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## **DOCTOR OF PHILOSOPHY**

**An exploration of factors affecting goal choice, attrition and attendance at follow-up in an alcohol treatment unit.**

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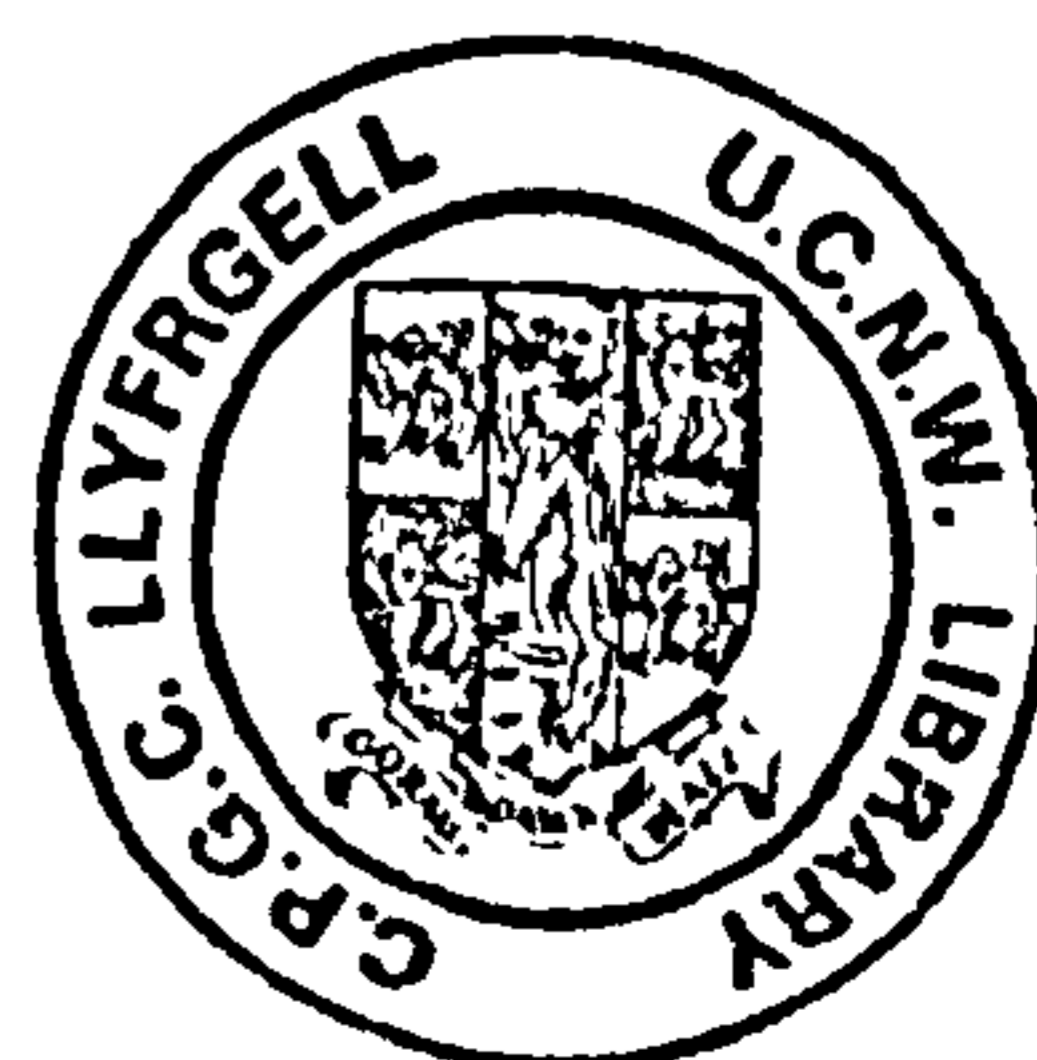
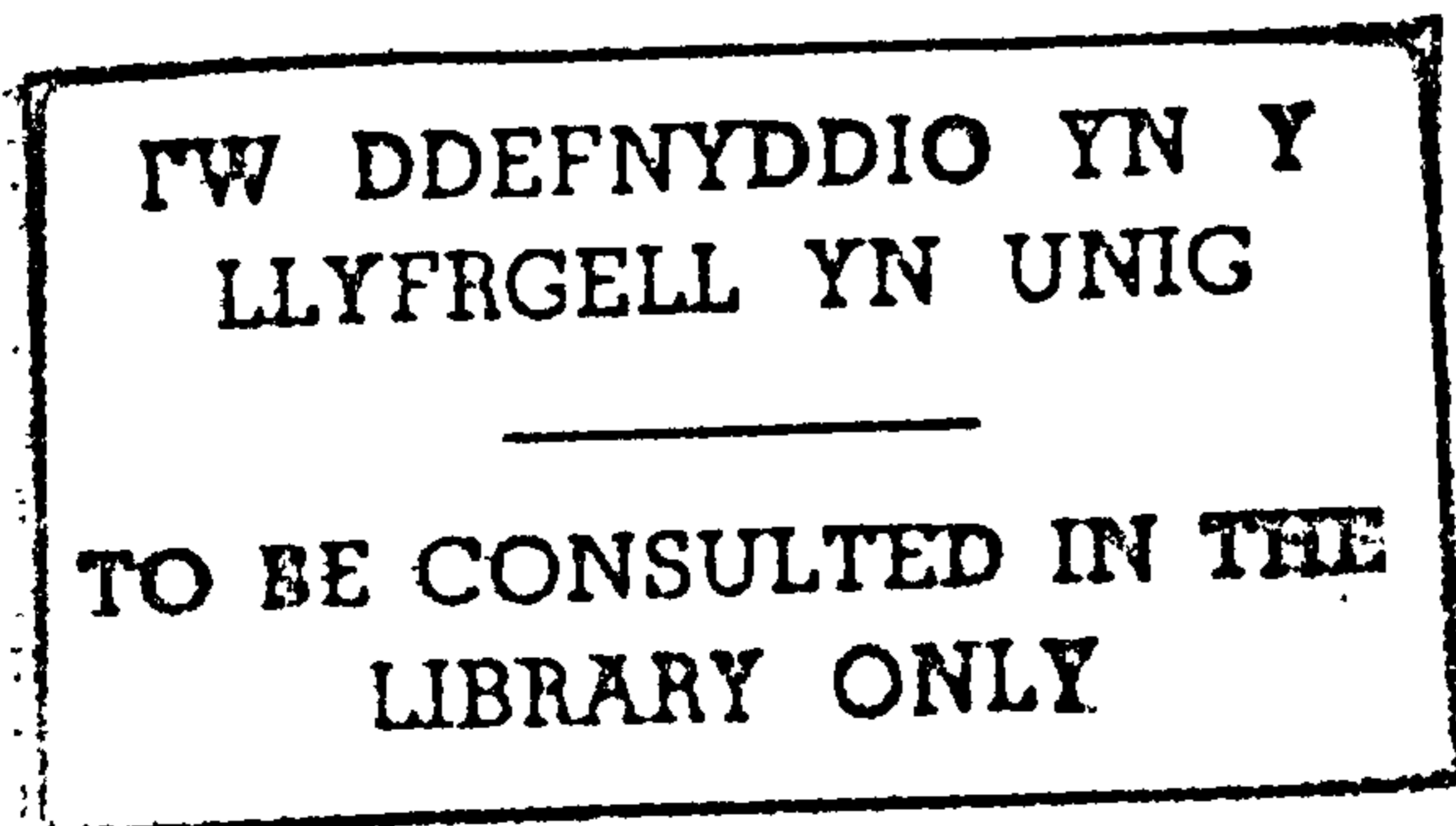
UNIVERSITY OF WALES, BANGOR

(Lancashire Clinical Psychology Course)

An Exploration of Factors Affecting Goal Choice, Attrition and Attendance  
at Follow-up in an Alcohol Treatment Unit.

Angela Mallen

Submission for the Doctor of Clinical Psychology, 1995.



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## ABSTRACT

Fifty problem drinkers attending a specialist alcohol treatment unit took part in this study to investigate factors affecting choice of treatment goal, length of time people stay in treatment and attendance at follow-up.

Heather, Tebbutt, Mattick & Zamir(1993) proposed that the Impaired Control Scale (ICS) may prove useful in enhancing clinical descriptions of the drinking behaviour of those entering treatment, and as a measure of change and outcome.

Participants who had requested attendance on a ten week day programme at the clinic completed the ICS and the Severity of Alcohol Dependency Questionnaire (Stockwell, Hodgson, Edwards, Taylor & Rankin, 1979). Data on age, employment status, marital status, maximum period of abstinence and average daily quantity consumed was collected from assessment forms and case sheets. Four and a half months after assessment participants were invited to attend a follow-up interview. Fifteen people attended from the original fifty, and completed the ICS, the Severity of Alcohol Dependence Questionnaire if they had been misusing alcohol, and an outcome evaluation questionnaire.

Results demonstrated that the ICS had acceptable reliability and was of some assistance in clarifying the difference between those who achieved their goal at follow-up and those that did not. With regard to differences between people who chose abstinence and those who chose controlled drinking, those who saw themselves as more physically dependant chose abstinence as a treatment goal.

The clinical implications of the results are discussed in relation to factors affecting goal choice, the problems of attrition and attendance at follow-up. The usefulness of the ICS and its potential to assist in the clarifying these areas is commented on.

This thesis also contains three small scale research projects completed during placements in the Learning Difficulties, Child and Elderly specialities.

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## INTRODUCTION.

The present study examines the application of a particular measure of impaired control (Heather, Tebbutt, Mattick & Zamir, 1993) to a clinical population of problem drinkers. Associations between scores on the scale and treatment outcome, choice of treatment goal and length of time spent in treatment are explored. The introduction begins with an overview of the disease model of alcoholism, and the inherent loss of control over drinking behaviour that it proposes. This is followed by the presentation of the Alcohol Dependency Syndrome (Edwards, 1977), with its roots in social learning theory, as an alternative explanation for drinking and issues concerning control. Difficulties in the operationalisation of the concept of control and, therefore, subsequent measurement of it, are briefly examined. Following on is the description of the Impaired Control Scale (Heather et al., 1993). The introduction also reviews the literature concerning factors affecting individuals goal choice, outcome and follow-up data within the alcohol field including research on attrition rates. Finally, an overview of the Alcohol Treatment unit where this research is based, is presented.

### *Theories of loss of control.*

A number of theories have been developed in order to explain and understand the concept of loss of control. Heather (1991) notes that a feeling of being out of control is one of the most prominent complaints made by many individuals in treatment for addiction to many substances, not just alcohol. He also says that 'a satisfactory account of the phenomena denoted by loss of control remains central to a proper understanding of problem drinking and other addictive behaviours' (p.154). A review of the most influential theories explaining loss of control, in relation to alcohol misuse, are presented to put this study into context.

### *The disease model.*

Historically 'control' is the most important concept distinguishing the alcoholic from the social drinker. As far back as 1884 writers were commenting on the

lack of control the disease of alcoholism imposed on those people who had contracted the illness, 'In alcoholism the will is destroyed, and intentions- like the arrows in a slain chieftains quiver- become the passive agents of the victors bow' (Gustavson & Gustavson, 1884).

The classic disease concept of alcoholism, developed in the 1930's, proposes a simple hypothesis with respect to control of alcohol intake: chronic heavy drinkers do not stop or limit their drinking, despite the medical, emotional, social and financial problems they may encounter because they cannot control their drinking, even when they realise that it would be prudent or preferable for them to do so. (Fingarette, 1989).

Jellinek, a physiologist, developed his theories around the disease model from the 1930's to the 1960's. His research was conducted in close conjunction with Alcoholics Anonymous members and was very influential both during this period and in later years.

Jellinek (1952) differentiated between 'alcohol addicts' and 'excessive drinkers'. Only the addicts experience loss of control over their drinking and it is to them the disease model applies. Jellinek reserved judgement about whether there was an innate pre-disposing factor that could explain loss of control or if this was acquired as a result of excessive drinking. Jellinek described the emergence of alcohol problems as 'a series of barriers which less serious types of problem drinkers successively fail to surmount, leaving only the alcohol addict at the finishing line'. He describes a continuum of addiction from a prealcoholic phase (relief drinking) through a prodromal phase (preoccupation with alcohol) to the crucial phase (loss of control over drinking), and finally to the chronic phase (incapacitation).

In later years Jellinek explored drinking behaviour in greater depth across many cultures. In his book 'The Disease Concept of Alcoholism' (1960) he defined 'alcoholism' as 'any use of alcoholic beverages that causes any damage to the individual or society or both'. Jellinek acknowledged that drinking habits varied widely and described five types of alcoholism; alpha alcoholism was described as drinking to relieve physical or mental pain that could lead to social

or psychological problems, but where no withdrawal symptoms are evident. Beta alcoholism was described as regular heavy drinking, often in accordance with cultural norms and causing physical damage. Gamma alcoholism is where alcohol has caused biological changes such as altered metabolism, leading to withdrawal symptoms, craving and loss of control over drinking. Once the gamma alcoholic has started drinking they cannot stop. Delta alcoholism was described as being like gamma alcoholism in respect of biological changes, but that withdrawal symptoms are such that alcohol is always necessary. Finally epsilon alcoholism is binge drinking with drinking bouts separated by periods of abstinence. Jellinek only considered gamma and delta alcoholism as being disease forms of the illness as only they entailed biological changes, whose consequences were craving and loss of control or inability to abstain.

A disease model of addiction to alcohol very similar to that developed in the late nineteenth and early twentieth centuries has continued to be used in modern psychiatric/ medical professions.

The concept of loss of control is central within agencies such as Alcoholics Anonymous (Fingarette, 1989). AA therefore in their twelve step programme of teaching requires individuals to acknowledge this permanent loss of control as the first step towards treatment:- 'we admitted that we were powerless over alcohol- that our lives had become unmanageable'(Mann,1950). AA theory posits that the alcoholic's ability to control his or her conduct with regard to drinking is destroyed by a bodily malfunction. Just as someone with a cold cannot stop sneezing, or someone with nerve damage cannot control a paralysed limb, alcoholics cannot voluntarily control their drinking behaviour. In their view alcoholics are victims of physiological and neurological abnormalities that cause uncontrollable behaviour (Fingarette,1989). Abstention is therefore viewed as the only treatment option. This same model is applied to addictions to other substances in for example Narcotics Anonymous (McMurrin,1994).

#### *Alcohol dependency syndrome.*

During the 1970's an alternative model was developed to categorise and understand individuals who had experienced problems with alcohol. The

Alcohol-Dependency Syndrome (Edwards, 1977) consists of seven components which jointly in their presentation indicate that an individual is a problem drinker. The components are:-

- (i) a narrowed repertoire of drinking with respect to both time and context,
- (ii) high salience of drink seeking behaviour over other behaviours,
- (iii) increased tolerance to alcohol,
- (iv) repeated withdrawal symptoms,
- (v) drinking to escape or avoid these symptoms,
- (vi) awareness of a compulsion to drink or 'impairment of control' over drinking and,
- (vii) a rapid reinstatement of all these features if drinking takes place after a period of abstinence.

Within this model, control is viewed as 'variably or intermittently impaired rather than lost' (Edwards, 1982). The concept of loss of control is therefore viewed as not quite as black and white as the disease model suggests; rather there are different degrees and variations (Heather et al., 1993).

Over the last decade there has been a significant increase in the consideration of locus of control as a variable pertaining to research in treatment for problem drinkers (Foon, 1987). The concept of locus of control has its roots in social learning theory. Rotter (1966) contended that people can be differentiated on the basis of the extent to which they attribute responsibility for the outcome of their own actions or to external agents. An individual with internal locus of control perceives that personal events in their life and their consequences depend on their own actions, and that there is a relationship between behaviour and these personal events. Whereas an individual with external locus of control perceives that reinforcements depend on external factors such as chance, fate and other individuals, and that personal events are independent of behaviour. Thus, an individual's locus of control indicates the variability of responsibility that they perceive themselves to have on various meaningful events in life.

Within social learning theory as applied to problem drinkers, it is assumed



that cognitive control will tend to be impaired but that an individual can learn to control or regulate their drinking behaviour (Hodgson & Stockwell, 1985). The problem drinker has not 'lost' the mechanism to self regulate as the disease model suggests, rather it is the case that their perceived self efficacy is reduced (Bandura, 1977). For the problem drinker a state of 'learned helplessness' may develop. In this state motivation is affected and pessimism about attempting to control alcohol intake occurs. No attempt to stop drinking is made because they have learned from past experience that it is futile to try (Hodgson & Stockwell, 1985). With assistance they can influence factors pertaining to control that are both internal and external in nature. Within this perspective a treatment option of controlled drinking is viable, and it is now widely accepted within the alcohol field that people who have experienced difficulties with alcohol misuse can learn to drink in moderate amounts (Heather & Tebbutt, 1992).

