

DISCRIMINANT ANALYSIS OF FACTORS DIFFERENTIATING AMONG SUBSTANCE ABUSE TREATMENT UNITS IN THEIR PROVISION OF HIV/AIDS HARM REDUCTION SERVICES

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Given the association between HIV/AIDS and drug use, substance abuse treatment organizations must play a prominent role in the prevention of HIV/AIDS. Effective HIV/AIDS prevention efforts targeting intravenous drug users require the use of harm reduction strategies. Current substance abuse treatment approaches stress abstinence from drug use as the primary desired treatment outcome, which might be perceived to contradict harm reduction strategies. Using data from the national Drug Abuse Treatment System Survey, this article explores the effect of ideological beliefs held by substance abuse treatment personnel on the delivery of harm reduction services to clients in outpatient substance abuse treatment (OSAT) units. Results of a discriminant analysis suggest that both abstinence-based ideologies of care and harm reduction ideologies of care distinguish between OSAT organizations engaged in harm reduction activities and organizations not engaged in such activities.

Keywords: AIDS/HIV; harm reduction; Ideology; substance abuse

Given the association between HIV/AIDS and drug use (Centers for Disease Control, 1993), substance abuse treatment organizations have a vital role to play in the prevention of HIV infection (Friedman, Des Jarlais, & Goldsmith, 1989). However, there may be disparity between HIV/AIDS prevention ideologies and current substance abuse treatment ideologies (Des Jarlais, 1995). For instance, effective HIV/AIDS prevention efforts targeting intravenous drug users (IDUs) may require the use of harm reduction strategies (Des Jarlais, 1995), whereas current substance abuse treatment approaches stress abstinence from drug use as the primary desired treatment outcome (Price et al., 1991). Harm reduction strategies acknowledge that some drug users initially are unwilling or unable to stop using drugs, and these strategies place greater priority on minimizing harm to the health of the drug user and the general public than on abstinence (Des Jarlais, 1995; Newcombe, 1992). Controversial interventions such as needle exchange programs often are associated with the harm reduction approach. Conflicts between substance abuse treatment and HIV/AIDS prevention ideologies have the potential to impede responsiveness by substance abuse treatment organizations to the HIV/AIDS epidemic.

Proponents of institutional theory note that organizations' responsiveness to demands from the external environment is integral to their survival and essential for organizations to secure and maintain legitimacy (DiMaggio & Powell, 1983). Adopting policies and practices consistent with government regulations, accreditation requirements, or formal agreements such as contracts is

one of the primary ways in which organizations achieve legitimacy. In addition, professional and peer organizations also may exert influence on organizational practices, as can public opinion.

Evidence suggests, however, that it is not uncommon for human services organizations (HSOs) to be confronted by competing ideological demands in an external environment marked by fragmentation and change (Hasenfeld, 1992a, 1992b). Not surprisingly, when confronted by competing and even conflicting ideological demands, organizations often must search for a compromise (Oliver, 1991). The potential ideological conflict may be especially significant in substance abuse treatment settings, given the distinct nature of such HSOs. According to Hasenfeld, in human services settings where definitive information about the relationship between intervention technology and outcomes often is lacking, ideology can have substantial influence on the type of practices adopted by HSOs. These include practices reflected in the full range of administrative and clinical decisions made in HSOs, such as staffing, client eligibility determination, treatment planning, and services provision and termination. Thus research into the nature of the relationship between ideologies of care in substance abuse treatment settings and HIV/AIDS prevention has the potential for providing further evidence about the role that ideology plays in HSOs and to determine whether ideological factors enhance or inhibit the provision of such services in substance abuse settings.

Recent studies have begun to explore the influence of ideology (Clapp, 1995; Clapp & Burke, 1997) on the provision of educational services aimed at reducing the spread of HIV infection among clients in OSAT units. Clapp and Burke (1997) reported that, net of client characteristics and organizational resources, management beliefs about care help account for variation in the extent of involvement by OSAT units in HIV/AIDS education. Specifically, OSAT units with clinical managers who were more supportive of harm reduction ideologies tended to provide more extensive HIV/AIDS educational services to their clients. In this earlier study, however, adherence to an abstinence-based ideology of care was not related to the provision of HIV/AIDS-related educational services in OSAT settings. Similarly, Clapp (1995), using a different set of indicators, found no relationship between abstinence-based ideologies of care and the provision of HIV/AIDS-related educational services in OSAT units.

