up was conducted at anywhere from 9-22 months after release from the treatment program in which they participated. The results showed that those in the experimental program did not differ significantly from the controls in return to the use of narcotics. Those participants in the halfway house that did not leave against program advice significantly differed from controls on employment (greater likelihood of employment for experimentals who left early) and new convictions (greater likelihood of no new arrests for experimentals who stayed in the program). Experimental early leavers were significantly more likely to be unemployed than those in the control condition and were more likely to have become readdicted.

Rationale of the Present Study

A major problem in the treatment of addiction has been the relative inability to find an effective treatment (i.e. one that reduces the probability of the addict returning to crime, institutional care, and the abuse of addicting drugs). Treatment methods, with the exception of methadone, have usually been predicated upon intervention involving some version of verbal therapy. Even the Synanon approach, with its apparent reliance on the social community and getting jobs, places a heavy emphasis on the importance of the synanon game. This assumption does not appear to be tenable in light of all the studies reviewed by Bandura (1971) on treatment of the mentally ill. Bandura points out that when considered in the light of treatment outcomes determined under experimental conditions, the "so-called conversational therapies" are an ineffective treatment modality for the treatment of the mentally ill.

In contrast to much of the traditional approaches to treatment has been the work of Fairweather and his associates (Fairweather, et al., 1960, Fairweather, 1964, Fairweather, 1967, Fairweather, 1969, Fairweather, et al., 1973). In 1964, Fairweather found that with mental patients, length of stay in the community was related to the degree of supportiveness of the living situation and the frequency of employment in a low status job. These findings led to the development of the community lodge (Fairweather, 1969). This program is a member-governed residential program which is entirely self-supporting through the operation of the

lodge business. The staff serves in the program as consultants to the residents rather than playing the traditional roles of psychologist or psychiatrist. As a whole the intent of the program is to provide meaningful occupational and social roles for the residents. This program has been shown to be highly effective in the treatment of the mentally ill (Fairweather, et al., 1969). The program's emphasis on a social system approach with a task orientation (self-government and business) rather than a verbal therapy orientation is somewhat similar to Synanon.

The contrast between the lodge approach and the halfway house approach is obvious. One involves the creation of a coherent social system with autonomy and meaningful social and occupational roles for its members; the other continues the medical model treatment approach with an adjunct emphasis on traditional or neo-traditional psychotherapy. In a review of the existing treatment literature there is no direct comparison involving the relative effectiveness of these two disparate treatment approaches. It is therefore the first major purpose of the present experiment to evaluate treatment of chronic drug abusers in one of two settings; a traditional halfway house or a lodge type program.

The failure of many of these programs to prevent relapse to the use of narcotics may be that they do not match the addict to the program best suited for him. Geis (1966) has spoken out about this in the following way:

" . . . The house can serve as a useful therapeutic weapon . . . if initial screening is undertaken to admit only individuals who are apt to be most responsive to the things which it offers (p. 185)."

Some social and/or psychological characteristics have been found to be correlated with an addict's degree of success in a given program. The most commonly studied variables have been demographic. Variables of this type are easy to measure and are not influenced by the reactive technique of most experiments. In addition they are relatively inexpensive to obtain because they are usually kept in institutional records. A number of demographic characteristics have been shown to be related to relapse rate or attrition from a treatment program including age (Duvall, Brill, and Locke, 1963; Hunt and Odoroff, 1962; Winick, 1962; Zahn and Ball, 1972), education (Chambers, Cuskey, and Wieland, 1970; Geiss, 1966; Vaillant, 1966), employment history (DeFleur, Ball and Snarr, 1969; Vaillant, 1966; Zahn and Ball, 1972), marital status (Vaillant, 1966; Zahn and Ball, 1972), race (Geiss, 1966; Hunt and Odoroff, 1962), time spent in treatment (Hunt and Odoroff, 1962; Volkman and Cressey, 1966; Zahn and Ball, 1972), volunteer-non-volunteer status (Hunt and Odoroff, 1962; Vaillant, 1966), social class (Jones, 1958), and family background (Geis, 1966). These variables are related to relapse such that favorable treatment outcomes are expected when the client is an older, married, white, non-volunteer, who has a higher education, better family background, a better employment record, and who spends a longer time in treatment.

Personality variables have also been looked at by several investigators. Gendreau and Gendreau (1971) studied differences between addicts and non-addicts on the MMPI. They found that if criminality is controlled for by equating groups on criminal behavior (time in jail) there are no differences on MMPI scores between addicts and criminal non-addicts. Carroll (1968) failed to find relationships between Rotter's internal-external control and an addicts age at first heroin use, number of times arrested, age at first arrest, or race. DeMeritt (1970) found that there was no difference in self-concept of non-drug users and abusers while former users seemed to have a better self-concept than abusers and non-abusers as a class.

One of the major problems with the studies cited above has been the lack of multivariate statistical analyses of data on addict characteristics and treatment outcomes. One of the major purposes of the present study is to subject data on treatment outcomes and abuser characteristics to analysis using the BCTRY system (Tryon and Bailey, 1970). This analysis will not only allow us to determine the dimensionality of the data but also, through O-Analysis, will allow us to look at data on individuals who are successes and failures. Through the use of the latter technique it is hoped that we can discover what type of people do best in what type of program. Demographic variables will be used in this analysis because of their previously demonstrated relationships to relapse and attrition.

The purpose of the present experiment is two-fold:

- 1.) To examine the relative efficacy of two treatment approaches (halfway house and lodge) in the treatment of chronic drug abusers; and 2.) To examine the characteristics of drug abusers employing the technique of cluster analysis (Tryon and Bailey, 1970) and relate these characteristics to degree of success within a given program.

CHAPTER II

METHODS

Social Subsystems

The halfway house. The halfway house studied in this research provides its residents with a structured living situation. The facility is located on the predominately black, west side of Lansing in an old house. The total capacity is 15. During the course of the study the program was structured to keep drug abusers there a minimum of six months. During this time the residents are supposed to find a legitimate job and complete any educational deficiencies that they might possess. On-going group therapy is used to aid the client in discovering personal attributes or problems that have maintained his drug taking behavior. At the end of the six month period the individual client would take up residence in the place of his choice.

The lodge. Fairweather, et al. (1969) have characterized a lodge as a "special kind of social organization in the community which differs radically from other, more traditional forms of residence (p. 3)." The main differentiating characteristics of the lodge are: 1.) It depends on the clients themselves to keep its members in the community rather than the support of other personnel;

and 2.) Members, as a group, are responsible for the control of the living and working aspects of the lodge operations. Like the halfway house, the facility is located on the west side of Lansing in an old house. The total capacity is 24. Unlike the halfway house there is no set time limit on length of stay of individual clients. It was also expected that within the first several months of operation that the members would decide upon the nature of the business operation they were to set up.

