

Supervisor Ideology and Organizational Response: HIV/AIDS Prevention in Outpatient Substance Abuse Treatment Units

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In the late eighties and early nineties, the HIV/AIDS pandemic gained increasing concern among policy makers and practitioners nationwide. Furthermore, the association of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) with intravenous drug use has been well-documented (U.S. Center for Disease Control, 1993; Conviser & Rutledge, 1989; McBride et al., 1990). Intravenous drug users (IVDUs) account for 27% of all AIDS cases in the United States (Center for Disease Control, 1993). In addition, the use of alcohol and other drugs (AOD) is associated with increased risk for behaviors related to acquiring HIV such as unprotected sexual intercourse and multiple sexual partners (Lowery et al., 1994). Further, drug use itself may damage the immune system and increase drug users' vulnerability to HIV (McBride et al., 1990).

Given the increased evidence for an association between AIDS and AOD use, substance abuse treatment providers must figure prominently in any effective national response to HIV/AIDS. Substance abuse treatment organizations will increasingly be called upon to educate clients about

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HIV/AIDS (Brown & Beschner, 1989). In particular, publicly-funded treatment organizations may eventually be required to become more involved in such efforts. Currently, under the federal block grant programs for substance abuse treatment and prevention services (P.L. 102-321, 1992), "designated states" (those with an AIDS prevalence rate of 10 per 100,000) are required to develop early intervention programs. With the Center for Disease Control's new surveillance definition of AIDS (Des Jarlais et al., 1992), and the progression of the pandemic, increasing numbers of states should become "designated states."

Several authors have noted, however, that inherent ideological conflicts exist between traditional approaches to substance abuse treatment that emphasize abstinence from drug use, and intervention efforts associated with HIV/AIDS prevention which place higher priority on harm reduction than abstinence (Des Jarlais, 1990, 1995; Oppenheimer, 1993). Such ideological conflict may impede efforts by substance abuse providers to engage in HIV/AIDS prevention.

Examined here is the relation between clinical supervisor ideology and variation among human service organizations (HSOs) in their provision of HIV/AIDS prevention services. More specifically, data from a national sample of outpatient substance abuse treatment (OSAT) units are analyzed to provide evidence about the extent to which these HSOs are engaged in HIV/AIDS education activities. Such activities encompass efforts aimed at increasing AOD clients' knowledge concerning the risks associated with the transmission of HIV (i.e., unprotected sexual activity, needle sharing, etc.). Education efforts typically take the form of one-on-one counseling and distribution of written materials (D'Aunno & Mohr, 1990), but also sometimes include attempts to prevent non-IVDUs from beginning IV drug use (Friedman et al., 1983).

To date, little empirical evidence exists to reveal how beliefs about AOD treatment are related to variation in the response of substance abuse providers to the HIV/AIDS pandemic. This study represents a preliminary effort to address this gap in the research. It is anticipated that the more strongly supervisors adhere to beliefs about the value of a harm reduction approach to HIV/AIDS, the greater will be HIV/AIDS prevention efforts in their units. By contrast, organizations in which stronger support exists for an AA/NA, abstinence-oriented ideology of care will be less involved in HIV/AIDS prevention efforts. Moreover, it is anticipated that the effects of ideology on HIV/AIDS prevention activities will be significant, in the direction indicated, while controlling for other factors that might also be expected to influence organizational performance in this regard. The specific research questions to be addressed include:

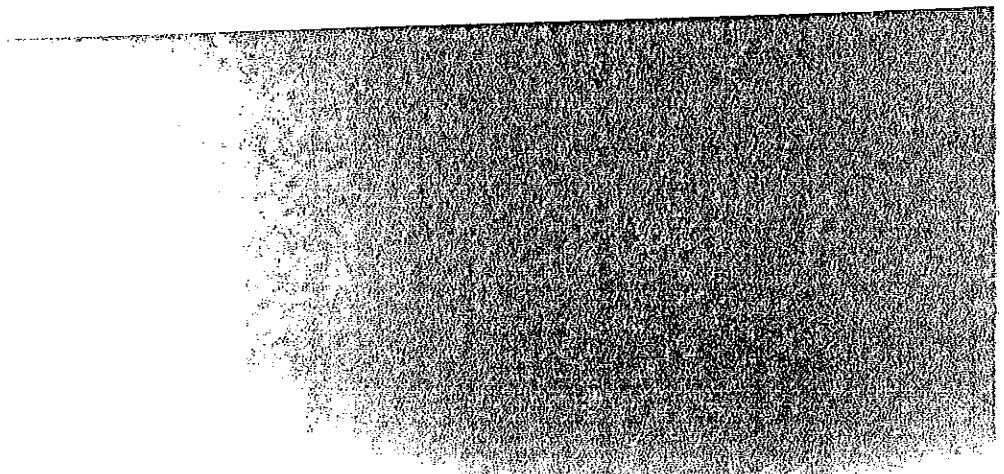
1. To what extent are beliefs about care in OSAT units related to the level of involvement in HIV/AIDS education?
2. Do particular ideologies of care support such activities and others impede or inhibit organizational efforts in this regard?
3. Are the effects of ideology on HIV/AIDS prevention efforts significant, net of other factors that might be expected to influence organizational responsiveness such as client characteristics and resource availability?

