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Motivational levels and abstinence rates in substance abuse clients

Stephen Sean Borchers

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MOTIVATIONAL LEVELS AND ABSTINENCE RATES
IN SUBSTANCE ABUSE CLIENTS

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

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

by
Stephen Sean Borchers
June 2006
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Approved by:
Dr. Tom Davis, Faculty Supervisor
Social Work

Tinya Holt, MSW, Executive Director
Perris Valley Recovery Program

Dr. Rosemary McCaslin,
M.S.W. Research Coordinator

5/9/06
Date
ABSTRACT

The object of this study was to analyze motivation of clients beginning a drug and alcohol treatment program to see if their level of motivation affects their success in the program, as measured by drug screens. In order to achieve this, 36 participants from the Perris Valley Recovery Program took a motivation for treatment questionnaire containing questions in problem recognition (PR), desire for help (DH), and treatment readiness (TR) reflecting their levels of motivation for treatment. The responses of the clients were compared to the participant's clean or dirty drug screens determining association between motivation and abstinence levels. An independent sample t-test was used to examine the relationship between the dirty and clean drug screen groups. Data reflected significant results in PR, DH, and TR. Every effort was made to collect the data accurately and protect the confidentiality of the client, reflecting a high level of validity in the results.
ACKNOWLEDGMENTS

I wish to thank Perris Valley Recovery Program and the executive director Tinya Holt, MSW for allowing me to conduct my research project at their agency. I would also like to thank my research advisor Dr Davis for his advice and incite.

I wish to acknowledge the contribution made by my professors, Colleagues and friends, giving me encouragement and support. Finally, I would like to express my deep appreciation to my family for their support, wisdom, and encouragement throughout the educational process.
DEDICATION

This paper is dedicated to my late wife, Loralee Kaye Borchers. We dreamed of a time when my education would be over and we could start planning our future lives together. Her love and support has carried me through even in her absence.
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CHAPTER ONE

INTRODUCTION

Motivation for treatment as it relates to effective substance abuse treatment is an important first step in changing human behavior (DiClemente, Bellino, & Neavins, 1999). The high relapse rates that have been a stigma for substance abuse treatment programs, demonstrate that motivation to enter treatment is problematic. After significant and partially successful attempts to stop substance abuse, relapse rates continue to be high. Motivational considerations are a critical part of effective treatment. In addition, treatment facilities need to have knowledge of the substance of addiction, the degree of substance use, the history of its use, previous substance abuse treatment, social needs, criminal records, economic stress, and the presence of physical or psychological symptoms. This information is needed to facilitate a sufficient assessment, thus allowing the initiation of proper treatment modalities for the individual client (McCaffrey, 1996).
Problem Statement

There is presently an increasing problem of substance abuse in our nation and a subsequent need for effective treatment. In the United States there are approximately 10,805 alcohol and drug treatment facilities (Elk, Grabowski, Rhoades, & McLellan, 1993). Studies done at these facilities reflect the importance of motivation as a predictor of client’s successful participation and recovery (DeLeon, Melnick, & Kressel, 1997; Simpson & Joe, 1993).

"Addictions have been called the disease of denial. In practice, this means that the individual with a serious drug or alcohol problem is often the last one to recognize a problem that supervisors, spouses, children, and society have already acknowledged" (DiClemente, 1993, p. 102). People dependent on drugs or alcohol experience an array of complications that are physical, emotional, psychological, economical, and social (McCaffrey, 1996). These can create isolation from family and society. In many ways substance abusers are totally isolated from their social structures. Their addictive behaviors affect their family, their friends, the larger community, and especially themselves (McCaffrey, 1996).
Studies have shown that substance abuse treatment is effective in reducing drug use and criminal activity associated with drug use. However, costs of treatment are rising and third party payers are forcing treatment programs to improve their effectiveness (French, Zarkin, Hubbard, & Rachal, 1991). Identifying substance abuse programs that stimulate motivation for treatment is vital (McCaffrey, 1996). To do this, treatment programs must understand motivation for treatment and how it affects patient readiness to engage in behavior changes (DiClemente, Schlundt, & Gremmell, 2004).

Because of Proposition 36 from the Substance Abuse and Crime Prevention Act of 2000, substance abusers who are non-violent are allowed the option of going into treatment instead of being incarcerated (Alcoholism and Drug Abuse Weekly, 2005). Proposition 36 gives treatment facilities the ability to utilize intervention models. These models will assist with the client’s motivation to achieve abstinence. Along with assisting non-violent drug abusers to obtain appropriate treatment this proposition will help reduce overcrowding in California’s Jails. This research project will collect data from drug offenders.
participating in the Proposition 36 drug diversion program at the Perris Valley Recovery Program (PVRP).

Purpose of the Study

The purpose of this study was to evaluate the motivation for treatment of clients at PVRP. Understanding their motivation will help predict the potential success of the treatment interventions that the program is currently utilizing. It will also allow the therapist to assist the client with treatment approaches for motivational deficiencies. This will increase the client's chances for long-term recovery (DiClemente et al., 1999). This study was initiated by the clients' completion of the Motivation for Treatment tool and the collection of urine drug screens. The success of the client's progress was measured by evaluating drug screens on admission to the program and two additional tests thereafter.

McCaffrey (1996) expressed how the need for adequate substance abuse treatment programs affects drug abusers, law enforcement, the legal systems and the entire social system. Increased concern about this problem is highly visible in today's world. The goal of treatment programs
is to help break the cycle of dependency. These services are provided by agencies such as hospitals, long-term residential treatment programs, walk-in clinics or outpatient programs, counseling centers, psychotherapists, and neighborhood churches. Many of these treatment agencies have a very low abstinence rate and warrant the proper follow-up studies to assist the needs of the addict (McCaffrey, 1996).

Assessing motivation and the stages of the change process, provides useful information for the chemical abuse counselor. This includes how and when change takes place (Gusella, Butler, Nichols, & Bird, 2003). This information will allow the change model to be individualized and tailored to meet the needs of the client (DiClemente et al., 2004).

The findings of this research can help other agencies become more efficient in providing appropriate treatment at the most effective time in the therapy. By measuring the motivation for treatment as it relates to the results of drug screening data it will provide an understanding of what can affect client’s success in obtaining abstinence, thus reducing health care cost and increasing success rates of clients.
Significance of the Project for Social Work

This research project offers social workers data on clients’ motivation for treatment prior to admission in an outpatient substance abuse program. This will allow a better understanding of the type of interventions needed and when they can best be delivered.