Subjects

All subjects, except one, were volunteers from one of several sources. Of the 48 subjects, 18 came from the streets, 14 were referred from the Ingham County Jail, 6 were referred from local crisis centers, 3 were referred from the methadone and detoxification program, and 7 were referred from local community mental health center. One of the referrals from the jail was assigned to the lodge as a condition of his parole. Of the 24 people assigned to the halfway house, one had been assigned to the outpatient condition and later returned for reassignment, one was hired as a staff counselor, one was refused admission, one was assigned to the lodge and then was reassigned to the halfway house, and one never showed after being assigned. Twenty persons stayed in the house for some period of time after their assignment. Of the 25 persons assigned to the lodge, one was not accepted, six left before they moved in, one was assigned to the lodge and didn't show up until several

months later, and one was assigned to the lodge as a condition of his parole. Seventeen clients lived in the program for some period of time after their assignment.

Instruments

Four sources of information were utilized in the present study; an intake questionnaire, administered by the interviewer, an expentancy questionnaire, which was self-administered, institutional records from the Ingham County Jail and local community mental health centers, and program records from the individual treatment programs. These latter two sources of information allowed calculation of rejailings and reinstitutionalizations, dirty urines, and length of stay in the program.

Intake questionnaire. The intake questionnaire (Appendix A) was designed to measure certain demographic characteristics of the participants including employment history, arrest record, family history, military history, treatment history (i.e. for drug and mental health problems), education, marital status, race, sex, and age. In addition a detailed drug history inventory was included which assessed past and present use of seven categories of drugs; marijuana/hash, alcohol, CNS depressants, CNS stimulants, cocaine, hallucinogens, and narcotics. This section was scored as follows:

1 = never used or used once or twice

2 = used less than once a month but not currently using

3 = used greater than once a month but not currently using

4 = used greater than once a month and currently using

A score for each specific drug used was calculated and a mean derived for each class. In addition to this drug section, each addict completed a special section of the questionnaire which was designed to measure certain characteristics of the heroin habit such as cost, age at first use, length of time spent mainlining heroin, and the means used to support the habit.

Expectancy questionnaire. This questionnaire (see Appendix B) was a modification of that used by Fairweather, et al. (1969). It was designed as a series of statements of behavioral intentions or guesses about how well the client thought he would be satisfied in the program.

Program and institutional records. These records provided information for the determination of program outcomes. The outcome variables utilized in the present study were number of reinstitutionalizations, number of rejailings, time spent in the program, and percentage of clean urines. Urines were analyzed for amphetamines, barbiturates, opiates (as morphine), and quaaludes by United Medical Laboratories using paper chromatography. Percentage of clean urines was calculated by dividing the total number of clean urines by the total number of urines taken and multiplying the result by 100. All four of the outcome variables were assessed at a three month interval after a person entered the program.

Experimental Design and Procedure

The experiment was designed as a 2 X 2 analysis of variance design (heroin-non-heroin X halfway house-lodge) and is pictured in Figure 1. Upon admission to the drug program each client was referred to the central intake

	<u>Heroin Users</u>	<u>Non-Heroin Users</u>
<u>Halfway House</u>	N=16	N=4
<u>Lodge</u>	N=12	N=5

Figure 1. A schematic representation of the experimental design.

coordinator for an initial intake interview. These interviews were conducted at either the point of initial referral, the central office of the drug program, or any place of mutual convenience. During the initial interview the Intake and Expectancy questionnaires were administered. Participants were then randomly assigned to one of the two treatment conditions. After a client had been in the program for 90 days, Program and Institutional Record outcome data were gathered.

CHAPTER III

RESULTS

The Environment

The milieu in which these subsystems were implanted can be described by looking at census data. Table 1 presents data on population, percentage of white and black residents, number of housing units, percentage of the population in the labor force, percentage of the population in the educational and professional services, and median family income for four geographical subdivisions of the subsystem's environment; the metropolitan region, the urban region, the local area, and the neighborhood (Fairweather, et al., 1969).

The metropolitan region is taken as the standard metropolitan statistical area (SMSA). The urban area is defined as the city of Lansing, Michigan. The neighborhood is defined as the census tract of which the subsystem is a part and all of the bordering census tracts. The local area is taken as the census tract in which the subsystem is located. As can be seen from the data presented in Table 1 the environments of the halfway house and lodge are dramatically different. The neighborhoods of the two subsystems differ in terms of percentage of blacks,

Table 1. A comparison of the halfway house and lodge on demographic data from four geographical subdivisions of their environment. HOC=Halfway house.

Subdivision	<u>Metro</u>	<u>Urban</u>	<u>Local</u>		<u>Neighborhood</u>	
			Lodge	HOC	Lodge	HOC
Population	378,423	131,546	21,211	15,680	2,899	4,153
% Black	3.9%	9.0%	---	---	7.0%	78.0%
Housing Units (All Housing Vacant or Not)	116,089	45,300	7,230	6,348	1,581	1,648
% Population in Labor Force	42%	42%	46%	46%	56%	41%
% Labor Force in Education and Profes- sional Services	16%	13%	11%	13%	23%	11%
Median Family Income	\$11,213	\$10,839	----	----	\$10,064	\$7,369

percentage of the total labor force in education and professional services, and median family income. The neighborhood of the halfway house is predominately black with a median family income well below that of either the SMSA or the urban area. The neighborhood of the lodge has a median income which is comparable to that of the SMSA and the urban area has a population composed of 7% blacks compared with the 78% black population of the halfway house neighborhood. These differences are all the more dramatic if it is considered that the two programs are only separated

by six city blocks (the halfway house is located at 402 S. Walnut while the lodge is located at 517 N. Walnut).

Outcome Variables

During the three month follow-up period a total of five persons were reinstitutionalized and three persons were sent to jail. Comparison of the halfway house and lodge on these two variables revealed chi-square values of 1.35 (1 df, $.20 < p < .30$) and .02 (1 df, $.80 < p < .90$) for reinstitutionalization and rejailling, respectively (see Table 2). The median time persons spent in the program during this three month period was 73.5 days. A comparison of the halfway house and lodge on median length of stay revealed a chi-square of 1.37 (1 df, $.20 < p < .30$). Median percentage of clean urines was calculated to be 92.2%. Comparison of the two programs on this variable revealed a chi-square of .04 (1 df, $.80 < p < .90$). The analyses for these latter two variables are presented in Table 2. Thus in terms of these outcomes at 90 days there are no statistically significant differences between the two programs.

In order to determine differences between heroin and non-heroin users on the outcome variables, comparisons were conducted using chi-square (see Table 3). As can be seen only one test reached significance (i.e. percentage of clean urines). Thus, persons who have used heroin in the past, not surprisingly, exhibit more dirty urines than do non-heroin users.

Table 2. Comparison of the halfway house and lodge on the four outcome variables; reinstitutionalization, rejailing, length of stay, and percentage of clean urines.