It is important to emphasize that these findings were based on analysis of the relation of abstinence-based ideology to the provision of prevention activities focused on HIV/AIDS education. Education efforts are considerably less controversial than harm reduction strategies such as the distribution of bleach solutions, condoms, or clean needles. OSAT units might very well attempt to meet expectations that they pay increasing attention to HIV/AIDS prevention by pursuing the least controversial strategy, such as providing HIV/AIDS education, thus minimizing or avoiding apparent ideological conflict. So it is possible that the abstinence ideology may pose a barrier to participation by OSAT units in such harm reduction practices while not impinging on their participation in the provision of HIV/AIDS education.

This article extends previous research by examining the effect of ideology in OSAT units on their involvement with more controversial harm reduction HIV/AIDS prevention practices. As such, the study provides evidence about an area that has been explored little in the human services literature. We hypothesized that in OSAT units where clinical managers embraced abstinence-based ideologies of care, such activities would not be provided to OSAT clients and

hypothesized the opposite outcome where clinical managers endorse the harm reduction ideology.

METHOD Design and Data

The relational study reported here uses secondary analysis of cross-sectional survey data from the 1990 Drug Abuse Treatment System Survey (DATSS). Funded by the National Institute on Drug Abuse, the DATSS is a national panel study of OSAT units conducted in 1988 and 1990 by the Survey Research Center at the Institute for Social Research at the University of Michigan, Ann Arbor. In 1990 data were obtained from 481 of the 546 units asked to participate in the DATSS, for a response rate of 88 percent. These units were all participants in the first wave of the DATSS conducted in 1988, drawn from a list of the approximately 8,500 treatment units that defined the population of such programs in the United States. The population was stratified according to treatment services offered (methadone versus nonmethadone), ownership (private versus public), and treatment context (hospital affiliated, mental health affiliated, and unaffiliated or "freestanding"). In each unit interviewers asked the top two managers (that is, unit director and director of clinical services) to complete telephone surveys. Interviewers asked directors to provide information about the unit's ownership, financing, strategies, and accreditation. Clinical supervisors were queried for information about personnel, clients, services, and HIV/AIDS prevention efforts.

For this article only units that reported staff specifically assigned to provide HIV/AIDS-related services were included in the analyses. Units were asked a series of follow-up questions about the nature of their involvement in harm reduction practices. Thus, analyses presented here are limited to the 328 OSAT units engaged in some type of HIV/AIDS-related prevention activities with the intent of differentiating between those engaged in education and those engaged in the more controversial harm reduction activities.

Measures

We conducted principle components factor analyses (PCAs) to develop several of the variables used for this study. Specifically, we conducted separate PCAs using the 328 cases in the subsample to develop measures for two major conceptual domains encompassing (1) ideologies of care related to substance abuse treatment and (2) ideologies of care related to HIV/AIDS harm reduction practices. Following Pedhazur and Schmelkin's (1991) suggestion, we used PCA only for constructing factor-based indexes when the retained factors accounted for 50 percent or more of the overall variance in the variable set.

Because our goal for the PCAs was to develop factor-based indexes for use in multivariate analyses, deriving independent factors was desirable. Thus, orthogonal rotation was used in each PCA (Hair, Anderson, Tatham, & Black, 1992). Only factors with eigenvalues of 1.0 were retained (Kaiser, 1958). Factor loadings of .5 and above were considered meaningful and were used in naming the factors. The investigators selected this value to simplify interpretation of extracted factors and enhance the conceptual robustness of each factor (Hair et al., 1992). Tabachnick and Fidell (1989) suggested that minimally each observed variable in any given factor analysis should have five cases. This criterion was met in each PCA used to develop

measures for this study. In addition, Kaiser-Meyer-Olkin's (KMO) measures of sphericity indexes were examined for all PCAs. Following Norusis's (1988) suggestion, PCAs with KMO values less than .5 were not used to develop measures for this study (Hair et al., 1992). We selected items for the PCAs by grouping them into the major conceptual domains of the model presented earlier: (1) ideologies of care related to substance abuse treatment and (2) ideologies of care related to HIV/AIDS harm reduction practices. Then we conducted PCAs for each conceptual domain in the model. We constructed factor-based indexes by summing values for variables loading on a retained factor across valid cases. Internal consistency was assessed using Cronbach's (1951) alpha coefficients for each index.

