COUNSELING DROP-OUT STUDY ON HARD TO REACH POPULATION

Christine Donohoe
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COUNSELING DROP-OUT STUDY ON HARD TO REACH POPULATION

A Project

by

Christine Donohoe

Approved by:

_____________________________, Committee Chair
Francis Yuen, DSW

______________________________
Date
Student: Christine Donohoe

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__________________________, Graduate Coordinator       ________________
Teiahsha Bankhead, PhD., LCSW                Date

Division of Social Work
Abstract

of

COUNSELING DROP-OUT STUDY ON HARD TO REACH POPULATION

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This study investigated factors associated with treatment completion and client drop out. The researcher sought out to gain a better understanding of why individuals do not complete treatment after they agreed, and what characteristics or variables are associated with individuals who do not complete treatment. This is a needs assessment using secondary data analysis and a focus group to validate and extrapolate information for service enhancement. The secondary data was demographic referral data. The researcher used a Data Collection form to extract the needed information from the records. The data displayed that the majority of the clients referred are low-income women of Hispanic origin and of childbearing age, and referred in the months March, April, May and October and on the waiting list for an average of 10 weeks. The focus group validated the findings based on the service records. Recommendations of specific research questions for future studies and areas that should be included in service records are included.

_______________________, Committee Chair
Francis Yuen, DSW

_______________________
Date

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Chapter 1
INTRODUCTION

A very large part of what social workers do is direct service. The majority of direct services is voluntary therapeutic services. What good can a social worker be if his/her clients do not show up? What is it about the process that it is deterring your clients from showing up and how can we change that process so that more people can receive services. Many social workers and helping professionals come across the issue of dropout, premature termination and no shows, and working with different populations will bring about different reasons for not showing up. Especially in the current economic climate it is important to be as thorough as a possible for funding reimbursement reasons and the personal therapeutic advantages. It is important to try and get a better understanding of what happens and why some potential clients don’t show up so that you can try and prevent it from happening.

This study aimed to investigate factors associated with treatment completion and client drop out. Treatment completion is a serious problem. There is a large population of people in the researchers community and elsewhere that are agreeing to therapy or treatment, and then for different reasons, never showing up or, not completing on the agreed upon sessions. The researcher wanted to gain a better understanding of why individuals do not complete treatment after they agreed to, and what characteristics or variables are associated with individuals who do not complete treatment, as to try and identify individuals who are high risk for dropout. The problem being is that this dropout population represents a large number of people in the researcher’s community. The individuals sought therapy and now are not getting the services they requested. With
resources being limited individuals who do not complete treatment take up clinician’s
time, backup the waiting list, keep others who are also waiting to wait longer and thus
costing agencies money.

**Background of the Problem**

The literature states that premature termination is a problem in therapy for
children, couples, adolescents, and adults. Treatment completion is also a significant
issue in the substance abuse treatment population and domestic violence treatment
population. The researcher wishes to gain a better understanding regarding the hard to
reach high-risk dropout population within the researcher’s community. The goal is to
make the researcher’s agency and community more efficient regarding this population.

**Statement of the Research Problem**

The researcher is assuming that the potential consumers well being will be
improved if they do receive services. Assuming that the referrals were made properly and
also assuming that seeking professional help is not a common practice for the likely
potential consumer. The local agency has attempted to address the issue of premature
termination by working with other referring agencies in the community to screen more
efficiently. However, there has been minimal improvement. The central issue being that
the agency and staff are faced with very lengthy waiting lists, budget constraints and
client concerns. The agency and the researcher wish to gain a better understanding of the
identifiable characteristics or variables that make up the premature dropout population.
The agency in which the referrals are coming from, is the agency that percentage wise
refers the most clients to Family Service of Napa Valley and also percentage wise refer
the most clients that dropout or prematurely terminate services. The majority of the population are female, mothers, single income households, Hispanic, Spanish speaking and around the age of 35-45. The agency and the researcher wish to reach this population and learn how to serve them more efficiently. Also, to better understand what is keeping some of the individuals from not showing to therapy after they had an agreed upon referral.