Outcome Variable	<u>Halfway House</u>		<u>Lodge</u>		<u>df</u>	<u>x²</u>
	N	%	N	%		
Reinstitutionalization						
In treatment some time	1	3	4	11	1	1.35
Remained out of treatment	19	51	13	35		
Rejailing						
In jail some time	2	5	1	3	1	.02
Remained out of jail	18	49	16	43		
Length of stay						
Above median	12	32	6	16	1	1.37
Below median	8	22	11	30		
Percentage clean urines						
Above median	11	30	9	24	1	.04
Below median	9	24	8	22		

Cluster Analysis

An empirical V analysis (Tryon and Bailey, 1970) was conducted on the data from both programs. In order to form an outcome cluster percentage of clean urines and other cluster definers derived from the empirical V analysis were preset (Preset Key Cluster Analysis, Tryon and Bailey, 1970). In this way it was possible to examine outcome variables and related measures. In addition variables found to be independent of outcome could also be defined. The three preset clusters derived from the present analysis

Table 3. Comparison of non-heroin and heroin users on the four outcome variables, reinstitutionalization, rejailing, length of stay, and percentage of clean urines.

Outcome Variable	<u>Heroin</u> <u>Users</u>		<u>Non-Heroin</u> <u>Users</u>		<u>df</u>	<u>χ^2</u>
	N	%	N	%		
Reinstitutionalization						
In treatment some time	3	8	2	5	1	.10
Remained out of treatment	25	68	7	19		
Rejailing						
In jail some time	2	5	1	3	1	.10
Remained out of jail	26	70	8	22		
Length of stay						
Above median	14	38	4	11	1	.01
Below median	18	48	1	3		
Percentage clean urines						
Above median	10	27	8	22	1	5.73*
Below median	14	38	5	13		

* $p < .05$

are presented in Table 4. The correlations between the oblique cluster domains are presented in Table 5.

Table 4. The three preset clusters.

<u>Cluster</u>	<u>Loading</u>
Cluster 1. Outcome	
1. Greater number of dirty urines	.69
2. Shorter time in the program	.33
3. Heroin	
a. Greater time mainlining heroin	.82
b. Longer time spent clean	.69
c. Greater cost of habit	.38
d. Tendency to support habit illegally	.46
4. Less optimistic expectations for treatment	.77
5. Greater amount of time spent in jail after beginning illegal drug use	.44
Cluster 2. Drug Behavior	
1. Greater number of drugs used	.91
2. Drugs	
a. More frequent use of marijuana/hash	.76
b. More frequent use of hallucinogens	.68
c. More frequent use of narcotics	.67
d. More frequent use of CNS depressants	.65
e. More frequent use of CNS stimulants	.75
f. More frequent use of cocaine	.53
g. More frequent use of alcohol	.42
3. Tendency to be younger	.48
Cluster 3. Institutionalization	
1. Institutional history	
a. Older at first institutionalization	.43
b. Greater number of institutionalizations	.56
c. Higher probability of being reinstitutionalized	.41
2. Greater number of residence changes	.42
3. Tendency to be female	.42
4. "Middle class"	
a. Tendency to be white	.82
b. Parents have a higher occupational code	.54
5. Older at first illegal drug use	.45
6. Tendency to be married	.38
7. Tendency to have been born and raised in the same town	.33

Table 5. Correlations between the oblique cluster domains. Cluster 1 is outcome, Cluster 2 is Drug Behavior, and Cluster 3 is Institutionalization.

	Cluster 1	Cluster 2	Cluster 3
Cluster 1	----	.09	-.09
Cluster 2	.09	----	-.01
Cluster 3	-.09	-.01	----

Cluster 1 (outcome). This cluster was termed outcome because its primary definers were the percentage of clean urines and length of stay as well as other variables found to be related to those outcomes in the initial empirical V analysis. The cluster has a relatively high reliability (.80) and high domain validity (.90). As can be seen in Table 5 it is relatively uncorrelated with the other two clusters. It is correlated .09 with cluster 2 and -.09 with cluster 3. In all this cluster contains eight variables. The first two variables, percentage of clean urines and length of stay in the program are inversely related to one another. Four variables related to the use of heroin are also found in this cluster; time spent mainlining heroin, longest time spent free of heroin, cost of the habit, and the nature of habit support (legal vs. illegal). These variables were all negatively related to the percentage of clean urines and length of stay in the program. The score on the Expectancy Questionnaire and

the amount of time spent in jail after beginning illegal drug use also were included in this cluster. Taken together these variables give a picture of a short-time intensive user of heroin, with limited extra-legal involvement, and an optimistic view of treatment, as having a good treatment prognosis.

Cluster 2 (drug behavior). This was the most reliable cluster discovered in the analysis (reliability = .87). It seems to represent a highly colinear subset of variables related to drug usage or behavior. Nine variables are found in this cluster. The first variable, total number of drugs used, has a loading of .91 on the cluster and correlates positively with all other variables in the cluster except age. The next seven variables measure the use of drugs in the following seven classes: 1.) marijuana/hash; 2.) cocaine; 3.) hallucinogens; 4.) narcotics; 5.) CNS depressants; 6.) CNS stimulants; and 7.) alcohol. The usage pattern (i.e. frequency of use) is highly positively correlated with the total number of drugs used and negatively correlated with age. Age has a loading of .48 on this cluster and was found to be negatively correlated with the other variables. Thus, a greater number of drugs used and a greater frequency of the use of drugs was found in the younger members of the sample. This cluster was essentially unrelated to the other two clusters.

Cluster 3 (institutionalization). This has been the most difficult cluster to interpret. The relatively low

reliability (.69) coupled with the relatively low loadings (seven out of ten at or below the .40 level) seem to limit its generality. Ten variables are found in this cluster. The first three (age at first institutionalization, number of institutionalizations, and number of reinstitutionalizations) form a group of variables that might be termed institutional history. Two other variables, race and parents occupational code, formed a second group termed "middle class." The five other variables which are found in this cluster were number of residence changes, sex, age at first use of illegal drugs, marital status, and whether or not the person was born and raised in the same town. Taken as multiple predictors of reinstitutionalization it would be predicted that the probability of being reinstitutionalized is greatest when the person is a white middle class female who began illegal drug use at a later age, who was or is currently married, has changed residences a greater number of times, has had a history of past institutionalization, was institutionalized at a later age, and who was born and raised in the same town. These variables seem also to be descriptive of the non-heroin using population which is heavily white and has generally been institutionalized in the course of treatment.

O-Analysis

O-Analysis (Tryon and Bailey, 1970) was conducted in order to determine individual profiles with respect to the scores on the three clusters. Nine O-Types were defined

which accounted for 35 out of the 37 subjects. These O-Types are presented graphically in Figure 2. Means, standard deviations, number of persons in each O-Type, and homogeneity are presented in Table 6.

