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**A program analysis of an adult chemical dependency day
rehabilitation program with a special focus on African American
clients who successfully complete treatment**

Dozier, Cheryl Davenport, D.S.W.

City University of New York, 1994

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A PROGRAM ANALYSIS OF AN ADULT CHEMICAL DEPENDENCY
DAY REHABILITATION PROGRAM WITH A SPECIAL
FOCUS ON AFRICAN-AMERICAN CLIENTS WHO
SUCCESSFULLY COMPLETE TREATMENT

by

Cheryl Davenport Dozier

A dissertation submitted to the Graduate Faculty
in Social Welfare in partial fulfillment of the
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1994

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ABSTRACT

A PROGRAM ANALYSIS OF AN ADULT CHEMICAL DEPENDENCY
DAY REHABILITATION PROGRAM WITH A SPECIAL FOCUS ON
AFRICAN-AMERICAN CLIENTS WHO SUCCESSFULLY COMPLETE TREATMENT

by

Cheryl Davenport Dozier

ADVISER: PROFESSOR PAUL R. KEYS

The current literature on African-Americans and chemical dependency is limited in documentation of positive treatment outcomes for African-American clients. The primary purpose of this research was to study African-American male and female clients who successfully completed treatment at an outpatient rehabilitation program. A primary goal was to discover the strengths of the clients and of the treatment program.

This qualitative study explores the underlying theories and their applications that promote or support a culturally-based treatment approach. It specifically examines the provision of chemical dependency treatment services to the African-American client. The methodology was a phenomenological approach which captured the essence of the experience of successful clients. It incorporated a systems and a strengths perspective from an Africentric framework. Two sets of interviews were conducted with 18 clients and 12 staff.

Findings from the study suggested that the client's internal strengths were a primary factor in successful recovery. Clients' use of spirituality and belief in a higher power guided their recovery process. Clients' relationship to their peers and counselors in the treatment program was also a significant support system. A primary source of external support was the twelve step programs which were also found to be culturally focused. Findings support the conclusion that cultural aspects of the treatment program are contributing factors to the identification of a culturally based treatment model. This study raised questions that should be further addressed in future research.

One of the major recommendations is that chemical dependency treatment programs with a predominantly African-American client population should incorporate a culturally based treatment approach as a means to obtain successful treatment outcomes. Another recommendation is that chemical dependency treatment programs need staff diversity reflecting race, ethnicity, social class as specific characteristics of counselors and staff.

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"Where there is no struggle, there is no progress"
Frederick Douglas

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INTRODUCTION OF THE STUDY

Problem Statement

The current literature on African-Americans and chemical dependency (alcoholism and other substance abuse) is limited in documentation of positive treatment outcomes for African-American clients. The existing literature primarily addresses the problem of chemical dependency among African-Americans and within the African-American community. Unfortunately, few of the studies on successful chemical dependency treatment outcomes address race and ethnicity as key variables.

There have been treatment programs developed with local, state and, federal funding for the purposes of outreach and treatment of African-American alcoholics and substance abusers. This has resulted in an increase in the number of African-Americans who have participated in chemical dependency treatment programs. Some of these programs have been successful in outreaching and retaining African-American clients and have seen many clients successfully complete treatment. However, there are few outcome studies documented regarding successful chemical dependency treatment for African-American clients. This may be due to a lack of program and funding emphasis on program evaluation and research.

Purpose of the Study

The purpose is to:

1. study African-American male and female adult clients who have successfully completed treatment with the purpose of "discovering the client's strengths" which enabled them to maintain their recovery.
2. identify the "essence of the treatment experience" as it relates to African-American clients in recovery.
3. study the treatment approaches and modalities with a goal of discovering the strengths of the program and of the clients.
4. examine culturally-based treatment that focuses specifically on African-Americans in chemical dependency or clinical treatment programs.
5. explore the significant role of clients' environment in interpreting an appropriate practice approach when treating African-American clients.

Significance of the Study

This study is critical because there are few studies that document how and why African-American clients in chemical dependency treatment programs recover, particularly from the client's perspective of what "works" for them. There are even fewer studies that present these findings from a strength's (non-deficit) perspective. These findings are critical in program development and evaluation. Much of the literature has focused on problems of chemical dependency in the African-American community and, the clinical approaches that do not work (Staples, 1991; Nobles & Goddard, 1989; Harper, 1976; Watts & Wright, 1983). However, some current literature has included recommended approaches, models and theories that do work with this population (Bell & Evans, 1981; Brisbane & Womble, 1992; Freeman, 1993; Gordon, 1993).

It was reported in the Third Special Report to the United States Congress on Alcohol and Health of the National Institute of Alcohol Abuse and Alcoholism (1978) that "a major barrier to treatment of alcoholism among Blacks has been the lack of development of culture-specific treatment programs for Black alcoholics. Further research could center on specific areas of investigation, including the patterns of alcohol use, social context of that use, definition of alcohol abuse and help seeking patterns among Blacks . . . " (Watts & Wright, 1983, p. ix).

Theoretical Framework

This study is grounded in the underlying theories of an African centered treatment model as presented primarily by African-American social scientists. This study will explore the underlying theories and their applications that promote or support a culturally-based treatment approach. It will specifically explore the provision of chemical dependency treatment services to the African-American client.

This topic is important in that many treatment programs for chemical dependency provide clinical services to African-American clients with no regard to culture, race or ethnicity issues (Brisbane & Womble, 1985; Brisbane & Womble, 1992). Traditional social work intervention models and theoretical approaches have tended not to work when the client population is primarily African-American. (Jones, 1979; Boyd-Franklin, 1989; Pinderhughes, 1989). They are not sensitive to the specific cultural issues that affect African-Americans such as racism, oppression, classism, cultural diversity, socio-economic issues and religion (Jones, 1979; Boyd-Franklin, 1989; Pinderhughes, 1989).

The program studied bases its culturally-based philosophy and treatment approaches on recommended research models and theories by African-American theorists for treating African-American clients. This study will document the results of this application and some natural phenomena that are present in a culturally-based treatment program.

Key Definitions

The following terms are defined for the purpose of clarity. These terms are referenced throughout this literature review. It must be recognized that the literature may have different meanings for many of these terms. The following definitions will be used in this study.

African-Americans are persons of African descent living in the Americas (Billingsley, 1990). The cultural heritage may include persons who were born in, or have their permanent residency in countries of Africa, North, Central and South America, or the Caribbean. This study uses the term African-American to convey the combined heritage of Black persons living in the Americas (Baker, 1992). However, this investigator acknowledges that Caribbean-Americans' cultural heritage is distinctly different from African-Americans even though the race of both ethnic groups is Black. Persons from Caribbean countries will also be identified by their ethnic origins and nationality, e.g. Jamaican, Barbadian, Haitian, Trinidadian. The term Blacks is used more broadly to define race and will be used synonymously throughout this study.

Afrocentricity is "the intellectual and philosophical foundation used to develop the political, scientific and moral criterion for authenticating the reality of African family processes. It is the utilization of the African

experience as the core paradigm for human liberation and higher level human functioning" (Nobles, 1984, p. 127). Afrocentric refers to a world view centered in Africa as the historical point of generation (Meyers, 1988). The term's Afrocentric and Africentric will be used synonymously throughout this study. The latter is the more current term which speaks to Africa as the "land base" versus "Afro" which was previously used in the literature.

Alcoholism, alcohol abuse and/or other drug abuse, is identified in the literature as: problem drinking, alcohol problems, substance use, substance abuse, chemical dependency, alcohol/drug addiction. Below, the following terms to be used in this study are defined, alcohol abuse, alcoholism, drug abuse, drug dependency and chemical dependency:

Alcohol Abuse is the use of ethyl alcohol in a quantity and with a frequency that causes the individual significant physiological, psychological or sociological distress or impairment (Rinaldi, et. al., 1988).

Alcoholism is a primary chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking. The most notable

distortion is denial (NCADD, 1990).

Chemical dependency is the physical and/or psychological addiction to one or more chemical substances. Dependency can occur after periodic or prolonged use of a drug and its characteristics vary according to the drug involved (O'Brien, R., et. al., 1992, p. 95). Chemical dependency/chemical abuse is also viewed as a disease and follows the disease model in treatment.

Drug abuse is the use of a mind-altering substance in a way that differs from generally approved medical or social practices (Schuckit, 1989).

Empowerment in chemical dependency recovery is "the process of equipping Black, alcoholic clients with the knowledge and skills necessary to transcend their chemical dependency through culturally sensitive and socio-historically relevant clinical intervention techniques" (Beverly, 1989, p. 374).

Ethnicity refers to connectedness based on commonalities (such as religion, nationality, region, etc.) where specific aspects of cultural patterns are shared and where transmission over time creates a common history (Pinderhughes, 1989).

Success is the client's ability to reach an achievable predetermined treatment goal and the ability to obtain positive levels of achievement in the treatment program.

Successful completion of the treatment program is operationally defined as a client's ability to maintain a minimum of one year of abstinence and be discharged from treatment; the client must also be involved in a positive productive life activity. Positive productive life activity means being involved in a school, volunteer or paid work, training program, daily family activities such as child care, elder care or being a homemaker.

Successful recovery means complete abstinence from drugs including alcohol, for a significant period of time, characterized by improving psychological, interpersonal and spiritual well-being. Recovery can be described as repairing and reversing the effects of addiction in a holistic sense (Cohen, Evans & Fine, 1992). The significant period of time used for this study will be a minimum of one year of abstinence.

Goals and Objectives of the Study

1. To document profiles of chemically dependent African-American clients who attended the selected treatment program.
2. To identify the therapeutic interventions and approaches used by the counselors and determine the impact of the interventions on client success.
 - (a) To identify the presence or absence of a culturally-based or Africentric treatment approach based on criteria outlined in the literature review and interpreted through the interviews.
3. To examine the role of staff for the purpose of identifying their contribution to clients successful treatment outcomes.
4. To document internal and external strengths and resources of clients that may have contributed to their successful completion of treatment.
 - (a) To identify and analyze the impact of environment, community, staff and family support systems on the client's success.
5. To document those elements of the treatment program that may have contributed to the clients successful completion of treatment.
 - (a) To identify the role of peer support in relation to client success.

- (b) To examine the role of Alcoholics Anonymous and Narcotics Anonymous (two Twelve Step Programs) in relation to client success.
- (c) To examine the role of church and spirituality in relation to clients success.

Description of Treatment Agency

The Archway program was chosen as the focus of this study due to the following: (a) its outpatient alcoholism treatment program consists of the largest number of African-American clients and staff in the mid-Hudson region of New York State; (b) it is recognized for its effective culturally-based treatment focus for African-American clients.

Archway has been recognized by the Westchester County Department of Community Mental Health and New York State Office of Alcoholism and Substance Abuse Services (NYS OASAS) as one of the most effective providers of chemical dependency treatment services especially to African-Americans in Westchester County. This effectiveness as determined by county and state agencies is based upon service utilization, high number of outpatient clinic visits and provision of culturally diverse treatment services to African-American clients. According to NYS OASAS for the

fiscal year, 1993 to 1994, Archway provided 27,046 outpatient treatment visits.

Primarily for fiscal reasons, (e.g., Medicaid reimbursement) Archway became a part of Yonkers General Hospital in March 1991. Archway is licensed as an outpatient clinic and outpatient rehabilitation program by the New York State Office of Alcoholism and Substance Abuse Services.

Archway is an outpatient alcoholism/chemical dependency treatment program located in the city of Mt. Vernon in Westchester County, New York. Westchester County is a northern suburb of New York City. Mt. Vernon, with a population of 67,000 in a 4.0 square mile area, is in the southern tier of Westchester County on the northeast border of New York City. According to New York State officials, Mt. Vernon is known as one of the ten most densely populated cities in the United States. Archway is a program of Yonkers General Hospital, which is located in Yonkers, New York. It began as a component of the Westchester Community Opportunity Program Inc. (WESTCOP). WESTCOP is a not-for-profit community based agency in Westchester County.

Archway was originally licensed as a day rehabilitation program in October, 1982 and initially named Westcop Rehabilitation Alcohol Program (WRAP). Archway added an outpatient clinic component in 1983, a children and family module in 1986, a Pelham satellite in 1988, 4 homeless

satellite clinics between 1991-1993 and a parole/jail based program in 1993. The original goal of Archway was to provide outreach and treatment services to the primarily low-income, inner-city community of Mt. Vernon, New York. Special program emphasis was placed on outreach to hard core, unemployed Black males and females who traditionally did not respond to formalized treatment services.

This research focus is on the Archway outpatient rehabilitation program. The outpatient rehabilitation program began primarily as a day treatment unit with hours from 9:00 a.m. to 2:00 p.m., six days weekly. In 1991, an evening rehabilitation program was added to address the expansion needs and develop an intensive program for clients working or attending school. The hours of the intensive program are 3:00 p.m. to 8:00 p.m.

At the time of this study, the staff of the outpatient rehabilitation program consisted of a multi-disciplinary team of six alcoholism/addiction counselors, one (MSW) social worker, one masters level rehabilitation counselor, a nurse, a vocational/activity counselor, a clinical supervisor, and two physicians (internist and psychiatrist), seven support staff (including three clerical staff, two drivers, a cook, and a biller). Approximately 90% of the staff identify racially as Black. All of the clinical staff have received alcoholism and substance abuse training. Three counselors are New York State credentialed alcoholism

counselors (CAC) and two are pending their license. Fifty percent of the staff in this unit have bachelors or masters degrees in a human service area and several are currently in undergraduate or graduate social work or counseling degree programs. Two staff persons are certified social workers, one is a licensed practical nurse who has a Bachelors in Social Work.

Over fifty percent of the staff are recovering persons who have previously been in treatment and/or who may be involved in these Twelve Step Programs, Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). These employees usually have at least three years experience post-recovery before working at the Archway program.

Staff at this agency are carefully selected to work in the outpatient rehabilitation program because of the cultural aspects of the program. This selection is based on their ability to work with a predominantly African-American client population. They need to have some familiarity with culturally-based treatment with African-Americans. The staffing in this program is very critical to the success of the program. Staff are trained to understand and address the cultural (race and ethnic) issues that surface in the treatment setting.

The racial population of these Archway clients has always been between 90 and 100 percent African-American. Most of the African-American clients at Archway are poor and

live in the most impoverished areas of the city. Mt. Vernon's physical and social environment in the poorer sections of the city (e.g., drug infested street corners, dilapidated housing, billboards with negative messages, etc.) lends itself to negative behavior. Clients residing in these areas sometimes have negative feelings about self and community. Many clients are also from chemically dependent families who may have experienced generations of "poverty" and have usually been in the public welfare system.

Between 1982-1986, the primary drug of choice of Archway clients was alcohol. From 1986-1994, the client's drug of choice has been primarily alcohol and crack/cocaine. Archway has had to adjust its treatment and staffing over the years to adapt to the change in drug of choice.

Most of the staff's theoretical orientation is a combination of the disease model, 12 step philosophy and culturally-based treatment. The mode of treatment is primarily group therapy, confrontational and supportive individual counseling.

At Archway, the assessment process applies a psychosocial theoretical model that focuses on the relationship between the clients and their significant environment. When treating addictions, the client's environment becomes very important. The influence of significant others and the significant environments is critical in addressing the

reality of the person becoming abstinent.

In chemical dependency treatment with African-Americans, it is important that treatment begin with acknowledgement of client strengths (Brisbane & Womble, 1992). The first strength acknowledged at Archway is their 'presence', the fact that they came into treatment. This is important because culturally, African-Americans do not seek help in clinical agencies. The treatment emphasis should continue to be on the client, identifying their strengths and supports from both their family, or community.

The activities of Archway's day rehabilitation program were developed with the participation of clients and staff with the goal of incorporating culturally relevant therapeutic groups, projects and events. These cultural elements reveal to the client that an integration of their culture and addiction issues has a direct impact on their success and progress in treatment. Success is determined by positive responses from the clients, their active participation and, levels of achievement.

These components are considered an integral part of the program as they allow the client to connect and understand the relationship between their culture and behavior. These concrete activities displayed through ceremonial and bonding events provides a 'continuity of care' essential for connecting treatment to everyday life. The effectiveness is measured by the number of African-American clients in

treatment and returning to treatment. It is also measured by the large numbers of African-American clients who have successfully completed treatment.

A sample of Archways' current and past cultural components are: (a) female rites of passage - a women's group facilitated by Black female clinicians and based upon the seven principles of Kwanza (an African-American holiday ceremony held annually); (b) circle of recovery men's group focuses upon Black men's issues with Black male facilitators as the clinicians; (c) arts and crafts include cultural, ceramic and art such as Nefertiti head pieces, metal appliques and ethnic paintings; (d) an African-American dance troupe, drummers and drama group.

The physical environment of the program is also of vital concern. At Archway, there is a cultural milieu depicted by African-American framed art and artifacts displayed throughout the facility. The client's ethnic drawings, paintings, ceramic art, poetry, and slogans are displayed throughout the program. Ethnic art by African American artists are also displayed throughout the program. This is important because clients become immersed in positive expressions of themselves and their culture. This results in increased positive self-esteem and cultural enrichment.

Since 1983, an AA group began holding its meetings at the Archway program Tuesday and Thursdays afternoons. In

the mid-1980's, an NA group began holding its meeting Wednesday evenings and has continued through present. In 1992, NA meetings were added Monday and Wednesdays afternoons. Each of these meetings was initiated by recovering employees who are active members of the twelve step fellowship. These twelve step meetings have been an integral part of the treatment program. All clients are strongly encouraged to attend the NA and AA meetings.

REVIEW OF THE LITERATURE: INTRODUCTION

Literature and research findings, primarily by African American social scientists, will be highlighted so that the knowledge base presented will be more of an Africentric perspective than Eurocentric. The Africentric perspective attempts to portray African-Americans, the people of the African diaspora in the Western hemisphere in ways that are free of European ethnocentrism (Turner, 1991).

Ethnocentrism is the tendency to see one's own group and way of life, including behaviors, beliefs, values, and norms, as superior to the groups and ways of life of others. The Eurocentric perspective raises two issues: (a) "the implicit ethnocentrism of theories that label behavior as deviant and psychopathological rather than culturally different and; (b) the extent to which theory blamed victims of oppression for conditions that had their etiology within the socioeconomic system" (Turner, 1991, p. 45).

This research will document a body of knowledge pertaining to the treatment of African-American families in clinical treatment settings. There is a void in the literature that specifically addresses chemical dependency treatment issues with African-Americans. Therefore this review will draw from and examine mental health treatment issues with African-Americans as well as chemical dependency issues of the general population.

Ethnicity and Chemical Dependency

Ethnicity has been one of the most popular independent variables in the study of use and misuse of drugs.

Ethnicity, according to Cheung (1990-91), is based on ethnic group identification defined as "a group of people who share the same culture or are descendants of such people who identify themselves and/or identified by others as belonging to the same involuntary group" (Isajiw, 1974, p. 122).

Furthermore, ethnic identity may be defined as "commitment to a social grouping of common ancestry, existing within a larger society of different cultural origins, and characterized by the sharing of some common values, behavioral patterns of symbols different from those of the larger society" (Isajiw, 1974, p. 129).

There are many findings in the drug use literature indicating differential use of legal and illegal drugs among different ethnic groups. Despite this, the relationship between ethnicity and drug use has not been thoroughly examined (Cheung, 1990-91). The major reason for the paucity of well formulated and tested theories of ethnicity and drug use is the inadequate use of the concept of ethnicity in the literature.

Literature on ethnicity and chemical dependency is growing in demand and has increased in quantity and quality over the past decade. In 1987, Trimble, Padilla and Bell reviewed over 150 drug use articles which dealt specifically

with America's major ethnic minority populations. They said "that the literature points to an unevenness in the amount of information currently available and that we lack even the basic and essential information necessary to understand the rate and extent of drug abuse among ethnic minority groups and individuals" (p. 1).

In 1989, Trimble and Bolek completed a review of 186 articles published between 1953 and 1988 on ethnic minority groups. One criteria used to select the articles was the representation of six major ethnic minority, social, and political groups in the United States. Alcohol was excluded as a drug category but cocaine and marijuana were two of the drugs included in this study. These 186 articles represented approximately 85% of the published articles on this topic submitted since 1950 (Trimble & Bolek, 1989).

There is concern about the validity of studies on alcohol or drug abuse and ethnic minorities. There are questions about the manner in which researchers specify and describe ethnic and culturally specific respondent populations (Trimble, Padilla and Bell, 1987). "For a vast majority of the studies in the ethnic minority drug use literature, descriptions of ethnic and cultural groups tend to rely on the use of broad 'ethnic glosses', superficial, almost vacuous, categories which serve only to separate one group from another" (Trimble, 1990-1991, p. 152). Ethnic glosses are broad ethnic labels used to identify major

ethnic majority groups. The use of broad "ethnic glosses" to describe a cultural or ethnic group in a research venture may be poor science and are gross misrepresentations that can violate certain tenets concerning external validity (Trimble, 1990-91). The use of such "glosses" do not address the richness and cultural variation within the ethnic groups.

The major ethnic groups (e.g., African-Americans, Caribbean-Americans, Latinos, Native Americans) in the United States represent very diverse socio-cultural and subgroup categories. The research on these groups especially in the drug use and abuse literature does not give descriptive characteristics of the subject or respondent population. One major issue in the literature is the need for replication of studies on ethnic groups in substance research (Trimble, 1990-91).

In addressing the sources of bias in methodological issues in alcohol research, Westermeyer (1989) identified the following:

1. ethnic and racial bias in census data reporting.
2. ethnic and racial sampling bias.
3. bias in research and data collection designs because data collection instruments fail to address ethnic and cultural issues adequately.
4. bias of the researcher or data collectors.
5. ethnic and racial bias in data analysis and

interpretation (p. 462).

These areas of ethnic and racial bias can begin to be avoided if researchers consider the ethnic and cultural diversity of their research participants. Special attention must also address the impact that socio-cultural and environmental issues may have on the research.

Heath (1990-91) discussed the terminology of ethnicity as race as used in alcohol studies literature. The predominant focus was the contrast of the terms "Blacks" to "Whites" in all issues reviewed. He acknowledged that until the 1960's, the literature referred to "Blacks" as "Negroes." He questioned why terms like "Afro-Americans" or "African-American" have been so infrequently used by those who write about alcohol use and its outcome. He further suggests that "many of the patterns that were earlier attributed to Black drinking appear to be more closely linked with social and economic characteristics of the samples than with any overall racial characteristics" (Heath, p. 617). Harper (1983) said that racial discrimination and racism continues to have an effect on the etiology and treatment of Black alcoholism in this society.

The literature also addresses the importance of the difference between ethnicity and race (Cheung, 1990-91; Heath, 1990-91; Trimble, 1990-91). Many studies of ethnicity and drug use, utilize race as the sole indicator of ethnicity. This is an inappropriate use of that

indicator. If one uses the most basic ingredient of the definition of race as physical characteristics (usually skin color) then that becomes one basis for defining and identifying ethnic groups (Cheung, 1990-91). Many persons of the same "race" belong to different ethnic groups, speak different languages, and have distinctly different cultural values and behaviors. This diversity of cultural traits affects their use of alcohol and drugs and their utilization of treatment services. There is a need for further research to explore the differences between Blacks born in countries of the Caribbean versus those born in the states in relation to their cultural use of substances.

As a result of their unique racial and cultural influence, Black alcohol abusers have also developed different treatment needs which distinguish their needs from other alcoholic populations. This is primarily related to the fact that the development of drinking patterns and practices arose out of different circumstances. Research efforts have not been applied toward the identification and assessment of the level and extent of the disabling conditions, as well as the rehabilitation treatment needs of the Black alcohol abuse client (Smith, E.R., 1990).

In examining these issues, Benjamin and Benjamin (1981) state, "the need at this time in sociocultural research on alcohol and Blacks is for research conceptualization and design that show recognition and appreciation of Blacks'

values, life-styles, social definitions and belief systems: that make subgroup comparisons within the Black population; and that can be used as the data base for programs targeted to Blacks in the areas of prevention, treatment and education in the alcohol field" (p. 244).

Cheung (1990-91) describes ethnicity at the collective level as a matter of community. Ethnic communities include levels of social organization "to compete with other ethnic groups for power and resources in the social, economic and political spheres. The results of such competition is the distribution of ethnic groups in the various socioeconomic and political echelons of the society" (p. 595). This illustrates the correlation of ethnicity with social class.

In discussing some limitations of studies of ethnicity and drug use, Cheung (1990-91) identified two levels of limitations: methodological and theoretical. The methodological inadequacies are based on collecting accurate data from studies of known addicts and from self-report surveys. The theoretical limitations are based on researchers inability to offer theoretical explanations for the ethnic or racial variations in drug use. According to Cheung "it is not enough to know the presence of ethnic variations in drug use; it is important to ask 'why' there are such variations" (p. 589). He further suggests that "the search for explanations for the relationship between ethnicity and drug use is not only of relevance to

theoretical pursuits; also it has direct bearing on the design of treatment programs that can be sensitive to the ethnic or racial backgrounds of their clients" (p. 589).

Over a decade ago, Johnson and Nishi (1976) stated:

"it would be wrong to conclude that minority drug use is better understood simply because more data about it are now available. In fact, the extensive amount of research seems to have contributed relatively little to a realistic understanding of minority drug use. All of the research effort and fact gathering so far has yielded only meager results barely beyond the descriptive level" (p. 26).

It is really unfortunate that current research studies on ethnicity and chemical dependency have not advanced beyond this.

The existing studies of ethnicity and drug use have not adequately addressed the relationship or impact of a person's ethnicity on the development of, or provision of treatment services. Herd (1986) in discussing implications for research concluded that research data on Blacks from alcohol programs reporting systems should be made more available. More complete data on the racial breakdown of alcohol-related treatments is needed to assess the magnitude of black alcohol problems and plan interventions.

Few studies have examined ethnic or gender differences in drug users attitudes toward drug treatment (Longshore, Hsieh and Anglin, 1993). These authors conducted a study among a sample of 1,170 drug using arrestees to determine their demographic differences in perceived need for treatment. Forty-one percent (41%) of the sample (n = 1,579) interviewed were Black, 36% were Hispanic, and 67.6% were male.

The findings regarding African-Americans include that:

1. African-Americans have negative views of treatment, especially regarding methadone maintenance and detoxification.
2. African-Americans are less comfortable with self-disclosure in therapeutic settings.

The authors recommended that special emphasis be placed on engagement of African-American clients at each level of the treatment process. They further suggested that there be special attention at the engagement process regarding one's spirituality, communalism and African heritage. They further suggested that the treatment providers establish closer ties with the African-American community and community leaders.

Cheung (1990-91) challenges the popular method of treatment programs providing interpreters or employing staff of various ethnic groups to address the diversity of their clients. His premise is that ethnic staff should be trained

to address ethnicity factors in assessment and treatment. This would be a means to improve communication and treatment outcomes.

In reporting the findings of an NIAAA sponsored workshop, held in the summer of 1981, Williams (1982) identified the following as major concerns:

1. the need for race and racism to be included as intervening variables in alcoholism research among Blacks.
2. the need for longitudinal studies that measure long-term effects of services provided to participants of treatment programs.
3. a need for empirical support for treatment programs to be designed and tailored to special needs of Blacks (Williams, 1982).

Racial and ethnic background as well as intra-ethnic experiences need to be considered as treatment programs are designed (Primm, 1993). In order to design appropriate treatment and prevention programs, the diverse socio-cultural characteristics of these populations must be given serious consideration (Benjamin & Benjamin, 1981; Trimble, 1990-91).

African-Americans and Chemical Dependency

Many researchers perceive alcoholism and other drug addiction as one of the major health, mental health and social problems affecting African-Americans (Gary, 1978; Harper, 1983; Murphy, 1991). Historically, alcoholism and substance abuse were perceived as mental health problems or legal/criminal issues in the black community. Gary (1978) defined mental health problems of Black people to include those conditions that affect a significant number of Black people in ways that they consider undesirable (i.e., alcoholism, drug abuse, and violence).

Harper (1983) expressed concerns about the limited quality and quantity of literature on alcohol use and abuse and Blacks. He stressed the need for additional studies in this area. Harper and Dawkins's (1976) compiled a comprehensive literature review covering a 30 year period (1944-1974) of archival data on alcoholism among Blacks. Their review showed that only 77 of the 16,000 alcohol related articles in scientific journals contained findings about Black alcohol use. Of that, only 11 articles focused specifically on Black Americans and five articles focused on Blacks from the Caribbean, South America and Africa.

According to Watts and Wright (1983), there have been over 400 articles, books and other published materials concerning alcohol abuse and alcoholism among Black people between the years 1977 and 1985. This is a considerable

increase since Harper and Dawkins' 1976 study. However, most of those 400 articles address 'the problem' versus 'treatment outcomes' or research studies. Benjamin and Benjamin (1981) explored these issues also and stressed "an urgent need to obtain baseline data within Black populations" (p. 243).

According to the U.S. Department of Health and Human Services Report of the Secretary's Task Force on Black and Minority Health (1986), data on the prevalence of chemical dependency for the minority population and the resultant impact on health status are limited. However, data on excess deaths among minorities provide an indication that chemical dependency has had a greater negative affect on the health of minorities. Preliminary data suggested that the intensity and impact of drug abuse among minority populations is of significant proportion and is not expected to diminish. Black clients were more likely than white clients to report a primary problem with heroin, cocaine, marijuana and P.C.P. This report further addressed minority admission data to treatment centers, emergency rooms, and medical examiner reports. Such data can be viewed as secondary indicators of prevalence and can indicate to a degree the extent and consequence of drug abuse among minority populations.

"Data obtained from the 1982 National Drug and Alcoholism Treatment Utilization Survey (NDATUS), a national

survey of public and private treatment units, suggested that Blacks are three times more likely to be in treatment for drug abuse-related problems than are whites" (Herd, 1986, p. 117).