The project will provide useful information allowing PVRP to develop new interventions which will assist future addicts. The findings will also benefit PVRP in grant writing about interventions, motivations and change theories in order to assist in the client’s development toward sobriety.

Social workers and clinical counselors at PVRP deal with individuals with substance abuse problems that co-occur with other social issues such as domestic violence, homelessness, or child maltreatment (Barber, 1995). Many social workers have direct contact with substance abusers in treatment facilities and can use interventions such as individual counseling, group counseling, brokering, program initiation, and education (Zastrow & Kirst-Ashman, 2004).

Understanding the role of motivation in the precontemplation stage of change will allow patients to
be more ready to engage in and complete each stage in the change model. This will increase social workers ability to reach and influence substance abusers (DiClemente et al., 2004). According to the generalist model the questionnaire and the admission drug screen are in the assessment stage of change steps. The second and third drug screens fall under the evaluation change step (Kirst-Ashman & Hull, 2002).
CHAPTER TWO

LITERATURE REVIEW

Introduction

The history of relevant literature will help explain research on treatment. The following sections will cover the medical model, the twelve-step model which is the basis of the agency where the research was conducted, and the readiness to change model. The readiness to change model is the model that this research was based upon.

Treatment Modalities

Current literature comparing relapse rates for addictive behavior with relapse rates for chronic care conditions has yielded rather surprising results. By evaluating relief of symptoms rather than complete abstinence in the drug-abusing patient, the studies show a 75% improvement rate equal to or better than the rate shown in chronic medical conditions such as diabetes and hypertension (McLellan, 2002).

Due to the phobia associated with total abstinence as described by Hall (1979), a complete state of abstinence for drug abuse patients no longer becomes the goal in treatment. Instead “control of symptomatic
success factors were shown to have a strong relationship to success (Fals-Stewart, 1992).

Multidimensional Family Therapy focuses on the interconnected relationships within the family and recognizes these relationships as crucial elements in drug addictive behaviors of one or more family member. In fact, substance use disorders are commonly referred to as multidimensional disorders. Family therapy is based on the premise that interventions should occur at the family level. The therapy consists of educational sessions, discussion of problems, counseling for problems (both group and individual), and family conferences. Some family focus groups use the 12-Step philosophy. In all family therapy programs interaction within the family is critical in making changes (Center for Substance Abuse Treatment, 2002a).

Behavioral approaches according to Stitzer, Bigelow, and Liebson (1979), are validated by research showing that substance abuse can be reduced with the use of contingency management procedures. They also describe a success rate with alcohol and substance abuse using methadone and antabuse.
Behavior reinforcement focuses on treatment interventions which directly affect drug acquisition and ingestion behaviors. Incentives or contingent reinforcement procedures are used to promote reduction of drug use. Positive reinforcement is the heart of behavioral reinforcement. The therapy consists of teaching behavior modification techniques and contingency management procedures. Socially acceptable behavior is rewarded with the point system. Managing and contracting behavior outcomes influence substance abuse by altering the environmental consequences (Stitzer, Bigelow, & Liebson, 1976).

Muck, Zempolich, Titus, and Fishman (2001) examined the effectiveness of the 12-Step programs and concluded that success in these programs is directly related to completers verse non-completers. There were no significant differences between these groups at the two years post treatment timeframe. The research showed greater improvement for females over males. Success in this research was measured by complete abstinence.
Theories Guiding Conceptualization

Theories on substance abuse are abundant and warrant adequate recognition. Various types of theories exist in substance abuse treatment and are an integral part of all treatment programs.

Bowen’s theory is a multigenerational model which is used for behavioral intervention with people of all ages. This theory states that relationship patterns between family members govern how problems develop. Symptoms usually develop during periods of prolonged or heightened stress. The clinical techniques used in Bowen’s therapy are the genogram, interviewing, relationship experiments, and neutralization of symptomatic triangles, supportive treatment, I-position, and displacement stories (Carlson & Kjos, 2005).

After behavioral theory was developed, many modifications were made to the theory. The major changes were regarding the cognitive aspect of change. This can best be described as focusing on a variety of coping skills related to thinking, feelings and behaviors as they relate to substance use. Even though more emphasis is applied toward behavioral coping skills, the focus is still on the way clients think before they act, as well
as their expectations of the results of their actions. When used, this therapy can help reduce client's substance use. This works by assisting the client to be aware of certain conditions that trigger substance use, therefore helping them to develop skills to avoid drug use by channeling their thinking associated with substance use toward a more positive constructive way of thinking. Cognitive behavioral therapists use three main elements in the initiation of their theory. These activities are: 1) functional analysis, 2) coping skills training, and 3) relapse prevention (Center for Substance Abuse Treatment, 2002b).

The idea of this study was to understand motivation for change in substance abuse clients. The theory that best addresses motivation is the change model. Rollnick, Heather, Gold, and Hall (1992), explained the usefulness of Prochaska and DiClemente's stages of change model. The purpose of this model is to help explain the process of change. The authors expressed that this change can take place in or out of a treatment setting. The main purpose of the model is to help to identify multiple treatment strategies for each stage of change, therefore being able
to accurately assess a client and help them reach their goal.

The readiness to change model consists of five stages, 1) Precontemplation is the stage where a client is unable to realize their problem for themselves. There are outside influences that are playing a key role in the client’s enrollment in a program. 2) In the contemplation stage, a client is actually thinking about change but they have not made any physical changes. The current study focused on clients in this stage. It measured their motivation for treatment scores against their drug screens scores. 3) The decision making stage is when the client is determined to change their substance use. 4) The action stage is when the client is actually changing their behavior toward recovery. 5) The maintenance stage is developing new behavior toward change, away from substance use (Barber, 1995).

Social workers need to become more aware of the role of motivation in the treatment and recovery of substance abuse. They should incorporate motivational enhancement strategies into their treatment programs. DiClemente, Bellino, and Neavins (1999) suggested that “motivation is an important first step toward any action or change in
behavior" (DiClemente et al., 1999, p. 86). Interventions are useless unless the patient is self-motivated. According to current research studies, there is a need for tools to predict patient's participation in their treatment and recovery. Internal motivation is associated with greater long-term change. Motivational treatment approaches need to be included as a pre-treatment modality. Researchers and clinicians have much to learn about how to influence patients with internal motivation (DiClemente et al., 1999).