In the discussion below only those O-Types will be discussed which had at least one mean cluster composite score greater than $\pm$ one standard deviation from the standardized mean. Of the nine O-Types only one, O-Type 5, had all three cluster scores within the range of expected values. The other eight had at least one cluster composite score outside this range.

O-Types 1 and 4--low institutionalization non-whites.

Both these O-Types scored low on cluster 3 and both are formed of non-white males with little or no history of institutionalization. The two are differentiable on the basis of length of stay in the program with O-Type 1 remaining in the program the full 90 days and the individuals of O-Type 4 remaining in the program for the first month before leaving.

O-Types 7 and 8--drug experienced whites. Both these O-Types are composed of white individuals who had had a considerable background of drug use. In terms of outcome and institutionalization they are within the range of expected values.

O-Type 6--institutional white female. This O-Type is composed of three white women with a past history of institutionalization. They generally stayed in the program less

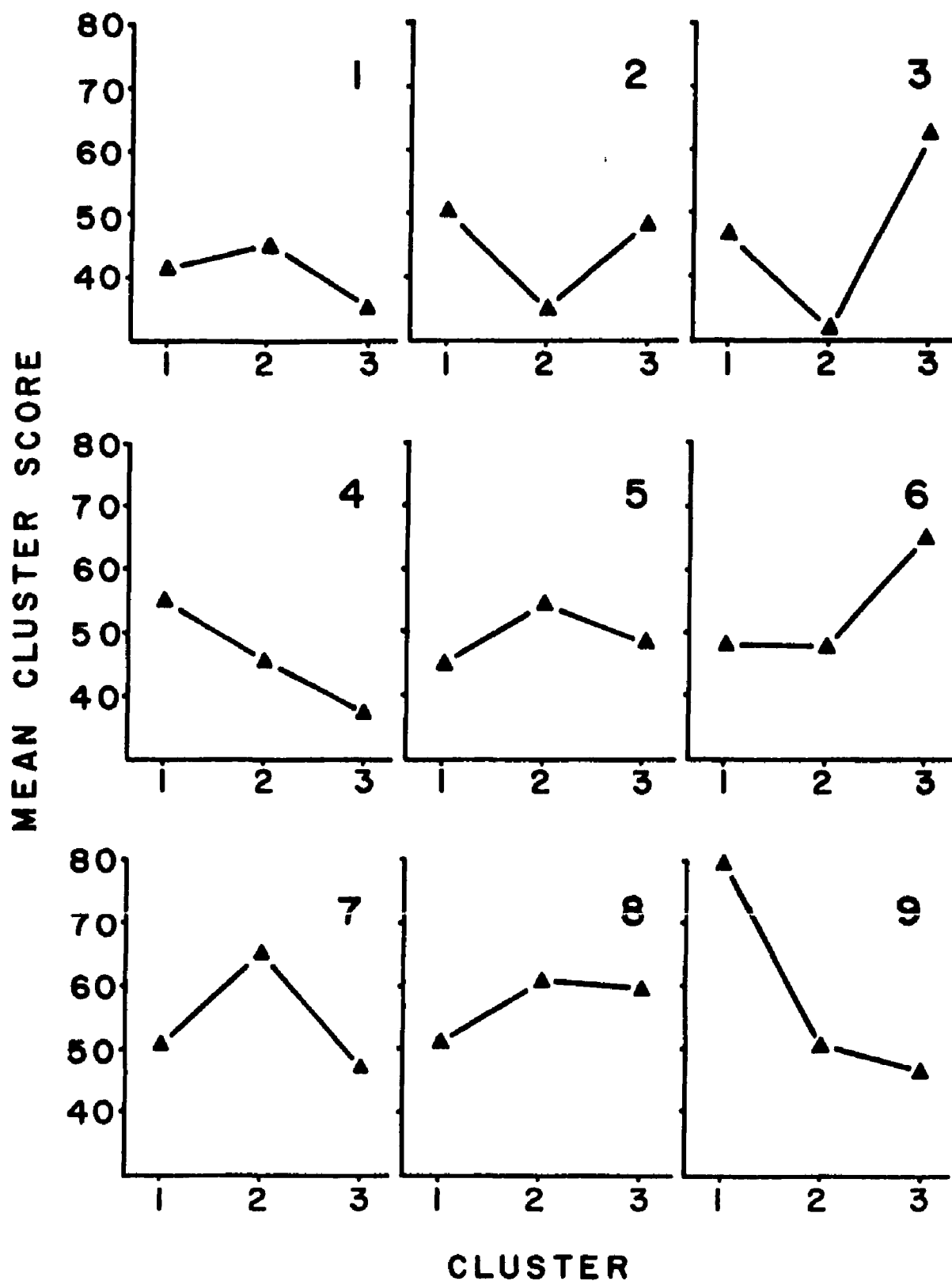


Figure 2. A Graphical Representation of the O-Types. Cluster number is represented on the abscissa while mean cluster score is on the ordinate.

Table 6. Means, standard deviations, N, and Homogeneity of the O-Types derived from the analysis. The first number in each tetrad is the mean followed by the standard deviation, N, and homogeneity.

O-Types	<u>Cluster 1</u>	<u>Cluster 2</u>	<u>Cluster 3</u>
O-Type 1	40.8642 2.3955 4 .9709	45.5988 2.9846 4 .9544	35.7641 2.9896 4 .9543
O-Type 2	50.8975 4.9940 2 .8661	34.1106 3.1796 2 .9481	49.1679 5.3652 2 .8439
O-Type 3	47.7706 7.6192 4 .6477	32.7034 4.6921 4 .8831	62.4120 3.6437 4 .9313
O-Type 4	55.3129 3.2777 4 .9448	46.2659 4.0470 4 .9144	37.1588 3.5526 4 .9348
O-Type 5	44.2772 2.1994 9 .9755	54.0009 3.7429 9 .9273	48.9769 4.6671 9 .8844
O-Type 6	48.4892 1.6398 3 .9865	48.7836 2.6613 3 .9639	64.2297 1.3637 3 .9907
O-Type 7	50.2548 4.3390 2 .9010	64.9256 1.0040 2 .9949	48.0468 .3427 2 .9994
O-Type 8	50.6029 3.5547 5 .9338	60.9817 1.6440 5 .9864	59.4552 2.6425 5 .9645
O-Type 9	80.4095 11.4177 2 -.5510	51.7684 3.9264 2 .9197	47.5050 1.0226 2 .9948

than the full 90 days. They were average with respect to scores on the other two clusters.

O-Type 9—high risk. This O-Type is formed of two individuals who used heroin for over 5 years (i.e. main-lined). Both were rejailed and left the program within the first month.

O-Types 2 and 3—drug naive. These two O-Types represent individuals who scored low on cluster 2, drug behavior. O-Type 2 is composed of two individuals, both non-white, who have had little history of use of drugs other than heroin. O-Type 3 is composed of four individuals, all white, who have used very few different types of drugs but had a relatively high composite score on the institutionalization cluster (cluster 3).

