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EVALUATION OF THE NEW JERSEY ACCESS INITIATIVE MENTOR
PROGRAM

by
Tasha R. Binet

A Thesis

Submitted in partial fulfillment of the requirements of the
Master of Arts Degree
of
The Graduate School
at
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Approved by _____
Advisor

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ABSTRACT

Tasha R. Binet

EVALUATION OF THE NEW JERSEY ACCESS INITIATIVE MENTOR PROGRAM

2006/07

Dr. MaryLou Kerwin

Master of Arts in Mental Health Counseling and Applied Psychology

The purposes of this study were to (a) evaluate the effectiveness of the New Jersey Access Initiative Mentor Program and (b) determine if an increased number of sessions of ancillary, psychosocial services was related to improved treatment retention, periods of abstinence and decreased number of relapses with opiate-addicted participants. Correlational analyses were planned utilizing data collected and recorded in the NJAI database by program staff; however, analyses were unable to be performed due to a large amount of incomplete and missing data. For those participants with data, descriptive results are reported on alcohol and illegal substance usage in past 30 days prior to data collection, living conditions, employment status, educational level, and number of services provided. Limitations of the study design and potential implications for importance of including access to psychosocial, ancillary services in addition to addiction treatment are discussed.

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CHAPTER ONE

INTRODUCTION

Opiate addiction is a significant health problem. According to a 1997 survey conducted by the U.S. Department of Health and Human Services, approximately 2.4 million Americans have tried heroin, with a quarter of a million people admitting to using it within a month of the survey. In addition, the illicit use of opiates has been associated with increased mortality and criminal behavior. Furthermore, the intravenous self-administration of opiates has been found to be a major vector in the transmission of HIV (Downey, Helmus, & Schuster, 2000).

Because opiate addiction is such a significant health problem, much research has been done in the area of addiction treatment. Three major problems with drug abuse treatment have been addressed in the literature: retention in treatment, initiating abstinence, and maintaining abstinence. Higgins, Badger and Budney (2000) discussed how treatment retention has been demonstrated to be an important predictor of longer term outcomes. For example, being retained in outpatient treatment or long-term residential treatment for three or more months has been associated with significant improvements in follow-up outcomes. The results of their study support this, but with an important caveat. Being retained in treatment for at least 12 weeks was associated with increased odds of abstinence during follow-up when participants also achieved a sustained period of abstinence during treatment. This study indicates how retention,

initial abstinence and long-term abstinence may be related and why it is important to address all three.

Treatment Retention

Drug abuse treatment and outpatient drug-free treatment (OPDF), in particular, consistently face poor retention as a major problem. Outpatient drug-free treatment does not include medications and encompasses a wide variety of programs for patients who visit a clinic at regular intervals. Most of the programs involve individual or group counseling. Katz et al. (2004) report that one half or more of patients who enter OPDF terminate treatment within 90 days. Simpson et al. (1997) reported that longer client participation in treatment is related to more favorable post-treatment outcomes, contending that at least three months of treatment are recommended to achieve “clinical benefits,” and that this period extends up to a year for a person in an outpatient methadone program. Furthermore, Simpson et al. reported that OPDF programs recommend 6 months or more of treatment, but the median length of stay was only 3 months. Simpson et al. suggest that there are several factors that may account for poor treatment retention, including having a dysfunctional and hard to treat problems within the clientele or having deficiencies in the quality or quantity of services being provided. OPDF with intensive counseling regimens (three or more sessions per week) may also be susceptible to dropout due to client’s perceived restriction on time due to treatment versus other more lenient treatments.

One possible technique that can be used to address poor retention in treatment is role induction. Role induction (RI) techniques, which seek to increase client engagement

by clarifying client role and by addressing misperceptions about treatment, have been shown to improve retention and compliance with treatment (Katz et al., 2004). An RI session of 30-45 minutes with the counselor, with whom the client would continue in treatment, was found to facilitate client engagement, as measured by percentage of clients returning for a second session, and program retention through the first three months of treatment (Katz et al., 2004).

