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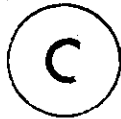
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LA THÈSE A ÉTÉ  
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A FORMATIVE EVALUATION OF THE TREATMENT ENVIRONMENT  
OF A RECOVERY HOME FOR ALCOHOLIC WOMEN

by



Raymond F. Marchand

A Thesis  
submitted to the Faculty of Graduate Studies  
through the School of Social Work in  
partial fulfillment of the requirements for  
the Degree of Master of Social Work at  
the University of Windsor

Windsor, Ontario, Canada

1982

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1982

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RESEARCH COMMITTEE

Doctor Forrest C. Hansen, Chairman

Doctor James Chacko, Member

Doctor G. Anne Foster, Member

## ABSTRACT

The primary purpose of this research project was to carry out an evaluative study of the treatment environment at the House of Sophrsoyne, a recovery home for alcohol and drug dependent women. Particular emphasis was placed on the assessment of the social climate through the use of the Community-Oriented Programs Environment Scale (COPEs) as developed by Rudolf Moos. The project was classified as an evaluation of program implementation and further sub-typed as treatment specification.

A review of the literature was presented on alcohol and it's effects, women and alcohol, and treatment of alcoholism. The remaining topics include halfway houses in general, and the treatment of women and alcoholics in Ontario halfway houses.

Accessibility sampling procedures were employed in selecting the sample. More specifically, included in the study were all the residents (N=10) and all the staff (N=7) participating in the program. Data collection methods included questionnaires, interviews and a review of agency manuals. The researcher used both qualitative and quantitative approaches to the measurement of the important variables that describe the program's treatment environment.

The major findings and conclusions in this research project were that the House of Sophrsoyne program shares many of the common characteristics of a typical alcoholism halfway house. The program is essentially a blend of professional treatment philosophy and the traditional Alcoholic's Anonymous approach. The program objectives and activities were well articulated and the corresponding causal assumptions were plausible. In general, the building, facilities and organizational structure were adequate given the size and nature of the program. The program places higher than average emphasis on relationship and system maintenance dimensions, and significantly higher than average emphasis on personal development dimensions. With the exception of spontaneity, the residents and staff generally agree on the direction of change they wish to see in each of the ten subscale program dimensions.

The researcher recommended that measurable, objective program outcome indicators be established. It was also recommended that additional information be included in the agency's intake sheets, that admission times between individual residents be separated by several days, and that program information forms be used during the orientation process. Another recommendation focused on residents and staff implementing change, by placing more emphasis on seven of the ten subscale dimensions, and working towards a compromise on the remaining three subscale dimensions. Future research on the comparison of alcoholism treatment programs and the establishment of an Ontario normative sample on alcoholism treatment programs was also recommended.

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The research project could not have been completed without the consent or cooperation of Miss Patricia Laforet, Executive Director of the House of Sophrosyne, and the staff and residents in the program. The author also wishes to acknowledge the cooperation and support received from Mr. Gary McCarthy and the staff at United Way, whose advice greatly facilitated the research efforts.

The author wishes to sincerely thank the considerable and invaluable contribution made by his sister Michele, who typed this thesis in it's entirety.

Finally, sincere thanks are extended to his family and friends whose conviction in his ability served as added dimensions of inspiration and confidence.



## DEDICATION

This thesis is dedicated to:  
my wife Vicki, whose love and  
support has made all of this  
possible, and to my son Andrew,  
whose recent entrance into my  
life has truly been a gift  
from God.

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## CHAPTER I

### PROBLEM IDENTIFICATION

The House of Sophrosyne, a Recovery Home for alcohol and drug dependent women, is located in the City of Windsor, Ontario, and serves both the City and the County of Essex. A heavily industrialized city of approximately 200,000 people, Windsor is often characterized as the centre of Canada's automotive industry and as the country's most southern city with hot summers and relatively mild winters. Windsor was initially a French settlement, with its prime farm land and the surrounding Great Lakes providing the main attractions to the early settlers.

The House of Sophrosyne has been in operation since November 1, 1978 and has provided a number of services to the community regarding problems associated with alcohol and drug abuse. Dedicated individuals connected with the twelve facility have demonstrated a continuous effort to improve the treatment program, as well as other aspects of the agency.

Preliminary discussions were held with the Executive Director of the House of Sophrosyne in order to define what needed to be studied. The problem for research was identified as, an evaluation of the House of Sophrosyne program. As stated by Rossi, Freeman and Wright (1979):

Evaluations may be undertaken for a number of different reasons. They may be undertaken for management and administrative purposes, to assess the appropriateness of program shifts, to identify ways to improve the delivery of interventions, and to meet requirements of funding groups who have fiscal responsibility for allocation of program monies. They may be undertaken for planning and policy purposes, to help decide on either expansion or curtailment, and to reach decisions on whether to advocate one program or another. Finally, they may be undertaken to test a particular social science hypothesis or a professional practice principle - the particular program in this case may be mainly a matter of convenience. (p. 21)

In general terms, the Executive Director was viewing an evaluation from a management perspective. She was seeking information that would help to identify the more important elements of the treatment program and consider ways to improve the delivery of the program interventions.

According to Patton (1978) the evaluator's role serves an "active-reactive-adaptive" function. The evaluator is not alone in making the choices about nature, purpose, content and methods of evaluation. Identifiable decision makers and information users share the responsibility of decisions with the evaluator. Several basic questions must be considered when attempting to identify and focus the evaluation question. What is the purpose of the evaluation? How will the information be used? What will be known after the evaluation that was not known prior to the evaluation? In short, the evaluation needs to generate useful information for the decision makers and information users.

The identified decision makers and information users in this study were members of the Program Committee and the Executive Director of the House of Sophrosyne. In discussions with the evaluator they were able to identify and recognize that the treatment environment

was a key component in the residential program. Thus it was determined that characterizing the treatment environment of the House of Sophrosyne would not only provide an overview of the nature of the treatment environment, but would also assist the Executive Director and the Program Committee in identifying those dimensions or elements of the treatment environment which are either adequate or in need of improvement. The study would also act as a starting point, from which to implement future treatment environment evaluations.

Future evaluations can be compared to the initial evaluation in order to measure the degree of change of the various environmental dimensions over a period of time.

In order to focus more clearly the direction of the research and the formulation of the research questions. The Review of Literature chapter will examine the causes, effects and extent of alcoholism, and the use of halfway houses in the treatment of alcoholism. An understanding of alcoholism and its treatment will assist in determining which dimensions or elements of the treatment environment at the House of Sophrosyne need to be considered. Following this will be a review of the literature which will highlight the importance of being able to characterize the treatment environment and what are some of the more salient dimensions which need to be considered when evaluating the treatment environment.

The section on Problem Formulation will draw together the significant issues related to both the treatment of alcoholism and the evaluation of the treatment environment in order to establish the rationale for the research questions to be used in the study.

4

The research questions will focus on the areas of the treatment environment that are considered to have the most impact on the residents and staff at the House of Sophrosyne.

The Research Methodology chapter deals with the classification of the research project, how the actual research will be operationalized, and the limitations, reliability and validity issues pertinent to the project.

The Data Analysis chapter will analyze and describe the information collected on the physical and social environment of the House of Sophrosyne.

Chapter five outlines the conclusions made regarding the treatment environment of the House of Sophrosyne, as well as making specific recommendations to improve the treatment environment.

The final chapter is a summary of the major findings and recommendations regarding the treatment environment of the House of Sophrosyne.

## CHAPTER II

### REVIEW OF THE LITERATURE AND PROBLEM FORMULATION

Alcohol is the most widely used psychoactive drug known to man. Going back to the early civilizations; the Romans and Egyptians and even the Stone Age prehistoric man. The use and misuse of alcohol has been almost universal.

### ALCOHOL AND IT'S EFFECTS

In 1973 the Commission of Inquiry into the Non-medical Use of Drugs classified a number of drugs based on their effects. Alcohol was classified as a "sedative-hypnotic" (p. 282) drug. Other drugs such as barbituates and tranquilizers were also classified under the same category.

Alcohol is the term employed to refer to "ethyl alcohol" the chemical which produces the effects on humans. The amount of ethyl alcohol in the different types of alcohol beverages are;  
beer and ale - 4 to 8 percent, table wine - 11 to 14 percent,  
fortified wine - 18 to 23 percent, spirits - 35 to 50 percent  
(Grant and Gwinner, 1979, p. 12).

Alcohol is rapidly absorbed into the bloodstream and dispersed throughout all the tissue fluids and thus has ready access to all

organs. Alcohol readily infiltrates the cells of the central nervous system. Alcohol exerts important effects on thinking, feeling and behaviour. According to Grant and Gwinner (1979) alcohol is also a rich source of energy, yielding more energy than an equivalent amount of protein or carbohydrate and only slightly less energy than an equivalent amount of fat. However, it is a poor food source, since it lacks proteins, vitamins and other essential nutrients.

#### SHORT TERM EFFECTS

At low dose levels alcohol has a stimulating effect on the brain, but this is soon overtaken by a depressant action which affects areas of the brain responsible for the integration and control of complex thinking, feeling and behaviour. Such effects depend to a large extent on the individual and the situation in which the drinking occurs. The effects may include one of the following; drowsiness and lethargy, the lessening of inhibitions, feelings of well being, sociability, the relief of tension and anxiety, hostility and aggression.

At low dose levels alcohol may relieve feelings of anxiety and depression, at higher levels there is a strong tendency for these feelings to be worsened.

At higher dose levels thinking becomes slow and superficial, learning and retention of information becomes faulty. Less attention is paid to both external and internal stimuli. Delusions, illusions and amnesic blackouts may occur with high doses in some individuals. Heavy alcohol use is often followed by hangover symptoms including nausea, fatigue, dizziness, poor coordination, headache, heartburn,

and other aches and pains. Anxiety, guilt and depression may also occur. The frequency and intensity of such symptoms tend to increase in proportion to the amount of alcohol consumed.

LONG TERM EFFECTS

Both the Commission of Inquiry into the Non-Medical Use of Drugs (1973) and Grant And Gwinner (1979) provide an extensive discussion on the long term effects of heavy alcohol consumption.

Heavy drinking frequently leads to a variety of psychological and physiological difficulties.

The physical health of heavy alcohol users is often poorer than the general population. Some illnesses may result from the direct effects of alcohol, or due to such factors as general life style, nutritional deficiencies, heavy use of other drugs, injury due to accidents, inadequate hygiene and rest, and over exposure. Other long term effects of alcohol on the body include, short-term memory loss, cirrhosis of the liver, inflammation of the stomach lining, and anaemia.

The development of tolerance and dependence are two important effects of the chronic consumption of alcohol.

Tolerance refers to the need to consume more alcohol in order to produce the same effect.

Dependence is when the person's thinking is dominated by thoughts of alcohol and how to obtain it, when the person is no longer able to choose whether or not to have a drink, the person feels that they must have a drink. (Grant & Gwinner, 1979, p. 18)

Withdrawal symptoms in the physically dependent alcoholic include tremulousness, convulsions and delirium. Such symptoms can also occur

while the alcoholic continues to drink.

Tremulousness, or the "shakes" vary in severity and may be accompanied by nausea, weakness, feelings of apprehension and a tendency to startle readily.

Grant and Gwinner indicate that the most severe form of withdrawal symptoms is "delirium tremens" and constitutes a life threatening situation. Such a situation is characterized by persistent tremulousness, extreme restlessness, increased perspiration rapid pulse and a slight rise in body temperature. The individual's thinking is confused and she suffers from hallucinations. The emotional state of fear and distress in response to these experiences is either aggressive or suicidal behaviour.

Psychological dependence on alcohol occurs in many individuals. People turn to alcohol for relief prior to or after facing a stressful situation, to escape worries, troubles or boredom, to relax and enjoy a party, to sleep. "There is a strong psychological component in the drinking behaviour of the developing alcoholic as his drinking becomes more and more compulsive in spite of the obvious consequences" (Commission of Inquiry, 1973, p. 405).

Finally, the excessive use of alcohol has consequences for others in society, such as increased numbers of automobile accidents, resulting in increased injury and deaths, increased costs to society by way of legal, court, medical and insurance costs, and increased problems and hardships for the family of an alcoholic.



## ALCOHOLISM

"Scientific studies of alcoholism have been hindered not only by the emotionalism which surrounds the subject, but also by the widely different meanings, definitions, and biases characteristic of terms related to alcohol and its use" (Kinsey, 1966, p. 15).

Despite the controversy over the meaning of alcohol Kinsey cites the World Health Organization's definition of alcoholism. "Alcoholism is a progressive, chronic behavioral disorder manifested by repeated drinking of alcoholic beverages in excess of dietary and social uses of the community resulting in an increasing dependence upon alcohol and leading to physical, emotional and social disorders" (1966, p. 13).

The Ontario Blue Cross (1976) discusses alcoholism in a manner consistent with the preceding definition. There are a number of symptoms which indicate the progress of alcohol dependency. First, firm drinking patterns develop. Second, the drinking within this pattern is markedly increased. Third, the increased alcohol consumption increases in frequency. Fourth, alcohol consumption becomes central to one's life, despite the individual denying such a dependency. In this sense, the individual loses control over their drinking behaviour. As loss of control becomes more complete it reaches the point where a single drink can trigger off a chain reaction of drinks.

## CAUSES OF ALCOHOLISM

Considering that the definition of alcoholism is itself subject to

some controversy, it is reflected in the theories about what actually causes alcoholism (Goldstein & Linden, 1969; Replogle & Hair, 1977; Roebuck & Kessler, 1972).

Both Kinsey (1966) and Grant and Gwinner (1979) describe three major categories of theories regarding the cause of alcoholism.

First, the physiological hypotheses which are biological models of alcoholism which focus on the pharmacological properties of alcohol and its effects on the central nervous system. Due to metabolic defects and genetic predisposition the individual is more sensitive to the effects of alcohol.

Second, psychological hypotheses which show a marked influence from Freudian and Adlerian schools of thought. Such theories rest on the assumption that alcoholics share certain personality traits or tendencies believed to be of crucial importance in the development of the disorder. Such a view has developed an "alcoholic personality" in which a constellation of traits, attitudes and aptitudes constitute a psychological vulnerability to develop alcoholism.

More recently attention in this area has focused on the misuse of alcohol as a learned maladaptive behaviour.

Third, sociological hypotheses, which explore the strong empirical relationships that exist between socio-cultural variables and the incidence of alcohol use and dependence. The reasons why an individual drinks are primarily sociological and anthropological. In this model occupational factors, ethnic factors, familial factors, stress and the availability of alcohol significantly contribute to alcoholism.

Rates of alcoholism can be influenced by the cultural patterns in three ways. "The degree to which the culture operates, to bring

about acute needs for adjustment or inner-tensions in its members... The sort of attitudes toward drinking which the culture produces in its members.... The extent to which the culture provides suitable substitute means of satisfaction" (Kinsey, 1966, p. 40).

Kinsey has developed a "symbolic-interactionist" perspective which has a set of psychosocial conditions associated with alcoholism. In this theory there is a combination of three main factors; a core personality which acts as a predisposing factor, the use of alcohol as the culturally defined solution to tension and anxiety, and the emergence of a vicious circle in which the use of alcohol creates a dependence upon this form of tension and anxiety management.

In conclusion, reasons for consuming alcohol in addition to its pharmacological properties are the many longstanding customs, traditions and superstitions.

It is symbolically associated with the acknowledgement of birth, death, marriage, and other contracts, adulthood and friendship. It may imply masculinity, affluence and cultural refinement, or the opposite.

Considering the various attitudes which interact with the diverse pharmacological potentials of alcohol in understanding the overall drug effect, the complexity of alcohol's effects become apparent.

ESTIMATE OF ALCOHOLISMCANADA

The Le Dain Commission in its report on the non-medical use of drugs cites the prevalence of dependence on alcohol in Canada as one hundred times greater than dependence on narcotics.

It is estimated that 5.45 percent of the drinking population in Canada, that is about 617,000 persons consume a 'hazardous' amount of alcohol, defined as 100 ml (about 3 1/2 ounces - equivalent to about five social drinks) of absolute alcohol per day... Between the years of 1959 to 1968, deaths in Canada due to alcoholism increased by 74.8 percent for males and 107.4 percent for females. (1972, p. 42)

ONTARIO

Based on data for deaths ascribed to cirrhosis or alcoholism, and sales volumes of alcoholic beverages in 1976 there was an estimated 229,300 alcoholics in Ontario or approximately 3.89 percent of the population 15 years and older.

"It is anticipated that the number of alcoholics in the province will continue to increase as a result of both increased size of the drinking population and increased per capita consumption" (Marshman, 1978, p. 1).

WINDSOR

According to Rush, Timney and Ekdahl (1980) in 1979 the estimated range of alcoholics and the prevalence rates per one thousand adults in Windsor were; 8,438 to 9,788 and 34.82 to 40.39 respectively (p. 55).

WOMEN AND ALCOHOL

Recognition of sex differences in drinking patterns and alcoholism is continuing to develop. Previously women alcoholics were considered to be non-existent or the same as male alcoholics. Knowledge of, and research on female alcoholism is in no way as extensive as that on male alcoholism. Investigations into the female alcoholic has been undertaken in a limited fashion (Badiet, 1976; Burtle, 1979; Burton, 1976; Cooperstock, 1976; Fraser, 1976; Kinsey, 1966; MacLennan, 1976; Sandmaier, 1980).

There is a particularly harsh stigma attached to female alcoholism. "As women are historically the guardians of social values, their abuse of alcohol is seen as a threat to family stability: When they deviate from the female role, they are even more threatening than their male counterparts" (MacLennan, 1976, p. 58).

Alcoholic women are considered sicker than the alcoholic men. They seem to have more basic personality disorders, being more hostile, angry, self-centered, depressed and emotional than males. The notion of being sicker may be a reflection of societal attitudes toward women. According to MacLennan, women tend to share society's opinion and are likely to suffer more self-loathing and self-contempt than men.

This double standard, like any sex-based double standard, is rooted in the dichotomous roles of men and women in our culture which demand a radically different and mutually exclusive set of behaviours for each sex.

The double standard on alcohol abuse does more than keep the problem drinking woman invisible. She is likely to internalize her culture's harsh judgement of her and learn to view herself with

hopelessness and hatred. Studies repeatedly show that alcoholic women suffer significantly more guilt, anxiety, and depression than alcoholic men, have lower self-esteem, and attempt suicide more often. (Sandmaier, 1980, p. 9)

Although alcohol is a depressant, it first works on those brain centres which inhibit behaviour. Thus impulse behaviour is increased. By current cultural standards such unsocialized behaviour released by alcohol is identified as being masculine in nature.

The female alcoholic is viewed as failing to fulfill her nurturing role, unable to care for children and husband. An alcoholic woman is seen as a failure as a wife, a mother, and as a woman.

MacLennan (1976) undertook an extensive review of the literature on the subject of female alcoholism. Some of the information which she found included; the higher divorce rate for alcoholic women than the general population; husbands of alcoholic women are four times more likely to be alcoholic versus wives of male alcoholics; husbands of alcoholic women are more likely to deny the problem or to terminate the marriage compared to wives of alcoholic men; a women alcoholic's feelings about children are an important factor in her feelings about herself. Intensifying the feelings of guilt and self-contempt, women use more psychotherapeutic drugs than men.

MacLennan goes on to indicate that the reasons for women taking more drugs than men is related to the physician's attitudes which reflect the values of society more than medical or scientific information. "Doctors are in a position of having to balance the time available for practice against the time demanded for medical care. Prescribing is at least a means of terminating the interview in a manner that satisfies both doctor and patient" (MacLennan, 1976, p. 71).

Burton (1976) takes this issue a bit further by indicating that despite the notion of the female alcoholic being more difficult to detect than the male counterpart it would be misleading to suggest that women do not make attempts at resolving their problems. The main difference lies in the type and source of assistance which they seek. The female alcoholic tends to seek help with marital, financial or parent-child problems by approaching clergy, family physicians, psychiatrists, and so forth. With the highest proportion of women seeking help from physicians, the tendency is for women to be diagnosed as a neurotic or having a psychiatric disorder.

Another important characteristic which is fairly common among women alcoholics is summarized by Burtle (1979). "Women appear to telescope the time scale of developing alcohol problems. They typically have begun to drink at a later age than men, but both sexes have been about the same age at hospital admission for alcoholism" (p. 9).

The extent of female alcoholism in Ontario is at best a rough estimate. The proportion of male to female alcoholics in 1973 was 6.5 to 1. Admissions to hospitals for men and women diagnosed as alcoholics in 1973 was 5.6 to 1 (MacLennan, 1976, p. 64). Marshman (1978) estimates that women constitute 25 to 35 percent (55,000 to 80,000 persons) of the total alcoholic population in Ontario (p. 26).

Considering the processes of identification, problem assessment, establishment of treatment goals, and the selection of treatment approaches it is necessary to take into account the particular characteristics of alcoholic women and the differences between alcoholic women and men. Alcoholic women tend to have different patterns of interaction with resources in the community when compared to alcoholic men.

### SELECTION OF TREATMENT

In Ontario the position on treatment of alcoholics is based on a set of general goals of treatment; "to arrest the processes of deterioration, to effect optimal repair of existing damage, and to assist in developing an altered lifestyle which will facilitate the development and maintenance of an improved state of physical, mental, and social well-being" (Marshman, 1978 p. 6).

However, the nature of the treatment approach is dictated by the described characteristics of the condition under consideration. The importance of such characteristics are described by (Groupé, 1978; Kissin, Platz & Su, 1970; Krimmel, 1971; Marshman, 1978; Mayer & Black, 1974; Pattison, Coe & Rhodes, 1969; Robinson, 1979; Schmidt, Smart & Moss, 1968; Smart, Brown & Blair, 1980; Vogler, Compton & Weissbach, 1975), and a host of other researchers and experts in the field.

There are a variety of approaches to the treatment of alcoholism. Knowledge of patient variables, such as social economic functioning, social class, and so forth can be used to select appropriate treatment for different groups of alcoholics.

Mayer and Black (1974) point to the social class of the individual as influencing his or her attitudes toward drinking, and to a certain extent, the types of treatment that will be accepted and used by the individual. They indicate that the lower class, as a group, have fewer organized social interactions, use less verbal communication and place fewer formal restrictions on behaviour than do the middle or upper class.



The skid row alcoholic is not attracted to A. A. due to demands of regular attendance, verbal interchange about problems and the lack of the social and economic supports required by such individuals.

The upper class tend to reject the abstinence from alcohol as a goal of treatment, and to avoid public exposure or interaction with other levels of society they wish to avoid.

On the other hand the group therapy approach to A. A. has a particular attraction to the middle class.

The lower class tend to be attracted to drug therapy. Many appreciate treatment given in a simple authority-oriented framework without discussion of underlying problems.

Behavioural conditioning aimed at abstinence or controlled drinking tends to be favoured by middle and upper class individuals. Enduring discomfort in the present in order to feel better later is the underlying premise to this technique.

Schmidt, Smart and Moss (1968) studied the influence of social class and concluded: "First, drinking patterns and clinical picture of alcoholism differed among the three social classes, secondly, the therapies recommended and administered were affected by the alcoholic's class position" (p. 92).

In short, the treatment approach selected must take into account the salient characteristics of the alcoholic individual.

Without disregarding the uniqueness of each individual, Vernon Johnson (1980) presents the concept of a universal alcoholic behaviour pattern. This is not to be confused with an "alcoholic personality", which considers certain individuals to be psychologically predisposed to becoming alcoholic. Rather it recognizes the fact that certain

identifiable and consistent behaviour patterns exist in the overall behaviour patterns of the alcoholic individual, regardless of the individual's background. It is in recognizing the alcoholic's problems and "game-playing" that Johnson characterizes the stages of treatment in alcoholism: (1) Recognition of the problem by the individual and acceptance of help (2) Detoxification from alcohol (3) The education of the individual in order to develop an understanding of the primary nature of the chemical dependency syndrome. The explosion of myths. The emotional and psychological effects of the chemical dependency are given specific attention. This includes the operations of psychological defense systems, and the emotional effects of desocialization (4) Examination of value systems and the contradiction of those values by the emotional effects of behaviour. Resolution of value conflicts are considered (5) Spiritual impoverishment is described and resolutions are made clear (6) Communication problems are considered, and constructive communication skills are developed (7) The twelve steps of Alcoholics Anonymous are presented (8) The goals and methods of treatment are described to minimize resistance and misunderstanding. To maximize commitment to cooperate in treatment and accept responsibility for their own recovery (9) The use of the group process; to identify the person's defenses and describe them in ways that will give them an opportunity to recognize themselves; to understand and appreciate oneself and others as feeling human beings (p. 68).

Johnson (1980) goes on to describe four stages of recovery in the treatment process: (1) Admission of the problem signifies that the individual has accepted reality that he or she requires treatment for chemical dependency. (2) Compliance, the individual accepts the

reality of his or her problem but tends to not accept personal responsibility for recovery. (3) Wholehearted acceptance of personal responsibility for recovery. Yet there remains an element of unrealistic expectations. (4) Surrender, acceptance of problem coupled with more realistic expectations about the future.

Johnson's approach to therapy for the alcoholic considers the whole person. The alcoholic is considered to be suffering emotionally, mentally, physically, and spiritually.

#### HALFWAY HOUSES

Descriptions of halfway houses and the significant contributions which such facilities make in the overall human services network are discussed by a number of authors, including (Almond, 1971; Almond, Keniston & Boltax, 1969; Glasscote, Gudeman & Elpers, 1971; Lansing, Marans & Zehner, 1970; Ogborne, 1978; Raush & Raush, 1968).

The development of the halfway house is characterized by many historical influences which in turn reflect the diversity of the types of halfway houses which exist today. A universal definition of a halfway house is difficult to apply considering the wide range of residential programs with quite different aims and practices. Some halfway houses only admit persons discharged from a hospital or a prison for the purpose of assisting the individual in his or her transition from institution to community. Other halfway houses admit persons off the street, serving as a crisis centre. Some encourage lengthy stays while others only permit stays of short duration. Some houses have highly structured therapeutic programs, while others emphasize a homelike atmosphere.

A common point of agreement amongst most halfway house operators is that halfway houses serve as transitional facilities for a variety of individuals. Halfway houses are often an intermediate step between institutional placement and living in the community.

The effects of institutionalization on individuals was first noted and efforts made to ameliorate the situation in the eighteenth century by Philippe Pinel. He began to remove the chains from those incarcerated in mental institutions. His reformation discovered that insanity was curable by mildness of treatment and attention to the mind alone. Failure to place emphasis on humane treatment would cause the insanity to become even more established and incurable.

This trend did not last and tended to disappear with the industrialization of the world and the popularized "Darwinistic" thinking. The movement did not take root again until the 1950's in England, when the notion of the "therapeutic community" was espoused.

There were six basic elements characterizing the therapeutic community.

1. The total social organization - not just the doctor-patient relation - is seen as affecting therapeutic outcome.
2. The social organization is not simply a background but a vital force, useful for creating a milieu that will maximize therapeutic effects.
3. The notion includes opportunity for patients to take an active part in the affairs of the institution-democratization in various forms.
4. All relationships within the hospital are regarded as potentially therapeutic, including those among the patients themselves.
5. The atmosphere or emotional climate is recognized as important.
6. Communication per se is highly valued. (Rausch & Rausch, 1968, p. 13)

From such concepts, the environment was beginning to be recognized

as having important therapeutic potential.

Raush & Raush (1968) go on to describe some of the more prominent features of the halfway house. They indicate that as much as 80 percent of halfway houses are found in urban-residential areas. This not only reflects the increasing urbanization of the general population but also suggests the transitional function halfway houses ascribe to themselves.

There is a high degree of diversity possible for potential halfway house facilities. Use of big old residences for halfway houses increases the availability of such facilities in urban-residential areas, and the cost is likely to be less than new construction.

Furnishings and room arrangements are reflective of a home environment in terms of variability, freedom of movement and privacy.

Often limitations in recreational facilities are intended, in order to involve the resident with the community in interactions which may help towards community re-integration.

Most halfway houses are small organizations allowing for relatively simple administrative staff structures. This means that relations among residents, and between staff and residents are likely to be more immediate, more direct and more personal than in larger organizations. The halfway house can adapt closeness and distance to the residents wishes and needs.

The small size of a halfway house tends to demand more of individual members. The demands may be too great for a particular individual, and the addition of new members will have a greater

effect on a small group.

With respect to the administrative structure of halfway houses, "data suggest that there is no specific professionally based training presently directed toward the management of a halfway house" (Raush & Raush, 1968, p. 95). Although social work appears to be the predominant single profession among trained directors, there remains to be a variety of disciplines involved.