Limitations

The major problem in the interpretation of the results of both the preset analysis and the O-Analysis is that only 37 individuals were studied. In the latter analysis O-Types generally contained only two or three individuals which makes it difficult to determine the meaning of the groupings. While the use of this technique is a viable one for studies seeking to determine types of persons who do best in treatment the small sample size of the present study limits the generalizations which could be derived from such an analysis.

CHAPTER IV

DISCUSSION

Comparison of Programs

The major results of the study seem disappointing at first examination. No statistically significant differences were found between the halfway house and lodge in terms of length of stay, percentage of clean urines, reinstitutionalizations, and rejailings. Our major hypothesis, that the lodge would be superior to the halfway house in terms of outcomes in treating drug abusers, is not supported by these findings. Several factors, though, inveigh against a consideration of this study as an actual comparison of the two different systems.

While the subsystems were intended to be radically different approaches to the treatment of drug abusers many of these differences existed on paper only. Thus, while the lodge had intended to start its own business, such a business has not yet materialized because the director has felt that a stable population of clients was a necessary precondition to its formation. Also, group autonomy is not like that of the original lodge developed by Fairweather, et al. (1969). At both the lodge and the halfway house terminations of persons from the program are made by the respective directors of the program and their staff. At the lodge, in distinction to

the halfway house, there are no restrictions placed on new entrants to the program. In the halfway house clients are placed on a 30 day restriction during which time they cannot leave the program without being accompanied by another resident. Both programs seek to find employment for their clients on an informal basis. Clients in both programs are encouraged to make use of the job placement services offered by the community action work center, another component of the comprehensive drug treatment program. While residents of the halfway house are not permitted to have any drugs including alcohol, lodge residents are permitted to have alcohol. Residents of both programs are charged with the responsibility of physical maintenance of the structures in which they reside; residents of the lodge are required to do their own cooking while the members of the halfway house have a part-time cook. In the halfway house the resident with the least seniority is required to cook breakfast.

In general the halfway house is marked by a greater reliance on staff decision making and chain-of-command than is the lodge. In the halfway house problems are communicated to an expeditor rather than going to the director as in the lodge. Visiting privileges are set by the staff at the halfway house while at the lodge they are set by the residents. In terms of staffing, the lodge has two co-directors and one staff person while the halfway house has a director, three counselor aides and a half-time consulting psychologist. The latter staff function on an around-the-clock basis while the lodge staff are physically present

from 8:00 A.M. to 5:00 P.M. after which time they serve on an on-call basis.

As can be seen from the above description the lodge is a much less authoritarian program than the halfway house but does not completely have the two characteristics which were evidenced in the prototype lodge with mental patients; autonomous self-government and economic self-support. From the present findings it would seem, though, that the less authoritarian approach evidenced by this "lodge" is at least as effective as the more structured approach taken by the halfway house.

Another feature of the lodge as it was operated in Lansing which distinguishes it from the prototype lodge (but not subsequent lodges) was that it housed both male and female residents. This seemed to represent a major source of problems for the lodge program. In one incident a male resident accosted a female resident and in the ensuing struggle was stabbed to death. This tragic occurrence, coming as it did in the infancy of the program, resulted in an entire change in structure. Now, instead of the staff serving on a consulting basis, there is 24 hour staffing. It is hard to determine the causes of the incident (i.e. whether or not it was due to lack of program structure) but as a result the program is moving away from the original concept toward a more structured program.

The finding that it seems to make little difference in outcomes whether the program is loosely or highly structured and staff dominated is important for several reasons. In

any treatment program of a residential nature the greatest costs are generally for staff. The halfway house expended approximately 70% of their budget for staff salaries. The lodge, on the other hand, expended only 26% of its budget on staff salaries. This represents a savings of 44%. Coupled with the fact that the lodge ultimately becomes self-supporting, through the operation of the lodge business, the economic advantages of the lodge program represent a substantial improvement over the halfway house.

In addition to the economic arguments the finding of no difference between the two programs, seriously argues against current conceptions of the treatment of drug abusers. It has generally been assumed that in order to cure an addict either methadone or a highly controlling treatment program was needed. Advocates of the therapeutic community approach generally stress the need for a confrontative therapeutic game as a critical element of treatment (Yablonsky, 1965). The findings of the present study show that a therapeutic game, as was practiced in the halfway house, did not produce superior treatment outcomes. The fact that Synanon has a business as well as a confrontative game is of special significance here. While advocates of the Synanon approach argue that the game is the critical element of treatment it would seem as if the game and the effects of owning and operating a business are confounded. In looking at the principles of Synanon operation cited by Diessler (1972) and discussed in the introduction, only one of his five principles of operation is not a principle that was operative

in the prototype lodge, the therapeutic game. Thus in the lodge members learn from their peers, interact frequently with the community, support themselves, and are generally away from their original neighborhoods. The present experiment has allowed an investigation of the operation of a therapeutic game independent of a member owned and operated business. These findings argue for an interpretation of the "success of Synanon" in terms of the operation of a task oriented community rather than a verbal confrontative one as the necessary component of success.

The finding that the median percentage of clean urines was 92.9% and the overall attrition rate was 59.5% was quite surprising. The programs were well below the national attrition rate of 70%-80% (Glasscote, et al., 1972). The fact that the Lansing programs seem to be doing better than the national average could be due to the fact that the population of drug abusers in Lansing is radically different from the "big city" users usually studied.

Correlates of Treatment Outcomes

No evidence was found that related treatment outcomes to social class, age, education, employment history, marital status, or drug use history. Several investigators (see Chapter I) have reported such relationships. The majority of factors related to outcome were factors descriptive of the heroin habit such as cost of habit, length of time spent mainlining heroin, illegal vs. legal support of the habit, and longest time spent clean. The Expectancy Questionnaire

had a cluster loading of .77 on the outcome cluster indicating that statements of behavioral intention may be useful in multivariate prediction of treatment outcomes. Involvement in criminal activities subsequent to beginning illegal drug use was also found to be related to outcome. These characteristics seem to represent an individual's degree of assimilation into the "heroin culture." The longer an individual has been mainlining heroin, the greater the cost of the habit, and use of illegal means to support the habit all indicate that an individual is involved in behaviors which are peculiar to the "heroin culture." Thus the individual effectively becomes "marginalized" at the periphery of a society which does not sanction drug use. Involvement in criminal acts subsequent to beginning illegal drug use also results in increasing "marginalization." It is interesting in this respect to note that addicts who had "kicked the habit" for a longer period of time and then returned to heroin use were less likely to have favorable treatment outcomes than those who had "kicked" for shorter periods of time. This relationship could possibly be due to the fact that addicts who had "kicked" the habit for a relatively long period of time and then returned to it had more of a failure set than others who had not been able to "kick" for such longer periods of time. The correlation between a pessimistic expectancy and longer time spent clean was .42 which adds some strength to this interpretation. Table 4 shows that there are two classes of variables related to treatment outcomes. One class, those which measure

amount of criminal activity subsequent to beginning illegal drug use and characteristics of the heroin habit, seem to measure assimilation into the role of an addict. The more assimilation into this role the more unfavorable will be the treatment outcome. The second class of factors, those which measure the behavioral intentions of persons entering treatment (Expectancy Questionnaire), may measure past experience with particular emphasis on failing to "kick" the habit. The likelihood of favorable treatment outcomes seems to be related to success of past treatments.