IDEOLOGIES OF CARE IN HSOs

Ideology is central to both means and ends in HSOs, helping to define the organization's mission and goals, and establishing guidelines for practice and procedures widely regarded as legitimate in pursuing them. Distinct practice ideologies or ideologies of care are deemed to influence greatly the selection of intervention methods and the mix of services adopted by providers (Hasenfeld, 1992). Ideologies of care are especially important for HSOs where knowledge about the effectiveness of various interventions is often weak or inconclusive (Hasenfeld, 1983, 1992; D'Aunno, 1992). Moreover, ideologies of care endow managers and staff with justification for action in the face of technological uncertainty, and the wide-ranging problems clients present that often defy routinization (Hasenfeld, 1986, 1992).

In the substance abuse services arena the ideology of abstinence, rooted in a disease model of alcohol and drug abuse, prevails as the dominant ideology (D'Aunno, Sutton, & Price, 1991). The concepts of abstinence and disease were widely promoted by moral entrepreneurs who founded Alcoholics Anonymous, and continue to be core beliefs shared by large numbers of individuals who participate in AA and related (i.e., Narcotics Anonymous) 12-step groups. Abstinence and disease concepts have also figured prominently in national drug policy. Abstinence as a guiding principle is consistent with legal mandates which prohibit the use of alcohol by minors, and ban the use of other substances altogether. In the eighties admonitions to "just say no" to drugs and calls for "zero tolerance" reflected renewed emphasis on abstinence as a national priority, backed up by greater willingness to use criminal sanctions to enforce adherence to this principle (Burke, 1992).

The central assumption of continued drug use inherent in the harm reduction approach to HIV/AIDS prevention is fundamentally at odds with the abstinence-disease approach to substance abuse treatment. According to Newcombe (1992):



Harm reduction has its roots in the scientific public health model, with deeper roots in humanitarianism and libertarianism. It therefore contrasts with abstentionism, which is rooted more in the punitive law and enforcement model, and in medical and religious paternalism. (p. 1)

More specifically, HIV/AIDS prevention targeting IVDUs often focuses on strategies aimed at reducing risk or minimizing the harm associated with AOD use rather than relying on abstinence to protect substance abusers (i.e., education concerning sterilization of needles, the dangers of needle-sharing, or needle exchange). Harm reduction approaches assume that many individuals who use drugs are unwilling or unable to abstain from further drug use. Hence, limiting the danger to clients and the public at large is determined to be the first priority guiding intervention (Oppenheimer, 1993; Des Jarlais, 1995). This sentiment is expressed clearly in Des Jarlais' assertion: "Drug users are an integral part of the larger community. Protecting the health of the community as a whole, therefore requires protecting the health of drug users" (p. 11).

Given the potential divergence in ideological orientation toward AOD substance abuse treatment and HIV/AIDS prevention, it is reasonable to assume that the willingness of OSAT units to engage in HIV/AIDS prevention efforts may very much depend on the relative strength of these two ideologies of care in the organization. This is especially likely to be true for programs that strongly endorse "12-Step" approaches proposed by AA and NA, predicated on abstinence and the disease model (Blume & Roman, 1985), where even "To discuss AIDS with a person in treatment raises the possibility of treatment failure" (Des Jarlais, 1990, p. 338).