Understanding substance abuse treatment by utilizing the process of change helps us to recognize the need to increase recruitment and retention and improve successful completion and recovery. Although substance abuser's motivations are complicated, they play an important role in recognizing the need for change.

DiClemente, Schlundt, and Gemmell (2004) recognize that readiness in the form of motivation indicates a willingness to internalize change. Multiple addictions for drug abusers are more difficult and problematic than specific chemical addictions. However, in all types of addiction, readiness for treatment (motivation) remains a primary target goal. Until clients can understand the
need for change, change cannot occur. The stages of change provide a meaningful way to process change, however without understanding the role of motivation the process cannot occur.

Nwakeze, Magura, and Rosenblum (2002) researched a project that compared three components of motivation for change: drug problem recognition, desire for help, and treatment readiness in a high-risk drug use population. The article stressed the importance of motivation in the treatment of addictive behavior. The literature review talked about many studies which have examined predictors of motivation among substance abusers. In the conceptual framework of motivation, they viewed motivation as a continuum which starts with the drug problem recognition, leads to the desire for help and culminates in treatment readiness. They evaluated personal and social variables as they relate to intensive patterns of abuse. The presents of depression history, addiction treatment, and having job skills were major predictors of problem recognition. The presents of health problems, caring for children, frequency of use, and desire for help were predictors of treatment readiness. The article concluded that: 1. Individuals with intensive patterns of drug use
were more motivated toward change. 2. Individuals with depression symptoms were likely to have higher motivation for change. 3. Individuals with physical health problems were more ready for treatment. 4. Problem recognition had a strong affect on desire for help and 5. Desire for help had a strong affect for treatment readiness (Nwakeze, Magura, & Rosenblum, 2002, p. 304). The practical applications were to identify clients in different phases of motivation for change and provide additional counseling and support for those with low motivation for change. The patient with low motivation should be exposed to motivational enhancement techniques prior to beginning their standard treatment.

Rollnick, Heather, Gold, and Hall (1992), explained the usefulness of Prochaska and DiClemente’s stages of change model and expressed that the purpose of this model was to help explain the process of changing behavior in substance abusers, and help surface multiple treatment strategies from within each stage of change. This will allow the provider to accurately assess a client and help them to reach their goals.
The Agency

The mission of the Perris Valley Recovery Program consists of developing public awareness of substance abuse in the surrounding communities, and county awareness of drug programs that are available, including all ancillary programs for women, children and families who are severely impacted by alcohol and drug abuse. PVRP is attempting to reduce problems associated with families exposed to chemical abusive behaviors (personal communication, 2004).

The PVRP’s goals are:

1. Enhancing the quality of life by reducing alcohol and/or drug related problems, such as personal suffering, social damage and economic loss,

2. Rendering services regardless of the clients ability to pay,

3. Ongoing enhancement of direct and indirect program services,

4. Utilizing capable community volunteers in carrying out the work, and
5. Building a solid, diversified and growing financial base with which to carry out the work (Holt, personal communication, 2004)

PVRP is an outpatient drug rehabilitation facility which treats clients who have substance abuse problems and are referred either from the criminal court system, Child Protective Services (CPS), or are "walk-ins." PVRP treats problems using the following methods: 12-step meetings, substance abuse prevention presentations, employee assistance programs, referrals to other Riverside County substance abuse services, random drug testing, referrals to county and community resources, drug diversion (P.C. 100) and Proposition 36 offenders with proper policy protocol (Holt, personal communication, 2004).

The funding sources for PVRP funding, include federal and state Medi-Cal monies processed through the County of Riverside. In addition, CPS funding is available for families that have had their children removed from their homes. People who walk-in for assistance and have jobs or other income, are charged according to a sliding scale based on their incomes. Some people have private insurance. PVRP works with schools in
the immediate area to assist children who have drug problems and funded by the local school districts (Holt, personal communication, 2004).

PVREP geographic service area is the city of Perris and the united corporate areas of Mead Valley and Romoland. This area is considered rural and is often isolated from much needed services (Holt, personal communication, 2004). The population of Perris was 71,831 in 2000. The population age breakdown at that time showed that 35.9% of the people were less than eighteen, 38% were people between the age of eighteen and forty four, 16.9% of the people were between the ages of forty five and sixty four, and 9.2% of the people were greater than sixty five (Holt, personal communication, 2004).

The targeted population consists of all ethnicities. However, the majority of the population is Caucasian and Hispanic. They are referred to the PVREP from the criminal justice system, CPS, employers, or are self referred adults that understand they have a problem. Furthermore, PVREP targets children of all ages and their families. Teachers refer troubled teens to the program; church organizations refer people who are having trouble with chemical abuse. PVREP is involved with athletic
organizations within the City Park and Recreation Department and local clubs such as Head Start.

Twelve Step Programs

The 12-Step treatment approach is also known as the Minnesota Model or Alcoholics Anonymous/Narcotics Anonymous. This treatment approach is the most widely used model in the treatment of substance abuse. The 12-Step model views chemical dependency as a disease and emphasizes the need for the individual to manage their symptoms throughout their lifetime. Other components of the program include group therapy, individual counseling, psychosocial education, family therapy, written assignments, recreational activities, after care and meeting attendance. The 12-Step treatment approach is available in both residential and outpatient settings (Center for Substance Abuse Treatment, 2002a).

PVRP, the agency where the research took place, uses the 12-step model as the basis for the program’s interventions. Warfield and Goldstein (1996) describe the 12 steps in detail from an Alcohol Anonymous perspective. The first 3 steps are most pertinent to this study.
Alcohol Anonymous believes that clients:

Step 1: admit we are powerless over alcohol that our lives had become unmanageable.

Step 2: come to believe that a power greater than ourselves could restore us to sanity.

Step 3: make a decision to turn our will and our lives over to the care of God, as we understand Him.

Step 4: make a searching and fearless moral inventory of ourselves.

Step 5: admit to God, to ourselves, and to another human being the exact nature of our wrongs.

Step 6: become entirely ready to have God remove all these defects of character.