According to Raush and Raush two thirds of the houses have immediate supervisors that are nonprofessional and usually have a close working association with a professional organization or with one or more individual professionals on an advisory or consulting basis. In addition, many houses have an administrative board which deals with policy issues and serves as a resource in a number of pertinent administrative areas of the house.

Regarding the selection of new residents, most houses have some formally established procedure for application and admission to the program. Before admission, an introductory orientation visit usually takes place in most houses for each prospective applicant.

Codes of behaviour differ from house to house. Houses that have unwritten rules stress the need for less regimentation, de-emphasize institutional characteristics. Houses with written rules support the view of the residents need for structure. They argue that residents need to know very clearly what is expected of them, and that by removing some ambiguity from the living situation they simplify life and provide security.

Common amongst all houses are rules which relate to communal

living, issues of medication, the sharing of work, maintaining one's own room.

The primary method for the enforcement of rules is that of social pressure. Discussion about the undesirable behaviour is usually employed. If discussion is ineffective in resolving the issue; then as final recourse the resident will be asked to leave the house. The removal of privileges is also an occasional enforcement device. The enforcement of rules does not represent that of a family model nor that of an institution. "There is nothing wholly unique about the way halfway houses handle rules - except for the quality of in-betweenness" (Raush & Raush, 1968, p. 129).

With a commitment to bring residents into a closer integration with the general community, the issue of employment is considered. Depending on the halfway house philosophy, obtaining work or enrollment in a vocational training program is encouraged or expected.

During the course of a resident's stay in a halfway house, the interchange between residents and staff focus on issues of direct life experience. Providing numerous opportunities to point up "reality" issues and to help the resident differentiate what is real from what is fantasy.

Raush and Raush point out that most halfway houses set a fixed time limit for length of stay in the program, which is made known to incoming residents. The belief is that fixed time limit acts to encourage the residents' orientation toward independence and to enhance their progress in the time allotted.

Easing the departure has been approached in several ways. The most common method is a gradual departure, either by encouraging

visits and participation in the house social events by newly separated members or by having the former resident live nearby.

Premature departures by residents suggest that they were perhaps mis-selected for the particular house. The individual may reject the values, the social atmosphere or the work emphasis of the house.

Although the initial growth in the establishment of halfway houses arose from the need for transitional facility for ex-patients discharged from mental hospitals, more recent developments reflect the importance placed on the environment.

Raush and Raush outline two models which reflect the house structure. First, the traditional medical model, in which the house serves as a neutral or supporting environment where progress is given time and an opportunity to occur. But the corrective process takes place outside the house.

Second, the sociological model, in which the house program itself is designed to play the major active role in the corrective process. The house events and relationships are structured so as to produce conditions and provide experiences which effect significant changes in the residents.

Some halfway houses also serve a supportive function for those who may never be able to live wholly independently.

Halfway houses have a range of approaches from educative to integrative, from using the tasks of daily living to provide opportunities for socialization, to therapy programs which emphasize re-organization, insight, and self-realization. "The small number of people, the relative lack of hierarchical structure, the intimacy of arrangements, all enhance flexibility in approaching problems.



As needs arise staff can shift rapidly from focus on the house as a whole to focus on an individual, or from focus on problems of socialization to focus on problems of personal integration" (Raush & Raush, 1968, p. 204).

#### ALCOHOLISM HALFWAY HOUSES

Halfway houses for alcoholics had received little attention until the 1960's when there was considerable growth in their numbers. Descriptions on alcoholism halfway houses are found in Baker, Sobell & Sobell, 1976; Cahn, 1969; Le Dain, 1973; Orford, Hawker & Nicholls, 1975.

Initially halfway houses for alcoholics lacked varied or innovative services, and had very little association with professionals or health or social service agencies. The main affiliation was with Alcoholic's Anonymous or religious groups and churches.

The major characteristics of the alcoholism halfway houses which are considered as "therapeutic communities" include: (1) Demanding total abstinence, (2) Emphasizing the "here and now" rather than events in the past, (3) Forcing the alcoholic to accept responsibility for his or her behaviour, (4) Stressing the participation in small group encounters which confront the individual with aspects of his behaviour and use peer pressure to modify his or her conduct, (5) Relying heavily on the influence of reformed alcoholics.

Burtle (1979) outlines the objectives which need to be included when helping the woman alcoholic. They are to assist her in self-acceptance of both her strengths and weaknesses; reducing guilt

and selfblame; increasing her frustration tolerance level; rechanneling hostility and rage in a constructive manner, rather than dealing with anger by supressing it and becoming depressed or at the other extreme having total lack of impulse control; providing assertiveness training, helping her to develop alternative lifestyles and behaviours to gain confidence in and act on their own choices.

In the majority of alcoholism halfway houses the Acoholic's Anonymous philosophy remains influential. Members are urged to "work the twelve steps", the major mode of AA activity which is considered the basis of the recovery program. The step activities can be categorized as surrender, alliance with a Higher Power, settling with the past, self-analysis, maintenance of a good spiritual condition and lifestyle, and working with others.

Ogborne (1978) indicates that AA-oriented halfway houses have traditionally not been designed for the skid row alcoholic. Such alcoholics although not specifically excluded have not elected to take up residence in large numbers. In short, the AA philosophy tends to appeal to alcoholics whose drinking history follows the AA pattern and who have fallen from social grace.

Large numbers of publicly funded halfway houses is only a recent development, largely as the result of negative reactions to institutionalization.

Halfway houses with professional input tend to be more treatment-oriented than either AA-oriented or church operated houses. In treatment-oriented halfway houses the residents length of stay is usually limited to a few months but such houses also encourage continuing contact after discharge.

Debatable issues which continue to remain in the alcoholism halfway house scene are issues of resident selection: skid row versus those who have not hit rock bottom; staff selection and training: recovered alcoholics versus professionally trained and educated individuals; the in-house program: homelike versus a structured treatment program; length of stay: from three months, to a year, to as long as needed.

However, like halfway houses in general, there is a consensus regarding certain issues, including: abstinence; the desirability of follow up; of resident participation in running the house; and residents making an effort to pay their own way.

#### ALCOHOLISM HALFWAY HOUSES IN ONTARIO

Ogborne (1978) estimated that Ontario has approximately 50 halfway houses for alcoholics, with an estimated approximate total of 960 beds for men and 180 for women. There is also a small number of long stay, three quarter way houses and many short stay hostels such as those run by the Salvation Army.

The vast majority of Ontario's alcoholism halfway houses were originally founded by AA of church groups. The Ontario Ministry of Community and Social Services support 21 houses, seven of which were opened with Ministry assistance.

Most Ontario halfway houses are affiliated with the Ontario Alcoholism Recovery Homes Association which was founded in 1973. The Association has developed standards of operation.

The Addiction Research Foundation of Ontario plays an important role in the halfway house network, including the development and monitoring of house facilities and the training of house staff.

As of 1973 the Ministry of Community and Social Services regard the following statement as the goal of halfway houses. "The purpose is to ensure that the halfway house residences for alcoholics utilize rehabilitative means to achieve rehabilitative objectives. The residences are not to serve as chronic care homes for alcoholics; they are to serve as home centres from which the individual can re-establish himself in the community" (Ogborne, 1978, p. 17).

The Ministry of Community and Social Services established the following as relevant to the rehabilitation of clients and to the evaluation of halfway houses: "(1) reduction in arrests for drunkenness, (2) increased employment, (3) improved accomodation, (4) improved money management, (5) greater involvement in recreational activities, (6) decrease in marital discord and in deviant behaviour" (Ogborne, 1978, p. 17).

Statements by both halfway house directors and the Ontario Alcoholism Recovery Homes Association stress that such houses are transitional residences and not chronic care. The position of the Association is that, "programs and services are designed to assist residents to change their modes of behaviour and patterns of thinking to forms which are constructive to themselves and others, legally and socially acceptable, responsible, and non-dependent on alcohol" (Ogborne, 1978, p. 18).

Although there are some differences of opinion on specific rehabilitative goals, the staff of halfway houses generally accept the rehabilitative goals.

In addition, the staff focused on bringing about a change in the client's attitudes, referring to such areas as: "(i) to make residents happy, (ii) to make residents feel that this (the house) is a place where people care about them, (iii) to give residents a realistic picture of themselves, (iv) to help residents develop self-respect, and (v) to give residents a better understanding of the social situations in which they find themselves" (Ogborne, 1978, p. 19).

Items concerning "process" goals were also identified by staff, ranging from involvement in Alcoholics Anonymous, to the development of social and home life skills, to the provision of food and shelter.

When the issue of house funding was presented to staff, the greater majority of staff indicated that house performance should not be based on outcome criteria but rather on "process goals", such as running a good program.

The Ontario halfway houses like alcoholism halfway houses in general, were divided into two different philosophical approaches. The unstructured AA house or the highly structured, specific people changing technique type of house.

In a study conducted using an all male sample, several factors were found to be associated with duration of stay in a program and successful discharge. These factors were: "(1) resident skid row involvement, age, age related factors, and work involvement, (2) whether or not a house had a structured program, and (3) source of referral"

(Ogborne, 1978, p. 24).

Men who were self-referred or referred from a hospital program tended to stay longer. With the exception of the skid row character, all types of men tended to stay longer in houses with structured programs. Men with skid row characteristics were more likely to be prematurely discharged for drinking or the breaking of other rules.

#### WOMEN IN ALCOHOLISM HALFWAY HOUSES

Data on alcoholism halfway houses for women is extremely meager. Based on data from one house which admitted both male and female alcoholics, a comparison was made of the characteristics of male and female residents. "Results indicate that men and women were similar at intake in age, referral source, physical health, intellectual functioning, and education" (Ogborne, 1978, p. 31).

Differences were noted in the following areas.

(1) Drinking: women reported problems with alcohol consumption for periods of shorter duration than men, as well as, having fewer alcohol symptoms (ie. blackouts).

(2) Accomodation: women were less likely to be homeless or identified as having a skid row lifestyle.

(3) Interpersonal Relationships: women were more likely to have been married and to have maintained ongoing relationships with important others.

(4) Employment: women worked less than half the amount of time of the men.

(5) Principle Sources of Income: women were more likely to

receive welfare or rely on income from a spouse or partner.

(6) Treatment: women were less likely to have received long term residential treatment. However, treatment for psychiatric disorders was higher for women.

(7) Utilization: female occupancy rates were significantly lower than those of men. Length of stay was also lower for women.

Ogborne (1978) indicates that successful program completion was the same for females and males (24 percent). Females were more likely to be discharged for drinking, but also more likely to inform staff of their leaving prematurely.

The Ogborne Task Force on Halfway Houses made a number of recommendations regarding such facilities in Ontario. The most salient recommendation focuses on the selection procedures of halfway houses. Ensuring that the appropriate types of clients are matched to the particular type of rehabilitative program.

ALCOHOL RELATED PROBLEMS:  
SOME STATISTICS ABOUT WESTERN ONTARIO SERVICES

Brian Rush and Robert Brook (1981) indicate that the distribution of alcohol-specific resources in the Western region of Ontario in 1979-80 were: For hospital-based resources, 5 detox centres, 6 residential facilities, and 3 non-residential programs. For community-based resources there were, 21 residential facilities, 13 non-residential programs, and 11 assessment and referral services (p. 19).

From a total of 21 identified community-based residential, alcohol-specific settings in Western Ontario, there was a cumulative total of 479 beds. This represented 0.23 number of beds per 1,000 adults 15 years and older (Rush & Brook, 1981, p. 23).

In 1979-80, the 63 identified community-based residential settings in Ontario dealt with an estimated 6,134 cases, at an associated treatment cost of 6,290,520 dollars, representing 23.0 percent of total costs (p. 31).

Rush and Brook point out that these figures do not represent and distinguish the overlap in agency populations. They do however, provide an estimate of the penetration rate of community-based residential treatment programs.

The mean percentage of alcohol related referrals received by alcohol-specific resources were: self and family 25.7 percent, alcohol-specific services 27.1 percent, medical and psychiatric services 16.8 percent, social services 9.8 percent, correctional services 11.8 percent, other 8.7 percent (p. 38).

Eighty-three percent of the identified community residential resources were halfway or three-quarter-way houses.

Rush, Timney and Ekdahl (1981) point out that for community-based residential settings in Ontario (1979-80), females were specifically cited as comprising 12.7 percent of the target population, while 60.3 percent of the cited target population were males, and the remaining target population percentages being distributed among youths, natives, other groups, or non-specific groups (p. 19).

For community-based residential settings in Western Ontario



the estimated sex distribution of caseload for alcohol-specific resources in 1979-80 were; 2,344 males and 196 females or a male:female ratio of 12:1 (p. 27).

Windsor, has an estimated 9,788 alcoholic population representing a prevalence rate of 40.39 per 1,000 adults aged fifteen years and older (p. 59). Windsor has three community-based residential, alcohol-specific resources, with a total capacity of 43 beds (p. 63).

The House of Sophrosyne, with a bed capacity of twelve, is the lone community-based residential program for women in the Windsor area.

A total of 1,241 individuals were served in Windsor for alcohol-related problems by community-based residential resources. This represented 56.3 percent of the total caseload in 1979-80 for alcohol-specific resources (p. 73).

Of the 1,241 individuals served in Windsor for alcohol-related problems by community-based residential resources, 1,115 were male and 126 were female, representing a male:female ratio of 8.8:1 (p. 75).

#### CHARACTERIZING THE TREATMENT ENVIRONMENT

Throughout the 1960's and early 1970's it became apparent that there was a need for more systematic methods for describing and comparing the actual social environments provided by different types of community-based psychiatric programs. Glasscote Hall (1971) called for studies to measure the "quality of life" of groups of patients,

some, who were assigned to halfway houses. Raush and Raush (1968) were quite aware of the significance of the social environment, stating that "the major impact of the halfway house on its residents very likely comes from the milieu it provides.... Environments do influence people.... and if they do, possibly some environments are better than others for affecting a course of social adaptation to the ordinary requirements and opportunities of the community" (p. 160). They support the need for a method by which to assess social environments in widely varying halfway house programs.

Rudolf Moos has done the most comprehensive work in conceptualizing the treatment environment for purposes of program evaluation. Moos (1974a) calls his work "a social ecological approach" to evaluation research.

Social ecology is defined as "the multidisciplinary study of the impact on human beings of physical and social environments" (Moos, 1974a, p. 18). The "social ecology" approach attempts to understand the impact of the environment from the perspective of the individual, as opposed to the unit of study being the entire community, culture or civilization.

The social climate perspective advocated by Moos assumes that environments have a unique "personality" just like people. Some people are more supportive than others or have a strong need to control others. Similarly social environments are more supportive or controlling. Many people desire order and clarity or regulations to direct their behaviour. Similarly many social environments have order and clarity, as well as regulating the behaviour of

people within them. The terms used by Moos in examining an environment are descriptive in nature. It is a way of thinking about the differences among various types of environments. Under certain conditions one type of program environment may be desirable, while under other circumstances a different type may be desired.

Moos (1976) identifies seven major trends that underlie the recent interest in man's surroundings.

First, the historical and geographic perspective that examines the rise and fall of civilizations. The idea that men need "stimulus and change" from the environment to develop advanced societies.

Second, the development of human ecology and cultural ecology which are reflected in sociology and anthropology.

Third, the idea that environmental factors influence health and disease.

Fourth, from the Industrial Revolution emerged the study of organizations and bureaucracy.

Fifth, the developments of experimental psychology and personality theory. The idea that personality traits did not explain all the individual's behaviour. This led to development of community oriented and environmental perspectives.

Sixth, the architectural profession began to conceive of buildings as actively shaping the behaviours that occur in them.

Seventh, the rising interest in conservation and the "quality of life".

The geography of man's immediate environment places specific demands on man's need to adapt accordingly, such as transportation

and home construction.

The weather and climate has influences not only on immediate behaviour (ie. type of clothing worn or types of activities allowed), but it also has a significant effect on the long range behaviour or predisposition of man. For instance, in the author's opinion in a colder climate such as Canada where a good part of the year is primarily spent indoors, the Canadian character tends to be marked as being controlled and reserved. In contrast, the warm climate of the Caribbean influences the behaviour of the native people who tend to be more expressive and passionate.

The architectural environment is also considered by many to influence behaviour (Griffin, Mauritzen & Kasmar, 1974; Hall, 1970; Horowitz, Duff & Stratton, 1970; Ittelson, Rivlin & Proshansky, 1970; Izumi, 1970; Maslow & Mintz, 1956; Parr, 1970; Schorr, 1970; Stea, 1970; Wohwill, 1974:). The physical design of the space of a room, building or enclosure is conducive to some types of behaviours and activities.

Population density (Lynch & Rodwin, 1970; Milgram, 1970) and the individual's sense of personal space influence the nature and content of interaction patterns of behaviour.

The importance of the social and organizational settings are discussed by (Dubos, 1970; Gump, 1974a, 1974b; Katz & Kahn, 1978; Sells, 1974a, 1974b). Typical behaviours displayed by others in a setting exert a degree of influence on the behaviour of the individual. The distribution of roles and responsibilities in an organization, the distribution of authority and the patterns of

communication influence the behaviour of individuals.

In effect, both the individual and the environment interact with each other and adapt to each other on a continuous basis in an effort to maximize the person - environment "fit". The person-environment fit concept is described from various perspectives (Alexander, 1970; Barker, 1978, 1974, 1968; Boutourline, 1970; Helson, 1964; Lichtman, Cary & Hunt, 1971; Mischel, 1968; Porter & Lawler, 1965; Stern, 1970; Wicker, 1974) each of which support the interdependent relationship between the individual and the environment.

Moos (1976) provides an excellent contrast used to highlight the importance of the overall treatment environment. In the film "One Flew Over The Cuckoo's Nest" the patient's having to submit to the authority of the Big Nurse served its purpose, while in the film "I Never Promised You A Rose Garden" the constructive, humanitarian setting, served quite another purpose.

In the literature there has been a consistent emphasis on the importance of the social environment and the critical role of situational and environmental factors in the determination of individual behaviour.

In order to specify the actual problem to be investigated it will be necessary to further describe the approach used by Moos in evaluating the treatment environment and to discuss its applicability to the treatment setting of the House of Sophrosyne. These matters will be dealt with in the section on Problem Formulation.

### PROBLEM FORMULATION

Problem formulation involves "the articulation of the precise problem to be investigated" (Tripodi, Fellin & Meyer, 1969, p. 3). The importance of identifying the precise problem to be investigated cannot be overstated, for it has very practical implications to evaluation. "The power of evaluation varies directly with the degree to which the findings reduce the uncertainty of action for specific decision makers" (Patton, 1978, p. 50).

As indicated in the first chapter, the Program Committee and the Executive Director of the House of Sophrosyne, identified the treatment environment as a key component in the residential program. It was further established that characterizing the treatment environment of the House of Sophrosyne would be the general purpose of the research project.

Characterizing the treatment environment has been considered a form of program implementation evaluation. "It is important to know whether or not a program is effective after it is properly implemented, but to answer that question it is first necessary to know whether or not the program was indeed properly implemented" (Patton, 1978, p. 150). A decision maker can use implementation information to check out if a policy is being put into operation according to design or to test the feasibility of the policy.

It would seem fair to say that most programs are not implemented exactly as designed. Programs are implemented incrementally by adapting to local conditions, organizational dynamics and various

unknowns. - With such impinging factors to consider, an implementation evaluation needs to establish the "degree" to which programs are actually operating as desired. Such a purpose can be served by a "Discrepancy Evaluation", which is a comparison of the actual program with the ideal program, derived from the perceptions of the program staff and the client population being served.

The reality is that actual programs look different from ideal program plans. The challenge to the decision makers is to determine how far from the ideal plan the program can deviate, and in what ways it can deviate, while still meeting fundamental criterion. The combination of successful implementation and significant change or improvement in program participants requires a process of mutual adaptation, in which objectives and methods are modified to meet the requirements of the program.

Rudolf Moos (1974a) has developed an approach which considers the question; what is going to happen in the program that is expected to make a difference? Patton (1978) refers to this approach as "treatment specification", which means measuring the degree to which specified treatments actually occur. Treatment specification reveals the causal assumptions supporting program activity, it tells one what to look for in order to find out if the program's causal theory is actually being put to the test.

The approach used by Moos is concerned with the assessment and optimization of human milieu, both in it's emphasis on the measurement of objective physical characteristics of environments, and in it's emphasis on the short term evolutionary adaptive consequences of

these environments.

It is linked to psychology and sociology in the way in which it emphasizes the importance of the social environment and in consideration of environmental impact on variables such as self-esteem and personal development.

It is linked to concerns in psychiatry and medicine by focusing on the identification of dysfunctional reactions (ie. Anxiety, anger) and their relation to environmental variables.

Moos describes six areas that need to be considered when characterizing the treatment environment. They are as follows:

(1) Ecological Dimensions: This is essentially the idea that culture, character, and activities of societies are significantly shaped by the climate, topography and other geographical features of the region in which people live. Other ecological dimensions include the man-made environment such as the architectural and physical design of buildings, the physical patterns (of the layout) of shopping centres, public transportation and so forth. "Behavioural mapping" can show the frequency of various activities in different types of available physical locations.

(2) Behaviour Settings: Behaviour settings have pervasive effects on individuals, both in terms of specific behaviour which is required by the setting (ie. reading and writing in classroom) and on the effects experienced by individuals (ie. mood, self-esteem). For example, members in small groups feel more pressure to participate than those in large groups. Members in small groups would tend to take on more responsible positions, to be challenged to be involved,



to feel valued, to gain moral or cultural values.

(3) Dimensions of Organizational Structure: The relatively objective organizational dimensions are related to behavioural and attitudinal effects on the organization members. Dimensions such as size, staffing ratios, average salary levels, and organizational control structure act as indices to member and staff perception of the treatment milieu.

(4) Personal and Behavioural Characteristics of the Milieu Inhabitants: Factors related to the individuals inhabiting a particular environment can be considered to be situational variables that partially define relevant characteristics of the environment. In a sense the character of an environment is dependent in part on the typical characteristics of its members.

(5) Psychosocial Characteristics and Organizational Climate: This area focuses attention on the general norms, value orientations, and other psychosocial characteristics of institutions. Measurements are taken of the following ten dimensions: involvement, support, spontaneity, autonomy, practical orientation, personal problem orientation, anger and aggression, order and organization, program clarity, and staff control.

These dimensions are considered salient in community oriented treatment programs and are related to such criteria as morale, indices of coping behaviour and treatment outcome (ie. drop out rate, discharge rate).

(6) Variables Relevant to the Reinforcement Analysis of Environments: Attempts are made to identify those stimuli and stimulus changes which produce and maintain behaviour and behaviour change. (ie. praise,

social approval, money).

The most comprehensive instrument developed to date was designed by Rudolf Moos. He has developed scales to measure variations in treatment environments for a number of settings. He is working toward a taxonomy of social environments and has already developed nine social climate scales.

The social climate scale has a broad range of applications. First, it can provide a detailed description of how various participants in a social environment view that environment. The scale can be used to compare the perceptions of different groups of program participants, such as residents and staff in a treatment program. The monitoring of fluctuations in the social climate of an environment over time can be made. A discrepancy evaluation can be undertaken, which compares the differences between the program participants perception of the "real" environment and their concept of an "ideal" environment. Second, the social climate scales can be filled out by observers or other individuals who are not directly participating in a particular environment. Third, the scales can be used in the comparison of different social environments. Fourth, the scales can be used to focus on assessing the degree to which social environment changes when some major program change is instituted. Fifth, the environmental impact can be evaluated based on institutional outcome criteria: subjective criteria, such as morale and self-esteem and objective or performance criteria, such as achievement and drop out rates. Sixth, the concept of social climate may help in the understanding of how some of the observed relationships between other types of environmental dimensions and specific outcome criteria are mediated, such as the

effects of large size and poor staffing ratios in treatment programs. Seventh, the scales can serve to plan social change, where information about the social climate can be fed-back to the participants in a social environment in order to motivate people in the environment to seek to change it. Eighth, the information generated from the scales help in more appropriate matching of the environment and the individual. Often a treatment program knows a fair amount about the type of individual it seeks to serve, however, the reverse situation is often not the case. An individual who had more information about the treatment environment would be in a better position to select the more desirable treatment program. Ninth, the information obtained by the scale would also make for richer and more meaningful clinical case descriptions. Having information about a person's environment just as they do about his or her personality and behaviour, would provide a more complete picture.

One of the scales developed by Moos (1974a) is the Community-Oriented Program Environment Scale (COPEs). The scale has been used for social research in the past. Examples of the use of COPEs include its application to drug and alcohol treatment programs.

The scale was used by M. Bell in, "Therapeutic Communities in the Treatment of Drug Abuse" in Dissertation Abstracts International (1976, 37, 5822) and again by D. Palkon in "An Exploratory Ecological Evaluation of an Alcoholism Treatment Program: A Methodological and Substantive Investigation" in Dissertation Abstracts International (1978, 38, 5717). Other examples include the following: "The Social Climate of Alcoholism Treatment Programs" in Archives of General Psychiatry (Bromet, E., Moos, R. & Bliss, F., 1976, 33, 910-916),

also, "Evaluating Alcoholism Treatment Program: An Intergrated Approach", In Journal of Consulting and Clinical Psychology (Cronkite, R. & Moos, R., 1978, 46, 1105-1119).

There are also numerous examples of COPEs application to the assessment of change in the treatment program. One example is "Monitoring change in Community-Oriented Treatment Programs", in the Journal of Community Psychology (Bliss, F., Moos, R. & Bromet, E., 1976, 4, 315-326).

The COPEs instrument focuses attention on the general norms, value orientations, and other psychosocial characteristics of institutions.

More specifically, there are three basic types of dimensions that characterize and discriminate among different subunits of the environment.

(1) Relationship dimensions - which assess the involvement of individuals in the environment and the extent to which they support and help one another. The basic dimensions included in this category are Involvement, Support, and Spontaneity.

(2) Personal Development dimensions - assess the basic directions along which personal growth and self-enhancement tend to occur in the particular environment. The basic dimensions included for this study are Autonomy, Practical Orientation, Personal Problem Orientation, and Anger and Aggression.

(3) System Maintenance and System Change dimensions - which relate to keeping the programs functioning in an orderly, clear, organized and coherent manner. The basic dimensions included are Order and Organization, Program Clarity, and Staff Control. Refer to Table 1 for COPEs subscale definitions.

The three basic types of dimensions are considered salient in

TABLE 1.

## --COPEs Subscales and Definitions

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1. Involvement	measures how active members are in the day-to-day functioning of their programs, i.e., spending time constructively, being enthusiastic, doing things on their own initiative.
2. Support	measures the extent to which members are encouraged to be helpful and supportive towards other members, and how supportive the staff is towards members.
3. Spontaneity	measures the extent to which the program encourages members to act openly and express their feelings openly.
4. Autonomy	assesses how self-sufficient and independent members are encouraged to be in making their own decisions about their personal affairs (what they wear, where they go) and in their relationships with the staff.
5. Practical Orientation	assesses the extent to which the member's environment orients him towards preparing himself for release from the program. Such things as training for new kinds of jobs, looking to the future, and setting and working towards goals are considered.
6. Personal Problem Orientation	measures the extent to which members are encouraged to be concerned with their personal problems and feelings and to seek to understand them.
7. Anger and Aggression	measures the extent to which a member is allowed and encouraged to argue with members and staff, to become openly angry and to display other aggressive behavior.
8. Order and Organization	measures how important order and organization is in the program, in terms of members (how do they look), staff (what they do to encourage order) and the house itself (how well is it kept).
9. Program Clarity	measures the extent to which the member knows what to expect in the day-to-day routine of his program and how explicit the program rules and procedures are.
10. Staff Control	assesses the extent to which the staff use measures to keep members under necessary controls, i.e., in the formulation of rules, the scheduling of activities, and in the relationship between members and staff.

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treatment programs and are related to such criteria as morale, indices of coping behaviour, and treatment outcome such as drop out rate and discharge rate (Moos, 1974a).

The relevance of the six areas which characterize the treatment environment as outlined by Moos, and the ten dimensions which measure the social climate are particularly significant to a setting such as the House of Sophrosyne. The Review of Literature highlights the strong environmental factors which influence the problem of alcoholism both in its cause and treatment. The environmental influences are particularly strong for the female alcoholic, given her traditional role in society. To a large extent social environmental factors serve as a major cause of the female alcoholic's problem. By the same token, the goal of most alcoholism halfway houses is to assist the individual to abstain from alcohol and re-integrate into the community as a healthy and productive citizen. In short, a major part of the cause of alcoholism (ie. the environment) serves as a major part of the solution. The nature of the social and physical environment, the types of individuals that participate in the environment, the kinds of activities that take place, and the organizational structure in which the treatment program exists all have a degree of influence upon the treatment outcome.