Although the organizational capacity and willingness to engage in HIV/AIDS prevention may very well depend on the ideological orientation of all staff members, the beliefs held by those who occupy a leadership position within the organization are expected to be particularly critical to agency performance in this regard. In AOD treatment units, clinical supervisors are key gatekeepers who can influence decisions about hiring and training of staff, program development, and allocation of counselors and other staff to various agency services. Thus, in agencies where supervisors are more sympathetic to a harm reduction approach to HIV/AIDS prevention it is likely that the organization will be more involved in the provision of HIV/AIDS education services.

Sample and Data Collection

This study uses data from the 1990 Drug Abuse Treatment System Survey (DATSS) funded by the National Institute on Drug Abuse. The

DATSS is a national survey of outpatient substance abuse treatment units, conducted in 1988 and 1990 by the Survey Research Center at the Institute for Social Research, the University of Michigan. Data for these analyses were obtained from respondents in 481 of the 546 units asked to participate in the 1990 DATSS for a response rate of 88 percent. These units were all participants in the first wave of the DATSS conducted in 1988, based on a random sample of OSAT units drawn from a list of the population of approximately 8,500 treatment units in the United States. The population was stratified according to treatment modality (methadone vs. nonmethadone); ownership (public vs. private); and treatment context (hospital-affiliated, mental health affiliated, and unaffiliated or "free-standing"). In each unit the top two managers (i.e., unit director and director or supervisor of clinical services) were asked to complete telephone interviews. Directors were asked to provide information about the unit's mission, financing, licensing and accreditation arrangements. Clinical supervisors were asked for information about referral arrangements, personnel, clients, services, and HIV/AIDS prevention efforts. Table 1 provides a brief description of the demographic characteristics of the sample (Price et al., 1992; Burke & Rafferty, 1994).

Ideally, a second, independent data source reflecting the dependent measure would have been included in the present study (i.e., observational data). However, given the survey design of the DATSS, coupled with the study's national scope collection of such data was not possible. Without a second measurement method, the issue of common method error variance (i.e., that correlations between variables may be a function of correlated measurement error rather than valid variance) must be considered when interpreting the present results (Andrews & Withey, 1976). Thus, the results of the present study must be viewed conservatively.

Measures

Two indexes (AIDS Education & Harm Reduction Ideology) used in this study were constructed on the basis of principle components factor analysis. Principle components analysis (PCA) was selected for data reduction over other factor analytic methods because of the exploratory nature of the present study. Hair et al. (1992) noted PCA detects "the minimum number of factors needed to account for the maximum proportion of variance represented in the original set of variables" (p. 231).

All items relating to AIDS education activities and managers' beliefs about AIDS-related services in the DATSS were included in a PCA (see Appendix for factor loadings, etc.). Orthogonal varimax rotation was used to derive independent factors (Hair et al., 1992). The PCA yielded a two

TABLE 1. Select Demographic Characteristics of OSAT Units' Staff, and Clinical Management

<u>Ownership</u>	<u>Percent (n)</u>	
Public/Non-Profit	68.9 (266)	
Private/For-Profit	31.1 (102)	
<u>Size/Employee Education</u>	<u>X</u>	<u>SD</u>
Full-Time Employees (FTE)	14.0	17.65
% FTE with Ph.D. Degree	2.6	8.1
% FTE with MD/DO	5.5	10.8
% FTE with Master's Degree	40.5	31.7
<u>Clinical Manager's Education</u>	<u>Percent (n)</u>	
No Degree	10.3 (33)	
AA/RN	3.2 (11)	
Bachelor Degree	58.6 (188)	
Master Degree	24.9 (80)	
Doctorate Degree	2.7 (9)	

Note: Percentages may not equal 100 due to rounding. 37.2% of clinical supervisors had a degree in psychology; 18.9% had a degree in social work.

factor solution and each factor had an eigenvalue above 1.0 (Kaiser, 1958). No individual variable loaded on more than one factor (based on .50 factor loading criterion) (Hair et al., 1992), and each factor loading in the factor solution was above .68. Factor-based indexes were obtained by calculating the mean for all items which loaded at .5 or above on each factor (Pedhazur & Schmelkin, 1992). Chronbach's alpha coefficients were computed for each index (including nonfactor-based indexes) to assess internal consistency.

Examination of several indicators suggests that the factor model is appropriate for these data. The KMO measure of sampling adequacy value for the above PCA is .78, which exceeds the .50 criterion suggested by Norusis (1988). In addition, the factor solution derived by the PCA ex-

plained 70.8% of the variance in the model, which is above Pedhazur and Schmelkin's (1992) criterion of 50%. Also, Bartlett's test of sphericity was computed and yielded a statistically significant value (1290.45; $p < .001$) which indicates the factor model is appropriate. Finally, all of the variables had measures of sampling adequacy above .5, again indicating that the factor model was appropriate (Norusis, 1988).