### *Craving.*

Within the disease model loss of control over alcohol intake is viewed as central. Later theories emphasise the view that control is impaired rather than lost and that the phenomenon is reversible. One of the assumptions upon which the concept of loss of control is predicated is physical withdrawal which goes hand in hand with the psychological phenomenon of craving, that is a strong desire or compulsion to drink (McMurrin, 1994). The experience of a strong desire to drink affects the likelihood of continued drinking and the degree to which a person feels in control of their drinking behaviour.

Cues associated with alcohol use can elicit various conditioned responses. Reactivity to these cues, it has been suggested, gives the best differentiation between problem drinkers and non problem drinkers (Pomerleau, Fertig, Baker & Cooney, 1983). Rohsenow, Niaura, Childress, Abrams & Monti (1991) point out that it is not only physical cues which elicit reactivity but also internal cues such as states resembling withdrawal, negative emotional states and positive emotional states. This has been demonstrated in a number of experimental studies. In 1966, Merry conducted an experiment that raised doubts about the physiological basis for craving. He gave problem drinkers an

orange vitamin drink, in some cases laced undetectably with vodka and in some cases not, and then asked participants to rate the strength of their craving for alcohol. He found no differences between those given alcohol and those not given alcohol. This suggests that craving is linked with the knowledge that alcohol has been consumed, rather than it being the drug ethanol triggering off an internal mechanism that explains craving.

Desire may be seen as a precursor to loss of control in that a preoccupation with thinking about alcohol may lead to actions directed at fulfilling that desire (McMurrin, 1994). This does not mean that desire always leads to drinking, it is possible for people to resist temptation. Hodgson (1990) states that desire does not occur in a vacuum but that it is linked to the antecedents and consequences of a behaviour and to the persons outcome expectancies. Craving or strong desire is therefore important in understanding the concept of loss of control which in itself is of a highly complex nature.

*Measuring the concept.*

Despite the centrality of the concept of impaired control, there are few measures that examine the construct in its own right (Heather et al., 1993). Davidson (1987) reviewed five major self-report scales developed for use in measuring the various components of the alcohol dependency syndrome. None of these scales measured all of the seven components of the syndrome, rather, the emphasis is on the physiological aspects of alcohol dependency. Questionnaires have included items indicating the presence of loss of control in surveys of the general populations drinking habits (Cahalan & Room, 1974).

Researchers have encountered many difficulties in attempting to operationalise and measure the concept of impaired control. A major difficulty is encountered in defining whether impaired control is a continuous variable, and in defining what actually happens cognitively and behaviourally in terms of individual choice in the matter (Heather et al., 1993).

Edwards (1982) stated that it is unclear 'whether the experience is truly one of losing control rather than one of deciding not to exercise control'. Kelly (1972) proposed that the problem drinker had not lost control over drinking but

that they could not be sure that once started they would be able to stop. Chick (1980) found that participants in his study were perplexed by questions about whether they were 'unable to keep to a limit' or found it 'difficult to stop getting drunk'. Chick concluded that it was problematic deciding whether a person had intended to keep to a limit, how hard they were trying, and if they did 'fail' in this intention was it due to simply 'changing ones mind' or, temporarily losing the ability to control the behaviour. An example of elective loss of control might be the individual who chooses to go out and become intoxicated to celebrate a special occasion, this being very different to the feeling of being out of control that many heavy drinkers express (Heather, 1991).

A further reason why impaired control is difficult to operationalise is because the experience can only occur in people who have tried to limit their drinking (Chick, 1985). Stockwell, Hodgson, Edwards, Taylor & Rankin (1979) in their self-completion questionnaire (The Severity of Alcohol Dependency Questionnaire) rely on the participant recalling a recent month when he or she was drinking heavily which 'for you was fairly typical of a heavy drinking period'. If participants are reminded which month they have selected, they can recall fairly consistently the sorts of symptoms they experienced in that period when tested two weeks apart. However, there may be problems in the participant knowing which month to chose; consumption elicited by this procedure correlates rather poorly with blood tests known to be affected by heavy recent consumption (Stockwell, Murphy & Hodgson, 1983), and this suggests either that they tend to answer about a month two or three months ago, or that the method is not very reliable.

#### *The Impaired Control Scale.*

The need for a comprehensive measure of impaired control having been identified, researchers (Collins & Lapp, 1992,; Heather et al., 1993, Stockwell, Sitharthan, McGrath & Lang, 1994 ) have either expanded upon old measures or developed new questionnaires in order to examine the concept in more detail.

The Impaired Control Scale (Heather et al., 1993) appears to be one such

comprehensive measure of impaired control. It is divided into three parts. Part one measures the degree to which a person has attempted to exercise control over his or her drinking in the past six months. Part two measures the degree of success in controlling drinking over the past six months. Finally, part three measures the person's belief in his or her ability to control drinking if it were attempted. Heather et al. (1993) reported that impaired control can be measured in a reliable and valid fashion using their scale. They state that difficulties previously noted by Chick (1980) in the measurement of impaired control were addressed in the Impaired Control Scale by including the three separate parts measuring different aspects of control over drinking. Thus, the difficulty in deciding whether or not there had been an intention to control drinking was addressed by directly assessing the extent to which participants had formed a conscious intent to exert control over drinking during the previous six months. This was seen as the rationale for including part one of the scale. Also drinkers who had never perceived a need to control drinking were distinguished from heavy drinkers who had abandoned attempts to do so by including part three which measures the extent to which participants believed that they could exert control if they attempted to do so.

Such a measure, they argue, could enhance clinical descriptions of drinking behaviour of those entering treatment. In their study, Heather et al. (1993) found all behavioural aspects of impaired control (ie:- inability to stop, inability to abstain, inability to cut down over the longer term and speed of drinking) contributed to a single dimension of impaired control. They report that the questionnaire may prove useful as a measure of change and of outcome from treatment. In particular, part three, it was suggested, could 'discriminate between individuals attending abstinence-oriented treatment and those attending moderation-oriented programs'.

Finally Heather et al. (1993) point to the fact that many theories of loss of control have not received empirical support. They emphasise the need to develop and test theoretical accounts of impaired control, taking advantage of advances in related psychological theory. The example given being the recent

interest in viewing addictive behaviours in general as examples of breakdowns in self-regulatory processes (Heather, Miller & Greeley, 1991).

### *Goal choice.*

Unless the contraindications of liver disease or other serious physical problems exist, problem drinkers may be offered a goal choice of controlled drinking as an alternative to abstinence. The literature reports that abstinence is still statistically the preferred treatment option ( Cannon, Baker & Ward, 1977, Pachman, Foy & Erd, 1978) There are however reported inconsistencies in the proportions of clients choosing controlled drinking. Heather & Robertson (1981) suggest that these may be partly due to the way in which questions about goal preference are asked and partly due to the orientation of the treatment setting.

Variables affecting a goal choice of controlled drinking seem to be age (younger), regular employment, low severity of drinking symptoms and less contact with Alcoholics Anonymous (Heather & Robertson, 1981). They also suggest that the extent to which periods of control and abstinence are present in a clients drinking history are also important issues when deciding on a treatment goal. This suggestion, concerning the development of the Impaired Control Scale, has since been modified (Heather et al., 1993). Within this they report that past attempts at controlling alcohol intake, as measured by part two of the ICS, are not as good predictors of goal choice as clients beliefs about capability of drinking in moderation.

### *Outcome and attrition.*

The study of outcomes of treatment in the alcohol field is often a neglected area. This is not to isolate the alcohol field, rather it is the case across the spectrum of therapies and client groups. Follow up studies assessing outcomes are extremely important to discover whether treatment is having any effect, be it positive or adverse. It is also important data for refining treatments on offer and matching individuals to treatment programs (Booth, 1993). Booth (1993) points to the 'ultimate issue in quality' as being whether individuals improved following treatment and whether the improvement is maintained. In the current

Health Service climate it is of paramount importance that purchasers are provided with information concerning the effectiveness of a service. Without back up data on outcomes, a service can become vulnerable (Booth, 1993).

The two prominent difficulties with outcome research in alcohol addictions are high attrition rates (Goldbeck, 1994) and a striking lack of an agreed definition of outcome categories following treatment (Heather & Tebbutt, 1992).

Heather & Tebbutt (1992) reviewed a number of influential outcome studies from the alcohol literature. They found that different investigators define both controlled drinking and even in some cases abstinence in entirely different ways, which accounts possibly for difficulties in comparing outcome studies. The overriding aim of treatment should be the elimination of alcohol related problems and Heather & Tebbutt (1992) propose a behavioural model as a basic device for classifying outcomes. Within this model outcomes are classified at two levels. Level one relates to dependence and individuals are classified by either abstinence, non problem drinker, drinking but improved and unimproved. These categories are further divided into a second level concerning quantities consumed, to provide more detailed outcome data. Seven months is advocated as a long enough period to establish the stability of a particular outcome, though it is acknowledged that this length of time will vary according to the practical considerations of different studies. Alcohol related problems, signs of dependence and consumption are outcome categories used to establish where an individual is placed in the model. Though the model is behavioural, Heather & Tebbutt (1992) state that it can be expanded upon to include issues pertaining to control such as intention or self-concept.

Attrition or dropping out of treatment is a common occurrence in the alcohol field. Booth (1987) reports that 'the client who completes treatment satisfactorily is the exception and the client who completes treatment and is then satisfactorily followed-up is rarer still'. Reported non attendance for first appointment or drop out rates in this field range from 12.3 per cent to 52 per cent (Addenbroke & Rathod, 1990). The majority of those individuals who do

enter into treatment will have dropped out of day patient treatment by the fourth session. Booth (1987) reported that between 52% and 75% will drop out of treatment by the fourth session. Various attempts have been made to encourage individuals to re-enter treatment using either letters, phonecalls or domiciliary visits (Booth & Dale, 1985,; Nirenberg et al., 1980). Both of these studies found that phonecalls were more effective than letter reminders.

Earlier studies such as Baekeland & Lundwall (1975) suggest factors that may reduce attrition such as offering a wide range of ancillary services, a variety of treatment modalities, explaining treatment practises and minimising therapist absences. In a more recent study, Goldbeck (1994) concluded that follow up attendance was affected by two factors, age (above thirty-five) and being employed. In his study 67% of those offered a follow-up appointment attended. Rees (1985) found that low expectations of treatment and dissatisfaction with initial clinic visit were related to dropping out of treatment. Nirenberg, Sobell & Sobell (1980) studied people who had dropped out of out patient clinics and found that reasons given for non-attendance were; inability to attend, receipt of treatment from another agency and achievement of their own desired standard of improvement. Booth & Dale (1985) conducted a similar study finding that improvement in drink problem, travel distance, transport costs and dissatisfaction with group therapy were reasons given for not completing treatment. Non-attendance at follow-up is often taken to indicate that an individual has fallen into difficulties with their drinking behaviour again. However, as the above studies appear to indicate and as Bowen & Twemlow (1980) suggest, caution should be applied in assuming that non-attenders are faring worse than those still attending treatment or follow-up.

#### *The alcohol treatment unit.*

Despite difficulties, outcome evaluation has always been strongly prioritised at the unit in which this study was conducted. Follow up studies of both short (six months) and long term (ten years) have been carried out (Booth, Dale & Ansari, 1984,; Booth, 1993,; Booth, 1991). Outcome research is ongoing.

The unit was the last of the purpose built Alcohol Treatment Units to be

commissioned. It opened in 1977 and has been recently relocated. The clinic offers detoxification on an in-patient or out-patient basis, a three week residential treatment programme, a day service treatment programme and evening groups. The philosophy upon which treatment is based does not use the sickness, illness disease model, rather it is based on psychological theory of a behavioural predisposition. Individuals are therefore offered an option of drinking in moderate amounts (unless contraindications exist), after a period of three months abstinence. This period of abstinence is recommended in order that the individual can learn new patterns of behaving without alcohol playing a major role in their lives. It also gives any reversible physical damage (for example, to the liver) a chance to heal.

Within the day service a ten week programme taking place on a Monday and a Wednesday is offered. The groups are primarily run by nursing staff with input from Clinical Psychology and Occupational Therapy. Over the ten week period many areas relating to alcohol are covered including its effects on the family and work. Input from Clinical Psychology is based around relapse prevention involving problem solving, stress management strategies and dealing with low mood. Information is also given within the ten week programme on controlled drinking (setting limits, triggers etc) for use after the three month period should clients want to follow this option. The programme is aimed at helping individuals understand why they experience difficulties and developing alternative coping strategies (Taylor, 1995). Figures for day group attendance during 1993 to 1994 show a total of 1807 individuals and an average group size each week of twenty people (Booth, 1994).

#### *Research aims.*

*Aim one.* Heather et al. (1993) developed the Impaired Control Scale in Australia, therefore using an Australian participant population. There exists the need to examine the internal consistency of the questionnaire with an English population of problem drinkers.

*Aim two.* Heather et al. (1993) suggest that the Impaired Control Scale may be useful in discriminating between those who chose abstinence oriented goals and



those who opt for a controlled drinking goal. They suggest that part three of the questionnaire has potential in this respect. Relating to this is the second aim of this research, examining whether there is a difference between those who chose abstinence and those who chose controlled drinking as treatment options and, scores on the ICS (part three). In order to fully explore this area, examination of parts one and two of the Impaired Control Scale will also be carried out. Any differences between those who chose abstinence as opposed to those who chose controlled drinking in terms of age, severity of dependence and maximum period of abstinence prior to treatment on goal choice will also be considered.

*Aim three.* A further aim is to examine any association between scores on each part of the Impaired Control Scale and length of time that participants remain on the ten week treatment programme. Booth (1987) states the importance of investigating any variables that may influence potential drop-out rates.

*Aim four.* To examine whether there is any difference between those who do achieve their goal by follow-up and those who do not on scores on the Impaired Control Scale. While it is acknowledged that a six month follow-up is the recommended minimum, due to time restrictions participants in this study are requested to attend eight weeks after treatment has ended.

*Aim five.* A secondary but extremely important product of the research will be the collection of data that can be used as a formal evaluation of outcomes for the day service. Outcome generally will be assessed, broadly based on Heather & Tebbutt's (1992) model of classification. Evaluation of treatment outcomes from the day service programme has not to date been carried out prior to the present study.

## METHOD

### *Ethical approval.*

Ethical approval for this study was applied for and granted by the appropriate research ethics committee on 26th October 1994.

### *Participants.*

Participants had all been defined as problem drinkers by their referring agents, a multidisciplinary team at the clinic and by the client themselves. Briefly, this process involved the individual firstly being referred to the clinic by either a GP, Psychiatrist or other professional body. That person would then attend for an assessment session and physical examination. The assessment is structured and results in the collection of approximately 134 pieces of information concerning the client. At the end of the assessment, which takes approximately one hour, the individual is asked what his or her goal is concerning their drinking (ie:- abstinence or controlled drinking) and which treatment programme he or she would like to attend. The person's case is then summarised at a multi-disciplinary team meeting by the assessor. The case is discussed and a decision made about the person entering treatment. The person is then informed of the decision and arrangements made for their first attendance date. Fifty individuals who chose to attend the Monday-Wednesday ten week day programme and attended on at least one occasion following assessment were selected for this research.

Participants had attended the clinic between the months of October 1994 and January 1995. Exclusions were made if participants were mentally ill, had a learning disability or were awaiting a court hearing to face criminal charges.

Fifty participants completed the first stage of the research. Thirty-two were men and eighteen women. From the original fifty, fifteen attended the follow-up interview. Of these fifteen, twelve were men and three were women.

### *Measures.*

Two questionnaires were used in the study, The Impaired Control Scale (Heather et al., 1993) and The Severity of Alcohol Dependency Questionnaire (Stockwell et al., 1979). A brief outcome questionnaire based on Heather &

Tebbutt's 1992 model was also designed to be used as a structured interview.

*The Impaired Control Scale.*

The scale is constructed in three parts:-

Part one consists of five questions designed to assess the frequency of intentions to limit drinking in the previous six months. Part one attempts to distinguish between those drinkers who have and have not attempted to control their drinking. Part two consists of ten questions assessing the frequency of failures at attempts to control drinking in the last six months. Part two assesses not what individuals believe would happen with their drinking but what actually happened.

Part three consists of ten questions assessing beliefs concerning the current ability or inability of the individual to control various aspects of drinking if he or she were to attempt it.

For parts one and two, individuals are asked to rate their response on a five point scale, never, rarely, sometimes, often and always. In part two a category of 'does not apply' is also provided. For part three the following five point scale is used; strongly agree, agree, undecided, disagree and strongly disagree.