Considering the types of problems experienced by many alcoholics (e.g. lack of self-control, poor self-image, poor communication skills, depression, over dependence) the ten dimensions of the treatment environment as outlined by Moos have considerable influence on how the female alcoholic experiences the environment and subsequently to what extent she is able to function at an acceptable level prior

to her return to the community. The ten dimensions are representative of the areas which the female alcoholic will need to deal and incorporate to some degree into her own life once she returned to the community and is basically on her own. Spending time constructively, the ability to express feelings, making independent decisions, dealing with day to day problems, and the ability to function within the rules and regulations of society are some of the areas which the ten dimensions address and have direct applicability to living successfully in the community.

In order to characterize the treatment environment at the House of Sophrosyne in a systematic fashion, the framework developed by Moos provided the basis for the research questions.

RESEARCH QUESTIONS

The five basic research questions posed in this study are:

- (1) What are the salient architectural and physical design characteristics of the treatment environment at the House of Sophrosyne?
- (2) What are the salient behaviour settings which exist in the treatment environment at the House of Sophrosyne?
- (3) What are the salient dimensions of organizational structure which exist in the treatment environment at the House of Sophrosyne?
- (4) What are the salient personal and behavioural characteristics of the residents and staff at the House of Sophrosyne?
- (5) How are the salient climate characteristics of the treatment environment perceived by the residents and staff at the House of Sophrosyne?

In addition to identifying the salient dimensions relevant to each of the research questions, the components of each dimension will be examined in order to provide a better understanding of how each dimension effects the treatment environment. The information will assist the staff and residents in assessing and improving the overall treatment environment at the House of Sophrosyne.

A secondary purpose of the study is to include an examination of the administrations understanding of the program objectives at the House of Sophrosyne. Such information will help to determine if the program objectives can be put into measurable terms, a requirement which is crucial to a future impact assessment.

The following chapter will examine the classification of the research, how the research will be operationalized, and the limitations of the research.



## CHAPTER III

### RESEARCH METHODOLOGY

Research methodology refers to the specification of an approach to answering the questions posed for study.

### CLASSIFICATION OF RESEARCH

Experts continue to deliberate upon the differences between applied and basic research, ranging on a continuum from pure research to engineering research. In the final analysis, most research has both basic and applied elements.

In light of the synthesis of the two extremes between applied and basic research, evaluation research is a combination of the discovery of knowledge and a testing of the application of knowledge.

The uses of evaluation research is a contentious issue. Discrepancies in perspective regarding evaluation research is reflected in the differences in opinion by various experts in the field regarding the applicability of evaluation in general. In addition, the symptomatic response by those most affected by an evaluation is the tendency to misinterpret the purpose of the evaluation, and to attribute to the evaluation devious or underlying motives.

It seems clear that establishing the purpose of the evaluation is the first and most important step in the evaluation process. Rossi,

Freeman, and Wright (1979) identify five basic questions which are not only at the heart of evaluation research, as applied to social programs, but also initiates the direction and purpose of the evaluation:

1. Is the intervention reaching the appropriate target population?
2. Is it being implemented in the ways specified?
3. Is it effective?
4. How much does it cost?
5. What are its costs relative to its effectiveness? (p. 20)

Rossi et al. (1979) relate these questions to corresponding types of evaluation activities: program planning, program monitoring, impact assessment, and economic efficiency.

Program planning studies consist of: "(1) the extent and location of problems for intervention, (2) ways targets can be identified in operational terms, and (3) whether the proposed intervention is suitable" (p. 16).

Program monitoring on the other hand is an "assessment of whether or not a program is (1) operating in conformity to its design, and (2) reaching its specified target population" (p. 16).

The concept of an impact evaluation is the "assessment of the extent to which a program causes changes in desired direction in the target population" (p. 16).

When referring to economic efficiency, Rossi makes two distinctions; cost-benefit and cost-effectiveness. Cost-benefit analyses are "studies of the relationships between costs and outcomes of social projects, usually expressed in monetary terms." (p. 16).

Cost-effectiveness analyses are "studies of the relationships between project costs and outcomes, usually expressed as costs per unit of outcome achieved" (p. 16).

According to Rossi, evaluations that include all four areas of planning, monitoring, impact, cost-benefit and cost-effectiveness, can be considered a comprehensive evaluation.

From a realistic and practical perspective Rossi et al (1979) recommend that evaluations be viewed as an incremental activity, where implementation is examined first, then impact, and if efficacious, then cost-benefit or cost-effectiveness undertaken, thus comprising a comprehensive evaluation. Undertaking an evaluation before any preceding stages are assessed can often result in useless information and poor decisions.

It cannot be overemphasized that it is essential from the beginning to clarify the primary purpose of an evaluation. Whether it is to make an overall judgement about the effectiveness or efficiency of a program or primarily for ongoing program development and improvement.

Michael Scriven (1967) made the distinction between the two evaluation purposes by coining the terms "summative evaluation" and "formative evaluation". The terms have evolved into a fundamental evaluation typology. This typology although more general in its frame of reference than those employed by Rossi are comparable. In the opinion of the author, Rossi's descriptions of program planning and program monitoring evaluations constitute "formative evaluations", while the impact, cost-benefit and cost-effective evaluations are comparable to "summative evaluations".

Summative evaluations are aimed at determining the essential effectiveness of programs and are particularly important in making decisions about continuing or terminating an experimental program or demonstration project. As such, summative evaluations are often useful to funders. (Scriven, 1967, p. 40)

Formative evaluations, in contrast, focus on ways of improving and enhancing programs not only in their initial development, but at any point in the life of the program. Formative information is particularly useful to program administrators and staff. (p. 40)

With the explosion of health, education and social services in the sixties and seventies, there was a demand for increased accountability, particularly with the realization that funds were limited and could not meet all the identified needs. Despite the surge in evaluative research, more specifically program evaluation, it became disappointingly evident that the research was not being used as a basis for decision making.

The evaluator needs to be able to match the research methods to the nuances and the idiosyncracies of the specific decision makers needs. Michael Patton (1978) describes the evaluator's role as "active-reactive-adaptive" in working with decision makers or information users to focus the evaluation questions and in making methods decisions. In short, the ideal flexible methodological approach is tempered by the constraints of resources and time, as well as the influences from the real world of politics, people, and methodological prejudice.

Patton (1978) refers to his approach to evaluation as "Utilization-Focused Evaluation". The first step in the utilization-focused approach is the identification and organization of relevant decision-makers and information users. Being able to identify individuals or groups of people who have an interest and stake in the evaluation and the information it generates. The second step is to identify and

focus the relevant evaluation question in conjunction with the decisionmakers and information users. The numerous alternatives which might be considered for potential study have to be narrowed down and a choice made. It is important to determine whether the primary purpose of the evaluation is to assess the effectiveness of the program or to collect information that can be used for program development and improvement.

Patton (1978) points out that evaluation research has been dominated by an emphasis on measuring outcomes. That is the comparison of actual program outcomes with desired outcomes. Many outcome evaluations focus on the input and output, a before and after measurement which does not take into account the throughput, the in-between content of the program. What is missing is information about the actual nature of the program being evaluated. How in fact was the program actually implemented. The danger lies in making a decision about the fate of a program based solely on an outcome evaluation which may only assume to know how the program operates. The decision might be to cancel a program based on poor results, or to expand a program based on good results, obtained from the outcome evaluation. It might well be that the outcome evaluation was not appropriate because it was evaluating the wrong program. Information about actual program operations and an assessment of the reasons for the program's success or failure is crucial for appropriate decision-making. "Unless one knows that a program is operating according to design, there may be little reason to expect it to produce the desired outcomes" (Patton, 1980, p. 69).

Patton refers to the evaluation of the "throughput" as "Implementation Evaluation". He establishes three types of implementation evaluation: the effort approach; the process approach; and the treatment specification approach. These three types, Patton does not consider to be mutually exclusive in implementation evaluation.

Tony Tripodi, quoted in *Utilization-Focused Evaluation*, has stated that:

Evaluation of program effort refers to an assessment of the amounts and kinds of program activities considered necessary for the accomplishment of program goals within a particular stage of development. It refers not only to staff time, activity and commitment, but also to allocation and use of material resources. (Patton, 1978, p. 164)

On the other hand the process evaluation attempts to understand the day to day reality of the setting. It looks for the major patterns and important nuances that give the program its character.

Process evaluations focus on why certain things are happening, how the parts of the program fit together, and how people perceive the program. This approach takes its name from an emphasis on looking at how a product or outcome is produced rather than looking at the product itself. (Patton, 1978, p. 165)

The treatment specification approach to implementation evaluation means measuring the degree to which specified treatments actually occur. It attempts to specify the intended treatment in nominal terms. It "involves identifying and measuring precisely what it is about a program that is supposed to have an effect" (Patton, 1978, p. 167)

Patton identifies Rudolf Moos as being perhaps the most prominent expert in the area of treatment specification. Patton indicates that Moos (1974a) is one of the few to have conceptualized certain key dimensions of the environment of organizations, families and treatment programs.

The previous discussions in this chapter provides a frame of reference in which to consider the classification of this research project. The general, more global classification of this project is that of formative research. This project can be further classified as an evaluation of program implementation sub-typed: treatment specification.

#### POPULATION SELECTION

The term population may refer to a number of different things. Within the framework of social program evaluation Ferguson's definition is adequate. "In everyday language the term population is used to refer to groups or aggregates of people" (1976, p. 6).

For the purpose of this study, the population of interest was operationally defined as alcoholism halfway houses for women currently operating in the province of Ontario.

#### SAMPLING STRATEGY

A sample is a smaller representation of a larger whole. The study of a subgroup, in place of a whole population, has several advantages. Time and expense is greatly reduced, allowing more investigations to be conducted. In large and widely scattered populations the use of a sample may produce more accurate information by reducing the chances of error in data collection.

In the process of choosing samples, if the laws of probability determine which elements of the population to include in the sample, it is referred to as, probalistic sampling. If other criterion

other than the laws of probability are used to select which elements of the population to include in the sample, it is referred to as, nonprobabilistic sampling.

The advantage to probability sampling lies in fact that one can generalize from the sample to the population. Generalizing from a nonprobability sample to the population is tenuous at best.

Convenience sampling is most commonly used where representativeness is not a crucial factor. As stated by Eckhardt and Ermann, if a researcher selects those units or "cases which are convenient, he is using accessibility sampling procedures" (1977, p. 159).

In assessing the treatment environment at the House of Sophrosyne, accessibility sampling procedures were employed. More specifically, included in the study were all the residents (N equals 10) and all the staff (N equals 7) participating in the program during the week in which the questionnaires were administered.

The practical problem of the proportion of members and staff who need to answer COPES to obtain an adequate profile in a particular program was investigated by Rudolf Moos (1974a). He concludes that:

The profile correlations were all quite high, indicating that it is not necessary to test all the members or staff in larger programs, particularly if an investigator is primarily concerned with a general assessment of the program environment. As a rule of thumb, an investigator needs to test only half the members on programs having 21 or more members and half the staff on programs having 11 or more staff. The mean interclass correlation was .88 for the 7 programs with 21 or more members and .92 for the 3 programs with 11 or more staff. (p. 246)

Moos indicates that smaller programs should try to obtain close to 100 percent responses.

Another method employed in the research project is referred to as purposive or judgement sampling. In this regard, an "insight



stimulating" (Yeakel & Ganter, 1975, p. 105) individual namely the Executive Director was selected as a participant in this project.

#### DATA COLLECTION METHODS

Methods refer to the means of gathering data. The data collection methods employed in this evaluative study include questionnaires, interviews, and review of agency manuals.

According to (Epstein & Tripodi, 1977, 10) in program evaluation "questionnaires can be used to ask administrators... and clientele about their subjective evaluations of social programs". The questionnaires designed for purposes of data collection were:

- (1) "Questionnaire: Executive Director of House of Sophrosyne",
- (2) "Questionnaire: Residents of House of Sophrosyne", (3) "Questionnaire: Staff of House of Sophrosyne".

The Executive Director questionnaire, the Resident and Staff Questionnaire, plus the accompanying covering letter, and the COPEs scoring key are included in Appendix A, B and C respectively.

Interviewing is a data collection method involving verbal communication by telephone or in a face-to-face situation. The face-to-face method was employed in this study; that is, (4) an interview with the Executive Director of the House of Sophrosyne.

Following is a discussion of a frequently used social climate scale, the Community-Oriented Programs Environment Scale (COPEs). This scale was incorporated into both the resident and staff questionnaires for the purpose of assessing the social milieu of the House of Sophrosyne.

COMMUNITY-ORIENTED PROGRAMS ENVIRONMENT SCALE (COPEs)

Each of the Social Climate Scales has three basic forms. All items are in a true-false format. The Real Form (Form R) asks people how they "perceive" their "current" social environment. The Ideal Form (Form I) asks people how they "conceive" of an "ideal" social environment. The Expectations Form (Form E) asks prospective members of an environment what they "expect" the environment they are about to enter to be like. In addition, there is a Short Form (Form S) of each of the Social Climate Scales which has been developed primarily for use by investigators who wish to obtain relatively rapid or repeated assessments of a social environment.

For the purpose of this study only the Real and Ideal Forms will be employed. See Appendix B regarding the specific subscale items used in the questionnaires.

The COPEs subscales items both in the questionnaire to the residents and the staff are identical. The questionnaires differ in the other types of data collected, such as, demographic information.

It should be noted that some changes have been made in the COPEs. First, the items were re-ordered to facilitate hand scoring and to make the first 40 items the Short Form items. Second, two items were dropped from the Involvement Subscale in order to reduce COPEs to an even 100 items. Third, in those items where the word "member" was used it was replaced with the word "resident". Fourth, in those items where the male gender was used it was changed to the female gender.

Fifth, the original item number 4; "There is no membership government in the program" was replaced by, "Residents have no voting rights". In particular, the third, fourth and fifth alterations were undertaken in order to more accurately represent the House of Sophrosyne program.

A scoring direction has been determined for each item on the scale. An item listed as "true" (T) is scored 1 point if marked "true" by the individual taking the scale, and an item listed as "false" (F) is scored 1 point if marked "false". The total subscale score is simply the number of items answered in the scored direction. See Appendix C for the scoring key for the subscale of the different forms of COPEs. The Real program and Ideal program are directly parallel, and all items are scored in the same direction on both forms.

Results of the tests are displayed in graphic form, with subscale dimensions on the horizontal axis and standard scores and/or subscale means on the vertical axis. "Real" scale profiles for residents and staff are displayed on the graph, as well as, "Ideal" scale profiles for residents and staff, and "Real-Ideal" Program Discrepancies as perceived by residents and staff.

Further investigations by Moos (1974a, p. 279) yielded information about types of program characteristics related to the environment, and more specifically characteristics related to alcoholism treatment programs (Cronkite & Moos, 1978, p. 1105-1109). The more salient characteristics identified in these studies were included in the questionnaire for either the residents or staff, depending upon its applicability. In some instances the word used to describe and identify the salient characteristics were changed to more accurately

reflect the type of information collected and understood in the program at the House of Sophrosyne.

#### PHYSICAL ENVIRONMENT

The important influences which the physical environment exerts upon the inhabitants are discussed by Barker, 1968, 1978; Griffin, Mauritzen & Kasmar, 1974; Gump, 1974; Helson, 1964; Lansing, Maraus & Zehner, 1970; Maslow & Mintz, 1956; Milgram, 1974; Moos & Chisel, 1974; Proshansky, Ittelson & Rivlin, 1970; Sells, 1974; Wachtel, 1982. On the last page of the questionnaire to both residents and staff, the most commonly cited variables considered important aspects of the physical environment were included. For the most part it is an attempt to obtain a general "feel" of the residents and staff perceptions of specific physical characteristics. In addition, the responses of the residents and staff were supplemented by the direct physical examination of the environment by this researcher, in an effort to provide a well rounded picture of the actual physical environment at the House of Sophrosyne.

#### EXECUTIVE DIRECTOR QUESTIONNAIRE

The purpose of the questionnaire to the Executive Director was to provide an overview of the House of Sophrosyne's program objectives, the activities undertaken to achieve the program objectives and the causal links connecting the program activities to the program objectives. In addition, it will provide some insight regarding the Administrations

understanding of the program objectives as they relate to the salient dimensions of the treatment environment which have been included in the questionnaires to the residents and staff.

#### REVIEW OF AGENCY MANUALS

Finally, the other data collection method used in the evaluation study was the examination of agency manuals. (Katz & Kahn, 1978; Porter & Lawler, 1965), indicate that the organizational structure has considerable influence upon the inhabitants. Significant characteristics of the organizational structure of the House of Sophrosyne were extracted from the agency manuals.

#### DATA COLLECTION TECHNIQUES

Techniques refer to specific procedures that are used in a given method. The techniques used in this study include (1) administering the questionnaire designed for the Executive Director of the House of Sophrosyne. The questionnaire was delivered in person and a verbal explanation given to the Executive Director regarding it's purpose. (2) a questionnaire designed for the residents of the House of Sophrosyne was administered to the residents as a group, during a specific time set aside for the completion of the questionnaire. (3) a questionnaire designed for the staff of the House of Sophrosyne was administered to the staff as a group, during a regularly scheduled staff meeting. (4) an interview was conducted with the Executive Director of the House of Sophrosyne on agency grounds. (5) Agency

manuals were examined.

The Executive Director was allowed three weeks to complete and return the questionnaire. The major advantages of the way the questionnaire was administered to the Executive Director of the House of Sophrosyne were: (1) It provided the Executive Director with an understanding of the purpose of the questionnaire and increased the appropriateness of the response. (2) It provided the Executive Director with more time for completing the instrument and, therefore, permitted for more considered answers. (3) It allowed the Executive Director the time to search files for information, if necessary. The disadvantage of having the Executive Director complete the questionnaire on her own was the possibility of misinterpretation of questions. However, this possibility was greatly reduced, as a follow-up interview was conducted in which the researcher could clarify questions or answers as necessary, probe for additional information, and collect supplementary material.

Regarding the questionnaires which were administered in a group setting to both the residents and staff (as separate groups), the major advantages are as follows. (1) It was less time consuming than personal interviews. (2) It provided the respondents with an opportunity to obtain clarification on items which might otherwise be misunderstood or misinterpreted. (3) Considering that the primary nature of the agency was that of a residential setting, the use of a group setting to administer the questionnaire was in keeping with the "group process" inherent in such a setting. (4) Use of the group setting also eliminated any influence or contamination effect which might have occurred had the questionnaire been handed out to respondents to be

completed on their own time. In which case some respondents may have completed the questionnaire before other respondents even began filling out the questionnaire. Therefore increasing the risk of having some respondents influencing the other respondents either consciously or unconsciously. (5) It provided the respondents with a greater sense of privacy and anonymity than personal interviews warrant. (6) The completion and response rate was expected to be higher compared to mailing the questionnaire.

The disadvantages of the resident and staff questionnaires being administered in a group setting were: (1) The possibility of the researcher influencing the residents or staff. (2) The consideration that residents or staff may respond favourably to questions if the researcher assisted them, as opposed to the individual completing the questionnaire on their own. (3) The possibility of fatigue developing in the respondents due to their having to complete the questionnaire in one sitting.

The researcher attempted to minimize these concerns by restricting his comments while respondents completed the questionnaire, to procedural matters and to refrain from interruptive statements, other than for the defining of a word, if necessary. In addition, the group sessions for the purpose of administering the questionnaires were deliberately scheduled at the time of day (mid-morning) when most residents can be expected to be functioning reasonably well, and the fatigue created by a long and busy day would be minimized. Finally, it was anticipated that most respondents would require approximately forty-five minutes to complete the questionnaire. Considering the nature of the typical scheduling in the program the respondents would

have been required to participate in activities for a period in excess of forty-five minutes, and it was therefore assumed that a forty-five minute period would not cause a greater than naturally occurring rate of fatigue.

#### ASSUMPTIONS and LIMITATIONS

Since researchers cannot study all variables, it is necessary to make assumptions about relevant variables based on previous research or theory. Assumptions are defined as, "propositions which have not been verified, but which are taken as givens for purposes of investigation" (Tripodi, Fellin & Meyer, 1969, p. 74). Assumptions are classified into two types; value assumptions and validity assumptions.

Value assumptions refer to beliefs or motherhood type statements such as, "Human life is worth saving". Moos (1974a) explicitly states his value assumption:

Social ecology has an explicit applied value orientation in that it gathers and utilizes knowledge for promoting maximally effective human functioning. The field utilizes basic research and practical techniques for the application of knowledge derived from this research toward the end of increasing the quality of the human environment. (p. 21)

In contrast to value assumptions, "validity assumptions are much more specifically related to program objectives" (Suchman, 1967, p. 42). Programs designed to produce change must make validity assumptions concerning the worthwhileness of the services being provided. An effort should be made to identify the value assumptions which underlie a program.

In general theoretical terms the validity assumptions which are



pertinent to this study are once again highlighted by Moos:

Human behaviour cannot be understood apart from the environmental context in which it occurs. This statement implies, for example, that accurate predictions of behaviour or of treatment outcome cannot be made solely from information about individuals; information about their environments is essential. Physical and social environments must be studied together, since neither can be fully understood alone. For example, both architectural design and psychosocial treatment milieu can significantly influence patient and staff behaviour. (1974a, p. 21)

Following are the two validity assumptions which have specific relevance to the study of the House of Sophrosyne program: (1) it was assumed that an alcoholism halfway house was the most preferred and effective method in assisting the alcoholic female to resolve her alcohol dependency and return to a normal life style; and (2) it was assumed that female alcoholics upon making a decision to obtain help with their problem would prefer a short-term residential facility comprised of other female alcoholics.

Shipman (1972) describes the limitations of social research in which he states: "Authors have a variety of motives for writing. They have in common only a desire to spread information, expert influence and gain material rewards or prestige" (p. 31). In response to this statement, this study constitutes a Master's thesis which was undertaken as partial fulfillment of a degree requirement issued by the School of Social Work at the University of Windsor.

The most significant limitation of this study lies in the overall scope and depth of the research. Despite the broad theory base and procedures used by Rudolf Moos to develop the social climate scales from a cross section of institutional environments, the empirical generality or generalizability of the study is limited to the House of Sophrosyne program.

### RELIABILITY and VALIDITY

The evaluation of the reliability of any measurement procedure consists in determining how much of the variation in scores among individuals is due to inconsistencies in measurement" (Selltiz, Jahoda, Deutsch, & Cook, 1959, p. 166). Different methods of estimating reliability focus on different sources of variation in scores. Selltiz et al (1959) refer to two types of estimates; stability and equivalence:

The stability of results of a measuring-instrument is determined on the basis of the consistency of measures on repeated applications. It is important, however, to distinguish between inconsistency due to genuine changes in extraneous factors. (p. 168) Estimates of equivalence concern the extent to which different investigators using the instrument to measure the same individuals at the same time, or different instruments applied to the same individuals at the same time, yield consistent results. (p. 172)

A further delineation regarding methods of estimating reliability are discussed by Leonard Kogan (1975) where he describes the five major methods: "(1) immediate retest with same test; (2) delayed retest with the same test; (3) immediate retest with an equivalent or parrallel form of the original test; (4) delayed retest with an equivalent or parrallel form of the original test; and (5) internal analysis of a test given on one occasion" (p. 85).

Kogan goes on to indicate that "other factors such as the variability and general level of the group on the particular property or characteristic, as well as the number of items used in obtaining the score for an individual, are also reflected in the estimate of reliability" (1975, p. 87).

The other major consideration given when establishing instruments of measurement is the concept of validity.

The validity of a measuring instrument may be defined as the extent to which differences in scores on it reflect true differences among individuals, groups, or situations in the characteristic which it seeks to measure, or true differences in the same individual, group, or situation from one occasion to another rather than constant or random errors (Selltiz et al, 1959, p. 155).

There are numerous types of evidence used to infer the validity of the instrument. The types of evidence considered in this study are; face validity and consistency.

Face validity refers to "the relevance of the measuring instrument to what one is trying to measure is apparent 'on the face of it'" (Selltiz et al, 1959, p. 165). In determining the "face validity" in needs to be assessed if the instrument provides an adequate sample of that kind of behaviour.

A valid measure must also have consistency. Rossi, Freeman, and Wright (1979) indicate that "a valid measure of a concept must be consistent with past work that used that concept.... must be consistent with alternative measures that have been used effectively by other evaluators.... must be internally consistent"(p. 170). An example of internal consistency would be the use of several questions or statements to measure autonomy, the answers to those questions or statements should be related to each other as if they were alternative measures of the same thing.

According to Kogan (1975) evidence for validity usually comes from two major sources, the logical or rational approach and the empirical or statistical approach.

In the logical or rational approach the determination of validity involves the critical examination of the form, structure and content of the measurement procedure as it relates to the claimed measurement. In the empirical or statistical approach, validity is based on determining the relationship of the measures to outside criterion.

#### DEVELOPMENT OF THE COPEs

In an effort to respond to concerns of reliability and validity regarding COPEs it would seem warranted to at least provide a brief overview of its development and applicability. The reader is referred to Moos (1974a, 1974b, 1974c) for a more detailed explanation.

Moos (1974a) calls attention to the variety of research undertaken in the past regarding the variability of behaviour over settings. Hartshorne and May (1928) conducted studies regarding the conflict in individuals between honest and deceitful behaviour. They concluded that consistency in behaviour from setting to setting was not due to personality traits but was due to similarities in the setting.

Raush, Dittman, and Taylor (1959) and Raush, Farbman, and Llewellyn (1960) studied the interactions of a group of pre-adolescent boys at two phases of residential treatment. They concluded that there was some individual consistency in social behaviour across settings and some setting consistency across individuals. The interactive effects of child and setting were considered more important than child or setting alone.

Studies by Endler and Hunt (1968) concluded that persons, settings, and person-setting interactions each contributed significantly to the

variance in both anxiety and hostility.

Mischel (1968) summarizes the literature which criticizes the empirical legacy regarding trait models of personality.

Moos and others have demonstrated that persons, settings, modes of response, and their interactions, each contributed statistically significant and practically important proportions of the total variance in behaviour.

Moos (1974a) points out a variety of different scales which were developed to measure patient and staff evaluations, opinions, and ideologies. The Staff Opinion Scale (Rice et al, 1966), the Philosophy of Treatment Form (Barrell, DeWolfe, & Cummings, 1965), the Opinions about Mental Illness Scale (Cohen & Struening, 1963), and the Ward Evaluation Scale (Rice, et al, 1963).

More directly related work includes Jackson (1969) who constructed the Characteristics of Treatment Environment Scale, consisting of statements about conditions in the environment of a mental hospital.

Ellsworth et al (1968) developed the Perception of Ward scales which measured the sociopsychological characteristics of treatment settings in an attempt to relate the characteristics to treatment outcomes.

Spiegel and Keith-Spiegel (1971) developed a Ward Climate Inventory from Ellsworth scales.

King and Raynes (1968) developed a scale to measure practices adopted in the management of children in residential institutions.

Kellam et al (1966) developed the Ward Information Form by studying the atmospheres of psychiatric wards by grouping certain

objective, easily observable items along given dimensions.

Drawing from the various theory and research Moos based his work on three methods; the subjective perceptual assessment of assessing organizational climate; the use of objective organizational dimensions, such as size; and the identification of the average personal and/or behavioural characteristics of their inhabitants.

Most of the items in the initial form of COPES were adapted from the Ward Atmosphere Scale (Moos, 1974a) by patients and staff who were familiar with the characteristics of the social environments of day hospitals and halfway houses. The remainder of the items were developed from program descriptions and interviews with patients and staff in various programs. Although some items on COPES are directly parallel to items in the Ward Atmosphere Scale other items were reworded in order to obtain better item splits in community programs.

The initial COPES form comprised of 130 items was administered to 373 members and 203 staff in 21 community-oriented treatment programs, representing a broad range program types. Items were initially sorted by agreement between three independent judges into 12 subscales. The final results of 10 subscales of COPES was derived through the use of the following criteria:

1. Each subscale should have acceptable internal consistency, and each item should correlate more highly with its own than with any other subscale. Two of the original 12 subscales were dropped because they did not meet these criteria.... More than 90 percent of the items for members and more than 95 percent for staff correlated above .30 with their appropriate subscales.... using Cronbach's  $\alpha$  and Average within-program item variances. The results indicate that all the subscales have acceptable internal consistency and moderate to high high average item-subscale correlations. In addition, the items correlate much more highly with their own than with other subscales.