**Purpose of the Study**

This was a needs assessment using existing service records for secondary data analysis. A focus group of agency staff is also used to validate service record findings and further extrapolate information for service enhancement. The secondary data were service and referral data in the Family Services of Napa Valley (FSNV). These data are collected and organized as service records. This researcher used a data collection form to extract the needed information from the records. After all of the data was collected the researcher conducted content analysis and use appropriate statistical analysis to analyze the data. The study indentified the major contributing variables or issues that are related to the drop out or refusal to utilize services. Based on the findings, literature and focus group recommendation, the researcher developed further study recommendations and program extension recommendations based on the need of the drop out population.

**Theoretical Framework**

The dropout population that is being studied is made up of mostly women, Hispanic and head of the household (i.e. single mothers). The theories being used to inform this study are ecosystems theory and family systems theory. Ecosystems theory is
unique in that it encompasses three different levels of human interaction. The ecosystem levels are the micro, being interpersonal relationships and interactions; the meso, the interactions at the community and agency level and the macro level being your interactions with government and policy structures. The theory states that the levels of interaction are interrelated with the individual being the focal point and each level of interaction plays a more integral role depending on the person (Voydanoff, 2010).

Family systems theory as part of ecosystems is a theory that looks at the individual or consumer and places them in a context of who they are in their life. Family systems theory also allows the researcher to take a look at the consumer and their interactions at the different levels as part of a system and not just an individual. The theory is a useful theory especially when working with men and women of multi-cultural backgrounds that place a high importance on the extended families (Corey, 2008).

**Definition of Terms**

Prematurely can be defined as occurring, coming, or done too soon, dropping out or no show can be defined as a person who with draws from a competition, job, task, etc, counseling services can be defined as, professional guidance in resolving personal conflicts and emotional problems and referral can be defined as a person recommended to someone or for something, consumer could also be defined as a person or organization that uses a commodity or service (Dictionary.com, 2010).

In regards to this research project, consumers as it is defined for this study are any persons referred in the year 2009, to Family Services of Napa Valley for counseling, therapy or treatment services. The study is focusing on referrals made from a local
agency health clinic named Clinic Ole. The term dropping out, or premature termination as it pertains to this study, is any persons or consumer from the stated agency who was referred for counseling, therapy or treatment services and did not show up for the first appointment and/or did not return to the second as well as could not be reached (because of i.e. insufficient contact information), consumer definition as it will pertain to this study is any person who is seeking mental health therapy services.

**Assumptions**

There could be a number of possibilities why these consumers decide to not continue with the services they agreed upon. The researcher has two main assumptions about why the consumers prematurely dropout. The first assumption being that the consumer sought the services in the midst of a crisis or emergency, after the initial referral was made, the consumer would have been called by a masters level social work intake therapist with the agency from there, the consumer is placed on the waiting list and called for counseling on a first come first serve order. The assumption being that by the time the consumer was called for therapy the urgency of their situation had subsided and the consumer no longer felt the need for services.

**Justifications**

The study conducted will benefit the social work community of the Napa Valley as well as, add to the knowledge base that already exists regarding premature termination. The study will hopefully give the clinicians a better understanding of who represents a high-risk dropout, and allow the clinicians to confidently plan.
Limitations

The study conducted has some limitations. The study findings were produced using statistical analysis of the dropout client data as well as a professional focus group. The researcher does not however have access to the clients themselves. So the direct question of “why” or “what” were the reasons or circumstances behind your premature termination” were not asked.
Chapter 2
LITERATURE REVIEW