Herd (1986) examined Black drinking patterns and identified indicators of alcohol related problems, both medical and psycho-social among U.S. Blacks during the 1950's through the 1980's. The medical problems included that Blacks are extremely high risk for morbidity and mortality for acute and chronic alcohol related diseases such as liver cirrhosis, alcoholic fatty liver, alcoholic hepatitis, and esophageal cancer. Alcohol consumption has been determined to be a primary etiological agent in the development of the esophageal tumor among Blacks. "An analysis of contemporary Black drinking patterns suggested that Blacks may be at greater risk for physiological diseases due to a later onset and more prolonged pattern of heavy drinking than whites" (Herd, 1986, p. 117).

In addition, Herd (1986) reported that Blacks have been greatly over represented in psychiatric admissions for alcohol-related diagnoses especially between the 1930-1970's. As the National Institute on Alcoholism and Alcohol Abuse (NIAAA) was established in the 1970's, studies showed that Blacks were overrepresented in the NIAAA funded Alcoholism Treatment Centers by forty percent. There was also gross over-representation of Blacks in public inebriate

and drinking driver programs. Herd further stated that "the high proportion of Blacks in the alcohol treatment system, particularly in agencies serving the poor and homeless, may be related in part to the general over-institutionalization of Blacks in the mental health and criminal justice system" (Herd, 1968, p. 118).

Leffall (1990) reported that the growing threat of chemical dependency, particularly the use of illegal drugs such as crack, marijuana and PCP (angel dust), is tearing at the very fiber of the African-American community. Its dramatic impact is evidenced by increased crime, wanton violence, mental disorders, family disruptions and social problems in school and on the job. Mbanaso (1991) also implied that urban poor and ethnic minorities, particularly African-Americans, bear the burden of the effects of rampant drug abuse, especially drug related violence.

According to Nobles and Goddard (1989), the prevalence of drugs in the Black community, with its concomitant violence, has served to reduce the quantity and quality of Black life. He stated, "that substance abuse in the African-American community can be judged as an instrument of genocide" (p. 175). The quantity of life in the African-American community is directly affected because "drug use is a primary contributory factor to the lower life expectancy of the African-American population. . . . Given the violence, unpredictability, and volatile nature of drug

trafficking and drug related behavior, we can estimate that 80 percent of the "excess deaths" due to homicide are drug-related" (p. 176).

Staples (1991) described the use of alcohol and drugs by Blacks of the underclass as having been the opiates used to ease the pain of their oppressed status. He further stated that since poorer Blacks feel the sting of racism and poverty more directly than affluent Blacks, they are more likely to seek the palliative effect of drugs and alcohol. Because of poverty and powerlessness, they are the most public of drug users and sellers, and the easiest to arrest. This, however, may explain why we see a higher prevalence of addiction and illegal drug behavior among low income African-Americans and in the poorer communities.

Cheung (1980) agreed that "ethnic groups occupying the lower parts of the class ladder are prone to have higher crime rates than those groups who fare better in society" (p. 595). The reasons that he identified: economic deprivation, sense of powerlessness, and other disadvantaged conditions that go with low socio-economic positions are conducive to higher rates of crime and drug misuse. The "underclass" was able to reach a false level of status and success in the drug culture that they are usually unable to achieve in the larger society.

Nobles and Goddard (1989) reported that the "participation in drug-related activity represents an

attractive alternative to poverty and despair. . . . For others of the underclass, participation in a drug-related lifestyle is part of their normal routine of living. . . . Lacking the resources and the inclination, few have ventured outside of their immediate surroundings to explore the wider society" (p. 62-63).

Nobles and Goddard (1989) further addressed the impact that drugs have had on African-American families and children. They identified the shift in cultural orientation from a traditional Black family orientation to the drug culture orientation. The general design for living, as described by Nobles and Goddard's (1989) drug culture orientation, includes: "(a) to trust no one, and (b) anything is permissible. The drug culture is, in fact, creating a 'psychopathic' environment wherein 'effective family functioning' is determined not by the rules or moral values of one's socio-cultural group, but by the dictates of a system of deviancy and chaos" (Nobles and Goddard, 1989, p.172). These authors suggested that this cultural shift by the drug culture is the most powerful danger that African-American families and children must confront.

The impact of this drug culture on African-American youth and adults has been seen in several respects, both economically and clinically. In the presence of high levels of unemployment, drug dealing and drug related activities have emerged as viable economic alternatives for urban youth

and adults. Young children observe this 'acceptable lifestyle' of materialistic gain. To mental health service providers, the act of participating in drug trafficking represents behavioral dysfunctioning and social deviancy (Nobles and Goddard, 1989).

Their study further suggested that the conflict associated with an illegal activity that also benefits the family be seen as one expression of psychological stress/trauma in African-American children. Some of these young children are recruited to be a part of this drug culture as 'look-outs', and 'runners'. Other children who may not be directly involved experience a sense of fear of the violence, hostility and tension that is ever present in the communities where drug activity is operated.

Substance abuse has played a significant role in destabilizing, disrupting and/or dissolving Black families (Harper, 1991). He further reported that the deteriorating and diminishing Black family has been negatively influenced by the escalating availability of inexpensive drugs. This is especially true in urban areas and is related to a continuing value of use of alcohol for social/conviviality, and for psychological coping.

REVIEW OF THE LITERATURE: THE TREATMENT

Culturally-based Treatment Approach

Human service providers are becoming more aware of the need to develop culturally appropriate treatment services to their clients (Robinson, 1989; Chau, 1991, Comas-Diaz, 1988). In the field of chemical dependency (alcoholism and substance abuse treatment), professionals have also grappled with the problem of providing prevention and treatment services to culturally diverse populations.

According to Green (1982) cross cultural encounters between workers and clients involve issues of race, culture, social class, minority status and ethnicity. Each of these terms must be clearly defined by the practitioner or agency and explored as to its significance in the treatment process. Effective programs and treatment interventions demand that those providing the services understand and be sensitive to the values, culture and special needs of all groups served. This is especially true of ethnic minorities (Jacobs and Bowles, 1988).

Williams (1982) found that counseling from a cultural perspective has always existed since the beginning of counseling. It involves understanding the client's frame of reference and incorporating it into therapeutic strategies to maximize their effectiveness.

Smith, et. al. (1993) stated, "the quiet revolution, using culturally relevant models, whether they be church, clinic or residential programs, has saved many lives and has done much to counter the therapeutic pessimism and despair that dominate so many inner-city communities ravaged by the drug epidemic" (p. 97). Black counselors and therapists need widespread cooperation from the personnel of predominantly white treatment centers to be more sensitive to culturally diverse clients. There is a need to continue to develop and implement treatment programs which address the complex cultural, historical and psychological issues unique to Black Americans (Thompson & Simmons-Cooper, 1988).

Clinicians in chemically dependent treatment programs must pay attention to culture as a factor in clinical assessments. This process includes problem identification, diagnosis and the intervention plan. Pinderhughes (1989) identified the following as questions that practitioners should ask to ensure that their own cultural lens not be the basis of assessment:

1. To what extent is the problem related to issues of transition such as migration and immigration (p. 149)? This question is particularly significant when working with chemically dependent persons from the Caribbean, South America or the continent of Africa.

2. To what extent is the client's understanding of the problem based on a cultural explanation, for example, evil curse (p. 149)? This is often seen with clients who may practice a different religion or belief systems that may include voodoo.

3. Is the behavior that is a problem considered normal within the culture or is it considered dysfunctional (p. 149)? The use of drugs and alcohol in some cultures may be acceptable, especially during ceremonies, rituals, or for medicinal purposes. The social use of some illegal drugs, such as marijuana, may be acceptable but the inability to "hold one's liquor" may be considered dysfunctional.

4. To what extent is the problem a manifestation of environmental lack or insufficiency, or lack of access to resources and supports (p. 149)? The lack of adequate treatment programs and the overwhelming presence of drugs in the African-American community is an example of the environment's impact.

5. To what extent is the problem related to cultural conflict in identity, values, or relationships (p. 149)? A client's treatment may be affected by his/her acceptance of his racial or

ethnic group's identity (Robinson, 1989).

6. To what extent is the behavior a consequence of psychological conflict or characterological problems (Pinderhughes, p. 149)?

7. What are the cultural strengths and assets available to the client, such as cultural values and practices, social networks, and support systems (p. 149)? The identification of clients strengths in treatment is an example of non-deficit treatment approach.

In discussing this further, Pinderhughes (1989) suggested that practitioners must be aware that within these specific cultural groups, clients are from various social classes, levels of education, and acculturation. These contextual factors must be considered when understanding and assessing the client problems. Practitioners must also be ". . . cautious in generalizing about a specific individual or family, based on cultural knowledge of that group. The characteristics of the group may not be relevant to that individual" (p. 149).

One need is for more cultural sensitivity which is defined by the Office of Substance Abuse Prevention as "an awareness of the nuances of one's own and other cultures" (Orlandi, 1992, p. vi). The other is for culturally relevant or appropriate treatment programs. Culturally appropriate is defined as "demonstrating both sensitivity to

cultural differences and similarities and effectiveness in using cultural symbols to communicate a message" (Orlandi, 1992, p. vi).

African Centered Treatment Approach

Jones (1985) asserted that it is essential to use an African-American cultural framework in evaluating African-American clients. She examined the differences between using the two frames of reference (Afrocentric and Eurocentric). The Anglo-European framework often results in an inappropriate, inaccurate, and often negative evaluation of the African-American client. The Afrocentric framework tends to clarify the functionality of certain behaviors of the African-American client. The Africentric perspective delineates and explicates some differences in culture, world view, and historical experiences between African-Americans and European-Americans. This has many implications for the construction of paradigms of human behavior (Turner, 1991).

Meyers (1988) developed, from an Afrocentric perspective, a Black model of psychological functioning. This "Black model of psychological functioning, or Afrocentric psychology, is based on the study of the principle of life; or based on a particular kind of reason: the unity that contains and transcends all opposites. Reason, or divine wisdom manifest in the creation, government, and redemption of the world, is the controlling

principle of the universe" (p. 24). "This paradigm assumes an optimal world view, a holistic Afrocentric approach to knowledge . . ."(p. 24).

Nobles (1985) uses Afrocentricity or Africanity as a theoretical model for viewing the Black family. Nobles (1984) defines Africanity or Afrocentricity as "the intellectual and philosophical foundation used to develop the political, scientific and moral criterion for authenticating the reality of African family processes. It is the utilization of the African experience as the core paradigm for human liberation and higher level human functioning" (p. 127). "A primary concern for this discussion is ultimately to offer a theoretical framework to critique the literature on the Black family which therefore will provide us with a systematic way to refute theoretically and empirically the erroneous and destructive conceptualizations of Black family life found in the literature to suggest the initial guidelines for guaranteeing an accurate and authentic characterization of the Black family" (Nobles, 1986, p. 3,4).

Nobles (1985, 1986) challenges the research and treatment of Blacks in the social sciences by Eurocentric and Euro-trained social scientists where there was a negative study of the Black family. Nobles also acknowledges the African-American social scientist who challenged the deficit perspective. They include

Billingsley (1968), Hill (1972), Ladner (1971), and Staples (1991).

Nancy Boyd-Franklin's book Black Families in Therapy (1989) highlights many aspects of the diversity of black families that are often overlooked and misunderstood. One major premise of the book is how the African-American culture represents a distinct ethnic and racial experience. This experience is unique due to its history, its African legacy, the experience of slavery, racism, discrimination, and the victim system.

Gary (1978) agreed that both personal and institutional racism must be seen as key variables related to stressful events in the lives of Black people. The research has suggested that the impact of racism and race on a client's life must be assessed and addressed at the initial phase of treatment (Robinson, 1989; Brisbane and Womble, 1992). Brisbane and Womble (1992) believe that it is important for clients to know that racist acts, whether they're perceived or factual, are treatment issues. These issues should be addressed with the client by their counselor/therapist or other appropriate persons.

Gary and Jones (1978) discussed how Black mental health professionals had begun seriously questioning the applicability of traditional models of mental health to the black community. Individual functioning should be viewed within the context of the social, political, economic and

other institutional forces with which the individual must cope, according to these professionals.

An understanding of the Black perspective helps to assess the problems of Black clients more accurately and helps to develop solutions and treatment plans (Chunn, Dunston & Ross-Sheriff, 1983). These authors define Black perspective "as the conscious and systematic process of perceiving and understanding the unique values, attitudes and behavioral patterns of Black Americans as a subculture embedded within but different from the larger society" (p. 104). This illustrates how Black clients must learn to function in two worlds: their cultural environment and the society at large.

Chestang, (1972) was one of several social work theorists who supported the dual perspective as a model to address cultural diversity and incorporated the person's interaction with their environment. Norton (1993) suggested that social workers should continue to use the dual perspective to focus on differences and apply it within the context of an anthropological-ecological approach in order to emphasize the universal goals of societal organization that underlie human behavior.

According to Norton (1993) "the dual perspective posits that all people are embedded in at least two interrelated social systems. The first is their immediate socioeconomic, cultural, or racial environment represented by their family

and community (the nurturing system of Chestang (1972)). The second is described as the economic, political and educational systems of the wider society, i.e., the general social and political macrosystem" (p.85).

When developing a treatment model for African-Americans, it is important to explore the theory of dual perspective or cultural duality. One must recognize the duality or "double-consciousness" contained in the Black American culture (Jaynes, 1989; Jacobs & Bowles, 1988; Chestang, 1972). Chestang, (1972) described three conditions that are socially determined and institutionally supported that characterize the Black experience. They are: social injustice, societal inconsistency and personal impotence. Social injustice is the denial of rights; social inconsistency is the institutional disparity between work and deed; and personal impotence is the feeling of powerlessness to influence the environment.

The concept of black empowerment incorporated into alcoholism treatment is "the process of equipping Black, alcoholic clients with the knowledge and skills necessary to transcend their chemical dependency through culturally sensitive and socio-historically relevant clinical intervention techniques" (Beverly, 1989, p. 374). One such technique that he describes is the use of dual consciousness.

Bell and Evans (1981) addressed the concept of Black double-consciousness in alcoholism counseling. They stated "that it is important to help Black alcoholic clients understand themselves in terms of dualities of: (a) how they see themselves as a Black person and (b) how they see whites." That double consciousness model is sometimes perceived as "successfully schizophrenic", existing in two worlds, one Black and one White. The stress, pain and negative self-perceptions that schizophrenia causes must be explored by the counselors seeking to help black clients successfully achieve sobriety (p. 30). These authors further suggest that it is essential to understand the racial issues that cause inner stress.

Staff need to deal with issues of powerlessness as it relates to their ability to affect change in other aspects of their client's lives. Solomon (1976) defines "powerlessness as the inability to manage emotions, skills, knowledge or material resources in a way that effective performance of valued social roles will lead to personal gratification" (p. 16). The power deficiency so often seen among African-Americans, other minority individuals and, communities stems from a complex and dynamic inter-relationship between the person and a hostile social environment. There is often a direct relationship between powerlessness felt by a client and powerlessness experienced by the staff. The issues of trust and mistrust, which are

so crucial in forming treatment relationships with African-Americans, cause staff to often disclose some of their powerless roles to the client so as not to mislead them. The power base of the clinician reflects both the level of ability to accept responsibility for self and society, as well as to understand the limitations and obligations of power and authority (Robinson, 1989). All these issues are important when developing culturally-based treatment programs for African-Americans.

Murphy (1991) describes the treatment needs of Black chemically dependent clients who have been involved in the criminal justice system. She stresses that the treatment must be culturally sensitive and address the special needs of this population. However, she cautions that the first step must be to get the addicted person to stop using drugs and to involve their families in the treatment. She suggests that one incorporate all models that work because "the treatment for the Black addict must be multimodal" (p. 161).

Strengths of African-American Families

In a strengths perspective, the emphasis on positive qualities and attributes creates a qualitatively different context for social work practice. "It aligns the 'doing' of social work with its system of values" (Weick, et. al., 1989, p. 354). In strengths based practice, the worker must

develop a "strength assessment" of the client. This assessment focuses exclusively on the client's capabilities and aspirations in all life domains. In this approach, the client decides what course of action to pursue and the worker helps them to see that they "possess much of what they need to proceed on their chosen path" (Weick, et. al., 1989, p. 354).

These authors further discussed how the social work profession--historically--addressed the need to recognize individual strengths in practice encounters. Social work has at times bordered on focusing more narrowly on individual pathology while ignoring individual strengths. Focusing on human strengths is one significant strategy for helping people reclaim a measure of personal power in their lives. "Assessment based on a strengths perspective places environmental and individual strengths in a prominent position" (Cowger, 1992, p. 146).

Black Family Orientation is based on the cultural themes and values system as identified by such social scientists as Andrew Billingsley, Robert Hill, and Robert Staples. Billingsley (1968) views the Black family as imbedded in a network of mutually interdependent relationships with the Black community and the wider society. He describes the various subsystems that are a part of the Black family, community and wider society.

Understanding the Black value system and its importance to the client is useful in making diagnostic assessments and developing plans for intervention. Workers must be sensitive to the psychological damage associated with the menial status of the low-income Black family. Black families have many residual strengths that can be tapped by practitioners (Hall & King, 1982).

In his classic "Strengths of Black Families," Hill identifies five major strengths. The first which relates to Billingsley concepts of family functions is: (a) 'adaptability of family roles'. The others are: (b) strong kinship bond, (c) high achievement orientation, (d) strong work orientation and (e) strong religious orientation (Hill, 1972). Billingsley described the history of "high achievement orientation" in the Black community among low and middle income families. The categories of achievement include educational advances and high occupational aspirations. The use of identifying Black clients strengths versus their deficits initially in treatment has been a means of treating African-Americans from a non-deficit model.

Many authors also stress how important it is to focus on and assess the client's strengths, as a basic treatment strategy (Pinderhughes, 1989; Solomon, 1976; Brisbane & Womble, 1992). They base these premises on Hill's (1972) classical work where he stressed the importance of scholars

and researchers focusing on Black families strengths as opposed to the customary white researchers preoccupation with pathology and the "blaming the victim". Solomon (1976) says that it is most important to assess client's strengths in the engagement-assessment process. This requires identifying the potential client's capacity, and the recognition of opportunities available in the social and physical environment.

In assessing the strengths of African-American female clients, the female-dominated survival role of family hero in Black alcoholic families is significantly related to racial and cultural factors. These females in alcoholic families assumed the mothering role in a mother-alcoholic Black family. This is in keeping with Hill's (1972) findings that "adaptability of family roles" is a strength.

In chemical dependency treatment with African-Americans, it is important that treatment begin with acknowledgement of client strengths. The first strength acknowledged is the clients 'presence', the fact that they came into treatment. This is important even if they are mandated clients because culturally, African-Americans do not usually seek help in traditional treatment agencies.

The treatment emphasis should continue to be on the client, identifying his/her strengths and supports from both his family, or community. Brisbane and Womble (1992) identified a psycho-social cultural assessment that focuses

specifically on cultural strengths, race issues and stereotypes. These characteristics may impede treatment if not addressed initially. Many clients bring issues of this nature into treatment, but are uncomfortable exploring them with their therapist. Cultural assessment instruments are currently being developed and incorporated into existing psychosocial assessment tools.

It is helpful if the assessment process also utilizes models of identifying client ethnic sub-society, family structure and family functioning (Billingsley, 1968; and Bell and Evans, 1981). Family function or family role is an important issue to address with African-American clients. Their perception of their role in the family as well as their feelings about not fulfilling their role often have a great impact on their feelings of self worth. This is a major issue with African-American males and females especially those who are parents and chemically dependent. They have often experienced feelings of helplessness, hopelessness and powerlessness when interacting with their families. Client's feelings of inadequacies and failures accompany their assessment of their roles as parents. It is important that this is addressed in a non-judgmental manner using empathy and acknowledgement of those feelings.

When clinicians identify and build upon the existing strengths of the client, they become more in touch with the client's current level of functioning and current sources of

individual and personal power (Gutierrez, 1990; Pinderhughes, 1989; Solomon, 1976).

Support Systems: Spirituality and Twelve Step Fellowships

"Blacks' constant reliance on family, religious beliefs and church attendance, as well as faith in spiritual forces is well known" (Brisbane & Womble, 1985, p. 249). In addition, Knox (1983) discusses how "folk beliefs and practices have been a cultural tradition and a source of support in times of personal, emotional and physical stress" (Knox, p. 1). "It is believed that one reason Blacks have been able to survive in this society is related to their own efforts to solve problems" (Gary, 1978).

This survival is based on their own use of the cultural support systems. The support system for African-Americans includes: the extended family, (blood relatives and non-blood relatives); informal and formal networks in the community (i.e., community leaders, community centers, barbers, local businesses); informal and formal organizations (i.e., neighborhood associations, fraternal organizations, professional organizations); churches, ministers, and spiritual leaders. The use of family as a support system by chemically dependent persons is often primarily to help in the "parenting role." The extended family members (i.e., grandmothers, aunts, godmothers) are often raising the children of chemically dependent

relatives. Some are doing this informally while others have formally become "foster or adoptive parents" to these children.

Strong religious orientation is one of the five strengths identified by Hill (1972). This encompasses spirituality which is a very important cultural trait that should be addressed when treating chemically dependent African-Americans. There is a clear distinction in being religious and being spiritual which will be discussed in this chapter. Spirituality will be examined more closely for the purposes of this research. The assessment should include a series of questions that address clients spirituality, belief system and/or religion. When assessing clients, their sources of hope and strength should be identified. This will often lead to discussions regarding their concept of God and spirituality (Knox, 1985). The three sources of hope and strength that Knox (1985) identified are: (a) the family as a source of support; (b) faith in God for help in the removal of psychological stresses and; (c) the church as an emotional release of the tensions faced in an oppressive society (p. 35). These three sources are the basis of a strong religious and spiritual orientation that has accounted for much of the survival of the Black family. In treatment, these issues must be explored and incorporated.

In treatment sessions with African-American alcoholics specific questions concerning spirituality must be addressed (Knox, 1985). They include the following questions:

1. to whom does the client turn for hope and strength when feeling overwhelmed?
 2. has the client had any negative experiences with organized religion where they now feel cut-off spiritually?
 3. has the client had a spiritual guide in life (e.g., a minister, spiritualist, Santero, etc.)?
- (p. 36) If so, the therapist should consult this guide.

According to Knox (1985) the relationship between client and therapist must be expanded to include a spiritual dimension.

"In culture-specific or Afrocentric models of treatment of alcoholism in African-American communities, spirituality is an important component in the recovery process" (Potts, 57). "Spirituality is a way of being and experiencing based upon one's relationship with self, others, nature and whatever one considers the Ultimate or God" (Potts, p. 54).

Brown and Peterson (1991) developed an instrument, (Brown-Peterson Recovery Process Inventory [B-PRPI]) to measure long-term spiritual progress in treatment center graduates. Among the spiritual practices described by their subjects, over two-thirds reported engaging in prayer, and belief, trust and faith in a Higher Power. Their findings

supported a "broad-based approach to the presentation of spirituality in twelve step oriented treatment programs" (p. 39).

Brown and Peterson's (1991) research included a review of the literature on Alcoholics Anonymous (AA) and how individuals work the program. Alcoholics Anonymous, founded in 1935, is the first twelve step fellowship. It began in middle class white America. "Historically, participatory and observational data indicates that the fellowship of Alcoholics Anonymous was an effective treatment resource for Black alcoholics long before the advent of formal medical based alcoholism treatment programs in the Black community" (Hudson, 1985, p. 29). The first AA group in a Black community was started by a Black physician in Washington, D.C. in 1945. In 1947, another AA group began in Harlem (New York City). Today, there are AA meetings in Black communities throughout the nation.

"AA and other traditional twelve step fellowships are spiritual programs. Spirituality is at the core of their effectiveness as a means to ongoing sobriety and recovery. That fact cannot be denied" (Smith, et al., 1993, p. 103). It is important that one does not confuse this spiritual focus with being "religious."

Currently, Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), are the major self-help support systems for chemically dependent persons. They have been accepted in

most of the Black communities. The foundation of spirituality is very appealing to many African-Americans who have traditionally utilized the church. Okpaku (1985) shared that "the Black church by its spiritual focus becomes readily compatible with the doctrines of AA and the church can therefore serve as a base of Black AA programs" (p. 150). Descriptive studies have shown regular association between AA attendance and better treatment outcomes (Westermeyer, 1989).

REVIEW OF THE LITERATURE: PROGRAM EVALUATION STUDIES

Successful Chemical Dependency Treatment

Much of the research in the field of chemical dependency before the 1980's on the effectiveness of treatment modalities or outcome studies focused primarily on the treatment of two drugs: alcohol and heroin. Since the mid-eighties, there has been a focus on cocaine/crack in the literature. This section will focus on treatment effectiveness issues primarily related to alcohol and cocaine/crack with outpatient treatment.

Two types of research are frequently identified in the literature: (a) outcome research which provides data on the overall impact of therapeutic interventions and, (b) process research which investigates the underlying elements involved in treatment (Institute of Medicine, (IOM) 1992). The focus is on the broader questions being investigated, (i.e., Does treatment work? Are any of these treatments effective?) (Longabaugh & Lewis, 1988). "It has become imperative for research to document which treatments succeed for whom, and how" (p. 168). These authors particularly focused on the need for more single treatment programs to do in-house program evaluations. Longabaugh and Clifford (1992) concurred ". . . any treatment program for alcohol or polydrug abuse needs to measure alcohol/drug involvement after treatment completion" (p. 231). He further states

that "evaluating treatment effectiveness should be an ongoing priority and activity for all substance abuse treatment programs" (p. 246). This has been recognized as a need by most treatment providers but the cost and staffing of research departments is prohibitive.

Frawley (1988) defined three main types of treatment outcomes which are important to program evaluation as: (a) outcome of the individual patient based on agreed treatment goals; (b) programmatic outcomes which are based upon measurable outcomes and; (c) outcome research on specific treatment modalities and methods (p. 213). "In addition, knowledge of patient characteristics is critical to understanding outcome reports, even more important is an ability to analyze the methods used to collect data about treatment outcome" (Miller, 1986).

A major concern in outcome research is the reliability and validity of patient self-reporting. "Research on alcoholism treatment has been based largely on information provided by alcoholics themselves about their behaviors" (Fuller, 1988, p. 181). There is a consensus that self-reports alone are not sufficient to measure treatment outcomes and that simultaneous measures of treatment effectiveness are necessary (O'Farrel and Maisko, 1987; Fuller, 1988, Sobell & Sobell, 1989). Cheung (1990-91) identified three major problems of self-report survey which included that: (a) they are prone to errors such as memory

failure, lying, interviewer effects, etc.; (b) there are systematic under reporting of levels of drug use, and; (c) that different researchers employ different time intervals for counting drug use. All these issues affect the comparability of results.

Sobell & Sobell (1989) found that research on the veridicality of self-reports should be considered a strength of outcome research. They conclude that self-reports in the alcoholism field will continue to be a major source of outcome data. They argue that several major reviews have discovered that there is no factual basis for widespread skepticism about self-reports especially when the interviews are conducted in a clinical/research setting and participants are alcohol free (Sobell & Sobell, 1989).

Fitzpatrick (1992) conducted a study which reviewed measures used in evaluating treatment programs. This study's results showed that among the most useful information collected were the observations of treatment programs and reports of respondents concerning treatment.

Hollister (1990) concurred that it is essential that a variety of treatment programs be studied, since success rates would vary. He suggested that other information to study should include issues such as: what is the optimal site for treatment, optimal length of stay, treatment sequence based on modalities (inpatient, outpatient). According to Miller (1992) a "comprehensive treatment system

should offer a range of alternative modalities that have been shown to be effective. . . . Interventions are best tailored to the needs and characteristics of individuals, with regard to the optimal length, setting, goals, and methods of treatment" (p. 99).

A literature review on drug abuse treatment by Allison and Hubbard (1985) identified three treatment modalities; one was outpatient drug free. The authors also briefly address information on outcome research. They found that issues such as program philosophy, policy and goals of treatment often influence the outcomes of treatment. They further addressed the therapist and client relationship as an important determinant of outcome. Another predictor of program performance is "client likability" which emerged frequently in the literature.

In another study, Siddal and Conway (1988) identified client retention in treatment as an essential prerequisite to successful treatment. They suggested the need to reliably identify factors associated with client retention and success as means to improve the effectiveness of treatment services. One of their findings, of primary factors predictive of retention, included the client's social support network and employment status.

Westermeyer's (1989) research on the effects of "non-treatment" factors on treatment outcomes identified positive treatment implications. One of the implications was that

successful treatment outcomes were associated with alcoholic patients who had regular or steady employment. Employment is usually considered a positive support system.

Gainey's, et al. (1993) study addressed treatment retention among 110 cocaine addicted persons of which 88% also abused alcohol. The demographics of the client subjects included 84% whites, 13% Blacks, 64% male, and 36% female. Data was collected through self-reporting interviews using two instruments. One was the Addiction Severity Index and the other was a Drug Use Supplement. One result of their study was that "age was the important demographic predictor of treatment completion. Older clients were more likely than younger clients to complete treatment" (p.497). An observation was that those clients who were less involved in serious drug-misusing or illegal life-styles were more likely to complete treatment (Gainey, et al., 1993). These authors further reported evidence of a strong relationship between treatment retention and positive outcomes in substance abuse treatment.

A similar trend was found in the research related to social supports and treatment outcomes by Sandberg, et al. "Treatment success, insofar as it can be evaluated is also a function of such variables as the presence of legal pressure, degree of family involvement, social support, the willingness of the individual to make a commitment to being drug free or to a long term residential program, . . . "

(Sandberg, et. al., 1991, p. 369). This study addressed the issue of mandated treatment referrals and client internal willingness to become drug free.

Oyabu and Garland (1987) conducted a study which examined the role of social support in recovery from alcoholism. This study surveyed 83 patients from a hospital based inpatient rehabilitation program, of which 70 were male and 13 were female. Sixty patients identified alcohol as their primary drug, three identified drugs only and, 19 identified alcohol and drugs. Race and ethnicity of these patients was not identified. Statistical analyses revealed that those who started using alcohol or other drugs at older ages showed relatively more improvement from the treatment than their younger counterparts (Oyabu & Garland, 1987). This study did not show a significance with available social support and patients total improvement. One possible explanation for this may be the patient's interpretation of "social support" (Oyabu & Garland, 1987). Sometimes clients still interpret their "old people, places and things" to be their supports, when in fact, these were their negative influences.