2. Insofar as possible, not more than 80 percent not less than 20 percent of subjects should answer an item in one direction. This criterion was established to avoid items that were characteristic only of extreme programs. Ninety-five percent of the COPES items had item splits between 20-80 for members or staff or both....
3. There should be approximately the same number of items scored true as scored false within each subscale, to control for acquiescence response set.
4. Items should not correlate significantly with the Halo Response Set Scale, which assessed both positive and negative halo in program perceptions and was also given to members and staff. (Moos, 1974a, p. 229)

The final ten subscales used in COPES are listed in Table 1.

Moos (1974a, 1974b) describes in detail the development of normative samples for COPES. A broad range of American programs were included in a normative sample in order to make it representative of the types of programs providing alternatives to hospitalization.

The sample included 54 programs. Both members and staff were tested in 32 programs and only members tested in the remaining 22 programs. The programs in which both members and staff were tested included 2 rehabilitation workshops, 2 partial hospitalization programs, 11 halfway houses, and 17 day care centres. The 22 programs in which only members were tested, included 20 foster homes, an outpatient support group, and a patient-run self help unit. A total of 779 members and 357 staff were included in the normative sample.

A British reference group of 20 programs was also collected. The sample included 2 psychiatric day hospitals in two major teaching hospitals and 18 halfway houses.

The means and standard deviations for the ten subscales were calculated for all programs. The standard deviations for programs are used if mean subscales scores for an entire program are being compared to the normative sample. The standard deviations over individuals are

used if an individual resident or staff member is being compared to the normative sample.

The subscales have acceptable internal consistency (Member Mean .79, Staff Mean .78) and moderate to high average item to subscale correlations (Member Mean .41, Staff Mean .47).

The highest intercorrelation of the ten subscales for the same programs was .50. The ten dimensions measure distinct, though somewhat correlated characteristics of member and staff perceptions of program atmosphere.

The extent of differences among programs was calculated using a one-way analyses of variance, which indicated that all ten subscales significantly differentiated among the programs for both member and staff responses.

Test-retest reliability, profile stability, and relationships of the subscales to the background variables of the respondents and to social desirability scales were not calculated for COPES. Such calculations were done for the Ward Atmosphere Scale and found to be satisfactory. Since both COPES and the Ward Atmosphere Scale were directly parrallel in both content and structure, the results were generalized as being applicable to COPES.

Five structural program variables: the total capacity of the program, the number of members, the staff-member ratio, the monthly program cost per member, and the number of years a program has been in operation, were significantly correlated between member and staff perceptions for all ten subscales. Six of the ten being significant at P < .01.

Three average member background characteristics were related to



staff perceptions of the treatment environment. Mean age, mean length of stay in the program, and the proportion of members working or going to school were significantly correlated to staff perceptions. The level of significance for the ten subscales ranged from  $P < .01$  to  $P < .10$ . Mean staff age was also significantly correlated to staff perceptions of the treatment environment.

From a sample of 13 programs, correlations were calculated between COPEs subscales and the members' reaction to the program. The three relationship dimensions were highly correlated with general satisfaction, liking for staff, and personal development. The treatment program and system maintenance dimensions also had significant correlations with these variables, although the relationships were fewer in number.

A number of studies were also undertaken which focused on the concept of homogeneity and its correlations to various aspects of congruence in a program. The reader is once again referred to Moos (1974a) for the details.

In conclusion, Moos (1974c) responds to a number of conceptual and methodological issues. First, Moos indicates that each of the social climate scales is only moderately correlated to the more objective environmental dimensions and therefore information about the social climate adds unique information about an environment. Second, social climate scales discriminate among environments about as well as personality traits discriminate among people. Third, social environments remain highly stable over relatively long periods of time, provided the program retains a reasonably consistent overall treatment philosophy. Fourth, a respondent's perception of the social

environment is only minimally related to the tendency to answer items about themselves in socially desirable directions. However, the role position of the individual tends to have a mediating effect on their environmental perception. Fifth, applications of the social climate concept have a greater degree of applicability in smaller environments in which the individuals usually have face to face contact with each other. Sixth, the subjective social climate methodology, need not be discarded in favour of a more objective methodology, since it is the subjective global impressions which individuals remember and take into consideration when making major decisions about their lives. Seventh, the three categories of dimensions appear to account for the major proportion of the differences among environmental subunits in most situations, although additional dimensions may need to be developed in certain specific situations. Last, some of the dimensions tend to be growth producing while others tend to be growth inhibiting. However, emphasis on certain dimensions such as personal development (e.g. competition) may relate to an increase in drop out rates while emphasis on other personal development dimensions (e.g. autonomy) may relate to maladaptive behaviour or physical and mental symptoms.

#### ANALYSIS OF THE DATA

Analysis in research includes the process of summarizing and communicating the data collected to answer the questions posed in the study. In the following chapter, concise presentations of facts about the sample studied are provided in either table or graph form.

Statistical analysis is a key phase of the research process.

Statistics have been categorized as either descriptive or inferential. Descriptive statistics are used to describe the data that has been collected. Inferential statistics are used when the purpose is to generalize and make inferences based upon the sample data.

Rudolf Moos (1974a) has employed a considerable amount of statistical analysis to support his methodological approach to evaluating the social climate of treatment programs. In this regard, the descriptive statistics employed in this research project will be applied to the normative samples established by Moos in his research.

Statements of findings regarding the House of Sophrosyne program are supported by and compared to the normative sample statistics obtained by Moos (1974a). More specifically the raw data pertaining to COPES were analyzed according to the procedures developed by Moos, including the tables used to convert program mean raw scores into standard scores (1974b). The remaining raw data were analyzed by calculation using commonly accepted statistical formulas used to obtain such statistics as mean, median, mode, percentage, and frequency.

Finally, the interpretation of any given set of data depends on the person interpreting the statistics and more importantly, the decision makers who, in the end, must translate data into decision and action.

#### A REVIEW

The Community Oriented Program Environment Scale was used to measure the residents and staff perception of the following ten dimensions of the treatment environment: involvement, support,

spontaneity, autonomy, practical orientation, personal problem orientation, anger and aggression, order and organization, program clarity, and staff control. The information from this scale will focus on the research question: how are the salient characteristics of the treatment environment perceived by the residents and staff at the House of Sophrosyne?

Information was obtained from the residents and staff regarding their perception of the physical environment in the following areas: room size, furniture layout, decorations, lighting, heating, ventilation, and noise level. The information from this area will focus on the research question: what are the salient architectural and physical design characteristics of the treatment environment at the House of Sophrosyne?

Additional information was obtained from the residents and staff regarding personal data. The areas included: (A) Residents: length of stay in the program, age, marital status, number of children, source of income, perception of drinking problem, referral source, education, and occupation. (B) Staff: length of present employment, education, special training, and age. This information will provide the focus on the research question: what are the salient personal and behavioural characteristics of the residents and staff at the House of Sophrosyne?

From a review of agency manuals and a questionnaire and interview with the Executive Director of the House of Sophrosyne, information was obtained in the following areas: the shape, size and functional structure of the organization, the prominent behaviour settings of the

program, the program objectives and activities, and the rationale as to why the program activities are expected to achieve the objectives. This information will provide the focus on the following two research questions: (a) what are the salient dimensions of organizational structure which exist in the treatment environment at the House of Sophrosyne? (b) what are the salient behaviour settings which exist in the treatment program at the House of Sophrosyne? This information will also help to examine the Executive Director's understanding of the program objectives, and the appropriateness of putting the program objectives into measurable terms.

Finally, the physical environment was examined in order to provide an overall description of the House of Sophrosyne, while at the same time providing the perceptions of an outside observer.

The following chapter will analyze and describe the data collected in the research project.

## CHAPTER IV

### DATA ANALYSIS

#### THE HOUSE OF SOPHROSYNE

Sophrosyne is a Greek word meaning "a wise, balanced life". The use of self-restraint or the idea of "temperance" has also been associated with the word sophrosyne; the spirit of the disciplined life. Sophrosyne includes such things as humility, humanity and mercy.

In 1975, an interested group of people representing the primary alcoholic agencies in the City of Windsor formed a committee known as the Resource Council for Alcoholism.

In late 1976 the need for an alcoholic women's residence was identified. A steering committee was formed to work on the project of establishing a facility for women. In January 1977 a Board of Directors was formed and in May of 1977 the organization became known as the House of Sophrosyne.

In January 1978 the property and building on Chappell Avenue was purchased and a volunteer women's group offered supportive services until full time staff were hired in October 1978.

On November 1st, 1978, with renovations completed, the House of Sophrosyne officially opened.

Originally the House of Sophrosyne provided only detoxification of the female alcoholic. With the growing need for an on-going program

of recovery group sessions were established, based on a twelve-step self-help program of recovery.

By May 1979 the House was full to its 12 bed capacity, with the periods of April-May and November-December usually having a waiting list for admission.

By November 1979 the financial position of the House was very unstable. In December 1980 an agreement was reached with the City of Windsor, granting remuneration for group and individual counselling services being provided for women who qualified. The additional sources of revenue supplemented the financial assistance received from United Way - Special Projects which had provided funding since 1979. In the latter part of 1981, the House of Sophrosyne was admitted as a full member of United Way Windsor-Essex County.

Questionnaire: Executive Director of House of Sophrosyne

In the questionnaire to the Executive Director, the House of Sophrosyne program objectives were considered, as well as the program activities designed to obtain the objectives, and the rationale linking the program activities to the program objectives.

Following are the program objectives, program activities and related causal assumptions which were explicated in the questionnaire designed for the Executive Director of the House of Sophrosyne. The statements on the questionnaire are specified in the following order; program objectives, program activities, causal assumptions:

- (1) Understanding and Acceptance: of alcoholism as an illness that can be arrested and that alternatives exist in changing lifestyle.
  - (1.1) Completion of an individual assessment form.
    - (1.1a) The individual assessment form provides both staff and the

woman with an overview of her personal history. This gives a clearer understanding of drinking patterns, family history, and behaviour and personality characteristics.

- (1.2) Individual counselling.
  - (1.2a) This activity uses the information obtained through the assessment, including short and long term goals to assist the person in learning more about herself. Individual counselling provides the opportunity for self-discovery and an opportunity to look at changing traditional patterns.
- (1.3) Group counselling.
  - (1.3a) Group counselling is especially salient for identification with other women who have shared similar experiences, and to identify the extent of her problem with chemical dependency.
- (1.4) Didactic lectures.
  - (1.4a) Didactic lectures gives each woman information on topics of the dependent personality; physical aspects of alcoholism; myths about alcohol and alcoholism; to assist her to identify and accept her problem.
- (2) Behaviour Change: is important to assist each woman in interrupting the cycle of chemical dependency.
  - (2.1) Individual counselling.
    - (2.1a) Individual counselling provides the opportunity for short term and long term goal setting, with assistance from staff in following up on insights and exercises in changing behaviour.
  - (2.2) Goal-setting and follow-up.
    - (2.2a) Achievement in short term and long term goal setting is a reinforcement in itself; that encourages continuation of positive behaviour change.
  - (2.3) Completion of an individual assessment.
    - (2.3a) The individual assessment form provides information that is the starting point for goal-setting and behaviour change.
- (3) Personal Development: improvement in self-image and self-confidence through the achievement of short and long term goals.
  - (3.1) Completion of an assessment form.
    - (3.1a) The information obtained in the assessment form is valuable in giving each woman an overview of past behaviour and coping patterns, as a starting point for changing behaviour.
  - (3.2) Individual history and progress reports.
    - (3.2a) History and progress reports are kept for each woman on a shift-by-shift basis. This provides an in-depth and highly chronological review of her development during treatment.
  - (3.3) Role playing exercises.
    - (3.3a) Role playing gives each woman an opportunity for practical experience in trying out new behaviours in a controlled setting (group sessions), with feedback from staff and other residents.



- (4) Information Giving: to educate and inform on topics that assist in understanding of the disease as well as a change in lifestyle.
  - (4.1) Didactic lectures.
    - (4.1a) A didactic lecture is an information session that gives each woman insight into numerous topics related to alcoholism; self-concept and personal development.
  - (4.2) Written assignments.
    - (4.2a) Written assignments are based on the topics that are discussed in the didactic lectures. This allows the staff to be sure that the presentation is understood and to some extent retained.
  - (4.3) Program booklet.
    - (4.3a) The program booklet is a forty page summary of the lectures and group sessions that take place during the treatment program. This is given to each woman a few days after admission and is used during sessions and as a reference.
  
- (5) After-Care and Follow-Up: to offer continuing support after the residential program has been completed.
  - (5.1) Group counselling sessions for women who have completed the program.
    - (5.1a) Sessions are held weekly, specifically for women who have completed the treatment program, allows an opportunity to discuss new concerns that are encountered, having returned to the home environment.
  - (5.2) Continuation of individual counselling.
    - (5.2a) Each woman continues to work with an individual case-worker after discharge from the program to ensure that she is given assistance in long term goals.
  - (5.3) Continued re-evaluation of goals.
    - (5.3a) Both short term and long term goals are evaluated with the individual caseworker and in group setting, with an opportunity for input from staff and other women who share similar experiences.
  - (5.4) Involvement in a self-help group (A.A.).
    - (5.4a) Involvement in A.A. or similar self-help group is essential to continued maintenance of quality sobriety. This is strongly encouraged during after-care.
  - (5.5) Referrals to community resources.
    - (5.5a) Referrals to other community support systems is essential to continuation of change in behaviour. This may include financial counselling; family and marriage counselling or legal assistance.
  
- (6) Life Skills Experience: acquisition of skills required to cope with day to day living.
  - (6.1) Didactic lectures.
    - (6.1a) Didactic lectures provide the basic working information to change behaviour and lifestyle. Women become familiar with assertiveness; relaxation as a means of coping with stress, budgeting, nutrition, family planning, first aid and others.

(6.2) Role playing exercises.

(6.2a) After the didactic lectures, each woman is given an opportunity to practice the skills that have been discussed, with feedback from staff and residents.

(6.3) Written assignments.

(6.3a) Specific written assignments are other means of measuring the extent to which the material that has been presented has been understood and retained. This helps to determine if the delivery and content of the information is appropriate or needs changes.

Finally, other mechanisms (i.e. policies, guidelines, assumptions) listed in the questionnaire, which promote the achieving of the stated objectives include:

1. Respect of confidential information to allow each woman the freedom to express herself and share with the group, without fear of disclosure or loss of privacy.
2. The residential setting itself provides a unique support mechanism. Women in treatment are exposed to other women who share the same concerns and who have similar strengths and weaknesses. This setting also provides an intensive treatment setting that is often necessary to arrest chronic alcoholism.
3. Respect for each person as an individual with unique characteristics and needs.
4. Responsibilities of residents and staff are made clear to avoid misunderstandings.

The objective and the underlying causal assumptions in the House of Sophrosyne program are well articulated, and therefore, do not require further explanation. Based on the preceding description of program objectives and the plausible causal assumptions, the establishment of specific indicators can be appropriately undertaken which provide measurable criteria on which to evaluate program outcome and effectiveness.

Regarding the activities in the House of Sophrosyne program, a more detailed description will be provided later in this chapter.

The importance of various environmental influences upon the individual has been described by numerous authors and researchers,

including (Bromet, Moos, Bliss, & Wuthmann, 1977; Finney, Moos, & Chan, 1981; Horowitz, Duff, & Stratton, 1970; Martin, & Segal, 1977; Maslow, & Mintz, 1956). In this study there are five research questions which consider the more salient environmental aspects of the House of Sophrosyne program.

#### RESEARCH QUESTION I

What are the salient architectural and physical design characteristics of the treatment environment at the House of Sophrosyne?

#### ECOLOGICAL DIMENSIONS

##### Physical Building and Surroundings

The House of Sophrosyne is situated in a quiet, residential area, adjacent to a park, within one half block of a bus route, and two blocks from both a shopping mall and Windsor Western Hospital. This arrangement allows for a homelike atmosphere while at the same time offering easy access to community resources.

The building itself was originally built as a church and is in the shape of an "A" frame, symmetrical triangle. The outside dimensions of the building are approximately 34 feet wide by 76 feet long.

##### Room Characteristics

(A) Conference Room: a major portion of the structured program

activities take place in this room. It must be able to accommodate a maximum of fourteen individuals, including all residents and two staff. The room measures 15 feet wide by 24 feet long by 9 feet high.

The room is completely panelled in a neutral tone, is carpeted from wall to wall, and has a white suspended ceiling. There are several plaques and banners on the walls with sayings that are related to the treatment program philosophy.

The furniture is casual in nature and arranged along all four walls, along with various materials such as a blackboard, flow chart, and tables, with the centre of the room being open space.

The lighting in the room is comprised of two eight foot fluorescent bulbs on the ceiling. The heat is supplied by a single hot water radiator at one end of the room. The ventilation in the room is limited to three 1 foot by 1 foot windows situated at the top of one wall, just below the ceiling. The room is in the basement and isolated from other activities and frequently used rooms.

(B) Admission Room: this room is one of two rooms used for individual counselling. It measures 15 feet wide by 13 feet long, with a cathedral ceiling.

The walls are a combination of wood panelling and painted foundation blocks, and the floor is carpeted. The couch, chairs and desk are casual in nature and well spaced in the room. Library resource materials and a private washroom are additional major features.

The lighting is comprised of two incandescent bulbs located in the ceiling, as well as two desk lamps. The heat is supplied by a hot water radiator all along the outside wall. The ventilation is provided by one average size house window. The room is separated from

the main living quarters and resident traffic in the building.

(C) Front Lounge: this room is used for individual counselling. It constitutes a portion of the front lobby of the building and measures 14 feet wide by 8 feet long.

The walls are a combination of painted foundation blocks, wood panelling and wall paper. The furniture is in excellent condition and arranged for intimate discussions. There is plush carpeting throughout which is maintained in a clean fashion.

The lighting is a combination of lamps and four incandescent ceiling bulbs. The heat is supplied by hot water radiators across both walls. The room is semi-isolated from the rest of the building. Located by the front entrance but separated from the main living quarters.

(D) Recreational Lounge: this room is the primary day to day living area for residents of the program. It measures approximately 18 feet wide by 24 feet long. The walls are a combination of wood panelling, wallpaper and painted foundation blocks. It is carpeted throughout, with tapestry and pictures spaced out along the walls. The couches and tables are casual in nature and are located all along the walls, leaving the centre of the room as open space. Plants and book shelves are also added features.

The lighting is provided by three lamps, while the heat is supplied by a hot water radiator across the outside wall. Ventilation for the room is supplied by one window.

(E) Visiting Area: this area is located in the basement. There are two visiting areas within large open basement which measures 50 feet by 36 feet. The basement is quartered off for functional purposes, and the visiting areas constitute approximately half the area.

There are several couches and chairs in each visiting area. The walls are painted foundation blocks and are sparsely decorated. The floor is tiled throughout and the lighting is provided by two rows of fluorescent bulbs. The heat is once again hot water, with the radiator placed along the outside walls. The visiting areas are very open and privacy is limited.

(F) Kitchen: this room is located in the basement, opposite of the visiting areas. The kitchen measures approximately 18 feet by 21 feet, with two full walls comprised of cupboards. A large six burner, grill and stove is in the corner. There are three sinks, two refrigerators and a large chest freezer in the adjoining room.

(G) Bedrooms: each bedroom is basically the same in size and layout. A typical bedroom measures 17 feet by 16 feet, has a tiled floor, painted walls and some personal decorations. There are three beds per room, each with an accompanying night stand and one large dresser which is shared by three occupants. In addition, there is a table and chair and one large shared closet per bedroom.

The lighting is supplied by several lamps, and the heat is generated by a hot water radiator across the outside wall. The ventilation comes from one average size window. An added feature to each room is an electric fire alarm.

(H) Washroom: the main, communal washroom is 16 feet by 16 feet in size and is supplied with two toilets, three sinks and two showers. The walls are painted, the floor is tiled and the lighting is supplied by fluorescent bulbs. A large eight foot mirror and cabinet is located opposite the showers.

Both residents and staff were asked for their personal perception

of the room characteristics in general.

(1) Room Size: Table II highlights the perception by residents and staff regarding room size. The majority of residents and staff (14, or 82.3%), perceived the room to be the "right size".

TABLE II. --Perception of Room Size by Residents and Staff:  
Showing Frequency and Percentage

	ROOM SIZE					
	Residents		Staff		Total	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Too large	--	--	--	--	--	--
Right size	8	47.0%	6	35.3%	14	82.3%
Too small	2	11.8	1	5.9	3	17.7
Total	10	58.8%	7	41.2%	17	100.0%

(2) Decorations: Table III shows the perception by residents and staff regarding decorations. The majority of residents and staff (15, or 88.2%), perceived the decorations to be "acceptable".

TABLE III. --Perception of Decorations by Residents and Staff:  
Showing Frequency and Percentage

DECORATIONS						
	Residents		Staff		Total	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Attractive	2	11.8%	--	--	2	11.8%
Acceptable	8	47.0	7	41.2%	15	88.2
Ugly	--	--	--	--	--	--
Total	10	58.8%	7	41.2%	17	100.0%

(3) Furniture: Table IV shows the perception of residents and staff regarding the furniture. The majority of residents and all staff (14, or 82.6%), perceived the furniture to be "acceptable".

TABLE IV. --Perception of Furniture by Residents and Staff;  
Showing Frequency and Percentage

FURNITURE						
	Residents		Staff		Total	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Attractive	2	11.8%	--	--	2	11.8%
Acceptable	7	41.2	7	41.2%	14	82.6
Ugly	1	5.9	--	--	1	5.9
Total	10	58.9%	7	41.2%	17	100.0%



(4) Furniture Arrangement: Table V shows the perception of residents and staff regarding the furniture arrangement. The majority of residents and all staff (15, or 88.2%), perceive the furniture as being "very well arranged".

TABLE V. --Perception of Furniture Arrangement by Residents and Staff:  
Showing Frequency and Percentage

	FURNITURE ARRANGEMENT					
	<u>Residents</u>		<u>Staff</u>		<u>Total</u>	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Very Well Arranged	8	47.0%	7	41.2%	15	88.2%
Acceptably Arranged	2	11.8	--	--	2	11.8
Poorly Arranged	--	--	--	--	--	--
Total	10	58.8%	7	41.2%	17	100.0%

(5) Noise Level: Table VI shows the perception of residents and staff with respect to noise level in the building. The residents and staff are evenly distributed with 47 percent perceiving the noise level as "somewhat noisy" and/or "very little noise".

TABLE VI. --Perception of Noise Level by Residents and Staff:  
Showing Frequency and Percentage

	NOISE LEVEL					
	Residents		Staff		Total	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Very Noisy	1	5.9%	--	--	1	5.9%
Somewhat Noisy	5	29.4%	3	17.6%	8	47.0
Very Little Noise	4	23.5	4	23.5	8	47.0
Total	10	58.8%	7	41.1%	17	99.9%

(6) Lighting Arrangement: Table VII illustrates the perception of residents and staff regarding the lighting arrangements. A total of 52.9 percent of residents and staff perceive the lighting to be "very well arranged", while 23.5 percent of residents and staff perceive the lighting to be "acceptably arranged" and/or "poorly arranged".

TABLE VII. --Perception of Lighting Arrangement by Residents and Staff:  
Showing Frequency and Percentage

	LIGHTING ARRANGEMENT					
	Residents		Staff		Total	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Very Good	4	23.5%	5	29.4%	9	52.9%
Acceptable	3	17.6	1	5.9	4	23.5
Poor	3	17.6	1	5.9	4	23.5
Total	10	58.7%	7	41.2%	17	99.9%

(7) Temperature: Table VIII shows the perceptions of residents and staff regarding the inside temperature. The residents and staff are evenly distributed with 47 percent, perceiving the temperature to be "too cold" and/or "right warm".

It should be noted that the majority of residents and staff who indicated on the questionnaire that it was "too cold" also indicated to the researcher that it was also "too hot" on a number of occasions, but felt that they were only allowed to make one choice. The researcher followed up on the dual answers given by a significant number of residents and staff and found that there was a total of two thermostat controls for the entire building, one for each floor.

TABLE VIII. --Perception of Temperature by Residents and Staff:  
Showing Frequency and Percentage

TEMPERATURE						
	Residents		Staff		Total	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Too Cold	6	35.3%	2	11.8%	8	47.0%
Right Warmth	4	23.5	4	23.5	8	47.0
Too Hot	--	--	1	5.9	1	5.9
Total	10	58.8%	7	41.2%	17	99.9%

(8) Ventilation: Table IX shows the perceptions of residents and staff regarding the ventilation in the building. Both residents and staff are evenly distributed with 35.3 percent perceiving the ventilation in the building as being "too drafty", 29.4 percent perceiving the ventilation as "neither drafty or stuffy", and 35.3 percent perceiving the ventilation as being "too stuffy".

TABLE IX. --Perception of Ventilation by Residents and Staff:  
Showing Frequency and Percentage

	VENTILATION					
	Residents		Staff		Total	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Too Drafty	4	23.5%	2	11.8%	6	35.3%
Neither Drafty or Stuffy	2	11.8	3	17.6	5	29.4
Too Stuffy	4	23.5	2	11.8	6	35.3
Total	10	58.8%	7	41.2%	17	100.0%

RESEARCH QUESTION II

What are the salient behaviour settings which exist in the treatment environment at the House of Sophrosyne?

BEHAVIOUR SETTINGS

Consideration is given to only the most prominent formal and informal behaviour settings.

(1) Introduction and Admission: each applicant is required to have an introductory admission interview. This serves two purposes, to provide an orientation to the applicant and to provide staff the opportunity to determine if the applicant would be appropriate for the program.

In addition to an initial interview, the applicant will be considered appropriate for admission when some, or all, of the following criteria are met:

- (1) Physical and/or psychological dependence.
  - (2) Physical disease recognized as resulting from, or related to, alcoholism.
  - (3) Marital stress related to alcoholism.
  - (4) Evidence of deteriorating physical ability.
  - (5) History of law violation related to alcohol abuse.
  - (6) Complaint of one or more of the following as a manifestation of alcohol abuse:
    - (a) Blackouts, (b) Hallucinations, (c) Delirium Tremens.
  - (7) inability to decrease/control the amount of alcohol ingested.
  - (8) Willingness to participate in the rehabilitation program.
  - (9) Depression or suicidal thoughts related to alcohol abuse.
- There are also contradictory indications for admission:
- (1) In an agitated state to the degree that use of restraints are necessary.
  - (2) Bizarre, confused or disoriented behaviours to a degree indicative of a psychiatric diagnosis.
  - (3) Acute physical problems such as:

- (a) infectious disease requiring isolation, (b) acute hepatitis,
- (c) comatose state, (d) evidence of acute cardiac stress,
- (e) any medical condition requiring hospital and/or nursing care.
- (4) Denies use of any alcohol.
- (5) Exhibits signs of Wernicke's-Korsakoff's Syndrome.

During the course of the orientation for the applicant, she is given a tour of the facilities, as well as a written copy of the house rules and an explanation of a resident's rights.

Table X provides an outline of the written rules given to each prospective resident.

As reflected in the house rules, each resident must successfully complete a twenty-one day trial period, prior to an increase in privileges. Essentially, the rationale for such a trial period is to minimize the chances of a new resident to act impulsively and thus increase the chance of behaving in an unacceptable manner and possibly being discharged prematurely. In addition, it allows staff the opportunity to become familiar with each resident through an initial period of close contact and supervision.

TABLE X. --House of Sophrosyne: House Rules

1. All prescription medication must be submitted upon admission. Medication will be administered by the staff according to the doctor's instructions. No mood altering drugs or sleeping pills can be given.
2. Residents are expected to consult with staff before leaving the residence. Only staff are permitted in the offices unless personal concerns are to be discussed.
3. Any resident returning intoxicated or in possession of drugs or alcohol is subject to immediate discharge. The House of Sophrosyne reserves the right to send any resident who is suspected of being under the influence of chemicals to the hospital for a drug screen.
4. Each resident is required to participate in the program, including two A.A. meetings per week.
5. No smoking is allowed in the bedrooms.
6. Residents are required to have a physical examination within five days of admission.
7. Weekly visiting hours are between 6 p.m. and 8 p.m.; weekends between 1 p.m. and 8 p.m. Visitors are allowed twice a week; once during the week and once on the weekend.
8. No dating is allowed during the first 21 days after admission. After that time dating is allowed once a week on the weekend.
9. Overnight leaves are not permitted during the first 21 days after admission. Weekend leaves start Saturday at noon and end Sunday at 11 p.m. No one is allowed to leave Saturday until all the housekeeping is completed.
10. The residential phone can be used for personal calls until 11:30 p.m. No long distance calls are allowed. To ensure adequate rest, T.V.; radios; and lights will be turned off by 12:30 a.m.
11. Each resident is expected to do her share of housekeeping according to a rotating schedule.