On the contrary, Katz, Chutuape, Jones, and Stitzer (2002) found that a voucher incentive program did not improve retention or drug abstinence when implemented with a group of recently detoxified heroin addicts required to abstain from both opiates and cocaine to earn monetary vouchers during outpatient treatment. Mean retention in treatment was 37 days with only about 15% of clients remaining abstinent for 4 weeks or longer. Katz et al. suggested that voucher programs may be more useful for preventing relapse than for motivating initial abstinence.

To sum up, despite research that supports the important relationship between treatment retention and abstinence from substance abuse, there is little consensus about which techniques and programs best facilitate and encourage treatment retention. Because of this lack of consensus, substance abuse treatment continues to be plagued by poor retention rates, and ultimately, poor outcomes.

Initiating Abstinence in Drug Treatment

Drug abuse is often described as a chronic relapsing disorder because patterns of excessive drug use often recur following periods of abstinence (McLellan, Lewis, O'Brien, & Kleber, 2000). In terms of opiate addiction, 15 years of abstinence may not

necessarily mark the end of one's addiction. According to Silverman et al. (2002), more than half of the patients in drug abuse treatment have received at least one prior drug treatment, with many patients having had multiple prior treatments. Additionally, between 40% and 60% of patients who received treatment relapsed to drug use within a year.

One intervention approach that has been demonstrated to address treatment retention, initiating and maintaining abstinence is contingency management. Contingency management is a versatile and effective tool for treatment of substance dependence and has drawn significant attention in the research and treatment communities over the past several years (Schroeder, Gupman, Epstein, Umbricht & Preston, 2003). Contingency management interventions have proven moderately successful in initiating abstinence. Contingency management interventions are based on a position that drug use is a form of operant behavior (Roll, Chudzynski & Richardson, 2005). If this is true, the propensity to use drugs should be influenced by the environment in which drug use generally occurs. To be more specific, the availability of alternative non-drug reinforcers should decrease drug use if they are available in sufficient magnitude and according to a schedule that is incompatible with drug use.

Maintaining Abstinence in Drug Treatment

Several studies have demonstrated that contingency management interventions are efficacious in reducing drug use in opiate-addicted patients. Petry and Martin (2002) evaluated the efficacy of contingency management in reducing concurrent cocaine and opiate use among methadone patients. Forty-two patients were randomly assigned to 12

weeks of standard treatment or standard treatment plus contingency management. When a contingency management patient submitted a urine sample negative for cocaine and opiates, they received an opportunity to draw a prize from a bowl, ranging in size from \$1 to \$100 in value. Their results suggest that a prize reinforcement system is efficacious in reducing drug use in cocaine-abusing methadone patients. Furthermore, the effects persist, at least temporarily, after discontinuing the reinforcement.

Petry, Alessi, Marx, Austin, and Tardif (2005) compared the efficacy of voucher and prize contingency management procedures in illicit drug users receiving treatment at community settings. Their expectations were that both contingency management procedures (vouchers and prize bowl) would increase retention in treatment and increase duration of abstinence. In voucher contingency management, the reinforcer for a negative urine sample is a voucher that is exchangeable for retail goods and services. The prize bowl contingency management procedure provides the chance to win prizes rather than vouchers as the reinforcers (Petry, Martin, Cooney, & Kranzler, 2000; Petry & Martin, 2002). The prize bowl contingency management procedure provides patients with the opportunity to draw a slip of paper from a bowl. Each slip is associated with a chance of winning a prize ranging in value from \$1 to \$100.

Results from this study indicated that both contingency management procedures, voucher and prize, increased retention and duration of period of abstinence relative to standard treatment. The results also suggest that both contingency management procedures are equally efficacious. These results lead the authors to contend that

contingency management may be an effective addition to standard treatment in terms of increasing retention and duration of periods of abstinence.

Importance of Psychosocial Activities

Despite demonstrating the efficacy of contingency management as a tool for behavioral change in substance abuse patients, community based treatment providers have not embraced these procedures citing cost as the main reason (Amass, Bickel, Crean, Higgins, & Badger, 1996). Roll et al. (2005) suggest that a way to reduce cost would be to use “naturalistic sources of reinforcement” that are available in the treatment environment and easily accessible. The authors note several activities that patients report as reinforcers, including ceremonies recognizing a patient’s success, certificates for attendance and assistance in finding employment. Of particular interest are the items that patient’s identified as “more punishing.” In general, items that related to loss of services at the clinic were identified as “more punishing.” This finding suggests that services that address psychosocial needs such as child care, educational services, financial services, medical care, and assistance in finding housing are valued by patients receiving drug abuse treatment. Additionally, provision of these ancillary services may be of use in retaining patients in treatment.

