

Perceptions of Client Needs in Chemical Dependency Treatment Programmes

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INTRODUCTION

The delivery of leisure services to disabled populations through therapeutic recreation services is based on the accurate identification of problem areas or client needs. Peterson and Gunn (1984) indicate that this identification of needs is an essential prerequisite to quality programme development and client assessment. Bullock, McGuire and Barch (1984) found that the identification of treatment needs which can be met through leisure is one of the top five research priorities identified by therapeutic recreation professionals.

There is evidence to indicate that, in general, staff and clients in psychiatric and chemical dependency treatment programmes do not agree on the identification of treatment needs (Dimsdale, Klerman and Shershaw, 1979; Jordan, Roszell, Calsyn and Chaney, 1985; Mayer and Rosenblatt, 1974). The degree to which clients and therapists concur about treatment needs directly affects the outcomes of treatment (Hurst, Weigel, Thatcher and Nyman, 1969; Starfield, Wray, Hess, Gross, Birk and D'Lugoff, 1981). Jordan et al. (1985) found that client and staff perceptions of treatment needs in a chemical dependency setting were markedly different. They indicated that patients participated more actively and displayed more commitment toward groups which they rated as important. They concluded that including patients in treatment planning increases the likelihood of active participation. Not including patients reduces their commitment to the treatment programme. Rollnick (1982) indicated that patients who disagree with staff in relation to treatment issues often have poor relationships with staff and, as a result, experience less success in treatment.

Within the area of chemical dependency, there are two general approaches to treatment. The first approach (the unitary model) is based on the concept that addiction is the primary problem and that any other functional problems are a result of the addiction (McLellan, Luborsky, Woody, O'Brien and Kron, 1981). Abstinence is the main criterion for evaluation of treatment effectiveness (Hart, 1977).

The second approach to the treatment of chemical dependency is labelled the multidimensional approach (Hart, 1977). This approach emphasizes the psycho-social problems (such as physical health, social activities, psychological state, and occupational performance) and the patterns of these problems exhibited by chemically dependent individuals. These psycho-social areas become one of the primary focuses of treatment. The proponents of this approach feel that the remediation of the addiction and return to a high level of functioning is dependent on a variety of factors, not merely abstinence. The multidimensional approach provides the framework for this study.

METHODS

The purpose of this exploratory research was to identify those addiction related problems which can be addressed through therapeutic recreation programming and which are agreed upon by therapeutic recreation specialists, programme administrators, and clients. Data were collected by therapeutic recreation specialists working in chemical dependency treatment programmes. Initially, 43 agencies (identified through the American Therapeutic Recreation

Association, the National Therapeutic Recreation Society, and the University of Illinois internship list) were contacted to request assistance with this project. Of this 43, nine agencies participated in the data collection process. The agencies which did not participate in or complete the data collection cited several reasons for non-participation: lack of adequate numbers of clients, lack of clients who fit the stated criteria, lack of support from agency administrators, and lack of time and/or staff to complete the data collection procedures.

The total sample reported herein consisted of nine programme administrators, 11 therapeutic recreation specialists, 39 pre-treatment clients, and 40 post-treatment clients. One therapeutic recreation specialist (TRS) from each of the nine agencies administered questionnaires to ten clients and one programme administrator, as well as completing a TRS questionnaire. The client group was divided into two groups: the first group consisted of five clients who completed the questionnaire during their first week in treatment and the second group consisted of five different clients in their last week of treatment. The selection of clients was based on pre-determined criteria (such as over the age of 18, no prior chemical dependency treatment, and willingness to participate) and random sampling techniques.

The instrument used in this study was developed from an extensive review of the literature. Psycho-social problems considered appropriate for therapeutic recreation intervention were generally found in three broad categories: physical problems, emotional/cognitive problems, and social/family problems. Specific leisure related problems were grouped according to the Leisure Ability Model of therapeutic recreation (Peterson and Gunn, 1984). These areas include: knowledge of leisure, self-awareness related to leisure, attitudes towards leisure, leisure activity skills, and leisure resources. Each of the eight areas identified consisted of specific problems which were translated into 43 behavioural problem statements. Included on each questionnaire were demographic and informational questions specific to the individual (client, TRS or programme administrator) completing the questionnaire.