THE ABOVE RULES ARE FOR EVERYONE'S BENEFIT. ABUSE OF THE HOUSE POLICIES WILL RESULT IN A LOSS OF PRIVILEGES FOR ALL RESIDENTS. IF THERE ARE ANY QUESTIONS PERTAINING TO THE ABOVE PLEASE ASK THE STAFF.



The maximum length of stay at the House of Sophrosyne is twelve weeks. Residents who stay beyond this time period are the exception rather than rule.

The structured treatment program takes essentially four weeks to complete. It is repeated three times during the twelve week length of stay, as experienced by most residents.

(2) Individual Counselling: there are a total of five staff available for casework with residents. The main purpose of the one to one sessions is to explore individual goals and goal attainment alternatives, as well as to discuss issues which are inappropriate for a group setting. Individual sessions are usually scheduled around the structured daily activities, and usually take place in either the admission room or front lounge. A degree of continuity is maintained in the individual counselling sessions through a review of counselling records by the Executive Director or Program Director.

(3) Group Counselling: the basement conference room serves as the setting for the daily group counselling sessions. All residents attend the sessions along with two staff members. During the group sessions there is an exchange of thoughts, ideas and feelings. The group sessions allow individual residents to identify with others around commonly shared problems. At the same time staff provide a healthy model for residents to follow, as well as assisting in exploring alternatives to solve problems, encouraging group feedback, and developing task oriented exercises for residents based on group input. Lack of a member's participation is brought to the group's attention by staff in order to deal with the lack of participation and keep the group functioning at an optimum level. Each group

session is summarized in a written report by staff and reviewed by the Executive Director or Program Director.

(4) Didactic Lectures: the basement conference room serves as the setting for the lectures. All residents and two staff participate in this activity. The primary purpose of the didactic lectures is education and information giving. Topics range from physical dependence on alcohol to developing assertiveness. Efforts are made to have the topics in the lectures relevant to the group session for that week.

(5) Films and Tapes: all residents and one or two staff meet on a weekly basis in the conference room. The films and tapes are educational, and seek to help the residents identify with their own problems, by way of role playing and re-enactments of alcoholics and their families. Once again efforts are made to present the films and tapes that are relevant to the other program activities taking place in that week.

(6) Guest Speakers: on a regular basis various individuals, such as recovered alcoholics discuss their recovery with the residents. These sessions usually take place in either the dining area or the conference room. The primary purpose of the guest speakers is to stress the ability to succeed in recovering from alcoholism.

(7) Women's Meetings: these meetings take place on a weekly basis in the conference room. All the residents meet with recovered alcoholic women to discuss alcoholism and issues peculiar to women. These meetings are also open to former residents as part of the after-care emphasis. Once again the primary function of these meetings is to allow a positive identification to be made with the recovered alcoholic

women, by the residents, as well as establishing an orientation to Alcoholic's Anonymous.

(8) House Meeting: this meeting takes place once per week in either the dining area or the conference room. Attendance is compulsory for all residents. The main purpose of the meeting is to allow residents to voice concerns regarding any difficulties experienced in the House, to seek permission for weekend passes, and to determine the following week's schedule for the making of meals.

(9) Quiet Time: no specific time is set for a period of quiet time, although each resident is strongly encouraged to take time out alone sometime during the day and hopefully before dinner. Each resident is allowed to have this time out at any location in the building, except where it may be interfering with other activities.

(10) Visiting Hours: visits by family or friends is allowed each day after dinner. The visits are restricted to either the front lounge or the basement lounging area. Each resident is allowed two visits per week, and no restrictions are placed on who is allowed to visit, unless the visitor becomes violent and aggressive. The primary purpose of the visit is to allow residents to maintain contacts with important others.

(11) Exercise: a minimal amount of regular exercising is encouraged in order to establish a sense of taking care of one's body on a continuous basis, and to release tension and anxiety. In addition to the limited exercise activities residents are encouraged to use community facilities.

(12) Meals: all residents must be present at each meal time during the week days. All meals take place in the dining room, adjacent to

the kitchen. The rationale behind compulsory attendance is to have the residents collected as a group without supervision. This provides an informal, unstructured atmosphere and permits residents to be somewhat more relaxed and possibly more willing to share their feelings and thoughts.

The structured activities which represent the major behaviour settings in the House of Sophrosyne are outlined in Table XI. Although the schedule of activities appear very structured, there is a degree of flexibility, which allows activities to be re-ordered or interchangeable, depending upon the circumstances of the day.

Another factor which in a relatively small behaviour setting has a significant influence is that of resident and staff turnover. A total of 105 residents were registered as being in the House of Sophrosyne program in a twelve month period from March, 1981 to March, 1982. A total of 28 residents were listed as leaving the program before completion, or 26.7 percent leaving the program prematurely.

Some of the reasons listed for residents leaving the program prematurely included; "abuse of house rules"; "inappropriate for residential program"; "personal decision by resident"; "unwillingness to participate in the program"; "other commitments (home, family, work) that could not be avoided".

During the same time period there were a total of two staff leaving the program. One staff was "discharged" while the other "moved" elsewhere.

TABLE XI. --House of Sophrosyne Schedule of Activities

DAILY PROGRAM

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
7:30	Rising	Rising	Rising	Rising	Rising	Rising
8:00	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast
9:00	Housekeeping	Housekeeping	Housekeeping	Housekeeping	Housekeeping	Housekeeping
10:15	Group Session	Group Session	Guest Speaker	Group Session	Group Session	Group Session
12:00	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch
1:00	Exercise	Exercise	Exercise	Exercise	Exercise	Exercise
1:30	Group Session or Didactic	Group Session or Didactic	Group Session or Didactic	Group Session or Didactic	Group Session or Didactic	Group Session or Didactic
3:00	Quiet Time	Quiet Time	Quiet Time	Quiet Time	Quiet Time	Quiet Time
5:00	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner
6:30	Visiting Hours	Visiting Hours	Visiting Hours	Visiting Hours	Visiting Hours	Visiting Hours
8:30	Women's Closed Group Discussion		Film/Tape and Discussion			

\*\*Two A.A., meetings per week on Tuesday, Thursday or Friday are also part of the Program.

\*\*Each resident receives two or three individual counselling sessions per week.

RESEARCH QUESTION III

What are the salient dimensions of organizational structure which exist in the treatment environment at the House of Sophrosyne?

ORGANIZATIONAL STRUCTURE

The overall size and hierarchical shape of the House of Sophrosyne organization is presented in Figure 1.

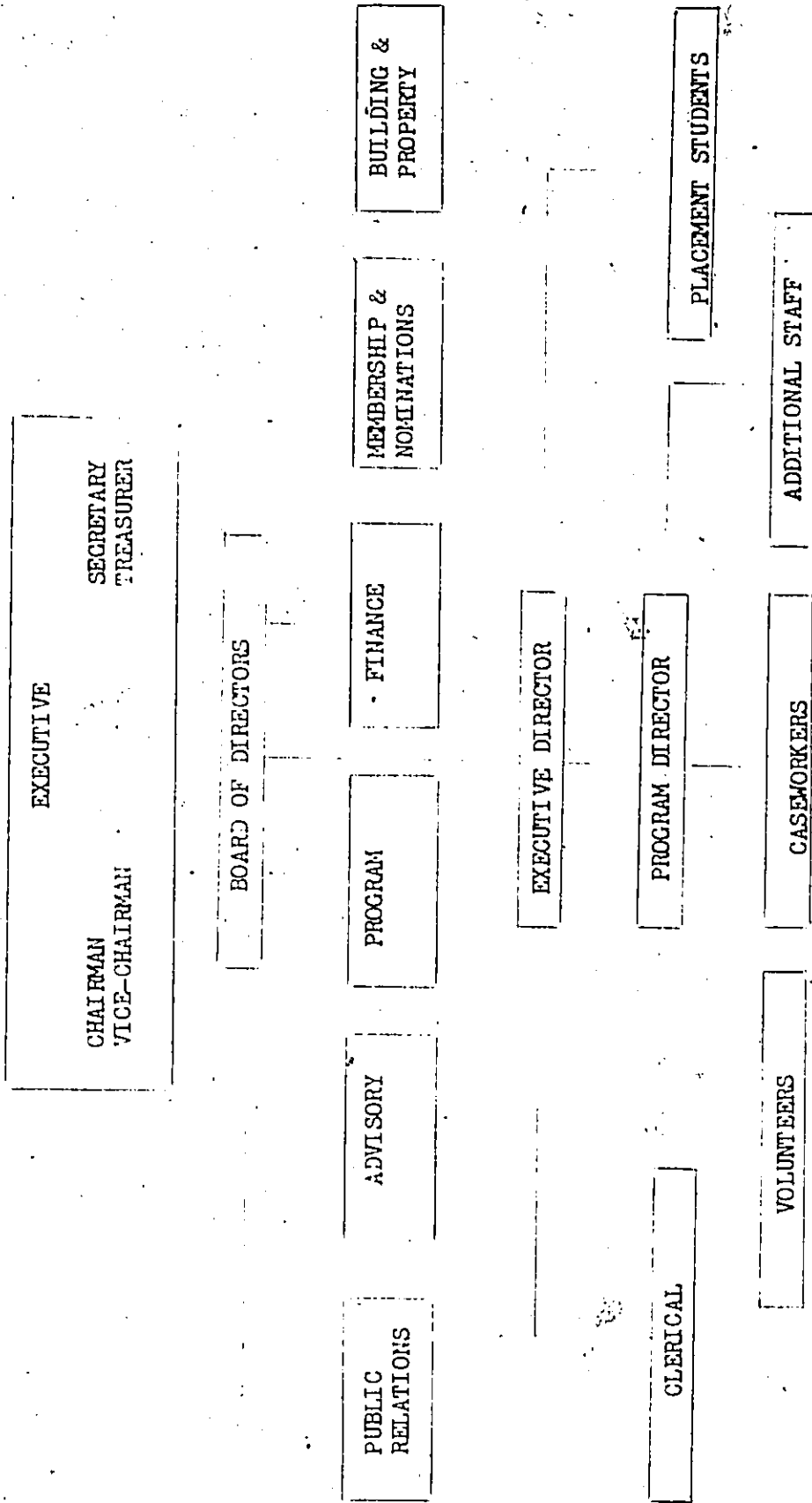
Although the organizational chart (Figure 1) indicates the various positions and committees which exist in the House of Sophrosyne, from a "functional" perspective, only three organizational levels exist. These are, the Board of Directors, the Executive Director and her assistant the Program Director, and front line staff.

The Board of Directors are primarily responsible for all policy matters and program development. The Executive Director and Program Director are responsible for implementing policy, supervision of staff and other administrative duties. The front line staff are primarily responsible for the actual delivery of service.

At the time the questionnaire was administered there were ten women in residence, out of a maximum bed capacity of twelve. There were seven full time staff employed in the program. Representing a resident:staff ratio of 1.43:1. During peak periods when the House is at full capacity the resident:staff ratio is 1.7:1, not including part-time staff, volunteers and student placements.

FIGURE 1.

HOUSE OF SOPHROSINE



RESEARCH QUESTION IV

What are the salient personal and behavioural characteristics of the residents and staff at the House of Sophrosyne?

RESIDENT CHARACTERISTICS

(1) Age: Table XII pertains to the variable of age. It should be noted that one resident did not indicate her age on the questionnaire. Therefore the mean and median ages of the residents were based on the ages of nine residents.

At the time the questionnaire was administered the resident mean age was 37.33 years old, the median age was 40 years old, with an age range from 19 to 53 years old.

TABLE XII. --Residents' Age Range: Showing Frequency and Percentage

AGE		
<u>Age Range</u>	<u>Frequency</u>	<u>Percentage</u>
50-59	2	22.2%
40-49	3	33.3
30-39	2	22.2
19-29	2	22.2
18-under	-	--
Total	9	99.9%

$\bar{x}=37.33$



(2) Length of Stay: Table XIII shows the length of stay by residents in the House of Sophrosyne program. The mean length of stay is 5.6 weeks, the median is 4.6 weeks, and the range in length of stay is 1 to 12 weeks.

TABLE XIII. --Residents Length of Stay: Showing Frequency and Percentage

LENGTH OF STAY		
<u>Weekly Range</u>	<u>Frequency</u>	<u>Percentage</u>
11-12	3	30.0%
9-10	-	--
7-8	-	--
5-6	1	10.0
3-4	3	30.0
1-2	3	30.0
Total	10	100.0%

$\bar{x}=5.6$

(3) Marital Status: Table XIV refers to the marital status of residents in the program. It should be pointed out that 40 percent of the residents were married or living common law and 30 percent were either divorced or separated.

TABLE XIV. --Marital Status of Residents: Showing Frequency and Percentage

MARITAL STATUS		
	<u>Frequency</u>	<u>Percentage</u>
Single	2	20.0 %
Married	3	30.0
Common-Law	1	10.0
Separated	1	10.0
Divorced	2	20.0
Widowed	1	10.0
<hr/>		
Total	10	100.0 %

(4) Number of Children: Table XV indicates the residents number of children. The mean number of children is 2.1, the median is 1.5, the mode is 1.0, while the range in the number of children was 0 to 6. It should be noted that 70 percent of residents had two or less children.

(5) Education: Table XVI refers to the highest grade completed by the residents. Nine out of ten residents had completed a portion of high school. The mean grade completed is 10.3, the median grade is 10.16, the mode grade is 10.0, and the range of grade completed is 8 to 13.

(6) Source of Income: Six of the ten residents reported that their main source of income was through employment or other personal sources, while three residents received welfare and one resident's source of income was from a pension.

TABLE XV. --Residents Number of Children: Showing Frequency and Percentage

NUMBER OF CHILDREN		
<u>Children</u>	<u>Frequency</u>	<u>Percentage</u>
6-8	1	10.0%
3-5	2	20.0
0-2	7	70.0
Total	10	100.0%

 $\bar{x}=2.1$ 

TABLE XVI. --Education of Residents: Showing Frequency and Percentage

EDUCATION		
<u>Grade</u>	<u>Frequency</u>	<u>Percentage</u>
Univ.	1	10.0%
13	1	10.0
12	2	20.0
11	3	30.0
10	2	20.0
9	1	10.0
1-8		
Total	10	100.0%

(7) Usual Occupation: Three residents reported their usual occupation as being in the professional category. One resident's reported occupation was classified as skilled, three residents' as semi-skilled and three residents' as housewives.

(8) Referral Source: Two residents each were referred by friends, family and self. One resident was referred to the House of Sophie by each of the following; doctor, hospital, employer and clergy.

(9) Ethyl Alcohol: Table XVII pertains to the amount of "ethyl alcohol" consumed by residents on an average day. The amount of "ethyl alcohol" consumed was calculated by determining the amount of alcohol by volume in the various alcohol beverages common to Canada. Beer was rated at 5 percent alcohol by volume, wine was rated at 12 percent (average) alcohol by volume, and spirits were rated at 40 percent alcohol by volume.

TABLE XVII. --Residents' Daily "Ethyl Alcohol" Consumption in Ounces:  
Showing Frequency and Percentage

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ETHYL ALCOHOL CONSUMPTION

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<u>Ounces</u>	<u>Frequency</u>	<u>Percentage</u>
20-up	1	10.0%
15-19	-	--
10-14	2	20.0
5-9	3	30.0
0-5	4	40.0
Total	10	100.0%

---

Each resident was asked to indicate the amount of alcohol consumed in a typical day prior to their admission to the House of Sophrosyne. The type of alcohol beverage most frequently consumed was also requested in order to calculate the amount of "ethyl alcohol" consumed by each resident.

The mean amount of "ethyl alcohol" consumed by residents' per day was 8.35 oz., the median amount was 6.6 oz., while the range in the amount consumed was 1.45 oz. to 28.8 oz. It should be noted that the two residents consuming the two lowest amounts of "ethyl alcohol" regularly combined other psychoactive drugs on a daily basis.

(10) Blackouts - Hallucinations - Delirium Tremens: Table XVIII highlights the responses by residents regarding the frequency of blackouts, hallucinations, and delirium tremens experienced prior to admission into the House of Sophrosyne program.

A total of 50 percent of the residents reported to have experienced blackouts "often" or "fairly often". Hallucinations were "never" experienced according to 70 percent of the residents. Delirium tremens were experienced "fairly often" by 30 percent of the residents, while 50 percent reported to have "never" experienced them.

TABLE XVIII. --Residents' Experience of Blackouts, Hallucinations, Delirium Tremens: Showing Frequency and Percentage

	BLACKOUTS		HALLUCINATIONS		DELIRIUM TREMENS	
	<u>Freq.</u>	<u>Percent</u>	<u>Freq.</u>	<u>Percent</u>	<u>Freq.</u>	<u>Percent</u>
Often	3	30.0%	--	--	--	--
Fairly Often	2	20.0	1	10.0%	3	30.0%
Occasionally	1	10.0	1	10.0	1	10.0
Very Occasionally	3	30.0	1	10.0	1	10.0
Never	1	10.0	7	70.0	5	50.0
Total	10	100.0%	10	100.0%	10	100.0%

(11) Perception of Drinking Problem: Six of the residents indicated their drinking to be "fairly often" a problem, while the remaining four residents rated their drinking as being "quite often" a problem.

(12) Employment in Last Six Months: Five of the residents indicated that they were employed in the six month period prior to admission, while the remaining five residents indicated that they were not employed in the six month period.

STAFF CHARACTERISTICS

(1) Age: Table XIX shows the age of staff at the House of Sophrosyne. The staff mean age is 35.8 years old, the median age is 38 years old, and the range in the staff age is 22 to 45 years old.

TABLE XIX. --Age Range of Staff: Showing Frequency and Percentage

AGE		
<u>Age</u>	<u>Frequency</u>	<u>Percentage</u>
50-59	-	-
40-49	3	42.8%
30-39	2	28.6
18-29	2	28.6
-----		
Total	7	100.0%

(2) Length of Present Employment: Table XX refers to the total time period that each staff have been employed at the House of Sophrosyne. The mean length of employment is 19 months, the median length of employment is 15 months, the range of length of employment by staff is 4 months to 43 months.

(3) Education: Staff were asked to indicate the level of education they achieved. Two staff reported that they had a high school level education. The remaining five staff reported that they had achieved a university level of education.

TABLE XX. --Staff Length of Present Employment: Showing Monthly Range, Frequency and Percentage

LENGTH OF PRESENT EMPLOYMENT		
<u>Months</u>	<u>Frequency</u>	<u>Percentage</u>
49-60	-	-
37-48	1	14.3/
25-36	1	14.3
13-24	2	28.6
1-12	3	42.8
Total	7	100.0/

(4) Special Training: Staff were requested to indicate if they had any special training prior to employment, which had some relevance to the House of Sophrosyne program. Two staff had completed a number of social work and psychology courses. One staff has a Bachelor degree in Psychology and a Master's degree in Education. One staff is a Registered nurse with experience in a hospital psychiatric ward. One staff was trained as a medical secretary.

#### RESEARCH QUESTION V

How are the salient climate characteristics of the treatment environment perceived by the residents and staff at the House of



### Sophrosyné?

The Community-Oriented Program Environment Scale (COPEs) was incorporated into the questionnaire. The COPEs are grouped into ten subscales: three subscales assess Relationship dimensions (Involvement, Support, Spontaneity), four assess Personal Development dimensions (Autonomy, Practical Orientation, Personal Problem Orientation, Anger and Aggression), and the other three assess System Maintenance dimensions (Order and Organization, Program Clarity, Staff Control).

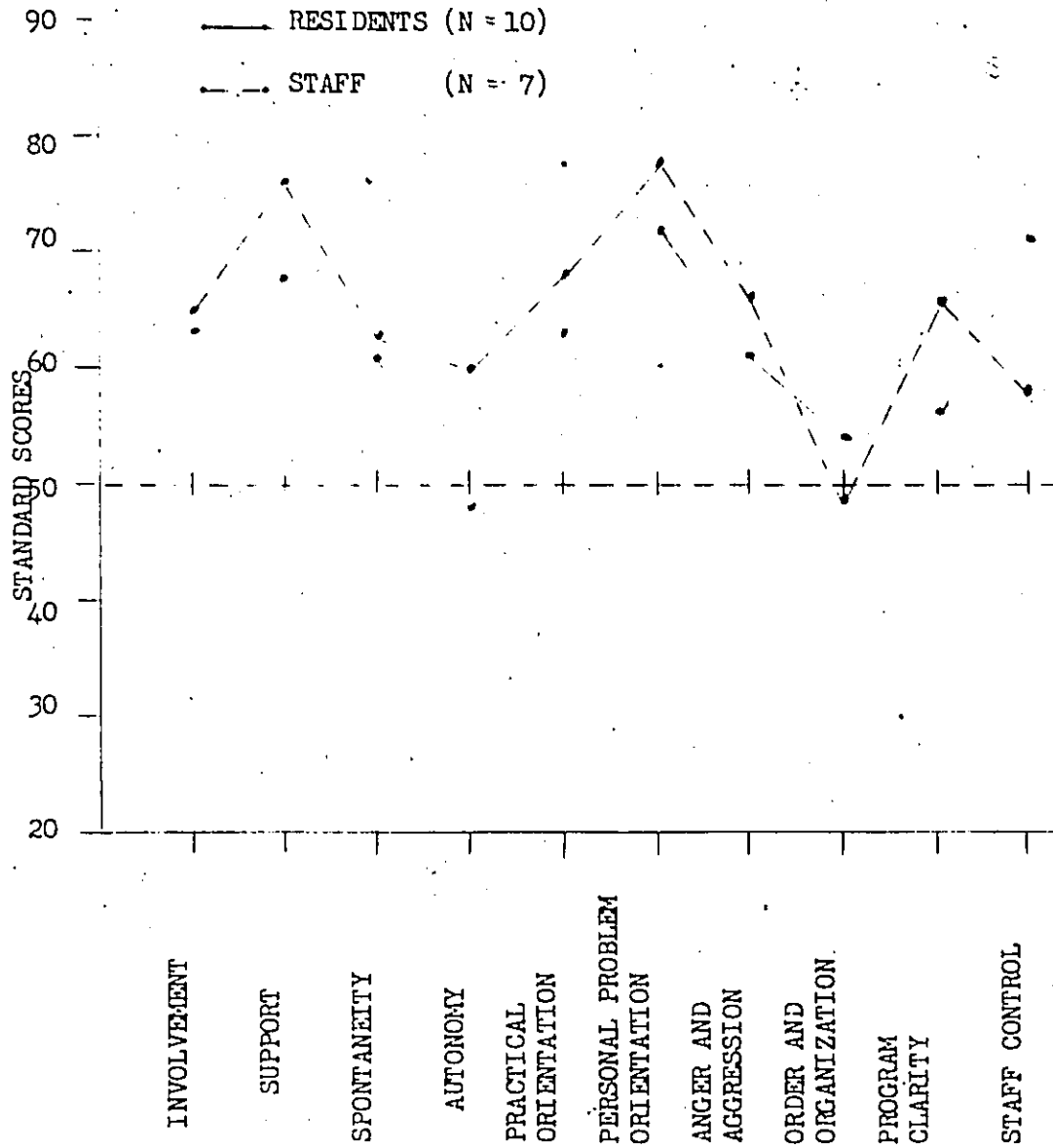
The three profiles of the House of Sophrosyne program show the detailed information that can be derived when both "Form R" (real) and "Form I" (ideal) are used.

### COPEs FORM "R"

Figure 2 shows the COPEs "Form R" profiles for the residents and the staff as compared to the average score obtained by members in the American normative sample (Moos, 1974a). The standard scores for residents and staff were obtained from a conversion chart (Moos, 1974b) which converted "Form R" program mean raw scores into standard scores.

Both residents and staff in the House of Sophrosyne program have different perceptions in several areas. They do agree that Relationship dimensions have a fairly strong emphasis, with staff placing slightly more emphasis than residents on the subscale dimensions of Involvement and Spontaneity, and considerably more emphasis on the subscale dimension of Support. For example, all staff disagreed that

Figure 2. COPEs Form R Scale Profiles For Residents and Staff in the House of Sophrosyne Program



"residents seldom help each other" and agreed that "residents are given a great deal of attention here" (Support). Both residents and staff disagreed that "residents tend to hide their feelings from one another", and both residents and staff agreed that "residents are strongly encouraged to express themselves freely here" (Spontaneity).

On three of four Personal Development subscale dimensions, both residents and staff agree that there is a fairly strong to very strong emphasis. They agree that Practical Orientation, and Anger and Aggression are fairly strongly emphasized, while Personal Problem Orientation is very strongly emphasized. For example, both residents and staff disagree that "there is relatively little emphasis on teaching solutions to practical problems" (Practical Orientation). They both disagree that "residents here rarely argue" (Anger and Aggression). Residents and staff agreed that "personal problems are openly talked about" and disagreed that "residents are rarely encouraged to discuss their personal problems here" (Personal Problem Orientation).

On the Autonomy subscale there was a significant difference between residents and staff. Residents feel that there is an average amount of emphasis, while staff feel that there is a fairly strong emphasis on Autonomy. For example, the majority of residents disagreed, and a majority of staff agreed that "residents are expected to take leadership here".

There is some variation between resident and staff perceptions of the System Maintenance dimensions. Both residents and staff agreed that there is an average emphasis on Order and Organization. In addition, residents felt that Program Clarity had slightly above average emphasis, where as they felt that emphasis on Staff Control

was very strong. For example, residents agreed that "the program rules are clearly understood by residents" (Clarity). Residents agreed that "once a schedule is arranged for a resident, the resident must follow it" and that "it is important to carefully follow the program rules here" (Staff Control).

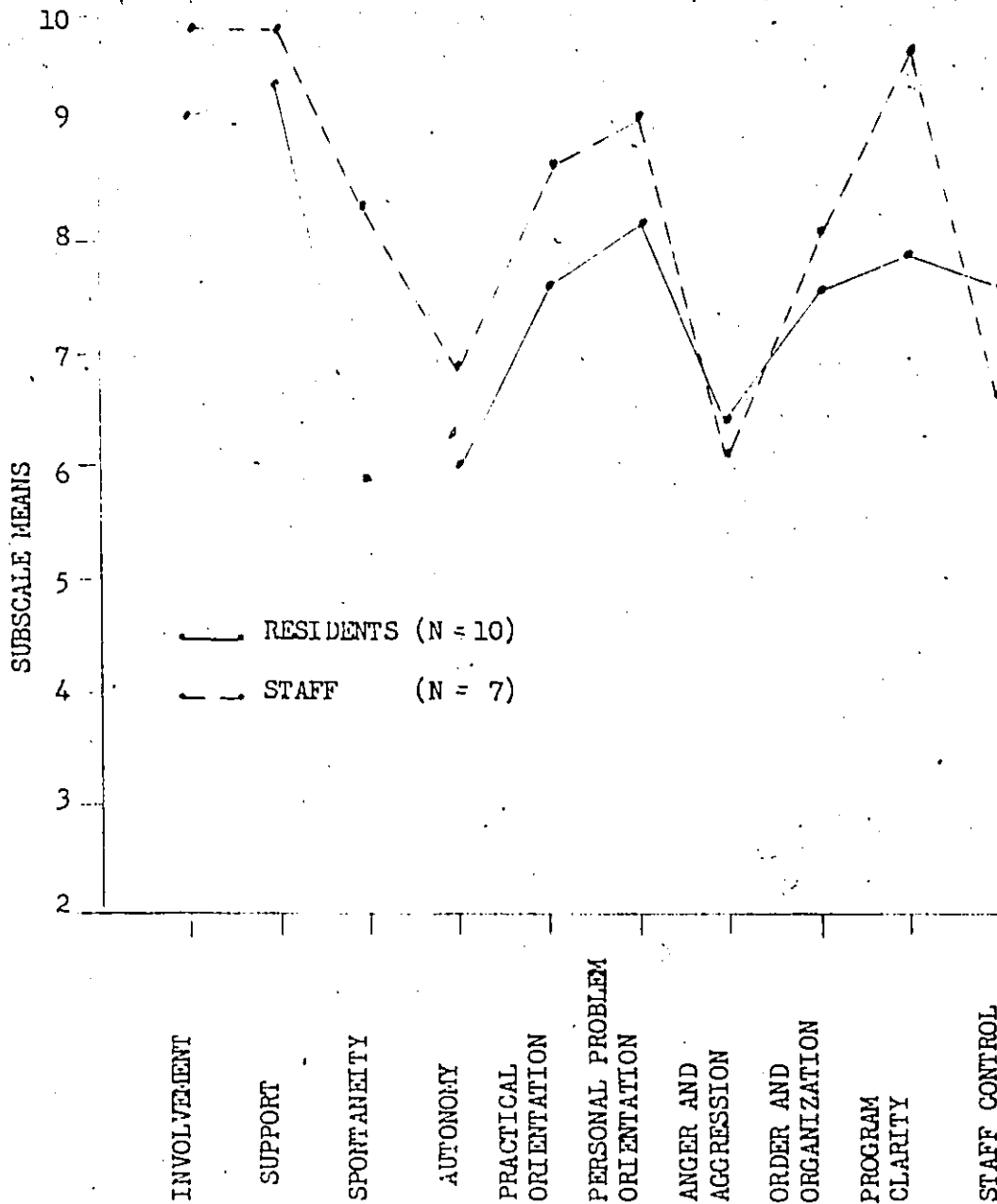
Staff felt that there was a fairly strong emphasis on Program Clarity and only slightly above average emphasis on Staff Control. Staff agreed that "if a resident's program is changed, staff always tells her why" and they disagreed that "staff rarely give residents a detailed explanation of what the program is about" (Clarity). Staff agreed that "the staff make and enforce all the rules here" and that "staff don't order the residents around" (Staff Control).