Laudet, Magura, Vogel and Knight (2004) expand on the importance of psychosocial issues and drug abuse treatment. The authors assert that psychosocial networks, expectancies of drug effects, boredom, dysphoria, unemployment, and poverty “are critically important in the presentation, development and course of substance abuse and in the process of helping people attain sobriety, stable abstinence and recovery” (p.

366). Several implications are important to note. First, encouraging contact with recovering peers is suggested. As such individuals can function as role models, providing inspiration for recovery and sharing coping strategies that have proven effective. Second, substance users who recover cite psychosocial factors such as hope, new beliefs, new relationships, and new activities as key to their recovery. Furthermore, psychosocial factors, both in treatment and outside of treatment, are critical to the recovery process. People who recover from substance abuse develop a satisfying life that includes regular, meaningful activities such as jobs and hobbies, meaningful relationships with others, and a safe living environment. Finally, effective substance abuse interventions endorse a long-term perspective and involve psychosocial processes that build on pathways to recovery, including a combination of substance abuse counseling, social network interventions, and comprehensive attention to other needs, such as employment, housing, or physical health (Laudet et al., 2004).

McLellan et al. (1999) conducted a study in which clinical case managers (CCMs) were integrated into standard, outpatient, addiction treatment programs to address the demonstrated need for medical, employment, housing, and other social services among patients. CCMs addressed these needs through pre-contracting to a battery of “core support services” such as parenting classes, employment referral, recreation classes and nutrition programs offered by community agencies (p. 92). In McLellan et al.’s design, the CCM was part of a team that worked with the counselor. In these teams the counselor was responsible for providing group and individual therapy focused on the drug abuse problems and the CCM was responsible for evaluating the additional health, social and

environmental problems of the patient and linking the patient with community resources outside the program. Results were obtained in two waves. When the first wave of patients who had been assigned to the CCMs was compared with those patients from the same program who had not been assigned a CCM, there were very few significant differences in the total amount of sessions attended or social services received. Furthermore, analysis of improvement and post treatment outcomes also failed to show statistically or clinically significant group differences on most of the outcome measures. On the contrary, CCM patients in Wave 2 received significantly more alcohol, medical, employment, family, and legal services than those non-CCM patients. Further, the CCM patients showed 20-40% better post-treatment outcomes in the alcohol, drug, medical, psychiatric, employment and legal areas.

McLellan et al. (1999) concluded that the CCM was an important and effective adjunct to standard addiction treatment. Those addicted patients who were assigned to a CCM, received more appropriate services, showed more improvements, and had better post-treatment outcomes than similar patients treated in the same program, who were not assigned to a CCM. The authors believed that there are three major reasons why clinical case management was effective in their study versus previous studies which have obtained mixed results. First, case management was designed to provide access to targeted ancillary, supplemental social services, not additional drug and alcohol counseling. Second, the CCMs received extensive training and continuous supervision for 2-years. In addition, the CCM and the counselors were encouraged to act as part of a team with the counselor focusing on the drug and alcohol use of the patient and the CCM

acting to assist this effort with the opportunity the access social services that would support the addiction recovery process. Finally, the services to be accessed by the CCMs were made available through pre-contracting with local agencies.

New Jersey Access Initiative

A recent program that has tried to apply this model on a statewide level is New Jersey Access Initiative (NJAI). The NJAI is a treatment program designed to enhance traditional addictions treatment and facilitate the transition from treatment to long-term recovery for those New Jersey residents addicted to opiates receiving drug free outpatient treatment (Division of Addiction Services, 2006). NJAI provides funding for assessment, detoxification (if necessary), and a Recovery Mentor (RM). All services through the NJAI are provided through an electronic voucher system in which the voucher is exchanged for services. Vouchers are provided to every client enrolled in NJAI, can only be used to obtain treatment services through a provider in the NJAI network and have no monetary value. Additionally, use of the term voucher varies from its meaning in contingency management interventions. Vouchers for drug treatment have considerable face validity but limited empirical investigation according to Sorensen et al. (2005). Results obtained by Sorensen et al. suggest that participants who obtained a voucher to enter methadone maintenance treatment (MMT) were more likely to be enrolled in MMT at the 3- and 6-month assessments than those not receiving a voucher.