There are many different reasons why someone would seek out services and then not follow through. It is the goal of this review of the literature to try and get a better understanding why someone in the referral stage or currently participating in treatment would prematurely dropout. Another goal of this review of the literature is to emphasize that treatment dropout is a significant problem in the mental health field. In a review of the literature (Backeland & Lundwall, 1975) regarding premature dropout, dropping out after the first session was as low as 20% and as high as 57% of the total clinicians intake client base and among certain populations as high as 65%. That is an alarming statistics. The statistic is even more alarming because recent research has concluded that 50%-60% of mental health consumers should participate in 11 of 13 sessions of evidence-based interventions in order to be considered recovered (Hansen, Lambert & Forman, 2002). That statistic means that there are a lot of mental health consumers that aren’t getting adequate services. Premature dropout doesn’t only negatively impact the consumer or consumer system trying to access services. Prematurely dropping out wastes staff time, denies access to others in need, adds to the waiting lists and could potentially change the community’s perception of the agency and their ability to provide services (Barrett, Chua, Christophe, Gibbons & Thompson, 2008).

Other important contributing variables that the researcher is going to discuss in regards to completing treatment are demographic data such as age and gender as well as clients perceptions and motivation to complete. The variables associated with a child non
completer are very different from a teen or even an adult. This review of the literature will also discuss some of the treatment non-completion contributing factors associated with being a person with substance abuse issues, person with a mental health diagnosis, domestic violence victim or perpetrator, sexual assault victim, being a mother and what a huge factor motivation can have on whether you complete treatment or not. The researcher will also be trying to discover what some of the high risk variable trends throughout these studies for consumers that prematurely drop are.

The research on this topic is extensive. However the current available research is very narrow in subject nature. The majority of available treatment dropout studies are in the field of substance abuse and are not ethnically or gender diverse. The picture the literature paints is scattered and very unclear. Each study is tailored for their population and need; major limitations being ungeneralizability of the studies and a lack of consistent operational definitions. Meaning, the term dropout means something different in each study. When trying to take a look at premature drop out and the bigger, it is difficult to get a clear understand without a consistent definition.

The study that the researcher is performing is in the field of mental health psychotherapy and with a population of mostly Hispanic women, a study that appears to be unique. However, using the literature and the study the researcher hopes to gain a better understanding of who is at risk for prematurely dropping out or not completing treatment. With that information the clinicians will hopefully have a better understanding of what to do to try and combat the problem of premature dropout. With drop-out
statistics as high as 65%, nonprofit donors and (Castaneda, Garen & Thornton, 2008) the competition for resources up it is as important now as ever.

**Age as the Prominent Contributing Variable**

Each client comes in for treatment or therapy at a different time in their life and that also means at a different age. The variable age as well as other demographic data is being used in the current researchers study. In some cases age was proven to be a helpful variable regarding treatment completion. Buttell and Carney (2002) who were attempting to identify the differences between treatment completers and treatment dropouts, using psychological and demographic variables among court ordered domestic violence batters. The domestic violence batters were currently participating in an outpatient treatment. Buttell and Carney found that treatment dropout was unrelated to any of the demographic data used except age and referral source. The mean age in the study was 34 years old, the mean age of completers was 36 and non-completers 30. The study conducted by Buttell and Carney was conducted using a means of secondary data analysis, the variables tested were pulled during the referral stage and using the findings a logistic regression model was developed and the team was able to predict treatment dropout in nearly 75% of the sample. Although in the end 93% of the men referred to the program never actually completed and remained at a high risk for abusing again but, the program was forever impacted.

The study by Buttell and Carney does not stand alone. Gerlock (2001) conducted a study attempting to identify how treatment completers and non treatment completers compare for domestic violence batters. Gerlock identified that age, employment and court
mandated status characterized treatment completers versus non-completers. The mean age for the treatment completers was 33 and the mean age for non-completers was 42. In this study age was still a major predicting variable however it differed from that of Buttell and Carney in the way that the completers were younger men. Gerlock also did something different in that she incorporated the stories of the victims to try and get a better picture of the relationship between the abuser and the victim. Gerlock also through her findings created a logistic regression model that predicted 88% of non-completers, 78% of the completers and had an overall predictability for the study sample of 84%. Another program that will be difficult to generalize to programs outside its own however, it is having an impact on the needs of the local domestic violence treatment community.