Dependent measure. The dependent measure used here, HIV/AIDS harm reduction activities, is a dichotomous variable reflecting the presence or absence of involvement by the OSAT unit in harm reduction activities. A score of 1 on this variable indicates that OSAT units engaged in at least one of the following types of harm reduction efforts: distribute bleach solutions to IDUs, talk to IDUs on the street or in places like crack houses, or distribute condoms to IDUs. All other OSAT units were coded 0, indicating no involvement in HIV/AIDS harm reduction activities. These indicators are consistent with the harm reduction model presented by Buning, van Brussel, and van Santen (1992). Ideally, a measure reflecting needle exchange and clean needle distribution would have been included in this index. Although such measures were available in the DATSS, the frequency of OSATs reporting such practices was so low, inclusion of these items in the study was not feasible. Given that these data were collected in 1990, during a time when needle distribution and needle exchanges were extremely controversial, it is not surprising that few organizations reported or engaged in such activities.

Discriminating variables. We used the data reduction methods detailed earlier to create three factor-based indexes representing ideologies of care. One index reflected clinical supervisors' attitudes toward HIV/AIDS harm reduction practices. The "HIV/AIDS harm reduction ideology" index was constructed from four Likert-type items indicating the extent to which (1 = no extent, 5 = a very great extent) clinical supervisors endorse the following harm reduction practices: distributing clean needles to IDUs to prevent HIV/AIDS, distributing bleach solutions to IDUs to prevent HIV/AIDS, distributing condoms to IDUs to encourage safe sexual practices, and providing needle exchange programs to IDUs. Cronbach's alpha for this index was .87. The valid value range for this variable was 4 to 20.

The second factor-based index reflects the extent to which OSAT unit managers believed in employing staff recovering from AOD problems for various reasons. D'Aunno (1992) noted that in OSAT units that embrace the Alcoholics Anonymous/ Narcotics Anonymous (AA/NA) model, the treatment staff typically includes recovering addicts and alcoholics, a practice based on the notion that "they have a first-hand knowledge of AA's 12 steps to recovery" (p. 352). Thus, managers may believe that recovering staff possess some special insight or understanding of an abstinence-oriented recovery process. Moreover, such hiring practices may be integrally linked to efforts to maintain legitimacy in an institutional environment where abstinence-based, 12-step programs continue to be regarded as core strategies for effectively treating substance abuse problems. The hire-recovering-staff index included the following four Likert-type items: (1) the extent to which the unit employs recovering staff to keep up with the field, (2) agreement or disagreement that a job applicant should have a personal history of substance abuse problems,

(3) that ex-addicts or recovering staff have a special kind of experience that enables them to work more effectively with clients than nonrecovering staff, and (4) a recovering substance abuser is better able to deal with client denial and resistance than nonrecovering staff (for all items, 1 = no extent, 5 = a very great extent). Cronbach's alpha for this index was .75. The valid range for this variable was 4 to 20.

The third factor-based index in this variable set reflected the extent to which OSAT units have adopted drug-free treatment practices "to keep up" with the substance abuse treatment field and to enhance or maintain their unit's public image. The "drug-free image" index is composed of four Likert-type items: (1) the extent to which the OSAT unit has adopted complete abstinence from alcohol and drugs as a treatment goal to keep up with the treatment field; (2) the extent to which the OSAT unit encourages clients to participate in AA or NA self-help groups because it is important to keep up with the substance abuse treatment field; (3) the extent to which the OSAT unit encourages clients to participate in AA or NA self-help groups to enhance the public image, reputation, or acceptance of their outpatient unit; and (4) the extent to which the unit has adopted complete abstinence as a treatment goal to enhance the public image, reputation, or acceptance of their outpatient unit (1 = no extent, 5 = a very great extent). Cronbach's alpha for this index was .81. The valid value range for this variable was 4 to 20.

Several individual items also were used to reflect ideologies of care. These items include (1) "AA/ NA model is effective," a single Likert-type item (1 = no extent, 5 = a great extent) reflecting the extent to which clinical supervisors believe the AA and NA approach is an effective treatment intervention with substance abuse clients; (2) "abstinence is important treatment goal," a Likert-type item (1 = strongly disagree, 5 = strongly agree) reflecting agreement or disagreement by clinical supervisors that complete abstinence from alcohol and drugs is an important treatment goal; and (3) "responsible AOD use not an important treatment goal," a Likert-type item (1 = strongly disagree, 5 = strongly agree) indicating the extent to which clinical supervisors agree or disagree that learning how to use alcohol and drugs in a socially responsible way is an important treatment goal for clients. Responses on this item were reversed, so higher scores indicated agreement that controlled use was not an important treatment goal.