Step 7: humbly asked Him to remove our shortcomings.

Step 8: make a list of all persons we had harmed, and become willing to make amends to them all.

Step 9: make direct amends to such people wherever possible, except when to do so would injure them or others.

Step 10: continue to take personal inventory and when we are wrong promptly admitted it.

Step 11: seek through prayer and meditation to improve our conscious contact with God, as we understand
Him, praying only for knowledge of His will for us and the power to carry that out.

Step 12: have a spiritual awakening as the result of these steps, we are trying to carry this message to alcoholics, and to practice these principles in all our affairs.

It is from stage one through three that the decision to evaluate motivation for treatment as an important contributor towards the success of clients in drug and alcohol programs. These steps reflect the contemplation stage of the change model that occurs when a client is considering change but not yet willing to make the decision to change. In step three the client chooses to turn their lives over to God and have a willingness to start the process. The client is beginning to see the value of sobriety and is willing to look at the implications of being sober. The client’s interventions are directed at teaching them how to go about making the change.

There are nine other steps that are import in this model. These last nine are important because after a client makes a decision to change, they need to go
through these steps thoroughly in order to assist them in the change process.

Perris Valley Recovery Program recently began using the matrix model for their intensive outpatient treatment program. This model was created by Richard A. Rawson, PhD, Jeanne L. Obert, M.F.T, Michael J. McCann M.A., and Walter Ling, M.D. This model was created as a comprehensive, evidence based, sixteen week individualized program with more than twenty years of research and development by the Matrix Institute on Addictions, an affiliate of the University of California at Los Angeles (UCLA) Integrated Substance Abuse Program. Its mission is to improve the lives of individuals affected by alcohol and drug addiction through treatment, education and training, and research. The primary goal is to improve the quality and availability of treatment services. The focus is to disseminate accurate, empirically based information into the health care system (Rawson, Obert, McCann, & Ling, 2005).

Summary

The final research question was: Do high motivation levels affect abstinence rates in substance abuse
clients? While there are multiple treatment modalities and multiple reasons for clients to participate in drug treatment programs, success or failure of a client in a program is thought to be related to the client's motivation for change. In order to implement a change in behavior one must consider external influences and pressure, as well as internal thoughts and feelings (Cunningham, Sobell, Sobell, & Gaskin, 1994).
CHAPTER THREE

METHODS

Introduction

This study explored the relationship of motivation to the success of the client in achieving abstinence as measured by drug screens. The collection and processing of the data is described as follows.

Study Design

This study explored the role of motivation for treatment from within the change model perspective. Due to time and cost constraints, the research data was collected with a quantitative research design using a self-administered questionnaire evaluating client motivation for treatment. It included ordinal levels of measurement with a Likert scale, nominal levels of measurement for the demographic questions and age is measured at an interval level.

The Motivation for Treatment Variable Tool was used for this project. The instrument was developed to measure problem recognition, desire for help, and treatment readiness, and has warranted qualifying results. The tool is a valid instrument which has measured motivation for
treatment in both drug and alcohol dependent patients (De Weert-Van Oene et al., 2002). The data collected from this questionnaire was correlated with three drug screen results collected over a period of two months. The data was collected by administering the questionnaire to both court appointed and walk-in substance abuse offenders.

The study sample consisted of 36 subjects who were currently enlisted at Perris Valley Recovery Program (PVRP). The participants in this study were selected on the bases of their age and their substance abuse status. These participants were 18 and over and in the process of recovery.

The overall purpose of this study was to determine the level of motivation in treatment of both drug and alcohol dependent patients and see how it affected their abstinence levels. Motivation is the independent variable. The dependent variable is defined by their abstinence levels and was measured by the drug screens.

Sampling

This study consisted of 36 subjects who were residing in Riverside County, specifically Perris, Moreno Valley and Murrieta. It was given to all the clients
presently enrolled at Perris Valley Recovery Program. The population consisted of male and female adults, equal to or greater than 18 years old, who were in recovery for drug and alcohol abuse. There were no exclusions based on ethnicity, socio-economic status, religion, education, or length of addiction. Participants of PRVP are referred by the courts, the probation department or CPS. Some clients are walk-ins.

Data Collection and Instruments

Data was collected on demographics (age, marital status, living conditions, race, residence, and income), motivation for treatment (problem recognition, desire for help, and treatment readiness) and drug screens (abstinence levels) (see Appendix D). Participants were asked about problem recognition, desire for help, and treatment readiness.

The independent variable, motivation for treatment, was operationalized by utilizing a previously developed scale that measures motivation for treatment (see Appendix A). The Motivation for Treatment Scale consisted of a 24-item instrument measuring a client’s motivation for treatment (De Weert-Van Oene et al., 2002). The tool
was measured in a Likert Scale. The questions reflected the client’s acceptance of how the substance abuse affected their lives, whether they need help dealing with their addiction and whether they were accepting of the treatment program.

The dependent variable, abstinence level, was operationalized by evaluating drug screens on admission to the program and two additional tests thereafter. The results of either a dirty or clean drug screen were compared against individual results of the questions in the motivational for treatment (MfT) score on the test.

Procedures

The first step of the data collection process was speaking to the director and staff members at PVRP. Once the acceptance from the staff was received, clients were gathered into the group room where they were assured of confidentiality and ask to sign and date an informed consent (see Appendix B). This allowed the researcher to distribute the questionnaires.

After the completion of the questionnaire the participants were asked if the questionnaire created any personal stress or discomfort. If a participant had a
negative reaction due to the questionnaire, the staff provided referrals and telephone numbers to agencies that could assist the participant. The questionnaire took 20-30 minutes to complete. The survey asked personal questions about age, gender, marital status, living conditions, race, and income. It also asked questions such as whether they recognize that they had a drug or alcohol problem, if they had a desire for help, and were they ready for treatment. Abstinence levels were measured by drug screens.

So that confidentiality could be maintained, each client was assigned an identification number that was attached to their questionnaire and their drug screen results. There was one copy showing each patient’s name and identification number. This information was kept in a locked cabinet until all data was collected. Once the raw data was collected the only paper recording the names of the client was destroyed. The data was then entered into the statistical analysis program and evaluated.