Parts two and three of the questionnaire have a balance in reverse wording to guard against response bias. When scored, the scales need to be reversed accordingly. Scores on part one of the scale could range from zero to twenty with a high score indicating that a person had made many attempts to control their drinking in the previous six months. Scores on part two of the scale could range from zero to forty. A high score on this section indicated that an individual had experienced a high number of failed attempts at controlling his or her alcohol intake in the previous six months. Scores on part three of the questionnaire could range from zero to forty, with a high score indicating that an individual does not believe that he or she could control their alcohol intake should they have attempted it.

*The Severity of Alcohol Dependency Questionnaire (SADQ).*

The SADQ was developed in 1979. It is a widely used questionnaire designed as a standard measure of alcohol dependence, identifying which symptoms a

person experiences.

It requires respondents to select one of four frequency responses to each of twenty items relating to 'a recent period of heavy drinking'. The responses are scored from nil to three resulting in a maximum possible score of sixty. Scores of thirty or over have been found to correspond with 'severe alcohol dependence'. Sub-sections of the questionnaire cover physical withdrawal, affective withdrawal, the experience of craving, drinking for the relief of withdrawal, typical daily alcohol consumption and reinstatement of these symptoms following a period of abstinence.

*Additional data collected.*

Information was also taken from the assessment questionnaire that people complete during their first session at the clinic, on choice of treatment goal, age, employment status, marital status, maximum period of abstinence prior to entering the clinic and average daily quantity consumed in units.

*Outcome interview questionnaire.*

This was a short questionnaire devised for the study (Appendix 1). It was broadly based on the model proposed by Heather & Tebbutt (1992) and adapted from a similar instrument already in use at the unit. The questions were asked by the researcher in a structured interview fashion. Data collected included whether participants had achieved their goal, treatment attendance rates, drinking data if relevant and information on any alcohol related problems in work, family and health since assessment.

*Procedure.*

The study was conducted at an Alcohol Treatment Unit in the grounds of a large general hospital. Participants were asked whether they would take part in the research project during their first attendance at the day service programme. Full explanations were given regarding the nature of the study and what taking part would involve. Participants were asked to sign consent forms before taking part in the research (Appendix 2). Special emphasis was placed on attendance for follow-up. Those that agreed to participate were asked to complete the Impaired Control Scale and the Severity of Alcohol Dependence questionnaire.

Due to time restrictions, the second stage, follow-up took place four and a half months after assessment. The Impaired Control Scale was changed accordingly to read four and a half months as opposed to six months. Follow-up took place as near to this point as possible. Participants from stage one were sent an appointment letter (appendix 3) inviting them to attend follow-up. When some individuals failed to attend a further letter was sent out (appendix 4) to encourage attendance. Follow-up interviews lasted approximately thirty minutes during which participants were asked to complete the Impaired Control Scale, the SADQ (if they had a period of heavy drinking since assessment) and the outcome interview questionnaire.

#### *Statistical analyses.*

Data was analysed using the SPSS for windows package. The internal consistency of each part of the questionnaire was assessed by calculating a Cronbach's alpha for each section.

The variables of pre-treatment scores on each part of the Impaired Control Scale, SADQ scores, age, maximum period of abstinence goal choice and achievement of outcome goal produced interval data, and differences between controlled drinkers and abstainers were tested using independent t-tests (equal variance estimate, two-tailed test).

Relationships between scores on the Impaired Control Scale and scores on the SADQ data and were examined through the calculation of the Pearson's Product-Moment Correlation Coefficient. Similarly relationships between scores on the ICS and maximum period of abstinence prior to entering treatment, were explored through the calculation of the Pearson's Product-Moment Correlation Coefficient. The number of sessions that participants attended was classified into categories of one session, two to five sessions, six to ten sessions, eleven to fifteen sessions, sixteen to twenty sessions and finally, completion of treatment programme and attendance at follow-up support groups. As this variable yielded ordinal data, relationships between pre-treatment scores on the Impaired Control Scale and number of sessions attended were investigated using Spearman's rho.

## RESULTS

*Demographic data of participants.*

Demographic data for the participant sample is tabulated below;

**Table 1: Demographic Data.**

|                    | <i>N</i> = | %  |                          | <i>N</i> = | %  |
|--------------------|------------|----|--------------------------|------------|----|
| <b>SEX</b>         |            |    | <b>EMPLOYMENT STATUS</b> |            |    |
| male               | 32         | 64 | employed                 | 11         | 22 |
| female             | 18         | 36 | unemployed               | 36         | 72 |
|                    |            |    | missing data             | 3          |    |
| <b>GOAL CHOICE</b> |            |    | <b>MARITAL STATUS</b>    |            |    |
| abstinence         | 21         | 42 | single                   | 17         | 34 |
| controlled         | 25         | 50 | married/cohabits         | 21         | 42 |
| missing data       | 4          |    | divorced                 | 9          | 18 |
|                    |            |    | missing data             | 3          |    |

Of the total sample most were male ( $N= 32$ ), unemployed ( $N= 36$ ), married or co-habiting ( $n= 21$ ) and chose a goal of controlled drinking ( $N= 25$ ). The ages of the participants ranged from 28 years to 65 years. The mean age of the sample was 42 years ( $SD= 8.03$ ). The range of scores on the Severity of Alcohol Dependency questionnaire (Stockwell et al., 1979) were ten to 58. The group reported a mean SADQ score of 30.22. The number of units that participants estimated that they drank per day ranged from eight to fifty. The mean number of units consumed per day was 29. The number of days that participants had managed to abstain from drinking over the course of their heavy drinking histories, prior to entering treatment is represented in table two.

**Table 2.** Summary of days abstinent.

| Days abstinent             | N= | %  |
|----------------------------|----|----|
| nil                        | 5  | 10 |
| nil to one week            | 10 | 20 |
| one week to one month      | 17 | 34 |
| one month to three months  | 9  | 18 |
| three months to six months | 6  | 12 |
| six months to one year     | 2  | 4  |
| more than one year         | 1  | 2  |

The mean number of days that participants estimated to be their maximum period of abstinence prior to entering treatment was forty-eight.

*Internal consistency of parts one, two and three of the Impaired Control Scale.*

The internal consistency of the scales within the Impaired Control Scale, were evaluated through the computation of Cronbach's alpha (Cronbach, 1960). Data for each question on the ICS is presented in table three. The recommended alpha for satisfactory reliability is 0.8 or above. The calculated alpha for part one of the ICS was 0.57. This score is less than satisfactory and indicates a low internal reliability for this part of the scale. As part one of the ICS had a low calculated alpha, to further investigate the reliability of the items, corrected item-total correlation scores were calculated. Heather et al., (1993) used a procedure described by Nunnally (1978) for deleting items from their original pilot study, to leave only items that had corrected item-total correlation scores of 0.4 and above. Results of this analysis of part one of the ICS demonstrated that question two had a high standard deviation and a corrected item-total correlation score of 0.28. With the removal of question two alpha increased to a satisfactory 0.88. For the purposes of this study question two data is eliminated from the final analysis in order to ensure high internal reliability for

all parts of the ICS within this research. Comment as to the reason behind this low alpha score is made in the discussion .

**Table 3: Reliability analysis-scale (alpha) ICS parts one,two and three.**

| Items             | Mean | Standard Deviation | Corrected Item-Total Correlation | Alpha Item Deleted. |
|-------------------|------|--------------------|----------------------------------|---------------------|
| <b>Part one.</b>  |      |                    |                                  |                     |
| Q1                | 1.70 | 1.14               | .63                              | .46                 |
| Q2                | 2.41 | 4.65               | .28                              | .88                 |
| Q3                | 1.87 | 1.19               | .54                              | .48                 |
| Q4                | 1.91 | 1.30               | .28                              | .44                 |
| Q5                | 1.72 | 1.28               | .46                              | .50                 |
| <b>Part two</b>   |      |                    |                                  |                     |
| Q1                | 3.20 | 1.98               | .69                              | .84                 |
| Q2                | 3.20 | 2.24               | .67                              | .84                 |
| Q3                | 3.40 | 1.88               | .59                              | .85                 |
| Q4                | 1.88 | 2.08               | .71                              | .84                 |
| Q5                | 3.00 | 1.66               | .39                              | .86                 |
| Q6                | 1.55 | 2.36               | .70                              | .84                 |
| Q7                | 1.73 | 1.91               | .47                              | .86                 |
| Q8                | 3.57 | 1.57               | .38                              | .86                 |
| Q9                | 2.88 | 1.83               | .58                              | .85                 |
| Q10               | 1.55 | 2.09               | .59                              | .85                 |
| <b>Part three</b> |      |                    |                                  |                     |
| Q1                | 2.55 | 1.13               | .77                              | .83                 |
| Q2                | 2.23 | 1.12               | .48                              | .86                 |
| Q3                | 2.63 | 1.20               | .72                              | .84                 |
| Q4                | 2.21 | 1.28               | .59                              | .85                 |
| Q5                | 2.44 | 1.36               | .30                              | .87                 |
| Q6                | 2.65 | 1.29               | .62                              | .85                 |
| Q7                | 1.93 | 1.32               | .68                              | .84                 |
| Q8                | 2.63 | 1.25               | .74                              | .84                 |
| Q9                | 2.12 | 1.31               | .33                              | .87                 |
| Q10               | 2.06 | 1.25               | .61                              | .85                 |



There appeared to be two main groups of people attending follow-up; those who were attending follow-up groups and achieving their goals and those who had dropped out of treatment and wished to re-enter the service. Booth & Dale (1985) reported that twenty-six per cent of participants in their study used a routine follow-up domiciliary visit as a route back into treatment at the clinic. The fact that eight participants probably attended because they were still attending the clinic positively biases the outcome conclusions. This is a difficulty encountered with outcome research in the drug and alcohol field (Maisto & Cooper, 1980). This result does seem to support earlier findings that the uptake of out-patient follow-up support is associated with success (Booth, Dale & Ansari, 1984). However there may be problems in generalising these results to the clinic population as a whole due to the small participant number and the fact that these people self-selected to attend the follow-up interview. It is also impossible to state conclusively that taking up the offer of follow-up support groups is definitely going to result in a positive outcome. There are many variables such as changes in life events and existence of other support networks that probably contribute to an individual successfully controlling their alcohol intake (Maisto & Cooper, 1980). Further investigation into the variables affecting success would constitute another research study.

From a comparison between the original group and the follow-up group, married, unemployed men made up the majority of the follow-up participants. With respect to employment the majority of the participants were unemployed so it is not surprising that they made up the majority of the follow-up group. Of the twelve men who attended, four had resumed heavy drinking. They requested re-entry into treatment due to the adverse effects their behaviour was having on their partners and children. The subject characteristic of motivation has been called an important variable in outcome research (Baekeland, 1977). Thus an important question is the classification of extrinsic motivation (eg:- family pressure) and intrinsic motivation (eg:- self-improvement) as predictors of outcome (Maisto & Cooper 1980). These variables would be important to consider in further research.

Factors affecting attrition within this study would need to be explored in further research. Speculation is only possible about the reasons behind such a high drop out rate. Questions concerning the course structure, content, the medium of group therapy, a change in decision to change drinking behaviour and intensiveness of the program would yield interesting data. Booth & Dale (1985) noted the following reasons for drop-out in their study of a clinic population; improvement in drinking problems, dissatisfaction with the medium of group therapy, distance needed to travel and the timing of treatment for those in employment. For eight of the participants in this study, dropping out of the day program served the purpose of being able to transfer to the three week in patient program. While the course content is the same on this program, it is more intense, with people entering the clinic for a three week period and, receiving input five days per week.

Schroeder & Bowen (1982) in a study of attrition found the size of the group and the program length to be influential factors. The results of this study may be seen as partial support for having a day treatment programme of shorter duration that is, five days. However a full exploration of reasons why people in the clinic tend to drop-out of treatment, early in the program, would need to be carried out, before reducing the number of sessions.

The phenomena of attrition is further examined in the following discussion concerning follow-up.

#### *Follow-up data.*

When treatment is not followed as recommended and individuals drop out of treatment the prospect of evaluation becomes fraught with difficulties (Booth, 1993). However, it still needs to remain a vital part of clinical practise.

Thirty percent of participants ( $N=15$ ) attended the follow-up interview four and a half months after assessment. For eight of the participants the four and a half months consisted of ten weeks of the treatment program and attendance at follow-up support groups. For seven of the participants this time period consisted of attending between one and ten days of the treatment program and then dropping out.

prior to entering treatment did not appear to affect participants choice of goal which supports Heather et al., (1993).

There are numerous areas that could be explored further in relation to goal choice. Some examples are the effect of family pressure to opt for a goal of abstinence or, peer pressure to choose controlled drinking so that a person can still drink with their peers. Also goal choice can change over the course of treatment. How people feel when they abstain can affect whether they choose to continue with that option as they begin to feel psychologically and physically healthier. Some individuals initially choose controlled drinking but find that abstinence suits them better and, some who chose abstinence later, as they gain in confidence about controlling their drinking opt for drinking in moderation. These are simply observations made by the researcher while working at the clinic, but exploration into these areas may help to clarify variables affecting goal choice.

#### *Number of Sessions Completed and Pre-treatment ICS Scores.*

Booth (1987) reported that between 52% and 75% of individuals attending the alcohol treatment unit during his research dropped out of treatment by the fourth session. The results of this study are consistent with this finding in that 50% of participants had left treatment by the fifth session. Variables examined in relation to attrition were sex of participant, employment status, goal choice, marital status and scores on the Impaired Control Scale. Numerically single participants noticeably drop out of treatment by the fifth session whereas, those who were married or cohabiting did not show any particular point of drop-out. The question arises of why single people were more likely to drop out of treatment at early into the day program. Polich, Armor & Braiker (1980) reported that young, unmarried controlled drinkers were ten times more likely to relapse. It is possible that married individuals felt more supported in their decision to alter their drinking behaviour, or possibly that single people felt that they had less to loose by returning to heavy drinking in the absence of partners and children. Scores on the ICS did not help to clarify why people dropped out of treatment from this participant group.

would have increased the significance of this relationship. Past research has demonstrated that goals of moderation are most likely to be chosen and achieved by individuals who believe that control is possible (Rosenberg, 1993).

Related to this may be the result that severity of dependence on alcohol as measured by the SADQ was found to have a significant effect on goal choice. Participants in this study who viewed themselves as severely physically dependent on alcohol were more likely to choose a goal of abstinence. A score of thirty and above on the SADQ has been found to correspond with 'severe alcohol dependency' (Stockwell et al., 1979). This supports the claims of Heather & Robertson (1981) that those who show less symptoms of dependency on alcohol are more likely to choose controlled drinking as a goal. McMurrin (1994) reported that people who believe themselves to have the illness 'alcoholism' are more likely to choose abstinence as a goal. He ties this in with the expectancy theory originating from the work of Tolman in 1932. With respect to outcome expectancy this is explained as the knowledge of the relationship between behaviour and behavioural outcomes. It is the anticipatory 'if-then' relationship between events which is the defining feature of outcome expectancy. If the individual does not believe that they can control their alcohol intake after being exposed to it (having one drink) then possibly they would rather opt for the black and white rule of abstinence.

Other variables examined in this study are effects of age and previous periods of abstinence on goal choice. Earlier studies demonstrate that controlled drinking is more likely to be chosen by younger (< thirty-five years) people (Heather and Robertson, 1981,; Booth, 1987). No such effect was found to exist for this participant group. Again, there exists the possibility that a type two error was made in analysis. Alternatively, this group of people may not be representative of the population as a whole that attend alcohol treatment units. In fact upon examination of the data there were very few individuals in the group who were either below the age of thirty-five or above the age of fifty, possibly not enough to pick up a statistically significant difference between controlled drinkers and abstainers on the variable of age. Periods of abstinence

increased to 49% when data collected annually at the clinic was examined. Booth et al. (1984) also suggest that the figures may well be a result of the clinics promotion of both abstinent and controlled drinking goals.

Many treatment centres do not offer the option of learning to drink in moderation following a history of heavy drinking, as abstinence is seen as the only viable option. It appears that agencies who do not cater for this goal conclude that the individual is either denying the full extent of their dependence on alcohol or they are not a 'true alcoholic'. An interesting extension of this research would be exploration of previous treatment at abstinence based agencies and its effect on goal choice. Heather & Robertson (1981) report that those who chose controlled drinking as an option have tended to have less contact with Alcoholics Anonymous than those who chose abstinence.