Individuals completing the questionnaire responded to the following directions: "Please indicate the extent to which you think each of the following is a problem for you [your clients] in your [their] leisure during recovery". Staff and clients rated all 43 items on a four point Likert-type scale with 1 = "often a problem", 2="sometimes a problem", 3 = "rarely a problem", and 4="never a problem".

Data were analyzed using SPSS-X subprogrammes RELIABILITY and MANOVA. Cronbach's alpha was computed on each of the eight subscales to determine the reliability of the scales. MANOVA was used to determine if there were differences between therapeutic recreation specialists, programme administrators, pre-treatment clients, and post-treatment clients on their responses on the eight subscales. Means, standard deviations, and frequencies were used to determine the relative rankings of the items by clients and staff.

RESULTS

Results of the Cronbach's alpha indicated that seven of the eight subscales had acceptable alpha coefficients (0.6980 to 0.9144), while including all items on the scale. The last scale, Leisure Resources, had an initial alpha coefficient of 0.5891, but the alpha coefficient rose to 0.7194 when one of the items was deleted (lack of knowledge of leisure opportunities available in the community). This item was deleted for the remaining analysis.

The MANOVA results indicated that there were no statistically significant differences between therapeutic recreation specialists and programme administrators ($F=0.4142$; $p = 0.910$), or between pre-treatment clients and post-treatment clients ($F= 1.4312$; $p = 0.195$) on their subscale scores. As well, each subscale was examined in isolation for each of these groups and there were also no differences found. There were, however, statistically significant differences between all staff (combining therapeutic recreation specialists and programme administrators) and all clients (combining pre-treatment and post-treatment clients) ($F=13.6521$; $p=0.000$).

Further analysis of the items on each subscale indicated that the vast majority (over 80%) of staff rated most of the problems (91% for TRS and 95% for programme administrators) as being sometimes or often a problem. There was less agreement on the ratings of specific items by clients. In each group of clients, over 50% of the clients perceived 16 of the 43 items as sometimes or often a problem. The ratings of the remaining items were fairly evenly split as to whether the item was perceived as a problem or not. Of the sixteen items each group of clients perceived as a problem, there were twelve items which were common to both groups. These twelve items were also identified as sometimes or often a problem by staff. The twelve agreed upon items were: experiencing feelings of boredom; feeling depressed; difficulty appropriately expressing feelings; lack of friends who don't drink or use drugs; difficulty coping with stress; difficulty communicating with family; lack of interest in community leisure opportunities; questioning my own self worth; not feeling comfortable in social situations; not feeling in control; lack of physical fitness; and feeling like I should be doing something else when involved in leisure.

DISCUSSION

The results of this study are limited in generalizability because of the small sample size. However, they do continue to contribute to the body of evidence that there are discrepancies between clients and staff in the identification of treatment needs. This discrepancy may be explained in one of several ways. First, the clients may have an accurate perception of their treatment needs and the staff do not. If this were true, the assessments and programmes designed by staff would not address the treatment needs identified by clients.

Second, staff may have an accurate perception of client treatment needs and clients do not. This second notion may have been accepted in the past, but the current literature indicates that clients in psychiatric and chemical dependency treatment do have the ability to accurately identify their own treatment needs (Fitzgibbons, Cutler and Cohen, 1971; Leonard, Dunn and Jacob, 1983).

The final explanation is that both clients and staff may have accurate perceptions of treatment needs. Even though the results indicate that there are differences, both groups may have accurate perceptions of treatment needs in that staff may be referring to population treatment needs (that is clustered needs based on general population characteristics) while clients are focusing on their own personal treatment needs. It is clear that there is a discrepancy between staff and client perceptions of treatment needs and this discrepancy potentially has an impact on the efficacy of treatment services, however more research is required in this area before any conclusions may be drawn.

The ratings of items considered important by clients and staff also has implications for the delivery of services. Currently, the delivery of therapeutic recreation service is based upon therapeutic perception of client needs; however, the twelve items agreed upon by clients and staff could provide validation or direction in the programme development process conducted by therapeutic recreation specialists. Further, the fact that staff basically felt most of the items were important validates all of these items as issues which should be considered when defining treatment goals and interventions.

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