Protection of Human Subjects

The study proposed to explore the relationship between motivation for treatment and abstinence. To
obtain these data the clients were asked to complete a survey questionnaire. In order to protect this population, all participants were required to sign the informed consent. Informed consent was obtained before the distribution of the questionnaire. A debriefing statement was provided. The staff members were available to give referrals to any participant that experience negative consequences directly related to the questionnaire.

Participants were told verbally and in the informed consent that participation in the study was voluntary and they could have stopped at any time. The participants were instructed to refrain from putting their names anywhere on the survey. Each participant returned the surveys to the researcher, excluding the informed consent and debriefing. This was locked in a file cabinet to be retained for three years and then destroyed.

Data Analysis

The study used a quantitative procedure. The statistic that was used was an independent sample t-test. This determined if there was an association between clients motivational as measured by the MfT scale and
drug screen results. Descriptive statistics were examined to check the data set, \( N = 36 \), for accuracy of input.

Summary

This chapter described the study design and explored the role of motivation and how it relates to clients' success measured by abstinence levels. Care has been taken in the selection of the study design, tool, and sampling in order to give an accurate result. The procedures for data collection and protection of the human subjects have been carefully outlined so as to ensure the protection of the participants from any possible negative outcome. This data was analyzed using an independent sample \( t \)-test determining any association between motivation and abstinence levels. The results of this research information will allow social workers to evaluate motivation as a possible treatment modality-preparing clients who are beginning substance abuse programs.
CHAPTER FOUR

RESULTS

Introduction

Procedurally, the research focused on motivation for substance abuse clients that are in treatment. Their motivational levels are then compared to their success or failure in their treatment program as measured by three drug screens. There are three types of statistics reported in this chapter: demographics, an independent sample t-test, frequency and descriptive statistics. The demographics were reported to describe the characteristics of the respondents. The independent sample t-test was used to compare the motivation for treatment scores with the drug screens. Frequency and descriptive statistics were used to explain the effectiveness of the motivation for treatment scale and the sample population.

Presentation of the Findings

The 36 participants included males (n = 28) and females (n = 8). The mean age was 34.08 years. The mean length of stay in the substance abuse treatment program was 10.91 weeks. Participant marital status included
single (n = 20), married (n = 8), and divorced (n = 8). Reported ethnic group membership was: Hispanic/Latino = 17; African American = 3; Native American = 2; Caucasian = 12; and Bi-racial/multi-racial = 2. Reports of county of residence was Riverside County = 33, San Bernardino County = 1, Los Angeles County = 1, and other county = 1. Fifteen participants reported an annual income of $0 - $10,000; 6 reported $10,000 - $20,000 per year; 6 participants reported annual income of $20,000 - $40,000; 3 noted $40,000 - $60,000; and 1 participant responded to the "other" income category.

Prior to the main analysis, statistical assumptions were evaluated. Appropriate levels of measurement were used in the design: the dependent variable was an interval, continuous scale to measure motivation for substance abuse treatment; and a categorical variable was used to group participants—clean or dirty. Sampling was not random, but instead was self-selection by the volunteers which is often the case in real-life social research. Independence of observations was maintained.

Independent sample t-tests were conducted on three separate occasions to compare mean scores of participant
motivation for substance abuse treatment. Five measures of motivation were analyzed; 1) I am in this treatment program because someone else made me come; 2) This treatment program can really help me; 3) I gave up my friends and hang-outs to solve my drug/alcohol problems; 4) Causing problems with the law, and 5) Going to cause my death if I do not quit soon. Participants were grouped as "clean," if the drug indicated no recent drug use, or "dirty," if drug screens revealed recent drug use.

Below are the reported mean, standard deviation, standard error mean, and the significant scores for the independent sample t-tests.
Table 1. T-Test Time One

<table>
<thead>
<tr>
<th>Drug test One</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem with Law</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clean</td>
<td>21</td>
<td>4.10</td>
<td>.944</td>
<td>.206</td>
</tr>
<tr>
<td>Dirty</td>
<td>12</td>
<td>2.83</td>
<td>1.467</td>
<td>.423</td>
</tr>
<tr>
<td><strong>Someone Else Made Me Come</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clean</td>
<td>21</td>
<td>3.33</td>
<td>1.494</td>
<td>.326</td>
</tr>
<tr>
<td>Dirty</td>
<td>12</td>
<td>3.75</td>
<td>.866</td>
<td>.250</td>
</tr>
<tr>
<td><strong>Program Can Really Help Me</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clean</td>
<td>21</td>
<td>4.43</td>
<td>.676</td>
<td>.148</td>
</tr>
<tr>
<td>Dirty</td>
<td>12</td>
<td>4.17</td>
<td>.389</td>
<td>.112</td>
</tr>
</tbody>
</table>

Independent Samples t-test

<table>
<thead>
<tr>
<th>Test one</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem with Law</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal variance assumed</td>
<td>9.804</td>
<td>.004</td>
</tr>
<tr>
<td>Equal variance not assumed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Someone else Made Me Come</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal variance assumed</td>
<td>9.429</td>
<td>.004</td>
</tr>
<tr>
<td>Equal variance not assumed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Program Can Really Help Me</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal variance assumed</td>
<td>10.336</td>
<td>.003</td>
</tr>
<tr>
<td>Equal variance not assumed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The statistically significant mean difference were found between the groups clean (n = 21) and dirty (n = 12), in response to the statement, "I am in this treatment program because someone else made me come" and drug test one is (M = 3.75, SD 1.494, t (31) = -.881, p = .004). During test one, participants also responded to "This treatment program can really help me" and a
significant mean difference was noted, \((M = 4.43, SD .676, t (31) = 1.226, p = .003)\).

The question of "Problem with the law" was evaluated and significant mean differences were noted, \((M = 4.10, SD .944, t (31) = 3.015, p = .004)\).