The results of this study demonstrate that for this participant group the ICS was not particularly helpful in clarifying data on who chooses abstinence and who chooses controlled drinking. This does not support Heather et al. (1993) who say that part three of the questionnaire may be useful in such a task. It has often been noted that people who misuse alcohol are a particularly untruthful group of individuals (Davidson, 1987). Scales such as the ICS are open to falsification if the person so wishes. However this point has been argued by researchers who report that, in fact, problem drinkers do give highly accurate drinking histories irrespective of the sensitivity of the information being sought (Hesselbrock, Babor, Hesselbrock, Meyet and Workman, 1983). Again further research on the effect of past treatment at abstinence based organisations may help to clarify the relationship between impaired control and goal choice.

There exists the possibility that through methodological problems such as participant number that a type two error was made. A trend demonstrated by the mean scores was found to exist between part three of the questionnaire and goal choice. It appeared that in this study those choosing abstention were more likely to believe that they could control their drinking should they have attempted it, than those opting for a goal of controlled drinking. This indicates that perhaps a larger group of people being tested or more sensitive measures

scoring. In fact the results of this study demonstrated that internal consistency was not reduced by treating the two responses as equivalent.

Heather & Booth (in preparation) address the same concern but offer a different solution to the problem. They substituted the score from the equivalent item in part three of the scale. Thus by using this method they report stronger relationships with other internal and external variables. Therefore, this method of scoring is recommended as a more valid procedure in future use of the questionnaire.

#### *Goal choice.*

With respect to goal choice, a greater number of participants chose a controlled drinking option ( $N=25$ ) than abstinence ( $N=21$ ). This would seem to differ from earlier studies that report abstinence to be numerically the preferred option (Booth, Dale & Ansari 1984,; Cannon et al.; 1977, Pachman et al. 1978 ). One possible explanation for the results found in this study is that the way in which questions regarding goal preference are asked and the orientation of the treatment setting is influential in participant's goal choice (Heather & Robertson, 1981): The clinic from which the participant group were drawn offers controlled drinking as a treatment goal. The model of dependency upon which treatment is based is not a sickness/ illness model therefore abstinence is not viewed as the only option available. Problems with alcohol abuse are viewed as learned behaviours that can be unlearned with the appropriate treatment and support. Only individuals who have permanent physical damage are advised to abstain. The orientation of the clinic is made clear to clients during assessment through the explanation of the behavioural model and emphasis on the treatment goal being the individual's decision. Possibly the promotion of this model and encouragement in individuals choosing their own aims in treatment accounts in part for the high number of people choosing the controlled drinking option in this study. Interestingly, the study carried out by Booth et al. (1984) was from the same clinic as in this research. While reporting a figure of 32% of participants choosing a controlled drinking option, they note that this was somewhat higher than other studies. This figure

(Davidson, 1987). Specification of a particular occurrence of heavy drinking behaviour may offer further help to individuals who find it difficult to answer general questions such as whether they had tried to resist the opportunity to drink in the last six months.

However as this question was not problematic in either Heather et al. (1993) or Heather & Booth (in preparation), it is possible that the result was affected by methodological difficulties with this study. Size of participant group is often a contributing factor for failure to establish significance (Coolican, 1994). It is possible that the participant number of fifty was not sufficiently large to overcome any susceptibility of Cronbach's alpha to sizes in sample. The two quoted studies using the ICS report numbers of 115 and 141 respectively. Alternatively the large sample sizes used by Heather et al. (1993) and Heather & Booth (in preparation) may have obscured the effect of question two on the scales internal consistency (Coolican, 1994).

As the difficulty lay seemingly with only one item and was not a general problem with the scale, the solution to the problem of question two encountered in this study was to eliminate it from all analyses, therefore maintaining satisfactory internal consistency.

Concern about the scoring of the category 'Does not apply' in part two of the Impaired Control Scale as equivalent to the 'Never' category was raised within this study. This concern was borne out of the possibility that some participants had not attempted to control their drinking at all, and were answering 'Does not apply' accordingly. This would not necessarily give the same meaning to an answer as a participant who answers 'Never' to the same question. This is perhaps best demonstrated by examining the two responses to an example question; Question 1 'During the last six months I found it difficult to limit the amount I drank.' An individual who answered 'Never' to this question would possibly be someone who had not found it difficult to completely resist drinking or to stop once started. A participant who answers 'Does not apply' to this question would be giving a very different answer. Therefore it seemed inaccurate to treat the two answers as equivalent when

## DISCUSSION.

It is appreciated that the sample size and number of variables examined can only give a small part of a complex picture. Therefore, interpretation of the results of this study should perhaps proceed with caution. The discussion will take each of the aims in turn and discuss them in terms of the results of this research and relationships to previous studies. Methodological considerations will be commented on and ideas for further research and service development suggested.

*Aim: The use of the ICS with a British population.*

With respect to the internal consistency of each part of the Impaired Control Scale Heather et al. (1993) report that items within each part of the scale formed highly homogenous groups and were all answered by participants in a highly consistent fashion. Heather & Booth (in preparation) quote similar results in a recent study conducted using a British population.

The results of this study support the above concerning parts two and three of the questionnaire, however part one proved problematic. Question two; 'during the last six months I tried to resist the opportunity to start drinking' was the source of the difficulty. It is possible that participants found this question difficult to understand and randomly answered it or they may have found the answer scale restrictive (Coolican, 1994). Chick (1980) pointed to difficulties he encountered regarding participants being perplexed by questions about whether they were unable to keep to a limit when drinking. Davidson (1987) stated that the concept of impaired control is difficult to operationalise and can be subject to idiosyncratic interpretation on the part of both researchers and participants.

Arguably the most crucial methodological issue which must be taken into account when designing a scale assessing any area of dependency is specification of an appropriate time period. In past research, inquiries have been made based on between one and twelve months of the individuals past drinking history, depending on the questionnaire measure being used



those who had been trying and not failing to control their alcohol intake over the four and a half month period between assessment and follow-up.

**Table 8.** Calculated mean and *t* scores.

|                 | Achieved goal<br>( <i>M</i> = ) | Did not achieve<br>goal. ( <i>M</i> = ). | <i>t</i> = | d.f. | significance |
|-----------------|---------------------------------|--|------------|------|--------------|
| Pre-treatment   |                                 |  |            |      |              |
| Part 1          | 8.75                            | 5.16                                     | 1.46       | 12   | .169         |
| ICS             |                                 |  |            |      |              |
| Part 2          | 28.62                           | 17.40                                    | 3.10       | 11   | .01**        |
| ICS             |                                 |  |            |      |              |
| Part 3          | 24.75                           | 22.80                                    | .92        | 11   | .378         |
| Post-treatment. |                                 |  |            |      |              |
| Part 1          | 14.77                           | 6.50                                     | 6.21       | 13   | .001***      |
| ICS             |                                 |  |            |      |              |
| Part 2          | 7.77                            | 24.16                                    | -3.65      | 13   | .003**       |
| ICS             |                                 |  |            |      |              |
| Part 3          | 13.22                           | 24.33                                    | -1.71      | 13   | .11          |

\*\*  $p < .01$ . \*\*\*  $p < .001$ .

**Table 7.** Comparison of original group and follow-up group.

|                    | Original group<br>(N=50) | follow-up group<br>(N=15) |
|--------------------|--------------------------|---------------------------|
| male               | 64%                      | 80%                       |
| female             | 36%                      | 20%                       |
| employed           | 22%                      | 14%                       |
| unemployed         | 72%                      | 86%                       |
| single             | 34%                      | 27%                       |
| married/cohabits   | 42%                      | 60%                       |
| divorced/separated | 18%                      | 13%                       |
| age (M)            | 42yrs                    | 40yrs                     |

*The effect of Pre and post-treatment ICS'scores on outcome goal.*

In order to examine whether there was any differences between individuals who had achieved their goal at outcome and those that had not, pre-treatment scores on the Impaired Control Scale were compared using *t*-tests for independent samples were calculated. Post-treatment scores were similarly examined. The results are summarised in table eight. As can be seen from table eight a significant difference was found between people who had and had not achieved their goal at follow-up and scores on part two of the ICS given prior to treatment commencing ( $t=3.10$ , d.f. =11,  $p < .01$ , two-tailed). This indicated that individuals who had achieved their goal at follow-up had a history of more failed attempts to control alcohol intake prior to entering treatment than those who had not achieved their goal.

Significant differences were also found between people who had, and had not achieved their goal at follow-up on scores on parts one and two of the ICS given out at the follow-up interview. Individuals who achieved their goal were

16% ( $N=8$ ) of participants attended the follow-up groups offered at the clinic. Of these, 14% had achieved their goal at the time of the follow-up interview. One female participant had chosen to attend another agency after one session at the clinic and attributed her success to that agency. Therefore she did not attend follow-up groups. However further data from the clinic has shown that since the interviews, one of these participants has recently begun drinking heavily and, three have stopped attending the groups. There is no information on these individuals drinking at the present time.

Six participants (male), reported at follow-up that they had run into difficulties with drinking again since dropping out of treatment. Of these six, three requested re-entry into treatment at the follow-up interview and their needs were met accordingly. With respect to drink related problems experienced since assessment, the outcome questionnaire covered the areas of work, health, family and legal matters. One male participant had been involved in an alcohol related offence. Of the six participants who had not achieved their goal, four had experienced drink related health problems. Memory problems, stomach and joint pain and panic attacks were reported. One participant had also been to hospital as he was intoxicated. All six of the participants who had not achieved their goal reported family difficulties as a result of their heavy drinking. Partners, parents and children were reported to have been adversely affected by participants drinking behaviour.

Comparisons were made between the fifteen participants that attended the follow-up interview and the original group of fifty. The results are summarised in table seven. From inspection of the data it appears that those who attended follow-up were more likely to be males who were unemployed and married or co-habiting. The average age of the two samples differed only by two years.

participants scores on each part of the Impaired Control Scale and number of sessions attended for this sample.

*Outcome data.*

Follow-up took place approximately four and a half months after assessment, eight weeks after treatment was completed and, data was obtained from 15 of the original participants. Therefore there was a rather high attrition rate at follow-up of 70%. Thirteen individuals attended at the first appointment request and two upon being given a second appointment.

*Summary of outcome data.*

**Table 6:** Numbers of participants achieving various categories of outcome.

| Abstainers |       | Non-problem  | Drinking but | Unimproved |
|------------|-------|--------------|--------------|------------|
| Mostly     | Total | Drinkers(CD) | Improved.    |            |
| (N=)       | (N=)  | (N=)         | (N=)         | (N=)       |
| 2          | 5     | 2            | 3            | 3          |

Individuals were classified in terms of the model proposed by Heather & Tebbutt (1992). Of the fifteen who attended follow-up interviews nine had achieved their goal. Those participants who had experienced less than five relapses(one period of intoxication=one relapse) were classified as 'mostly' abstaining but still as successes. Twelve men and three women attended the follow-up interview. The age range of participants was 28 to 65 years. Thirteen out of the fifteen were unemployed.

Of the twelve men who attended the follow-up interview, five were successful abstainers and one was a successful controlled drinker. Of the three women who attended the follow-up interview, two were successful abstainers and one was a successful controlled drinker. Therefore from the original participant group nine out the original fifty (18%), had achieved the goal that they had chosen during assessment at outcome.

**Table 5:** Number of individuals dropping out of treatment after between one and twenty sessions.

|              | sex          |              | employment   |              | goal choice  |              | marital status |              |
|--------------|--------------|--------------|--------------|--------------|--------------|--------------|----------------|--------------|
|              | Male\        | female       | unem         | emp.         | CD           | Abst         | single         | married      |
|              | <i>N</i> =32 | <i>N</i> =18 | <i>N</i> =36 | <i>N</i> =11 | <i>N</i> =25 | <i>N</i> =21 | <i>N</i> =26   | <i>N</i> =21 |
| 1            | 3            | 6            | 6            | 3            | 6            | 3            | 5              | 4            |
| 2-5          | 12           | 4            | 9            | 4            | 6            | 7            | 10             | 3            |
| 6-10         | 7            | 1            | 8            | 0            | 5            | 3            | 4              | 4            |
| 11-15        | 2            | 1            | 3            | 0            | 0            | 3            | 1              | 2            |
| 16-20        | 2            | 3            | 3            | 2            | 4            | 1            | 1              | 4            |
| follow<br>up | 6            | 3            | 7            | 2            | 4            | 4            | 5              | 4            |

To summarise, female participants were most likely to drop out of treatment after session one ( $N=6$ ). Male participants were most likely to drop out of treatment between sessions two and five ( $N=12$ ). Participants were least likely to drop out of treatment between sessions eleven and twenty regardless of marital or employment status and goal choice. Single or divorced participants were most likely to leave treatment between sessions one and five ( $N=15$ ).

*Pre-treatment scores on the ICS and attrition rates.*

Correlations between pre-treatment scores on parts one, two and three of the Impaired Control Scale and number of sessions attended, were examined using Spearman's rho. For part one of the scale the calculated  $\rho = -.03$  ( $N=47$ ) which was not significant. For part two of the Impaired Control Scale the calculated  $\rho = -.21$  ( $N=44$ ) and for part three of the questionnaire the calculated  $\rho = -.15$  ( $N=46$ ). Therefore none of the results were statistically significant. This indicates that no significant relationship exists between

the computation of Pearson's Product-Moment Correlation Coefficient. A statistically significant relationship was found between part one of the ICS (frequency of attempts to control alcohol intake prior to entering treatment) and individuals rating of severity of physical dependence on alcohol ( $r = -.4261$ ,  $d.f. = 48$ ,  $p < 0.01$ , two-tailed). The results for part two of the ICS and scores on the SADQ showed a non-significant relationship ( $r = .2324$ ,  $d.f. = 45$ ,  $p < .125$ , two-tailed). A statistically significant relationship was found between subjective belief in ability to control alcohol intake should it be attempted (part three of the ICS) and severity of physical dependence on alcohol ( $r = .5625$ ,  $d.f. = 47$ ,  $p < 0.001$ , two-tailed).

*The relationship between previous abstinence and scores on the ICS.*

Relationships between maximum period of abstinence prior to entering treatment and scores on each of the three scales of the ICS were explored through the computation of Pearson's Product-Moment Correlation Coefficient. No statistically significant relationship was found between part one of the ICS and length of abstinence ( $r = -.2260$ ,  $d.f. = 48$ ,  $p < .122$ , two-tailed). Similarly no statistically significant relationships were found between part two of the ICS and period of abstinence ( $r = -.0073$ ,  $d.f. = 45$ ,  $p < .962$ , two-tailed), or part three of the ICS and maximum period of abstinence prior to entering treatment ( $r = .1527$ ,  $d.f. = 47$ ,  $p = .305$ , two-tailed).

*Number of sessions completed.*

Participants could have attended between one and twenty sessions of treatment over a ten week period followed by an option of a follow-up support group. The mean number of sessions attended was three demonstrating a high attrition rate around sessions two to five. Fifty per cent of the participants had dropped out of treatment before session six. Only twenty per cent completed the ten week programme. Length of time spent in treatment according to the variables of sex, employment status, marital status and goal choice are summarised in table five.

Table 4: Calculated mean and *t* scores for each variable.

|                              | Controlled<br>Drinking. | Abstinence | <i>t</i> = | d.f. | significance |
|------------------------------|-------------------------|------------|------------|------|--------------|
| Part one<br>(ICS)            | 7.08                    | 6.50       | -.46       | 42   | .651         |
| Part two<br>(ICS)            | 24.18                   | 26.94      | .92        | 39   | .364         |
| Part three<br>(ICS)          | 21.28                   | 25.50      | 1.63       | 41   | .111         |
| SADQ                         | 24.20                   | 37.09      | 3.5        | 44   | .001***      |
| Age                          | 42.44                   | 41.47      | -.41       | 44   | .687         |
| Max period<br>of abstention. | 50.84                   | 75.85      | 1.07       | 44   | .292         |

\*\*\* $p < .001$ .

As can be seen from the table above respondents who chose a goal of abstinence viewed themselves as more dependant on alcohol than those who chose a goal of controlled drinking ( $t=3.50$ ,  $d.f.=44$ ,  $p < .001$ , two-tailed). No other significant differences were found, however a trend within the means indicated that people who chose abstinence saw themselves as being more able to control thier alcohol intake should they have attempted it than those who chose controlled drinking.

*The relationship between severity of dependence on alcohol and impaired control.*

Relationships between scores on the Severity of Alcohol Dependency questionnaire and scores on the Impaired Control Scale were examined through

Part two of the ICS was treated in two ways; the response category of "Does not apply" was first coded as 0 as it was done in the original article describing the questionnaire (Heather et al., 1993), and then as a missing value. The reason behind this was concern that the categories of 'does not apply' and 'never' may not be equivalent as suggested in Heather et al. (1993). When 'does not apply' was coded as a 0 the calculated alpha was 0.86 which suggests satisfactory internal reliability and supports the equivalence of the two response categories. When 'does not apply' was coded as a missing value the calculated alpha was 0.79. The first method of scoring was therefore retained as it produced higher internal consistency. Part three of the ICS had a calculated alpha of 0.86 indicating satisfactory internal reliability. Heather et al. (1993) produced alpha scores of .86, .84 and .89 respectively in their study indicating high internal reliability.