We included several other variables in the model that might help discriminate between OSAT units involved in harm reduction practices and those that are not. Including such variables in the model allows the discriminating capacity of ideology variables to be assessed net of other possible explanations. Previous research (Clapp & Burke, 1997) indicates that three organizational variables appear to be important in accounting for variation among OSAT units regarding their involvement in HIV/AIDS education-related prevention activities. These variables are the percentage of multiple-drug using clients, the percentage of IDU clients, and an index reflecting the extent to which OSAT units have the resources (dollars and staff) for HIV/AIDS prevention. Cronbach's alpha for this index is .78 (valid value range = 3 to 15). As earlier research suggests, OSAT units with higher proportions of clients who are abusing multiple drugs or administering drugs intravenously were more involved in providing HIV/AIDS education to their clients as were OSAT units reporting that they have more resources available. We hypothesized that OSAT units with more IDU clients, more polydrug clients, and

more resources also were more likely to be involved with one or more of the harm reduction activities identified in this study.

Regulation and accreditation often are cited as important influences on organizational behavior and performance in HSOs (Hasenfeld, 1992a; McCaughrin & Price, 1992). In research exploring the effects of informal regulations (adherence to the Joint Commission on Accreditation of Healthcare Organizations [JCAHO] quality assurance standards) on organizational performance, McCaughrin and Hooijberg (1992) noted that "organizations that comply with institutional norms may not only obtain legitimacy, prestige, and status but may also develop more effective ways of performing" (p. 17). Substance abuse treatment organizations may be influenced directly or indirectly by such regulations to the extent that they reflect abstinence-based ideologies of care.

Three single-item predictor variables were selected to represent regulation as a form of institutional influence on the practices adopted by OSAT units in the present study: (1) hiring based on regulation, a Likert-type item (1 = no extent, 5 = a very great extent), reflecting the extent to which OSAT units employ professional treatment staff to comply with government agency regulations; (2) abstinence treatment goal based on regulation, a Likert-type item (1 = no extent, 5 = a very great extent) reflecting the extent to which the OSAT unit has adopted complete abstinence from alcohol and drugs as a treatment goal to comply with government agency regulations; and (3) QA plan based on JCAHO standards, a Likert-type item (1 = no extent, 5 = a very great extent) reflecting the extent to which the OSAT unit's formal quality assurance plan is based on (JCAHO) standards.

RESULTS

We used linear discriminant analysis to analyze the dichotomous dependent variable reflecting whether OSAT units participated in harm reduction practices. Discriminant analysis is useful because it permits this dichotomous variable to be studied in relation to multiple independent (discriminant) variables (Hair et al., 1992).

Of the 328 OSAT units allocating staff time to HIV/AIDS prevention efforts, 55.2 percent reported engaging in harm reduction activities. The groups differed on two of the discriminating ideology variables: HIV/AIDS harm reduction ideology ($F = 5.6, p < .05$) and the variable reflecting clinical managers' beliefs in the efficacy of the AA/NA model ($F = 8.7, p < .01$). In addition, the groups significantly differed on two of the control variables: the percent of IDU clients ($F = 23.1, p < .0001$) and extent to which the unit has resources to provide HIV/AIDS prevention services ($F = 28.9, p < .0001$) (Table 1). Box's M was statistically significant, indicating that the assumption of equal covariance matrices may have been violated (Table 1). It is important to note, however, that Box's M may be overly sensitive to heterogeneity and should be considered in the context of other information about the study sample (Olson, 1974). More specifically, greater concern about covariance heterogeneity is warranted when sample sizes are small or when sample sizes for the two groups are dissimilar (Huberty, 1984). Neither of these conditions exists in the current study. Moreover, the linear discriminant function has proven to be robust to violation of assumptions of equal covariance matrices and normality (Hair et al., 1992; Stevens, 1992).

Overall, the discriminant function was statistically significant [$\text{Chi}^2(12,0) = 54.95, p < .0001$]. Thus the two groups--harm reduction and no harm reduction--differ on the discriminating scores and group centroids. However, the eigenvalue for these data, .39, suggests the discriminant function is not very powerful. Similar to the eigenvalue, the canonical correlation coefficient (R^2) is a measure of association between the groups and the discriminating scores (Hair et al., 1992) (Table 2). When squared the canonical correlation coefficient (R^2) reflects the proportion of the variance in the discriminant scores explained by the groups. For these data, R^2 (1- Wilk's lambda) is .28, suggesting the discriminant function is only marginally powerful.