Table 2. T-Test Time Two

<table>
<thead>
<tr>
<th>I Give Up My Friends</th>
<th>Drug Test Two</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clean</td>
<td>23</td>
<td>4.30</td>
<td>.822</td>
<td>.171</td>
<td></td>
</tr>
<tr>
<td>Dirty</td>
<td>9</td>
<td>3.67</td>
<td>1.414</td>
<td>.471</td>
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Independent Samples T-test

<table>
<thead>
<tr>
<th>Test two</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Give Up My Friends</td>
<td>Equal variance assumed</td>
<td>4.026</td>
</tr>
<tr>
<td></td>
<td>Equal variance not assumed</td>
<td></td>
</tr>
</tbody>
</table>

During test two, mean differences in motivation between the groups, clean \((n = 23)\) and dirty \((n = 9)\), were found to be not statistically significant as a function of participants' response to "I give up my friends and hangouts to solve my drug/alcohol problems," \((M = 4.30, SD .822, t (30) = 1.599, p = .054)\).
Table 3. T-Test Time Three

<table>
<thead>
<tr>
<th>Drug Test Three</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Give Up My Friends</td>
<td>Clean</td>
<td>16</td>
<td>4.56</td>
<td>0.512</td>
</tr>
<tr>
<td></td>
<td>Dirty</td>
<td>6</td>
<td>4.33</td>
<td>0.816</td>
</tr>
<tr>
<td>Program Can Really Help Me</td>
<td>Clean</td>
<td>16</td>
<td>4.56</td>
<td>0.512</td>
</tr>
<tr>
<td></td>
<td>Dirty</td>
<td>6</td>
<td>4.33</td>
<td>0.816</td>
</tr>
<tr>
<td>Cause My Death</td>
<td>Clean</td>
<td>16</td>
<td>4.00</td>
<td>0.966</td>
</tr>
<tr>
<td></td>
<td>Dirty</td>
<td>6</td>
<td>3.17</td>
<td>1.835</td>
</tr>
</tbody>
</table>

Independent Samples t-test

<table>
<thead>
<tr>
<th>Test three</th>
<th>Equal variance assumed</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Give Up My Friends</td>
<td>Equal variance assumed</td>
<td>3.649</td>
<td>.071</td>
</tr>
<tr>
<td></td>
<td>Equal variance not assumed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Can Really Help Me</td>
<td>Equal variance assumed</td>
<td>3.649</td>
<td>.071</td>
</tr>
<tr>
<td></td>
<td>Equal variance not assumed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cause My Death</td>
<td>Equal variance assumed</td>
<td>5.891</td>
<td>.025</td>
</tr>
<tr>
<td></td>
<td>Equal variance not assumed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For test three, participants were asked to respond to the statements “I give up my friends and hangouts to solve my drug/alcohol problems” and “This treatment program can really help me.” The mean difference in motivation scores between groups, clean (n = 16) and dirty (n = 6) was not statistically significant, (M = 4.56, SD .512, t (20) = .794, p = .07). In response to “Going to cause my death if I do not quit soon” significant differences were found, (M = 4.00, SD .966, t (20) = 1.402, p = .025).
Tables below are the reported descriptive statistics: Mean, median, mode, standard deviation, and range for each item on the questionnaire.

Table 4. Survey Question Items (Part A)

<table>
<thead>
<tr>
<th></th>
<th>Problem for Me</th>
<th>Trouble for Me</th>
<th>Problem with Law</th>
<th>Problem in Thinking</th>
<th>Problem with Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>N Valid</td>
<td>36</td>
<td>36</td>
<td>36</td>
<td>36</td>
<td>36</td>
</tr>
<tr>
<td>N Missing</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mean</td>
<td>3.81</td>
<td>3.86</td>
<td>3.75</td>
<td>3.00</td>
<td>3.44</td>
</tr>
<tr>
<td>Median</td>
<td>4.00</td>
<td>4.00</td>
<td>4.00</td>
<td>3.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Mode</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Std. Deviation</td>
<td>1.117</td>
<td>1.018</td>
<td>1.296</td>
<td>1.219</td>
<td>1.319</td>
</tr>
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<td>4</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>Problem in finding a Job</th>
<th>Problem with Health</th>
<th>My Life Become Worse</th>
<th>Cause My Death</th>
<th>Need Help</th>
</tr>
</thead>
<tbody>
<tr>
<td>N Valid</td>
<td>36</td>
<td>36</td>
<td>36</td>
<td>36</td>
<td>36</td>
</tr>
<tr>
<td>N Missing</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mean</td>
<td>2.81</td>
<td>3.31</td>
<td>3.50</td>
<td>3.53</td>
<td>3.75</td>
</tr>
<tr>
<td>Median</td>
<td>2.50</td>
<td>4.00</td>
<td>4.00</td>
<td>4.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Mode</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>3(a)</td>
<td>4</td>
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<tr>
<td>Std. Deviation</td>
<td>1.451</td>
<td>1.191</td>
<td>1.082</td>
<td>1.253</td>
<td>1.180</td>
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<td>4</td>
<td>4</td>
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</tbody>
</table>

a Multiple modes exist. The smallest value is shown.
Table 5. Survey Question Items (Part B)

<table>
<thead>
<tr>
<th></th>
<th>Urgent That I Find Help</th>
<th>Tired Of The Problems</th>
<th>I Give Up My Friends</th>
<th>Quit Using Drugs</th>
<th>My Life is Out Of Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>N Valid</td>
<td>36</td>
<td>36</td>
<td>36</td>
<td>36</td>
<td>36</td>
</tr>
<tr>
<td>Missing</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mean</td>
<td>3.56</td>
<td>4.06</td>
<td>4.08</td>
<td>2.61</td>
<td>3.25</td>
</tr>
<tr>
<td>Median</td>
<td>4.00</td>
<td>4.00</td>
<td>4.00</td>
<td>3.00</td>
<td>3.50</td>
</tr>
<tr>
<td>Mode</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Std. Deviation</td>
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<td>1.068</td>
<td>.996</td>
<td>1.202</td>
<td>1.296</td>
</tr>
<tr>
<td>Range</td>
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<td>4</td>
<td>4</td>
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<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Life Straightened Out</th>
<th>Outside Responsibilities</th>
<th>Treatment Is Too Demanding</th>
<th>Last Chance</th>
<th>Treatment Will Not Be Much Help</th>
</tr>
</thead>
<tbody>
<tr>
<td>N Valid</td>
<td>36</td>
<td>36</td>
<td>36</td>
<td>36</td>
<td>36</td>
</tr>
<tr>
<td>Missing</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mean</td>
<td>4.56</td>
<td>2.86</td>
<td>2.25</td>
<td>3.50</td>
<td>2.03</td>
</tr>
<tr>
<td>Median</td>
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<td>2.50</td>
<td>2.00</td>
<td>4.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Mode</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Std. Deviation</td>
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<td>1.457</td>
<td>1.079</td>
<td>1.108</td>
<td>1.183</td>
</tr>
<tr>
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<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Stay In This Treatment</th>
<th>Someone Else Made Me Come</th>
<th>Program Can Really Help Me</th>
<th>I Want To Be In Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>N Valid</td>
<td>36</td>
<td>36</td>
<td>36</td>
<td>36</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mean</td>
<td>3.94</td>
<td>3.53</td>
<td>4.36</td>
<td>3.72</td>
</tr>
<tr>
<td>Median</td>
<td>4.00</td>
<td>4.00</td>
<td>4.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Mode</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Std. Deviation</td>
<td>.826</td>
<td>1.276</td>
<td>.593</td>
<td>1.085</td>
</tr>
<tr>
<td>Range</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>
Summary