*The effect of age, control, severity of dependence and period of abstinence on goal choice.*

21 participants chose abstinence as a goal and 25 chose controlled drinking. Four participants failed to make a decision at the assessment stage. Differences between those who chose abstinence and those who chose controlled drinking as a treatment goal at assessment, on the variables of age, scores on the Impaired Control Scale, scores on the SADQ and maximum period of abstinence prior to entering treatment were explored by calculating *t*-tests for independent samples.



The Impaired Control Scale appeared to be of value in clarifying interview data collected at follow-up. Those individuals who had tried to limit their drinking and succeeded prior to and during treatment were more likely to achieve their chosen goal. There did not appear to be a statistically significant difference between those who did and did not believe in their ability to control drinking should they have tried, and achievement of outcome goal. This does not seem to support Heather et al.(1993). Heather & Booth (in preparation) are currently evaluating a study of seventy participants who have been followed-up six months after leaving in-patient treatment. Qualities of the ICS in clarifying the relationship between impaired control and treatment outcome are being explored.

With regard to the thirty-five participants on whom no follow-up data is available only speculation is possible. Bowen & Twemlow (1980) encourage caution in assuming that non-attenders have resumed old drinking habits and indeed, studies examining non-attendance have found that the most frequently stated factor was improvement in drinking (Leigh, Osbourne & Clelland, 1984, Nirenberg et al.,1980). Of the seven individuals from this study who attended follow-up but who had not completed treatment, six had resumed heavy drinking. However as stated earlier it is virtually impossible to generalise from these six to the other thirty-five people who did not attend, as the numbers attending follow-up were too small, and all self-selected to attend the follow-up interview.

Methodological problems in addiction outcome research generally need to be considered in relation to this study to explain the problems encountered in conducting follow-up. The first of relevance to this study is continuity of therapist (Caddy, 1980). It is possible that as the researcher was not known to all participants prior to entering treatment that this affected attendance at follow-up. Nursing staff helped in the distribution of questionnaires at the assessment stage due to the researchers commitments on another placement therefore not all participants were known to them. Should the study be carried out again this would be an important factor to change.

Controversy exists around the appropriate length of the follow-up interval (Maisto & Cooper, 1980). Heather & Tebbutt (1992) state that after six or seven months the stability of a particular outcome is likely to be established. Those that are likely to have relapsed will have done so by six months after treatment. A difficulty with this study was the relatively short period between assessment and follow-up interview. Armor, Polich & Stambul (1978) suggest that more controlled drinkers emerge between one and three years following treatment than in the first year. Booth (1993) encourages caution in assuming that short term success or failure is predictive of longer term outcome. Therefore, the results of this study are tentatively reported. Of the nine participants who when interviewed reported that they had achieved their goal, one has since reverted back to heavy drinking and no longer attends the clinic. Also three other individuals have since left the service, though there is no reason to assume that resumption of heavy drinking behaviour has taken place. Should this research be developed further, follow-up contacts at frequent points of say two months over a period of two years would perhaps yield more sensitive outcome data (Caddy, 1980).

Caddy (1980) suggests that multiple collateral information sources should be used to verify self-reports. Possibly requesting the names and telephone numbers of participants friends or family would have at least been a way of acquiring some information on those who did not attend follow-up. Though participants were briefed prior to taking part in the research about the nature of follow-up, there still seems to be an ethical consideration regarding the lengths clinic staff should go to obtain follow-up data on non-attenders. At the clinic people are followed-up by domiciliary visits if they do not respond to a letter request to attend. While it is acknowledged that this is useful for some (Booth & Dale, 1985), obviously individuals should have the right to refuse follow-up. At the time of writing the day service does not have any protocol for gaining consent from individuals regarding follow-up. It is recommended therefore that this becomes standard procedure with the understanding that clients can withdraw without explanation if they so wish.

To conclude, high attrition rates in the study of outcomes in addiction research are still a major source of problems (Goldbeck, 1994). To some extent services such as the specialist alcohol treatment units rely on high attrition rates to keep them at a manageable level (Booth, 1991). Nevertheless researchers and practitioners continue to explore those variables that affect retention in and outcome from treatment. The results of this study seem to suggest that the Impaired Control Scale does have some use in clarifying the effect of 'control' as a variable. However measurement of the concept is still in its infancy.

*Implications for practise and future research.*

The Impaired Control Scale seems to be a useful tool in clarifying client information prior to entering treatment. Future research could examine its relationship with other scales developed to measure impaired control such as the Temptation-Restraint Inventory (Collins & Lapp, 1992). Also though it appears that the questionnaire was not useful in exploring the relationship between impaired control and length of time that people spent in treatment for this participant group, further research may explore whether this is the case with other groups of problem drinkers. Numerous areas relating to goal choice could be explored in further research for example, the effect of previous treatment at abstinence based agencies prior to entering treatment at the clinic on choice of treatment goal. Goal choice can vary over the course of treatment and clients can change their minds at any point in treatment and follow-up. Exploration of relationships between impaired control and changes in choice of treatment goal would also contribute a greater understanding of what influences goal choice. The area of follow-up within the mental health field generally is still fraught with difficulties. Possibilities for future research generated from this study in the alcohol field may be, the effect of extrinsic versus intrinsic motivation as predictors of outcome. This would require another separate study to explore this area. Also, a comparison of the clinic population as a whole with this group, to assess whether the group used in this study are representative of the population as a whole in the clinic. To conduct this study would simply involve an extension of the current research using the same

participant group.

With regard to implications for future practise a protocol for following clients up who attend the day patient programme needs to be developed in order that people are aware that follow-up is seen as an integral part of clinic practise. Also the case for a reduced number of sessions may be argued as individuals tended to drop out of treatment after five sessions. However this would need to be carefully explored in terms of why people drop out of treatment and whether five sessions would be equally if not more effective than the current ten week programme.

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**APPENDICES.**

APPENDIX 1. The Outcome Questionnaire.

APPENDIX 2. Consent form.

APPENDIX 3. First appointment letter for the follow-up interview.

APPENDIX 4. Second appointment letter for the follow-up interview.

## OUTCOMES/ FOLLOW UP

NAME:-

DATE:-

1. Did you complete the ten weeks of treatment ? If not how many sessions did you attend ?

2. If you had decided on a treatment goal, what was it; abstinence or controlled drinking.

3. Drink diary for week preceding interview:-

MONDAY

TUESDAY

WEDNESDAY

THURSDAY

FRIDAY

SATURDAY

SUNDAY

4. Would you say that this was a typical week ? Is it more or less if not ?

5. Is your alcohol intake:-

much worse/ worse/ same/ slightly improved/ much improved

since assessment?

6. How do you view your alcohol consumption since assessment:-  
much worse/ worse/ same/ slightly improved/ much improved.

7. Have you been intoxicated since assessment?

If yes then has it been more or less than five times?

8. How much control do you think that you have over your drinking now ?

none/ some/ alot/ total.

9. Have you had any hospitalisations or visits to the Doctors since assessment? Drink related or not?

10. Have you had any drink related problems in the following areas:-

work

health

family/ relationships

legal

11. Have you sought any help from other agencies such as counsellors or AA since assessment?

CONSENT FORM.

Does whether you think you can control your drinking  
affect how well you do in treatment?

I have read the client information sheet and understand exactly what is required of me in taking part in this study.

I understand that I am free to withdraw from the study at any time without having to give a reason if I do not wish to do so. This action will not affect further care.

I understand that information from this research will remain confidential though it may be discussed with others directly involved in my care.

I have been given a contact number if there are any queries about the study.

In view of the above I agree to take part in the study and sign below:-

CLIENT:-

RESEARCHER:-

DATE:-

use quote our reference in reply)

Ref.

Ref.

When let

use ask for

.....

.....

Dear

Approximately four months ago you attended the  
During one of your first sessions either on a Monday or Wednesday  
one of the nursing staff will have asked you to complete two  
questionnaires. These were part of my research project.

Here at the .. Clinic we are always trying to improve the  
service given to clients. Research such as this helps to meet  
these aims. We also find it extremely useful to review clients  
progress.

Could I ask you to attend the Clinic once more to  
complete a brief interview and two further questionnaires.

An appointment has been made for you at the Windsor Clinic on:

DATE

TIME

please contact me if this is not convenient and I will arrange  
a different time.

Many thanks for your cooperation.

Yours sincerely

Trainee Clinical Psychologist



case quote our reference in reply)

r Ref.

ur Ref.

When telephoning or calling please ask for

.....

.....

Dear

Unfortunately you were unable to attend your follow up appointment on ..... I do hope that this was not due to illness.

Could I please stress the importance of attending follow up appointments as they are an extremely useful way of helping us improve our service.

I have taken the liberty of arranging a second appointment for you on:

Date:

Time:

I hope that you are able to attend. Should you wish to arrange a more convenient time please do not hesitate to contact me on the above number.

Many thanks for your cooperation.

Yours sincerely

Trainee Clinical Psychologist  
CLINIC

Small Scale Research Project Completed on Learning Disabilities  
Placement.

A Single Case Observational Study of Staff-Client Interaction Before and  
After Resettlement.

Word Count, 2,815 (excluding references)

3,115 (including references)

## ABSTRACT

This single case study examined the nature and frequency of staff-client interactions for one 31 year old man across two settings, a large institution that he had lived in for 24 years and the community home he was resettled to. Direct observational data using momentary time sampling was collected one month prior to resettlement, one week after, and at a six week follow-up.

Results show, as was hypothesized, that for the client under investigation, frequency of staff-client contact increased from five percent to 40% following resettlement. Whilst this was a large improvement, still for 60% of the time observed, the client did not receive any contact.

The nature of the contact taking place was of a positive, neutral or assistance type, however interestingly results also showed an increase in negative contact in the form of verbal reprimands, following resettlement.

## INTRODUCTION

The move to community care has emphasized the provision of an ordinary life in small community based houses. Smaller settings, however, do not necessarily guarantee an improved quality of life for residents. (Mansell & Beasley, 1990).

The North Western Regional Health Authority is currently moving towards closure of its large hospitals for the learning disabled, including its three largest, one which closed in 1992, another that is due to close in 1996 and the third, due to close in 2000.

Interaction in facilities for people with learning disabilities has been suggested as being an important determinant of quality of care (Pratt, Burnstead & Raynes, 1976). A number of studies have examined the amount and quality of interactions between direct care staff and clients within both institutional settings and or small group homes within the community. As people with learning disabilities are moved into smaller homes with increased staff ratios it may be reasonable to expect that the frequency of client contact increases and the nature improves, ie: more positive contact.

Within large institutions many studies have shown that desirable interactions take place less than 25% of the time (Cullen, Burton, Watts & Thomas, 1983, Reuter, Archer, Dunn & White, 1980). Behymer (1953) and, Kandler, Behymer, Kegeles & Boyd (1952) found that staff-client interactions in hospitals tended to be of short duration (generally less than one minute) and nursing staff interacted more with each other than with clients. Dailey, Allen, Chinsky & Veit (1974) found that the average client in an institution was engaged in either a positive or social play interaction for less than one percent of observed time. Hile & Walbran (1991) found that direct care staff observed in various large institutions spent the majority of their work time engaged in either supervision type interactions with clients or in pursuit of their own leisure activities which did not involve contact with clients. In their study, during an average hour, clients received 0.21 minutes of training,

0.67 minutes of personal care and 2.3 minutes of socialization. Presumably for the remaining time no interaction was observed. Hile & Walbran (1991) stated that increased numbers of staff did not necessarily result in an increased number of staff-client interactions. It usually meant that staff interacted more with each other. This finding is supported by earlier studies for example, Harris, Veit, Allen & Chinsky (1974), Orłowska, McGill & Mansell (1990).

A number of studies have examined whether the move to a smaller setting in the community increases the frequency of interaction between staff and clients. Landesman-Dwyer, Sackett & Klienman (1980) looked at twenty group homes with varying numbers of clients. The group homes had between six and twenty individuals living in each one. They concluded that the frequency of interaction did not differ between the homes.

Mansell & Beasley (1990) carried out a three year longitudinal study looking at pre and post move settings. They state that small staffed homes can provide improved client experience as measured by engagement in meaningful activities. Staff-client contact was seven percent in hospitals and 13- 26% in group houses. They also found that there was an increase of assistance given in the houses; two percent in hospitals as opposed to 11% in the group homes. Mansell & Beasley(1990) concluded that there was also an increase in the amount of neutral and social contact that clients received after resettlement. Earlier studies by Mansell & Beasley show improvement in staff-client interaction and interestingly an increase in negative contact in the small homes in the community. However, despite an increase in staff-client interactions following resettlement these studies show that for two thirds of a clients day they do not receive any contact from staff.

Following the cited studies and the emphasis on resettlement and community care, this study examines the nature and frequency of staff-client interaction before resettlement, one week and six weeks following resettlement for one 31 year old male with learning disabilities.

The method of momentary time sampling was chosen to collect data as it

provides a reliable and unbiased method of monitoring multiple behaviors (Adams 1991). It is also a method used by Hile & Walbran (1991) and in the Mansell studies.

Specific questions examined in this study are:

1. What kind of interactions do staff engage in with this particular client ?
2. Does the quality of interaction improve after resettlement ?
3. Does the amount of time receiving no contact decrease after resettlement ?

The hypotheses state that for the client under investigation:

- (i) The frequency of contact with staff will increase following resettlement and,
- (ii) The nature of contact will move towards positive, neutral/ assistance rather than negative or no social contact after resettlement.

## METHOD

### *Design*

The design was a within series single case design. Over three phases; one month prior to resettlement, one week after resettlement and a follow up phase six weeks after resettlement, observations were made over one week periods for a total of eight hours.

### *Participant.*

PH was a 31 year old man who had resided in a large institution in Lancaster for 24 years. He was admitted in 1969 at the age of six years. PH has severe learning disabilities and no speech. He was resettled on 23rd August 1993 to a house in the Blackpool area with two other men who had lived in the same institution.

### *Settings*

The first phase observations were carried out at the large hospital where the client had lived for 24 years. The observations took place in a flat/ward in the hospital. Eleven other men all of whom had severe learning disabilities also lived on the ward. The only areas accessible to the men were the main living area and an enclosed courtyard. The material environment was barren; the main living area consisting of chairs, cupboards and a television. Staff numbers were generally two to three to twelve residents. The hospital is due for closure in 1996. 'Activities' available were sitting, walking around or watching television.

The second and third phase observations were carried out in a terraced house in Blackpool. The house is placed in a newly built group of houses about one mile from the nearest shops. There is a small garden to the rear. Three men reside in the house all resettled from the same hospital on the same date. The house consists of a small dining/living area, kitchen, three bedrooms and a bathroom. The client observed had access to all rooms and the garden. Staffing levels varied with one or two staff working at a time. None of the staff had worked in a large institution.

### *Measurement*

The measure used was a 30 second momentary time sample collected using a hand held computer (Psion Organizer). This measure (Beasley, Hewson & Mansell, 1989) samples how much time the individual spends in various categories of behavior in their everyday life. The main data collected was that of social contact initiated by the client and contact to the client by staff or visitors.

Social contact initiated by the client was coded under, no social behavior, clear social act (e.g.: speaking to someone, tugging their sleeve), unclear social act (e.g. vocalizing or waving arms near someone), and social act to observer (intended to provide a check of reactivity). Contact by staff/ visitor codes were none, positive (e.g.: staff praising or visibly encouraging client), negative (e.g: staff restraining, restricting or shouting at the client), neutral (all contact which is neither positive or negative), assistance (physical help or guidance resulting in a positive activity) and other client to observed client contact. The full definitions of the codes are defined in the MTS Handbook for observers; Beasley & Mansell (1989).

The observer entered one code for each of the four sections every thirty seconds. The observer followed the client as unobtrusively as possible. Observations were not made in intimate or private situations such as: bathing or visits to the toilet.

### *Procedure*

Phase A: Observations were made on the ward of the large institution that PH had lived for twenty-four years. Observations were carried out for two hours per day for four days in a one week period. The hours observed covered the majority of the client's average day.

Phase B: Observations were carried out for the same number of hours and covering a typical day as in Phase A, but one week after resettlement as PH's new home in the community.

Follow-up: Observations were carried out six weeks after resettlement at the community home over a one week period, for a total of eight hours, approximately



two hours per day.