Table 2 also presents the discriminant loadings that suggest the relative importance of each discriminating variable to the discriminant function. Hair et al. (1992) suggested loadings of .30 and above should be used as the cut-off criterion for meaningful loadings. For the present analysis three variables met this criterion: percent of IDUs (.59), resources for HIV/AIDS prevention (.65), and managers' perceptions that the AA/NA model is effective (-.36). As expected the loadings for these variables indicate that OSAT units with larger proportions of IDU clients and with more resources for HIV/AIDS activities were more likely to be in the group involved in HIV/AIDS harm reduction practices. Also as expected OSAT units were less likely to be engaged in such practices in which managers agreed more strongly that the AA/NA model is an effective approach to substance abuse treatment.

Like discriminant loadings, standardized discriminant function coefficients (b) can be used to determine the relative importance of each discriminating variable to the discriminant function (Hair et al., 1992) (Table 2). When this procedure is used, important discriminant coefficients are determined by dividing the value of the highest coefficient by two. For these data the "importance" criterion is .29 or one half the value of the coefficient for "resources to provide HIV/AIDS services" (.58). Coefficients for other variables equal to or greater than .29 are considered important to the discriminant function. With this method the following variables can be considered important to the discriminant function: HIV/AIDS harm reduction ideology (.33), abstinence is important treatment goal (-.36), percentage of IDU clients (.52), and resources to provide HIV/AIDS services (.58). Similar to the findings for the discriminant loadings, OSAT units are more likely to be involved in HIV/AIDS harm reduction practices when they have higher percentages of IDU clients and more resources to provide HIV/AIDS prevention services. In addition, OSAT units also are more likely to be in the harm reduction practices group if managers more strongly endorse the harm reduction ideology. By contrast, OSAT units are less likely to be in this group if abstinence is more strongly endorsed as an important treatment goal by managers. Hair et al. (1992) indicated, however, that discriminant function coefficients are less stable than discriminant loadings and should be interpreted more cautiously.

Using the discriminant loadings, the following discriminant function can be calculated:

$Z = .65$ (resources for HIV/AIDS prevention) + $.59$ (percent IDU clients) + $-.36$ (AA/NA model is effective), where Z = the discriminant function and .65, .59, and $-.36$ = significant structure coefficients, respectively.

Overall, the discriminant function correctly classified 72.41 percent of the cases. Using an improvement-over-chance index (I), which is a version of Cohen's Kappa (Cohen, 1960), the improvement over chance as indicated below is

$$I = H_o - H_e / 1 - H_e = .72 - .50 / 1 - .50 = .22 / .50 = .45$$

where H_o is the observed hit rate, and H_e is the rate expected by chance. Thus the model improves over the chance classification of cases by 45 percent.

Hair et al. (1992) suggested that an adequate discriminant function will accurately classify cases at least 25 percent better than random assignment of cases. Thus, the discriminant function for these data meets this criterion.

DISCUSSION

This article reports findings of an effort to examine empirically the influence of ideology on the delivery of preventive services aimed at reducing the spread of HIV/AIDS among clients in OSAT programs. Although the model presented in this study is only marginally effective in discriminating between groups, it is consistent with the hypothesis that ideology influences the provision of harm reduction services in OSAT units. Specifically, OSAT units that provided harm reduction HIV/AIDS prevention services to their clients tended to have clinical managers that supported such practices. In contrast, units that did not provide harm reduction-related services tended to have clinical managers that embraced abstinence-based ideologies of care. Thus, harm reduction activities may be more sensitive to the influence of abstinence-based ideology than HIV/AIDS education (Clapp & Burke, 1997). In addition to ideology, the availability of resources to address HIV/AIDS prevention issues is an important factor determining whether such programs engage in harm reduction practices. Client characteristics also are related to the likelihood that a unit is engaged in harm reduction practices as indicated by the fact that units serving higher percentages of IDU clients are more likely to be involved in harm reduction efforts. Given the fact that these findings are based on a subsample of 1990 DATSS respondents, caution should be exercised in generalizing from these findings to OSAT units overall.

Des Jarlais (1990) and Bayer (1991) have both argued that the substance abuse treatment field was slow to respond to the HIV/AIDS epidemic during the late 1980s. In contrast, the data presented here indicate that by 1990 when these data were collected, a majority of OSAT units dedicated to the provision of HIV/AIDS prevention services were engaged in at least one type of harm reduction practice.