Court mandated influence and age seems to be identifiable variables when attempting to predict who will complete domestic violence treatment. However not all court mandated programs are centered on domestic violence abuse. Hickert, Boyle and Tollefson (2009) who were attempting to identify factors that predict adult felony drug court completion and drop out. Hickert, Boyle and Tollefson differed from the domestic violence study in that the demographic variables were controlled for and the researchers and they found that the consumers who were most likely to dropout were suffering from depression, stimulants were their drug of choice, they chose to spend their free time alone or with friends and tend to have a more extensive criminal history. The researchers also concluded that the variables that predict treatment completion were older age at intake and spending free time with family as opposed to being alone or with friends. The study conducted by Hickert, Boyle and Tollefson brought up a very important component and
that is ones support system and positive relationships. Maulik, Eaton and Bradshaw (2010) examining the effect of positive social support systems of consumers with diagnosed mental health disorders, found that having friends, families, significant others around decreased the likelihood of symptoms like panic attacks and other psychological symptoms. Furthermore, Hickert, Boyle and Tollefson also created a model that correctly predicted 65% of graduated sample and 73% of dropouts in their sample.

Substance abuse doesn’t only impact adults, it also has a great impact on adolescents, in fact 2009 42% of high school students reported periodic use of alcohol and binge drinking and 21% of high school students reported they have used marihuana and 20% of high school students admitted to using prescription drugs in 2009 (CDC.gov, 2010). Where there is an adolescent struggling with substance abuse there is a family struggling with that adolescent’s problem. Hickert, Boyle and Tollefson touched on the importance and the impact of the family support structure. A recent study conducted by Liddle, Dakof, Turner, Alexander and Kogan (2006) goes more into depth the importance of a positive relationship, but differs in that the study is attempting to identify the importance of the relationship between the adolescent and the therapist as well as the relationship between the mother and the therapist. The family systems were participating in multidimensional family therapy for adolescents who abuse drugs. The goal of the study was to try and identify variables demographic in nature and relational in nature to predict treatment completers and treatment dropouts. The study concluded that adolescents who dropped out were on average older, and they reported less internalizing and externalizing symptoms than those who completed treatment and the dropouts were
also reported by their parents to have less externalizing symptoms. The study however pointed out the strength of the therapeutic relationship. The study concluded that the therapist must have established therapeutic rapport with both the child and the parent involved by the 1st or 2nd sessions to be able to predict the family’s risk of dropping out of treatment. Having a strong therapeutic rapport is important when working in a helping profession. Johansson and Eklund (2007) trying to distinguish identifiable variables of psychiatric non-completers versus completers, the researchers found that the strongest correlating variable distinguishing the two were the lack of rapport, the lack of the working relationship between the staff and the non-completers.

Substance abuse transcends gender lines, age lines and in the same way the epidemic of substance abuse transcends socioeconomic status. Unfortunately, due to access of resources and for many other reasons the substance abuse issue seems to be more prominent in lower socioeconomic minority populations. In the year 2000 Black or African Americans made up 12% of the US population and also made up 8% of the substance users. The statistic is even more alarming for the American Indian or Native American population. The Native American population makes up .1% of the population in the year 2000, but make up 12% of the substance abuse population (US Census, 2000). Non-completion is a major problem in the substance abuse treatment community (Weisner et al., 2001). In a study conducted by Vendetti, McRee, Miller, Christiansen, Herrell & The Marijuana Treatment Research Group (2002) who aimed to identify consumer characteristics and other variables that could be associated with treatment non-completion. The researchers found that variables associated with treatment non-
completion were age, being unmarried, unemployed, less education, Asian American or Native American and also associated with self perceived dependence. The substance abuse literature and more specifically marijuana users literature seems to paint a picture of a treatment non-completer as being of poor insight of their issue, coming from a background of lower socio economic stature and lacking a positive support network and that conclusion is consistent across the literature as verified in a study conducted by Weisner et al. (2001) whose research also stated that the variables that correlate with treatment completion are higher socioeconomic status, external pressures and consumer’s perception of completion importance and willingness to change.