### *Reactivity*

Dubey, Kent, O'Leary, Broderick & O'Leary (1977) warn against the 'implicit assumption' that the observer does not affect the behavior of the participant. A pilot study was carried out two weeks before the data was collected in the hospital setting. During this period methodology was tested along with the experience of being observed and observer. Carers in both settings received full explanations with regard to the data collected and consented to the observations on the client's behalf. Reactivity (contact to the observer) was 0.59% in phase one, in phase two 0.30%, and 0% in phase three.

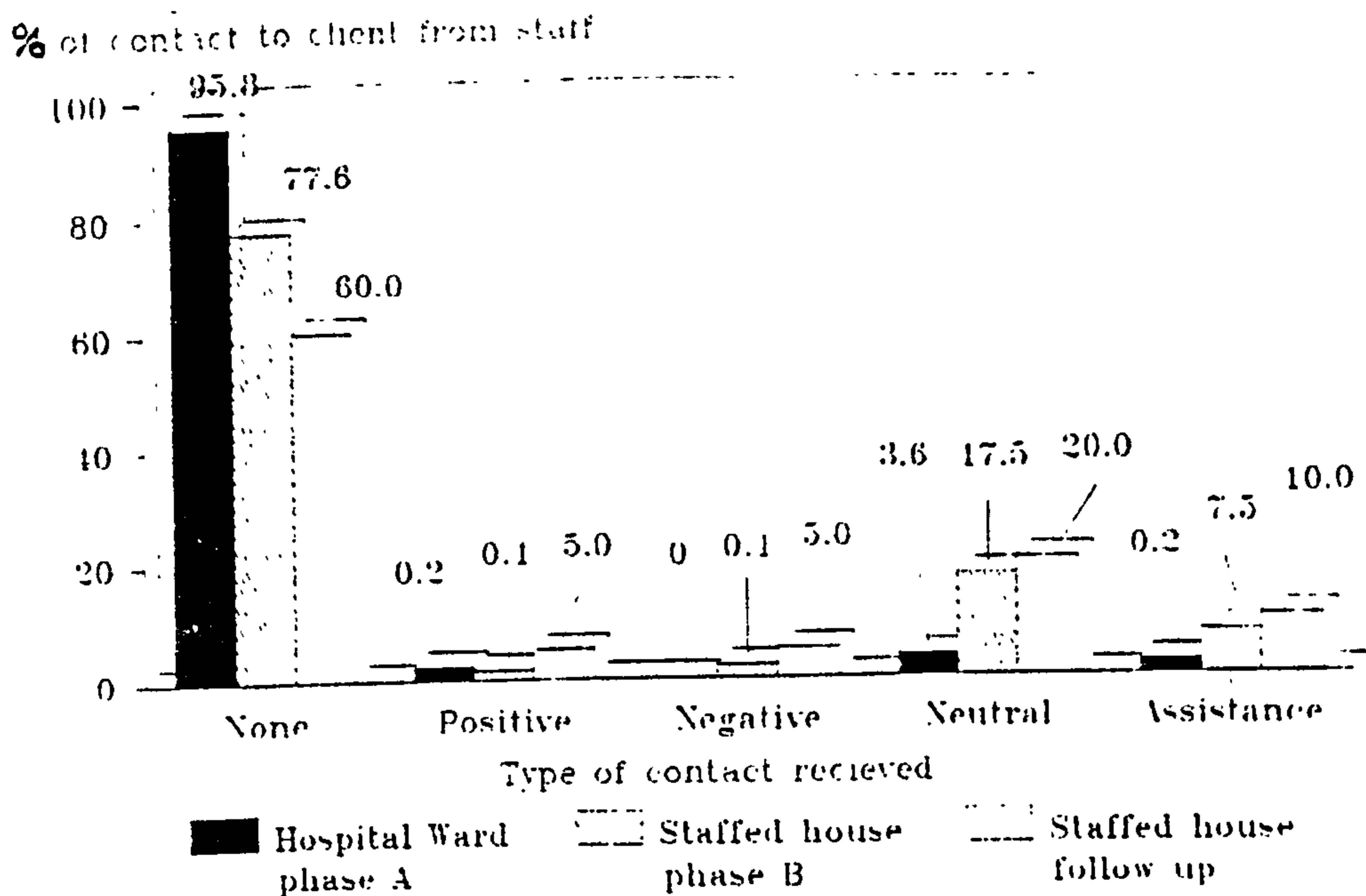
### *Inter-rater reliability*

For one hour at each phase of observations, a second observer independently collected data. Observers were seated apart and did not communicate throughout the one hour period. This was to assess inter-rater agreement. This was approximately 12% of observation time for each phase. Cohens Kappa was calculated for each code (Kazdin, 1982).

## RESULTS

*Percentage of time client received staff contact and nature of contact for the three phases.*

**Figure 1.** Summary of client contact over the three phases



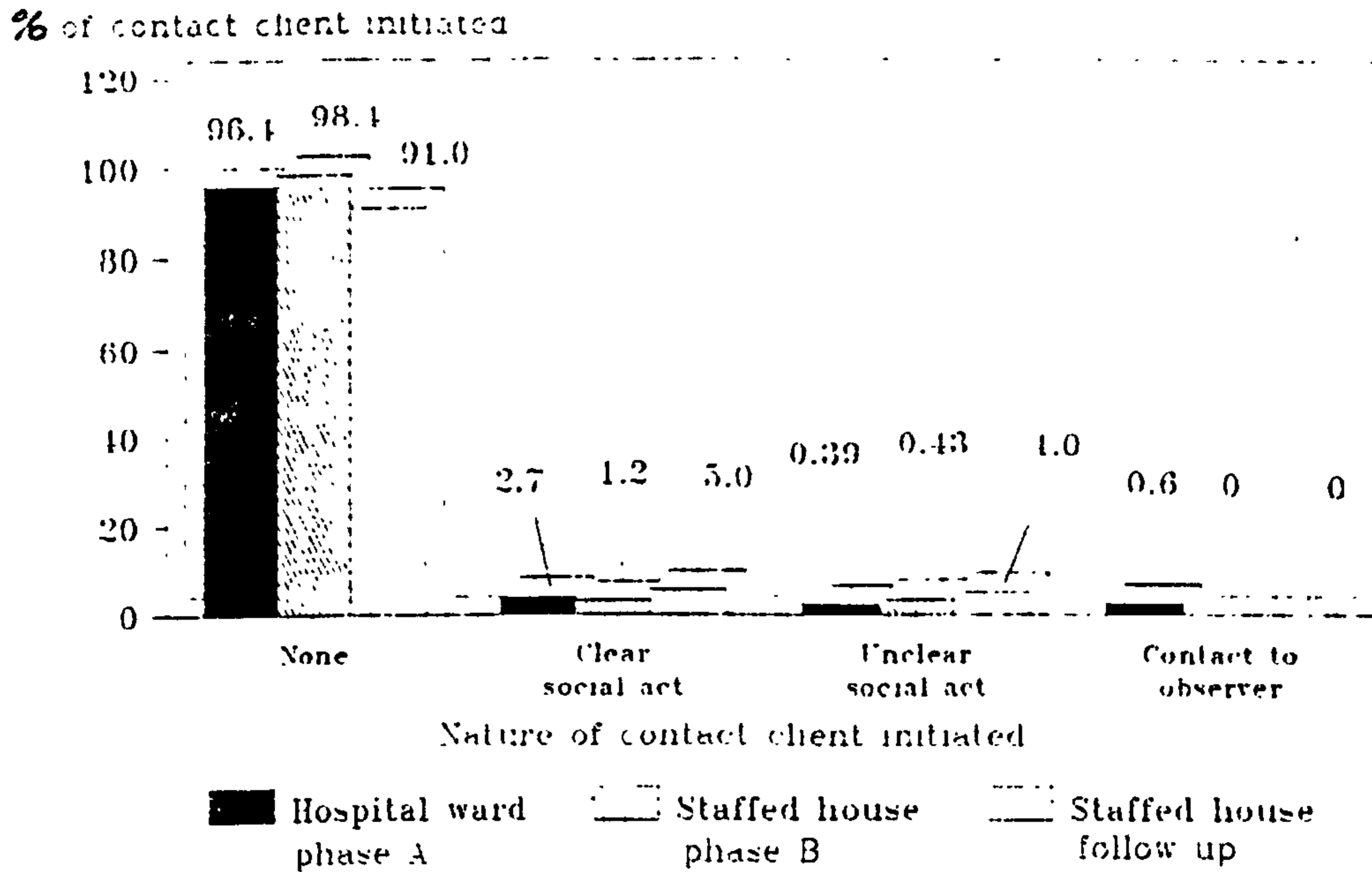
Data shows that over the eight hour period of observations in the institutional setting, PH received less than five percent contact from staff. Inter-observer agreement ( R ) for this variable was 99.1 % and Kappa ( K ) was 0.884.

Following resettlement at the one week phase contact had increased to approximately 23 % and at the six week follow up to 40 % ( R = 95.7%: K = 0.79)

A breakdown of the contact that PH received demonstrated that positive, neutral, assistance and interestingly negative contact all increased following resettlement, initially at the one week phase and further at the six week follow-up.

*Percentage of time client engaged in social contact from the clients perspective.*

**Figure 2.** Summary of time client initiated contact over the three phases.



Data was collected with respect to interaction initiated by PH towards his direct carers. During the period that PH was observed at the institution/ hospital he initiated interaction less than four percent of the time. (R = 99.1%). This percentage decreased initially upon transfer to the community house to 1.6% (R = 97.46%). However observations made after six weeks in PH's new home showed an increase to nine percent of interaction time being initiated by PH himself.

## DISCUSSION

This study aimed to examine the staff-client interactions that took place within two environments, a large institution and a community home for one particular 31 year old man.

Within the institution ward, staff members interacted with PH less than five percent of the observed time. These results are consistent with other earlier findings (e.g.: Cullen et al, 1983; Reuter et al, 1980; Dailey et al, 1974).

A typical day seemed to consist of being supervised, occasional interaction during mealtimes and an opportunity to watch staff engage in their own socialization's. This is consistent with the findings of Hile & Walbran (1991). The interaction that PH did receive on the ward took the form of assistance during mealtimes and an occasional neutral comment while, for example, feeding him. Hile & Walbran (1991) found that clients with lower levels of functioning received more interactions that were of a personal care nature i.e. bodily care needs. Hile & Walbran (1991) also found that the more severely learning disabled a client was, the less socialization they received in the form of stimulating conversations.

It would appear that the levels of interaction observed between PH and ward staff were not untypical of institutions generally. One factor that may have possibly further exaggerated the lack of interaction, was the low staff morale due to the closure of the hospital in 1996. Discussions with the ward staff revealed that concern about their futures was affecting their performances at work.

The results of this study show that in terms of frequency of staff-client interaction, PH experienced more contact after transfer from the institution to the community house. Initially one week after resettlement the amount of interaction taking place increased to 23% and to a further 40% at the six week follow-up stage. These results are consistent with those of Mansell & Beasley

(1990). Neutral contact from staff showed the largest increase after the move from institution to community house. This involved staff chatting to PH.

At the six week follow-up, positive contact in the form of hugs, praise etc. increased to five percent of observed interaction time. One explanation for this may be that as PH settled into his new home and staff discovered his likes/dislikes they were able to provide increased opportunity to engage in activities that PH enjoyed. This is supported in part by the increased contact to staff initiated by PH himself as observed at the six week follow-up.

Despite the increased frequency of interactions taking place in the community house, the results of the study show that at the six week follow-up phase, PH still received no contact from staff for 60% of observed time. These results are consistent with the findings of Mansell & Beasley (1990). Mansell & Beasley (1990) state that just changing an individual's physical environment by the transfer from an institution to a staffed house does not ensure a greater involvement in activities. While the homes may provide a greater opportunity for constructive activity, these are often not taken up. Engagement in constructive activity with PH by staff may have increased opportunity for further interactions to take place. However a major difficulty faced by the staff working in the house was low staffing levels and therefore limited resources. Staff morale decreased quite rapidly due to factors such as these, and seemingly contact with PH also reduced.

The results of this study supported the suggested hypothesis that frequency of contact increases following resettlement and also that the nature of the contact would be more positive, assistance types of contact. However, the results also demonstrated an increase in negative staff-client contact in the period PH and his carer were observed. Possible explanations for this increase may be that transfer to a smaller environment may increase problem behavior and therefore more engagement in negative contact. Also the fact that there were less people in a much smaller environment meant that problem behaviors were less likely to

go unnoticed. The negative contact observed towards PH consisted of verbal reprimands when he engaged in behavior such as grabbing drinks and food from other people's plates during mealtimes. Also, it may be possible that as frequency of interactions increase, it would be inevitable that not all contact would be of a positive or helpful nature.

With regard to the generality of results from single case research. Kazdin (1982) states that no evidence exists to suggest that findings from single case research are any less generalizable than findings from research using larger participant groups. Kazdin does, however, point out that it is difficult to evaluate between treatments and subject characteristics.

The findings of this study are consistent with general findings from other studies, however caution should perhaps be exercised as staff and clients are all individuals who have different qualities, needs and opportunities which, in turn, may affect levels of interaction between staff and clients.

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Small Scale Research Project from Elderly Placement

On an Acute Psycho-geriatric Assessment Ward Without Psychological  
Input. Are Risk Factors Pertinent To Depression Being Identified?

Word Count, 2,200 (excluding references)

2,519 (including references)

## ABSTRACT

Participants were staff and clients on an acute psychogeriatric assessment ward. Currently the ward does not receive any psychological input. The aim of the study was to assess whether assessments made by the core disciplines, covering the care of depressed clients on the ward, identified certain psychosocial risk factors pertinent to depression.

Five clients diagnosed as depressed on the ward, and the core professionals involved in their care (two Psycho geriatricians, two Occupational Therapists and the Primary Nurses) were interviewed. Using a checklist of ten psychosocial risk factors that would be part of a typical psychological assessment; clients were asked whether each factor had been present, or not in the last twelve months. Each professional was asked whether they thought each factor had been present or not, in the last twelve months of the clients lives, as far as they knew.

Data was collected concerning how assessments are usually made by each discipline. An examination of the results showed that generally risk factors were identified, and more importantly, clients and professionals were in agreement as to the presence or absence of each risk factor. There were however some discrepancies and these are discussed.

## INTRODUCTION

Depression is the most common psychiatric disorder in the elderly (Gurland, Copeland, Kuriansky, Kelleher, Sharpe & Dean, 1983) and up to two thirds of admissions to acute psychiatric units for the elderly have a primary diagnosis of depression (Church, 1983).

Psychosocial factors involved in the aetiology of depression of the elderly have been identified in a number of studies. These are poor physical health, financial difficulties, enforced environmental change, bereavement, lack of a confiding relationship (Murphy, 1982), loneliness (Hale, 1982), feelings of helplessness, a decreased capacity to care for oneself, a decreased sense of lifelong achievements and a history of depressive feelings (Weiss, Nagel & Aronson, 1986). Some forms of depression do not result from psychosocial factors. About fifteen percent of depressive episodes may be the result of biological and cerebral organic factors (Murphy, 1982).

There has been much debate surrounding the comparative effectiveness of treatments for depression in all populations. Those that have examined older adults include Scogin, Jamison & Gochneaur, (1989), Karasu, (1990) and, Thompson, Gallagher & Breckenridge, (1987). Though evidence suggests that a variety of therapies are effective, including a combination of pharmacological and psychological components, the elderly are still typically treated with antidepressants or ECT alone.

Depressive illness in old age is often characterized by frequent and prolonged relapses. Murphy (1983) argues that this must in part reflect the degree of effectiveness of traditional treatments such as medication. Treatments should be based on formulations derived from complete, thorough assessment (Brown and Harris, 1978). Poor assessment is more likely to lead to ineffective treatment (Beirne, 1991).

By the time a person is admitted to hospital they have usually reached a crisis point. The ward examined in this study is an acute psychogeriatric unit where emergency admissions take place. Up to 50% of its patients at any one

period have a psychiatric diagnosis of depression. It operates on a multi-disciplinary basis with Psychogeriatricians, Nurses and Occupational Therapists forming its core team. Currently there is no psychological input on the ward. The district has two Clinical Psychologists and three Assistant Psychologists in the elderly speciality. The demands on service provision far exceed the supply potential. Particular unmet demands include ward based work (Tatham, 1993).

A typical assessment from a clinical psychologist carried out with a depressed client would include information from the person, family or carers and previous medical or psychological records. Life events, social supports and perceptions\ attributions form a large part of the assessment (Woods & Britton, 1985).

Clinical psychologists rate assessment as a core skill (Beirne, 1991). A broad range of measures developed from a multi theoretical base are employed with competence and flexibility (MAS 1989). However, Pilgrim (1990) argued that 'a major abandonment of assessment as an area of activity' has occurred.

The aim of this study was to identify whether on an acute psychogeriatric assessment ward without psychological input, psychosocial 'risk factors' pertinent to depression are identified.