Westermeyer's (1989) research identified several positive studies regarding the impact of social supports on successful treatment outcome. He theorized that "regular social involvement with church or community activities may enhance outcome" (p. 21). Several Minnesota studies of

alcoholics revealed higher treatment success rates from the patients who were more involved in community affairs.

One approach that needs further research is matching patients with treatments. This approach is an untapped possibility for improving the effectiveness and efficiency of treatment, especially with treatment of special populations (IOM, 1992). This approach would support the matching of clients with culturally relevant treatment.

There have been studies addressing the efficacy of inpatient versus outpatient treatment. The primary two reasons for selecting one modality over the other relates to treatment appropriateness and cost-effectiveness (Harrison, Hoffman & Streed, 1991; O'Brien, Alterman, Childress & McLellan, 1992). Some primary distinctions between outpatient treatment is that clients must "continue to function in their environment, maintaining for the most part their daily routines and responsibilities. Outpatients must continue to confront existing interpersonal and environmental stressors" (Harrison, p. 1165).

Hoffman and Miller (1992) conducted a study which consisted of 8,087 inpatients and 1,663 outpatients. Their findings were that:

1. both inpatients and outpatients who attend either AA or the aftercare provided by the treatment program are more likely to remain abstinent than non-attendees.

2. Up to 90% of those clients who attended both AA weekly and went to aftercare for the entire year maintained their abstinence (p. 406).

Another study that looked at patient treatment matching and treatment outcomes for 198 employed alcohol and/or cocaine abused males found a ninety-four percent success rate of aftercare follow-up in four outpatient treatment programs. In this study, the self-reported data on chemical use was supported by the results of concurrent drug testing (urinalysis and breathalyzer readings) (McLellan, et. al., 1993). Research also focused on the differences in efficacy among the four outpatient programs. Findings revealed that "the programs that provided the most services directed at a particular treatment problem, generally showed the best outcomes in that problem area" (p. 253).

Filstead (1992) reported the findings of a 1988 treatment outcome study conducted at a large national alcohol and drug treatment agency, Parkside Medical Services Corporation (PMSC) in Illinois. This study was one of the largest single outcome studies in the alcohol and drug abuse field. Filstead's study included data from 83 PMSC facilities from twenty states.

The sample consisted of 6,521 former patients of which 1,036 adults were from outpatient programs, 4,358 adults were from residential settings, and 1,127 were youth. For the purposes of this research the results of the adult

outpatient program will be reviewed primarily. This profile of adult outpatient clients was 74% male; 85% white, 11% Black, 4% Hispanic/other; 78% employed and the average age was 34 years. The primary drug of choice as reported: 54% alcohol only and alcohol primary; and 20% drug only or primary with the drug most used being cocaine; and 27% reported they commonly used both alcohol and drugs. The psychological profile found that those in outpatient programs had a higher degree of social stability and fewer psychological difficulties.

The results for all adults showed that 57% reported complete abstinence from alcohol and drugs following discharge. Sixty-four percent (64%) were defined as in recovery, where recovery consisted of either abstinence or abstinence plus one slip. A final conclusion was that participation in continuing care and self-help activities greatly enhances recovery for adults (Filsted, 1992).

In a comprehensive study conducted by Harrison, Hoffman and Streed (1991) the data was collected by Comprehensive Assessment and Treatment Outcome Research (CATOR) in the Minneapolis-St. Paul metropolitan area. The one year outcome study of alcohol and drug dependence outpatients in the CATOR registry provides information about the correlates of successful recovery. Of the 359 patients in the follow-up sample, 75% reported total abstinence for the year after treatment. Other factors of successful outcome included:

older patients versus younger; married patient versus unmarried; patients abusing alcohol versus abusing drugs. The findings indicated that "participation in an aftercare program and weekly attendance at peer support group meetings were predictive of successful recovery" (Harrison, et al., p. 1190).

Schneider and Googins (1989) discussed day treatment as an alternative modality to inpatient treatment for substance abusers. Their research identified some advantages of the day treatment model. They acknowledged the limited number of published reports on day treatment, and especially cited the lack of empirical data in the form of outcome measures or success rates.

Several studies addressed the role of Alcoholics Anonymous (AA) and other Twelve Step Programs with treatment outcomes. Most outcome studies show a positive relationship between attendance at AA and abstinence (Fuller, 1989; Westermeyer, 1989; Hoffman & Miller, 1992).

Successful Treatment with African-Americans

There is little in the literature addressing successful treatment outcomes specifically related to African-Americans in chemically dependent treatment programs. Therefore, this study will utilize literature that relates to one or more of the focus areas of chemical dependency, African-Americans, treatment, research and evaluation studies.

There are several studies that examine presumed causal relationships between substance use and homicides, family use as well as substance use of special populations: Black males, Black females, Black children, adolescents and, Black elderly. Some of these studies, while not addressing treatment specifically, do address some cultural factors that relate to the study of treatment in this study.

For example, Gary and Berry's (1985) empirical study explored how demographic factors, socio-cultural patterns and racial consciousness predict the attitudes of Black adults toward substance use. One of their findings was that respondents who were very conscious of racial issues were likely to be less tolerant of substance use than those who scored low on racial consciousness. Although this study is not directly related to chemical dependency treatment, the research suggests ethnic factors influencing substance use.

Lewis and Ford (1990) outlined a group treatment model whose major goal was to empower African-American women by increasing their systematic use of social support networks to resolve individual and community problems. "This model has the potential for increasing the utilization of social work interventions with populations of color" (p. 20). This study utilized the empowerment and strength's perspective as the foundation for an ethnic-sensitive model of group work for African-American women.

In discussing cultural issues and outcomes of the

Stimulant Treatment Outpatient Program (STOP) of San Francisco General Hospital, the authors identified several outcome indicators that related specifically to African-American cocaine and crack abusers (Perez-Arce, Carr & Sorenson, 1993). The ethnic makeup of the clients during the study period was 69% African-American, 17% non-Latino white, 7% Latino, and 7% Native American. At the end of the four-month sample, 80% of the clients who were still in treatment were African-Americans. Their findings showed that African-American males were receptive to and challenged by a confrontational treatment approach in groups that emphasize interdependence and emotional support. Strong bonding developed among the males of color during this process. This group was based on "verbal interaction-which promotes bonding and support systems through action, and it intensifies the therapeutic milieu through confrontation in a supportive setting" (Perez-Arce, Carr & Sorenson, 1993, p. 40).

Another report reviewed evaluation research studies which were conducted for alcoholism treatment and cocaine treatment using a new instrument, the Treatment Services Review (TSR) (O'Brien, Alterman, Childress, and McLellan, 1992). This instrument was based on the Addiction Severity Index (ASI) in that it focuses on the seven treatment problem areas commonly affected among substance abusers. The primary difference is that the TSR measures the

treatment program.

The first study consisted of 30 patients who were applying for treatment at Philadelphia Veteran's Administration Medical Center. The characteristics of the subjects included: majority Black men with a mean age of about 41 years, an average educational level of 12 years, and an average of 16 years of alcoholic drinking. The first group consisted of 15 alcoholic patients randomly assigned to a day-hospital rehabilitation program. The second group consisted of 15 alcoholic patients assigned to an inpatient rehabilitation program (O'Brien, et al. 1992).

The treatment outcomes revealed considerable self-reported ASI improvements in all the alcohol and drug related behaviors. Seventy-three percent of those treated in the day-hospital program reported total abstinence in the 30-day period prior to the four-month follow-up evaluation as contrasted with 60% for those treated in the inpatient program. At seven months, 73% of the day-hospital participants still reported abstinence, as contrasted with 40% of the inpatients according to the low Alcohol Severity Index scores which indicated good outcomes (O'Brien, et al. 1992).

A similar study was conducted with 94 men seeking treatment for cocaine dependence at the Philadelphia Veteran's Administration (VA) Medical Center. Of the participants, 48 were randomly placed into day-hospital

treatment and 46 into inpatient rehabilitation. The characteristics of the participants were similar to the first study: majority African-Americans, 33 years of age with 12 years of education. They averaged less than three years of cocaine use and an alcohol history of over seven years (O'Brien, et al. 1992).

The treatment outcome indicated that 87% of inpatients were more likely to complete treatment than day-hospital patients. However, 63% of the participants for day-hospital were abstinent versus 54.5% of inpatient participants. This study demonstrated that clients in inpatient treatment have a higher initial success of program completion. The day-hospital program which is outpatient has a higher loss of patients at the onset but, of those that continue in treatment, the success rate is much higher. This supports the research that finds that day treatment programming can produce successful treatment outcomes and long term abstinence (O'Brien, et al. 1992).

Mark (1988) discussed the problem that there are few outcome studies that address issues in treatment retention for African-Americans. The purpose of his study was to examine the role of the referral source in retention of a sample of Black and Puerto Rican patients of an inner-city outpatient alcoholism program. This study's findings were positive and clearly demonstrated that coercion works. This study also showed that ethnicity, birth/region, gender and

self-esteem have important roles in positive treatment outcomes. This program also mandated AA participation and was also culturally-based. The results from this study showed that the best candidates for recovery are southern born Black women, age 40 and over, who are referred into treatment by coercive agents. When locally-born Black men are referred by a family member, findings reveal that they show a high success rate of recovery.

Summary of the Literature

To conclude, it is important to summarize the major areas covered and their relationship to this research study.

The introduction focused on how the terms "ethnicity" and "race" are presented in the chemical dependency literature. This chapter set the tone for the discussion of specific treatment and research needs of African-Americans. It highlighted a significant need for chemical dependency literature and research to clearly identify and focus on "minority" alcohol and drug use.

The second chapter addressed chemical dependency among African-Americans and in African-American communities. This knowledge is necessary as a backdrop to understanding the problems and lifestyle that the client respondents in the research study have experienced. This summary focused on the personal, socio-cultural, environmental, and institutional impact of the disease of chemical dependency

among African-American children, adolescents, adults, families and the community at large.

The third chapter included literature from mental health and human services. This was necessary due to the paucity of literature on chemical dependency treatment issues among African-Americans. Culturally-based treatment was initially explored from a programmatic, clinical and administrative perspective. The need for culturally-based treatment was reviewed and substantiated. A further exploration into specific historical and cultural needs of African-American clients specifically suggested a need for a more direct focus on African centered treatment. A review of Africentric treatment approaches and research was presented as an alternate framework. This review further explored the historical strengths of African-American families. It especially focused on Black families, and the Black church. An understanding of spirituality among African Americans did distinguish this term from "religion" with which it is often confused in the literature. How these strengths can be used in the therapeutic environment was explored and illustrated with examples from practice. The role of 12 Step programs as a support system was reviewed and shown to be a major source of support for African-Americans in recovery.

Chapter four identified several successful chemical dependency treatment studies. These studies focused on

effective approaches both with the general population and more specifically with African-Americans. Outcome research techniques identified the treatment models as effective. Chapter four primarily summarized outpatient treatment models focusing on African-Americans. This chapter also examined some methodological issues in the literature and concluded that self-reports by chemically dependent persons are a valid technique for use in treatment outcome research. A combination of client self-reports and investigator observations increases the validity and reliability of this type of qualitative outcome research.

Existing outcome studies of African-Americans are enhanced by an evaluation of the impact of treatment on client's recovery. The impact of clients' personal and environmental issues on recovery was further reinforced in the literature. One of limitations in the literature review was the lack of studies that focused on African-American women particularly women with successful treatment outcomes.

METHODOLOGY

Research Method

This study describes African-American clients who successfully completed treatment at the Archway day rehabilitation program. This is a descriptive, qualitative analysis, which integrates several theoretical approaches. First, it is a phenomenological study in that one goal is to "capture the essence of the experience" of successful clients. The phenomenon is the "experience" of the clients at this specific program. This phenomenological perspective "focus[es] on what people experience and how they interpret the world" (Patton, 1990, p.70). The data was collected through the use of an interview schedule. The framing of the interview questions was guided by the literature and the goals of this study.

This study also incorporates systems theory, a systems perspective in assessing the client's strengths and their relationship to their environment, the program, their family and the community. Systems theory as interpreted by Billingsley (1968) interprets the view of the African-American client. This is accomplished through questions that relate to the role that their subsystems have had in their recovery process.

A strengths perspective was integrated into the process

by placing emphasis on a non-deficit model of viewing and treating African-American clients in chemical dependency treatment. This approach incorporates goals and assumptions of empowerment research which recognizes and develops individual and community strengths and resources (Holmes, 1992).

Empowerment research in social work, as described by Taylor and Bogdan (1984), allows the researcher to understand people from their own frame of reference. The researcher has a greater obligation to client empowerment than to traditional social science values (Holmes, 1992). He further suggests that the research design should focus on eliciting, understanding and developing clients strengths. The design should particularly understand how they have surmounted difficulties and managed. Goldstein, (1992) in a personal footnote states:

"If we can put aside our cherished theories and other presumptive notions about the human state and listen carefully to how people frame and define their own lives, it is then that we might truly learn something about the meaning of strength, . . . As well we might understand the ethical and moral incentives that shape the quality of life. The most reliable text . . . , is contained within the story our clients will tell us about their lives" (p. 36).

The literature shows very few program evaluation studies or focused treatment studies of African-American clients who successfully completed chemical dependency treatment. There is a striking paucity of studies that have the "voice" of the clients sharing "how they made it" into recovery through treatment. In discussing documentation of recovery success, Gathright (1991) relates that "researchers, however, tend to agree that success stories are usually obtained from heavier [drug] users instead of light or moderate users. Their rationale is that light or moderate users have not reached the level where the bottom has fallen out of their lives. Comparatively, the heavy users, who reach rock bottom, are more susceptible to any behavioral changes which may put them back on the right track" (p. 58).

There is also evidence in the literature that addresses a positive relationship between client treatment outcomes when the treatment program is culturally centered (Perez-Arce, 1993; Rowe and Grills, 1993; Brisbane and Womble, 1992). Since the focus of this study is on identifying client and program strengths, it is appropriate to use the strength's perspective. Also since the client's external support systems are examined, systems theory is a natural means to identify those relationships. And lastly, since the primary goal is to capture the essence of the program and client's strengths, a phenomenological means of inquiry

is employed.

According to Smith, M. (1990) qualitative data is especially useful in providing rich, descriptive data about the program's activities and outcomes, success or lack of success. This study identifies the strengths of the Archway program as reported from the findings of the interviews. One goal was to identify those aspects of the program that have contributed to the clients successes. This qualitative approach is sufficient to accomplish this goal.

Sampling

Clients were purposefully selected based on their meeting specific research criteria. Purposeful sampling as described by Patton (1990) means the researcher "selects information-rich cases for in-depth study. Size and specific cases depend on study purpose" (p. 182). "Intensity sampling" which promotes learning from information-rich cases that manifest the phenomenon intensely was used in this study (Patton, 1990).

According to Patton (1990), "there are no rules for sample size in qualitative inquiry" (p. 184). In addition, "the validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information-richness of the cases selected and the observational /analytical capabilities of the researcher than with sample size" (Patton, p. 185). Qualitative sampling designs should

specify "minimum samples" based on reasonable coverage of the phenomena to be studied.

Although this type of sampling may not represent the total population of clients in the program, it is quite representative of the clients who have successfully completed treatment. Smith, M. (1990) states "even if you are selecting the people who are more positive about the program, at least you have found some success cases" (p. 101).

This research consisted of 30 interviews with two types of respondents. First, there were 18 client respondents who had successfully completed treatment at Archway. Secondly, there were 12 interviews with staff who had worked in the day rehabilitation module for one year or more as a clinician, supervisor or support staff. Though the sample size of 18 discharged clients is a small percentage of the number of clients who successfully completed treatment at this program, evaluation research methodology suggests that this small size will yield "rich interviews."

Client Selection Criteria

Clients were selected according to the following criteria: (a) African-American; (b) 25-65 years; (c) primary drugs of choice were alcohol and/or crack/cocaine; (d) DSM-III diagnosis of alcohol dependence or polysubstance abuse; (e) successfully completed treatment within the past twelve

years and; (f) had one year or more of abstinence from alcohol and other non-prescribed licit or illicit drugs. There is a balance between client situations (at program admission) such as those who were homeless, those who were single and those who were living with families. These clients were selected because they have had an opportunity to leave the treatment environment, maintain their recovery and, have become re-integrated into positive productive life activities in their community.

Clients were selected based on the investigator and staff's knowledge of their successful treatment outcomes. Successful completion of treatment, as defined on page 8, includes minimum abstinence of one year and involvement in productive life activities. A list of alumni who met the criteria was reviewed and selected ones were contacted. Some were either regular attendees of the annual client recognition celebration, the monthly client party, or a regular speaker at the program's hosted twelve step meetings. Most were recommended by the staff as a client who is doing well or "having come a long way."

Respondents received a letter which described the study and requested their participation. Respondents either called or stopped in and made an appointment for the interview. They could discuss the purpose of the study with the investigator and other designated staff and ask any questions regarding their role as respondents. Each

participant signed a release form which addressed their protection and confidentiality rights. It was explained that they had the right to withdraw from the study any time (see Appendix B).

These clients are distinctive in that they have "beaten the odds" and are "working the program." Their recovery and completion of the program are indicative of their success. To accomplish this "giant step," they have had to use inner strengths and support systems.

A project-designed questionnaire collected data from the former clients about their "recovery experience." The goal of the interview was to obtain narratives or detailed accounts of their recovery experience in the clients own terms.

Client's names were not used, identification numbers were assigned to each person interviewed. The demographics of each client were collected separately from the interview data and used for research purposes only. All hospital and state licensing procedures regarding research of client. In addition, the Institutional Review Board's Committee for Protection of Human Subjects from Research Risks guidelines of Hunter College were followed.

Staff Selection Criteria

The criteria for staff selection was: (a) current or former supervisors; clinicians and support staff of the day

rehabilitation program; (b) one year minimum work experience. No more than one-half of the staff were former employees. No more than two-thirds of the staff selected were in recovery.

In discussing the studies of drug abuse treatment programs, Allison and Hubbard (1985) reported that counselor characteristics are a factor in client treatment outcome. They described several counselor types such as professional counselors with bachelors' degrees and no addiction history, professional counselor with degrees and an addiction history, paraprofessionals with no addiction history.

Machell (1991) conducted a study to test the impact of counselors with differing personal substance abuse histories on clients' sense of belongingness or "fellowship" with their treatment peers in a residential treatment setting and the counselors' impact on successful program completion. Findings inferred that a counselors' recovery status does not appear to affect the clients' perception of belongingness among their peers or on length of stay or relapse rate than their non-alcoholic counseling colleague. This conclusion has been debated in the literature.

Staff were selected based on their relationship with the treatment program, specifically they were selected with regard to their past work experience with discharged clients who were selected for this study. Staff were asked to voluntarily participate and were assured of no penalty for

refusal to participate. Staff at this agency usually are quite comfortable sharing positive information about the clients. They often provide useful feedback, from their perspective, regarding what parts of the program did and did not work (Smith, M. 1990).

The investigator's role was critical to the interview process. This investigator probably had an advantage having been the only administrator of the Archway program. Therefore, all former staff and clients interviewed had some familiarity with her. It also enabled her to be able to move about, observe and/or question in an unrestricted manner (see Lofland & Lofland, 1981).

Of equal importance, the research took all necessary precautions to protect the anonymity of the persons studied. As part of the research plan, field notes were kept at the investigators home in a locked file cabinet. Pseudonyms were used in field notes in case of loss at the worksite where the interview take place. Tapes of the recorded interview were stored with coded tags in a locked file cabinet at the investigators home.

Instruments

Two questionnaires were used as interviewing instruments. They are contained in the interview guide (see Appendix D and G). The first was a questionnaire for discharged alumni of the Archway Outpatient Rehabilitation

program. This questionnaire focused on their previous experiences with the program and an assessment of their success based on their personal strengths or the program strengths (see Appendix D).

Questions were selected in this instrument because they would from the clients perspective elicit how they achieved a successful recovery. Patton (1990) described a series of questions to elicit a variety of responses from the clients. The first series of questions can be classified as experience/behavior questions which were aimed at eliciting descriptions of the clients experiences, behaviors and activities at the Archway Program. Another type of question is opinion/value questions which were aimed at client perceptions of the program. There were a series of knowledge questions aimed at finding out factual information about the client's treatment and recovery process. All questions were important to the purposes of the study, particularly "determining the essence of the treatment experience" from the client's perspective.

The second instrument was a project-designed questionnaire administered to staff. This focused on their observations of the successful clients and the program's involvement in their success (see Appendix G). The questions selected in this instrument to staff also elicited knowledge and factual information about the staff's work with successful clients. These questions were chosen in a

similar manner as stated above regarding questions to the clients. These questions address the purpose of the study, particularly as it related to treatment approaches and identifying strengths of the program. Most staff persons have had contact with their former discharged clients who have successfully completed treatment. Clients often returned to share with staff their successes and struggles. Staff members also have received phone calls and letters from clients describing their progress and gratitude. Therefore, the staff have probably "captured a real sense" of the strengths of client's who succeed after treatment. This study captured and formalized these factors with the questionnaire.

There was also an interview face sheet (Appendix C) which consisted of demographic information about the respondents . This information included social characteristics such as race, sex, ethnicity, age, education. It also asked specific questions about the length of time involved at Archway, previous work history, education and, training in the area of culturally-based treatment.

The research plan used clinical records to obtain a brief demographic and social history of five clients who were interviewed. Staff who participated in the study were asked about these special cases. This added a more "in-depth study" of some special cases which adds to the limited

knowledge about this population. These case studies (Appendix H) illustrated the clients success through a review of their past life experiences, their bouts with treatment and recovery. This answered the questions of "discovering the client's strengths." The case study consists of documented data from the clinical record, in particular: respondent's psychosocial history, including mental and physical health, education, criminal justice and employment. A detailed substance abuse history and description of treatment regimen was presented. The case record was a valuable source in analyzing the selected cases.

Data Analysis

Analysis for this study began by organizing data into themes. In addition to field notes, all interviews were tape recorded. Data was coded and labeled into various classification schemes. The classification schemes were determined after analyzing and coding the data. The investigator built upon recurring themes and looked for unanticipated responses or new discoveries in the data. The investigator became immersed in the experience, questioning and dwelling upon the data collected. This process enabled new themes and patterns to emerge along with new discoveries (Patton, 1990; Smith, M. 1990).

The final process in data analysis was interpreting the results and the significance of the findings. This was done by offering explanations, drawing conclusions, making inferences, and building linkages.

Problems in Data Collection

One of the first, anticipated, problems encountered was that of collecting the data within the allocated time frame. More than two months was required to administer questionnaires to clients' respondents, and another month was needed for staff respondent surveys. Contacting client respondents and scheduling appointments was more complicated than expected. Some client respondents requested re-scheduling due to working and/or childcare commitments.

Another unforeseen problem was assuming that the client respondents contacted met the criteria for this study. Although client respondents were recommended by staff, several did not meet the established selection criteria. Two client respondents were so disqualified. One client respondent had a relapse six months before the study and therefore had less than the required one year of abstinence. The other had 14 year's abstinence. This was more than the 12 years that the Archway program had been open. This meant that this client respondent came into the program with two years abstinence.

The investigator originally proposed 15 client questionnaires. Twenty questionnaires were actually completed, of which 18 were qualified. More were completed than proposed because there were several persons who cancelled and re-scheduled after the interviews were completed. The literature substantiates that an additional number of interviews may be added to the study after the research unfolds (Patton, 1990).

The investigator's personal knowledge of client and staff respondents was both an asset and liability to data collection. The asset was the comfort level that all respondents had in sharing information. One liability was that respondents assumed that the investigator knew the responses in advance, so responses were very brief and prefaced with "you know what I mean." It was at times difficult to obtain embellishments from the respondents. More time was allocated to overcome this factor.

The other liability was the unanticipated impending resignation of the investigator, soon after the completion of the study. This influenced the interview process since staff and client respondents used either the beginning or end of the interview to express concerns regarding the investigator's departure. This did not affect the interview process negatively, but did add an additional level of emotion to the process which also extended the time frame allocated.

RESULTS, ANALYSIS AND DISCUSSION

Presentation of Findings

In this chapter are the major findings of this research study. These findings include only the data collected from client and staff respondents who have met the selection criteria. Their own words are quoted throughout this section. Excerpts from the interviews illustrate the findings and convey "the essence of the experience."

The findings consist of extensive quotes that express the feelings and opinions of persons interviewed. As a result, quotes are sometimes quite long. Any generalizations inferred are clearly unique to the respondents who participated in this research. Often, the empirical evidence is a quotation from one respondent. Therefore, it is important to note that a particular quotation may have been selected because it seemed to best represent the statements of several client respondents. It may also have been a singular quotation because it conveyed some important aspects of the "clients experiences" as it relates to the research questions.

Also, some minor editing to quotes has been done to remove non-related verbiage such as "ums," "you know," "kinda," "uhs," which were repeatedly used by respondents. Some struggled with how to articulate their thoughts and experiences and they often paused and changed direction.

Some incomplete thoughts have also been removed to eliminate confusion.

References to individuals, staff and family members, communities, institutions or situations have been deleted or disguised so as not to violate the anonymity of interviewees. Employees will be referred to as counselor or supervisor/administrator for the same reason.

Initially, findings from the client respondents will be presented, followed by findings from the staff respondents. The final section of this chapter is a discussion of the results. Due to the length of the findings, both client and staff interviews are presented separately. Terms, such as client respondents, staff respondents, interviewee and interviewer are used to describe the roles.

To best describe the sample (18 client respondents and 12 staff respondents), findings are presented in both percentages and numbers in charts, statistical tables, and in the discussion.

Findings: Client Interviews

Characteristics of Total Client Population

The first five tables illustrate the demographic characteristics of client respondents. Table 1 is a description of age, sex, and education of the 18 client respondents. There were 18 client respondents who were former clients of the Archway Program. The Archway Program was also formerly known as Westcop Rehabilitation Alcoholism Program (WRAP) to those who attended between 1982-1985.

The primary purpose of the research was to study African-American male and female clients who had successfully completed treatment at Archway over the past twelve years, with the purpose of discovering African-American strengths. The population consists of 11 male clients (61%) and seven females (39%). An almost equal proportion of the clients, ten (56%) were between the ages of 25-44 years, and eight (44%) were 45 years and older. Educational levels were also diverse ranging from third grade to two years of college. Eleven (61%) had not graduated from high school, though three (17%) had obtained their G.E.D. Of the seven (39%) who graduated from high school, one (5%) had graduated from a community college. Several clients had improved their educational level since completing the program.

In terms of race and ethnicity, all clients identified their race as Black or African-American. Only one person who identified their race as Black also identified their ethnicity as Jamaican.

TABLE 1

DEMOGRAPHIC CHARACTERISTICS OF CLIENT SAMPLE

N = 18

<u>VARIABLE</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
<u>GENDER</u>		
MALE	11	61%
FEMALE	<u>7</u>	<u>39%</u>
TOTAL	18	100%
<u>AGE AT INTERVIEW</u>		
25-34 YEARS	5	28%
35-44 YEARS	5	28%
45-54 YEARS	4	22%
55-64 YEARS	<u>4</u>	<u>22%</u>
TOTAL	18	100%
<u>EDUCATIONAL LEVEL AT ADMISSION</u>		
8TH GRADE OR LESS	2	11%
LESS THAN 12TH GRADE	6	33%
G.E.D.	3	17%
HIGH SCHOOL GRADUATE	3	17%
LESS THAN 2 YRS. COLLEGE	3	17%
ASSOCIATES DEGREE	<u>1</u>	<u>5%</u>
TOTAL	18	100%
<u>RACE/ETHNICITY</u>		
AMERICAN BORN BLACKS	17	94%
JAMAICAN BORN	<u>1</u>	<u>6%</u>
TOTAL	18	100%

Client respondents identified their drug of choice as one of three major drugs (see Table 2). Twelve (67%) identified alcohol, two (11%) identified marijuana, and four (22%) identified crack/cocaine. Those who abused more than one drug identified their secondary drug of abuse as shown in Table 2. Those clients who did not select a secondary drug identified themselves as alcoholics. It is also important to note that alcohol was identified as the third drug of abuse for those clients who identified crack and marijuana or marijuana and crack as their primary and secondary drug of choice.

TABLE 2

DISTRIBUTION OF PRIMARY AND SECONDARY
DRUG OF CHOICE

<u>DRUG</u>	N = 18		N = 9	
	<u>NUMBER</u>	<u>PERCENT</u>	<u>NUMBER</u>	<u>PERCENT*</u>
ALCOHOL	12	67%	2	22%
MARIJUANA	2	11%	4	44%
CRACK/COCAINE	4	22%	2	22%
HEROIN	<u>-</u>	<u>-</u>	<u>1</u>	<u>11%</u>
TOTAL	18	100%	9	99%**

Note. Those that did not select a secondary drug were alcoholics only.

* Not all persons identified a secondary drug.

** This totals 99% because the percentages have been rounded off to the nearest whole number.

Table 3 illustrates the number of years of abuse/addiction as identified by the respondents. Three (16%) were "out there" (using and abusing) for less than ten years, six (34%) were between 10-20 years, seven (39%) were 20-29 years and two (11%) identified 30 years or more of use/abuse.

TABLE 3
NUMBER OF YEARS OF ABUSE/ADDICTION

<u>VARIABLE</u>	<u>NUMBER</u>	<u>PERCENT</u>
LESS THAN 5 YEARS	2	11%
5 - 9 YEARS	1	5%
10 - 14 YEARS	3	17%
15 - 19 YEARS	3	17%
20 - 24 YEARS	4	22%
25 - 29 YEARS	3	17%
30 YEARS +	<u>2</u>	<u>11%</u>
TOTAL	18	100%

When identifying number of years clean (clean time, i.e., free of drugs and alcohol) (see Table 4), 14 client respondents (78%) acknowledged five years or less of clean time. The other four (21%) identified a range from six to twelve years of clean time.