The purpose of a Recovery Mentor (RM) is to “assist in brokering necessary services, provide support and remove barriers to recovery” (Division of Addiction Services, 2006). RMs will complement traditional drug treatment by providing support,

information, companionship and general assistance to clients enrolled in the NJAI. A voucher for a RM is good for a 6-month period, which includes a total of 50 contact hours, with a possible additional eight hours. This translates into an average of 2 hours per week. A voucher for a RM is issued immediately after contacting the NJAI and is available for the client to use immediately after assessment with the following conditions. If a client goes into residential treatment or a halfway house, the RM is available for 2 hours per month. Three weeks prior to discharge, the RM can increase hours to 2 hours per week. If the client goes into outpatient, intensive outpatient, or partial care, there is no reduction in hours and no lapse in service.

The RM encompasses features of the three categories recommended for an effective mentoring relationship by Allen, Eby, and Lentz (2006). The first category is participant-perceived input into the mentoring process in which the participant should feel that participation is voluntary and that they have input in the matching process. Participation in the NJAI is voluntary, as well as involvement with a mentor. Additionally, the client is provided with at least three RM providers from whom they can select to receive services. The second category is dyadic structure of the relationship which involves physical proximity of mentor and client as well as differences in “rank” or “department” (p. 568). RMs select the geographic areas in which they prefer to work, presumably based on what areas are closest to them. In terms of differences in “rank” or “department,” all RMs are required to have at least 2 years experience with individuals in recovery or in their own recovery. The third category recommended by Allen et al. is formal program training. RMs are required to attend a Recovery Mentor Training

Institute, consisting of 48 hours of training, in order to become certified. Eighteen hours will be specific to the Recovery Mentor (ethics, boundaries, role defined, legal issues, etc.); six hours of NJSAMS training and twenty-four hours of addiction training.

The purpose of this study is to evaluate the effectiveness of supplementing outpatient drug-free treatment with a Recovery Mentor. The hypothesis is that opiate addicts receiving outpatient drug free treatment who receive increased number of sessions of ancillary, psychosocial services through a Recovery Mentor will obtain increased retention in treatment, increased duration of abstinence from opiates, and a decreased number of relapses compared to those who received less or no ancillary, psychosocial services at 1-, 3- and 6-month status interviews.

CHAPTER TWO

METHOD

Participants

Participants for this study are New Jersey residents who contact the Addictions hotline, an NJAI treatment provider or faith based organization to receive drug treatment services for opiate dependence. In order to participate in the NJAI, the client must be opiate addicted and enter into outpatient drug-free treatment. Although the program is offered statewide, the hub areas of Camden, Trenton, and Greater Newark have been selected based on need. Participation in the NJAI is voluntary and adjunctive to traditional addiction treatment.

Intervention

The NJAI is an adjunctive service that enhances traditional addiction treatment and facilitates the transition from treatment to long-term recovery. The client enters the NJAI system after completing a brief screening provided by the Addictions Hotline, a NJAI network treatment provider, or community or faith based organization. A voucher is then provided to the client for an assessment to be completed by an NJAI Network Provider. A psychiatric diagnosis (if any), level of care necessary, and psychosocial needs of the client are determined by the assessment. Level of care includes detoxification; residential treatment or a halfway house; and, outpatient, intensive

outpatient, or partial care. Immediately following the completion of the assessment, the patient receives a voucher for a Recovery Mentor.