In addition to the two factor-based indexes, several other measures are included in the present study. These variables are either conceptually-based indexes, or single items from the DATSS. Each measure is detailed below.

AIDS EDUCATION

The dependent measure for this study, *AIDS Education*, is a four-item factor-based index asking clinical supervisors to rate the mean extent to which (1 = No extent, 5 = A very great extent) each of the following occurred in their OSAT unit: Counselors talked to clients about the risks of transmitting HIV/AIDS through sexual contact; Counselors talked to clients about ways to prevent transmitting HIV/AIDS through IV needle use; Counselors talked to clients about the risks of transmitting HIV/AIDS to unborn children; and Counselors distributed written materials to clients that explain how to prevent HIV/AIDS (Chronbach's Alpha = 0.87).

IDEOLOGIES OF CARE

Two measures of ideologies of care are used in the present study. *Harm Reduction Ideology* is a 4-item (mean of the four items) factor-based index reflecting the Clinical Supervisor's level of support for a harm reduction approach to HIV/AIDS prevention. This measure is based on their mean response to each of the following items: To what extent (1 = No extent, 5 = A very great extent) do you believe "Clean needles should be distributed to IVDUs to prevent AIDS"; "needle exchange programs should be available for IVDUs"; "bleach solutions should be distributed to IVDUs to clean their needles"; and "condoms should be distributed to IVDUs to encourage 'safe' sexual practices" (Chronbach's Alpha = .87). A second measure, *Abstinence Ideology* was developed to identify Clinical Supervisor support for the abstinence approach to substance abuse intervention. A dichotomous variable (0 = No, 1 = Yes) was constructed identifying Clinical Supervisors who regard the abstinence approach advocated by AA/NA

groups as the most effective approach to treatment for clients with substance abuse problems.

**CONTROL VARIABLES:
CLIENT CHARACTERISTICS AND RESOURCES**

Other factors besides ideology may be expected to influence the willingness and capacity of OSAT units to respond to the HIV/AIDS pandemic. Two of the most common alternative explanations for variation in organizational behavior and performance stem from market or demand-driven explanations and those that stress the importance of resource availability.

Des Jarlais (1990) has, for example, suggested that the prevalence rate of AIDS in the geographic area influences organizational response to AIDS. Higher prevalence of the disorder in the immediate area in which a service provider is located is expected to translate into increased awareness of client need for HIV/AIDS prevention-related activities. Although prevalence data for the geographic area surrounding OSAT units in this study are not included here, unit-level data are available which indicate the prevalence of HIV/AIDS among clients served in each organization. *Percent HIV/AIDS Clients* is a variable created to indicate the percent of all clients served by the unit in the most recent complete fiscal year who tested HIV positive, were diagnosed with AIDS, or died of AIDS-related causes.

In addition, it is logical to hypothesize that since IVDU clients are at greater risk for HIV/AIDS than non-IVDU clients, those units who serve more IVDU clients will be more interested in providing HIV/AIDS prevention services. *Percent IVDU Clients* represents the percent of all clients served by the agency in the most recent complete fiscal year who injected drugs intravenously. Similarly, those who deal with a more severely impaired client population might also be expected to be more concerned about this disease. The *Percent Multiple-Drug Clients* indicates the percent of a unit's total clients who are polydrug users.

In addition to client characteristics, the availability of personnel and funds to support HIV/AIDS prevention efforts may be expected to be a critical factor influencing the level of commitment to such activities. Proponents of a resource dependence perspective have placed greater emphasis on the availability of resources than institutional beliefs as the source of variation in organizational behavior and performance (Hasenfeld, 1992). *Resource Availability* to provide HIV/AIDS prevention efforts is operationalized here as the mean response to three questions. "To what extent is each of the following true for your unit?" (1 = No extent, 5 = A very great

extent): (1) Your unit has adequate funds to allocate for AIDS prevention efforts; (2) Your unit has enough staff members or staff hours to devote to AIDS prevention; and (3) Your unit has staff members who work specifically on AIDS prevention (Chronbach's Alpha = .80).