An overview of the assessment procedures used by Psychogeriatricians, Nurses and Occupational Therapists was collected. A checklist of ten psychosocial factors eg: loneliness, bereavement, physical health problems was used to identify whether these factors had been picked up during their assessment process.

## METHOD.

### *Participants*

Five female clients aged 66-83 years on an acute psychogeriatric assessment ward were interviewed. These were the only five females on the ward at the time of the research. Criteria for inclusion was; a psychiatric diagnosis of depression, no organic impairment, no psychotic symptoms and an orientation score of eight or above on the Clifton Assessment Procedures For The Elderly (Pattie & Gilleard, 1985). This indicated mild or nil impairment of orientation at the time of assessment. Staff interviewed were two Psychogeriatricians, two Occupational Therapists and the Primary Nurse for each client. Both staff and clients had the nature of the research and their would be role explained to them. They were then given the option as to whether they participated or not.

### *Materials.*

The following measures were used;

The information/ orientation questionnaire of the CAPE consists of two independent measures which can either be used together to give an overall assessment of cognitive and behavioral ability, or can be used separately depending on the situation and types of information required. In this instance the section used was to check that each client was orientated in time and place.

2. A risk factor checklist of ten psychosocial factors (appendix one) that have been demonstrated as being pertinent to depression in the elderly (Hale, 1982, Murphy, 1982, Weiss, Nagel & Aronson, 1986 ). The development of the checklist is described in procedure Stage one below.

3. Standardized structured interview format guidelines were followed when asking staff and clients about each item on the checklist. (appendix two).

### *Procedure*

Stage one: A checklist consisting of ten psychosocial factors pertinent to depression, drawn from the research of Murphy (1982), Hale (1982) and Weiss et al. (1986) was compiled. These ten factors would be incorporated into the cognitive-behavioral assessment of a Clinical Psychologist. For each factor a

standard question was asked concerning its presence or absence in the last twelve months. In order to check that the questionnaire was understandable, it was piloted on a similar ward with Nursing staff and clients. Factor ten, 'decreased sense of lifelong accomplishments' was regarded as confusing and difficult to answer. Therefore it was eliminated from the main study.

Stage two: Each client was briefly interviewed. Firstly the information\ orientation section of the CAPE was administered. If a score of eight or above was attained then participants were asked whether each factor on the checklist had been present or absent in the previous twelve months.

Stage three: Each staff member was asked three questions regarding the nature of the assessments they would carry out with a person admitted to the ward with depression. These were:-

- i. Do you use standardized questionnaires?
- ii. Do you interview the client?
- iii. Is there anything else involved in the assessment ?

This was carried out prior to using the checklist with staff to prevent bias of responses, possibly by suggestion of risk factors

Stage four: staff subjects were asked if they were aware of the presence or absence of each factor on the checklist for clients under their care. Staff used records if they needed to. Each discipline was interviewed as close together as possible in order to save time, and prevent response bias from them possibly discussing the nature of the research and questions asked.

The results consisted of graph data and descriptive analysis.

## RESULTS.

The results were divided into two sections; firstly a description of the type of assessments carried out by other disciplines and secondly, graphical representation of the data collected.

### *Assessment procedures*

With respect to assessment procedures carried out by each discipline the following data was collected: Psychogeriatrician assessment involved a physical examination, gathering information from the client if possible from an informant, and the collection of a past history. The two Psychogeriatricians in the study saw standardized questionnaires as having little to add to an assessment.

Nursing assessment concentrated on measurable behaviors. Sleep, food/fluid intake and mood are assessed. A standard checklist that looks at the above plus social skills, sexuality and attitudes to dying, is used with any new client admitted to the ward. Information is gathered from the client if possible. Approximately 30 minutes is spent with each client.

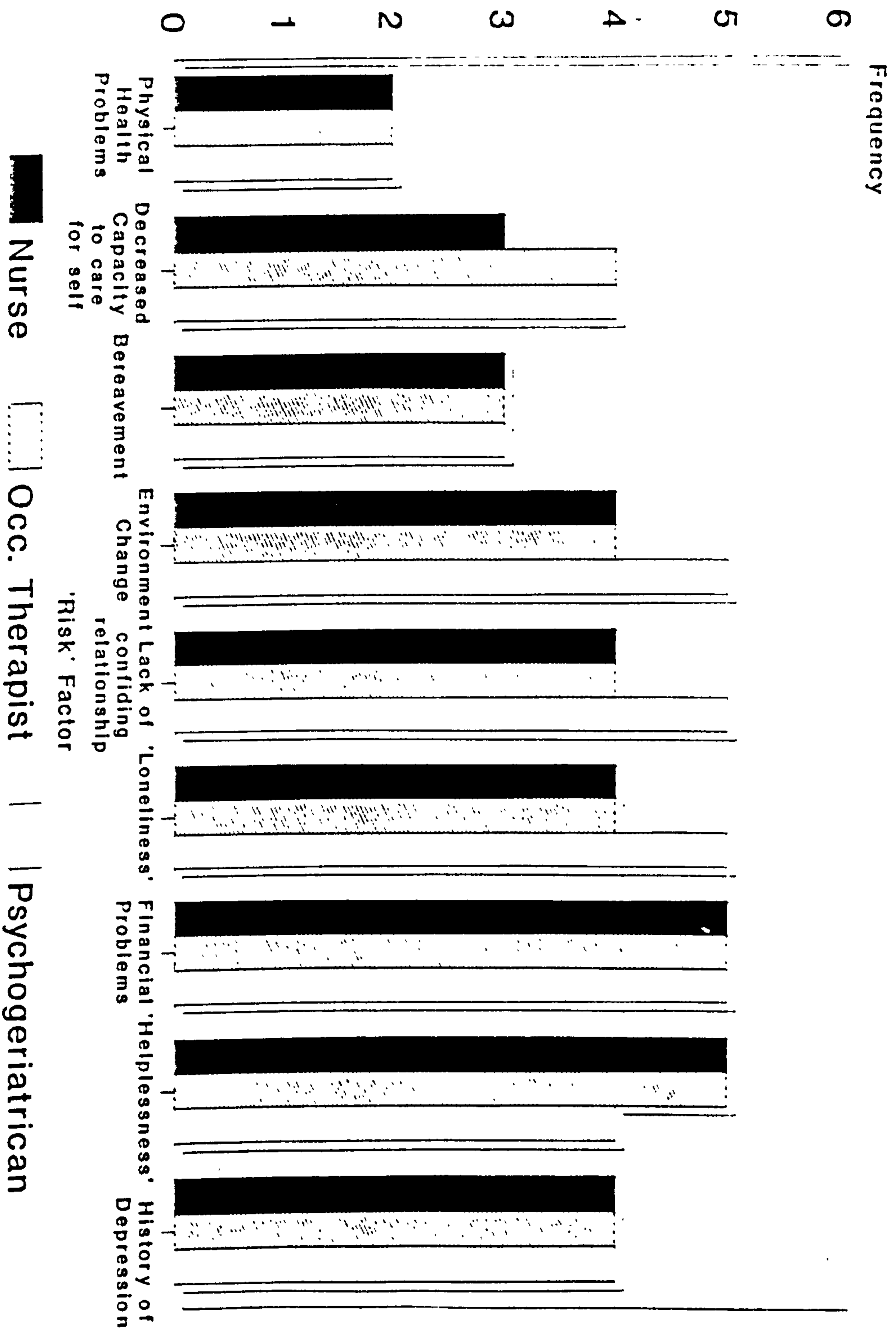
Occupational therapists assessment takes place either on the ward, at a clients home or both. Assessment of sensory and physical needs, skills assessments and specific questionnaires such as the Beck Depression Inventory are used. The needs of the family and/or carers are also assessed. The client is interviewed as well as being observed.

### *Data represented in figures one, two and three.*

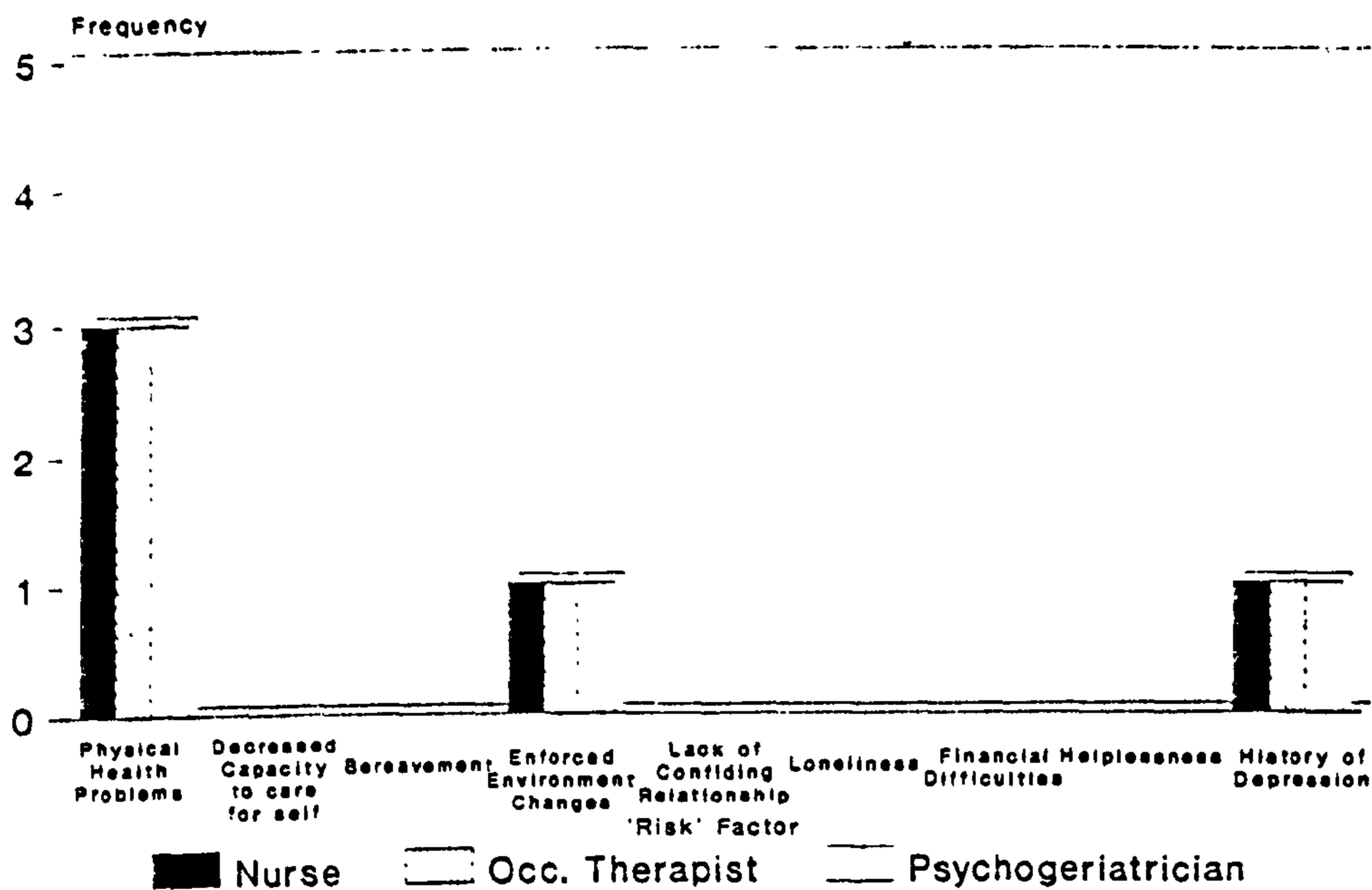
The three graphs represent firstly, the number of times the client and professional agreed on the presence or absence of each risk factor; secondly, the number of times a professional said a risk factor was present but a client did not (false positive); and lastly, the number of times that a client said a risk factor was present but the professional said not (false negative).



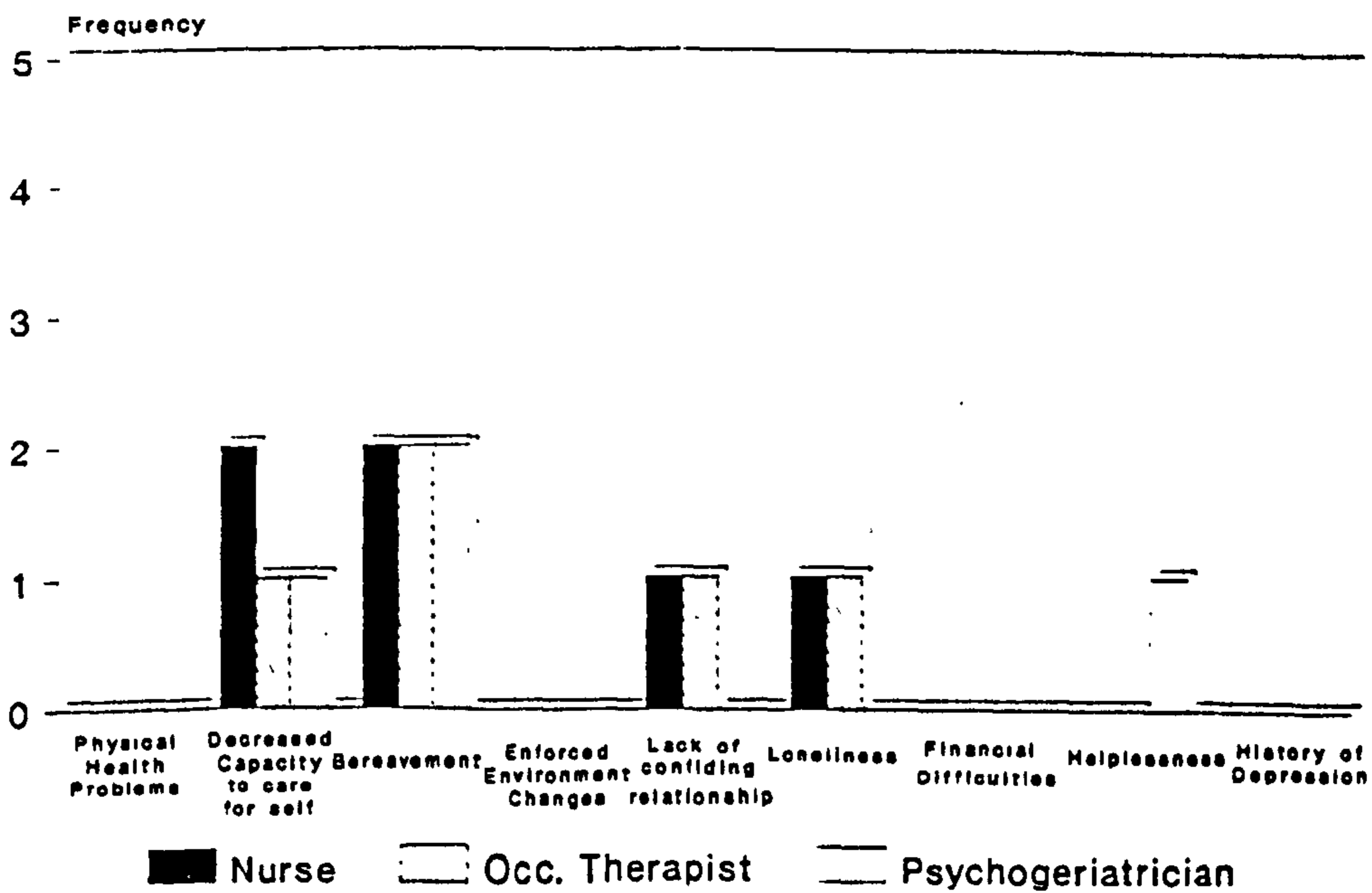
Graph One: Number of times client and professional agree on presence or absence of each risk factor.



Graph Two: Number of time a professional said a risk factor was present but the client said not (False Positive)



Graph Three: Number of times client said that a risk factor was present but professional said not (False Negative)



## DISCUSSION

Overall the results of this study show there was a general consensus of opinion between clients and professionals on this ward, as to the presence or absence of psychosocial risk factors pertinent to depression in the elderly. The Psychogeriatrician was most frequently in agreement with the client, followed by the occupational therapist, followed by the primary nurse. However some interesting points arose and need discussion.

In terms of the false negatives that is when the client said a risk factor was present but the professional did not, bereavement was missed by all staff with two out of five clients, and a decreased capacity to care for oneself by all professionals with one client and by the primary nurse of two clients. Though these figures may appear small perhaps in light of such a small sample size they warrant some comment. Interestingly, the professional interviewed often said that the client may for example perceive a decreased capacity to care for themselves but they disagreed. It was from their professional standpoint that formulations were made rather than from the clients perception. Clinical Psychologists view the subjective meaning of a presenting problem to the individual, as a central point, which would appear to differ from these disciplines (Woods and Britton, 1985). An alternative methodology could have been to ask each professional what they thought the client would say about each risk factor.