**Gender as the Prominent Contributing Variable**

Just as one’s age has a bearing on life’s circumstance, so can one’s gender. Being a woman or a man can drastically change the responsibilities you have. The correlating variables of why one would not complete a treatment could very much be a direct contribution to the role that is played at home or in society. When one thinks of domestic violence perpetrator, one usually pictures that perpetrator being a man and in fact there are treatment programs out there for aggressive women, not just men. Female victims of domestic violence make up 84% of the domestic violence community (Matthew R. Durose et al, 2005) and that leaves 16% for victims of women and same sex partner victims. The nature of the subject goes against how society pictures domestic violence. However, the issue is still very real; women abuse their male partners as well as their female partners. Tutty, Robins-Wagner and Rothery (2006) conducted a study, compiling demographic data on 64 women who began a domestic violence treatment group. After
the treatment group had finished the researchers compared the data of the completers and the non-completers. Tutty, Robins-Wagner and Rothery used pre, mid and post test evaluations to measure the demographic and psychological variables. The treatment completers were found to have improved in the areas of non-physical abuse of partner (e.g. verbal or emotional), stress, contentment, self-esteem and assertiveness. The report stated that none of the demographic data such as age or length of relationship showed any statistically significant difference between completers and non-completers. The women who completed the group found support in one another and improved in the areas stated above.

Much like domestic violence being male dominated so is substance abuse. For instance, a study conducted by Arfken, Klein, di Menza and Schuster (2000) sought to find out the gender differences and problem severity at assessment and the impact the gender difference had on treatment completion or non-completion. Men tend to make up the substance abuse population by about 70%-80% (Kendall, 1988). Arfken, Klein, di Menza and Schuster found that women had more severe problems at the time of assessment. The severity of the women’s situation was scored using The Addiction Severity Index. The variables in which women scored more severe on than the men on were drug, alcohol, medical, psychiatric, legal, family, social and employment issues. Although, women were the minority in the study sample they made up the majority of the treatment non-completers. Women made up 27% of the study sample and 76% did not complete the treatment.
As stated before being a woman has its societal role and responsibilities and being a mother does also. What impact could a women’s family status have on the completion of substance abuse treatment? Lennox, Rose, Bohlig and Lennox (2000) asked that very same question in a study that examined the role of the family status and compared other demographic data to try and identify what variables correlated to completing an intense outpatient treatment. The study concluded that the variables that correlated to treatment non-completion were being pregnant, having children, being African American, receiving detoxification treatment, drug is the substance of choice, being substance dependent and being under the age of 21. The study also concluded that the variables associated with treatment completion were being African American and having your children in the foster care system. The women who were more likely to complete treatment were getting support through the foster care system and motivated to get their children back. This study is one of the only studies that discussed race or ethnicity as a demographic variable. The access to resources and the socioeconomic factor correlate. In 2000 22% of African Americans in the US were living under the poverty threshold compared to 9% of Caucasians. An alarming statistic when one figures African Americans makes up 12% of the population and Caucasians almost 75% (US Census, 2000).

Women have different social stressors and it is also equally important to understand the social stressors of women of different ethnicities. It is known that African Americans and other minorities do not have equal access to resources. A possible reason as to why women drop out of treatment and more specifically women of color at such high rates is because not all substance abuse treatment are sensitive culturally or to
different genders (King & Canada, 2004). The programs are not created to fit the needs of women or women of different cultures. In a very thorough study conducted by King and Canada (2004) who aimed at identifying client related predictors of early treatment drop out in a substance abuse clinic. The substance abuse clinic was conducting individual therapy in an outpatient medical setting. The researchers discovered that only 39% of the women that started actually engaged in the therapy. A sad statistic when compared to the 74% of the men who engaged. The researchers also discovered that the variables that correlated to non-completion were again low education levels, African American, female, cocaine as the drug of choice and being referred by an outside source. Women aside, the study concluded that African Americans were 5 times more likely to not complete treatment than a Caucasian. The study conducted by Arfkin, Klaien and Schuster stated that many of the women’s problems were more severe at intake. Taking into account that 25% to 38% of girls are sexually abused before they are 18 (Alexander & Lupfer, 1987), in the year 2000 3.4 million families in the US were that of single mothers (US Census, 2000) and women still $.76 to every $1.00 (US Census, 2004) that a man makes and even among college graduates men makes $7,000 a year more on average than women (Bobbit-Zeher, 2007), the problem severity begins to make more sense. There does appear to be adequate reasons or assumptions about why non-completion statistics are so high among women and why women’s problems are more severe at intake.