Recovery Mentor. The purpose of the Recovery Mentor (RM) is to assist the client in accessing necessary services, provide support and remove barriers to recovery, as well as, complement traditional addictions treatment by providing information, companionship, and general assistance. The RM has five primary functions. First, the RM provides the client with mentorship, including providing companionship, support and encouragement, self help, and job training programs. Second, the RM provides information and knowledge to the client about local community services and education on the disease of addiction. The third function of the RM is working with NJAI network providers and the community to support and facilitate referrals for appropriate support services for the client. Fourth, the RM works with the client's treatment provider to support and encourage the client's treatment. The RM's final function is completion of the NJAI Status Interview Questionnaire 30 days after the client's assessment, every 60 days thereafter and at discharge. In addition to performing these functions, the RM must complete 48 hours of training, which includes 18 hours of specific RM training (role of RM, ethical and boundary issues, and accessing services for clients); 6 hours NJSAMS NJAI module (Njai Status Interview Questionnaire); and 24 hours of Addiction training (Certified Alcohol and Drug Counselor domains).

An Administrative Lead Agency (ALA) manages a 24 hour, 7 day a week hotline that screens potential clients. Screening can be done at any treatment, faith based or community provider agency. If the screening indicates that the client is eligible to

participate in the NJAI, the ALA will issue a voucher for an assessment and provide the client with at least three choices of agencies in the NJAI Provider Network that can complete the assessment. Once the assessment is completed, the assessor contacts the ALA for a voucher and choice of providers for Recovery Mentor Services. If appropriate and necessary, the assessor can also request a voucher for detoxification services and choice of providers. The client is provided with at least three Mentor Provider Agencies that he/she can utilize to obtain their RM. Clients are assigned RMs by the Mentor Provider Agencies according to gender: males with males and females with females.

A voucher for a RM is issued immediately after completing the assessment and is available for the client to use immediately with the following conditions. The voucher for the RM is good for a 6 month period and a total of 50 hours. The client is able to receive an additional eight hours of service if necessary and appropriate. On average, the client has two hours of contact weekly with their RM. If a client goes into residential treatment or a halfway house, the RM is available for 2 hours per month. Three weeks prior to discharge, the RM can increase hours to 2 hours per week. If the client goes into outpatient, intensive outpatient, or partial care, there is no reduction in hours and no lapse in service.

Measures

Measures are included to evaluate increased retention in treatment, increased periods of abstinence and decreased number of relapses as a function of increased contact hours with a Recovery Mentor and subsequent increased access to ancillary, psychosocial

services. Measures are completed at intake, 30 days after intake, every 60 days thereafter, and discharge and used client self report and Recovery Mentor reports.

NJAI Status Interview Questionnaire. The NJAI Status Interview Questionnaire is composed of 9 sections: (A) Record Management; (B) Drug and Alcohol Use Domain; (C) Family and Living Conditions Domain; (D) Employment, Education and Income Domain; (E) Criminal Justice Domain; (F) Social Support and Recovery Domain; (G) Service Domain; (H) Demographics; and (I) Discharge Information.

Record Management includes the client ID, intake ID, Grant ID, interview date, interview type, and status interview number. The record management questions are not asked of the client. Interview date and status interview number are the only areas that are altered by the person completing the status interview.

The Drug and Alcohol Use Domain includes 2 questions that assess drug and alcohol usage within the past 30 days and are the basis of the dependent variables. Type of drug, number of days used, route of administration (oral, smoking, inhalation, injection, other), and number of alcoholic beverages consumed are all addressed. Types of drugs include: cocaine/crack, marijuana/hashish, heroin/other opiates, hallucinogens/psychedelics, methamphetamines or other amphetamines, benzodiazepines, barbiturates, ecstasy and other club drugs, ketamine, inhalants, and other illegal drugs.

The Family and Living Conditions Domain is three questions that address where the client has lived most of the time in the last 30 days, the number of children he/she has and their living arrangements, and whether the client is currently pregnant. A client is considered homeless if they have no fixed address or are living in a shelter. A client is

considered to have a dependent living arrangement if they are living in a supervised setting such as a halfway house or group home. If a client lives on their own, is self-supported, or lives in a non-supervised group home they are considered to have independent living. If a client has been living in more than one place in the last 30 days, they are classified based on where they spent the most time or lived the longest.