It is important that future research continue to examine the nature and extent of involvement by substance abuse treatment settings in HIV/AIDS prevention. Such settings are vital points of contact for people who remain at high risk of HIV infection and tend toward a poorer prognosis once infected. It would also be interesting to continue to monitor beliefs about harm reduction efforts in the context of a service system that traditionally has been dominated by abstinence-oriented treatment beliefs and practices. It is possible that the HIV/AIDS epidemic over time has changed beliefs about the efficacy of abstinence-based models or increased the acceptability of

harm reduction approaches. Such a shift may have important repercussions, not only for HIV/AIDS prevention efforts, but also for substance abuse treatment.

The notion that ideology has both theoretical and practical significance to HSOs has widespread appeal. Too little empirical research has yet been conducted, however, to determine adequately how much and in what way ideology impinges on the behavior and performance of HSOs. Ideology remains a difficult concept to define, operationalize, and measure. Future research on ideologies of care must strive for greater conceptual clarity about the study of practice ideologies or ideologies of care. Too little is yet known about the extent to which providers are indeed guided in their work by a coherent set of ideals or beliefs "about the right thing to do for clients." Perhaps even more important is the issue of how best to ascertain the extent to which particular ideologies of care hold sway in various human services organizations and fields of practice. Should the study of practice ideologies focus on beliefs and practices held by individuals who work in human services organizations, or should such studies rely on analysis of documents reflecting organizational policies and practices?

Future efforts to describe ideologies of care will also benefit from more directly distinguishing between beliefs about practice (that is, what "should" be done for clients) and actual practice behaviors. Of course, further research on both practice beliefs and practice behaviors is important, and a good deal could be learned from determining the extent to which practice behaviors are indeed in sync with practice beliefs. Further clarification also is warranted in distinguishing among beliefs about the "means and ends" of practice with clients. Beliefs about "the right things to do for clients" encompass beliefs about goals and outcomes of care for clients, as well as beliefs about how such goals or outcomes can best be obtained (Heaney & Burke, 1998). Further development and refinement of tools to catalogue practice ideologies in substance abuse and other social work settings also is warranted. Findings in this article represent a modest but intriguing step toward redressing the lack of empirical study in this area.

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TABLE 1--Summary Statistics for Discriminating Variables by Type of HIV/AIDS Practice

Legend for Chart:

- A - Discriminating Variable
- B - Group Means/Harm Reduction
- C - Group Means/No Harm Reduction

A	B	C
Drug-free image	9.3	9.2
Hire recovering staff	10.4	11.4
HIV/AIDS harm reduction ideology	13.4	12.0[*]
AA/NA model effective	3.9	4.2[**]
Abstinence important treatment goal	4.8	4.9
Responsible AOD use not important treatment goal	4.1	4.3

Hiring based on regulation	3.1	3.3
Treatment goals based on regulation	1.8	2.1
QA plan based on JCAHO	3.3	3.3
Percent IDU clients	32.1	12.4[***]
Percent multiple drug-using clients	63.6	60.1
Resources for HIV/AIDS prevention	8.6	6.4[***]

NOTE: Possible n = 328; n for analysis equals 174 because of listwise deletion of cases with missing values. Box's M test for equality of group covariance matrices = 140.23.

AA/NA = Alcoholics Anonymous/Narcotics Anonymous; AOD = alcohol and other drugs; IDU = intravenous drug user; QA = quality assurances; JCAHO = Joint Commission on Accreditation of Health Care Organizations.

[*] p < .05.

[**] p < .01.

[***] p < .001.

TABLE 2--Discriminant Function 1, Group Centroids, and Model Summary Statistics

Legend for Chart:

A - Variable Centroid

B - b

C - s

	A	B	C
Drug-free image		-.09	.02
Hire recovering staff		-.07	-.24
HIV/AIDS harm reduction ideology		.33	.29
AA/NA model effective		-.21	-.36
Abstinence important treatment goal		-.36	-.20
Responsible AOD use not important treatment goal		-.08	-.08
Hiring based on regulation		-.07	-.10
Treatment goals based on regulation		-.26	-.13
QA plan based on JCAHO		-.03	-.01
% IDU clients		.52	.59
% Multiple drug-using clients		.27	.09
Resources for HIV/AIDS prevention		.58	.65

Centroids harm reduction = .57; no harm reduction = -.68

Eigenvalue = .39; R² = .53; Wilk's lambda = .72

NOTES: b = standardized discriminant function coefficients;

s = within groups structure coefficients; QA = quality

assurances; R² = canonical correlation coefficient.

N = 174; p < .0001.

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