It was found that drug behavior was highly independent of outcome. The only drug class which was loaded highly on the outcome cluster was narcotics. This is expected since the outcome cluster contained a number of factors directly related to heroin abuse. Thus, drug naive or drug experienced persons are equally as likely to succeed in treatment. In terms of the assimilation notion discussed above it would seem as if there should be a relationship between number of drugs used and involvement or assimilation into the "drug culture." Chambers, et al. (1970) reported that poly-drug users had a higher attrition rate from a methadone program than heroin-only users. It was found, though, that there was a strong negative correlation between the number of drugs used and the amount of time spent in jail after beginning illegal drug use ($r = -.48$). In view of this strong negative relationship it seems that the number of drugs used is not a measure of assimilation into the "heroin or drug culture." It would seem necessary that in order to reach such

conclusions variables indicating drug taking patterns should be used, not number alone. A measure was derived from the analysis which was utilized in an attempt to quantitatively describe drug taking patterns. The measure, HILO, resulted from subtracting the lowest score obtained for any one of the seven drug classes from the highest score obtained. It was felt that if an individual had utilized all the drugs about evenly then the HILO score would be low and the person would be drug experienced but with little involvement in just one drug type. The converse would apply for a high HILO score. It would not be expected that individuals who experimented with a large variety of drugs would be more assimilated into the "drug culture" than those who had used just one or two types of drugs more heavily. The relatively high correlation between jail after beginning illegal drug use and HILO ($r = .30$) would seem to support this interpretation.

The factors found in cluster 3, which are termed institutionalization, appear to be the non-heroin counterpart of those factors found in the outcome cluster (cluster 1). Thus non-heroin users tend to be white, middle class adults who entered into illegal drug use at a relatively older age than heroin users. The fact that none of these characteristics correlated with percentage of clean urines is due to the virtual absence of dirty urines in the non-heroin using clients of the present study.

The results of the O-Analysis tend to confirm the predictions made concerning the degree of assimilation and

outcome. O-Type 9, composed of two individuals in the sample who had been mainlining heroin for over five years did the poorest. In terms of length of stay in the program those persons in O-Type 1 did the best. In terms of assimilation characteristics of the members of this O-Type it was formed of two non-white males who had never abused any narcotic and two that had mainlined heroin for less than one year. While O-Type 9 seems to represent a clear-cut failure typology there was no clear success typology.

Problems in Implementation of Community Research

This study was designed to include a comparison group, outpatient aftercare, so that drug abusers would be assigned to one of three different treatment conditions (halfway house, lodge, and outpatient aftercare). Early in the study this condition had to be dropped because of pressure from the community mental health board. It was the board's feeling that assignment of drug abusers to a counselling condition represented ineffective and inadequate treatment. While the board had initially agreed to the empirical approach advocated by the investigators, they soon reversed their approval. This reversal in their attitude towards the research was probably attributable to the fact that during the first few months of the residential programs' operation very few clients applied for entry to the program. The board expressed their dissatisfaction with the small number of clients in treatment on several occasions. Concern centered around the fact that while the programs were

budgeted for \$100,000 each, both programs had only about four clients each. They felt that the lack of clients was due to the fact that some were being assigned to outpatient aftercare at the local community mental health centers. In addition there has always been some disagreement between the drug program in Lansing and the local community mental health centers and community mental health board. This conflict has arisen both because of differing treatment philosophies and because of the fact that drug programs have received large amounts of federal and state monies to the exclusion of community mental health programs. These factors resulted in the eventual removal of the outpatient condition from the study. The study had also originally included instruments designed to measure internal processes in both of the residential programs. Both because of delay in the construction of the instruments and lack of cooperation on the part of certain program personnel these instruments were never administered to the treatment populations.

These two problems illustrate two recurring problems in the implementation of community research; 1.) The need for written administrative agreements; and 2.) The need for researcher control of treatment programs. If written administrative agreements had been required initially the board would have probably been more reticent to not fulfill its commitments. Written agreements would have also provided a better incentive for the Lansing drug program director to stand behind the researchers. As it was the director did not staunchly ally himself with the research efforts. The

need for researcher control of the treatment programs was also a problem in the present study. Instruments designed for use within the programs would have been easily administered with a researcher running the program or had a researcher been in a position of authority over the treatment directors. As it was, one of the directors was quite hostile to the whole concept of research. To him the notion of random assignment to treatment programs was a severe impediment to treatment. Random assignment was cited as the cause of the relatively slow growth of the client population in the treatment programs. He also felt that random assignment was in fact biased assignment. This director saw the researcher as assigning all bad people to him. Even when all these criticisms were met and explained he was still antagonistic toward the research and the researcher. This points out an important principle of community research. In evaluating existing programs it is necessary to allow programs the option to not be a part of the study. The present research design was imposed on the treatment programs which, it was felt, promoted antagonism. Another problem which made the research more difficult was the fact that programs were intended to become an integral part of the Lansing drug treatment program rather than being designed as models to be tested empirically. Thus the need for research was seen as academic rather than the means for finding the "best" treatment modality. The imposition of the research design was consequently seen as more of an impediment to treatment than as an aid to discovering the

most efficacious means of treatment. Researcher control of the treatment programs would have partially insured the success of the original design. In addition it would have insured the commitment to model testing rather than the perpetuation of a particular treatment modality because of its political popularity.

Three critical elements have emerged which are necessary for conducting community research; 1.) Written, formal administrative agreements which clearly specify the obligations of all parties concerned with or affected by the research; 2.) The researcher must be in control of the treatment program; this control could be exercised in the formal directorship of the program or having researchers in supervisory control of treatment program directors; and 3.) Research designs cannot be imposed on unwilling programs; a trial period could be established during which, the programs could decide whether or not they wished to remain a part of the research design.

Summary

The present study originally had been intended to be a comparison of two disparate treatment modalities, the halfway house and the lodge. Instead, because of modification of the lodge structure, the comparison that was actually conducted was between an authoritarian program (halfway house) and a less-authoritarian program (lodge). The finding of no differences between the two approaches seriously weakens the arguments for the need for highly structured programs for the treatment of chronic drug abusers.