The present study found significant relationships between clients' motivation to be in substance abuse treatment and clean or dirty drug screens. In addition, there are tables for the frequencies that evaluated assumptions of normality, linearity and homoscedasticity (Pallant, 2005). No violations of these assumptions were noted. In addition, descriptive statistics were examined to check the data set, N = 36, for accuracy of input. All values were noted to be within range, means and standard deviations were plausible, and codes for missing values were accurately programmed.
CHAPTER FIVE

DISCUSSION

Introduction

This study examined motivation for treatment as it relates to clients' success in drug and alcohol treatment programs measured by drug urine screens. Motivation for treatment has always been recognized as a key indicator for success or failure in treatment programs. Only now are social workers beginning to recognize the importance of including treatment modalities directed toward measuring and raising motivation as a tool to increasing the effectiveness of substance abuse treatment programs.

While length of stay in treatment facilities has long been proven to be associated with motivational changes, assessment of pre- and early treatment motivation followed up by the inclusion of motivation therapy in the treatment process are of great importance (De Weert-Van Oene, Schippers, De Jong Guus, & Schrijvers, 2002).

Motivation for treatment scale (MfT) was used to compare clients at Perris Valley Recovery Program (PVRP) in order to understand their motivation as a predictor of
success as measured by abstinence, reflected in their urine drug screens. This tool according to De Weert-Van Oene et al, and based on their analysis, “is a useful and valid instrument to measure patients initial treatment motivation, both in drug and alcohol dependents” (De Weert-Van Oene et al., 2002, p. 8).

By using the MfT tool the final research question, “Do high motivation levels affect abstinence rates in substance abuse clients?” has been analyzed.

Discussion

The results obtained from this research project showed significance in the section of problem recognition (PR) which reflects pre-contemplative and contemplative aspects on question number three. Question number nine was approaching significant levels. On the section desire for help (DH) which reflects movement from contemplative toward action, question number four was approaching significance. In the section treatment readiness (TR) which reflects motivational action questions six and seven were significant. According De Weert-Van Oene et al (2002), a person is only ready for change in the action stage.
Question number three in PR, "Causing problems with the law" reflects the clients initial fear of legal implications, being made accountable for their actions, and overall fear of not knowing what to expect probably caused the significant level of $p = .004$ with the large effect size to be 22.7%. Therefore, there was a large amount of variation in motivation for clients in substance abuse treatment that can be explained by this question on the initial evaluation. As the clients became less threatened with possible adverse outcome the second and third drug test reflected no significance to this question. Question number nine, "Going to cause my death if I do not quit soon" showed no initial significance in urine test one and two. In test three it showed a significance of $p = .025$ with a variance of 3.1%. This result strongly suggests that a fear of death does not seem to be an issue to the clients while they are actively involved in a drug and alcohol life style. However, it becomes more significant during treatment as they return toward normal life situations.

In the second section DH question number four, "I give up my friends and hangouts to solve my drug/alcohol problems" reflects the clients movement from the
contemplative stage toward action stage. The clients who agreed that they would need to give up their friends and hangouts in order to solve their drug and alcohol problems had a show of movement toward significance in the urine tests two and three. An effect size of 11.3% variance in motivation of clients in substance abuse treatment can be explained by this question. As the clients move through therapy their recognition toward recovery becomes more acute.

In the final section TR, the section from which one can expect changed behavior, question six and seven were significant. Question number six, “I am in this program because someone else made me come” is the only question which reflects 2.5% of the variance toward the “dirty” urine test group. In the initial urine test, this question reflected the clients who stated they were there because someone else made them be there. The test showed active drug use. Subsequent urine tests did not reflect the same significance. In viewing this data, one can recognize the importance of the influence the judicial system has on clients by allowing them the option of substance abuse treatment over that of incarceration. In addition, family and social pressures can also contribute
to motivation for drug and alcohol treatment. Question number seven, "This treatment can really help me" reflects the confidence level that the clients have in the treatment program. Because the initial urine test was significant at \( p = .003 \) with a variance of 3.1\%, it is likely that clients who were confident in the success in the program came in with a higher level of abstinence. This higher level of abstinence was directly related to their confidence in the program.

Limitations

The motivation for treatment tool was initially created to measure alcohol and drug users in inpatient facilities. While there were no reliability factors to test for the use of this tool in an outpatient facility, the assumptions are that its validity remains consistent in outpatient as well as inpatient clients.

The subjects of this study were not randomly selected. Because the sample size of 36 is small, it is difficult to generalize data as it applies to social work practices. However, the conclusions made from the significance values less than \( p = .05 \) remains valid. Therefore, any generalizing needs to be done with
caution. The urine analysis results were measured as either dirty or clean. Due to the phobia associated with total abstinence, a urine analysis with specific drug values would be of greater significance in obtaining a more accurate drug use history as it relates to the research collected.

The relative strengths of the research tool include a pre-test done by De Weert-Van Oene et al (2002), demonstrating consistency through cultural barriers. Considering the ethnic background of the sample this tool is uniquely effective in this research setting.

Recommendations for Social Work Practice, Policy and Research

Further information comparing geographical information against questionnaire responses as well as urinalyses results would be valuable in several fields of study. For example, it might be useful to ascertain whether marital status affects urinalysis trends or questionnaire responses. Geographical information might give social workers clues on how to develop regional policy, enabling the social worker to evaluate and treat clients with low motivation, prior to De Weert-Van Oene
et al (2002), their integration into the standard treatment program.