TABLE 4

CLEAN TIME

N = 18

<u>VARIABLE</u>	<u>NUMBER</u>	<u>PERCENT</u>
LESS THAN 2 YEARS	3	17%
2 - 3 YEARS	7	39%
4 - 5 YEARS	4	22%
6 - 7 YEARS	1	5%
8 - 9 YEARS	2	11%
10 - 11 YEARS	-	--
12 YEARS	<u>1</u>	<u>5%</u>
TOTAL	18	99%*

* This totals 99% because the percentages have been rounded off to the nearest whole number except for 5%.

Eleven (61%) of the client respondents had been in outpatient or inpatient treatment prior. Seven (39%) said that attending Archway was their first treatment experience.

One of the measures of successful completion of treatment program was the client's involvement in positive productive life activities. Table 5 illustrates the categories that client respondents were involved in at the time of discharge.

TABLE 5

CURRENT PRODUCTIVE LIFE ACTIVITY

N = 18

<u>RESPONDENTS</u>	<u>PAID WORK</u>		<u>COLLEGE</u>		<u>TRAINING</u>		<u>DISABILITY</u>	
	No.	%	No.	%	No.	%	No.	%
MALES	6	33%	2	11%	2	11%	1	5%
FEMALES	<u>5</u>	<u>28%</u>	<u>1</u>	<u>6%</u>	<u>—</u>	<u>—</u>	<u>1</u>	<u>5%</u>
TOTAL*	11	61%	3	17%	2	11%	2	10%

Note. The two persons on medical disability stated they are also volunteers.

* This totals 99% because the percentages have been rounded off to the nearest whole number except for 5%.

Client Respondent Results

To present qualitative data findings, themes were developed as a way to organize the responses as they relate to the purpose of the investigation. Throughout the report of the findings, these themes will be listed as subheadings. After analyzing the data from the questionnaire, the respondent responses were grouped. The major groupings include:

1. Programmatic impact;
 - (a) contributions to successful treatment outcome,
 - (b) role of groups,
 - (c) staff support,
 - (d) peer support,
 - (e) program and cultural activities (client recognition),
 - (f) Black cultural aspects of the program.
2. External supports;
 - (a) role of family on recovery,
 - (b) friends,
 - (c) twelve step fellowship (AA/NA),
 - (d) spirituality/ religion,
 - (e) community.
3. Other supportive data;
 - (a) productive life activities,
 - (b) experiences with racism and discrimination,
 - (c) reflections/feelings about the program.

One major purpose of this investigation was to answer the core question, "What were the aspects of the treatment at this day rehabilitation program that contributed to your successful completion of treatment?" The investigator further asked alumni clients to describe "What worked? What aided your recovery process? The client respondents responded to this in several different ways. Their responses will be grouped together in categories under each theme.

Contributions to Successful Treatment Outcome

Several client respondents attributed their successful completion of treatment and initial motivation to family members. There were several persons who identified other persons, family members as very instrumental. Several males stated:

I had a brother in the rooms, my fiancé was in recovery then and my aunts were supportive.

My father was in a treatment program. It was the fear that drove me here because my father was cleaning himself up from the alcohol, he was in a detox.

You know, . . . I was tired, I had got out of detox and my wife was very supportive, she played my story.

Other persons including counselors and peers were what made a difference to other client respondents.

I knew a lot of the people (here), I could identify with them and there were a lot of people in my life who came through this program. I didn't find that out until I came here . . . but

if this program helped them, I knew it could help me . . .

I seen a glow on peoples faces. That's what I wanted to have. I wanted to gain something I'd lost. I wanted to gain myself. I had lost my identity. I didn't care about nobody and you know people cared about me. They gave me my hugs and they didn't care how I was smelling or looking and that kept me coming back.

What worked for me was, my counselor who helped me to have the courage to look at myself.

My counselor told me "you got to do it for yourself."

Self-determination was another major theme identified. This related to client respondents who finally just made up their minds that this time they were going to make it.

I had a strong desire to kick it. I asked God for will power. I got humble.

Yes, I had a lot of self-confidence. I like the way people would tell me how good I look and they wanted to know what I was doing.

. . . I loved this place. It was the first time I was beginning to feel good about myself. I could feel this power within myself like this is going to be it. There was a little fear there, but my desire was really good. I was truly enthusiastic. I was beginning to feel good about myself.

I signed myself into detox. Then, I came here. I came here with my mind made up. I wanted a change . . .

One client respondent described how he began to listen and learn.

I kept on coming; I started to listen; it took a while but I started learning about the disease of alcohol and it was fascinating to know the things that it does to you. Then, I started relating it to, you see my mother drank and you know, I hated it. I was very ashamed of her and I couldn't understand why until I got in here and they were

explaining what alcohol can do to you. And it was . . . , and I just started listening and trying to learn as much as I could . . . and surprisingly the desire to drink wasn't there.

Another client respondent who was a leader during his time shared how he was sick and tired and was going to "get it," (get recovery) not just for him but for everyone there.

I wanted to do this and I didn't want anybody that was living to come in here and play. I was hurting and I wanted to change and I just wasn't going to allow anybody to disrupt the process because I had tried so many times. So, it wasn't the question of trying to assume a leadership role. I think it was just the energy and effort that I knew that I had to put forth that to force me into a position. I wasn't going to take any one short. We had a lot of light moments here. We had room to laugh and joke.

Throughout this section there will be other statements grouped under other themes about the programs' contribution to clients' successful recovery.

Role of Groups

Most of the client respondents had positive feelings and praise for group therapy as the primary treatment modality in the program. The men particularly voiced their feelings regarding the men's group.

The men's group was where I could share about my family to the group. I would throw out a lot and get lots of feedback.

Men's group was great . . . we saw the movie Circle of Recovery and began one here.

Men's group is where you can throw a lot of things that you are going through out on the floor.

Men's group was positive and valuable.

The men's group was very effective. The counselor has a way of bringing out the best in people, being able to identify with our feelings, what we are going through.

The women also found the women's group to be helpful to them in several areas.

The women's group made me open up. I shared my abuse, incest and talked about how I was in so much pain when I came in. When I talked, they had to listen to me.

I would open up and cry in women's group.

In women's group, I was able to open up and share issues about my daughter.

[In] the women's group, I would bond with other women.

One woman expressed her feelings about the family program.

The parenting group was real helpful and my mother came to the family group.

A very special therapeutic group, "Healing the Child Within," was held on Saturdays by one particular counselor. Several client respondents commented on their experiences in that group.

The Healing the Child Within group was very painful, very deep.

The Healing the Child Within group was where lots of tears were shed here, every Saturday. I tried to run and hide.

The Healing the Child Within group, I needed that. It broke me down, I had to address issues from childhood.

The meditation group was the morning opening group co-lead by clients with staff support.

The morning group is where we would read the daytime book, our morning meditation. It would be

about 30 of us and the counselor would look at us say "you guys look great, here you are in a tough city like Mt. Vernon and you come up here everyday at 9:00 am in the morning, trying to save yourself."

I really liked the meditation group with my counselor because she got me to get in touch with some feelings. You know, I use to be ashamed to talk about this but now I'm not. I was sexually assaulted a while back and my counselor helped me to get in touch with those feelings in the meditation group.

The counselor gave the clients in orientation, like the freedom to run the groups and express yourselves, giving everybody time to . . . interact as a group. That was special.

One client shared that he liked the health and mens group.

The doctors group helped me to learn about my disease. I liked the mens group 'cause I could talk about things.

Several client respondents made some overall comments about groups in general and the skill of listening.

The smaller the group the more I opened up.

I think a lot of the material we were exposed to, it was very therapeutic and it was very educational. And then I think the way the program was structured, it had the relapse group, it separated the people who were relapsing and it separated the people who were sincere. I think [it was good] putting winners with winners and people who relapse together, it separated us.

I did lots of listening in groups.

I enjoyed each one of the groups. Once you start listening each and every one is interesting. The relaxation group, the men's group . . . each counselor had their own way, and I got a little bit from each one.

Staff Support

Another area of major support from the program was from the staff. The counselors were the ones mostly identified.

My counselor stayed on me. I had to give in. The staff was very positive. They [the counselors] were there [for you].

My counselor was sincere, [he] motivated me. Another counselor was instrumental, and another was very patient. I liked the love that was generated here. The program was very therapeutic.

My counselor was excellent, he got me to go to meetings at night, even though I wasn't going to as many as I said . . . but I did go. He gave you a sense of freedom. He also told you, you are somebody, you are not dirt that people step on.

The counselors were there for me. My counselor was very important. He stayed on me everyday. He never gave up. He was like my father. Today, me and him sit down and talk and I listen to what he say.

The individual one on one counseling sessions really made a difference.

My counselor, I owe a lot to her. She was always there for me, but so was other counselors and the office staff is as good as gold.

The counselors believed in me. My counselor was like a mother hen.

Archway helped me deal with issues with my children and my mother. My counselor was always there for me.

The staff took a special interest in people, like they cared, they really cared. And they didn't lie to you. They sat you down. I never cried till I came to Archway, it's like a cleansing process.

I saw powerful examples here. People [the staff] I've seen, they wasn't just talking the talk. They was walking the walk. They were doing what they had to do and I wanted to be like them.

In addition to the counselors, other staff were identified as instrumental to clients. This was especially for true for motivation.

Many people here at Archway and I [am] speaking more on the lines of the staff, they really made me believe that there was nothing that I couldn't do. I mean a lot of times I really put that face on because people were use to it, keeping that face. I guess I developed a reputation and I started to feel good about who I meant to Archway. They gave me strength and they reassured me and that was probably one of the greatest things, that reassurance. I felt and I was told that if anything shakes me up while I'm out doing what I have to do, dealing with life on life's terms that I can always come back here to those first smiles that I always catch right from the front desk and in the back, here to another staff. They all just make me feel like, if it's bad today it's probably going to be okay tomorrow, if God lets it.

The staff were a unique team, had a gentler approach, firm but gentle.

This program gave me back myself, I had low self-esteem . . . The warmth from you [the investigator] and other staff . . . when I got the job and you always took the time to hear whatever I needed to share. I felt that I had support. It made me feel that I am somebody . . . then going school . . . I now feel "I can do something."

Peer Support

Many client respondents shared the importance of their peer support system in their recovery process.

The other clients, the counselors, everybody was there for you. Yes, I have some solid friends from the program.

Other clients were helpful. I would talk to them before and after the group.

Some people were real "positive examples" of what I wanted.

I met so many good people here. They were really great. Talking to them made me stronger.

There were three people who were very supportive and was here when I came and they belong to the same AA group with me.

I would do a lot of listening to my peers. When we see each other on the street, we embrace. We can talk for an hour and then we realize we have someplace to go.

Another wonderful aspect was the peers that we had in '91. That was my first support network and there was a lot of genuine love, respect and honor among us. It truly was . . . I remember how we were, we were the best. I love those guys. My peers became my new family.

Program and Cultural Activities

The program activities at Archway are a mixture of traditional, cultural and recreational. Some former clients recalled the recreation and games.

I enjoyed playing cards at WRAP and the sobriety game, and watching Black movies, "Mississippi Burning" and "Eyes on the Prize." I really enjoyed that.

I enjoyed playing scrabble, spades, chess and the arts and crafts.

We did so much exercise at WRAP and African dance. I started walking to work instead of taking the bus.

There was the opportunity for a select group of clients to become involved in drama sponsored by a well known community theatre group.

I was involved in the drama troupe and choreographed the African dance for Kwanza

celebration.

I got involved in the drama, Open Cage Theatre. I think by nature and from what I'm told, everyone had this gift from nature, it's a God given gift.

One of the alumni organized monthly birthday parties as a means for clients to have fun in a clean and sober setting.

I remember that spring, the first party, it hit. It felt so good adding to good vibes to think that you can have this much fun in recovery. That was my first taste of actually being responsible more or less to the community as a whole, that led me to believe things that I couldn't believe would happen. . . .I didn't think I had it, to do, to make people want to move, using the music as a way to get them off their feet and it took away a lot of the fear of dealing with people. I use to get high before to get rid of the fear.

The parties, client recognition. I'm very ethnocentric from way back.

The client government was an opportunity for peer leadership.

I got involved in the program's government structure as far as becoming a chairperson of the [client council - community meeting] . . . that brought on a greater responsibility in reference to me being an example and trying to lead by the power of example . . . and when I got on the council, I realized that I had to . . . give people a chance.

The men got to play basketball initially outside and then at a local "Y." One client shared what this experience meant to him.

I got to go out and play ball with the fellers and the girls be watching and get cheered on; it was great. What I found hard to communicate with a gentleman, a brother, who is in my group who had so much anger in him. I found that playing ball brought a certain comradery that broke the ice that made it possible for us to get to the point where when we would come back from playing ball,

what we couldn't talk about in the morning, after we sweated with each other, bumped and grinded a little bit on the court, we could talk about it. We could talk about it because what happened was not too long ago because of something we all liked to do, play some basketball, you had to work with me. We had to be a team and that was like really very important. I am glad we moved from the concrete to the "Y."

Client Recognition

Annually, since 1983, there has been a client recognition night held either at the program site or in the banquet room of two African-American churches. This event is an activity that most alumni return to and new clients in recovery look forward to. Several client respondents expressed what this evening meant to them.

I remember how I loved the client recognition each year. It was very important for me to attend those occasions not only because I was one of them, but because it gave me great pleasure to see the clients making something out of themselves, also getting their self-esteem back.

Client recognition night, just having the chance to get involved with that you know, the community meetings. There were just so many things it was something that just happened, like that mystical force that you just can't pinpoint.

Client recognition was fantastic, it was great. I loved that so much . . . I was the master of ceremonies. We had fun, that was great.

I was overwhelmed, it took a lot. Something had to change for me to stand up there and put on a show in front of all those people. I was in the drama troupe. That got me to reading more. My cousins were there and they were shocked to see me up there.

That's an experience that I can't even explain in words because it is so gratifying. To look back

on where I came from and to continue into recovery. It's such a sight, I can't even explain it in words; wow.

My first recognition night was like the academy awards, more important than my anniversary.

Client recognition was the biggest thing for me because I was client of the year. Out of everyone in the group, I was chosen. That was special.

It was so rewarding, just being recognized for being what they are, they think it's a miracle. Just the fact they showed up in Archway that day . . . and they were clean and on the roster. They were recognized. . . . That client of the year award . . . that feel real great . . . that was really important it felt like that. The things that I had done for other people while I was here. It felt like I was appreciated.

Black/Cultural Aspects of the Program

The cultural activities that focused primarily on Black issues and interests were also very meaningful to some clients.

I really loved the Kwanza, Rites of Passage group, monthly parties and the arts and crafts. I kept busy. I enjoyed being recognized without drinking.

I enjoyed the African dance, boot dance, making of African clothes, tie dying of fabric, the arts and crafts and the Black speakers, especially during Black history month. Also I learned about Kwanza.

. . .Coming up, my day in school, I didn't learn about you know my people, more on the positive side. I learned more on the negative side. I did learn a lot here at Archway. The Kwanza celebration. The first Kwanza celebration taught me a lot about understanding and that there was another way to celebrate during that time of the year. I decided to turn over just to Kwanza last year officially and I had my family involved.

On Black history month, . . . the strongest evidence of the slighting I felt of knowledge that wasn't given to me when I was coming up. I enjoyed having the speakers come in here and speak to us and actually talk to us and look into someone's eyes who was an elder and tell me about what it was like to be around when the civil rights marches was happening. Also finding out that there are things out here available to us. That could help. There were museums and exhibits and there was ways of life that we could actually incorporate in our daily living principles that would actually fortify and give us some kind of extra feeling of pride and enhancement of a culture that I didn't know that much about than that Africa's a great continent.

Client respondents also shared their feelings about the program being culturally based specifically focusing on Black issues and concerns.

I was shocked that there was so many Black people, everyone up here for the same thing, I was touched. Yes, a few times I would try to get my music played. I always felt accepted. Being around in this program seeing a lot of Black adults that care, helping one another out, that really made a difference that kept me coming. The cultural program attracted me to Archway. I would tell a counselor I wasn't comfortable and she would tell me coming into recovery, you must be comfortable in your skin. She suggested, I start reading black history.

The cultural piece that was definitely key to being relaxed, feeling like these people who are working here with me who are helping me out . . . relate not just to arresting the disease of drug but realizing that in a society that sometimes many times, bumps us, people made me feel a part of my culture as far as being African-American.

I think the fact that we had the culture that was here. It helped me, no doubt, to include that also in the recovery process. That was very important . . . you know most of us were of African descent, so that was important . . . It had a lot to do with our self-esteem. It helped to nourish our self-esteem.

Others responded to how important it was to have a predominantly Black staff.

It meant numerous things for me. I have to go back and look at me growing up, me being Black, you know, there were a lot of key factors, you know. I think most importantly was that the majority of staff was Black. I don't want to sound racist, but most of the staff was Black . . . that was like a primary thing here. It was like a family thing. I felt a sense of belonging. I felt a sense of love, you know, women have always played a tremendous role in my life. Starting with my mother and older sisters and seems like a more sincere type of concern. An atmosphere of genuine concern and compassion. I think that's what motivated me and the fact that I wanted to stop too and being able to identify with those positive Black women here and the male staff too. They seemed to be very concerned, genuinely concerned, that's what I felt. I felt the love.

I was ready to submit but being able to identify with people who I came up, like growing up with Black people, you know, my mother and father. Being black, seeing Black people messed around so bad, devastated by the use of drugs . . . Yes, having a Black staff and persons in recovery made a difference because they had experienced it. Yes, they have suffered and they can pass it on.

When I came here I didn't think I would get here on that level, Afrocentricity. I didn't think that I would start relating to the symbols like the onyx, universal peace, being an Egyptian force. I didn't think that I would actually learn a piece of history about my people and really look beyond the bondage that started back in slavery time and here in the 1990's I actually put mental and emotional shackles on myself by using drugs. If people hadn't tell me, here at this program, that this is a Black American and that we are all people trying to do the same thing and yeah, the majority of this program is, was, still Black. I guess what it is, it's another thing, another part, another realm that I can touch . . . touch base with myself. It really was forgotten.

Role of Family on Recovery

The family of the client in treatment had several roles, some were supportive as shared by some client respondents.

My family was very supportive. I blamed one sister, but I later understood what she did was for me.

My family, mostly my mother has been my strongest support. My mother practiced "tough love," she locked me out, that was hard.

My sister was so happy that I was finally going to do something about this drinking. She said it [drinking alcohol] wasn't like me.

My wife, she was a 100% behind me and the kids. You know, I never thought I was harming the kids . . . all my kids were grown, but they said now We're so glad you're back to being Dad again.

My main support was my aunts.

I have a brother that's in the fellowship and he was very supportive. My fiance is in the fellowship, too. Me and my ex-wife have a good relationship today and she's in the fellowship and now I relate to all my children.

My family was very supportive. They participated in the family session at the inpatient rehabilitation, my uncle, son, sister and daughter. My family didn't know about the disease and didn't accept that I was an alcoholic, because I was a functioning alcoholic. I worked 25 years. My wife died and left me with 8 children and I raised them alone with my sister and extended family. My parents didn't drink but my wife's family did. My family came to my first anniversary and others at AA. I have brought two of my sons here to Archway and one is doing very well.

Some family members were a little cautious but supportive when they realized that the client was serious.

My family was supportive but cautious.

They were waiting around, a little bit, rightly so. You know, I had been through this process before . . . but they were supportive . . . I remember my mother even asking me. How could I get involved in drugs, you were such a bright child, and I remember telling my mother, Mom, this disease of addiction doesn't care about how bright we are or how rich we are.

My family didn't accept me at first.

I was married before and we're now friends but . . . I was very abusive in my first relationship and the fact that this sister had extended herself to us. She finally put me through treatment again, motivated me and I came back and used again and she didn't want to have anything to do with me again. My present wife, always playing my tape, you did this, you did that while I was in treatment. While I was going through the process of cleaning up and being here and she witnessing the change and just having that motivated me. That was the outside force. My son came to my anniversary and gave me a card . . . but that kind of shook me up, gave me a card saying, "Dad, keep up the good work" or something like that. He's 18 and got the attitude but just the fact that I was able to have him see that I was cleaning up was a blessing [he's crying now]. Just admitting to him that I was using drugs, I talked to him, that was the primary outside force.

Some client's family member were also chemically dependent and this had various impacts on them.

The plus for me was that my father was in recovery and that he went into recovery approximately six months before I started my official clean date and decided to surrender. That kind of gave me something to lean on . . . My family, they, you know all of them didn't understand at first. My father even though he was in the fellowship of AA, he didn't always understand. Because I was living at home and he would say we have bills to pay. I do appreciate that Archway has kept you on your feet and away from drugs and alcohol but I think you should go out and get a job.

None of my family understood. I had been put out of so many places, so I moved in with my mother and it seemed like when I stopped drinking

everyone else started drinking more, like to edge me more. My brother was doing drugs at the time and my mother was drinking and my grandfather was bootlegging liquor.

My family knew that I was in a program. At first, they thought it was all brainwashing to stop speaking to them. It took them a year to see what it was doing for me. My mother and father now they understand. They behind me now 100%. My father, he even stop drinking. My brothers, they use drugs. We not close now. It's like we getting further and further apart because of their lifestyles and what I am living for today. I try to live a better clean and sober life. One day, I know that I don't want to suffer that pain anymore. If I go to my brothers house or to Jamaica, I risk my recovery. My grandfather in Jamaica, he make that pure Jamaican rum.

My mother was drinking . . . my grandfather was bootlegging, they don't understand. My daughter still don't understand. No one understood in the family.

There were other client respondents who also felt that their families were not supportive.

I stay away from them. When I first came in, I thought they didn't care. I wasn't doing this for them. I was doing this for myself. So, whether they approved or objected, it didn't matter for me. I just wanted to stop the pain.

No, my family didn't understand. I was the youngest.

These things were told to me but, you know what I had to do was use the principles I learned here and this was one of the first principles that I wanted to learn, how to be a little more assertive. Then, I had to let my people know, my family, my friends from the area that right now I have a foundation that I can go in any direction and the direction that I go in. . . I could still go in a negative way of life or I have some options and I can go in a positive way. And from the outside, I don't think they more or less believe that this program was going to get me where I am today. you know, I'm in college full time . . . and today my mother understands a

little bit more.

Friends

Friends from the past tended not to be still around as several client respondents described.

I basically had to let those go from the past.

Had to let go of all those in past, my people, places and things. Had to let them go, it was hard.

Others kept in touch with friends from the past.

I had lots of non-drinking fiends that were supportive and I still have them.

I remember my anniversary. I threw a barbeque down at the park and it was the first time I had a large group of people from the fellowship together with a group of friends from my old neighborhood, people who some are still using. And I know that some of them wish they could be doing what I'm doing. Some are very successful today, involved in music, making lots of money. A lot of times I wish . . . you know, if I had followed them that fame and fortune route, I may not be here today. Things like on the negative aspect, I would have had a larger dose, might have taken me off this earth. I know I had to go through what I had to go through. I'm glad that I went through the beginning of it here at Archway because I didn't know I was really confused, more confused then anything when I was out there.

And other friends were newly found at the program or at other support systems.

Archway is where I met friends and would see the folks at meetings.

My church is where I have my friends and I sing in the choir.

Twelve Step Fellowship

The twelve step fellowship was identified as a major support system by the client respondents. They identified various aspects of both fellowships: Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) that have been instrumental to them. Clients refer to AA and NA as "the rooms," "the meetings," or "the program." Also "the steps" (12 steps, 12 traditions) is part of the philosophy of the fellowship, e.g., "working the steps." Getting a sponsor in "the rooms" is an integral part of the program. The first major area discussed was the meetings.

I started to make outside meetings because of the in house meetings we had here. At the time we just had AA. I started to make outside meetings and that when I got my clean date. That's how many months it took for me to realize that I couldn't even take a sip of champagne and that was my first experience. I held on to that sip when I told my sponsor about my sip about 45 days later and he told me my clean date is now.

My relationship with "the rooms" started here. I started right here. I jumped right in all the meetings, sponsor and all. I took all the suggestions . . . I was enthusiastic. It was like God had guided me to people that were ready to live. I was so excited.

I had joined AA before coming to WRAP. My sponsor made a difference and the steps. When I first came in, I made more meetings than I did now. And just listening to other people talk, I couldn't believe that other people did the same things I did.

I like going to the meetings. I do some sharing.

When things go wrong, go to meetings.

The meetings, I became, active this time. I got a sponsor. I did my 90/90. I was listening for the

first 90 days. I really wanted this, so I just took all of the suggestions. Make a meeting. My counselor would say "let him talk, he is making a meeting; he's doing what he's got to do," that was encouragement.

I've been in "the rooms" close to 4 years in an AA group. I still always attend everyday. I also go the NA.

I made a lot of meetings and got involved in the fellowship. I felt a part of it; I go to both AA & NA. In the beginning, it was a lot of listening. Listen and learn. When I got a sponsor and began the steps, right now the steps are my support. I was comfortable at meetings, a mixed group, no one judged me, I could go in and talk about what was going on with [me] for years.

Some persons had difficulty adjusting to the meetings at first.

I didn't accept it at first. I would go to three meetings a week and just sit and listen. I didn't get a sponsor at first but I believe in "Don't drink and go to meetings."

When I first came into AA, I was using my counselor more than my sponsor.

I was going to AA here but I wasn't listening. I always sat and listened and wouldn't participate . . . and then I started going to the classes . . . it's like they say, if you don't get AA, AA will get you. Next thing I knew I got my 90 days and went out to speak and the next thing I knew I was AA material . . . you know, in order to keep this gift, you have to use it.

Being in the meetings and hearing what another addict has to say, they saw it. Then I would identify with a lot of things they would say. Like at first I would go to the meetings and say, I didn't do all that. When I would speak they would say the same things. I had to stop looking at it that way. We all have a problem. We all did little things different. We all did it, a drug. We all chemically dependent. I love to share. I have a sponsor. I go to meetings.

Some expressed that they preferred the step meetings and sharing in particular, while others shared their experience with their sponsor.

I'm involved in NA. I prefer women's groups and the step meetings.

Working the steps was the hardest.

I received lots of support from my sponsor, learned the twelve suggestive steps and traditions. Sharing my stories showed that "I had one foot in hell and one slowly going behind it."

What made AA was the sharing of the stories, you know, the fellowship. Me and my sponsor, I think we're tight from a spiritual level, more so. He always thought that I was alright. Once he introduced the steps into my life and I had an understanding of them. You know I've never really gone back. As long as I knew that I could get back where I could be reminded, not to forget. I couldn't see why I would go back . . . I feel good that I can make a choice today.

Other External Support

Some client respondents identified other sources of support that aided them in their recovery.

You must have a support system.

My family and church was my primary support.

I got support from other addicts, they understand.

The [Black community agency], my church and a community action agency were there for me.

My caseworker . . . helped me . . .

Spirituality/Religion

There was a close spiritual connection that many client respondents identified as a major support to their recovery. Several related to their past religious or spiritual experience.

My grandparents are Deacons and Deaconess and we were always going to church. That was the environment I was brought up with.

I really thought that church was going to keep me sober but I learned that I had to separate from it. Going to meetings taught me about my disease.

Especially the brothers in my religious circle welcoming me back to the community, seeing the change, telling me "brother you look like your old self now, that motivated me."

I came from a close knit family that goes to church together. I'm into meditation and prayer. Alcohol steals your religion. When I was in rehab, the AA meetings were held in the chapel and I would go to the chapel every night.

I come from a spiritual foundation, church going family. I'm in church now. I'm working on being a deacon. I've been attending church regularly for four years. I practice my faith by reading the word, meditation and through prayer.

Well, when I came into this trip, I attempted to renew my faith, so to speak because I wasn't practicing my faith. As you know I'm Muslim, and Islam in the early 70's had motivated me to stop using drugs. I was a member of the Nation of Islam when there was no drinking, no smoking, and we heard "Black man stand up and be responsible." That was very instrumental but I soon lost that because I didn't have, maybe it was, psychological or spiritual reinforcement. I don't know what was missing but I used again. This time I started to practice my faith again. It's more like an orthodox Islam, it's more like a pure form of Islam. It's not so much the militant and national movement that was back in the 60's. I think that gave me a certain amount of serenity. I mean just asking a higher power to guide me and being

sincere and "I learned that there is only one God, practicing what you believe. Do good unto others, that's the bottom.

I returned to my Muslim community. They always told me that this was a spiritual program. A great prophet said "Hold fast to God . . . but don't forget to tie your camel." I am working with my Masjid and we are developing a 12 step program.

We worship the 12 Tribes of Judah and Selassie, and when I was young (10 years) we would gather in a circle, and smoke marijuana. I then took it beyond and started smoking on the street and everywhere. I am very spiritual. I thank my higher power, every morning I get up. I thank him for my still having a job. I pray . . . When I'm working, we deal with a lot of peoples who have drinks, alcohol in the house. Hey, I can't just say, I'm a recovering alcoholic and walk back out. I have to deal with that. I just pray and ask for strength.

The spiritual aspect for me, it's about change. I'm no longer that angry person inside. I come from a religious background . . . I rebelled from it when I first came in recovery. As time went on, I realized that I abandoned my God. My God never left me. That was easy to accept. I use daily prayer and a lot of meetings.

If you raise it right . . . it'll be right. I was raised in a church and I remember what my Sunday school teacher taught me about values.

Others related primarily to their spirituality and its integration with the 12 step fellowships.

Spirituality is major part of my life. I surrendered to God. I knew the power greater than me. I read my meditation books everyday.

Reading meditations made a difference.

Spirituality plays a big role and AA is not religious but is spiritual and when I read my meditation.

Besides making meetings as I do regularly, I do pray. Well not traditional prayer, basic prayers

that I was taught through the fellowship.

I always believed in this supreme being . . . I didn't know that I had a God of my own. All this I learned once I started going to the rooms.

But it developed through the rooms and the combination of coming here to Archway because nothing is forced on us here. Everything kind of patterned with what the rooms told us, suggested to us. Feeling better with myself through a spiritual means through the rooms, a God given program and that's how I look at Archway too . . . It was that first step on the ladder and even though it kind of felt shaky, though I was so close to the ground I could stand on that first step. The beautiful thing about it was that it was secure . . . I didn't know where I was going. I knew that I had certain goals that I would like to reach and I took things day by day. I kept GOD, as Good Old Direction, and my counselor kept putting me in check.