The Education and Employment Domain assesses school or job training status, employment status, status if not in labor force, and level of education. The purpose of this domain is to determine the client's current employment status. The focus of this interview question is based on the client's status during most of the previous week to determine whether the client worked at all or had a regular job but was off work. Also, only legal employment is counted as employment. If the client is not in the labor force, their status can be student enrolled in a school or job training program, homemaker, retired, disabled, inmate of an institution that restrains a person from the workforce, and other.

The Criminal Justice Domain pertains to general information about the client's involvement with the criminal justice system. This domain has three questions which address information about arrests and incarceration or detainment.

The Social Connectedness Domain is a five question domain that addresses the client's involvement in voluntary self-help groups for recovery, including religious/faith affiliated groups and level of family/peer support of recovery. Whom the client turns to when having trouble is also addressed.

The Services Domain is the basis for the independent variables being examined in this study. The Service Domain examines the number of days and type of treatment the

client received since the previous status interview, as well as the number of sessions and type of services the client has received. Types of treatment include: day treatment, inpatient/hospital, outpatient, outreach, intensive outpatient, methadone, residential/rehabilitation, detoxification and recovery support. Several types of services are addressed, including clinical treatment services, case management/recovery support services, medical services, after care/recovery support services, education/recovery support services, and peer-to-peer recovery support services.

The Demographics Domain is completed only at intake and includes gender, ethnicity, race and age.

The Discharge Information Domain is completed at discharge and includes the date of discharge and reason for discharge.

Procedure

Recovery Mentors are required to collect data from clients through the NJAI web-based reporting system, NJSAMS, using the NJAI Status Interview Questionnaire. The NJAI Status Interview Questionnaire is to be completed 30 days after the client's assessment, every 60 days thereafter and discharge. The client does not have to be present for the Status Interview Questionnaire to be completed, as the RM should be in frequent contact with the client and is therefore able to answer the questions knowledgeably.

The areas of the Status Interview Questionnaire that are of particular interest for this study are the Services Domain and the Drug and Alcohol Use Domain. For this study, the NJSAMS system is being utilized to access the completed Status Interview

Questionnaires in order to obtain the information necessary to analyze the Services and the Drug and Alcohol Use Domain.

Propose Data Analysis

The results of the NJAI Status Interview Questionnaires were analyzed using a correlation to examine whether increased number of sessions of ancillary, psychosocial services was related to improved treatment retention, periods of abstinence and decreased number of relapses.

CHAPTER THREE

RESULTS

At the time of data collection, there were 2,424 participants in the NJAI requiring Status Interviews to be completed. Of these 2,424 participants, 46 had completed Status Interview Questionnaires. Of these 46 Status Interview Questionnaires, only nine were completed in their entirety. The remaining 37 were missing several sections of information.

Demographics

Five of the completed Status Interview Questionnaires were completed on female participants, with the other four Status Interview Questionnaires being completed on male participants (see Table 1). The mean age of participants was 37.6 years of age, ranging from 29 to 48. Two participants identified themselves as Hispanic/Latino; six participants identified themselves as non-Hispanic/Latino; and one person was unknown. Seven of nine participants responded with “non-applicable” when asked about ethnicity. The other two participants responded with “other” in regards to ethnicity. In terms of race, eight participants identified themselves as white, with the ninth participant reporting “other.”

Table 1

Participant Demographics

Demographics	No. Participants
Gender	
Male	4
Female	5
Ethnicity	
Hispanic	2
Non-Hispanic	6
Unknown	1
Race	
Black or African American	0
Asian	0
American Indian	0
Native Hawaiian	0
Alaska Native	0
White	8
Other	1

Substance Usage

Two participants reported substance usage in the 30 days prior to completing the Status Interview Questionnaire (see Tables 2 and 3). The first reported four days of

alcohol usage and 15 days of illegal drug usage, including 1 day of marijuana and 15 days of intravenous heroin usage. The second participant reports three days of alcohol usage and 30 days of illegal drug usage, specifically intravenous heroin usage.