In summary, the House of Sophrosyne program appears to place higher than average emphasis on Relationship dimensions. Staff see Support as having particularly strong emphasis. There is significantly higher than average emphasis on Personal Development dimensions. Both residents and staff see Personal Problem Orientation as having a stronger emphasis than any other subscale dimension. There is above average emphasis on System Maintenance dimensions. Residents see very strong emphasis, and staff see only slightly above average emphasis on Staff Control. Staff see fairly strong emphasis, and residents see only slightly above average emphasis on Program Clarity.

#### COPEs FORM "I"

Figure 3 shows the comparison of the average raw scores of the residents and the staff on COPEs "Form I" (Ideal program form), reveal-

Figure 3. COPES Form I Scale Profiles for Residents and Staff in the House of Sophrosyne Program

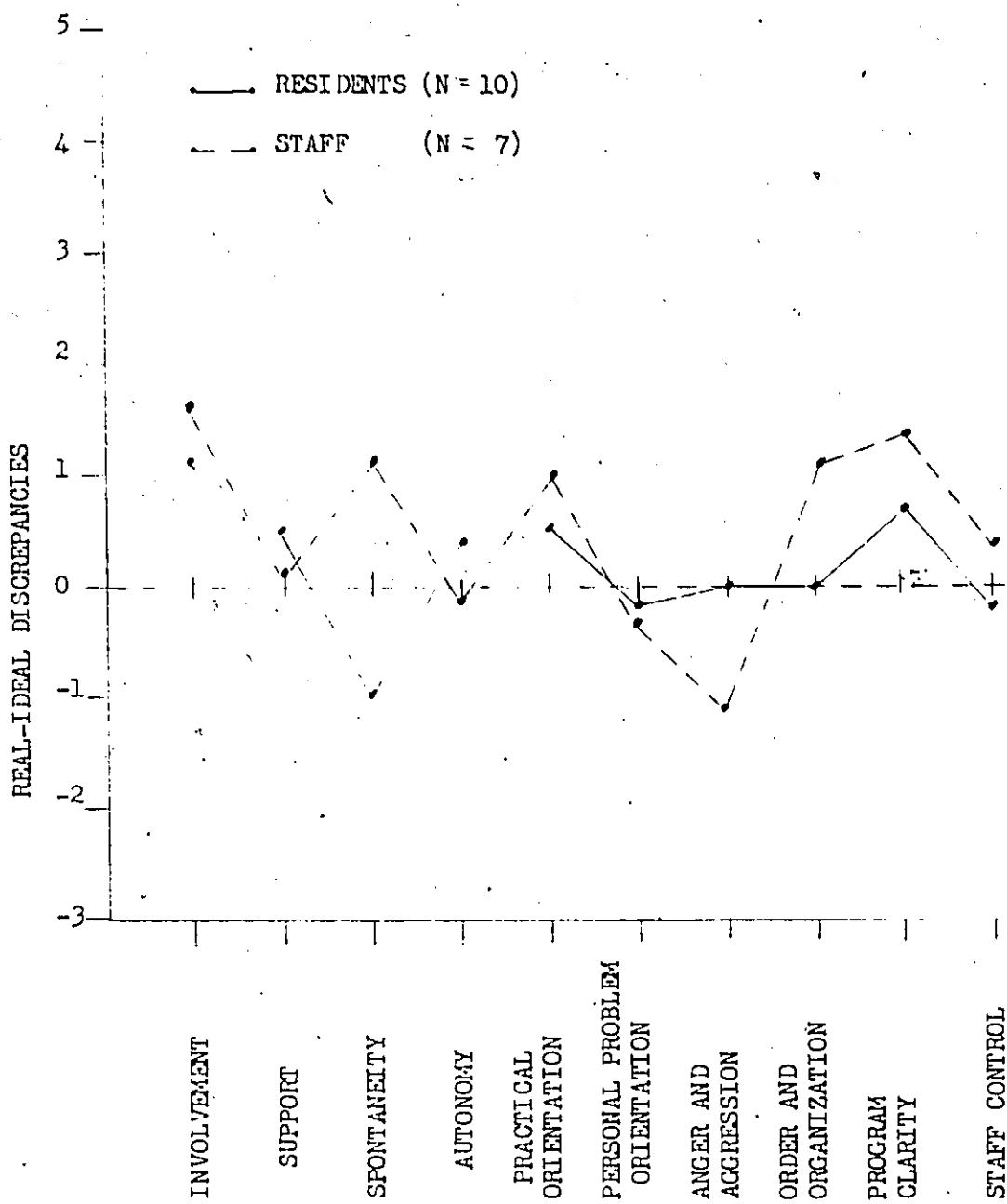


ing that the residents and staff would like to have a relatively similar kind of program. The staff wanted somewhat more emphasis on Involvement, on Autonomy, on Practical Orientation, on Personal Problem Orientation, and on Order and Organization than do the residents. However, staff wish much more emphasis on Spontaneity and Program Clarity than do the residents. For example, staff disagreed that "residents would be careful about what they say when staff are around" (Spontaneity). They also disagreed that "residents would never quite know when they will be considered ready to leave the program" (Clarity). The residents would prefer somewhat more emphasis on Staff Control than do the staff. Residents and staff are very similar in their emphasis on Anger and Aggression, on Order and Organization, and on Support. With the exceptions of Spontaneity and Program Clarity, the residents and staff generally share similar value orientations regarding an ideal program.

#### COPEs REAL-IDEAL DISCREPANCIES

Figure 4 compares the degree of change the residents and the staff would like to see in the House of Sophrosyne program. The amount of change desired was calculated by subtracting "Form R" subscale means from the "form I" subscale means. The profile shows the amount of increase or decrease needed in order for the program to become ideal as residents and staff conceptualize it. The line in the centre of the profile marked zero indicates no change desired in the program; i.e., that there is no discrepancy between "real" and "ideal" subscale means. Positive scores indicate a desire for increased emphasis in that area. Negative scores on the other hand indicate a desire for decreased emphasis.

Figure 4. Real-Ideal Program Discrepancies as Perceived by Residents and Staff in the House of Sophrosyne Program



With the exception of Spontaneity, the residents and staff generally agree on the direction of change they wish to see in each of the ten areas. Both residents and staff would like to see somewhat more emphasis on residents being involved in the program, on preparing residents for the future (Practical Orientation), and on clarity of rules and expectations. Both residents and staff feel that there is sufficient emphasis on the environment being supportive, on the residents being independent and taking responsibility (Autonomy), on concern for personal problems, and on the staff controlling the program. Residents feel that there is sufficient emphasis on Anger and Aggression, as well as, Order and Organization, while the staff would like to see somewhat less emphasis on Anger and Aggression, and be somewhat more orderly and organized. Staff would like to see somewhat more emphasis on the open expression of feelings (Spontaneity), while residents feel that there should be somewhat less emphasis in this area.

The last section of the questionnaire that was administered to both residents and staff, allowed for any open ended comments which the participants may have had regarding the program at the House of Sophrosyne. Four out of ten residents made general comments regarding their gratitude for being involved in a helpful and constructive program. One resident made comments with respect to making improvements (e.g. carpeting) and one resident commented on the need to individualize the treatment program.



COPEES AND ALCOHOLISM

Having presented the data collected, it would be appropriate to consider additional information on COPEES and its use in alcoholism treatment programs in general, and that has some relevance to this research project.

In an analysis of 16 programs (Moos, 1974b) indicated in large programs there was more emphasis on staff controlling residents and less emphasis on support and personal development dimensions. Newer programs, which tended to have younger residents and staff, placed more emphasis on openly expressing anger and on residents' gaining insight into their problems than did longer established programs.

A study by Otto and Moos (1974) examined the importance of newly admitted members' expectations on their participation in the program. They found that incoming members with unrealistically high expectations, as compared to members' evaluations, tended to show poor participation and to drop-out early. Otto and Moos concluded that prospective members who later did well in the program tended to have more realistic expectations than members who later do poorly.

In a study by (Bromet, Moos, & Bliss, 1976) on the social climate of alcoholism treatment programs, the results indicate that the COPEES is a useful way to systematically assess and compare treatment programs. One of the findings which emerged was that COPEES profiles distinguished between alcoholism programs in ways that were consistent with their treatment orientation.

Bromet, Moos, and Bliss go on to indicate "that paraprofessional

and other minimally trained staff can establish relationships that are no different in quality.... from those established by highly trained professional staff" (1976, p. 915). They also indicate that a program can be highly structured, allowing little independence, while at the same time encouraging interpersonal relationships and the sharing of experiences. The strong emphasis on the relationship dimensions and on Personal Problem Orientation points to a unique camaraderie among members in alcoholism programs. It is suggested that the high degree of sharing is perhaps due to the sharing of a common problem, namely alcoholism.

Moos (1974a) indicates that higher staffing ratios are associated with greater emphasis on Involvement, Support and Personal Problem Orientation, and lower emphasis on Staff Control.

In another study on alcoholism treatment programs, Cronkite and Moos (1978) suggest that recovery rates of treated alcoholics vary directly with the amount of treatment, length of stay, and level of participation in program activities. Cronkite and Moos also suggest that "the strong relationship between program-related variables and outcome may reflect not only treatment effects but also the combined effects of the patient's motivation to recover, a positive attitude toward the program, better functioning within the program, and a greater probability of participating in aftercare services" (1978, p. 1117).

Cronkite and Moos believe that the program is by far the most important determinant of a member's treatment experiences and perceptions of the environment. They also suggest that the effects of different background variables may vary "(e.g., women may perceive

the environment more positively, whereas better educated patients may perceive it more negatively)" (p. 1118). Finally, Cronkite and Moos indicate:

That patients with higher social background levels either enter and/or participate more actively in programs offering environmental and treatment experiences associated with better outcome. In addition, the indirect effects may reflect the fact that patients with certain background characteristics are (a) more motivated to become involved in program activities and thus receive more treatment and (b) function better within the program and thus perceive the environment as more positive. (p. 1118)

Besides characterizing the type of member and social climate in an alcoholism treatment program, COPEs is sensitive to change. In this regard COPEs is used to monitor change in alcoholism programs. Repeated measures provide an opportunity for self-analysis, which in turn can be used to help direct planned program change and system design. Regular feedback of data provides a way to monitor the evolution and function of a system over a period of time.

"Change is a multi-faceted process that is influenced by several important variables. Most generally, the existing program milieu sets the context for the ways in which change can occur" (Bliss, Moos & Bromet, 1976). Moos points out that since the dimensions of program climate are moderately intercorrelated, program change may result in several related subscales. For example, efforts to improve relationship dimensions may be initially confounded by resident reaction to the resulting greater emphasis on system maintenance.

Program Clarity is an indicator of effective program changes. Implementing new programs or re-emphasizing certain areas may be accompanied by initial confusion and a decrease in clarity. Good communication and involvement by all participants is important in the

change process.

There are four basic components in the change process. First, the systematic assessment of the program environment, which compares resident and staff perceptions. Second, the feedback and discussion of results helps residents and staff to formulate concerns, hopefully motivating the participants to become involved in the change process. Third, specific changes are implemented. Finally, reassessment of the program environment monitors the effects of program change. Bliss, Moos, and Bromet indicate that this methodology for change is likely to be most effective in relatively small settings which maximize involvement in the change process. In addition, they point out that "the program dimensions in which changes are planned need to be under "local" control of the program participants" (Bliss, Moos, & Bromet, 1976, p. 325).

Coping with resistance to change is discussed extensively by Moos (1974a). He indicates that staff are much more likely to accept feedback as accurate if it shows them as being above average in the results. Moos (1974a) refers to several key causes of resistance which he finds in the literature. First, if the individual experiences role conflict it may lead to resistance, in which case the individual may openly oppose change or withdraw from any involvement. Second, resistance may develop because an issue is too ego-involving. The individual has formed a strong opinion about an issue, becoming personally committed to the idea and unwilling to change. Third, resistance develops when those toward whom change is directed do not understand the reasons, methods or effects of the proposed change. Fourth, change that ignores existing social relationships may also

foster resistance. Moos indicates that these resistances have been effectively dealt with by sharing the information with and encouraging the participation of residents and staff in the overall change process. "Furthermore, since these modifications are based on the participants' own opinions and goals, as opposed to those of an outside observer, the chances of acceptance and cooperative implementation of changes are much greater" (Moos, 1974a, p. 266).

Moos goes on to indicate that resident-staff value congruence generally increases with experience in the treatment environment. Individuals who are not compatible with groups tend to leave the group. The dropout effect produces an increase in the overall homogeneity of the group. "There is extensive evidence indicating that congruence of individual perceptions in different milieus increases interpersonal attraction and compatibility, thus probably empathy, helping behavior, and positive outcomes" (1974a, p. 311).

In short, sensitivity to a range of environmental variables and their effects on individuals helps to identify the causes of environmental trouble spots and to suggest changes in them. Regular feedback about the environmental characteristics of a social system allows individuals within the system to plan, design, effect, and evaluate changes in it.

## CHAPTER V

### CONCLUSIONS AND RECOMMENDATIONS

#### CONCLUSIONS

The House of Sophrosyne is a relatively new twelve bed facility, serving as the only alcoholism halfway house for women in the Windsor area. It shares many of the common characteristics of a typical alcoholism halfway house as outlined in the literature. The program at the House of Sophrosyne is essentially a blend of the professional treatment philosophy and the traditional Alcoholic Anonymous approach.

#### Questionnaire to the Executive Director

The program objectives at the House of Sophrosyne as outlined by the Executive Director are: understanding and acceptance, behaviour change, personal development, information giving, after-care and follow-up, and life skills experience.

Each of the activities in the program are easily understood and the corresponding causal assumptions, which link the activities to the achieving of the objectives, are quite plausible in the opinion of the researcher.

The next step in preparation for a future impact evaluation, namely the establishment of measureable indicators, can now be undertaken.

RESEARCH QUESTION I

What are the salient architectural and physical design characteristics of the treatment environment at the House of Sophrosyne?

Based on the observations of the researcher, the findings related to the above question are outlined.

The overall building is a moderately large "A" frame building in the distinct shape of a symmetrical triangle. The building is located in a pleasantly landscaped, residential area, within a short walking distance of a major hospital and shopping mall.

The Conference room serves as the main room for the majority of the treatment program activities. The room size is sufficient to accommodate twelve residents and two staff. The walls and floors are fairly neutral in appearance, while the room decorations and furniture are casual but functional in nature, providing a relaxing atmosphere which serves to minimize the distractions for participants while they are involved in various activities. The furniture layout is conducive to group activities. The lighting in the room appears acceptable, however the heating and ventilation would seem to be problematic particularly during peak cold and humid periods. In instances when the room becomes particularly cold or stuffy, it would tend to distract the residents and staff from participating at optimal levels.

Both the Admission's room and the Front Lounge are adequately furnished and appropriately arranged for individual counselling, while reducing distractions and interruptions. The lighting, heating and ventilation also appear adequate in both rooms.

The Recreation Lounge serves as the main day to day living area for the residents. The furniture is casual and the room is modestly decorated. The lighting, heating and ventilation in the room is also adequate, with the possible exception of the facilities being somewhat strained during peak periods (e.g., all residents in the room at once, particularly humid periods).

The Visiting areas are primarily comprised of two large and rather open areas in the basement, with limited privacy. The furniture is very casual and the walls are plain and bare.

The Kitchen is large and has ample cupboards and facilities required for both residents and staff.

The Bedrooms are of modest size (three beds per room), the furniture and decorations are modest and casual. The lighting, heating and ventilation appear to be adequate under normal use, but may not be sufficient during peak periods.

The communal Washroom facilities are adequate for twelve residents when being used in an organized and orderly fashion.

The residents and staff were asked to indicate their own personal perceptions on a number of physical and environmental characteristics of the building. From a general overall perspective of the entire building, the majority of residents and staff perceived the rooms to be the "right size" and the room decorations to be "acceptable". The majority of residents and all the staff perceived the furniture to be "acceptable" and the furniture as being "very well arranged". The great majority of residents and staff felt that the noise level was "somewhat noisy" and/or having "very little noise". A slight majority of residents and staff considered the lighting arrangement within the



building to be "very well arranged".

Both the residents and staff were evenly split in their reaction to the temperature within the building, perceiving the temperature to be "too cold" or the "right warmth". The residents and staff who indicated that the temperature was "too cold" also mentioned that the temperature was "too hot" at times. It appears that a major reason for the large variances in temperature in different rooms throughout the building, is due to only two thermostat controls for the entire building. Therefore controlling and evenly distributing the heat throughout various sections of the building is rather difficult. Both residents and staff are evenly distributed amongst the three categories which refer to ventilation. They perceive the ventilation in the building as being either "too drafty", "neither drafty or stuffy", or "too stuffy". It would seem that the perception by residents and staff on ventilation depends upon the room or sections of the building which the individual may have placed emphasis on. In short, while some rooms are fairly well ventilated (e.g. Front Lounge) others are not (e.g. Conference room).

#### RESEARCH QUESTION II

What are the salient behaviour settings which exist in the treatment environment at the House of Sophrosyne?

The introductory admission interview which takes place with each prospective applicant, serves two crucial purposes. First, it allows staff, based on established criteria to determine if the applicant is to be admitted to the program or refused admission. Second, it provides

an opportunity for the applicant to receive an orientation to the program, including a copy of the written rules, and an explanation of expectations and resident's rights.

The other more important program activities at the House of Sophrosyne include: individual counselling, group counselling, didactic lectures, films and tapes, guest speakers, women's meetings, house meetings, periods of quiet time, regular visiting hours, and meal times. Each of the above mentioned activities are structured into a daily and weekly timetable. The treatment oriented activities (e.g. individual counselling, group counselling, didactic lectures, guest speakers, films and tapes) are organized and scheduled in a manner which will maximize the continuity between the activities that are scheduled for that week.

The rate of successful completion of the program in alcoholism halfway houses is only one third (Ogborne, 1978) that of the House of Sophrosyne. In this regard, the House of Sophrosyne compares favourably to the provincial average. However, in the researcher's opinion a significant proportion (26.7%) of the residents left the program prematurely during the period of March, 1981 to March, 1982. Some of the reasons for the residents leaving the program prematurely included: "inappropriate for residential setting" and "unwillingness to participate in the program". Considering the relatively small size of the program, the addition or the loss of an individual resident would have fairly significant effects. Thus a significant number of residents leaving the program prematurely would tend to have a considerable negative effect on the program.

On the whole, the salient behaviour settings (activities) are easily distinguishable from each other and appear to be reasonable

and appropriate activities in attempting to achieve the program objectives.

#### RESEARCH QUESTION III

What are the salient dimensions of organizational structure which exist in the treatment environment at the House of Sophrosyne?

The overall organizational structure is fairly small in size, with a relatively flat hierarchical shape. The lines of communication and authority are clear, as well as serving very functional purposes. The resident-staff ratio in the program, even during peak capacity periods, is very acceptable considering the type of program activities which take place. In short, the overall organizational structure is well suited to the needs of the program, and permits a maximum effort in the provision of services to the client.

#### RESEARCH QUESTION IV

What are the salient personal and behavioural characteristics of the residents and staff at the House of Sophrosyne?

In research conducted by Moos (1974a) he indicates that as resident and staff age increased, staff control increased, as staff age decreased there was less emphasis on staff control and more emphasis on the open expression of feelings and encouraging resident involvement. The mean age for residents is 37.33 years old, and the mean age for staff is 35.80 years old. This would suggest that there would be a

somewhat above-average emphasis on Relationship dimensions in the House of Sophrosyne program.

Moos (1974a) suggests that the longer the period of time that a program participant is involved in the program, the greater the degree of congruence between the participants perceptions of the treatment environment. The mean length of employment for staff at the House of Sophrosyne is 19 months.

This would support the observations that the residents perceptions on the whole were fairly similar to each other, and that the staff perceptions were very similar to each other. The degree of congruence between residents and staff perceptions were also fairly close overall.

Forty percent of the residents indicated that they had an ongoing relationship with their husband or common-law partner. This researcher would assume that the residents who have an adult partner would have the added emotional or moral support from the important other, as well as having a greater sense of motivation to complete the program and return home.

The average number of children per resident is 2.1. As MacLennan (1976) indicates, the ongoing relationship with children adds significantly to many of the female alcoholic's experiencing emotional trauma, and may also serve to put added pressure on the female resident to leave the program prematurely in order to return home and continue her parental duties.

Cronkite and Moos (1978) suggest that the higher the education the greater the tendency for the residents to perceive the environment more negatively. Moos (1974a) indicates that the higher the education on the part of staff the greater the emphasis on a treatment (Personal

Development) orientation. The majority of residents have a grade ten education, while the majority of staff had a university level of education, including training in the areas of social work, psychology and nursing. The limited highschool education of most residents and the high level of education for most staff support the observations that the House of Sophrosyne program places a considerably strong emphasis on the Personal Development dimensions.

Cronkite and Moos (1978) indicate that social class, employment, and referral source are significant factors associated with treatment outcome. If the participant was employed in the six months prior to admission, was referred by self or significant others and is from the middle or upper class, he or she will be more motivated to successfully complete the treatment program and return to their more appealing lifestyle that existed prior to the alcohol problem. Six of the ten residents reported their main source of income from employment, while five of the residents indicated that they were employed during the six months prior to admission into the House of Sophrosyne program. In addition to using income source as an estimate of social class, the usual occupation of the resident was also considered. Three of the residents reported their usual occupation as being in the professional category. At the other end of the continuum, three residents were not gainfully employed and reported that their usual occupation was that of a housewife. Six of the residents reported that their referral source was either self or important others. The remaining four residents were referred by less personally involved sources.

Based on the areas of significance as outlined by Moos, it would appear that the majority of residents will successfully complete the

program, probably in the same proportion as in the past, or three out of every four residents.

The amount of "ethyl alcohol" consumption, the frequency of alcohol related problems and the degree of the drinking problem were also considered by Cronkite and Moos (1978) to have a significant negative relationship to successful treatment outcome.

The greater the amount of alcohol consumed, the greater the extent of alcohol related problems, and the worse the perceived drinking problem, the lesser the possibility of a successful treatment outcome.

The average amount of "ethyl alcohol" consumed per resident is 8.35 ounces per day. The range of "ethyl alcohol" consumption by residents varied greatly, with one resident consuming less than 5 ounces per day (although two residents regularly combined other psychoactive drugs).

The alcohol related problems were categorized under three areas; blackouts, hallucinations and delirium tremens, each of which represent a progressively worse stage in the development of the alcoholic lifestyle.

Fifty percent of the residents reported to have experienced blackouts "often" or "fairly often". Seventy percent of the residents "never" experienced hallucinations. Thirty percent of the residents experienced delirium tremens (the worst of the three) "fairly often".

The degree of the drinking problem was based upon the individual resident's perception of the problem. All of the residents rated their drinking to be either "fairly often" or "quite often" a problem.

The information provided by the residents would suggest that they have been able to recognize and accept their alcohol problem. As

Johnson (1980) and others have pointed out, a significant step in the treatment of alcoholism is the recognition and acceptance of the problem, thereby accepting responsibility for the problem and subsequent treatment.

Considering the historical societal attitudes toward alcoholics and the "skid row" stereotyping that frequently occurs, criticism might be levelled at the accuracy of self-reports by alcoholics. Although there have been studies in the past which did verify the inaccuracy of self-reports by alcoholics, they focused on clearly identified "skid row" types. The tendency has been to project the findings on "skid row" alcoholics to include all types of alcoholics. Sobell and Sobell (1975) undertook a study on outpatient alcoholics and concluded that the self-reports were valid.

None of the female residents in the House of Sophrosyne program are in the opinion of the researcher, "skid row" alcoholics. In addition, the fact that the residents have already been accepted into the program, would provide less of a reason to report inaccurate information, for fear of not being accepted into the program.

#### RESEARCH QUESTION V

How are the salient climate characteristics of the treatment environment perceived by the residents and staff at the House of Sophrosyne?

The COPEs "Form R" profiles for residents and staff at the House of Sophrosyne were compared to the average score obtained from an American normative sample (Moos, 1974a). Both residents and staff placed a fairly strong emphasis on the subscale dimensions of;

Involvement, Spontaneity, Practical Orientation, and Anger and Aggression. Both residents and staff placed a very strong emphasis on Personal Problem Orientation. Once again, both residents and staff felt that there was an average emphasis on Order and Organization. In the remaining four subscale dimensions there was a significant difference between resident and staff perceptions. On the subscale dimension of Support, the staff felt that there was a very strong emphasis, while the residents felt that there was a strong emphasis. Staff placed a fairly strong emphasis on Autonomy, while the residents only placed an average emphasis. On the Program Clarity dimension, residents felt that there was a slightly above average emphasis, but staff felt that there was a fairly strong emphasis. Residents placed a very strong emphasis on Staff Control, while staff placed only a slightly above average emphasis.

The COPEs "Form 1" profiles for residents and staff were compared to each other. It revealed that the residents and staff shared a relatively similar view of an "ideal" program. The residents and staff scores on the ideal scale were relatively close on the dimension of Involvement, Support, Autonomy, Practical Orientation, Personal Problem Orientation, Anger and Aggression, Order and Organization, and Staff Control. There were significant differences of Spontaneity and Program Clarity. In each instance the staff "ideal" placed a stronger emphasis on the two dimensions.

The COPEs Real - Ideal Program Discrepancies for residents and staff were compared to each other. Generally speaking, the residents and staff agree on the direction of change they wish to see in each



of the ten subscale areas. In seven of the ten subscale dimensions, the difference between the residents' and staffs' mean discrepancy scores was equal to or less than .5, on the Real-Ideal scale. On the dimensions of Anger and Aggression, and Order and Organization the difference between the residents and staff was slightly greater than a score of one. Residents felt there was sufficient emphasis on both dimensions, while staff felt that there should be somewhat less emphasis on Anger and Aggression and somewhat more emphasis on Order and Organization. On the dimension of Spontaneity, the difference between the residents' and staffs' mean discrepancy score was slightly greater than a score of two. Residents felt that there should be somewhat less emphasis on Spontaneity, while staff felt that there should be somewhat more emphasis.

In a study by Penk and Robinowitz (1978) they concluded that the drug users' struggle is between achieving independence (Autonomy) and impulsivity (Spontaneity). The desire to meet the goal of autonomy, without sacrificing impulsivity (a spontaneity that is self-defeating), was also reflected in the drug users' struggle to accept or reject staff control. Penk and Robinowitz suggest that the elements of interpersonal involvement, control, and spontaneity constitute problem areas in drug abuse treatment" (1978, p. 142).

The issue of impulsivity is also a concern in the House of Sophrosyne program. This concern is reflected in the initial twenty-one day period during which new residents are not allowed off grounds without some form of supervision. The staff feel that impulsivity is a major characteristic of the alcoholic and that an initial period of controls will allow the resident to begin to develop a degree of self-control.