Realizing that the relationships that people were telling me about here that I had to get with myself. It was a relationship that I had to get with myself first and that hadn't been filled. It was other relationship with the higher power, talking about God. Am I supposed to get in touch with myself first or get in touch with God? Which relationship is supposed to happen? And then people were telling me that God comes first but yourself comes with it. So you know, it's like a simultaneous thing.

Spirituality was also a force unto itself, a relationship with God or their higher power.

There was something, I believed in God . . . so far as the sense of there being any God. I was not a religious person and then of course spirituality doesn't have to do with religion. I wasn't spiritual in the sense that I prayed on a regular basis and that I thought that you could build on having a closer contact with this higher power. I didn't. I thought that if it was something that had to do with a spiritual basis, I thought that it was like given to you. You just have it and it doesn't go anywhere. You just live and die and you know, I believed in that reincarnation and stuff.

[When speaking of faith], what I have today it was easily given to me by him and he can so easily take it away and put me back out there in the madness. By me doing the right thing for me, not for others.

I believe in God, God of my understanding. I pray always "God took care of me all during my drinking days, because I couldn't take care of myself.

Yes, I have faith because God had to be looking out for me because I should have been dead.

When people tell me I'm doing great, I knew it was God. It's been a spiritual journey that I've found to be so rewarding.

And one client respondent spoke about her new found faith in God who she didn't believe in before.

Recovery has been great for me. I'm regaining a relationship with my family. I'm regaining a relationship with my higher power. You know and like I always say, I like to thank God for everything because without Him I would not have anything today. I would not have myself today. I didn't believe in God before because of the things that happen to me when I was growing up. I said if there was a God, God wouldn't let this happen to me. So I did not believe in God. Now, I realize there is a God. God wakes us up in the morning. Today I know that there is a God. He restored me to sanity. I pray to my God everyday. I thank God at night for another day. For without Him, none of this would have happened.

Productive Activities

Client respondents were asked to share their productive life activities that they have been involved in since their successful discharge from treatment. Table #5 (p. 93) illustrates the various productive activities. There were two persons who were on medical disability and not working but speaking a lot at institutional meetings. One of the

major roles for the alumni, especially those under 40 years of age, has been returning to school.

I'm in college; I'm attending full time classes at the local community college and I'm handling outside life and I can reflect much of it back at what had been or what went down here at Archway and today my mother understands a little bit more.

My initial goal while I'm in school is to get my Associates Degree in food and nutrition, when I get this degree, it's a transfer degree and I want to attend four year university for physical therapy. While I'm working on my physical therapy degree, I would like to be a part owner of a business in food services, or a restaurant as a means of making money while I get my degree. I also want to use my acting skills, maybe I can be in a feature film. Inevitably, I want to get my master's degree.

I'm attending a four-year college full time majoring in psychology or journalism. I had also worked part time as a nursing aide. I'm engaged and have my own apartment now.

I just graduated in May with my Associates Degree. I want to work with the children at this child welfare agency. I've searched my soul and want to do this. I have a genuine concern for the children. I want to get my bachelors degree and this job I'm interviewing for will pay for tuition reimbursement.

I want to go back to school and am thinking of mortuary science.

Others are working and attending school or planning to attend school.

When I left, I went to school, a four-year college and worked. I'm now working for a federal program.

I'm in college now finishing my fifth semester, majoring in psychology. I want to work with children. I got my old job back at a grocery store as a cashier and I've been there for over five years now.

I want to go back to school to be a chef. I have a room in my mother's living room, a whole side of the wall is just my certificates "cooking awards." I like to cook. That's my main goal. My father says he will pay for me to go to chef school. They accepted by application. I will keep my job that the program got me at a furniture store. I've been there for over one year now. I really like it. I was able to get off welfare.

Others are or have been working full time on either new jobs or have returned to previous jobs.

After I left treatment, I have had several paid jobs as a doorman for three years in New York City; driver for escort services for nurses, on-call worker at the mens shelter that I once was in . . . driver for my church and now as driver here at Archway.

I've been working since I left the program. I had been at a local utility company for nine years. They put me in four rehabs and then I still lost my job. I then worked here and it took me three years to get my job back, but now I'm back at that same local utility company.

This alumni was hired by the program. He said thanks to staff for giving him a chance after 8 years. My long term goal is to be a counselor. I got accepted in the addiction counselors training program. Even counselors tell me that I should do this. I feel this is my life now. It's a gift, I guess. I can communicate with people and maybe when I share my story that can help them.

I'm not working right now. I have had several jobs. I would like to become a counselor you know, because I like helping people. And a lot of people say that I'm a positive example to them. And I had a sponsee and I helped him . . . like someone had to help me when I came in. And I helped him to realize that this is a disease.

There were a number of client respondents who obtained employment after going through an employment training program, either the county's work program, an employment for recovering alcoholics/addicts or a senior work training

program sponsored by a community based agency.

I was hired by the program as a food handler, then I went to school for food service. Then, I went to word processing training and have been working for a seniors part time work program for the past six years as an office assistant at Archway.

I was sent to [this work training program] after treatment and they got me this secretary job that I have had since I left almost two years. I was able to get off of public assistance.

I went to EPRA not looking for anything. I had worked for a major airlines company for 25 years after I left the Air Force. I was laid off and I took various jobs. I am mechanically inclined. EPRA sent me on an interview at a large Methodist church. I had no intentions of accepting the job as the custodian but I've been there for over five years now and was recently promoted.

I went to EPRA. They didn't find me a job. So, I took a job with Pride-in-Work. They placed me with the Board of Education as a custodian assistant. Then, they hired me and I've been there over two years and for the first time in over 15 years I'm off public assistance.

Racism

Client respondents shared some experiences of racism or discrimination that they had encountered. The first were experiences in "the rooms" or a treatment program.

I'm not comfortable sharing negative race issues at predominantly white meetings (AA/NA meetings).

You know coming in as a Muslim, there is always misconception about Islam. I had a white guy, very close to me. He's my neighbor and he told me that "I first I didn't like you and I said why and he said I didn't understand you because I automatically associated you with the Muslims hating white people and I said no. That's not the case at all. But I've shared at meetings that were predominantly all white and you know nobody has ever said anything bad to me, but I didn't get

as much hugs and as much attention as I felt I wanted as a newcomer there, but maybe I needed to reach out more. But all of the white members of Narcotics Anonymous that I've met are really down to earth people. I haven't had any problems.

We watched Tony Brown's Journal every Saturday at WRAP. So when I went to rehab, I insisted that the group watch it and I was accused of being prejudice.

I was a product of the Nation of Islam in the 60's and it wasn't that we was anti-white at that particular time but I always felt a lot of reverse racism . . . subconsciously. I went to other programs where there may have been Caucasian directors and Caucasian staff. I'm not going to say that they were not sincere at rehabilitating me but there was always a feeling of white supremacy with me. Just that those are my thoughts and there was always a thing that, you know, he's Black, or he's a nigger and he's never going to change. And when I didn't submit to treatment I felt they were holding that over me. Maybe it was my sick thinking and maybe because I was coming off of drugs . . . and I resented that . . . I think maybe most of the time when I didn't complete treatment it was for the simple fact that I was still protesting, fighting authority, just opposing authority. When I came to this program I never felt that sense of domineering, I never felt that. I felt sincerity and that's what motivated me.

Other experiences were from either the work place, social services or educational institutions.

So many people are so jealous because I am going to school. The whites at my job are asking me, why do you want to go to school?

Yes, I feel that I do experience racism now in the school/college. The white professors respond differently to me than to white students. I have to speak up.

The only racism and discrimination that I have probably felt is when dealing with the system, the Department of Social Services. There probably the only ones that made me feel like, why don't you do your time at Archway and we'll get you in a work

program. Well I had goals I wanted to reach. They really made it difficult for me to go to school. I had to go through so many things and I understand that it's the system but the way they would talk to you, tell you, you can't, mean you can't. If it's possible and I'm willing to go through the process of doing it, then I'm going to do it. That was probably the only form that I felt where it seem like it was the fact that I was a black man and maybe I should continue to use my body to do something instead of my mind.

Reflections/Feelings about the Program

Many client respondents shared their feelings about the program now that they have been gone awhile and can reflect back. Many of them had lots of praise for the program.

The program and staff made a difference. I've grown with the program. I get more out of it. It's successful to me.

I didn't want to be here initially, felt I wasn't alcoholic. I have to give all the praises here, back to Archway because it all started here . . . because if it wasn't for you guys, I would still be out there.

I realized the [benefits] of the program while I was there plus after I left. It made me feel stronger. I was able to look around instead of heading to the store and getting my usual 12 cans of beer. I was able to do more, dress better. You know, you smell better, than when you have the alcohol in you . . . and you want to reach out and help other people. And you put a 100% instead of 50% in your work.

The seed was planted here.

This program gave more. The staff gave more. They always found time for me.

I was told to keep coming. I felt safe here. I had to trust.

You have been a real inspiration and support . . . You have helped me, touched so many lives, my

mother, my kids, my father who saw me clean before he died.

Many shared how the program WRAP/Archway was so instrumental to their recovery.

Coming to WRAP saved my life. Talking to the women and guys made me stronger.

Coming to WRAP just opened up all avenues for me. You know when I go out and speak WRAP is a part of my story. It's where I got my beginning.

Archway lets me come back. Archway was there for me. As they say in the rooms, this keeps my memory green. Archway kept me going. WRAP and Archway were my roots.

WRAP was beautiful. It was the best thing. You know, when I was going to WRAP, people thought I was going to work and I never told them any different. In fact, I don't think my own family knew. Anyway, in WRAP, you got a sense of really belonging, more like one big family. You did ceramics and saw movies and they told you about yourself. They told me that I had high blood pressure and how to stay under the doctor's care and take medication. And the people were nice, I got a lot out of that program, met some nice people there too.

I was sober, that's the main piece and I was able to do more. Just being sober that's what worked and the people around were nice. Like I said before, it was a family, we all stuck together.

It's so beautiful [recovery]. Life is more; there is more to life now.

Other client respondents shared some of their story, pain and struggles in their reflection.

I came here homeless, broke, I had nothing, no shoes, no pants, no underwear, no nothing. Thank God I can pay bills now and I know where the money is going.

When I came around here when I first started here, I would dress up on the outside, you know, feeling bad on the inside. But I can dress up on the

outside and feel good in the inside today because I made a major accomplishment. You know, that's why I would like to become a counselor because of the counselors here who took the time to spend with me, to help me, you know I want to give that back to somebody.

Well, the first thing is having a place to come to on a day to day basis. When I came here initially, I was deeply in denial of what I thought I had a certain control of . . . and Archway, you know, the groups I was never afraid to communicate because I was open. But at first, I think I might have just wanted to play the game. You know, I made it into a game and it was just fun like that toying with words and having discussion and then one of the first counselors I got close to started to have the wheels turn about what I was doing . . . There was a certain amount of fear and embarrassment but as time went on, I realized that I had friends here and friends in the staff. It was hard for me to relate to some of the people who were here because I never ended up homeless . . . I was known as the good samaritan in the community . . . but people in neighborhood did shy away from me a little bit. Then, I realized as things passed on. My sister passed away, she died from AIDS and that is what propelled me to believe that there was a chance. When I got into the program here, I started to see in some ways that I had time to like really, take a look at myself at the same time . . . I thought maybe I could enjoy this a little better and get something out of this . . . I was coming here because there were people smiling at me.

The program works, you just got to give it time because when you were out there in the streets using drugs you gave that time. I loved the program. I would walk here in the snow and rain. I never missed a day!

Archway did a lot for me. At first when I came to Archway, I wasn't ready to surrender. I wasn't ready to stop doing the things that I was doing and one of the counselors seen something in me that I didn't see in myself. To know that I had the potential to be a better person. She was like the only counselor that I listened to. She was like always there for me. I cried on her shoulders. I went through a lot in Archway and the program finally got me. Today, I'm clean 3

years and 2 days.

This section on client respondents findings clearly captured the "essence of the experience" as articulated by the alumni clients. Their internal and external supports were identified. Their relationship to the program and involvement with various aspects and persons was also highlighted. There will be a thorough discussion of these results in the last section of this chapter.

Findings: Staff Interviews

Characteristics of Staff Population

The primary purpose for interviewing current and former staff is to address two of the study's goals. First, the research will identify the therapeutic interventions and approaches that are used in the treatment module by the counselors in order to determine the impact that they have on the client's success. Secondly, the research will identify the presence or absence of a culturally-based or Africentric treatment. Thirdly, staff profiles will be documented for the purpose of identifying their contributions as the primary treatment providers.

Table 6 illustrates the demographics of the staff sample. Table 6 is a description of the sex, age, race/ethnicity and education of the 12 staff respondents. The demographic characteristics show that seven (58%) of the staff were male and five (42%) were female. The majority, ten (83%) of the staff were under 50 years of age. Educational levels were diverse with six (50%) staff having some college and six (50%) having Bachelors or master's degrees. Three of the current employees are New York State credentialed alcoholism counselors (CAC). In the area of race and ethnicity eleven (92%) of the staff respondents identified themselves as Black or African-American. One person was identified as white or European-American.

TABLE 6

DEMOGRAPHIC CHARACTERISTICS OF STAFF SAMPLE

N = 12

<u>VARIABLE</u>	<u>NUMBER</u>	<u>PERCENT</u>
<u>SEX</u>		
MALE	7	58%
FEMALE	<u>5</u>	<u>42%</u>
TOTAL	12	100%
<u>AGE AT INTERVIEW</u>		
20-29	-	-
30-39	4	33%
40-49	6	50%
50-59	2	17%
60 PLUS	<u>-</u>	<u>-</u>
TOTAL	12	100%
<u>EDUCATION LEVEL</u>		
LESS THAN 2YRS COLL.	4	33%
ASSOCIATES DEGREE	1	8%
2 - 4 YRS.	1	8%
BACHELORS	3	25%
MASTERS	<u>3</u>	<u>25%</u>
TOTAL	12	99%*
<u>RACE/ETHNICITY</u>		
AFRICAN-AMERICAN	11	92%
EURO-AMERICAN	<u>1</u>	<u>8%</u>
TOTAL	12	100%

* This totals 99% because the percentages have been rounded off to the nearest whole number.

Of the 12 staff respondents, seven (58%) identified themselves as in recovery (see Table 7). Four (56%) staff respondents claimed nine years or less of recovery and three (43%) had ten years or more of recovery. Of these persons in recovery six (86%) attend twelve step meetings regularly.

TABLE 7

YEARS IN RECOVERY

N = 7

<u>VARIABLE</u>	<u>NUMBER (N)</u>	<u>PERCENT</u>
LESS THAN 5 YEARS	1	14%
5 - 9 YEARS	3	43%
10-14 YEARS	2	29%
15 YEARS + UP	<u>1</u>	<u>14%</u>
TOTAL	7	100%

Note. Six out of seven staff are a part of 12 step fellowship regularly.

The staff roles as shown in Table 8 included three supervisors, two of which were former employees of the outpatient rehabilitation program. One is the current supervisor who was previously a counselor for eight years. There were five counselors interviewed, three current and two former employees. Other clinical staff interviewed included one nurse, and one vocational/activity counselor. Support staff interviewed included one driver and one office manager. For the purposes of this study, staff will be grouped in three categories: supervisory staff, counseling staff and support staff. This will protect the confidentiality of those persons in singular roles.

TABLE 8
STAFF ROLES

N = 12

<u>STAFF</u>	<u>NUMBER</u>	<u>PERCENT</u>
SUPERVISORS	3	25%
COUNSELORS	5	42%
NURSE	1	8%
VOCATIONAL/ ACTIVITIES COUNSELOR	1	8%
DRIVER	1	8%
OFFICE MANAGER	<u>1</u>	<u>8%</u>
TOTAL	12	99%*

* This only totals 99% because the percentages have been rounded off to the nearest whole.

Table 9 illustrates the years of experience for the supervisory and counseling staff. As indicated seven (70%) of the staff respondents have over five years of experience in the field of chemical dependency. Four (40%) have been employed at this treatment program for more than five years. Though two (20%) of the staff were employed less than two years, they also have more than two years experience in the field. The two support staff not shown on this table have worked for the treatment program five years and eleven years.

TABLE 9
YEARS OF EXPERIENCE FOR
SUPERVISORY AND COUNSELING STAFF

N = 10

<u>VARIABLE</u>	<u>YEARS AT PROG. *</u>		<u>YEARS IN FIELD**</u>	
	NUMBER	PERCENT	NUMBER	PERCENT
LESS THAN 2 YRS	2	20%	-	-
2 - 4 YRS.	4	40%	3	30%
5 - 7 YRS.	2	20%	3	30%
8 YRS + ABOVE	<u>2</u>	<u>20%</u>	<u>4</u>	<u>40%</u>
TOTAL	10	100%	10	100%

Note. * Indicates number of years experience at the treatment program.

** Indicates number of years experience in the chemical dependency field.

Staff Respondent Results

Themes will also be used to present staff findings. They will follow the same format as outlined in the client interviews sections. Some theme groupings may be deleted if they were not areas addressed in the staff interviews.

Contributions to Successful Treatment Outcomes

Staff respondents identified several factors that contribute to African-American clients successful completion of treatment.

Caring, the fact that people cared about them, they knew that we care.

They had reached a point where they realized that it was time.

The mandates they have will get them in and then the program and staff keep them in.

One of the support staff shared:

Some came in not of their own free will and some come in wanting to change their lives. Some have outside supports and that helps.

This single female mother, always with her children always said, "I want to do right." She had "the will."

The supervisory staff added:

The cultural based aspect and how it encourages them. The staffing pattern being majority Black and recovering persons who also are community based.

Something within them, they came to terms with themselves. There is an invisible line that crosses over in recovery that makes them connect. Something clicks. It happens on more of a

spiritual plane than clinical. Sometimes their weaknesses becomes their greatest strength.

The strengths of specific client respondents were identified by the staff as really making a difference in their successful recovery.

Two of the clients who are Muslim came in different times but each brought in a spiritual calmness.

He had perfect attendance and people cared about him and gave him a chance.

When he [client] came in here, he would talk no matter what he did, he would talk no matter what, good or bad. He would confront other clients. He had no problem. It was like he wanted to be a co-leader.

Another counselor in referring to the same client stated.

He couldn't wait to get his 90 days to be up front to lead a group or something or share. He always had a game, but even with a game, he always showed up. His strength was that he had no fear in communicating with people. That was a positive strength I saw.

His strength is his cultural values. He was proud. He had a lot of good values that gave him good direction. He was not too proud to apologize. He never missed a day. Once he knew that you cared about him, he shared.

He just had no problem getting with people. He's a very nice person. He's a real people person.

He's very positive. He was the main one [client] up there, reading, telling his peers what they need to do. He was a good model. He was always very positive. He would make people get involved.

Another counselor described the strengths of three of the client respondents that he worked with.

This clients' ego was his strength. His ego propelled him in most situations. Once he saw that his peers could do this, then he felt that he

could do this too.

This client's ego too made a difference, though not in a competitive mode but in a materialistic mode that did drive him. He is also into how he looks, how he presents. He has to prove to others. He is too concerned about acceptance, but it keeps him straight.

This client has a desire to be self sufficient. His sense of independence is compromised by his use. This is a strength that he has utilized and it has worked. He is very stable in his recovery. He also recognizes and uses spirituality.

Several staff referred to clients' family strengths:

They had an aunt or grandma who were praying women.

They had family that attended the family program, children in treatment, everyone getting well.

They have family traditions and respect for the family.

Treatment Approach

Staff discussed their perceptions of the treatment styles and approaches that are provided to clients.

It wasn't very formal . . . more like a family type atmosphere.

The treatment is definitely applicable to where most of them are. It meets the need culturally. It meets them basically in their environment. We teach them that we can't always take them out of their environment, but we can help them to acquire tools here and apply them wherever they live. We treat the whole person here and I don't think we can separate the physical without dealing with the emotional and the spiritual. We do crisis intervention here . . . We meet the client where they are at . . . "

What I think we do and do well is use what we have [in order] to be where our population is.

During treatment, counselors must play it by ear as to what may or may not work. Counseling staff discussed their styles in group treatment.

You don't know what triggers to push that would work, but you know which one's won't. You don't know what's going to work 85% of the time. But you develop an ear and eye, for what won't work. The model cases that I've been exposed to in academic or the videotaped cases we see, I know their approach wouldn't work here. Their experiences are so different.

I use a direct approach and a mixture of what I was taught here. I learned that the "TC" [therapeutic community] approach is sometimes too harsh. I learn to use skill . . . Skill is when a client who is hard, and you have to step back from yourself and think how should you deal with that client. Skill is when a person, when he starts to make your stuff pop, you know what I mean. Then you have to use skill to step back and not come down on the level where he is. That's what I've learned since I've been here.

My job in orientation group is to work on that, to get them [the clients] so that when they leave for the next group [Mens and Womens Recovery Group], they can talk a little bit.

The staff have a "style", their own way of letting clients know that it's okay, appropriate to discuss their cultural issues in group. One group called "Let's Get Real" is where clients discuss their issues of powerlessness in dealing with their lives and their family .

In the Rites of Passage group, we talk about racism and sexism. We talk about how systems impact their lives. Most of the clients feel that they have no power; our role is to tell them where to go for help and how to advocate and empower themselves.

Staff's Role/Support

Most of the counselors talked about the clients as an extension of themselves, like an extended family.

You had to be 'familial' in order to build a relationship with the client. Then they would share information with you about their slips [drinking and drugging episodes].

I see my role as a role model, as a Black female and as a Black recovering female. They watch me. They watch how I dress, they watch how I talk. . .

Those counselors who are in recovery seemed to lean more toward the role modeling perception.

I view myself as someone whose been where they are and someone who can help.

I believe, especially in this field, . . . I happen to be in recovery and I think the clients feel a lot safer knowing that I'm also in recovery. Things that I tell them to do, I do myself; they can buy into that a little better, especially the Black male clients.

This counselor was able to relate directly to her role as female, Black and a recovering person.

One of my roles is to give folks information about who they are as a person of their heritage . . . and begin to give them that thirst, that knowledge to want to go seek and see what things are about, apart from the disease. I don't think this is just a role. It's a responsibility to give them this.

Several staff respondents dealt with the issues of the dual roles that they have. As one counselor stated:

Your role changes from day to day, minute to minute because there may be a time when one of them [clients] need nurturing. You may need to be a mother, or a big sister. There may be a time when they need a parent or may be a time when they just need an ear or to have somebody listen. There may be time when one of the greatest roles I see [is] in validating folks over there and letting them know that they're worthy and

that they're worthwhile.

This counselor has been observed as the maternal figure in this program, so she was asked if she views her role as the maternal figure.

Yeah, they view me as that! I found that for a lot of younger clients; that seems to be what they need. I can work with them from that standpoint and I let them know that I am not their mother; I'm the counselor and that the roles should not overlap, even though they do.

One of the counselors who had been at Archway over five years and was the only male counselor for a period of time while he was there stated:

I was viewed somewhat as an authority figure from the patient's perspective.

His supervisor during that time also was viewed as the authority figure.

Many clients viewed me as the principal. I was listened to by the clients. I was perceived as being fair.

The staff were asked to assess the role that other staff play in carrying out the cultural approach.

Support staff are not a separate entity in the patient's treatment; they are a part of it; just as significant. I bet you that 80% of the clients bond with the receptionist and the van driver before they bond with their counselor.

There is caring and support from the administration to everyone.

All staff gives the message of hope and encouragement.

They have you, the administrator; they know they can come to you; you are available to them; they see you as authority and they take pride in who you are.

Peer Support

Staff respondents referred to the client's peer group as a major motivating force. They described how this support is realized.

I think the most successful thing that I have that really really works is that, you go to involve their peers in their treatment. You got to hook them up, so when they leave up here, because they are scared when they first come in here because they hear guys talking about some really deep stuff and they have never talked about these things in front of anybody in their life. So to make them comfortable . . . we have to let them know that they are supposed to be in here and if they have something to say, usually the most simplest way is to go through their peers and the main thing is to hook them up on the outside and make sure that they get to those meetings.

You know what also motivates them, their peers. They look at someone and they can't believe that it's the same guy that I used to do whatever I was doing with. You know, when I was out in the street. They look at him and say no wonder I haven't seen him in the last 6-8 months. He's looking real good and participating and you see them one of the leaders.

When someone new comes into treatment, into group, what I like to do is get them and a couple of their peers together to give them some support. You got to hook them up with their peers.

What I really find out that works a lot is that they have to believe that you care about what you're doing and that you care about them because I see a lot of them, coming from being active. . . people don't really care about you there. So for the first time in a long time, they start to get around people who care about them and what works is that when you start to involve their peers in their treatment. I've seen it to be very successful.

Program and Cultural Activities

There were several cultural activities described which contributed to clients' successful recovery.

I look at the way of the lunch setting [family style] that provides the culture, that interaction. We stress bonding with their peers.

The serving of cultural foods, cornbread, ribs, greens, etc.

The end of the month sober parties and client of the month recognition is very cultural. The dancing and music is so important to Black clients.

Basketball is very important to the guys. It's a community, a family, your roots. You learn a lot on the court. It's really important here, your machismo comes out on the basketball court.

The celebrating and discussion of Black leaders birthdays like Martin Luther King, Malcolm X, etc.

The pictures of Black folks all over the walls and the cultural books in staff offices.

The picnics and cook-outs resemble family outings.

The rites of Passage Group for African-American women.

The Kwanza ceremony and other holiday celebrations.

Black history month events of speakers and lectures.

Ongoing discussions of African culture.

These activities are integrated into a five/six-day week, five hours daily schedule of therapeutic groups and recreational/vocational activities.

Black Cultural Aspects

Counselors discussed how important it is to integrate culture into treatment.

Whenever the opportunity arise, I also put some history in the treatment, be it in the didactic, be it in the women's group or the Healing the child within group or family group. I always bring some Black history in there . . . I always try to integrate some Black principles. I use genograms and Brisbane's book to help clients to find out that their families, black families, are not so bad.

I have to use some cultural things for their awareness because a lot of them don't have any type of awareness of culture and the significance of their people. So what ends up happening is that they don't think that they are worth anything. They have got caught in the media and the papers and all you see is the negative things about our people, not the positive things. You know how people lie to us. So when you bring that to their light, I see them light up a lot. It gives them a little pride about who they are.

Since 90% of the clients and staff are African-Americans, it takes on that tone automatically.

Maybe because this is an African-American setting, our clients feel more a part . . . Mainly the staffing helps the clients to relate to the program.

This program is unique; it deals with the African-American population; they wouldn't be here if it wasn't for Archway.

Counselors shared their client's reactions to the Black cultural activities.

I know that it has to make them feel real comfortable when it comes time for them to sit down and have an individual [counseling session]. They are looking at someone who looks just like them. I know that makes them feel real comfortable . . . When you see sisters and brothers and most of us come from the [community] and they know us and it makes them more comfortable. When they come in here and they see somebody that they know, I think that plays a

major role. They know one thing that we care about them. We'll fuss and fight and everything else and they'll cuss us out but they know we care, they know that.

Another thing about this program in particular is Black consciousness. You know things of that nature, and they know that's why they keep coming back because there is no other program that they can find that do the things that we do. I did a whole week and a half straight on Black history. They were really into it and a lot of them didn't know anything and once they started getting a little information, they were bringing it back to the group. They would go to the library and get a book and do a little reading, wanting to be a part of it and they felt really good because that really means a lot to them. That takes away a big part of you when you think that you are not about nothing. [I'm ain't going anywhere]. Once you bring that God and that spiritual part, that's that big hold you fill because all it is that, is that they know it's going to be okay and if you can get that back on them.

Some of the staff had a difficult time putting into words what they do. They often used the words "it comes naturally," intuitively, "we just do it," or they would say to me "you know . . . " As I asked one counselor, why it is so difficult to put it into words he said:

It's almost like trying to define Soul - you know, and you really get stuck . . . But I'll tell you this; not so much the in-services, not so much the staff meetings, but the informal congregations where we have a bulk of the staff and we have a client or a situation . . . and you're explaining how best to approach that; that I think is one of those chips that put together that block of the ethnic approach. You tell us that we can't do that . . . ; that we must do it this way . . . because this is us - family, people, etc. If you ever watch the Motown Special - 25 years - they are trying to define the Motown sound, same thing, you can't just put your finger on it. But you know it's there.

Culturally, a lot is taken for granted by African-American staff. Several staff respondents who have only worked in African-American settings say that a cultural approach is the only way they know.

Because I'm African-American and I came from where they are now; I just do as I would do; it comes natural; I don't know it by training; I do it intuitively.

I don't go head up with a brother when I feel his manhood is at stake . . . If you got to pull a man's coat you do it on the 'Q.T.'

Culturally, we must be patient with the client; we have to wait till they're ready to deal with us. That's hard sometimes. I may run a client the wrong way; I must accept that.

It's this common bond, not only the substance. We're all role models for each other; in recovery we all bond; it tends to give people hope that we do recover. If one person relapses in the group, they all feel it.

It's really important to peoples' recovery to see Black folks recovering together; to see Black folks as providers. I try to give them a sense of pride about where they walk in to everyday to receive their treatment; that Archway is very unique; you are very special because you are getting treatment right here in Mt. Vernon with other Black brothers and sisters; and it's Black brothers and sisters that is providing the services; and that's what makes this place special; that's what makes this place unique; and that's gives this sense of pride from the beginning.

We address cultural issues in the groups; we talk about pride; having pride in yourselves and you can't have that without talking about who you are . . . If you haven't identified, then we will help you to get those kind of tool so you can start looking at who you are; that inner person; that beauty that you possess; that's been passed on traditionally from your family.

We don't promote or push Blackness . . . We have an intrinsic idea of who, what, where our patient is.

Twelve Step Fellowship

Through the program, clients get exposed to self-help groups particularly NA (Narcotics Anonymous) and AA (Alcoholics Anonymous). Meetings are held daily in a cultural environment.