The factors that were found to be related to outcome generally supported the hypothesis that increased assimilation into the "drug culture" as measured by longer time spent mainlining heroin, greater habit cost, illegal support of the habit, and more time spent in jail after beginning illegal drug use, leads to unfavorable treatment outcomes. No evidence was found that related treatment outcomes to social class, age, education, employment history, marital status, or drug use history, as had been reported by several other investigators.

Three critical elements were also discussed which are necessary for the implementation of community research; 1.) Written administrative agreements; 2.) Researcher control of treatment programs; and 3.) The necessity to leave unwilling programs out of the research design.

APPENDICES

APPENDIX A
THE INTAKE QUESTIONNAIRE

Patient's Name _____

Address _____

Tel. Number _____

Social Security Number _____

Admission Date _____

Termination Date _____

Name of parent or next of kin to be contacted in case of
emergency:

Name _____ Relationship _____

Address _____

Tel. Number _____

How often do you see this person? _____

When was the last time you saw this person? _____

Program Assignment: Multi-Lodge _____ Half-way House _____

Outpatient aftercare (specify facility) _____

IF NON-VOLUNTEER: Specify program recommendation _____

Who referred you to us?

DEC

Mason CMH

North Side Crisis

Lansing CMH

West Side Crisis

Charlotte CMH

Listening Ear

St. John's CMH

Ingham County Jail Program

Sparrow Hospital

Kalamazoo State Hospital

Ingham Medical

Methadone Program

Other (specify):

Patient's program number _____

1. Date of admission _____
 day month year

2. Date of birth _____
 day month year

3. Age at admission

4. Sex: 1. M 2. F

5. Race: 1. B 2. W 3. Mex-Am 4. Other _____

6. Marital Status:

1. Single (never married)	3. Separated	5. Widow or Widower
2. Married	4. Divorced	6. Remarried

7. IF MARRIED: Does your spouse work? _____ If so, what does he or she do? _____

8. What was the highest grade in school completed by your spouse?

9. What is the highest grade you completed? _____

OMIT THE NEXT QUESTION AT CENTRAL INTAKE

10. Why did you leave school. Was it for:

1. Voluntary reasons 2. Involuntary reasons

11. How many children do you have? _____

12. What are their ages and where are they living?

13. With whom are you living now?

- | | |
|---|-----------------|
| 1. Parents only or parents and other family | |
| 2. Spouse | 3. Other family |
| 4. Friends | 5. Alone |

14. How many times have you changed residence in the last year? _____

OMIT THE NEXT THREE QUESTIONS AT CENTRAL INTAKE

15. What is the name of the last school you attended?_____

Address _____

16. Would you be interested in completing high school?

- | | |
|--------|-------|
| 1. Yes | 2. No |
|--------|-------|

17. What subjects did you like best in school?

18. What is your present religion?

- | | |
|---------------|-----------|
| 1. None | 4. Jewish |
| 2. Protestant | 5. Muslim |
| 3. Catholic | 6. Other |

FAMILY BACKGROUND

1. Where were you born? City_____ State_____
Country _____

2. Where did you grow up? _____
3. When you were growing up, who were the adults you were living with? I would like to know their ages and marital status also:

(IN ANSWERING THE FOLLOWING QUESTIONS, IF IDENTITY OF MOTHER AND FATHER ARE UNKNOWN, USE THE OCCUPATIONS OF THE ADULTS IN QUESTION #3)

4. While you were growing up, what was the highest grade completed by your: 1. Father _____ 2. Mother _____
5. While you were growing up, what were the occupations of your: 1. Father _____ 2. Mother _____
6. While you were growing up, what language was spoken at home? _____
7. What language do you prefer to speak? _____
8. How many brothers and sisters do you have? _____
For each, what is their sex, age, marital status, and number of children?

OMIT THE NEXT FOUR QUESTIONS AT CENTRAL INTAKE

9. What is your feeling towards your family at present?
- | | |
|------------|--------------------|
| 1. Distant | 3. Close |
| 2. Warm | 4. Family deceased |

10. IF MARRIED: What is your feeling towards your spouse and children (if any)?

1. Distant 2. Warm 3. Close

11. Do you have any close friends now? 1. Yes 2. No

IF YES: How many? _____

12. What was the economic status of your household while you were growing up?

1. Mostly on welfare 3. Average

2. Poor 4. Above average

EMPLOYMENT BACKGROUND

1. Are you presently employed? 1. Yes 2. No

2. IF YES:

Who is your employer? _____

What do you do there? _____

How long have you been employed there? _____

What is your gross income? _____

3. IF NO: What is your source of income?

1. Welfare 3. Veteran's Disability

2. ADC 4. Other _____

4. FOR THOSE WORKING: Do you receive any income other than from your job? 1. Yes 2. No

If so, what type? (use categories from question #3)

5. Do you support anyone else? 1. Yes 2. No

If so, how many (include yourself)? _____

6. How many jobs have you held in the past 10 years? _____

For each job, I want you to tell me the nature of the job, how long you worked there, and the reason for leaving (were you fired, laid off, or did you just change jobs?):

[illegible]

OMIT THE NEXT QUESTION AT CENTRAL INTAKE

7. What kind of work would you like to do?

MILITARY HISTORY

1. Have you ever served in the armed forces? 1. Yes 2. No
2. IF YES: How long? _____
3. Rank _____
4. Date and type of discharge _____
5. Any specialized training? 1. Yes 2. No
6. IF YES: What type? _____

ARREST RECORD (USE TABLE ON NEXT PAGE)

1. Have you ever been arrested? 1. Yes 2. No

IF YES:

2. How many times were you in jail before you started using drugs, and afterwards? BEFORE _____ AFTER _____
3. How much time did you spend in jail before you started using drugs, and afterwards? BEFORE _____ AFTER _____
4. How many arrests and convictions have you had for each of the crimes listed below before you started using drugs? After? (See table on next page.)

[illegible]

1. Did you ever use: (check if yes)	2. Are you currently using? yes no		3. IF NO: When did you stop? (months)	4. How often do (did) you use drug? < 1 mo > 1 mo		5. If > 1 mo. how often did you use it? (per mo.)	6. How long have you been using it? (months)	7. How many people do (did) you do it with?
Wine, beer, whiskey ₁								
Amphetamines								
Barbiturates								
Minor Tran- quilizers								
Marijuana								
Hashish								
Heroin ₂								
Opium ₂								
Morphine ₂								
Methadone ₂								
Codeine								
LSD								
Mescaline								
Psilocybin								
Cocaine								
Glue								
Major Tran- quilizers								
Other								

1. If yes go to question #8.
2. If yes go to question #9.

8. IF PATIENT HAS USED ALCOHOL:

1. How many times a week do you drink? _____
2. How many glasses of beer or wine, or shots of whiskey do you usually drink at one sitting? _____
3. What is the maximum you drink at any one sitting?