Table 2

Alcohol Usage for Past 30 Days

Days	No. Participants
0	7
3	1
4	1

Table 3

Illegal Drug Usage for Past 30 Days

Drug	Days	No. Participants
No Usage	0	7
Cocaine/Crack	0	0
Marijuana/Hashish	1	1
Heroin/Other Opiates		
	15	1
	30	1
Hallucinogens/Psychedelics	0	0
Methamphetamine	0	0
Benzodiazepines	0	0
Barbituates	0	0
Ecstasy/Other Club Drugs	0	0
Ketamine	0	0
Inhalants	0	0
Other Illegal Drugs	0	0

Services and Community Involvement

All of the participants reported receiving one Case Management service of screening and assessment. One participant reported receiving one service session of

medical care. Six of nine participants reported participating in voluntary self help groups and/or religious/faith based affiliated support group.

Living Conditions, Education, and Employment

Five of nine participants reported independent living, which includes living on their own, self supported, and non-supervised group houses (see Table 4). Four participants reported living in dependent living. Dependent living refers to dependent children and adults living in a supervised setting such as a halfway house or group home. None of the participants were homeless. Three participants were working in the community, one was working Part Time and the other two were working Full Time. Full time work required that the participant work 35 hours or more each week and included members of the uniformed service. None of the participants reported being enrolled in a school or training program. One participant completed the 8th grade; one participant completed the 11th grade. Six of the nine participants completed the 12th grade or received a General Equivalency Diploma (GED). One participant completed 2 years of college or received an Associates Degree.

Table 4

Living Condition, Education, and Employment

Living Condition	No. Participants
Homeless	0
Dependent	4
Independent	5
School or Job Training Program	
Not enrolled	9
Enrolled, Full time	0
Enrolled, Part time	0
Other	0
Highest Level of Education Completed	
8 th grade	1
11 th grade	1
12 th /GED	6
2 years college/Associates degree	1

Mentors and Mentor Provider Agency Contacts

Due to limited information being available from participants in the NJAI, both mentors and mentor provider agencies were contacted. This information cannot be found in the NJSAMS database and was completed with the purpose being to have more information available in the NJSAMS database.

Contact was attempted with 159 mentors. Of these 159 mentors, direct contact was made to 65 mentors (41%). Messages were left with 52 mentors (33%), either on an answering machine or with another person. Of the 159 mentors that were attempted to be contacted, 15 had numbers that were either wrong or disconnected (9%). There was no answer at 9 of the numbers (6%). One mentor hung up when contact was attempted (<1%).

Six potential mentors were no longer interested in working as a mentor and 4 (6%) were currently working as mentors. Of the 65 mentors contacted, 48 mentors have completed the addictions classes (74%); 1 completed part of the classes (2%); 32 received RMA certification (49%); and 41 were currently seeking work as mentor (63%).

A number of miscellaneous responses were also obtained including: 4 mentors awaiting applications (6%); 1 mentor who would like to waive the training (2%); 1 mentor who has completed the classes but they may have expired (1 mentor); 1 mentor who completed credentials in Puerto Rico (2%); 2 mentors recently sent in applications (3%); and, 2 mentors plan to finish their education prior to working as mentor (3%).

Mentors who were currently looking for work were asked which counties they would prefer to work in. Counties identified included Atlantic, Bergen, Burlington, Camden, Cumberland, Essex, Gloucester, Hudson, Mercer, Middlesex, Monmouth, and Ocean. Six mentors did not identify which counties they preferred to work in and 1 mentor wanted to work for current agency (Organization for Recovery).

Twenty five mentor provider agencies were contacted. Of the 25 agencies contacted, 3 were currently hiring recovery mentors. The agencies that were hiring

recovery mentors are Victory Counseling Associate in Bergen County, CURA Inc. in Cumberland County, and COPE Center Inc. in Essex County. All three agencies were currently hiring both males and females as recovery mentors.

Of the 25 agencies contacted, 10 were currently not hiring recovery mentors. Half of these agencies stated that their decision to not hire recovery mentors is not likely to change.

Messages were left at eight of the agencies to contact the Administrative Lead Agency (ALA).

Evaluation of the NJAI

The proposed data analysis was to be based on the results of the NJAI Status Interview Questionnaires and would have utilized a correlation to examine whether an increased number of sessions of ancillary, psychosocial services was related to improved treatment retention, periods of abstinence and decreased number of relapses. Because there was such limited data available from the NJAI Status Interview Questionnaires, this analysis was unable to be completed and, thus, the hypothesis was unable to be addressed.