AA had been alien to the clients. They need these social supports that maintain abstinence.

"The rooms" are the big part of it. After you leave here, you got to find something else to do, get hooked up with some type of group and some type of people that have the 12 step as a part of their life.

Ninety-five percent of the successful clients hook up with 12 step. You may get one client who stays clean without 12 step. It's rare. You got to hook up with some different people.

The main thing is to hook them up on the outside and make sure that they get to the meetings. I like to designate somebody that they can hook up with so they can feel comfortable walking in the meetings, because a lot of them haven't even been in a meeting. Most of them will go. The connection on the outside is most important.

Staff are supportive to the clients who choose to look at alternatives to AA and NA. The most acceptable alternatives are the Black church, mosque or temple which supports a drug/alcohol free environment.

Spirituality/Religion

Staff related how they incorporate spirituality into their treatment. As one staff respondent stated "All staff here have a spiritual foundation."

Spirituality is innate, we are born with it. Religion is different. You are a part of the

spirit and the spirit is within. They need to understand. I tell them to take time out with the candles, meditation.

The connection with the spiritual part and with the 12 step. As Black client, we didn't have too much but a reliance on God. We didn't have nothing else. And during our worst times, it was always in prayer. Please get me through this, so once you get clean and you can see certain things have happened that you can't explain. So one thing that makes your spirituality grow is some type of principles that you're going by.

Spirituality, I let them know that spirituality and church is two different ball games and I keep on repeating that while there in treatment. I'm not pushing church but you do need to get a higher power.

Racism/Discrimination

A counselor described his recent experience of accompanying a Black male client to a vocational program. He viewed this as a racist experience.

I watched that agency use Eurocentric testing instruments to evaluate the client. The evaluators were young white females who were obviously intimidated by this six-foot three inch, two hundred and fifty-pound Black 'street client.' This clients' goal was to go to college. He had passed his G.E.D. and felt ready. This vocational program recommended a trade where he could work with his hands. This client became very discouraged and wanted to lash back verbally and physically but since I was with him, he asked what to do. I said, "if you want to go to college, that's what you do; pursue your goal; we will help you."

The counselor said "when we give these clients answers, they believe us. Here, we don't lie to clients." That is why it is important that we use a reality based treatment approach.

This section on staff respondent findings captured their perceptions and views of the culturally based treatment program. In addition, it identified how and why some clients successfully complete treatment. These results will be thoroughly discussed in the next section.

DISCUSSION OF FINDINGS

This section will interpret the findings as they address the study's goals and objectives as stated in Section I (F). Goal's one through five will be examined by presenting a discussion of the significant and nonsignificant findings that relate to the specific goal.

Goal I. "To document several profiles of African-American clients who attend the program's day rehabilitation module."

Although as a group these African-American clients appear to be quite similar, their diversity and variations were highlighted in the findings. Case studies in Appendix H. describe five representative male and female clients who were respondents in this study. Their profiles illustrated the diversity of client background as documented in the clinical records. A brief summary of each included: chemical dependency history, mental health and medical history, psychosocial history (i.e., family, religion, education, employment), military history, criminal justice history and chemical dependency treatment plan.

Client characteristics as outlined in the findings present some distinct similarities and differences among the respondents. Age was a significant variable in the areas of

drug of choice, clean time and productive life activities.

Older clients tended to have been in treatment longer (years) and had the longest clean time. Of the eight (44%) older client respondents (45-64 years), six (75%) of them had 15 years of abuse/addiction. Of the ten (56%) younger client respondents (25-44 years), six (60%) had 15 years or more of the abuse/addiction. Of the 12 (67%) client respondents with 15 years or more of abuse/addiction, ten (55%) had a history of previous treatment. These ten were equally divided between five (50%) younger and five (50%) older client respondents.

One interpretation of these findings may be that persons who had a longer history of addiction tended to have been involved both in outpatient and inpatient treatment at least once prior to attending the program. Older clients (45-64 years) tended to be alcoholics with no secondary drug addiction, while younger clients, 44 years and under, were mostly polysubstance dependent (primarily alcohol and cocaine). Another interpretation is that this illustrates the difference in the progression of alcoholism versus other chemicals, specifically crack/cocaine.

In the area of productive life activities, six of the eight older clients (45-64 years) had previous long term work histories. All eighteen of the clients had returned to the workforce immediately after their successful discharge except two who were disabled. Younger clients (44 years or

less), tended to be involved in educational or training programs as well as being employed.

A comparison of the vocational aspirations and histories of the client respondents also indicated that older clients who tended to have had a long term work history came into treatment at a later age. This was often attributed to voluntary termination of employment or involuntary termination due to their addiction or work situation.

One client respondent had been employed by an airline for over 25 years and was laid off due to airline employment cutbacks. His drinking escalated to the point that he needed hospitalization. Another female client respondent was employed for over ten years. After taking off work one day, she began an episode of binge drinking, and never returned to her job. Both clients were, at the time of the study, involved in long-term employment since their successful completion of treatment.

Even though the interview instrument did not measure these variables, the investigator made several significant observations. The majority of the older client respondents (45-64 years) came from Black southern backgrounds, and were usually born in the south. Younger clients tended to also have a southern background (parents and/or grandparents born in the south) but most were born in the Northeast, with the majority being born in the county that they presently

reside. Those clients who were born in the south and the one client from Jamaica, West Indies tended to have a stronger past religious orientation. However, the younger clients tended to be currently more involved in spirituality or a religion.

Another observation regarding some client respondents related to their social status at the time of admission. Their social status prior to addiction may have been higher. The majority, approximately 15 out of 18 client respondents were on public assistance at the time of admission. However, since over half the older client respondents had prior long-term work histories, their income ranged from low to middle income. Approximately 25% of older client respondents and families of younger client respondents owned their own homes.

Even though this study did not measure social status with client success, this investigator suggests that there may be a significant relationship. This investigator further suggests that the higher the clients past social status, the more likely it may be that the client will have high achievement goals after their successful discharge.

Goal II. "To identify therapeutic interventions and approaches that are used in this treatment program by the counselors and determine the impact that the interventions have on clients success."

Both staff and client respondents identified the existence of a flexible program, consisting of treatment groups as the primary therapeutic intervention contributing to client success. These groups used peer and counselor confrontation that seemed to have "worked" for the client. The diversity of the groups and the way the clients moved into different groups seemed to make a difference. As clients recovery level increased, they were often promoted to join more advanced level groups. These promotions were symbols of excellence and high achievement.

Staff participants identified the group experience as a critical place where the client connected with his peers. As one counselor shared, "when someone new comes into . . . group . . . I like to get them and . . . their peers together to give them some support." But as one counselor cautioned, "culturally it is important to know that we don't talk about everything' in the group like the old cliché (don't hang your dirty linen in the street." The group process with its cultural and reality focus was a safe place for clients to discuss their struggles with addiction and recovery. The staff and peer support were integral to the

process.

Treatment programming and counselor group leadership had much cultural significance because many Black clients hesitate to attend treatment and therapeutic groups. This is due to their fear that they will be prodded and coerced to discuss personal and private matters. Therefore, the counselors' role was to assure clients that everything need not be shared in a treatment group. One of the supervisory staff respondents stated "I tell them that there are some things you share in the group, other things you only share with your counselors and some things you share with only your sponsor." This helped clients feel comfortable and to know that there are varying levels of sharing and of confidentiality incidental to group treatment.

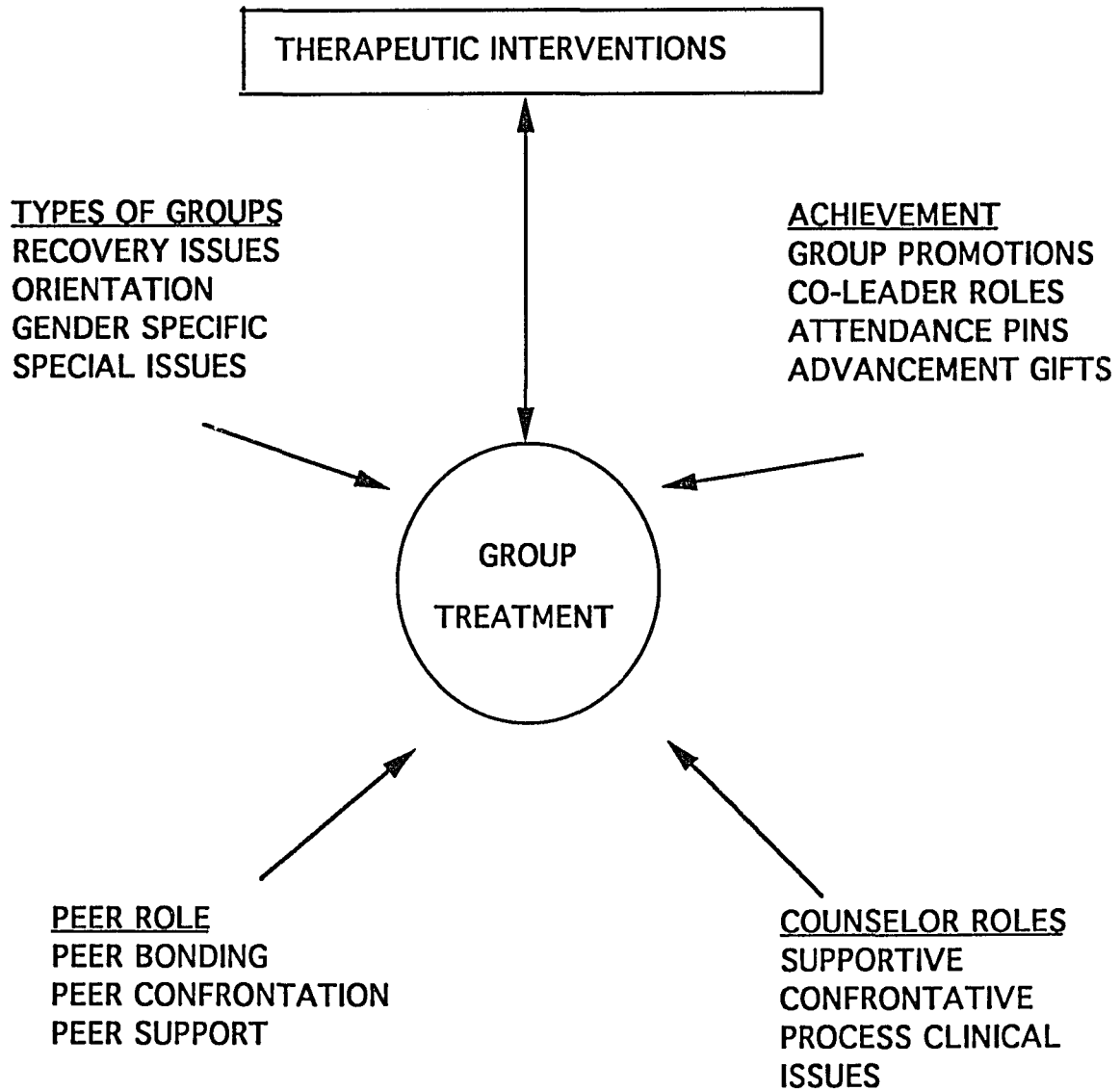
Brisbane & Womble (1992), state " . . . a group, in which issues and problems are abstracted so the individuals can personalize them without prodding by the professional, is often a preferred method for working with African-Americans" (p. 113). The counselor's role in a group was to integrate the client's experiences with the issues in treatment.

Groups were also used to process those difficult issues that clients had not previously discussed. One of the difficult issues was sexual abuse (rape, incest). Five (71%) of the female and three male (27%) client respondents shared that they had been sexually abused or raped during

childhood and adulthood. They shared how they used the treatment groups to discuss these painful feelings.

Consistent with the literature and prior research findings, group treatment with African-American clients can be considered a major method of treatment. However, there are many traditional Euro-centric group approaches that would not be appropriate. Some include: (a) use of traditional psychoanalytic, Gestalt or cognitive approaches without considering its possible cultural inappropriateness; (b) large groups that are not ethnically or gender balanced; (c) use of oppressive terminology; (d) value laden approaches and beliefs that represent the dominant culture. Therefore counselors must be culturally sensitized to the unique needs of African-American clients. An illustration of the group treatment as a therapeutic intervention is shown in Chart #1.

CHART 1: GOAL II



Goal II (a) "To identify the presence or absence of a culturally-based or Africentric treatment approach based on the criteria outlined in the literature review and interpreted through the interviews."

The findings clearly showed the presence of a culturally-based treatment approach. That approach was considered "Africentric" by some client and staff respondents. This may be due to the lack of understanding of the term Africentric.

Overall, the African-American clients who participated in this study found the cultural aspects of the program quite helpful to their recovery. They shared how the cultural environment made them feel more comfortable, and increased their self-esteem. In particular, having predominantly African-American counselors and staff was found to be most rewarding. It was viewed as a positive extension of their family. As one client stated, ". . . it was like a family thing. I felt a sense of belonging. I felt a sense of love . . . " Staff respondents viewed staffing as critical in the development of a culturally sensitive program. According to Allison & Hubbard, (1985) client likability is a predictor of program performance. These authors further stressed that the therapist and client relationship is an important outcome factor. Indications

from the data suggest that a cultural approach to treatment should be viewed as vital by all of the staff respondents. The cultural approach is vital because it connected clients with some awareness of their identity.

Staff interpreted their role as two-fold in that they needed to provide chemical dependency education as well as a cultural education. The literature addressed the need for African-American clients to learn to function in two worlds; their cultural environment, and the society at large (Norton, 1993; Chestang, 1972; Jacobs & Bowles, 1988). The literature also described the use of the concept of Black empowerment as defined by Beverly (1989). Beverly supported the need for Black alcoholic clients to be equipped with the knowledge and skills about both their cultural and their chemical dependency.

As one counselor stated "we're Black and they're Black, we must talk Black." Several staff respondents described how natural it was for them to integrate culture into the treatment. As Black clients in recovery, they shared that the cultural activities had a positive affect on their recovery. It made them feel good about themselves culturally. In order to have such positive feelings, clients must feel good about themselves and the treatment they are receiving.

Further indications from the literature identified ways that culture could be integrated into the treatment, through

the program activities (Pinderhughes, 1989, Jones, 1979, Brisbane & Womble, 1992). An example of the cultural activities that were most relevant to the client respondents include: Kwanza, Rites of Passage group, monthly sober parties, arts and crafts, African dance, and Black history lectures. The client respondents described in the findings how these activities enriched the treatment program. Celebrations were viewed as positive reinforcements for continued recovery. Clients related that they found the annual client recognition and monthly sober parties rewarding.

Additional activities, found to be culturally relevant included: the ethnic lunches, basketball, and cultural celebrations. These activities were seen as vital to clients' feelings of positive self-esteem. This relationship is documented in the literature as aiding clients to view themselves more positively. These feelings of positive self-esteem contributes to treatment effectiveness. An interpretation of these findings is that the better clients feel about themselves, the more likely that they may succeed in treatment.

In addition, staff respondents described the importance of the physical environment, ethnically visualized by African-American art, artifacts, books and dress by the staff and clients. This visual representation is critical since it reinforces the positive feelings of self. These

feelings contribute to the clients success in treatment. The findings clearly identify that the treatment approach is culturally-based.

Ninety-two percent of the staff respondents who were Black described how natural and comfortable the cultural approach was for them. It is extremely important for Black clients to "feel comfortable" in treatment. There appeared to be a direct relationship between clients' attendance and successful treatment outcomes with client comfort level in specific programs. Clients tend to attend treatment regularly when they feel comfortable. Those areas that were described as contributing to "feeling comfortable" in treatment included:

- having Black counselors and staff (custodian to director);
- having Black staff who are in recovery;
- having Black staff who come from the "community."

Unanswered questions primarily related to "feeling comfortable" in treatment is another area for future research with Black clients. This investigator believes that Black clients, who feel comfortable about their treatment program and the way they are treated, have higher levels of success. So, future researchers need to study the concepts of "comfort" (of Black clients) and its relationship to "success" of treatment. According to the literature (Sidal & Conway, 1988), client retention in treatment is an essential prerequisite to successful treatment.

Another identified component of culturally-based treatment is a sense of "Black consciousness." For the purposes of this research, Black consciousness in treatment is a sense of self-awareness and racial pride as African people, an awareness of one's past historically, and one's present conditions culturally. Both the positive aspects and negative influences must be addressed, particularly as they relate to the impact of alcohol and drugs on self, others, and the African-American community. This sense of Black consciousness varied with each staff person, depending on their own knowledge of African-American history, culture, and its relationship to chemical dependency.

Counselors described the fact that they integrate racial, cultural and gender issues into their therapeutic groups. The goal is to help the clients to understand how societal, social, environmental, and cultural factors influence their lives. This is supported in the literature section (Pinderhughes, 1989; Robinson, 1989; Orlandi, 1992). These authors address how vital it is to acknowledge these issues in the clinical process, particularly in assessments, and in treatment planning.

"Treatment for African-American clients, to be successful, must also reflect an African perspective as opposed to the common European world view which has values and beliefs that are inconsistent with African-Americans' philosophical assumptions" (Brisbane and Womble, 1992).

Staff respondents described essentially an Africentric approach to treatment. Many are not formally aware of this perspective. However, they tended to find the cultural approach quite natural. As several staff respondents shared, "If you know who you are, and you know who your clients are, then you do what you got to do. You give them a reason to have hope, you pull on their strengths, focus on the realities, confront the negativity, and support your client."

The culturally-based (Africentric) treatment model as identified in the client and staff respondent interviews consist of several components as illustrated in Chart 2. These themes, described in the results and discussion sections, can be used as the basis for the development of Africentric treatment model. Once further conceptualized, these themes can be the basis for staff training in both Black and white treatment agencies. Some modifications will be necessary when there are diverse social classes among Black clients and staff, (e.g., middle class).

CHART 2: GOAL II (A)

AFRICENTRIC TREATMENT MODEL

THEME	VALUE/QUALITY	ACTIVITIES
BLACK CULTURE	Self-esteem Feeling relaxed and comfortable	Physical ethnic environment Arts & crafts Ethnic foods
	Having fun	Music & dance Basketball
	Spirituality	Meditation group
BLACK HISTORY	Self-identity Sense of belonging Understanding roots and heritage	Kwanza Lectures, speakers & movies
BLACK CONSCIOUSNESS	Racial/ethnic pride Self-awareness Cultural awareness	Rites of Passage Black holiday celebrations
BLACK STAFF	Positive role model Positive identity Sense of family Friendship Caring, understanding Non-controlling or domineering Bonding Identify with familiar Black people	Individual & group counseling 12 step meetings (NA & AA)

Goal III. "To profile staff who work in this treatment program for the purpose of identifying their contribution as the primary treatment providers."

Indicators from the findings suggested that counselors had a major role in clients success. They trusted their counselors because they depended upon them and, most of all, identified with them as their role models. Therefore, the client-counselor relationship is critical in the therapeutic process.

The counselor's role in a day rehabilitation program goes beyond the traditional client-counselor relationship. This is primarily due to the intensity of the program. Therefore, counselors must be comfortable moving in and out of roles, using both their personal self and professional self. This role flexibility is a critical component of treatment.

The issues of the race and ethnicity of staff are programmatic issues. Hiring of staff reflecting the clientele served is necessary so that socio-cultural issues inherent in an effective cultural treatment model are addressed more readily. Studies have shown that clients tended to express preference for a therapist of their own ethno-cultural background (Comas-Diaz, 1988; Sue, 1981, Brisbane & Womble, 1992). The findings revealed the benefit

that a predominantly Black staff have on clients' successful treatment outcomes. White agencies that treat a predominantly Black client population may need to consider the value of this finding on client successful outcomes.

There were many references by client respondents regarding how their counselors and the staff were "there for them" which meant being supportive, empathetic, and understanding. In the findings, clients often referred to staff as their "friends." They emphasized the support, caring and understanding that they received from their counselors and other staff. Culturally, these qualities are essential to effective treatment of African-American clients. Brisbane and Womble (1992) identified several areas that African-American professionals are expected to achieve with their race-same clients to achieve effective treatment. They added that "race-same professionals must practice in a manner which is in keeping with whom they project themselves to be: concerned, healthy and proud African-American individuals" (p. 53). Client respondents saw these qualities in their counselors at Archway as evident by their describing how "they gave more."

The literature also addressed other professional roles of power and powerlessness, trust and mistrust that staff must focus when providing culturally relevant treatment (Solomon, 1976, Brisbane and Womble, 1992). Counselors may need to disclose their roles of power and powerlessness to

their clients in order for there to be a relationship of trust. For example, though a client who is on parole and probation is doing very well in treatment, the counselor does not have the power to reduce or revoke the conditions of mandated treatment. It may be necessary for the counselors to share their lack of power in this situation.

The literature has shown that African-American clients are most likely to remain in treatment with a race-same therapist if s/he actively promotes "positive transference feelings" (Brisbane and Womble, 1992). This is because of the high value African-American clients place on establishing and nurturing interpersonal relationships with other African-Americans. The expectation of race-same workers is to be friendly (not necessarily their friend) and to treat them as more than 'an alcoholic', 'a drug addict' or 'a client' (Brisbane & Womble, 1992). This level of bonding with clients in a 'familial' manner is evident by the way these staff respondents described their roles.

However, clients often mis-interpreted the counselors' friendly manner as real "friendship." They sometimes initially had difficulty when their counselors confronted their negative behavior because they assumed that their counselor "friend" would not address their issues in that manner. Counselors had to clarify these roles at the outset of the treatment intervention and the clients usually accepted the explanation. This was because clients are more

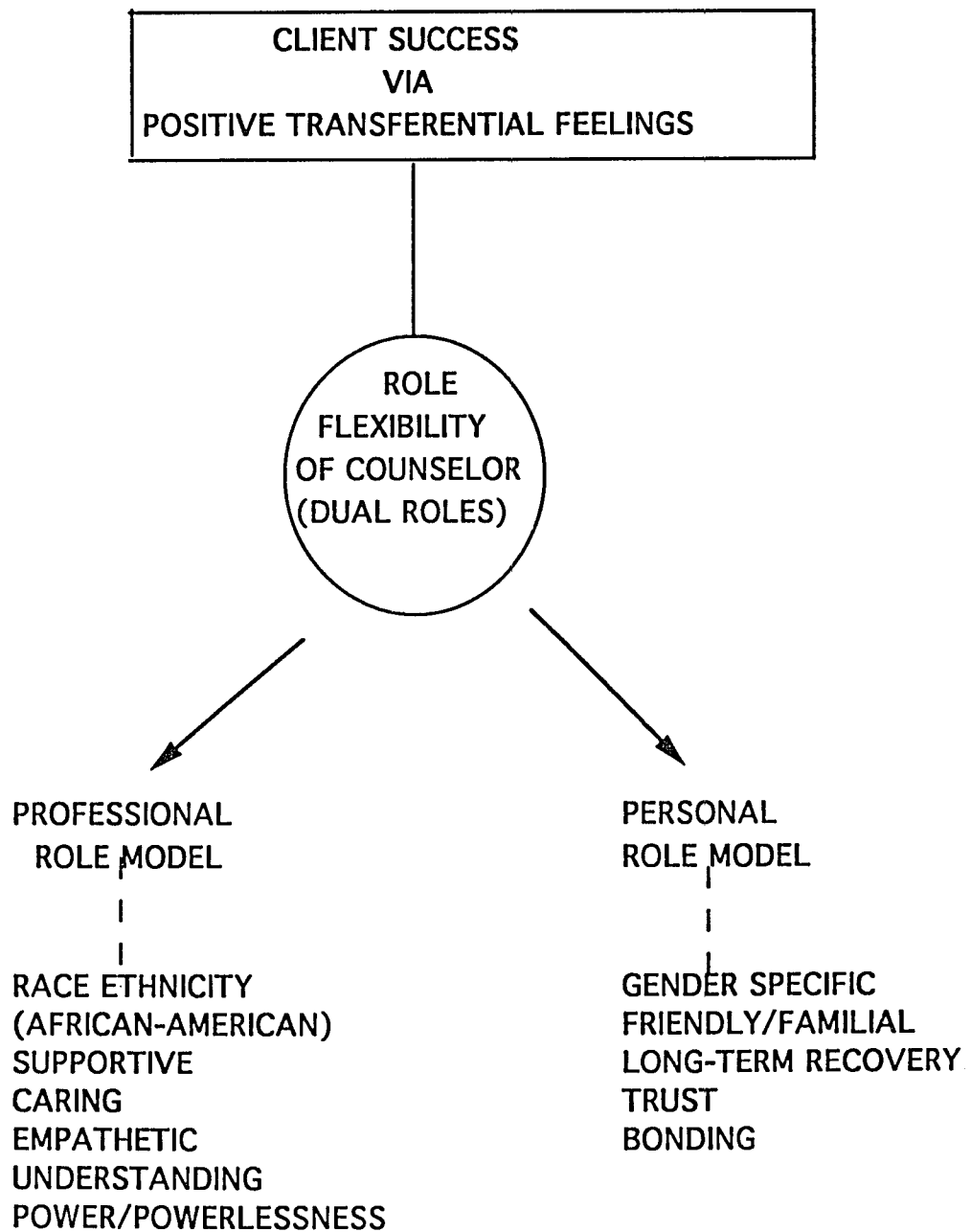
comfortable with counselors that they can identify with culturally.

Female client respondents found it helpful that they had positive female staff role models. It is definitely necessary for programs who treat Black women to have staff reflecting their culture and gender. Some womens' issues of sexual abuse and sexual promiscuity are better addressed by female counselors trained in these areas. Female client respondents often had issues of male/female relationships that they felt more comfortable discussing with female counselors.

Chart 3 illustrates the staff contribution to client success. In particular, it highlights the role flexibility of the counselors as demonstrated in both their professional and personal role.

CHART 3: GOAL III

STAFF CONTRIBUTION TO CLIENT'S SUCCESS



Goal IV. "To document internal and external strengths and resources of clients that may have contributed to their success.

The results suggest that those clients who successfully completed treatment contributed their successful recovery to several internal and external supports. The primary internal support used by those persons who were "sick and tired," was self-determination. This really made a difference in their "staying clean" and eventual successful recovery.

According to the results of that analysis, clients who identified determination as an internal support tended to be the persons who had longer histories of chemical dependency. They had been in other treatment programs for six to ten years. Most of them did not have the external support of family and friends any longer because they had already "burned their bridges." This meant that these clients' families no longer believed in them because they had made many promises to quit drugs before. These were the persons who tended to rely heavily on external supports from counselors and peers.

Other internal strengths of client respondents, as identified by staff respondents, included their motivation, ego, self-confidence, spirituality, cultural values and desire to change their life. These clients integrated the

programs' strengths with their strengths as a support. For example, the client with a strong sense of cultural values became very involved in the cultural aspects of the program.

An external support that contributed to clients' entering and staying in treatment was often their mandated referral source. The fact that many clients were referred by the criminal justice system and by welfare offices was an indirect incentive. One client described how their welfare caseworker was supportive and another described the interventions of their worker mandated preventive worker from a social agency.

Client respondents were usually ~~involved in~~ productive life activities since their successful discharge from treatment. At the time of this study, 16 (89%) of the client respondents were involved in productive life activities and two (11%) were on medical disability. Of the eleven (61%) client respondents who were employed full-time, nine (50%) held jobs for over one year. These persons were also no longer on public assistance. This is significant because all of the respondents were receiving public assistance benefits, i.e. Aid to Dependent Children (AFDC), Home Relief (HR), or Social Security Disability Insurance (SSDI) during their treatment. Becoming financially independent had a positive impact on clients self-esteem. These clients tended to work harder to keep full time jobs that would strengthen their financial

stability. This would also increase their chances of maintaining their successful recovery.

Client productive life activities (as defined in Section I-E) (employment, education and, training) are very important to successful recovery. Black clients tend to measure success based on their involvement in positive productive activities. Traditionally, "high achievement orientation" is one of the five cultural strengths of Black families as described by Hill (1972). Of the three clients who were attending college and the eleven clients who were employed, all of the former, and seven of the latter had long term career goals of "higher levels of achievement." They also tended to be willing to work at lower level jobs initially, with the hope of future advancement.

This investigator observed that single Black males who were receiving public assistance (home relief - HR) often had a more difficult time getting approval from social services department (welfare system) for college as an alternative to work. In addition, Black men who were involved in vocational training, such as employment preparation programs were often offered lower levels of work than Black women. Their starting wages were significantly lower than white males.

This investigator attributes institutional racism as the primary reason for this disparity. Of the seven client respondents who had shared experiences of racism and

discrimination, five also felt that they were intentionally discriminated against by the "system." Several researchers (Gary, 1978; Robinson, 1989; Brisbane and Womble, 1992) suggest that the issues of racism on clients lives must be addressed in treatment.

Three (18%) Black client respondents who had previously been employed in illegal drug dealing activities, all were currently involved in legal low paying employment. They had long term career goals of obtaining a college degree and working. These three clients who were involved in the drug trade not only had to adjust to a substantial decrease in salary but also to a safer work environment. They shared the danger of the drug trade and how they were overcome by their addiction. They expressed the fact that they had become less materialistic but they did not speak to the transition from financially "having" versus "not having."

The problems of economic gain in an impoverished community with high rates of unemployment were an issue with three of the male respondents. As stated by Nobles and Goddard (1989) in the literature review section, "in the presence of high levels of unemployment, drug dealing and drug related activities have emerged as viable economic alternatives for urban youth and adults."

Clients who integrate into the mainstream world of work and college are considered "successful" by counselors, the treatment program, their welfare caseworker, and others.

These clients' self-esteem is often improved since being considered "successful" contributes to a more positive feeling of self. The treatment plan for each client has a vocational goal that clients must achieve before being "successfully discharged." This vocational goal is also a measure of the treatment programs' effectiveness.

Goal IV. (a) "To identify and analyze the impact of community, staff and family support systems on the client's success."