9. IF PATIENT HAS USED AN OPIATE:

1. Do you use it currently? 2. IF NO: When was the last time you used?

Her	1. Yes	2. No	Her	_____
Op	1. Yes	2. No	Op	_____
Morph	1. Yes	2. No	Morph	_____
Dem	1. Yes	2. No	Dem	_____
Meth	1. Yes	2. No	Meth	_____
3. When you last used, was it to get straight or high?

Her	1. S	2. H
Op	1. S	2. H
Morph	1. S	2. H
Dem	1. S	2. H
Meth	1. S	2. H
4. Who first introduced you to the drug?

Her	_____
Op	_____
Morph	_____
Dem	_____
Meth	_____
5. How old were you when you first tried it?

Her	_____
Op	_____
Morph	_____
Dem	_____
Meth	_____
6. How did you first do it up?

Her	snort pop shoot smoke other
Op	snort pop shoot smoke other
Morph	snort pop shoot smoke other
Dem	snort pop shoot smoke other
Meth	snort pop shoot smoke other

7. How long did you spend skin-popping, snorting, and mainlining each drug?

Her	pop	_____	snort	_____	shoot	_____
Op	pop	_____	snort	_____	shoot	_____
Morph	pop	_____	snort	_____	shoot	_____
Dem	pop	_____	snort	_____	shoot	_____
Meth	pop	_____	snort	_____	shoot	_____

8. Do you mainline?

Her _____

Op _____

Morph _____

Dem _____

Meth _____

9. IF YES: How long?

Her _____

Op _____

Morph _____

Dem _____

Meth _____

10. Ever use any other route?

Her	1. yes	2. no
Op	1. yes	2. no
Morph	1. yes	2. no
Dem	1. yes	2. no
Meth	1. yes	2. no

11. How long have you been addicted? _____

12. How much per day do you use?

Her _____

Op _____

Morph _____

Dem _____

Meth _____

- Cost: in dollars per day

Her _____

Op _____

Morph _____

Dem _____

Meth _____

13. How do you support your habit?

14. Have you ever tried to kick the habit on your own?

1. Yes 2. No

15. IF YES: How many times? _____

How? _____

16. What was the longest time you stayed clean?

17. What was the shortest time you stayed clean?

10. What was the first drug you used? _____

11. How old were you when you first used it? _____

12. Has anyone in your immediate family, or with whom you are living, ever used any of the drugs listed in question #1?

1. Yes 2. No

13. IF YES:

1. Person

2. Drugs

1. Have you ever been treated for personal problems or drug use? 1. Yes 2. No

2. IF YES:

REASON FOR SEEKING TREATMENT	TYPE*	AGE AT TREAT- MENT	LENGTH	REASON FOR TERMINATION (voluntary or involuntary)	
				VOL	INVOL

* TYPES: Hospital
Out-Patient
Transitional

APPENDIX B

APPENDIX B
THE EXPECTANCY QUESTIONNAIRE

Name _____ Date _____
Employed _____yes _____no

Below are several statements in which you are asked to guess how you will like some aspects of your living situation.

Read each statement carefully and choose the one phrase that most accurately reflects your guess about the future. An example is given below:

Example: I will like the food where I will live.

<u> X </u>	A great deal
<u> </u>	Quite a bit
<u> </u>	Somewhat
<u> </u>	Only slightly
<u> </u>	Not at all

Please complete the following statements by choosing the one phrase which most accurately reflects your guess about the future.

1. I will like the place where I live.

<u> </u>	A great deal
<u> </u>	Quite a bit
<u> </u>	Somewhat
<u> </u>	Only slightly
<u> </u>	Not at all

2. I will like the people with whom I live.

<u> </u>	A great deal
<u> </u>	Quite a bit
<u> </u>	Somewhat
<u> </u>	Only slightly
<u> </u>	Not at all

3. I will like the sleeping arrangements.

_____ A great deal
_____ Quite a bit
_____ Somewhat
_____ Only slightly
_____ Not at all

4. The place where I live will make it easy for me to stay off drugs.

_____ Strongly agree
_____ Agree
_____ Undecided
_____ Disagree
_____ Strongly disagree

5. I will like the food.

_____ A great deal
_____ Quite a bit
_____ Somewhat
_____ Only slightly
_____ Not at all

6. I will like my room.

_____ A great deal
_____ Quite a bit
_____ Somewhat
_____ Only slightly
_____ Not at all

7. I will like to get out of the house and go to the movies or a party, or do something else.

_____ A great deal
_____ Quite a bit
_____ Somewhat
_____ Only slightly
_____ Not at all

8. I will like the recreational facilities in or near the place where I live.

_____ A great deal
_____ Quite a bit
_____ Somewhat
_____ Only slightly
_____ Not at all

9. I will like to see my friends.

_____ A great deal
_____ Quite a bit
_____ Somewhat
_____ Only slightly
_____ Not at all

10. The program that I am going to will help me get myself together.

_____ Strongly agree
_____ Agree
_____ Undecided
_____ Disagree
_____ Strongly disagree

11. I will like the way I will spend my free time.

_____ A great deal
_____ Quite a bit
_____ Somewhat
_____ Only slightly
_____ Not at all

12. I will like to spend my spare time with other people.

_____ A great deal
_____ Quite a bit
_____ Somewhat
_____ Only slightly
_____ Not at all

13. The staff in the program will help me with my problems.

_____ A great deal
_____ Quite a bit
_____ Somewhat
_____ Only slightly
_____ Not at all

14. I will like the job I find.

_____ Strongly agree
_____ Agree
_____ Undecided
_____ Disagree
_____ Strongly disagree

15. I will earn every cent of my salary.

_____ Strongly agree
_____ Agree
_____ Undecided
_____ Disagree
_____ Strongly disagree

16. I will be able to go as far as I would like to in the job I get.

_____ Strongly agree
_____ Agree
_____ Undecided
_____ Disagree
_____ Strongly disagree

17. I will be doing the kind of job I want to do.

_____ Strongly agree
_____ Agree
_____ Undecided
_____ Disagree
_____ Strongly disagree

18. I will remain on the job I find.

_____ Strongly agree
_____ Agree
_____ Undecided
_____ Disagree
_____ Strongly disagree

19. Compared with the way I now live, I will be well satisfied with my living conditions.

_____ Strongly agree
_____ Agree
_____ Undecided
_____ Disagree
_____ Strongly disagree

20. I will feel very proud of my living quarters.

_____ Strongly agree
_____ Agree
_____ Undecided
_____ Disagree
_____ Strongly disagree

21. I will want to live in the house where I go for a long time.

_____ Strongly agree
_____ Agree
_____ Undecided
_____ Disagree
_____ Strongly disagree

22. I will be happy to leave where I'm living now to live in the halfway house or lodge.

_____ Strongly agree
_____ Agree
_____ Undecided
_____ Disagree
_____ Strongly disagree

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