Women who have been abused or women who have been diagnosed with a mental health disorder face many of the same obstacles completing treatment as women who haven’t been abused or been diagnosed with mental health disorder. In a study comparing
treatment completers and treatment dropouts composed of women survivors of child sexual abuse by Fisher, Winne & Ley (1993), the study evaluated women survivors in an adult women’s survivors group. The study aimed to examine different characteristics and variables that correlate to the completion or non-completion of the group. The majority of the women in the group were mothers, living in poverty, had sought mental health services in the past as well as attempted suicide in the past. The study concluded that the women who did not complete the treatment group were battered as children, sexually abused from within their family of origin and also appeared to be more involved and less capable to remove themselves from their current abusive relationship. The women who completed the program were more likely to have been abused from within their family origin and also abused outside of their family. This study goes onto show the degree of difficulty some women have faced in their lives and the resilience and strength that has to be called upon to be a part of a group, to have the insight and motivation to want to heal.

Although, there have been many studies on completion and non-completion rates in substance abuse treatment centers and mental health centers, there has been little research on the dropout rates among married couples. The most recent study found on predicting marital therapy dropouts conducted by Allgood and Crance (1991) purpose was to try and identify variables that could help the clinicians recognize couples that were at high risk for non-completion. The researchers felt that if they could identify couples that were at high risk for non-completion they would be able to create a treatment plan that could better prepare the couple from the beginning and hopefully engage them in the process of therapy or identify from intake if the couples are ready for therapy. The
variables the researchers were able to find that could help them identify if a couple was high risk for not completing treatment were having a male intake clinician and having a presenting issue relating to individual or family issues. The researchers found that the couple was less satisfied with their treatment if there therapist was an inexperienced male therapist. Of the couples that came into treatment that received an inexperienced male therapist 82% did not complete the treatment. The couples came into therapy for one reason or another, but interestingly enough all couples who did not complete treatment came to that decision as a team. This study put a different slant on gender as a contributing variable. There are many different reasons why a possible couple would not want to continue therapy with a male, the researchers that conducted this study felt it was the anxiety that it created. That men are naturally less expressive and women more nurturing and admitting marital problems to a male create more anxiety and that helped contribute to the non-completion of treatment.

**Motivation as the Prominent Contributing Variable**

There are many different reasons why someone would be motivated to complete treatment. Whatever the reasons maybe motivation is a powerful tool when facing a difficult challenge. In a study conducted by Wickizer, Maynard, Atherly, Frederick, Koepsell, Krupski and Stark (1994), the researchers were trying to analyze completion versus non-completion rates in a drug and alcohol abuse treatment program and identify variables associated. The study consisted of two groups, inpatient and outpatient. The study concluded that completion rates were highest at 75% for inpatient alcohol treatment and the lowest for outpatient drug treatment. The researchers learned the importance of
goodness of fit. The importance of a consumer being in a treatment facility that matched what they were trying to achieve, a place where they can be motivated to complete their goal.