Since the impact of staff was previously discussed, this section will focus on the family and community role. Almost all of the client respondents found their family members to be supportive. Some were initially unsupported because of the clients past interaction with their family. However, as the client became more serious about recovery, the family tended to become supportive. Therefore, the family can be considered as an external resource for clients' recovery. Those families who were not sober and drug free were often unable to be supportive because of their need to be in treatment. When this was the situation, the clients tended to depend on other clients, their peers and staff to substitute as their family. These clients referred to the program, their counselors and peers as their new family in the findings. The family members who were in

treatment tended to be supportive of their family members in treatment because they understood the program.

Several clients' family members were a part of the Archway program either currently or in the past. At least three of the client respondents young children had attended the Children of Alcoholics/Addicts (COA) program. Two of the client respondents shared that their adult children had been in the day rehabilitation program. Several client respondent spouse/significant others or parents had also been a part of the treatment program. This further extension of the program into the clients family life was another indication of how the program supported the client.

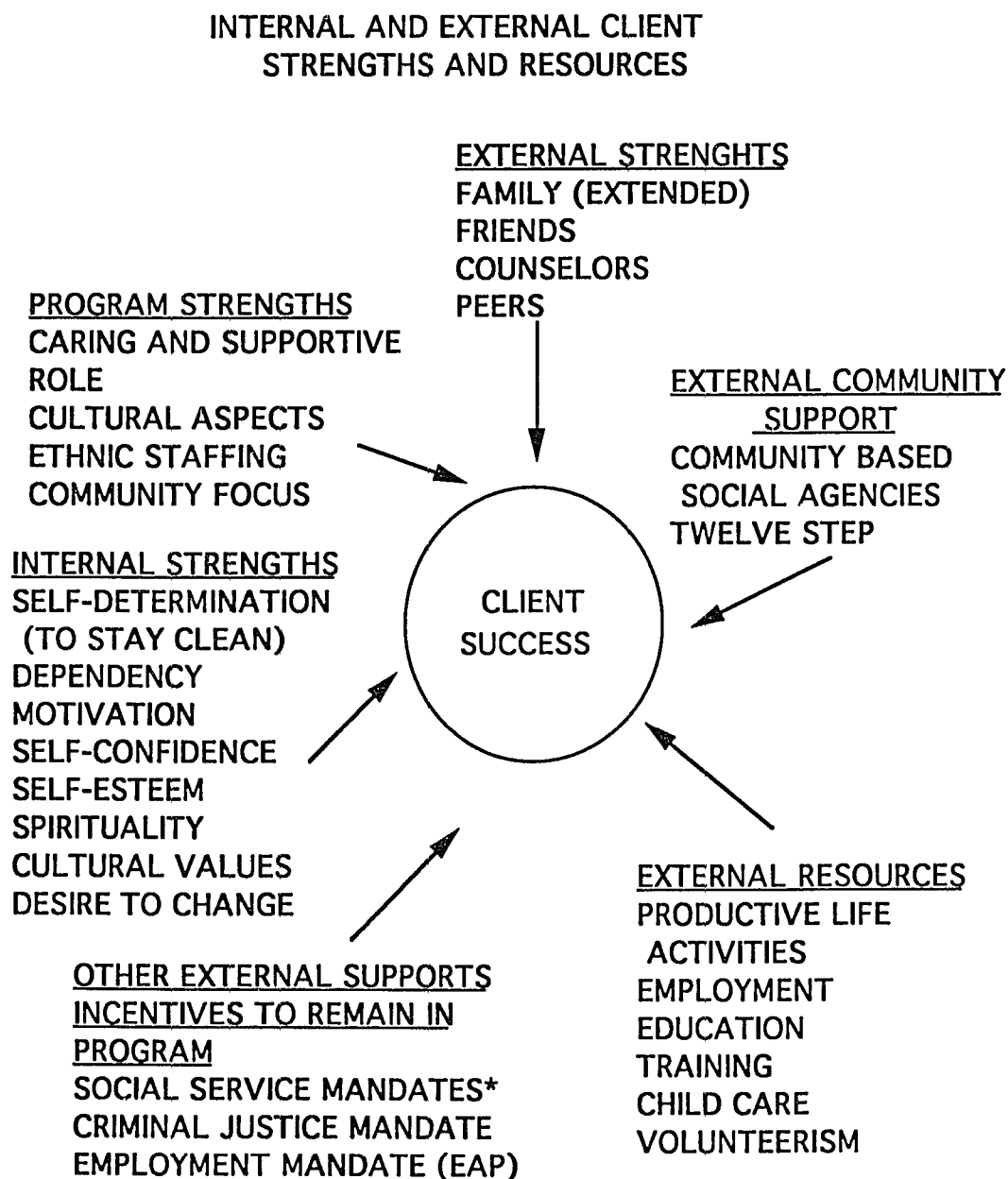
The need to involve the family in the treatment process and to understand the diversity of the family roles and levels of functioning is critical and illustrated in the literature (Billingsley, 1968; Bell & Evans, 1981; Hill, 1972; Murphy, 1991). Family had a two-fold role: being a strength for some clients and being their primary support. When client respondents referred to their family, they were often speaking of the extended family. Often, the grandmother, aunt, or uncle were identified by client respondents as the supportive family member. The literature (Hill, 1972; Hall & King, 1982; Brisbane & Womble, 1992) addressed the role of the clients' family from a strength's perspective. They acknowledged the importance of the extended family and the role flexibility of family members.

Family function and family role are viewed as major issues to be addressed in treatment.

Other community resources were not found to be very supportive to this population except the church (which will be discussed later in this section). One explanation for this lack may be that most of these clients had not been active in the community due to their years of addiction. Another explanation may be that the treatment program tended to provide a similar connection with the community resources.

Chart 4 illustrates the relationship between client strength and client resources.

CHART 4: GOAL IV & IV (A)



*Social Service Mandates may be AFDC, HR, Child Protective Services (CPS)

Goal V. "To document those elements of the treatment program that may have contributed to the clients successful completion of treatment."

Caring was a major factor. The fact that there was a program that cared about them was a critical factor in clients' success. Client respondents frequently referred to "caring" as a major issue in their acceptance of the program. Having persons who cared made a major difference in their attitude about treatment.

They also described the program as being "there for them" which meant that the program was an extension of themselves. "African-Americans who remain in treatment do so because they feel liked and appreciated by the professional and consider going to see her or him as making a visit to see a friend" (Brisbane and Womble, 1992, p. 122). These are important factors regarding successful treatment outcomes. Client respondents described the treatment professionals as very supportive. This investigator viewed this aspect as one of the most critical aspects of clients' successful completion of treatment. It once again focused on the clients comfort level. The program's effectiveness can be measured by the clients feelings of comfort which increases positive participation.

Other important factors included the "sense of

belonging," and "being a part of something." Clients translated how important it was for them to belong and be a part of their treatment program. The need to belong is not a new concept. It's one of Maslow's hierarchy of needs. These feelings are important qualities to effective treatment. Clients described how safe they felt in treatment as compared to the hazards of their past drug and drinking environments.

One client respondent shared how the program "lets me come back." This is very important part of the "belonging" concept. Once a part of the program, one can always return, no matter what their status was, successful or unsuccessful. This is critical culturally because if the program is viewed as a "functioning family," then the client is always welcome.

Having fun in treatment was a concept identified several times by client respondents. This is important because recreation and humor are strengths of African-American families. Treatment was viewed as being more than serious. The findings identified several activities that were intentionally planned for fun or recreation such as: the sober parties, basketball games, picnics, trips, and games. Most of these fun activities were culturally focused.

Other aspects that clients and staff respondents identified were "leadership roles." Several African-

American clients had previous experiences as leaders either in a positive or negative activity. The literature (Cheung, 1980; Nobles & Goddard, 1989; Harper, 1991) addresses the negative and false levels of status achieved by success in the drug culture. Other clients were previously involved in positive leadership roles in their families, churches or communities. Client respondents came into treatment with leadership qualities which they were encouraged to utilize. The types of opportunities for using leadership roles included:

1. being an officer in the client council which facilitate the weekly client community meeting.
2. co-leading morning meditation groups.
3. coordinating monthly sober parties.
4. being nominated client of month or client of year.
5. peer/buddy support, matching clients with peer.
6. assistant to chef in kitchen.

Counselors shared that most of the clients who were leaders during their treatment have continued to be leaders either in the "rooms" (AA or NA) or in their vocational life (work or college).

Chart 5 illustrates the aspects of the treatment program that contribute to client success.

ELEMENTS OF THE PROGRAM CONTRIBUTING TO CLIENT SUCCESS

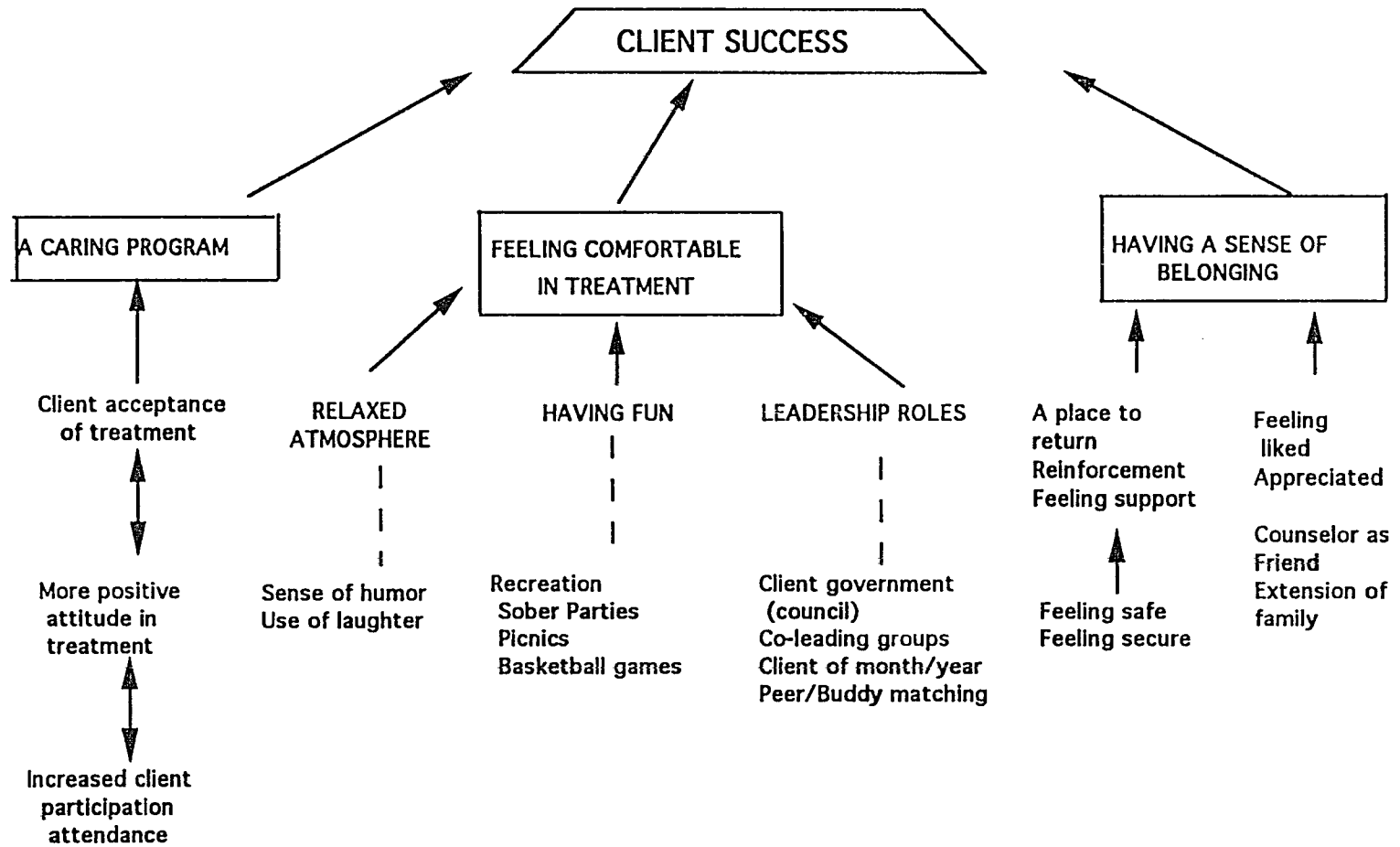


CHART 5:

Goal V. (a) "To identify the role of peer support in relation to the client success.

Goal V. (b) to examine the role of 12 Step Programs: Alcoholics Anonymous and Narcotics Anonymous in relation to client success."

This research objective was documented in the findings. The findings documented that the role of peers in chemical dependency treatment is a very crucial relationship and contributes positively to successful treatment outcomes. Client respondents shared how supportive and instrumental their peers were in treatment. Most of their peers became their new friends because their former peers were their "people, places and things." In the rooms (AA and NA), these are the old usually negative influences from which they must separate. Peers in treatment who are "working the program" are positive examples. All of the client respondents shared that most of their current friends are either from the treatment program or the rooms (NA and AA).

Changing one's "people, places and things" is a difficult step for many clients and it is an issue that is addressed in treatment. Returning to or not letting go of old friends who are still "using" are relapse triggers for clients attempting recovery. Those clients in recovery have successfully addressed this issue. These are key issues and suggestions in the 12 step programs and the therapeutic

treatment groups.

The treatment counselors recognized the importance of peer support. The bonding of peers is critical in the therapeutic group process. Several counselors intentionally matched clients as they entered the treatment group to create that bonding and trust. Culturally, this is important because clients often are treated by the staff as "sisters" and "brothers" are expected to look out for each other and keep each other "in check."

The client respondents in this study were heavily involved in the 12 step programs as a primary external support system. Almost an equal number (50%) were primarily involved in Alcoholic Anonymous and the other 50% in Narcotics Anonymous. Approximately twenty percent attended both AA and NA regularly. Most of these clients attributed their involvement in twelve step primarily to the fact that the AA and NA meetings were part of their treatment program and that the meetings were on the premises.

All of the client respondents are members of predominantly Black AA or NA groups. They shared how comfortable they are at those meetings because they culturally reflect themselves. Many staff respondents shared that they speak at their clients' anniversary meetings. This is another example of staff sharing beyond the traditional role of professional counselor.

All of the client respondents (100%) had been involved in the twelve step meetings at the program when they were in treatment. Each of them had also joined at least one outside group, had a sponsor and 16 (89%) had completed the steps, while two (11%) were still working the steps. At least half the client respondents had an official role at their home group meeting or at one of meetings held at the program. Often, they had been a chairperson of a group. All of the client respondents were regular speakers at outside meetings both locally and outside the city and county.

The client respondents often identified the twelve step program as their spiritual base. This has been documented in the literature (Smith, et al., 1993; Opaku, 1985) and the findings prove it further.

One staff respondent clarified the role of meditation and prayer. In twelve step, meditation means to listen to your higher power, and prayer means to speak to your higher power. It is suggested in the rooms that each morning you ask your higher power to give you the strength to make it through the day and at the end of the day you give thanks for having made it one day at a time. Client respondents identified meditation as an integral part of their recovery. The purpose of the daily meditation books that are utilized in the rooms and in the treatment program are to give clients strength and support one day at a time. In

treatment, meditation is also used as "a relaxation technique." Teaching clients relaxation through meditation gives them skills that they can use as sources of strength.

Goal V. (c) "To examine the role of the church and spirituality in relation to clients' success."

The general findings documented spirituality as a primary source of strength for client respondents. This spirituality was expressed in several different ways such as faith, belief in higher power or God, use of prayer, and meditation. The spiritual connection was often linked to childhood religious experiences. Religion and church, as an institution, was currently not viewed as a major support system by most client respondents. The literature and the findings support the practice of spirituality.

Staff respondents discussed how spiritually connected the clients were, though they often did not realize this until after they entered into treatment or twelve step programs. They linked this to their culture as African people and the historical role of "spirituality." In the findings, many staff counselors described how they integrated spirituality into their treatment approach.

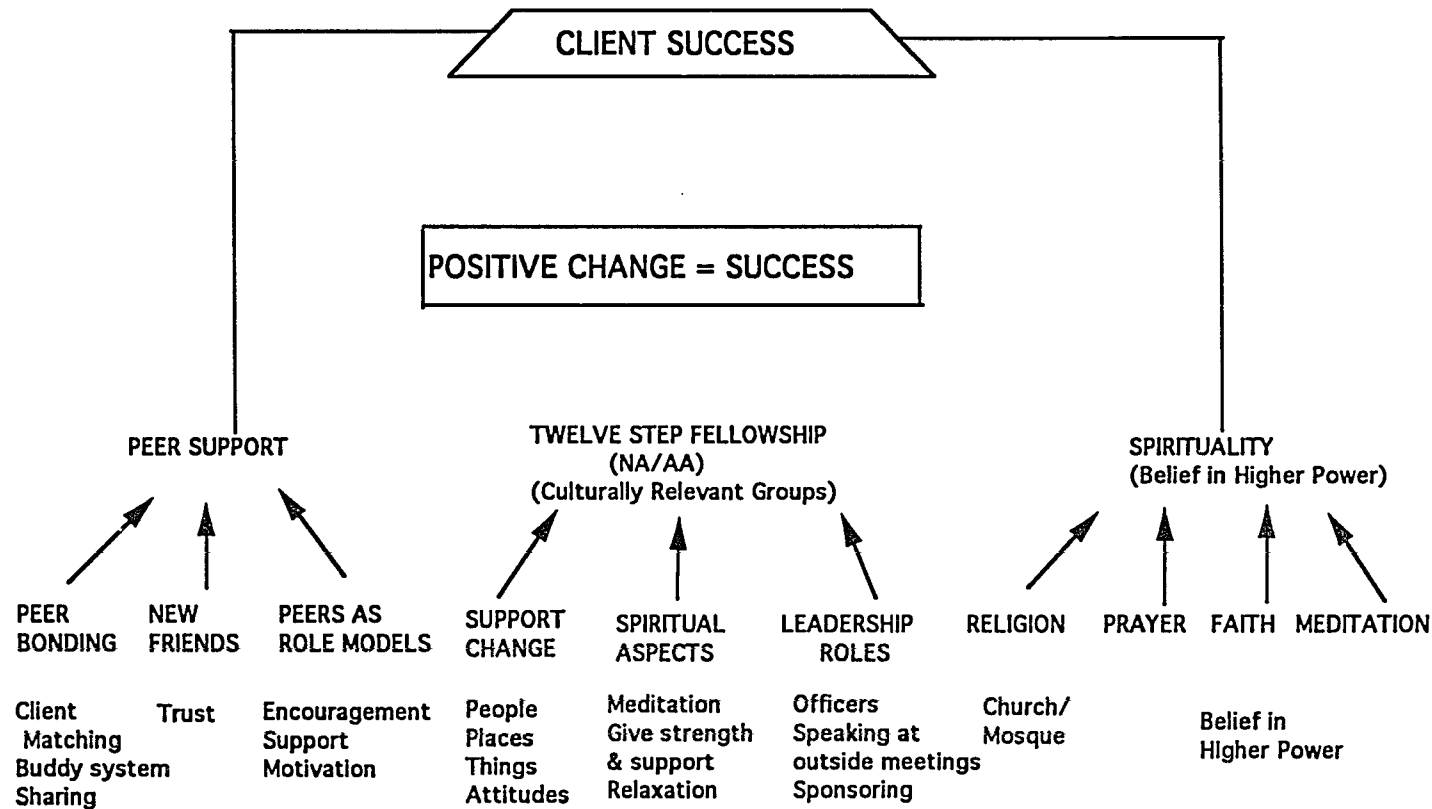
Some staff respondents confided that they made a clear distinction between spirituality and religion. The need to continue this distinction is documented in the literature

(Knox, 1985). The program encouraged spirituality as a support but did not focus on religion except to recognize its role as a support system.

Religion or being religious was not a necessary component of successful recovery but being spiritual was a vital factor. All of the client respondents could relate to a past religious experience, but they did not all identify those experience as spiritual. However, all client respondents did identify a current sense of spirituality. Spirituality is clearly an internal strength that clients become seriously connected.

Chart 6 illustrates the role of client support systems: peers, 12 step, and spirituality on client success.

CHART 6:
ROLES OF PEERS, 12 STEP & SPIRITUALITY ON CLIENT SUCCESS



Other relevant findings that supported the need for a culturally-based model included the identification of racism. Both client and staff respondents identified issues of racism and/or discrimination. These incidents were experienced at several levels in treatment, both personally and institutionally. The personal level included one-on-one encounters with individuals and the institutional level dealt with the system racism (i.e., welfare, college, work place). Several client respondents indicated that they had dropped out of other treatment programs due to incidents of perceived or actual racism. These clients found this treatment program's culturally-based model as a welcome, safe environment. The culturally-based approach with a focus on Black history helped clients to appropriately confront those experiences with racism.

There were several recurring themes that were congruent in both staff and client perceptions throughout the findings. These included:

1. the role of family as a support system;
2. the role of the treatment program and staff as "family" to clients;
3. the positive aspects of the cultural perspective in treatment;
4. the importance of the caring, support and understanding qualities of staff toward clients;
5. the value of client's self-determination in

their recovery.

There were several themes and principles identified in this research which were instrumental in "successful recovery" and culturally-based treatment. The principles for successful treatment outcomes in a culturally-based chemically dependent treatment program are illustrated in the Diagrams A #1-5. The components of these principles were suggested in the client and staff respondent interviews.

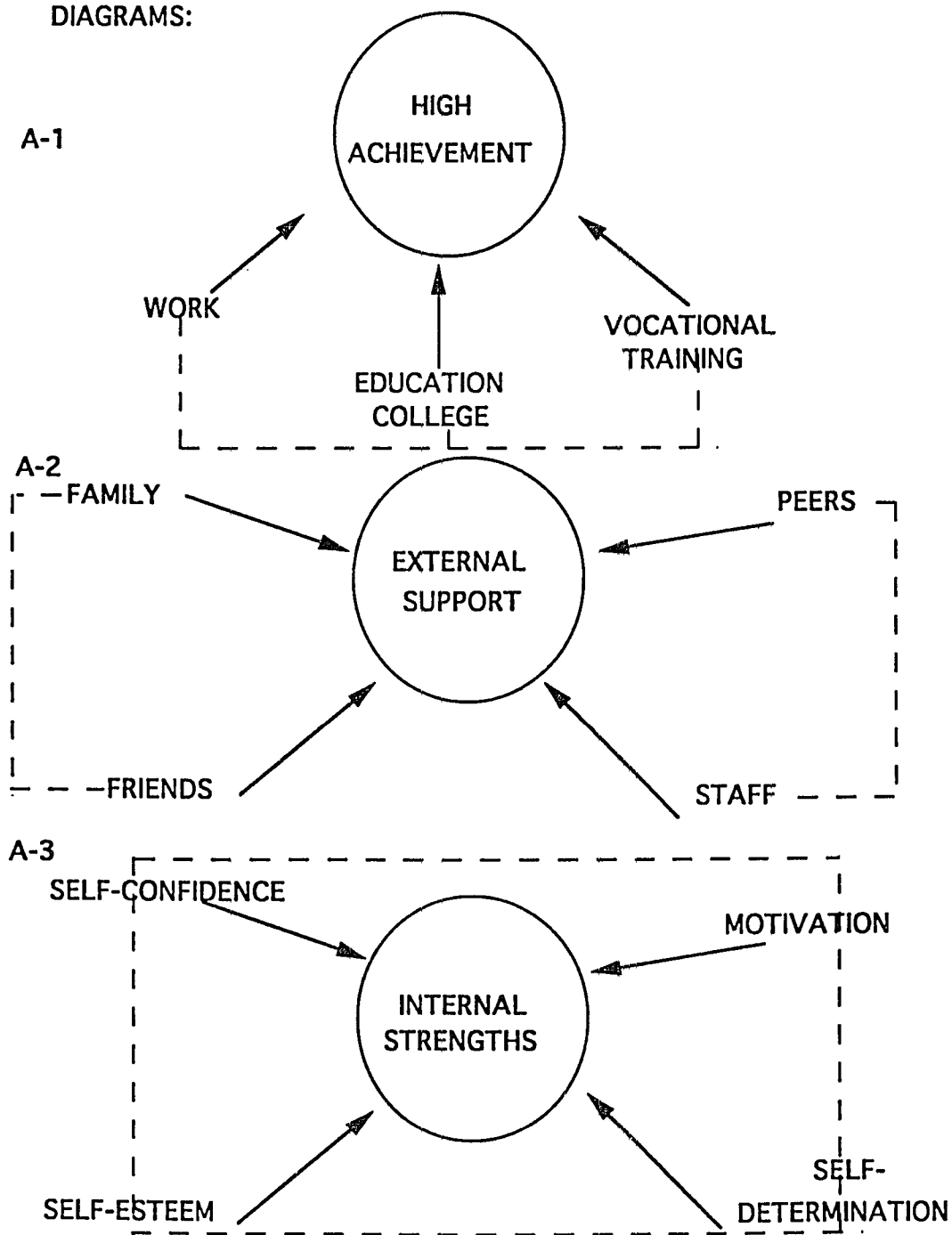
The five key principles highlighted are:

- a) high achievement;
- b) external supports;
- c) internal strengths;
- d) spirituality;
- e) program supports.

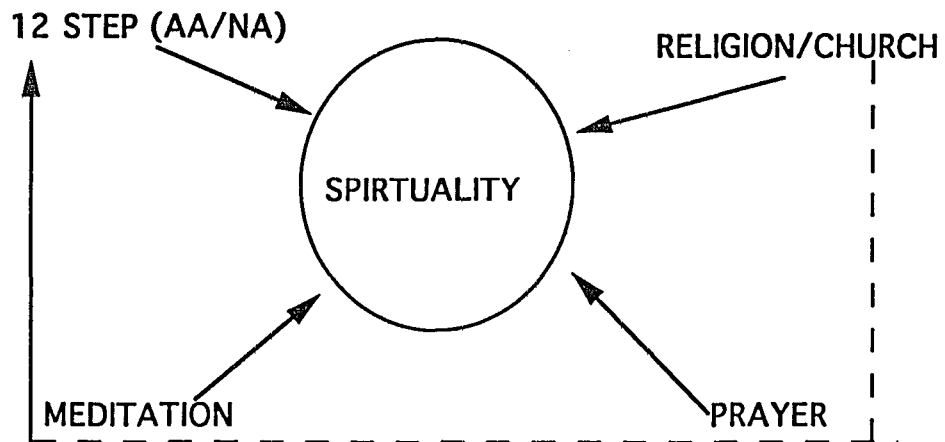
Each of the individual principles have been explained and described in the Results and Discussion chapter.

PRINCIPLES FOR SUCCESSFUL TREATMENT OUTCOME

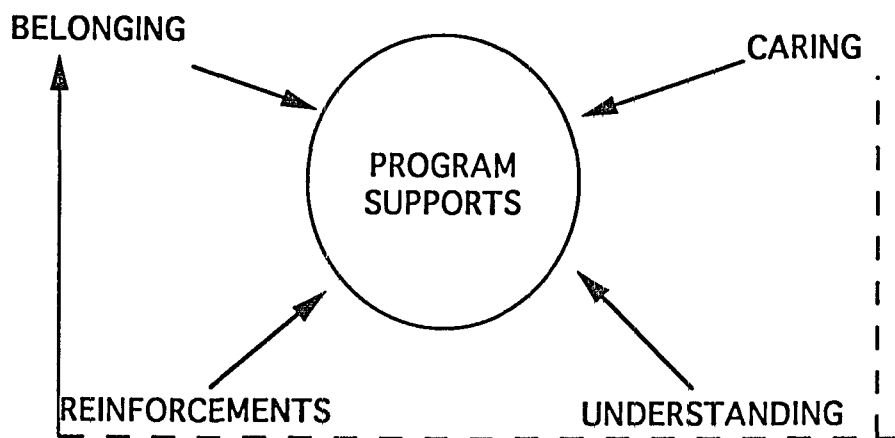
DIAGRAMS:



A-4



A-5



SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

The primary purpose of this research was to study African-American male and female clients who successfully completed treatment at an outpatient rehabilitation program over the past twelve years with a goal of discovering the strengths of the clients and the treatment program.

Interpretation of these findings cannot be widely generalized beyond this sample due to the limited body of knowledge of African-American chemically dependent persons in recovery. Another reason for selection was due to the paucity of information about culturally-based chemical dependent treatment programs. This sample was selected from one outpatient alcoholism rehabilitation program, Archway, in Mt. Vernon, New York. The reason for this selection was due to its years of effective treatment services to African-Americans clients as measured by its large number of service visits, and county and state agency recognition. All client respondents were in recovery one year or longer. Although there may be similarities in this outpatient client population to other outpatient and inpatient populations, further research with this population is required before any assumptions can be made.

Though the diagnosis of these clients in this sample included alcohol, marijuana, cocaine/crack and heroin

dependency, this research study was based on a licensed alcoholism treatment program. The approach and philosophy of that agency was based on an alcoholism abstinence treatment model. The results, therefore, must be measured taking these factors of treatment approach and client diagnosis into consideration.

Differences in treatment modalities, approaches, client demographics, community size, population, geographics and other demographics (i.e., poverty, racial make-up) also limit the generalizations that can be made based on other African-American chemically dependent populations and treatment programs.

The small sample size, the adequacy of which is substantiated by the literature, is another factor to consider when interpreting the data. Great care should be taken when making assumptions or comparisons about this qualitative study. This is due to size of this sample, among other factors.

This was a qualitative study which used rich descriptive data about the clients and the program. Two sets of interviews were conducted with 18 client and 12 staff participants. Data analysis was by classification schemes and building upon recurring themes and patterns within the data.

The methodology employed was a phenomenological approach which "captured the essence of the experience" of

successful clients. This was done by incorporating systems perspectives and a strengths perspective of black families. It is important to note one strength of this methodology was that the research design examined successful cases. This is a useful empowerment research approach as opposed to an experimental design which examines cases that are successes and failures.

Hopefully, this research has contributed to the paucity of literature which addresses the treatment needs of African-American clients. Furthermore, the addition to the body of knowledge of "what works" when treating these clients hopefully also reduces the literature void of this type of research. The data provided by this study offers additional explanations that chemical dependency treatment to African-American clients is effective. This program design may be considered for replication with some modifications to meet the diverse cultural needs of other ethnic groups.