CHAPTER FOUR

DISCUSSION

The proposed data analysis of a correlation to test the hypothesis that an increased number of sessions of ancillary, psychosocial services was related to improved treatment retention, periods of abstinence and decreased number of relapses was unable to be conducted due to limited available data. Since no correlation was completed, there are essentially no statistical results to report; however, there are descriptive results.

Descriptive results indicate that all participants received one Case Management service of screening and assessment. In addition, one participant reported receiving one service session of medical care. Only two of the nine participants reported substance usage in the 30 days prior to data collection; however, both reported using heroin, which was the drug being targeted by this study.

The NJAI attempted to implement a model similar to the one used by McLellan et al. (1999) in which case managers, or in this case Recovery Mentors, were provided to substance abusers seeking drug and alcohol treatment. The purpose of the Recovery Mentors or McLellan's case managers was to assist the individual in accessing ancillary, psychosocial services in addition to their substance abuse treatment. Had the NJAI been successfully implemented with data to support its success, there would be more support available for the appropriateness and usefulness of case managers or Recovery Mentors in supplementing treatment of substance abusers, particularly opiate addicts.

Previous research (e.g., Roll, Chudzynski, & Richardson, 2005; Laudet, Magura, Vogel, & Knight, 2004; McLellan et al., 1999) has demonstrated the importance of addressing psychosocial issues in addition to addiction treatment, both in terms of treatment retention and treatment outcomes. If a correlation had been found between service hours provided by Recovery Mentors addressing psychosocial issues and improved retention in treatment, increased periods of abstinence and decreased number of relapses, the support for addressing psychosocial issues in addition to addiction treatment would be expanded. The NJAI results could have been particularly beneficial to supporting the previous research due to having such a large number of potential participants and a central database to collect and maintain the data. In addition, the NJAI attempted to address many of the issues addressed in previous research, such as the importance of encouraging contact with individuals who can function as role models; development of hope, new beliefs, new relationships, and new activities that are considered to be key to recovery; developing a satisfying life that includes regular, meaningful activities such as jobs and a safe living environment; and, finally, endorsing a long-term perspective of recovery that involves psychosocial processes.

The NJAI, despite being well conceived both in terms of theory and potential ways to measure outcomes, was not devoid of several serious flaws. Many of these flaws related to data collection. The first of these flaws was that the NJSAMS database had no way to track which of the 2,424 participants had been assigned mentors or even who the potential agencies that participants were told to contact in order to be assigned a mentor. A second flaw of the NJAI and the NJSAMS database was that there was no one person

responsible for ensuring that data was being entered at the appropriate times, or even, at all. In theory, the Recovery Mentors were to be responsible for completing the Status Interview Questionnaires related to the participant(s) they were working with. As there were so few potential Recovery Mentors actually working as mentors, it is easy to see how virtually no data was entered into the NJSAMS database. A third problem which is also related to the limited number of Recovery Mentors actually working within the NJAI, was the limited number of services that were provided to participants. This was particularly problematic to this project as one of the key measures for the hypothesis was related to services.

In the future, a better way to match Recovery Mentors with participants needs to be addressed as the Recovery Mentors were the key to access to services and data collection. Some possible ways to address the lack of Recovery Mentors actually working with participants would be to increase the number of agencies hiring Recovery Mentors, as well as, increase the total number of Recovery Mentors thoroughly trained and employed. Another possible way to address this problem could be to limit the number of participants enrolled in the NJAI program. This would allow for better tracking and, ultimately, better data collection. In terms of data collection, the main problem that should be addressed in the future was that there was no way to track if information was being entered into the database at the appropriate times or at all, as well as no way to verify which participants had been assigned Recovery Mentors.

The possible implications of this evaluation of the NJAI program could have been support of previous research that would alter the way treatment of opiate addiction was

viewed. Effective treatment could be viewed as having multiple aspects, one of which is the actual treatment and the other being access and assistance to access of psychosocial, ancillary services through mentors or case managers. Much research reported here indicates the importance of addressing a client's psychosocial needs in order to obtain and maintain abstinence from substances. This evaluation had the potential to support and enhance that research.

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