Goodness of fit is great, but what if you don’t have a choice? And a consumer is court mandated into treatment and the consequence for non-completion is incarceration. For some avoiding incarceration would be motivation enough, but not for everyone. In a study conducted Evans, Li and Yih-Ing (2009) the researchers studied client factors associated with non-completion in a court mandated Prop-36 program. Prop 36, also known as the Substance Abuse and Crime Prevention Act. Prop 36 was designed to allow 1st and 2nd time drug possession offenders without a violent criminal history, the choice to go into substance abuse treatment instead of incarceration (Prop 36, 2010). The researchers set out to understand why court mandated drug offenders were not completing treatment and wanted to compare variables with those who were completing treatment. The researchers got interesting results, the researchers did not only compare demographic data, but they also gave a pre and post questionnaire to all completers and non complters. The questionnaire asked questions regarding what the consumers felt were the major barriers to not completing treatment or completing treatment. The researchers found that at intake non-completers were more deeply involved with the criminal justice system, had sever employment and mental health problems, the substance of choice was drugs and most commonly and notably non-completers reported facing difficulty in the program and expiring a lack of or very low motivation. They also found
that the majority of completers were living at home with dependent children during course of treatment.

One would think being incarcerated would be the epitome of mandated treatment. However, that is not the case. There are programs and skills trainings that an incarcerated individual has the option to complete that can help them. Not all programs are alike and much like therapy or substance abuse groups, programs for individuals incarcerated have issues with attendance as well (McMurran & McCulloch, 2007). In a study conducted by McMurran and McCulloch (2007) the researchers noticed that those inmates who completed the Enhanced Skills Training or ETS, were less likely to experience recidivism after being released back into society. ETS is a structured cognitive behavioral treatment program helping the incarcerated individuals work on skills like antisocial attitudes, anger management, critical reasoning etc. The researchers set out to find the variables that correlated with treatment non-completers and treatment completers. The researchers used pre and post structured interviews as well as demographic data in their study. The researchers concluded that among the variables that correlated with treatment completion the most prominent one was that completers were motivated to stop offending and motivated for treatment. The non-completers found it particularly difficult to work in a group like setting and suggested to the researchers there be one-on-one support session especially early in the beginning to help the individuals with coping with difficulties of the program.

Understanding the consumer’s perspective gives another dimension to understanding why someone who has entered into treatment does not complete. In a
recent study where the primary data was the consumers perspective conducted by Ball, Carroll, and Rounsanville (2006) the researchers wanted to gain a better understanding why the consumers were not completing treatment, but from their perspective. The researchers interviewed the consumers who completed treatment and consumers who did not with a formulated questionnaire. The researchers found that along with some of the demographic variables that identify treatment non-completers there were also issues with motivation and ability to complete treatment. The consumers who did not complete treatment also felt there were boundary issues regarding privacy during treatment.

Substance abuse is not the only field of treatment where motivation is needed. Motivation can be very useful while participating in therapy. Therapy in nature is set up differently than substance abuse treatment. Therapy usually has an open or close ended amount of sessions and ending once a goal has been achieved. However, consumers can prematurely terminate therapy and it is done in many of the same ways as terminating substance abuse (e.g. no show). It is understood by clinicians that not all consumers can participate in every session and not every consumer who misses a session has a disadvantageous outcome (Sheeran, Kellet & Aubry, 2007). In a study conducted by Sheeran, Kellet and Aubry (2007), the goal of the researchers were to try and increase psychotherapy attendance. The researchers created an intentions questionnaire, a questionnaire that was aimed at finding out the extent to which the consumer was motivated to attend the psychotherapy sessions. The researchers found that consumers who formed intentions to participate were more likely to complete. The researchers also found that consumers who formed intentions and returned the questionnaire were even
more likely to participate and complete. The consumers who completed believed that attendance would be beneficial to their growth as opposed to the consumers who did not complete were struggling with negative feelings (e.g. shame).