The findings of this research paper emphasizes the importance of 1) clients motivation for treatment, both in the initial assessment and in follow up care, 2) understanding the value of the clients confidence in the treatment program, 3) utilizing accurate value measurements in drug use, 4) the clients attitude toward the recovery program, and 5) the importance of initiation and retention of clients.

Conclusions

This study advances our knowledge regarding the importance of clients' attitudes and their substance abuse treatment. Rising costs in health care treatment are forcing programs to improve their effectiveness by identifying methods to increase success rates. To do this, treatment programs need to understand motivation for treatment and how it affects client readiness to engage in change behavior. Assessing motivation and the stages of change, including how and when change takes place, will allow the treatment plans to be individualized and tailored to meet the needs of the
client. Understanding the role of motivation in the pre-contemplation stage of change will allow the clients to be ready to engage in each stage of the change model. This will increase the social workers' ability to reach and influence the treatment of substance abusers. In all types of addiction, readiness for treatment (motivation) remains a primary target goal. The stages of change provide a meaningful way to process change, however without understanding the importance of motivation in treatment programs, the change will not occur.
QUESTIONNAIRE

Motivation for Treatment (MfT) Scale:
- Problem recognition (PR)
- Desire for help (DH)
- Treatment readiness (TR)

1. I have been in the program _________ weeks

Assessment of substance-related problems
In my opinion, my (drug/alcohol) use is:

1. A problem for me
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree

2. More trouble than it's worth
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree

3. Causing problems with the law
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree

4. Causing problems in thinking or doing my work
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree
5. Causing problems with my family or friends
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree

6. Causing problems in finding or keeping a job
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree

7. Causing problems with my health
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree

8. Making my life become worse and worse
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree

9. Going to cause my death if I do not quit soon
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree

Desire for help

1. I need help in dealing with my drug/alcohol use
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree
2. It is urgent that I find help immediately for my drug/alcohol use
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree

3. I am tired of the problems caused by drug/alcohol use
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree

4. I give up my friends and hangouts to solve my drug/alcohol problems
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree

5. I can quit using drugs /alcohol without any help
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree

6. My life has gone out of control
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree

7. I want to get my life straightened out
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree
Am I ready for treatment?

1. I have too many outside responsibilities now to be in this treatment program
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree

2. This treatment program seems too demanding for me
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree

3. This treatment may be my last chance to solve my drug/alcohol problems
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree

4. This kind of treatment program will not be very helpful to me
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree

5. I plan to stay in this treatment program for a while
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree

6. I am in this treatment program because someone else made me come
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree
7. This treatment program can really help me
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree

8. I want to be in a drug/alcohol treatment program
   a. Strongly Disagree
   b. Disagree
   c. Neither Agree or Disagree
   d. Agree
   e. Strongly Agree
INFORMED CONSENT

Motivational Levels and Abstinence Rates in Substance Abuse

You are invited to participate in a research study conducted by Stephen Borchers, MSW student, under the supervision of Dr. Tom Davis from the Department of Social Work at California State University, San Bernardino. The results of the study will contribute to Stephen Borchers' thesis. You were selected as a possible participant in this study because you are at least 18 years old as of January 1st, 2006, and in recovery for drug or alcohol addiction.

The purpose of this research is to evaluate the motivation for treatment of clients at Perris Valley Recovery Program (PVRP). Understanding their motivation will help evaluate the potential success of treatment currently used.

If you agree to participate in this study, you will be given a questionnaire. The questionnaire should take 20-30 minutes to complete. The survey will be asking personal questions about age, gender, marital status, living conditions, race, and your income. It will also ask questions such as whether you recognize that you have a drug or alcohol problem, if you have a desire for help, and are you ready for treatment. Abstinence levels will be measured by three of your drug screens from this program over a two months period. If you wish, the researcher will provide assistance with the questionnaire in a more private setting.

So that confidentiality can be maintained, each client will be assigned an identification number that will be attached to their questionnaire and their drug screen results. There will be one copy showing each patient's name and identification number. This information will be kept in a locked cabinet until all data is collected. Once the raw data have been collected the only paper recording the names of the client will be destroyed. The data will then be entered into the computer and evaluated.

Your participation is voluntary. You are free to withdraw your consent and discontinue participation at any time without penalty. Whether you participate or not will have no effect on the services you receive from PVRP. There are no foreseeable risks or direct benefits for participating in this study.

If you have any questions or concerns about the research, please feel free to contact Dr. Tom Davis, Research Advisor, at (909) 537-3839.

By my signature below, I acknowledge that I have been informed of, and understand the nature of the study and agree to participate. I acknowledge that I am at least 18 years of age.

______________________________  Date ____________

I give my permission for the researchers to record urine screen reports from my field. Yes____ No____
APPENDIX C

DEBRIEFING STATEMENT
DEBRIEFING STATEMENT

Thank you for participating in this study, conducted by Stephen Borchers, MSW student at California State University, San Bernardino. This study examined the effect of motivation for treatment on abstinence levels. It is hoped that the study will contribute to developing better programs and polices to help meet the needs of recovering substance abusers. A copy of the results of this study will be available at PVRP after September, 2006. For questions or concerns my research advisor, Dr. Tom Davis may be reached at (909) 537-3839. Please do not discuss the questions or your answers with other potential participants. We appreciate your cooperation in this endeavor.
APPENDIX D

DEMOGRAPHICS
DEMOGRAPHICS

1. My present age? ___________ (Years)

2. My gender is?
   a. male
   b. female

3. My marital status is?
   a. single
   b. married
   c. widowed
   d. divorced or separated

4. I live alone?
   a. Yes
   b. No

5. My race/ethnic group is? (please circle one)
   a. African-American
   b. Latino(a)/Hispanic-American
   c. Asian American/Pacific Islander
   d. Native American
   e. Caucasian
   f. Bi-racial/Multi-racial
   g. Other (specify: ________________)

6. I reside in? (please circle)
   a. San Bernardino County
   b. Riverside County
   c. Los Angeles County
   d. Orange County
   e. Out of State
   f. Other

7. My yearly income is?
   a. 0-10 thousand
   b. 10-20 thousand
   c. 20-40 thousand
   d. 40-60 thousand
   e. Other
REFERENCES