Data Analysis

Descriptive data are presented for each of the variables included in this study and are shown in Table 2. Multiple regression analysis, using the ordinary least squares (OLS) method and forced entry of all ideology and control variables is used to assess the research questions posed earlier in this paper. This strategy is selected because it facilitates assessment of the impact of ideology on the provision of HIV/AIDS prevention in OSAT units, while controlling for (net of) resource availability and client characteristics. Examination of the correlation matrix (Table 2) indicates that multicollinearity is not a significant threat in the model presented below. Similarly, autocorrelation is not likely, as the Durbin-Watson value for the present model is 1.9. Finally, examination of the residuals indicated the following: (a) the plot of the residuals approximated a normal distribution; (b) the normal probability plot approached a straight line; (c) the plot of the residuals against the predicted values for the outcome variable approached a horizontal band (Hair et al., 1992). Thus, the multiple regression model was appropriate for these data.

FINDINGS

Data shown in Table 2 reveal that, on average, clinical supervisors are moderately supportive ($\bar{X} = 3.14$, s.d. = 1.1) of a harm reduction approach to HIV/AIDS prevention. In addition, about one third (34%) of the clinical supervisors in this study indicate they believe the abstinence approach proposed by AA/NA type programs to be the most effective approach to treatment of drug and alcohol problems.

Only a small percent of all clients served in these units ($\bar{X} = 1.0$, s.d. = .49) in the most recent complete fiscal year were HIV positive, were diagnosed with AIDS or died from AIDS-related causes. On average, a much larger percent ($\bar{X} = 27.1$, s.d. = 32.9) of clients were IVDUs and a still larger percent ($\bar{X} = 57.3$, s.d. = 32.1) were multiple drug users.

Data used for these analyses indicate that, on average, OSAT units report a moderate level ($\bar{X} = 3.6$, s.d. = .84; 3 = To some extent) of effort directed at HIV/AIDS education. Sixty percent of OSAT units report they

TABLE 2. Correlation Matrix and Selected Descriptive Statistics for Ideology, Dependent and Control Variables

Variable	x ₁	x ₂	x ₃	x ₄	x ₅	x ₆	y
<i>Ideology Variables</i>							
Harm Reduction Ideology (x ₁)	---	-.07	.05	.04	<u>.15</u>	.03	<u>.19</u>
Abstinence Ideology (x ₂)		---	<u>-.12</u>	-.05	-.06	-.1	-.12
<i>Control Variables</i>							
% IVDU (x ₃)			---	.04	<u>.32</u>	<u>.44</u>	<u>.29</u>
% Multiple Drug Users (x ₄)				---	.01	.10	<u>.17</u>
Resources to Address AIDS (x ₅)					---	<u>.30</u>	<u>.50</u>
% HIV/AIDS Clients (x ₆)						---	<u>.23</u>
<i>Outcome Variable</i>							
AIDS Education (y)							---
Mean	3.1	.34	27.1	57.3	2.3	1.0	3.6
Standard Deviation	1.1	.49	32.9	32.1	1.0	.49	.84

Note: Underlined coefficients are statistically significant at the .05 alpha level. X₁, X₅ and y have valid value ranges from 1-5. X₃, X₄ and X₆ have valid value ranges from 0 to 100. X₂ is a dummy coded variable 0 = no abstinence ideology, 1 = abstinence ideology.

provide HIV/AIDS education to their clients to a "4 = Great" or "5 = Very Great" extent. Moreover, OSAT units report this level of involvement in HIV/AIDS education even though they typically report they do not have adequate ($\bar{X} = 2.3$, s.d. = 1.0) resources to support such efforts.

When all variables are entered simultaneously into a multiple regression model, it is evident that harm reduction ideology, resources and client characteristics are all important in explaining variation HIV/AIDS prevention efforts. As shown in Table 3, the overall model is significant ($F = 12.77$, $p < .05$), and the linear combination of all eight variables accounts for 22% of the variance among OSAT unit in the level effort directed at HIV/AIDS education.