The COPEs profiles of the residents however, do not support the conclusions by Penk and Rovinowitz, that the drug user desires strong emphasis on two seemingly conflicting characteristics (Spontaneity and Control). A situation which they feel constitutes both the definition and the dilemma in drug treatment. The residents at the House of Sophrosyne placed a fair degree more emphasis on Staff Control than on either Spontaneity or Autonomy.

Penk and Robinowitz indicate that in programs with a high degree of Staff Control, the drug user may attempt to neutralize the pressure toward accepting control. The drug user may deal with the conflict resolution by reducing their amount of involvement or support in the program, in short dealing with control by avoiding it as much as possible.

Once again the COPEs profiles on the residents in the House of Sophrosyne program do not indicate a desired decrease in the Involvement or Support dimensions, rather they prefer to have a significant emphasis in the two areas. In addition, the residents have placed significant emphasis on Personal Problem Orientation, suggesting that the residents are willing to submit to a degree of control by others, which they are willing to endure for a time in a treatment environment which they know, rather than continue the growing risks of supporting an alcohol problem which entails dealing with their old environment about which they have become less certain and less sure.

In contrast to the residents' perceptions, the staff would like a very significant increase (as compared to residents) on Spontaneity, and a small increase in the emphasis on Staff Control. In view of the differences between the perceived Spontaneity-Control relationships on the part of residents and staff, the decision to increase or decrease

emphasis on one dimension, needs to consider the subsequent effects on the second dimension.

Otto and Moos (1974), refer to the importance of a "socialization interview" (p. 15), as part of the program orientation procedures. As mentioned in the Methodology chapter, the COPES instrument is available in three forms, the real, ideal and expectation formats. The COPES "E" (Expectation) form can be administered to prospective residents, and the results incorporated into the orientation procedures. During the "socialization interview", staff might counsel the resident about her discrepant expectations. The use of such a method of preparation might increase the probability of a resident making the best possible use of a treatment program. In addition, the inclusion of the overall COPES profile of the House of Sophrosyne program into the program description would better prepare residents for admission into the program.

In a study by Pratt, Linn, Carmichael, and Webb (1977) they suggest that emphasis on Personal Development dimensions (Autonomy, Practical Orientation, Personal Problem Orientation, Anger and Aggression) encourages the use of after-care services. In the House of Sophrosyne program, three of the four Personal Development dimensions have considerable degree of emphasis placed upon them. However, the extent to which the program's residents have followed through on after-care services is unknown.

Perhaps the major qualification which applies to the issue of individual perceptions rests with the point that different individuals perceive the same environment in a different light, whether or not the environment in reality has all the best qualities. This may result

from different perceptions due to different personalities of the residents, or it may result from differential treatment by the staff. Another possible cause for a diversity of perceptions of a particular environment is the resident's individual relationships with various staff members. A resident's relationship with a staff member may affect significantly the resident's overall perception of the environment.

As a final point, it should be kept in mind that despite the differences in individual's perceptions, as noted previously, the understanding of these perceptions does provide an important indicator on which to assess the environment, and consider subsequent improvements which increase the chances of a successful treatment outcome. Pervin (1974) indicates that performance and satisfaction is a function of the "individual-environment fit".

#### RECOMMENDATIONS

It would seem warranted to preface the following recommendations with this comment. In the opinion of the researcher the decision to implement any changes in the program at the House of Sophrosyne should be undertaken through a cooperative effort between staff and residents. The decision to implement the recommendations depends upon the degree of emphasis which the Board of Directors, the staff and the residents, ultimately wish to place on the various dimensions.

The recommendations which have evolved from the process of conducting the evaluation follow.

(1) In light of the clearly articulated program objectives and activities and the plausible causal assumptions which link the activities to the objectives, it is recommended that measurable, objective outcome indicators be established. The development of commonly agreed upon criteria would be used to evaluate program outcome.

The House of Sophrosyne at present maintains a fairly structured system of administrative records, which include some pertinent demographic and assessment data on the individual residents, identification of the target problem, the establishment of individual and group objectives, time limits, program activities, and subjective assessments of the resident's accomplishments. The objective indicators can be included into the present record keeping system. Each objective indicator can be rated on a sliding scale from 5 meaning "completely attained" to 0 meaning "not attained at all". Finally, the assessment of each resident based on the objective indicators should be undertaken on a minimum of once per month. At the end of the first and second month, and at the end of the third month prior to discharge from the program.

(2) Considering the variability in room temperature throughout the building and the total of only two thermostats for the entire building, it is recommended that additional thermostats be strategically placed throughout the building (particularly the Conference Room) in order to maintain a more even heat distribution and reduce the frequency of adjusting the thermostat, which ultimately results in higher monthly heating costs. In addition, consideration should be given to increasing the insulation in the building, particularly the basement walls.

Serious consideration of this recommendation will not only reduce the heating costs, but will also maintain a more stable immediate environment for the residents and staff and therefore promote an optimal level of participation in the various program activities.

(3) It is recommended that information regarding resident's "employment in the last six months", the "number of children" and the amount of "ethyl alcohol" consumed per day be included on the intake face sheet. Such information in addition to the type of information that is already being obtained (e.g. alcohol symptoms, acceptance of problem) during the admission-orientation process would be helpful to staff in developing an overview of the individual resident's circumstances. The additional pressures to return home or the severity of the alcohol problem are potentially important contributing factors in the development of an individualized treatment strategy and subsequently the treatment outcome.

(4) Considering the relatively small size of the House of Sophrosyne program and significant effects which resident turnover has on the treatment program, it is recommended that the admission of prospective residents not be done on a group basis. Admission times of residents should be separated by several days, to allow each individual resident to receive the full attention of staff during a brief but crucial adjustment period, as well as minimizing the transitional effects experienced by the program as a whole when admitting a new resident.

(5a) The data presented in Figure 4 are important because of their implications for changes in the treatment program, especially since the residents and the staff agree closely on the desired direction for change. The ten dimensions assessed by COPES are mostly under local control, so that residents and staff can usually change their program along these dimensions simply by decisions which they themselves make.

It is recommended that staff and residents work co-operatively on implementing changes on mutually desirable objectives. More specifically, an increase in the emphasis on the involvement of residents in the program (actively participating), on preparing residents for the future (practical orientation), and on the clarity of program rules and expectations (ie., less change and more detail and/or structure).

(5b) On three of the treatment program dimensions there is a degree of disagreement between the residents and staff. On the dimensions of Anger and Aggression (e.g., arguments or disagreements) and Order and Organization (e.g., planning, neatness), residents feel that there is sufficient emphasis, while staff would like to see less emphasis on Anger and Aggression and more emphasis on Order and Organization. The difference between staff and residents is greater on the dimension of Spontaneity (e.g., the open expression of feelings), with staff preferring more emphasis and residents indicating that they would like less emphasis.

It is recommended that staff and residents discuss their differences on the three dimensions and establish a midpoint or compromise on the amount of emphasis to place on the three dimensions in the future.

(5c) In an effort to decrease the frequency of residents leaving the program prematurely and increase the probability of successful treatment outcome, the following three recommendations are pertinent.

A program information form should be included as part of the orientation process for the prospective resident. In addition to providing information about program activities and rules, and resident's rights, the program form would include a profile (COPEs) of the treatment environment. Such information on the treatment environment may act as a self-screening tool, by allowing prospective residents to decide if they are willing to commit themselves to such a program or to seek treatment elsewhere.

The program information form would also be useful when hiring a prospective staff member. The individual applicant would be able to make a more informed decision as to whether or not they were willing and able to work in the described environment. By the same token, the House of Sophrosyne is better served by having the more interested or motivated type of potential employees from which to fill the staff position.

(5d) For those residents admitted to the program the COPEs "Expectation" profile (Short form) can be administered. Obtaining the profile of a resident's expectations would be valuable information for staff, by comparing the results to the overall treatment environment profile and highlighting any areas of significant difference. In those areas identified as having a significant difference, appropriate measures would be taken by staff to ensure that during the course of setting individualized goals with the resident, the differences would be discussed and the decision made to place additional emphasis on dealing



with any potential problems which may occur in the identified areas.

The expectation profile, Form "E" is exactly parallel to the real (Form "R") and ideal (Form "I") profiles in both content and scoring direction. The only difference in the questionnaire is the changing of the verb "should" (Ideal) to "would" (Expectation). The short form in the GOPES profiles is simply the first forty statements of the one hundred included in the questionnaire. The scores from the short form show comparable results to that of the long form and it is quickly administered and hand scored in five minutes.

(5e) Individual resident's characteristics should also be carefully examined during the admission phase in order to better plan for the individual being admitted to the program. The characteristics presently covered in the intake face sheet and the additional characteristics presented in recommendation (3) should be considered when attempting to assess the individual's motivation and appropriateness for the program (as outlined in Chapter IV).

(6) Future treatment environment evaluations should be conducted at the House of Sophrosyne on a periodic basis, in order to assess the degree of change in the ten environmental dimensions, as well as to update the environmental profile of the program.

(7) In the role of researcher, ideally, one acts as a catalyst for future research. Accordingly, the researcher's seventh recommendation is that further research be conducted which compares the different types of alcohol treatment program's (i.e., community-based and

hospital-based) in the Windsor and Essex County area. The purposes would be (a) to ascertain the extent to which the alcohol treatment services are being used, (b) to compare the treatment environment profiles of the various alcoholism programs, and (c) to ascertain the effectiveness of each program.

(8) Finally, continued research regarding alcoholism treatment environments in Ontario is both needed and desired as the advancement and knowledge in alcoholism treatment, in community-based facilities depends upon the research performed and, subsequently, the utilization and dissemination of evaluation results. A specific area of focus should be on the development of a normative sample (similar to the American sample used in this study) comprised from the alcoholism halfway houses in Ontario. In addition, an Ontario normative sample would prove particularly useful if data on male and female alcoholics programs were purposely separated, given the unique qualities of female alcoholics, as cited in the literature. The Alcoholism Recovery Homes Association of Ontario would seem to be in the best position to undertake and conduct such a project.

## CHAPTER VI

### SUMMARY

A brief résumé of the major findings, conclusions, and recommendations is included in the summary.

The major findings in this research project were as follows:

- (1) Most typical of the House of Sophrosyne residents were those of middle age, in the program for one month or less who: had two or less children, had attained a grade ten level of education, obtained their main source of income from employment, were referred to the program by self or an important other, consumed five to fifteen ounces of "ethyl alcohol" per day, experienced blackouts "often" or "fairly often", and perceived their drinking as "fairly often" a problem.
- (2) The typical staff at the House of Sophrosyne was employed by the agency in excess of one year, had a university level of education, and had training in either the health or social science fields.
- (3) A significant number of residents (26.7%) left the program prematurely.
- (4) The majority of residents and staff indicated that the rooms were the "right size", that the decorations in the building were "acceptable", that the furniture was "acceptable" and "very well arranged", that the

noise level in the building was "somewhat noisy" and/or that there was "very little noise", and that the lighting was either "acceptable" and/or "very well arranged". The majority of residents and staff indicated that there was a large variance in the temperature between rooms and that the rooms were often "too drafty" or "too stuffy".

(5) The House of Sophrosyne program places higher than average emphasis on the Relationship dimensions (Involvement, Support, Spontaneity), significantly higher than average emphasis on Personal Development dimensions (Autonomy, Practical Orientation, Personal Problem Orientation, Anger and Aggression), and above average emphasis on System Maintenance dimensions (Order and Organization, Program Clarity, Staff Control).

(6) Residents and staff would like to have a relatively similar kind of "ideal" program.

(7) With the exception of Spontaneity, the residents and staff generally agree on the direction of change they wish to see in each of the ten program dimensions.

The major conclusions reached by the researcher were:

(1) That the House of Sophrosyne shares many of the common characteristics of a typical alcoholism halfway house as outlined in the literature. The program is essentially a blend of the professional treatment philosophy and the traditional Alcoholic Anonymous approach.

(2) The program objectives and program activities in the House of Sophrosyne are easily understood, and the corresponding causal assumptions which link the activities to the achieving of the objectives are plausible.

(3) In general, the building, rooms and facilities are adequate given the size and nature of the program. Emphasis is on a casual and functional setting. However, a number of rooms e.g., washroom and recreation lounge may not be sufficient during peak periods i.e., when being used by all residents at one time.

(4) The heating and ventilation in the building, although adequate in some instances, would seem to create problems particularly during peak periods of very cold or very hot weather.

(5) The most salient behaviour settings in the program include: the admission interview, individual counselling, group counselling, didactic lectures, films and tapes, guest speakers, women's meetings, house meetings, periods of quiet time, regular visiting hours, and meal times. The treatment oriented activities are organized and scheduled in a manner which will maximize the continuity between the program activities.

(6) The organizational structure is fairly small in size with a relatively flat hierarchical shape, and the resident-staff ratio is very acceptable. In short, the overall organizational structure is well suited to the needs of the program, and permits a maximum effort

in the provision of services.

The major recommendations proposed in this evaluative study were:

(1) That measurable, objective outcome indicators be established in order to evaluate the program outcome or impact.

(2) That additional thermostats be strategically placed throughout the building in order to maintain a more even heat distribution, as well as reducing the monthly heating costs, and increasing the abilities of program participants to focus their attention on the activities that are taking place.

(3) That information regarding resident's "employment in the last six months", the "number of children" and the amount of "ethyl alcohol" consumed per day be included in the intake sheet. The intake sheet would assist staff in more comprehensive preparation of residents for entrance into the treatment program.

(4) That admission of prospective residents not be done on a group basis. Admission times of residents should be separated by several days, to allow each individual resident to receive more staff attention during the crucial adjustment period, while at the same time minimizing the effects of resident turnover on the program as a whole.

(5a) That staff and residents come to a compromise on the amount of emphasis they wish to place on the dimension of Anger and Aggression,

Order and Organization, and Spontaneity.

(5b) That staff and residents work cooperatively on implementing changes towards the achievement of mutually desirable objectives. Such objectives include an increase in emphasis on the involvement of residents in the program, on preparing residents for the future, and on the clarity of program rules and expectations.

(5c) That a program information form be included as part of the orientation process for prospective residents. Included on the program form would be information about program rules and activities, resident's rights, and a COPES profile of the treatment environment. This would increase the matching between the residents and the program. It would also serve as a pre-screening process when hiring prospective staff members.

(5d) That residents admitted to the program be asked to complete the COPES Form "E" (short form). Assisting in the identification of large discrepancies between the resident's expectations and the COPES profile of the program overall.

(5e) That the individual resident's characteristics (listed in face sheet) also be carefully considered during the admission phase in order to better plan for the individual being admitted to the program.

(6) That future treatment environment evaluations be conducted on a periodic basis in order to assess the degree of change in the treatment environment over a period of time.

(7) That future research be conducted which compares the treatment environment and the effectiveness of various types of alcohol treatment programs in the Windsor and Essex County area.

(8) That research be conducted by the Alcoholism Recovery Homes Association of Ontario for the purpose of establishing an Ontario normative sample of both male and female alcoholism treatment programs.



APPENDIX A

## House of Sophrosyne

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Questionnaire: Executive Director of House of Sophrosyne

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1. An objective is a general and abstract statement of intent. Given this definition, please specify the objectives of the House of Sophrosyne program indicating their respective level or priority.

---

OBJECTIVE NO.

OBJECTIVES OF PROGRAM (IN ORDER OF PRIORITY)

---

2. Given that an activity is a means of achieving an objective, please specify the program activities aimed at fulfilling each of the objectives stated in question 1.

OBJ. NO.

PROGRAM  
ACTIVITY NO.

PROGRAM ACTIVITIES

OBJ. NO.	PROGRAM ACTIVITY NO.	PROGRAM ACTIVITIES

3. What other mechanisms (ie. policies, guidelines) exist to achieve the stated objectives?

4. In the first column below, list by number only the program activities as recorded in question 2 ("Program Activities No."). In the second column below, please state why each program activity is expected to lead to the fulfillment of the respective program objective. (Note that information is requested regarding the rationale linking program activities to program objectives, not a detailed description of each activity.)

PROGRAM ACTIVITY  
NO.

WHY ACTIVITY RESULTS IN FULFILLMENT OF OBJECTIVES

PROGRAM ACTIVITY NO.	WHY ACTIVITY RESULTS IN FULFILLMENT OF OBJECTIVES

## 5. (a) Number of residents in the program:

In the last 3 months .....

In the last 6 months .....

In the last 12 months .....

## (b) Number of residents discharged from the program:

In the last 3 months .....

In the last 6 months .....

In the last 12 months .....

## (c) Number of residents leaving the program prematurely:

In the last 3 months .....

In the last 6 months .....

In the last 12 months .....

## (d) List reasons for residents leaving the program prematurely in the last 12 months.

## (e) List the number and types of staff leaving the agency:

In the last 3 months .....

In the last 6 months .....

In the last 12 months .....

---

APPENDIX B

March 31, 1982

Residents and Staff,  
The House of Sophrosyne,  
1771 Chappel Ave.,  
Windsor, Ontario.

Dear Respondent,

~~As a resident or staff member at the House of Sophrosyne, your~~  
cooperation is requested in completing the attached questionnaire.

I am a graduate student at the University of Windsor and I have undertaken this research project in partial fulfillment of the requirements for the Degree of Master of Social Work. Doctor Forrest C. Hansen at the School of Social Work will be directing the research. Doctor James Chacko, also of the School of Social Work, and Doctor G. Anne Foster, of the Faculty of Education, are the other members of the Research Committee.

The main purpose of the research is to develop a better understanding of the present program and to consider possibilities for improving the program in the future.

Please be assured that all information provided will be treated confidentially. Your name will not appear on the questionnaire or in the research report; all responses to the questionnaire will remain anonymous.

In anticipating your cooperation, I thank you in advance for your assistance in this project.

Respectfully yours,

Ray Marchand BSW



## House of Sophrosyne

Questionnaire: Residents of House of Sophrosyne

Age: \_\_\_\_\_ Length of Stay \_\_\_\_\_ wks

Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_  
 Divorced \_\_\_\_\_ Separated \_\_\_\_\_  
 Widowed \_\_\_\_\_ Common-law \_\_\_\_\_

Number of Children: \_\_\_\_\_

Highest grade of school completed: \_\_\_\_\_

Source of Income: Self \_\_\_\_\_ Welfare \_\_\_\_\_  
 Family \_\_\_\_\_ Mother's Allowance \_\_\_\_\_  
 Pension \_\_\_\_\_

Usual Occupation: Professional \_\_\_\_\_ Skilled \_\_\_\_\_  
 Proprietor/Manager \_\_\_\_\_ Semi/skilled \_\_\_\_\_  
 Clerical/Sales \_\_\_\_\_ Housewife \_\_\_\_\_

Referred by: Self \_\_\_\_\_ Employer \_\_\_\_\_  
 Doctor \_\_\_\_\_ AA \_\_\_\_\_  
 Hospital \_\_\_\_\_ Clergy \_\_\_\_\_  
 Spouse \_\_\_\_\_ Agency \_\_\_\_\_  
 Friend \_\_\_\_\_ Family \_\_\_\_\_

Prior to admission, the amount of alcoholic beverages consumed on a typical day: \_\_\_\_\_ ounces.

Please indicate the type of alcoholic beverage most often consumed on a typical drinking day. \_\_\_\_\_

Prior to admission how often did you experience:

- (a) Blackouts:      Never .....
- Very occasionally: .....
- Occasionally .....
- Fairly Often .....
- Often .....

- (b) Hallucinations:      Never .....
- Very Occasionally .....
- Occasionally .....
- Fairly Often .....
- Often .....

- (c) Delerium Tremens:      Never .....
- Very Occasionally .....
- Occasionally .....
- Fairly Often .....
- Often .....

How would you rate your drinking or drug problem:

- No problem .....
- Very Occasionally a problem .....
- Occasionally a problem .....
- Fairly often a problem .....
- Quite often a problem .....

Were you employed during the six months prior to admission:    yes    no

## House of Sophrosyne

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Questionnaire: Staff of House of Sophrosyne

---

1. Length of present employment \_\_\_\_\_ yr. \_\_\_\_\_ mths.
2. Education: University/College \_\_\_\_\_  
High School \_\_\_\_\_  
Grade School \_\_\_\_\_
3. Special Training and/or Certificate (please state).
4. Age: \_\_\_\_\_

There are 100 statements in this section. They are statements about programs. They ask you what you think of the actual program (House of Sophrosyne) that exists at this point in time.

Circle the T if you think the statement is True or mostly True of the actual program.

Circle the F if you think the statement is False or mostly False of the actual program.

Please be sure to answer every statement.

Circle True (T) or False (F) for each of the following statements.

1. T F Residents put a lot of energy into what they do around here.
2. T F The healthier residents here help take care of the less healthy ones.
3. T F Residents tend to hide their feelings from one another.
4. T F Residents have no voting rights.
5. T F This program emphasizes training for new kinds of jobs.
6. T F Residents hardly ever discuss their sexual lives.
7. T F It's hard to get people to argue around here.
8. T F Residents' activities are carefully planned.
9. T F If a resident breaks a rule, she knows what the consequences will be.
10. T F Once a schedule is arranged for a resident, the resident must follow it.
11. T F This is a lively place.
12. T F Staff have relatively little time to encourage residents.
13. T F Residents say anything they want to staff.
14. T F Residents can leave here anytime without saying where they are going.
15. T F There is relatively little emphasis on teaching solutions to practical problems.
16. T F Personal problems are openly talked about.
17. T F Residents often criticize or joke about the staff.
18. T F This is a very well organized program.
19. T F If a resident's program is changed, staff always tell her why.
20. T F The staff very rarely punish residents by taking away their privileges.

21. T F The residents are proud of this program.
22. T F Residents seldom help each other.
23. T F It is hard to tell how residents are feeling here.
24. T F Residents are expected to take leadership here.
25. T F Residents are expected to make detailed specific plans for the future.
26. T F Residents are rarely asked personal questions by the staff.
27. T F Residents here rarely argue.
28. T F The staff make sure that this place is always neat.
29. T F Staff rarely give residents a detailed explanation of what the program is about.
30. T F Residents who break the rules are punished for it.
31. T F There is very little group spirit in this program.
32. T F The staff are ~~not~~ interested in following up residents once they leave the program.
33. T F Residents are careful about what they say when staff are around.
34. T F The staff tend to discourage criticism from residents.
35. T F There is relatively little discussion about exactly what residents will be doing after they leave the program.
36. T F Residents are expected to share their personal problems with each other.
37. T F Staff sometimes argue openly with each other.
38. T F This place usually looks a little messy.
39. T F The program rules are clearly understood by the residents.
40. T F If a resident fights with another resident, she will get into real trouble with the staff.
41. T F Very few residents ever volunteer around here.

42. T F Staff always compliment a resident who does something well.
43. T F Residents are strongly encouraged to express themselves freely here.
44. T F Residents can leave the program whenever they want to.
45. T F There is relatively little emphasis on making specific plans for leaving this program.
46. T F Residents talk relatively little about their past.
47. T F Residents sometimes play practical jokes on each other.
48. T F Residents here follow a regular schedule every day.
49. T F Residents never know when staff will ask to see them.
50. T F Staff don't order the residents around.
51. T F A lot of residents just seem to be passing time here.
52. T F The staff know what the residents want.
53. T F Residents automatically set up their own activities here.
54. T F Residents can wear whatever they want.
55. T F Most residents are more concerned with the past than with the future.
56. T F Residents tell each other about their intimate personal problems.
57. T F Staff encourage residents to express their anger openly here.
58. T F Some residents look messy.
59. T F The residents always know when the staff will be around.
60. T F It is important to carefully follow the program rules here.
61. T F This program has very few social activities.
62. T F Staff sometimes don't show up for their appointments with residents.
63. T F When residents disagree with each other, they keep it to themselves.

64. T F The staff almost always act on residents' suggestions.
65. T F Residents here are expected to demonstrate continued concrete progress toward their goals.
66. T F Staff are mainly interested in learning about residents feelings.
67. T F Staff here never start arguments.
68. T F Things are sometimes very disorganized around here.
69. T F Everyone knows who's in charge here.
70. T F Residents can call staff by their first names.
71. T F Residents are pretty busy all of the time.
72. T F There is relatively little sharing among the residents.
73. T F Residents can generally do whatever they feel like here.
74. T F Very few residents have any responsibility for the program here.
75. T F Residents are taught specific new skills in this program.
76. T F The residents rarely talk with each other about their personal problems.
77. T F Residents often gripe.
78. T F The dayroom or livingroom is often untidy.
79. T F People are always changing their minds here.
80. T F Residents may interrupt staff when they are talking.
81. T F Discussions are very interesting here.
82. T F Residents are given a great deal of individual attention here.
83. T F Residents tend to hide their feelings from the staff.
84. T F Residents here are very strongly encouraged to be independent.
85. T F Staff care more about how residents feel than about their practical problems.



86. T F Residents are rarely encouraged to discuss their personal problems here.
87. T F Staff here think it is a healthy thing to argue.
88. T F Residents are rarely kept waiting when they have appointments with staff.
89. T F Residents never quite know when they will be considered ready to leave the program.
90. T F Residents will be transferred or discharged from this program if they don't obey the rules.
91. T F Residents often do things together on weekends.
92. T F The staff go out of their way to help new residents get acquainted here.
93. T F Residents are strongly encouraged to express their feelings.
94. T F Staff rarely give in to pressure from residents.
95. T F Residents must make detailed plans before leaving the program.
96. T F Staff strongly encourage residents to talk about their past.
97. T F Residents here rarely become angry.
98. T F The staff strongly encourage residents to be neat and orderly here.
99. T F There are often changes in the rules here.
100. T F The staff make and enforce all the rules here.

There are 100 statements in this section. They are statements about programs. They ask you what you think an Ideal Program would be like. You are asked to decide which of these statements would be true of an Ideal Program and which would be false.

Circle the T if you think the statement is True or mostly True of an Ideal Program.

Circle the F if you think the statement is False or mostly False of an Ideal Program.

Please be sure to answer every statement.

Circle True (T) or False (F) for each of the following statements.

1. T F Residents would put a lot of energy into what they do.
2. T F The healthier residents would help take care of the less healthy ones.
3. T F Residents would tend to hide their feelings from one another.
4. T F Residents would have no voting rights.
5. T F The program would emphasize training for new kinds of jobs.
6. T F Residents would hardly ever discuss their sexual lives.
7. T F It would be hard to get people to argue.
8. T F Residents' activities would be carefully planned.
9. T F If a resident breaks a rule, she would know what the consequences will be.
10. T F Once a schedule is arranged for a resident, the resident would have to follow it.
11. T F It would be a lively place.
12. T F Staff would have relatively little time to encourage residents.
13. T F Residents would say anything they want to staff.
14. T F Residents would be able to leave anytime without saying where they are going.
15. T F There would be relatively little emphasis on teaching solutions to practical problems.
16. T F Personal problems would be openly talked about.
17. T F Residents would often criticize or joke about the staff.
18. T F It would be a very well organized program.
19. T F If a resident's program is changed, staff would always tell her why.
20. T F The staff would very rarely punish residents by taking away their privileges.

21. T F The residents would be proud of the program.
22. T F Residents would seldom help each other.
23. T F It would be hard to tell how residents are feeling.
24. T F Residents would be expected to take leadership.
25. T F Residents would be expected to make detailed specific plans for the future.
26. T F Residents rarely would be asked personal questions by the staff.
27. T F Residents would rarely argue.
28. T F The staff would make sure that the place is always neat.
29. T F Staff would rarely give residents a detailed explanation of what the program is about.
30. T F Residents who break the rules would be punished for it.
31. T F There would be very little group spirit in the program.
32. T F The staff would be very interested in following up residents once they leave the program.
33. T F Residents would be careful about what they say when staff are around.
34. T F The staff would tend to discourage criticism from residents.
35. T F There would be relatively little discussion about exactly what residents will be doing after they leave the program.
36. T F Residents would be expected to share their personal problems with each other.
37. T F Staff would sometimes argue openly with each other.
38. T F The place would usually look a little messy.
39. T F The program rules would be clearly understood by the residents.
40. T F If a resident fights with another resident, she would get into real trouble with the staff.