Interestingly, three out of five clients did not feel that physical health problems were important whereas professionals interviewed did. Murphy (1982) reported that physical illness acts largely through its meaning for the individual rather than through a direct organic effect via biological mechanisms. In her study Murphy (1982) found that some chronic conditions such as deafness, poor eyesight and aches and pains were so common that people rarely commented on them without prompting.

Another possible methodological problem is that the study relied on the good memory of the client, and it might be asked whether the elderly can recall events sufficiently well to ensure the method is valid (Bromley, 1990). Perhaps

a reliability study using a next of kin as an independent witness, would have ensured a greater degree of accuracy concerning some risk factors (Murphy, 1982). However again the importance of the clients subjective experience perhaps needs to be stressed.

Conclusions drawn can only generalize to this ward environment and assessments used on this ward. A comparison of other wards would give a broader picture regarding the nature of multi-disciplinary assessments used, and whether psychosocial factors are identified. However on this ward many factors were identified therefore, perhaps the role of the Clinical Psychologist on this ward would have its emphasis elsewhere. As a point of interest the treatment for each client was either antidepressant medication or electroconvulsive therapy. It would appear that though these risk factors were identified the subsequent formulations did not lead to psychological intervention. The Psychologists role may be to act as a cue in the ward rounds, to refer to the incorporation of psychosocial factors into formulations, and the usefulness of psychological methods and treatments.

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**APPENDICES**

**Appendix one: The risk factor checklist**

**Appendix two: Interview format guidelines.**

RISK FACTOR CHECKLIST

| RISK FACTOR                                     | PRESENT | ABSENT | OTHER DETAIL |
|---|---------|--------|--------------|
| PHYSICAL HEALTH PROBLEMS                        |         |        |              |
| DECREASED CAPACITY TO CARE FOR SELF             |         |        |              |
| BEREAVEMENT                                     |         |        |              |
| ENFORCED ENVIRONMENTAL CHANGES                  |         |        |              |
| LACK OF A CONFIDING RELATIONSHIP                |         |        |              |
| LONELINESS                                      |         |        |              |
| FINANCIAL DIFFICULTIES                          |         |        |              |
| FEELINGS OF HELPLESSNESS.<br>(LOCUS OF CONTROL) |         |        |              |
| HISTORY OF DEPRESSED EPISODES                   |         |        |              |
| DECREASED SENSE OF LIFE LONG ACCOMPLISHMENTS    |         |        |              |



1. Has this person to your knowledge had any problems with their physical health in the last 12 months?
2. Has this person to your knowledge been finding it difficult to look after themselves recently, e.g., washing, dressing, shopping, cooking?
3. To your knowledge has anyone close to them, family or friend, died in the past 12 months?
4. Has this person to your knowledge been forced to move house in the last 12 months, e.g., from their own home to a relative's home or to an EPH because they were not able to look after themselves?
5. Has this person to your knowledge got a friend or relative who they can talk to about things that worry them or personal things?
6. Has this person to your knowledge felt lonely over the past year?
7. Has this person to your knowledge ever had any problems with money over the last year? Have they found it difficult to make ends meet?
8. Has this person to your knowledge felt helpless at all? Do they feel that things are happening to them over which they have no control?
9. Has this person to your knowledge felt unhappy/depressed on any other occasions in the last 12 months?
10. To your knowledge, how satisfied are they when they look back on their life? Have they felt less satisfied in the last 12 months?

'RISK FACTOR' QUESTIONNAIRE

1. Have you had any problems with your physical health in the last 12 months?
2. Have you been finding it difficult to look after yourself recently, e.g., washing, dressing, shopping, cooking?
3. Have anyone close to you, family or friend, died in the past 12 months?
4. Have you been forced to move house in the last 12 months, e.g., from your own home to a relative homes or to an EPH because you were not able to look after yourself?
5. Have you got a friend or relative who you can talk to about things that worry you or personal things?
6. Have you felt lonely over the past year?
7. Have you ever had any problems with money over the last year? Has it been difficult to make ends meet?
8. Do you feel helpless at all? Do you feel that things are happening to you over which you have no control?
9. Have you felt unhappy/depressed on any other occasions in the last 12 months?
10. How satisfied are you when you look back on your life? Have you felt less satisfied in the last 12 months?

Small Scale Research Project From Child Placement.

Evaluation of a Support Group for Parents of Children With Diabetes

Word Count. 2,269 ( excluding references)

2, 488 (including references)

## ABSTRACT

At the request of professionals involved in a support group for parents of children with diabetes, a questionnaire was compiled to evaluate this group twelve months after its commencement. All parents of children with diabetes in the Burnley district who had attended the group, were invited to participate in the study. The questionnaire examined satisfaction with practical issues such as convenience of meeting venues and times, the structure and content of the group and finally dietetic and clinical psychology input. Results demonstrated that those who attended the group were generally happy with all areas.

## INTRODUCTION

Bell (1991) stated that consumer feedback or client satisfaction should be an important part of any examination of quality assurance. It should be viewed as a means of improving and monitoring the service a person receives (Stallard & Chadwick, 1991). There are numerous recent research papers written over the last two years that either suggest ways to evaluate a service and consumer satisfaction (e.g: Jenkins & Grey 1994, Bucknall, 1994) or report on their own consumer evaluation of a service (Squier,1994). Cape (1991) recommends the use of consumer opinion surveys or questionnaires to indicate which aspects of a service clients are happy with and which need to be re-examined with a view to possible change.

### *Diabetes: Children and parents.*

With medical advances in the last century diabetes, once a fatal illness is now a chronic disorder with much longer life expectancies for those who have it. The disease itself cannot as yet be cured, but it can be controlled reasonably effectively (Craig, 1981).

When a child is diagnosed as having diabetes the whole family is affected. A child is part of a family system, parents being the child's principle source of support (Finney & Bonner,1992). Attitudes of family members and how supportive they are, are essential to a child's well being (Shillitoe,1988).

Upon first diagnosis of the illness parents often enter into a grief like reaction. Guilt, self blame, anxiety and information overload are experienced (Shillitoe,1988). This reaction fades but it can increase as practical difficulties and complications arise. Many parents gain good control and management over their child' s diabetes but have continual worries over the future (Shillitoe,1988). An essential requisite for good coping is good communication between parents and professionals (Leventhal & Hirschman, 1982).

Group supports for people with diabetes are well documented as being

positive helping strategies ( Marrerro, Myers & Golden 1982, Warren-Boulton, Anderson, Schwartz & Drexler, 1981). Research on support groups for parents of children with diabetes are less well documented, however those that are report an increased confidence in coping of those involved (Marteau, Gillespie & Swift, 1987).

#### *Background on the group.*

There exists in Burnley a strong organisation of parents of children with diabetes. Their roles were originally prior to the group starting mainly as fund raisers. Approximately twelve months ago a number of these parents expressed a desire for a support group to be developed, to a pediatrician involved in the care of their child's diabetes. After experimentation with a number of venues the group decided on a room adjacent to a hospital ward as a suitable meeting place. The group meets once a month on a Tuesday evening. Though a Clinical Psychologist, a Dietician and a Diabetic Liaison Nurse attend the groups the approach is informal and not professional led. The group is open to any parents of children with diabetes in the Burnley district. Numbers of people who attend vary but usually between eight and twelve parents are at any one meeting.

#### *Research aims*

The aims of the evaluation were to ascertain how parents felt about the group twelve months after it commencing; whether their needs were being fulfilled and any areas of possible development.

In particular, practical issues such as venue and access to the group, structure and content of the group and opinions on professional involvement were explored.

## METHOD

### *Participants*

A possible twenty-one parents or sets of parents could have taken part in the evaluation. Not all of these attended the group regularly. All were parents of children of varying age with diabetes from the Burnley district. A total of ten families returned the questionnaires. Not all participants entered their sex or age of dependent with diabetes, though it appears that the majority of the parents were female. Only one father completed the questionnaire.

### *Measure.*

Evaluation was carried out using a questionnaire developed from a meeting between the Clinical Psychologist, Trainee Clinical Psychologist and Diabetic Liaison Nurse (appendix one). The questionnaire consisted of three parts. Part one looked at practical issues such as the timing, the venue and the frequency of meetings. Part two consisted of questions regarding content and structure of the group for example, in what way did parents find the group useful. Part three briefly evaluated the dietetic and clinical psychology input to the group. All questions were created by the professionals involved in the group and were seen as important areas to consider in the evaluation.

The Diabetic Liaison Nurses were not included in part three's staff input evaluation as they are seen regularly outside the group by parents and children. In order to retain anonymity and encourage free expression of answers participants were not required to give their names. Though the questionnaire was slanted in design towards those who attend the group regularly it was hoped that those who did not would also offer opinions.

### *Procedure*

The names and addresses of all parents of children with diabetes who had attended the group on at least one occasion, were obtained from the pediatrician primarily responsible for the child's medical care. The questionnaires were sent by post with an accompanying letter (appendix two) to twenty-one households. A further letter was sent one month later as a reminder for people who had not returned the questionnaire (appendix three).

## RESULTS

A total of ten questionnaires were returned. Though a reminder letter was sent out this did not result in further questionnaires being returned. Not all questions were completed by all of the respondents. Those that had completed the sections on respondent's age and sex, and age of dependent with diabetes were few. Participants had attended the group on between one and all of the dates in the last twelve months. Respondents it appears were mostly female and only one male seems to have taken part.

### *Part one: Practical issues*

Table 1 Percent responses for part one questions

| QUESTIONS               | %YES | %NO |
|-------------------------|------|-----|
| Convenient meeting time | 100% | 0%  |
| Frequency of meetings   | 100% | 0%  |
| Ability to attend       | 90%  | 10% |
| Convenience of venue    | 100% | 0%  |

Elaboration on the above answers yielded information that one person had difficulties with child care arrangements and was not able to attend as frequently as she or he would have liked. A suggestion that hospital might not be an appropriate meeting place for some individuals was made. However this person did not report it to be a problem for them, and nor did any other group member who completed the questionnaires.



*Part two: Group content and structure.*

The following reasons were given as to why people attended the group:

1. For personal support.
2. To pass on advice and help others.
3. To learn more about diabetes and its associated difficulties.

With regards to what participants were expecting to gain from the group prior to their first attendance, a number of reasons were identified:

1. To talk and listen to other parents.
2. To share concerns and feelings.
3. To learn from others experiences.
- 4 To have access to advice from professionals and have questions answered.
5. To offer support to others.

All participants reported that they found the group very useful, in particular being able to identify and share problems, and know that they are not alone. With respect to any improvements that participants would have liked to see in the group, the majority of individuals did not suggest anything. However, one person suggested looking at attracting more parents to the group and possible ways that this might be achieved. Discussion in small groups rather than staying as one large group for the duration of the meeting was also suggested. Finally in this area two people suggested that for some meetings there might be an agenda, with particular discussion topics to be arranged prior to the meeting. Presentations by for example the Clinical Psychologist were suggested.

*Part three: Staff input. Clinical Psychology and Dietetics.*

In response to the question of whether it was helpful to have access to the Clinical Psychologist all respondents agreed that it was. However apparently not everyone used the facility.

With respect to why participants might seek the skills of the Clinical Psychologists, the following reasons were given:

1. Putting concerns into perspective
2. Advice on how to deal with difficulties that might arise with for example compliance in management.

Two participants pointed out that the availability of a Clinical Psychologist was a relatively recent and much needed development. They also pointed out that, had this facility been available when their children had been first diagnosed it would have possibly helped overcome some of their original fears. Qualities such as caring and understanding were attributed to the Psychologist involved.

All participants found access to the Dietician helpful. The reasons stated were:

1. Up to date advice on new products.
2. Advice on varying foodstuffs given to their child.
3. Help in 'convincing' their children to eat healthy foods.

With respect to any suggested improvements in the area of staff input eight people either did not suggest anything or stated that they did not see any need for change. Two individuals reported that they would like to have staff presentations on topics associated with diabetes. In particular areas such as psychological difficulties in the management of diabetes and how to avoid them were suggested. Input on an individual or group level from the Clinical Psychologist, at occasional intervals with children was also put forward by one person.

## DISCUSSION

The general consensus of opinion was that those that attended the support group for parents of children with diabetes were satisfied with it in its current form. The group was regarded as a valuable source of support and advice for those that attend.

The results of the study are to be presented to those attending the group at the next Tuesday evening meeting. The results are also to be fed back to the wider group of parents and professionals in the newsletter that is distributed to all parent groups in the Burnley, Pendle and Rossendale areas.

The professionals involved found the exercise to be a useful one and are currently considering for example, the use of presentations at some meetings to give information and promote discussions. However there needs to be an awareness that not all changes generated by such a study will apply to all participants in the group hence the need to feedback and discuss with the whole group any suggested changes (Shillitoe, 1994).

With respect to any methodological difficulties encountered, unfortunately questionnaires are limited by the questions that they ask and as Shillitoe (1994) pointed out, they do not always assess individual persons needs in an area such as diabetes. Provision was made for expansion of answers, however it is possible that even this section was limited by the nature of the previous questions.

Replacement of the postal questionnaires by structured or semi-structured interviews may have been possible. However to have used interviews would have proved allot more time consuming, and some parents may have found this method a little too intrusive, particularly those who do not attend the group.

The return rate for the study was at fifty percent about average when using postal questionnaires. Squier (1994) reported that in his consumer satisfaction study participants were generally happier to complete questionnaires when they were anonymous. Though interviews may have

yielded more information and possibly a greater number of participants, for the aforesaid reasons the method chosen was that of the postal questionnaires.

Regarding the process of evaluating client satisfaction with the group, the research demonstrated that with relatively little effort and resource implications it is possible to generate valuable information for the use of professionals and clients alike.

Shillitoe (1994) stated that seeking the views of the client with diabetes or those in the immediate family are particularly important. Professional and client views may differ immensely. He also pointed out that people's views and priorities are not static. They are related to their developing experiences as they come to terms and live with a disease. Shillitoe (1994) suggested that seeking comments and feedback should be a regular feature of any service in the area of diabetes.

It can be assumed that the results of this study are representative of those attending the group, however it did not encompass the views and opinions of those parents who do not use this support.

Further research with respect to the group could involve exploration as to why some parents chose not to attend and why it appears that the facility is mostly taken up by mothers as opposed to fathers. This was outside the remit of this study but the questionnaire could possibly be expanded to encompass these and other identified important areas.

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**APPENDICES.**

Appendix 1. The questionnaire.

Appendix 2. The accompanying letter sent with the questionnaire.

Appendix 3. The reminder letter sent one month after the questionnaire and original letter.

# QUESTIONNAIRE

APPENDIX 1

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This questionnaire has been developed in order to ask people who use the Diabetic Support Group for parents of children with diabetes whether it is meeting their needs. Your answers will remain confidential. Please do not put your name on the questionnaire in order to retain your anonymity. Please complete the questionnaire as fully as possible. Thank you for your co-operation.

AGE:-

SEX:-

AGE OF DEPENDANT WITH DIABETES:-

No OF TIMES ATTENDED THE GROUP:-

## PRACTICAL ISSUES

( Please circle yes or no to indicate your opinion)

1. Does the group meet at a convenient time for you ? YES / NO.
2. Does the group meet often enough to be of help to you ? YES/NO.
3. Are you able to get to the meetings without difficulty? YES/ NO.
4. Is the teaching room a convenient/ appropriate place to meet? YES/  
NO.
5. Would you like to elaborate on any of the above answers?







*Direct Dial: 79*

*Our Ref. . . .*

*3rd August 1994*

*Dear*

*The Department of Clinical Psychology are currently evaluating the Support Group for Parents of Children with Diabetes. Enclosed is a questionnaire for this purpose. I would be extremely grateful if you would complete the questionnaire and return it in the provided envelope. I will be presenting the results of my research to the group on a Tuesday evening as soon as it is completed.*

*Many thanks for your co-operation.*

*Yours faithfully*

**TRAINEE CLINICAL PSYCHOLOGIST**

— —  
— —

*Direct Dial:*

*Our Ref:*

*28th September 1994*

*Dear Parent*

*At the beginning of August you were sent a questionnaire regarding the Parent Support Group for Children with Diabetes. As it is anonymous I do not know who has returned them completed and who has not. If you have then please ignore this letter and many thanks! If you have not managed to return the questionnaire, I would be very grateful if you could do so as soon as possible.*

*If you need another questionnaire please contact me on                      If it is the case that you have not used the group then a brief note to say this would be very helpful. Many thanks.*

*Yours faithfully*

**TRAINEE CLINICAL PSYCHOLOGIST**