Table 3 indicates that harm reduction ideology is significantly related to the dependent variable in the direction expected (Beta = .15, $p < .05$). Units where supervisors are more supportive of a harm reduction approach

TABLE 3. Regression of AIDS Education on Treatment Ideology and Control Variables

Variable	Beta	Standard Error of Beta
<i>Ideology Variables</i>		
Harm Reduction Ideology	<u>.15</u>	.04
Abstinence Ideology	-.08	.08
<i>Control Variables</i>		
% IVDU	<u>.14</u>	.001
% Multiple Drug User	<u>.10</u>	.001
AIDS Affected Clients	-.01	.025
Resources to Address AIDS	<u>.36</u>	.04
Adjusted R ² = .22		
Model: F = 12.77; P < .001		

Note: Underlined beta weights are statistically significant at a one-tailed alpha level of .05. The variable reflecting AIDS-affected clients was transformed by taking the square root of each case to correct for skewness.

to HIV/AIDS prevention are more involved in HIV/AIDS education. By contrast, abstinence ideology did not contribute significantly to the provision of AIDS education to clients at OSAT units (Beta = -.08, NS).

Client characteristics are also significantly related to variation in OSAT unit involvement in HIV/AIDS education. Organizations that serve more IVDUs (Beta = .14, $p < .05$), and have larger percentages of multiple drug-using clients (Beta = .10, $p < .05$) are, as hypothesized, more extensively involved in HIV/AIDS education. However, the percent of HIV/AIDS clients served by a unit is not related to the level of involvement in prevention (Beta = -.01, NS). As the data reported in Table 2 indicate, however, in 1990 the percent of clients in these OSAT units who were HIV positive, who had been diagnosed with AIDS or had died of AIDS-related causes were, typically, quite small—on average only one percent of all clients. As the pandemic progresses and these numbers increase, such characteristics may yet have an impact on organizational performance in this area of service delivery. Finally, it is important to note that resource

availability appears to be the single most important factor related to the level of involvement in HIV/AIDS education (Beta = .36, $p < .05$). Nevertheless, supervisor support for a harm reduction approach to HIV/AIDS prevention is a significant net of resources.

DISCUSSION AND CONCLUSION

This study reports findings from an initial effort to examine empirically the relationship between ideology and HIV/AIDS prevention in substance abuse services organizations. Data collected from a national sample of OSAT units in 1990 reveal that most OSAT units have made efforts to respond to this emerging social problem by routinely counseling clients about various risks associated with contracting and transmitting the HIV virus and distributing materials which advise substance abuse clients of measures that can be taken to reduce such risks. These findings report on such efforts undertaken by OSAT units at a critical period when the ramifications of this problem for such organizations were still relatively unclear, and while controversy about how best to approach both the treatment of substance abuse and prevention of HIV/AIDS abound. Moreover, such controversy and confusion may be expected to continue to confront service providers in the substance abuse sector as the incidence and prevalence of HIV/AIDS-related problems among their clients can be expected to grow.

These data partially support our hypothesis that beliefs contribute to organizational performance in OSAT units. For instance, personal beliefs concerning AIDS prevention among clinical managers may facilitate the involvement of OSAT units in HIV/AIDS prevention. Organizations in which there is more support for harm reduction appear to be more involved in prevention, indicating that such beliefs are conducive to HIV/AIDS prevention.

By contrast, adherence to beliefs that the AA/NA approach is the most appropriate AOD treatment approach do not seem to influence AIDS efforts in OSAT units. This finding is in contrast to our hypothesis that ideologies of care predict organizational performance. This finding may be a result of the variable used to measure abstinence-based ideology. Unlike the index reflecting harm reduction ideology, the variable assessing abstinence-based ideology was a simple dichotomous variable. It is possible that a more comprehensive set of items reflecting the various dimensions of abstinence-based ideology would yield different results. Further research might address this issue.

At a more conceptual level, it is possible that AIDS education and

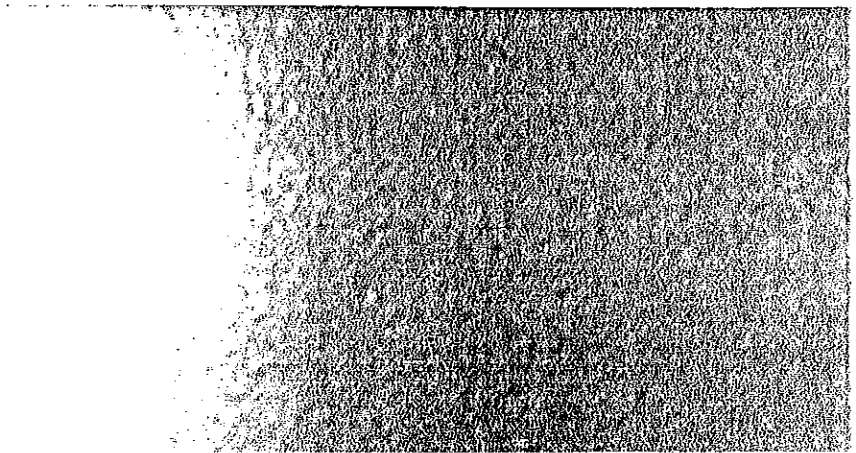
ideologies reflecting substance abuse treatment are "loosely coupled" in OSAT units (Hasenfeld, 1992). That is, certain organizational beliefs may conflict with other organizational beliefs or services. For instance, AIDS education might be perceived as being distinct from substance abuse treatment. Thus, the ideologies of care related to substance abuse treatment might be seen as unimportant to AIDS-related services. Again, further research is needed to explore this particular finding.