To develop appropriate treatment programs for African-American clients that will produce successful treatment outcomes, further research should focus on their unique treatment needs.

Conclusions

Several conclusions can be drawn from the findings of this study.

1. African-American clients' internal strengths, particularly, "self-determination" seems to be a primary factor in successful treatment outcomes.
2. African-American clients' use of "spirituality," and belief in a higher power, appears to guide their recovery process. The findings support the inference that this is a major cultural influence.
3. A primary source of external support was the twelve step programs which were also found to be culturally focused since all of the clients in this study participated in predominantly Black Alcoholic Anonymous and Narcotic Anonymous meetings.
4. African-American clients' involvement in the group modality was viewed as the major therapeutic intervention and treatment approach that significantly contributed to client's successful completion of treatment.
5. African-American clients' relationship with their counselors seemed to be both therapeutic and at times familial due to the influence of culture.

6. African-American clients' involvement in productive life activities (i.e., employment, education, training and volunteerism) appeared to have a major significance in terms of their successful recovery especially for those with long term abstinence.

7. African-American clients' relationships to their peers in treatment programs seem to be a significant support system. These peers had become "new friends" for clients in recovery.

8. Findings support the conclusion that cultural aspects of a treatment program (i.e., ethnic staffing, culturally relevant program activities, ethnic celebrations, culturally visual physical environment, ethnic meals), may be a contributing factor to the identification of a culturally-based model.

9. The programs open door policy which gave clients many chances and allowed them to return to the program was found to be a significance factor in clients' successful treatment outcomes.

10. African-American clients' past experiences with racism at other treatment programs can be significant in a client's feeling comfortable in a predominantly African-American treatment setting that utilizes a culturally-based treatment model.

In conclusion, this study of an adult chemical dependency outpatient day rehabilitation program provided evidence of cultural strengths and the existence of a culturally-based treatment model used by African-American clients who successfully completed treatment.

Recommendations

Several recommendations seem warranted from the findings of this study.

1. Chemical dependency treatment programs with a predominantly African-American client population should incorporate a culturally-based treatment approach as a means to obtain more successful treatment outcomes. Some of these program components are outlined in this study.
2. Chemical dependency treatment programs need staff diversity reflecting race, ethnicity, social class and religion as specific characteristics of counselors which may affect successful treatment.
3. Chemical dependency treatment programs that have a large African-American population should host Alcoholic Anonymous and Narcotic Anonymous meetings on premises, and incorporate them into the program's activities, as these are major determinants of effective treatment.
4. Chemical dependency treatment programs should

set up a buddy system by which new clients in the early stage of treatment are matched with existing clients who are successfully "working the program." This will enable the peer support that was documented as a source of strength for successful clients to be formally implemented and monitored.

5. Local, state, and national funding agencies of chemical dependency treatment programs need to develop more efficient measures of determining program effectiveness which extends beyond client utilization.

Implications for Future Research

This study raised many questions that should be further addressed in future research. As one moves beyond the problem of chemical dependency in the African-American community, one must focus on the issues of treatment and recovery.

1. There is a need for more qualitative studies to investigate the support systems of clients in recovery, as this seems to relate to matching clients to appropriate treatment.
2. Studies involving larger samples are necessary to determine if the findings of this study will be

replicated with similar, larger populations.

3. The treatment approaches of persons working with African-American clients as counselors and other staff needs further study as to their role in the clients recovery.

4. The role of spirituality among African-American clients in recovery needs to be further explored in relation to how spirituality can be effectively used in treatment.

5. There were some clear distinctions in clients' strengths and supports as described by male and female clients. Further research should focus more on gender issues, specifically related to African-American women in recovery. Research should examine if women who have young children have the same treatment outcomes of women without children.

6. Therapeutic groups as a treatment modality with African-American clients should be further explored to determine their long term effectiveness with this population.

7. There is a need for comparative research that studies the success and program components of white treatment programs with Black clients versus the success of Black treatment programs with Black clients.

8. Further studies should examine vocational and employment referrals for African-American clients, specifically males who have successfully completed treatment versus referrals for white clients.

9. Research is needed to examine the relationship between clients' attendance and retention as it relates to successful treatment outcomes based on clients comfort level in specific treatment programs.

10. Further research may be needed to explore the different treatment interventions and approaches that may be necessary when providing culturally appropriate treatment to the diverse ethnic groups within the Black community, particularly those from Caribbean countries.

11. Further research may be necessary to explore issues of clients who have been involved in the illegal drug market in relation to their transition from having materialistic and financial gain to becoming dependent on the welfare system.

12. Further research needs to examine those clients who successfully complete treatment who are mandated versus those who enter treatment of their own free will.

APPENDIX A

Letter to Interview Alumni Clients

Dear ,

I am presently attending the Hunter College of the City University of New York Doctoral Program in Social Welfare. I have decided to focus my research on the Archway day rehabilitation program. My specific interest will be on the program's impact on successfully discharged African-American clients.

One aspect of this study is to interview former clients and staff to obtain observations regarding their experiences with this program. This interview will ask questions about your experience as a client in the day rehabilitation program at Archway (formerly known as WRAP). This study is important because its findings will have a positive impact on treatment of African-American clients both at Archway and other treatment programs.

Your answers to all questions are voluntary and honesty is very important. All answers will be kept completely confidential. The interview will last about forty-five minutes. I will be collecting demographics (age, race, ethnicity, etc.) of the respondents and keeping that data separate from the respondent's responses to protect your confidentiality.

Your responses are very important to the goals of this research. I appreciate your willingness to participate in this study.

Sincerely,

Cheryl Davenport Dozier, CSW, CAC

APPENDIX B

Informed Consent Form

Instructions to the Research Participant:

PLEASE READ THE FOLLOWING CAREFULLY

Participation in this study is voluntary. There will be no penalty or loss should you decide not to participate. Withdrawal from this study at any time, even after you begin, will not affect you in any way.

Your identity as a participant in this research will remain confidential with regard to any publications and oral presentations of the results of this study. Your records in this study will be kept confidential to the extent permitted by law.

Your response will be reported anonymously and your identity disguised if any response could reveal your identity in anyway.

If you believe you have experienced any problems as a result of your participation in the research you should contact:

Ellen Weiner, Director
Yonkers General Hospital
Phone# (914) 964-7972

As a participant, I will be asked to do the following:

- participate in an interview and answer questions about my recovery process in the Archway treatment program. Most questions will focus on the positive aspects of this process.
- identify those internal and external supports and strengths that aided my recovery process.
- consent to the review of my clinical record and the use of some appropriate data from that record.

The following risks may be involved as a result of my participation:

- recalling the recovery process may bring up some painful memories or emotional reactions of your addiction experience and previous attempts at recovery. If this should occur, an Archway counselor/social worker will be available to provide counseling services to you.

Page 2
Informed Consent Form

The following benefits are expected to result from the study:

- to utilize your positive experiences to aid in helping others in their recovery process.
- to document the success of the clients in this program and emphasize that treatment works.

I _____, volunteer to participate in the research study under the supervision of Cheryl Davenport Dozier. I understand the information provided about what I will be asked to do as a participant, and I have had the opportunity to ask questions with respect to my participation. All of the questions I did ask were answered to my satisfaction.

Signature of participant

Date

APPENDIX C

Face Sheet of Demographics (Alumni Clients)

CODE # _____ DATE OF INTERVIEW _____

PLACE OF INTERVIEW _____

1. What is your gender? _____ male _____ female

2. What is your age range? _____ 25 - 34

_____ 35 - 44

_____ 45 - 54

_____ 55 - 65

3. How do you identify yourself racially and/or ethnically?

Race _____ Ethnicity _____

4. How long have you or did you attend the day rehabilitation program? _____

How many years at Archway? _____

5. What is your highest level of education? _____

6. How many years had you been addicted to alcohol and/or other drugs? _____ How many years clean? _____

7. What were your drugs of choice? _____

8. Have you attended other alcohol or drug treatment programs in the past? Yes _____ No _____

If yes, when were you first involved, how many previous treatment programs and, what were the results? _____

APPENDIX D

Interview Questions and Probes - Alumni ClientsCore Question

What are the aspects of the treatment at Archway's Day Rehabilitation Program that contribute to the successful completion of treatment by some African-American clients?

Questions:

1. Please describe your current or past role with Archway and your specific experiences with the day rehabilitation program.
Probes: client, staff, day or evening program, length of stay.
2. What was your opinion of specific aspects of the program such as, Morning Meditation, therapy groups, arts and crafts, community meetings, during your time there?
Probes: positive, valuable, rigid, not useful, crowded.
3. How has those opinions about the program changed since you completed treatment?
Probes: more positive, more negative.
4. Describe the treatment modalities and interventions that you feel were quite helpful to

your treatment success?

Probes: group therapy, individual therapy, relapse, health.

5. What were the factors that you believe contributed to your successful completion of treatment?
Probes: determination, family, consistency, counselor.
6. What types of internal support, such as from staff, peers, the group experience, did you receive while participating in the program?
7. What was the impact of having a predominantly black staff and black counselors in recovery on your recovery?
Probes: comfort zone, familiar, too close.
8. What type of external support, such as from family members, friends, other recovering persons, the rooms, the community at large, the church, temple or mosque, did you receive while participating in the program?
9. How has spirituality influenced your recovery process?
Probes: use of prayer, faith, belief systems, use

of religious ornament such as rosary beads,
statues, the cross.

10. (a) Are you or have you been an active member of twelve step groups, such as Narcotics Anonymous (NA), Alcoholics Anonymous (AA)? Yes ____ No ____
If yes, what was the racial make-up of that group?

(b) Did you have any experiences of racism/bias as a member of a 12-step group? Yes ____ No ____
Describe your experiences?

(c) Describe how have these groups been supportive to your recovery such as through the use of a sponsor, working the steps, sharing your stories, attending meetings?

11. Describe any experiences of racism/discrimination in the past or currently that have an impact on you and/or your recovery?

Probes: childhood or adult experiences, job experiences.

12. Describe any special activities of the program that you recall that were specifically positive, helpful or rewarding to you?

13. Did you participate in the any of the following activities? If yes, please describe the impact or what these activities meant to you?

_____ Kwanza	_____ Monthly parties
_____ Black History program	_____ Basketball games
_____ Community speakers	_____ Client recognition
_____ Rites of Passage group	_____ Arts and Crafts

14. In what ways is this treatment program different than any other treatment program that you participated in or attended?

Probes: staffing, structure, activities, client involvement

15. What kinds of productive activities have you been involved with since you completed this treatment program?

Probes: school, volunteer or paid work, training program, daily family activities such as child care, elder care, or being a homemaker.

16. Is there anything that has not been asked which you feel contributed to your successful recovery?

Probes: self-motivation, spiritual guidance.

APPENDIX E

Letter to Interview Staff

Dear _____,

I am presently attending the Hunter College City University of New York Doctoral Program in Social Welfare. I have decided to focus my research on the Archway Day Rehabilitation Program. My specific interest will be on the African American clients who were successfully discharged with over one year of abstinence.

One aspect of this study is to interview current and former staff to obtain your observations regarding your experiences working with these clients. This interview will ask you questions about your experience working in the day rehabilitation program at Archway.

Your answers to all questions are voluntary and honesty is very important. All answers will be kept completely confidential. The interview will last about forty-five minutes. I will be collecting demographics of the respondents and keeping that data separate from the respondent's responses.

Your responses are very important to the goals of this research. I appreciate your participation in this study.
Sincerely,

Cheryl Davenport Dozier, CSW, CAC

Face Sheet of Staff Demographics

CODE # _____ DATE OF INTERVIEW _____

PLACE OF INTERVIEW

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10. What has been your training in culturally based treatment or Afrocentric treatment?
-

APPENDIX G

Interview Questions and Probes - StaffCore question

What are the aspects of the treatment at Archway's day rehabilitation program that contribute to the successful completion of treatment by some African-American clients?

Questions:

1. Please describe your current or past role with Archway and your specific experience with the day rehabilitation program?
Probes: title, job function, job experience, problems, etc.
2. How would you describe the type of treatment that is provided at Archway to day rehabilitation clients?
Probes: the "clinical approach," addiction model, how it differs from treatment provided to clients in other units.
3. What do you view are the contributing factors that enable an African-American client in the day rehabilitation to successfully complete treatment?
Probes: motivation, external supports (i.e., job, family), being "sick and tired," involvement in

self help.

4. Describe "client strengths" of one or more of the African-American clients who have been successfully discharged? Did they come into treatment with those strengths intact?
Probes: support system, motivation, determination, self-starter.

5. Do you feel that the treatment that is provided to clients in the day rehabilitation program is culturally sensitive? If yes, how? If no, why not? Do you think the clients view it in this way?
Probes: Africentric based, relevant to the client's culture. Define culturally sensitive, process techniques, training.

6. Do you feel that a culturally based treatment approach in a chemically dependent treatment program aid in the clients recovery process? If yes, please explain how? Please give concrete examples of individual clients or situations.
Probes: Is it positive or negative? Is it over sympathetic? Is it enabling?

7. How do the African American clients at Archway's day rehabilitation program know that this program is responsive to their racial/ethnic/cultural issues?

Probes: staff response, What do they see, feel, hear, etc.?

8. What roles do other staff (clinicians, support staff, drivers and administrators), play in the implementation of the cultural treatment approach?

Probes: Name some roles. Are they a part of it? Do they believe in it? Is it supported by the administration?

9. What have you observed the client's relationship or role is with sober or drug-free support systems other than this program? How does this role affect on their recovery?

Probes: self-help groups (NA , AA), church, etc.

10. Do you feel that there is anything that should be added, deleted or changed at the Archway day rehabilitation program which would make the client's have more successful treatment outcomes?

Probes: improvements, additional support for staff/clients.

APPENDIX H

Case StudiesCase Study #1: Client # 15Entered Treatment:

Mr. A., a 34 year old African-American male, living in a men's shelter. Referred to the program by a hospital detoxification program in March, 1991 after completing seven days of treatment.

Chemical Dependency History:

Mr. A. states he began drug use at the age of 15 years by abusing alcohol and marijuana and becoming intoxicated. By the age of 18 years, he began using "hard drugs"-- heroin and cocaine. Other substances abused included speed, LSD, methadone, hash, tranquilizers and crack.

Mr. A's most recent use at time of admission was daily alcohol use of gin, wine and beer, beginning at 6:00 a.m.. Client admitted to alcoholism dependency symptoms of blackouts, delirium tremors (DT's), hallucinations, and insomnia. Clients use of other drugs included IV heroin eight (8) months prior, cocaine (free base) during the past 90 days, and marijuana periodically.

Client was aware that he had a drinking and drug problem at age 28 (1984) when he was spending his total paycheck on alcohol and drugs. Client's use continued over the next six years.

Mental Health:

Mr. A. has had two incidence of attempted suicides in 1986.

First incident: Client was intoxicated and jumped out of a 4th floor window. He stated that he wanted to end it all.

Second incident: Client swallowed a lot of pills as an attempt to avoid facing some pressing issues.

Since 1984, client has been in four mental health treatment facilities.

Medical Health:

Mr. A. received a physical examination upon admission. Client was found to be overweight but in good health. Client had a major injury from a prior stab wound and history of sexually transmitted disease.

Psychosocial History:

Family: Client is a 34 year old African-American male, youngest of seven children. His maternal and paternal family are from the South. His father was born in the Southeast and mother in the Northeast. Father died in 1988 of diabetes and complications after surgery. Client described mother as a "closet" drinker and himself as a child of an alcoholic. Client was raised by grandmother in the southeast from age three months to nine years. His feelings of abandonment and confusion over this were current

mental health issues. Client is unmarried, and has one teenage child.

Mr. A. described himself as the "black sheep of the family" not getting along with mother and siblings mostly due to his drug/alcohol use. Client has one sister residing in the same county who has been very supportive. This mother was fearful of him and he did not allow him in her house. He also stated that he gets along "alright" with his brother of the same faith living out of state. Mr. A. and his father never got along well, due to resentments toward him and he did not attend his funeral.

Religion:

As a young child, Mr. A. went to church every night with his grandmother who was very religious. Client converted to Nation of Islam (NOI), Muslim faith in the 1970's. Mr. A. is currently Islamic but no longer in the NOI.

Education:

Mr. A. had a high school diploma at time of program admission. Client enrolled at the county community college in the spring of 1992, while still in treatment and graduated with an associates degree.

Military:

No military service history.

Employment:

Mr. A. was unemployed at time of admission. His past included a sporadic employment history with longest job held for a period of approximately two years as a food service worker at a hospital. His work skills included: shipping and receiving, food service aide, laborer and sales person. Client admits that he lost many jobs due to his drinking and drug use.

Criminal Justice:

Mr. A. has history of twenty alcohol related arrests in five years prior to admission date. The charges included assault, petty larceny, disorderly conduct, violation of orders of protection, and criminal mischief. Client states that he was under the influence of chemicals at time of arrests.

Chemical Dependency Treatment:

Mr. A's first treatment experience was in 1984--an inpatient treatment program. Client had over six admissions, attended over six detoxification (detox) facilities (local hospital five times) between 1986 and 1990. Client's last detox admission was in March, 1991. Client last drink, a 16 ounce beer was on 3/5/91.

Client's treatment plan was to attend a structured day rehabilitation program five days weekly, five hours daily which provided intensive group sessions, individual sessions, random urinalysis and blood alcohol concentration

(BAC) tests. Client also attended NA and AA fellowships. Client abstained from alcohol and drugs, acquired an understanding of the general and specific effects of alcohol and drugs; developed positive peer support and positive social coping skills. Client was transferred to the clinic program after being accepted into the community college full-time. Client was discharged December 1992. Client graduated from community college May 1994 with an Associates degree in Human Services. Mr. A. has been selected as a youth counselor trainee for a local child welfare agency.

Case Study #2: Client #6Entered Treatment:

Ms. B., a 32 year old African American female, was first assessed for treatment June 1989 and admitted on July 1989. Client was discharged unsuccessfully twice and was readmitted twice. Client was referred to treatment by the local community mental health clinic after an inpatient hospitalization.

Chemical Dependency History:

Ms. B. states she was introduced to marijuana as a teenager. Client began drinking alcohol socially at age 18 in the Army. Client began using crack at age 30 (1987) continuously until hospitalization. Other drugs of abuse included LSD, acid, and PCP. For two years prior to admission, crack and alcohol were used daily when money was available.

Mental Health:

Ms. B. was a patient at a local community mental health outpatient clinic since 1986 diagnosed with Schizophrenia. Client reported that since using crack she has had bad dreams and heard voices. She was prescribed Thorazene 50 mg. and Benadryl 50 mg. by the local mental health clinic. Client was previously prescribed sleeping pills and Prozac. Ms. B. has a history of three suicide attempts; one at age 15 and at 18 years by taking an overdose of sleeping pills. The third time was several months prior to admission.

admission. Client said "voices told her to kill herself". The treatment program psychiatrist diagnosed client as Borderline Personality Disorder and Polysubstance Dependence. Client had another failed suicide attempt by taking an overdose of tranquilizers.

Ms. B. reported a history of depression, troubled childhood with sexual assaults, incest and other abuse from age five to her teens by father, an uncle and, cousin.

Medical Health:

Ms. B. presented no major current medical problems. She had a previous history of gonorrhea, gastritis and current damage to her lungs from the crack.

Psychosocial History:

Family: At time of admission, Ms. B. was a 32 year old African-American female, single divorced mother of two female young children. Client was in serious crisis at point of entry and at risk of losing her children.

Ms. B. is a child of two alcoholic parents who were in recovery. One parent attended same treatment program. Both parents drank during her childhood.

Ms. B. is separated from her husband of seven years. She states relationship was viable until he was discharged from service (Army) and became irresponsible. He is also alcoholic and their current relationship is negative. He currently resides in the Midwest.

Ms. B. reported that she has had few friends. Client says that she was very close to her mother, okay with father and described a loving and very close relationship with siblings.

Religion:

Ms. B. is Protestant and currently attending a local Baptist or Pentecostal church.

Education:

Ms. B. has a high school diploma.

Military:

Ms. B. enlisted voluntarily in the Army in 1976 and received an honorable discharge in 1982. She was an E-5 Sergeant.

Employment:

Ms. B. has had sporadic employment since her discharge from Army. This included working in a restaurant, laundromat and clerical work. Client has clerical skills as a Word processor. Client was unemployed at time of admission. Client was on Aid to Families with Dependent Children (AFDC) and receiving Medicaid health benefits.

Criminal Justice:

Ms. B. was arrested in 7/90 while coping drugs and charged with possession of cocaine. Child Protective Services was notified because she left her youngest child home alone.

Chemical Dependency Treatment:

At first admission (1989), Ms. B. was self-referred after attending a four week inpatient rehabilitation program, a hospitals' inpatient dual diagnosis program, and a one week detoxification at another hospital. Clients previous treatment history included three years as a patient at an outpatient community mental health clinic, an inpatient stay at a Veteran's Administration (VA) Hospital. Client attended detoxification and inpatient rehabilitation during her course of treatment at Archway.

Treatment plan recommendation was to attend outpatient day rehabilitation program five days weekly. Client was enrolled in the day rehabilitation program twice during her treatment. Client was also a part of the outpatient clinic dual diagnosis program and parenting group. Children were enrolled in Children of Alcoholics/Addicts (COA) group, and client and her mother were a part of family program. Ms. B. had several bouts of relapse, suicide attempts and depression.

At time of discharge Ms. B. was an active member of both Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). She was attending a four year college and working at the college full-time.

Case Study 3: Client #8Entered Treatment:

Ms. C., a 32 year old African-American female, referred December 1991 by a community mental health clinic through their employability assessment process. Client reported prior daily drinking and a drug use history.

Chemical Dependency History:

Ms. C. began drinking alcohol at age 15; became intoxicated at age 17; continued drinking and became aware of an alcoholic pattern at age 28. At that time, client was drinking anything (wine, beer or hard liquor), anywhere (on the street, bars, at a club) and all the time, beginning after 12 noon. Client presented a history of blackouts, sleeplessness, sweats, memory loss. Clients pattern was at times sporadic and binge. Other drug use history included marijuana from age 16-30, angel dust from age 18-31 and crack from age 25 (1985) to age 31 (1991). Client reported her last alcohol and drug use in December 1991.

Client became aware that she had a problem and wanted to stop. Client stated that she got "sick and tired." After her older brother died of drugs, she was more traumatized and reached out for help.

Mental Health:

Client denied any treatment, however she had one suicidal ideation where she wanted to end it all.

Medical Health:

Client has a history of high blood pressure and is on medication. Client also has had asthma and arthritis.

Psychosocial History:

Family: Ms. C. is the youngest of five siblings. One brother is deceased and died of drug use. Parents are both living, and are originally from the South. Neither parent had a drinking or drug problem. Client described mother as a very beautiful individual and father as very conscientious. Client was also close to grandmother who was 87 years old. Client stated she is close to her brothers. Client described a wonderful childhood; being showered with gifts of love by her mother.

Client is not married but described a pattern of negative relationships with addictive males. Client has no children.

Religion:

Client occasionally attends a Baptist church.

Education:

Client dropped out high school in the 11th grade. Ms. C. stated that she rebelled against her parents and hung out with the wrong crowd, abused alcohol and drugs. While in treatment, client returned to school and graduated from the G.E.D. program and college preparatory course. Client was accepted to the county community college which she began while still in treatment.

.

Military: None.

Employment: Sporadic work history.

Criminal Justice: None.

Chemical Dependency Treatment:

Ms. C. treatment plan recommendation was to attend outpatient rehabilitation five days weekly. Client attended the day rehabilitation program for four months from April to August 1992. When the client began school, she entered the evening rehabilitation program from September 1992 and attended for ten months. Client did excellent in treatment. At time of discharge, Ms. C. was still attending college full-time and acting in a drama troupe which she began while in treatment.

Case Study #4: Client # 17Entered Treatment:

Mr. D. entered treatment July, 1992 as a 23 year old unemployed African-American male from Jamaica referred by a local mens shelter.

Chemical Dependency History:

Client's drug of choice was alcohol, primarily beer. Mr. D. reported difficulty tolerating liquor. Client drank daily beginning at noon into the evening usually on the street.

Mr. D.'s onset of alcohol was between 10-12 years with his family. At age 12, client had his first intoxication. Client began smoking marijuana at age 10 years with family as part of religious ritual. Client began to abuse marijuana as he got older.

Mr. D. stated that his drinking and smoking pot caused him to have several car accidents and lose jobs. Client admitted to dependency symptoms of shakes, sweats, sleeplessness and blackouts.

Mr. D. acknowledged that he would be more prone to assaultive acts under the influence of alcohol. Client reported a history of a bad temper and fighting since attending middle school. Client recalled drinking while at school on many occasions.

Mental Health & Medical:

Mr. D. has no known mental health history and states

that he is in good health. Client had a physical at the homeless shelter assessment center a month prior to this admission.

Psychosocial History:

Family: Mr. D. is the youngest child of his parents. Mr. D. has nine older siblings. Client was born in Jamaica and came to the United States at age six years. Client describes a wonderful childhood and states "he had everything he wanted." Client describes good relationships with his parents and siblings except when he was drinking. Client has an aunt who lives locally with whom he has a close relationship. Client shared very little about his immediate or extended family initially in treatment. Mr. D. had been involved in a relationship for four years and has a three year old son. Client is not on good terms with the mother of the child but visits his son often. Mr. D. also states that he has a two year old child in Jamaica.

Religion:

Mr. D's family practices a traditional Jamaican religion called "Trailmen". They worship the 12 Disciples and Selassie. Part of their worship experience in their home included the smoking of marijuana.

Education:

Mr. D. was expelled from school in the 11th grade for fighting.

Military: None.

Criminal Justice: None.

Employment:

Mr. D. has had sporadic jobs consisting of cooking, security, driving and warehouse work. Client really enjoys cooking.

Chemical Dependency Treatment:

The treatment recommendation was to attend outpatient rehabilitation treatment five days weekly, five hours daily. Mr. D. began attending the day rehabilitation program on July 1992. Client often isolated himself and didn't share. Client also had several verbal conflicts with other clients lost his temper. Client was usually able to process those behaviors at a later time and shared his desire to improve on his temper, anger and attitude.

Client had difficulty staying sober initially and refused detoxication on one occasion when encouraged to attend. Client had much difficulty accepting that he was an alcoholic and dependent. Client began to acknowledge his family member's addiction and had difficulty being with those person when they were using drugs. Client became an active member of Narcotics Anonymous (NA), secured a sponsor and began attending meetings regularly.

At discharge, Mr. D. was gainfully employed, off public assistance (home relief), 19 months sober and applying to a culinary school.

Case Study #5: Client # 2Entered Treatment:

Mr. E., a 31 year old African-American male was assessed for treatment April 1990 at the age of 26. Client did not follow through initially and was re-assessed in 1991 and re-admitted. He was referred by a criminal justice referral program after being incarcerated for six months. Mr. E. admitted to being under the influence of alcohol at time of his arrest.

Chemical Dependency History:

Mr. E., was diagnosed as alcohol dependent. Mr. E. began drinking alcohol at the age of 14 years with friends. His drinking was periodic initially on weekends and progressed to daily use especially during periods of unemployment. The quantity varied from one pint daily to much more. His current use at time of admission was one to one and a half pints daily of rum/beer (when financial), beginning in morning into afternoon with others or home alone. He admits to dependency symptoms of blackouts and nausea. Mr. E. tried crack/cocaine and used it for about one year. Mr. E. states that he becomes violent and uninhabited when under the influence of alcohol.

Psychosocial History:

Family: Mr. E., a 26 year old African-American male, the third youngest of eight children. Client was deserted by mother and sibling when he was young. Raised by

grandmother and placed in foster homes.

Mr. E. has no relationship with father who was alcoholic. He has limited relationship with mother whom he has been angry with for deserting him; limited relationship with siblings except one sister whom he is close to. Mother drank heavily and then stopped. Some siblings use and abuse alcohol and drugs heavily.

Friends:

Mr. E. had few friends; is shy, quiet person.

Relationships:

Mr. E. has never been married but has had several relationships with women.

Mental Health History:

Mr. E. had two suicide attempts by taking overdose of pills. He was referred to a mental health agency but did not follow up.

Medical Health:

Mr. E. presents with no current medical condition. He had serious injury as a baby.

Religion:

No religious history. Family was Baptist.

Education:

Mr. E. dropped out of high school in the 11th grade.

Military: None.

Employment:

Mr. E. has held several odd jobs and one long term job

for four years at a hotel as a reservation clerk.

Criminal Justice:

Mr. E. was arrested for attempted armed robbery of an automobile where he stole the radio and a gun. He was incarcerated for six months at county jail. He was on probation at time of referral to treatment.

Chemical Dependency Treatment:

This was Mr. E.'s first chemical dependency treatment. He had two admissions and attended the day rehabilitation program for approximately 18 months. His last drink was in April 1991.

Mr. E.'s treatment plan was to attend structured day rehabilitation five days a week.

Mr. E. was transferred to the outpatient clinic two times per week after being referred to an employment program.

APPENDIX I

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Autobiographical Statement

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Dr. Dozier received her DSW from Hunter College School of Social Work, City University of New York, 1994. She received her Masters in Social Work from Atlanta University, School of Social Work, Atlanta, Georgia, 1980. Her B.A. degree in Elementary and Early Childhood Education was obtained from Fairleigh Dickinson University, Rutherford, New Jersey, 1975.

She is currently (1994) an Assistant Professor at the University of Georgia, School of Social Work, Athens, Georgia. She was formerly Associate Director of Outpatient Alcoholism Treatment Programs at Yorkers General Hospital in Westchester County, New York. Her primary role was founder and Coordinator of Archway, an outpatient clinic and day rehabilitation program in Mt. Vernon, New York from 1982 to 1994. In addition, she was an Adjunct Professor at several colleges and universities including Fordham and Rutgers University. She owned and managed a private practice and consultant business.

Dr. Dozier has provided local and national training in many areas including chemical dependency, and cultural diversity. She is active member and officer of many local and national professional, civic, and fraternal organizations. She is the recipient of many professional awards and honors.