41. T F Very few residents would ever volunteer.
42. T F Staff would always compliment a resident who does something well.
43. T F Residents would be strongly encouraged to express themselves.
44. T F Residents would be able to leave the program whenever they want to.
45. T F There would be relatively little emphasis on making specific plans for leaving the program.
46. T F Residents would talk relatively little about their past.
47. T F Residents would sometimes play practical jokes on each other.
48. T F Residents would follow a regular schedule every day.
49. T F Residents would never know when staff will ask to see them.
50. T F Staff would not order the residents around.
51. T F A lot of residents would just seem to be passing time.
52. T F The staff would know what the residents want.
53. T F Residents would automatically set up their own activities.
54. T F Residents would be able to wear whatever they want.
55. T F Most residents would be more concerned with the past than with the future.
56. T F Residents would tell each other about their intimate personal problems.
57. T F Staff would encourage residents to express their anger openly.
58. T F Some residents would look messy.
59. T F The residents would always know when the staff will be around.
60. T F It would be important to carefully follow the program rules.
61. T F This program would have very few social activities.
62. T F Staff sometimes would not show up for their appointments with residents.

63. T F When residents disagree with each other, they would keep it to themselves.
64. T F The staff would almost always act on residents' suggestions.
65. T F Residents would be expected to demonstrate continued concrete progress toward their goals.
66. T F Staff would be mainly interested in learning about residents feelings.
67. T F Staff would never start arguments.
68. T F Things would sometimes be very disorganized.
69. T F Everyone would know who's in charge.
70. T F Residents would call staff by their first names.
71. T F Residents would be pretty busy all of the time.
72. T F There would be relatively little sharing among the residents.
73. T F Residents would generally do whatever they feel like.
74. T F Very few residents would have any responsibility for the program.
75. T F Residents would be taught specific new skills in the program.
76. T F The residents would rarely talk with each other about their personal problems.
77. T F Residents would often gripe.
78. T F The dayroom or livingroom would often be untidy.
79. T F People would always be changing their minds.
80. T F Residents would be able to interrupt staff when they are talking.
81. T F Discussions would be very interesting.
82. T F Residents would be given a great deal of individual attention.
83. T F Residents would tend to hide their feelings from the staff.

84. T F Residents would be very strongly encouraged to be independent.
85. T F Staff would care more about how residents feel than about their practical problems.
86. T F Residents would be rarely encouraged to discuss their personal problems.
87. T F Staff would think it is a healthy thing to argue.
88. T F Residents would rarely be kept waiting when they have appointments with staff.
89. T F Residents would never quite know when they will be considered ready to leave the program.
90. T F Residents would be transferred or discharged from this program if they don't obey the rules.
91. T F Residents would often do things together on weekends.
92. T F The staff would go out of their way to help new residents get acquainted.
93. T F Residents would be strongly encouraged to express their feelings.
94. T F Staff would rarely give in to pressure from residents.
95. T F Residents would have to make detailed plans before leaving the program.
96. T F Staff would strongly encourage residents to talk about their past.
97. T F Residents would rarely become angry.
98. T F The staff would strongly encourage residents to be neat and orderly.
99. T F There would often be changes in the rules.
100. T F The staff would make and enforce all the rules.

1. Generally speaking the rooms are:

Too large \_\_\_\_\_ Right Size \_\_\_\_\_ Too small \_\_\_\_\_

2. Generally speaking the decorations are:

Attractive \_\_\_\_\_ Acceptable \_\_\_\_\_ Ugly \_\_\_\_\_

3. Generally speaking the furniture is:

Attractive \_\_\_\_\_ Acceptable \_\_\_\_\_ Ugly \_\_\_\_\_

4. Generally speaking, for the types of activities that go on around here, the furniture is:

Very Well Arranged \_\_\_\_\_ Acceptably Arranged \_\_\_\_\_

Poorly Arranged \_\_\_\_\_

5. Generally speaking, when scheduled activities are taking place the noise level is usually:

Very Noisy \_\_\_\_\_ Somewhat Noisy \_\_\_\_\_ Very Little Noise \_\_\_\_\_

6. Considering the type of activities that occur here, the lighting arrangements are:

Very Good \_\_\_\_\_ Acceptable \_\_\_\_\_ Poor \_\_\_\_\_

7. Generally speaking, it is usually:

Too Cold \_\_\_\_\_ Right Warmth \_\_\_\_\_ Too Hot \_\_\_\_\_

8. Generally speaking it is usually:

Too Drafty \_\_\_\_\_ Neither Drafty or Stuffy \_\_\_\_\_ Too Stuffy \_\_\_\_\_

9. Other comments you might wish to make about this setting or the questionnaire:



APPENDIX C

COPEs SCORING KEY

<u>REAL &amp; IDEAL FORMS</u>	<u>ITEM NUMBER</u>	<u>SCORING DIRECTION</u>
<u>INVOLVEMENT</u>	1	T
	11	T
	21	T
	31	F
	41	F
	51	F
	61	F
	71	T
	81	T
	91	T
<u>SUPPORT</u>	2	T
	12	F
	22	F
	32	T
	42	T
	52	T
	62	F
	72	F
	82	T
	92	T
<u>SPONTANEITY</u>	3	F
	13	T
	23	F
	33	F
	43	T
	53	T
	63	F
	73	T
	83	F
	93	T
<u>AUTONOMY</u>	4	F
	14	T
	24	T
	34	F
	44	T
	54	T
	64	T
	74	F
	84	T
	94	F

PRACTICAL ORIENTATIONITEM NUMBERSCORING DIRECTION

5	F
15	F
25	F
35	F
45	F
55	F
65	T
75	T
85	F
95	T

PERSONAL PROBLEM ORIENTATION

6	F
16	T
26	F
36	T
46	F
56	T
66	T
76	F
86	F
96	T

ANGER & AGGRESSION

7	F
17	T
27	F
37	T
47	T
57	T
67	F
77	T
87	T
97	F

ORDER AND ORGANIZATION

8	T
18	T
28	T
38	F
48	T
58	F
68	F
78	F
88	T
98	T

CLARITYITEM NUMBERSCORING DIRECTION

9	T
19	T
29	F
39	F
49	F
59	T
69	T
79	F
89	F
99	F

STAFF CONTROL

10	T
20	F
30	T
40	T
50	F
60	F
70	F
80	F
90	T
100	T

## REFERENCES

- Alexander, C. The goodness of fit and its source. In Proshansky, Ittelson, & Rivlin (eds.), Environmental psychology: man and his physical setting. New York: Holt, Rinehart & Winston Inc., 1970.
- Almond, R. The therapeutic community. Scientific American. New York: Scientific American Inc., 1971, 224, 34-42.
- Almond, R., Keniston, K., & Boltax, S. Patient value change in milieu therapy. Archives of General Psychiatry. Chicago: American Medical Assoc., 1969, 20, 339-351.
- Astin, A. W., & Holland, J. L. The environmental assessment technique: a way to measure college environments. In R. H. Moos & P. M. Insel (eds.), Issues in social ecology: human milieus. Palo Alto, Calif.: National Press Books, 1974.
- Badiet, P. Women and legal drugs: a review. In A. MacLennan (ed.), Women: their use of alcohol and other legal drugs. Toronto: Addiction Research Foundation of Ontario, 1976.
- Baka, T. B., Sobell, M. B., Sobell, L. C., & Cannon, D. S. Halfway houses for alcoholics: a review, analysis and comparison with other halfway house facilities. The International Journal of Social Psychiatry. London: The Avenue Publishing Co., Summer, 1976, 22 (2), 130-139.
- Barker, R. G. Habitats, environments, and human behavior. San Francisco: Jossey-Bass, Inc. Publishers, 1978.
- Barker, R. G. The ecological environment. In R. H. Moos & P. M. Insel (eds.), Issues in social ecology: human milieus. Palo Alto, Calif.: National Press Books, 1974.
- Barker, R. G. Ecological psychology: concepts and methods for studying the environment of human behavior. Stanford, Calif.: Stanford University Press, 1968.
- Barrell, R., DeWolfe, A., & Cummings, J. A measure of staff attitudes toward care of physically ill patients. Journal of Consulting Psychology, 1965, 29, 218-222.

Bliss, F. H., Moos, R. H., & Bromet, E. J. Monitoring change in community-oriented treatment programs. Journal of Community Psychology. Brandon, Vermont: Clinical Psychology Pub. Co., Oct., 1976, 4 (4), 315-326.

Boutourline, S. The concept of environmental management. In Proshansky, Ittelson, & Rivlin (eds.), Environmental psychology: man and his physical setting. New York: Holt, Rinehart & Winston Inc., 1970.

Bromet, E., Moos, R., Bliss, F., & Wuthmann, C. Post treatment functioning of alcoholic patients: it's relation to program participation. Journal of Consulting and Clinical Psychology. Washington, D.C.: American Psychological Assoc., Oct., 1977, 45, 829-842.

Bromet, E. J., Moos, R. H., & Bliss, F. The social climate of alcoholism treatment programs. Archives of General Psychiatry. Chicago: American Medical Assoc., June, 1976, 33 (6), 910-916.

Burtle, V. (Ed.). Women who drink: alcoholic experience and psychotherapy. Springfield, Ill.: Charles C. Thomas Pub., 1979.

Burton, C. K. Women and alcohol: problems and services, vancouver. Vancouver: Water Street Research Group, Sept., 1976.

Cahn, S. Alcoholism halfway houses: relationships to other programs and facilities. Social Work. New York: National Assoc. of Social Workers, Apr., 1969, 14 (2), 50-60.

Cohen, J. & Struening, E. Opinions about mental illness in the personnel of two large mental hospitals. Journal of Abnormal and Social Psychology, 1963, 64, 349-360.

Commission of Inquiry Into the Non-Medical Use of Drugs. Final report: of the commission of inquiry into the non-medical use of drugs. Ottawa: Information Canada, 1973.

Cooperstock, R. Women and psychotropic drugs. In A. MacLennan (ed.), Women: their use of alcohol and other legal drugs. Toronto: Addiction Research Foundation of Ontario, 1976.

Cronkite, R. C. & Moos, R. H. Evaluating alcoholism treatment programs: an integrated approach. Journal of Consulting and Clinical Psychology. Washington, D.C.: American Psychological Assoc., Oct., 1978, 46, 1105-1119.

Dibos, R. The social environment. In Proshansky, Ittelson, & Rivlin (eds.), Environmental psychology: man and his physical setting. New York: Holt, Rinehart & Winston Inc., 1970.

- Eckhardt, K. W. & Ermann, H. D. Social research methods: perspective, theory, and analysis. New York: Random House Inc., 1977.
- Ellsworth, R., Foster, L., Childers, B.; Arthur, G., & Kroaker, D. Hospital and community adjustment as perceived by psychiatric patients, their families, and staff. Journal of Consulting and Clinical Psychology Monograph, 1968, 32 (5), Part 2.
- Endler, N. S., & Hunt, J. S-R inventories of hostility and composites of the proportions of variance from persons, responses and situations for hostility & anxiousness. Journal of Personality & Social Psychology. Washington, D.C.: American Psychological Assoc., 1968, 9, 309-315.
- Epstein, I. & Tripodi, T. Research techniques for program planning, monitoring and evaluation. New York: Columbia University Press, 1977.
- Ferguson, G. A. Statistical analysis in psychology & education (4th ed.). New York: McGraw-Hill Book Co., 1976.
- Finney, J. W., Moos, R. H., & Chan, D. A. Length of stay and program component effects in the treatment of alcoholism: a comparison of two techniques for process analyses. Journal of Consulting and Clinical Psychology. Washington, D.C.: American Psychological Assoc., Feb., 1981, 49 (1), 120-131.
- Fleishen, B. & Kuldau, J. Compatibility and stability in home care groups. Social Psychiatry. New York: Springer-Verlag, May, 1972, 7, 11-16.
- Franklin, J. L. & Thrasher, J. H. An introduction to program evaluation. Toronto: John Wiley & Sons, 1976.
- Fraser, W. The alcoholic woman: attitudes and perspectives. In A. MacLennan (ed.), Women: their use of alcohol and other legal drugs. Toronto: Addiction Research Foundation of Ontario, 1976.
- Glasscôte, R. M., Budeman, J. E., & Elpers, J. R. Halfway houses for the mentally ill: a study of programs and problems. Washington, D.C.: National Assoc. for Mental Health, 1971.
- Goldstein, S. G. & Linden, J. D. Multivariate classification of alcoholics by means of the mmpi (minnesota multiphasic personality inventory). Journal of Abnormal Psychology. Washington D.C.: American Psychological Assoc., Dec., 1969, 74 (6), 661-669.
- Grant, Marcus, & Gwinney P. (Eds.). Alcoholism in perspective. Baltimore: University Park Press, 1979.

- Griffin, W. V., Mauritzen, J. H., & Kasmar, J. V. The psychological aspects of the architectural environment: a review. In R. H. Moos & P. M. Insel (eds.), Issues in social ecology: human milieus. Palo Alto, Calif.: National Press Books, 1974.
- Groupé, V. Alcoholism rehabilitation: methods and experiences of private rehabilitation centres. New Brunswick, N.J.: Rutgers Centre of Alcohol Studies, 1978.
- Gump, P. V. The behavior setting: a promising unit for environmental designers. In R. H. Moos & P. M. Insel (eds.), Issues of social ecology: human milieus. Palo Alto, Calif.: National Press Books, 1974(a).
- Gump, P. V. Big schools - small schools. In R. H. Moos & P. M. Insel (eds.), Issues in social ecology: human milieus. Palo Alto, Calif.: National Press Books, 1974(b).
- Hall, H. T. The anthropology of space: an organizing model. In Proshansky, Ittelson, & Rivlin (eds.), Environmental psychology: man and his physical setting. New York: Holt, Rinehart & Winston Inc., 1970.
- Hartshorne, H. & May, M. Studies in deceit. New York: Macmillan, 1928.
- Helson, H. Adaptation - level theory. New York: Harpet & Row, 1964.
- Horowitz, M. J., Duff, D. F., & Stratton, L. O. Personal space and the body-buffer zone. In Proshansky, Ittelson & Rivlin (eds.), Environmental psychology: man and his personal setting. New York: Holt, Rinehart & Winston Inc., 1970.
- Ittelson, W. H., Rivlin, L. G., & Proshansky, H. M. The use of behavioral maps in environmental psychology. In Proshansky, Ittelson, & Rivlin (eds.), Environmental psychology: man and his physical setting. New York: Holt, Rinehart & Winston Inc., 1970.
- Izumi, K. Psychosocial phenomena and building design. In Proshansky, Ittelson, & Rivlin (eds.), Environmental psychology: man and his physical setting. New York: Holt, Rinehart, & Winston Inc., 1970.
- Jackson, J. Factors of the treatment environment. Archives of General Psychiatry. Chicago: American Medical Assoc., 1969, 21, 39-45.
- Johnson, V. E. I'll quit tomorrow (Rev. ed.). New York: Harper & Row, 1980.
- Kanfer, F. H. & Saslow, G. Behavioral analysis/an alternative to diagnostic classification. Archives of General Psychiatry. Chicago: American Medical Assoc., June, 1965, 12, 529-538.



- Katz, D. & Kahn, R. L. The social psychology of organizations (2nd ed.). New York: John Wiley & Sons, 1966, 1978 (2nd ed.)
- Kellam, G., Schmelzer, J., & Berman, A. Variations in the atmospheres of psychiatric wards. Archives of General Psychiatry, 1966; 14, 561-570.
- King, R. & Raynes, N. An operational measure of inmate management in residential institutions. Social Science and Medicine, 1968, 2, 41-43.
- Kinsey, B. A. The female alcoholic: a social psychological study. Springfield, Ill.: Charles C. Thomas, 1966.
- Kissin, B., Platz, A., Su, W. Social and psychological factors in the treatment of chronic alcoholism. Journal of Psychiatric Research. New York: Pergamon Press, Oct., 1970, 8 (1), 13-27.
- Kogan, L. S. Principles of measurement. In Norman A. Proshansky (ed.). Social work research: methods for the helping professions (Rev. ed.). Chicago: The University of Chicago Press, 1975.
- Krimmel, H. Alcoholism: challenge for social work education. New York: Council on Social Work Education, 1971.
- Lansing, J. B., Marans, R. W., & Zehner, R. B. Planned residential environments. Ann Arbor, Mich.: Survey Research Center, Institute for Social Research: University of Michigan, 1970.
- LeDain, G. (chairman). Treatment: a report of the commission of inquiry into the non-medical use of drugs. Ottawa: Information Canada, 1972.
- Lichtman, C. H. & Munt, R. G. Personality & organization theory: a review of some conceptual literature. Psychological Bulletin. Washington, D.C.: The American Psychological Assoc., 1971, 76, 271-294.
- Lunch, K. & Rodwin, L. A theory of urban form. In Proshansky, Ittelson, & Rivlin (eds.), Environmental psychology: man and his physical setting. New York: Holt, Rinehart, & Winston Inc., 1970.
- MacLennan, A. (Ed.) Women: their use of alcohol and other legal drugs. Toronto: Addiction Research Foundation of Ontario, 1976.
- Marshman, J. A. (chairman). Summary of the treatment of alcoholics: an ontario perspective. The report of the task force on treatment services for alcoholics. Toronto: Addiction Research Foundation of Ontario, May, 1978.

- Martin, P. Y. & Segal, B. Bureaucracy, size and staff expectations for client independence in halfway houses. Journal of Health and Social Behavior. New York: American Sociological Assoc., Dec., 1977, 18 (4), 376-390.
- Maslow, A. H. & Mintz, N. C. Effects of esthetic surroundings: initial effects of three esthetic conditions upon perceiving "energy" and "well being" in faces. Journal of Psychology, Provincetown, Mass.: The Journal Press, 1956, 41, 247-254.
- Mayer, J. & Black, R. A description of some selected treatment approaches in alcohol abuse. In John G. Call & Richard E. Hardy (eds.), Alcohol abuse and rehabilitation approaches. Springfield, Ill.: Charles C. Thomas, 1974.
- Milgram, S. The experience of living in cities. Science. Washington D.C.: American Association for the Advancement of Science, March, 1970, 167, 1461-1468.
- Mischel, W. Continuity and change in personality. In R. H. Moos & P. M. Insel (eds.), Issues in social ecology: human milieus. Palo Alto, Calif.: National Press Books, 1974.
- Mischel, W. Personality and assessment. New York: John Wiley & Sons Inc., 1968.
- Moos, R. Evaluating correctional environments: with implications for community settings. New York: John Wiley & Sons Inc., 1975.
- Moos, R. H. Evaluating treatment environments. A social ecological approach. New York: John Wiley & Sons Inc., 1974(a).
- Moos, Rudolf H. Community-oriented programs environment scale manual. Palo Alto, Calif.: Consulting Psychologists Press Inc., 1974(b).
- Moos, Rudolf H. The social climate scales: an overview. Palo Alto, Calif.: Consulting Psychologists Press Inc., 1974(c).
- Moos, R. H. Systems for the assessment and classification of human environments: an overview. In R. H. Moos & P. M. Insel (eds.), Issues in social ecology: human milieus. Palo Alto, Calif.: National Press Books, 1974.
- Moos, Rudolf H. Changing the social milieus of psychiatric treatment setting. Journal of Applied Behavioral Science. Washington D.C.: NTL Institute for Applied Behavioral Science, 1973, 9, 575-593.
- Moos, Rudolf H. Sources of variance in responses to questionnaires and in behavior. Journal of Abnormal Psychology. New York: American Psychological assoc., 1969, 74, 405-412.

- Moos, R. H. & Insel, P. M. Systems for the assessment and classification of human environments: an overview. In R. H. Moos & P. M. Insel (eds.), Issues in social ecology: human milieus. Palo Alto, Calif.: National Press Books, 1974.
- Ogborne, A. C. (chairman). Report of the task force on halfway houses. Toronto: Addiction Research Foundation, Oct., 1978.
- Ontario Blue Cross. The alcoholic. Toronto: Ontario Blue Cross, Apr., 1976.
- Orford, J., Hawker, A., & Nicholls, P. An investigation of an alcoholism rehabilitation halfway house: IV attractions of the halfway house for residents. British Journal of Addiction. Burnt Mill, Harlow, Essex: Longman Group Ltd., June, 1975, 70, 179-186.
- Otto, J. & Moos, R. Patient expectations and attendance in community treatment programs. Community Mental Health Journal. New York: Behavioral Publications, Spring, 1974, 10 (1), 9-15.
- Parr, A. E. In search of theory. In Proshansky H. M., Ittelson, W. H., & Rivlin, L. G. (eds.), Environmental psychology: man and his physical setting. New York: Holt, Rinehart, & Winston Ind., 1970.
- Pattison, E. M., Col. Ronald, & Rhodes, R. J. Evaluation of alcoholism treatment: a comparison of three facilities. Archives of General Psychiatry. Chicago: American Medical Assoc., Apr., 1969, 20 (4), 478-488.
- Patton, M. Q. Qualitative evaluation methods. Beverly Hills: Sage Publications, 1980.
- Patton, M. Q. Utilization-focused evaluation. Beverly Hills: Sage Publications, 1978.
- Perk, W. E. & Robinowitz, R. Drug user's views of psychosocial aspects of their treatment environment. Drug Forum. Farmingdale, N.Y.: Baywood Pub. Co., 1978-1979, 7 (2), 129-143.
- Pervin, L. A. Performance and satisfaction as a function of individual-environment fit. In R. H. Moos & P. M. Insel (eds.), Issues in social ecology: human milieus. Palo Alto, Calif.: National Press Books, 1974.
- Polansky, N. A. (Ed.) Social work research: methods for the helping professions (Rev. Ed.). Chicago: University of Chicago Press, 1975.
- Porter, L. W. & Lawler, E. E. III. Properties of organizational structure in relation to job attitudes and job behavior. Psychological Bulletin. Washington, D.C.: American Psychological Assoc., 1965, 64, 23-51.

- Pratt, T. C., Linn, M. W., Carmichael, J. S., & Webb, N. L. The alcoholic's perception of the ward as a predictor of after-care attendance. Journal of Clinical Psychology. Brandon, Vermont: Clinical Psychology Pub. Co., July, 1977, 33 (3), 915-918.
- Proshansky, H. M., Ittelson, W. H., & Rivlin, L. G. The influence of the physical environment on behavior: some basic assumptions. In Proshansky, Ittelson, & Rivlin (eds.), Environmental psychology: man and his physical setting. New York: Holt, Rinehart, & Winston Inc., 1970.
- Raush, H., Dittman, A., & Taylor, T. Person, setting and change in social interaction. Human Relations, 1959, 12, 361-378.
- Raush, H., Farman, L., & Llewellyn, L. Person, setting and change in social interaction. Human Relations, 1960, 13, 305-332.
- Raush, H. L. & Raush, C. L. The halfway house movement: a search for sanity. New York: Appletton Century Crofts, 1968.
- Replogle, W. H. & Hair Jr., J. F. A multivariate approach to profiling alcoholic typologies. Multivariate Experimental Clinical Research. Wichita: Psychology Press, Nov., 1977, 3, 157-164.
- Rice, C., Berger, D., Klett, S., & Sewall, L. Measuring psychiatric hospital staff opinions about patient care. Archives of General Psychiatry, 1966, 14, 428-434.
- Rice, C., Berger, D., Klett, S., Sewall, L., & Lemkau, P. The ward evaluation scale. Journal of Clinical Psychology; 1963, 19, 251-258.
- Robinson, D. Talking out of alcoholism. London: Croom Helm, 1979.
- Roebuck, J. B. & Kessler, R. G. The etiology of alcoholism: constitutional, psychological and sociological approaches. Springfield, Ill.: Charles C. Thomas, 1972.
- Rossi, P. H., Freeman, H. E., & Wright, S. R. Evaluation: a systematic approach. Beverly Hills: Sage Publications, 1979.
- Rush, B. R. & Brook, R. C. The use of the ontario health and social social service system by persons with alcohol-related problems: provincial survey 1980. Toronto: Addiction Research Foundation of Ontario, 1981.
- Rush, B., Timney, C., & Ekdahl, A. Statistical supplement to the provincial survey, 1980: western region. The use of the ontario health and social service system by persons with alcohol-related problems. Toronto: Addiction Research Foundation of Ontario, 1981.

- Sandmaier, M. The invisible alcoholics: women and alcohol abuse in america. New York: McGraw-Hill Book Co., 1980.
- Schmidt, W., Smart, R. G., & Moss, M. K. Social class and the treatment of alcoholism. Toronto: University of Toronto Press, 1968.
- Schoer, A. L. Housing and it's effects. In Proshansky, Ittelson, & Rivlin (eds.), Environmental psychology: man and his physical setting. New York: Holt, Rinehart, & Winston Inc., 1970.
- Scriven, M. Perspectives of curriculum evaluation. In Tyler, Gagner, & Scriven (eds.), The methodology of evaluation. Chicago: Rand McNally & Co., 1967.
- Sells, S. B. An interactionist looks at the environment. In R. H. Moos & P. M. Insel (eds.), Issues in social ecology: human milieus. Palo Alto, Calif.: National Press Books, 1974(a).
- Sells, S. B. Ecology and the science of psychology. In R. H. Moos & P. M. Insel (eds.), Issues in social ecology: human milieus. Palo Alto, Calif.: National Press Books, 1974(b).
- Selltiz, C., Jahoda, H., Deutsch, M., & Cook, S. W. Research methods in social relations (Rev. ed.). New York: Holt, Rinehart & Winston Inc., 1959.
- Shipman, M. D. The limitations of social research. London: Longman Group Ltd., 1972.
- Smart, R. G., Gillies, H., Brown, G., & Blair, N. L. A survey of alcohol-related problems and their treatment. Canadian Journal of Psychiatry, Ottawa: Canadian Psychiatric Assoc., Mar., 1980, 25 (2), 220-227.
- Sobell, L. C. & Sobell, M. B. Outpatient alcoholics give valid self-reports. The Journal of Nervous and Mental Disease. Baltimore: Williams and Wilkins Co., 1975, 161 (1), 32-42.
- Spiegel, D. & Keith-Spiegel, P. Perceptions of ward climate by nursing personnel in a large NP hospital. Journal of Clinical Psychology, 1971, 27, 390-393.
- Stea, D. Space, territory and human movements. In Proshansky, Ittelson, & Rivlin (eds.), Environmental psychology: man and his physical setting. New York: Holt, Rinehart, & Winston Inc., 1970.
- Stern, G. G. People in context measuring person-environment congruence in educational industry. New York: John Wiley & Sons Inc., 1970.
- Suchman, E. A. Evaluative research: principles and practice in public service & social action programs. New York: Russell Sage Foundation, 1967.

- Tripodi, T., Fellin, P., & Epstein, I. Differential social program evaluation. Itasca, Ill.: F. E. Peacock Publishers Inc., 1978.
- Tripodi, T., Fellin, P., & Meyer, H. J. The assessment of social research: guidelines for use of research in social work and social science. Itasca, Ill.: F. E. Peacock Publishers Inc., 1969.
- Vogler, R. E., Compton, J. V., & Weissbach, T. A. Integrated behavior change techniques for alcoholics. Journal of Consulting and Clinical Psychology. Washington, D.C.: American Psychology Assoc., Apr., 1975, 43, 233-243.
- Wachtel, E. Toward the perfect crimeless town. Maclean's. Toronto: Maclean Hunter Ltd., Mar. 3, 1982.
- Weiss, C. H. (Ed.). Evaluating action programs. Boston: Allyn and Bacon, 1972.
- Wicker, A. W. Processes which mediate behavior-environment congruence.. In R. H. Moos & P. M. Insel (eds.), Issues in social ecology: human milieus. Palo Alto, Calif.: National Press Books, 1974.
- Wohlwill, J. F. The physical environment: a problem for a psychology of stimulation. In R. H. Moos & P. M. Insel (eds.), Issues in social ecology: human milieus. Palo Alto, Calif.: National Press Books, 1974.
- Wolf, R. The measurement of environments. In A. Anastasi (ed.), Testing problems in perspective. Washington, D. C.: American Council on Education, 1966.
- Yeakel, M. & Ganter, G. Some principles and methods of sampling. In Norman A. Polansky (ed.), Social work research: methods for the helping professions (Rev. ed.). Chicago: The University of Chicago Press, 1975.

## VITA AUCTORIS

Ray Marchand was born in Windsor on the 31st of August, 1951 and received his primary and secondary school education there.

In 1976 he graduated from the University of Windsor with his B.S.W. degree. After graduation he was employed as a social worker at the Roman Catholic Children's Aid Society of Essex County, where he remained until July 1981.

For the past academic year, 1981-82, he was enrolled in the M.S.W. program at the University of Windsor. His area of specialization was administration, and his practicum was with United Way of Windsor-Essex County. He was contracted by the University as a Graduate Research Assistant for the School of Social Work.

During the summer of 1982, he will be engaged in research for the Social Planning and Allocations Department of United Way of Windsor-Essex County. Mr. Marchand will graduate and receive his Master of Social Work Degree in the October 1982 convocation.