Further, the availability of resources does appear here as an important determinant of organizational behavior. Policy makers who want OSAT units to take a more active role in HIV/AIDS prevention ought to be concerned about finding ways to providing such resources—funding and staff—to substance abuse providers.

Findings presented here suggest, however, that more resources alone may not be enough. Even if sufficient resources can be made available to these HSOs, it is clear that some sets of beliefs are compatible with the provision of such prevention efforts. Not surprisingly, for HSOs where a tradition of moral entrepreneurship has played an important part in the development and implementation of policy objectives, ideological support by management appears to be an important precursor to achieving HIV/AIDS-related policy goals. In particular, management support for a harm reduction approach to HIV/AIDS prevention appears to have a substantial impact on organizational performance in this regard.

Increasing support among managers for such an approach to HIV/AIDS may be important if this effort is to succeed nationally. Furthermore, to get more support for this approach may require broader reconsideration of U.S. drug policy and training of substance abuse personnel. Adherence to a harm reduction approach to HIV/AIDS prevention would be easier to obtain if a consensus could be reached about the merits of such an approach for treatment as well. Moreover, finding the resources to pay for more extensive and intensive efforts by substance abuse providers to prevent the spread of HIV infection may require revisions to current drug policy. Given fiscal constraints, more money for HIV/AIDS prevention in substance abuse service settings may depend on redeploying resources from supply reduction to demand reduction efforts. Such reallocations may be important to overcoming the resource-related issues that pose barriers to greater involvement by OSAT units in HIV/AIDS prevention.

Although preliminary, the results of the present study raise some interesting issues for future research. First, inquiry into how other ideologies of care influence AIDS prevention within the context of substance abuse treatment might be important. Although abstinence-based ideology is the predominant ideology of care in the substance abuse treatment field (Blume &



Roman, 1985; Weisner & Morgan, 1992), other authors have noted that several ideologies of care exist in the AOD treatment field including psychosocial approaches, social learning approaches, and cognitive-behavioral approaches (Diwan, 1990; Hanson, 1991). Future research might probe whether these ideologies facilitate or preclude AIDS prevention.

Second, future studies should seek multiple methods of measurement where possible. As noted earlier, survey data using one informant to report on their own personal beliefs and the behavior of the organization can be problematic (i.e., common method error variance). To correct for this potential problem, future research in this area might employ designs that allow multiple and independent indicators of variables (e.g., both self-report and observational data). Further, such designs will facilitate structural equation modeling which allows for estimates of variance attributable to measurement and the construct validity of measures (Andrews & Withey, 1976).

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APPENDIX

Factor Structure of AIDS Prevention Items in the DATSS

Factor Name and Items	Loading
<i>AIDS Education (42.3% of the model variance; eigenvalue = 3.38)</i>	
<u>Item</u>	
Counselors routinely talk to clients about the dangers of transmitting AIDS through sexual contact.	.88
Counselors routinely talk to clients about ways to prevent transmitting AIDS through IV needle use.	.88
Counselors routinely talk to clients about the risks of transmitting AIDS to unborn children.	.88
Written materials that explain ways to prevent AIDS are routinely distributed to clients.	.68
<i>Harm Reduction Ideology (28.5% of the model variance; eigenvalue = 2.28)</i>	
<u>Item</u>	
Clean needles should be distributed to IVDUs to prevent AIDS.	.87
Needle exchange programs should be available for IVDUs.	.86
Bleach solutions should be distributed to IVDUs to clean their needles.	.84
Condoms should be distributed to IVDUs to encourage "safe" sexual practices.	.74

Note: KMO = .78; Bartlett's test of sphericity = 1290.45, $p < .001$; individual items all had measures of sampling adequacy above .5.