Motivation of the client has been studied to be a predictor of positive outcome. However, in the instance that the client is a child, the motivation to continue in treatment is not the choice of the child alone. The parents must want to follow through with treatment and can terminate at anytime depending on the setting. The dropout rate for children is still very high paralleling that of adults ranging from 47%-70% (Wizerbicki & Pekarick, 1993). The studies regarding treatment non-completion rates of children are very scarce and in fact only 1%-2% of all studies conducted on non-completion are focused on children (Kendall & Sugarman, 1997). In a study conducted by Chasson, Vincent and Harris (2008) the researchers used a symptoms severity measurement tool just before termination to try and predict the non-completion rates of their children consumers. The researchers found that avoidance was the key variables for the children not completing treatment. The findings from the study showed no correlation between any of the demographic data and completing or not completing the treatment program. The researchers felt that by dropping out of treatment the child, or parent would be avoiding the stressful situation that is causing the family anxiety. The researchers also discovered that in the majority of the children who did not complete treatment the decision was made by the parents. The therapy could have been more anxiety producing for the parents then it was for the child. This study showed that although the children were participating in the therapy, the motivation of the parents and the influence of the
parents to continue had a major factor on completing the treatment. The researchers noted that for further study, using avoidance behavior as a variable might be useful in predicting treatment dropout. One’s own internal motivator sometimes cannot be enough when faced with difficult situations, sometimes the influence and coercion of people we care about really can have weight on the decisions made. However, not all of those decisions appear to be for the better. One aspect of this study that could have been included and would have made the findings more clear was the child’s perspective and knowing if the child wanted to continue with the therapy or not.

Limitations in the Literature

From the researchers point of view the biggest limitation the current research has is that the picture the literature paints is confusing. The subject nature of the studies is very narrow. The majority of the studies found were regarding dropout statistic in the field of substance abuse treatment. Although, many of the studies discussed here are different the output is generally the same. Each study is enacted based on a need, a need of a specific population and for a specific agency. Each agency using their own data and tools to formulate their outcome and that makes the overall generalizability very difficult. The outcome that the different studies produced appear to have made a lasting impact and some agencies have come up with great screening tools and tips for ways to identify variables that correlate with consumers that are at high risk for not completing treatment, but tools created appear to be only useful for their agency alone.

Another major limitation that was mentioned in many studies was the fact that operational definitions for high risk for not completing treatment are not consistent
(Pelkonen, Marttunen, Laippala and Lonngvist, 2000; Sheeran, Kellett, Aubrey, 2007; Baruch, Vrouva & Fearon, 2008). Not only are the operational definitions of what it means to be high risk for not completing confusing so is the terminology. The terminology used are dropout, prematurely dropping out, premature termination, early termination, high risk for dropout, not completing treatment, attrition, negative attendance and incompliance and for the sake of this review of the literature all pertain to the same subject. In every study that was used for this review of the literature not-completing treatment or premature dropout carried different definitions and this change the reliability between each study a great amount. In a study conducted by Baruch, Vrouva and Fearon (2008) attempting to identify characteristics of adolescents that drop out and characteristics of adolescents that continue psychotherapy. The study concluded that the variables that correlated with completing treatment were adolescents who were on average older in age, have higher anxieties regarding sex and relationships and also scored higher on anxiety and depression scales. The variables correlated with not completing treatment were adolescents who were on average younger in age, scored higher on delinquency scales and were also more likely to be diagnosed with a hyperactivity-conduct disorder. The researcher’s only issue with this study and its findings is the definition for not completing treatment was, dropping out before the consumer had completed the 21st session. It is the opinion of the researcher that session 21 (6 months worth of sessions) as the limit is too high. Baruch, Vrouva and Fearon went on to redefine dropping out at session 10 (3 months worth of sessions) and it dramatically changed their results. Baruch, Vrouva and Fearon, feel that so many of their consumers
did not make it to the 21 session mark because they felt they had achieved improvement, enough improvement to feel satisfied and thus terminate. Which is a possibility; women who are participating in therapy, who have been diagnosed with depression tend to not complete the treatment because of the improvement in their family functioning and their social support network (Demyttenaere, Enzlin, Dewe, Boulanger, De Bie, De Troyer & Mesters, 2001). Furthermore, the study by Baruch, Vrouva and Fearon begins to outline the importance of defining what it means to dropout and how if not defined correctly can change the nature of your findings a great deal and be confusing the reader.

The study conducted by Baruch, Vrouva and Fearon, does not stand alone in the confusing nature of the operational definition of what it means to drop out. In a study conducted by Pelkonen, Marttunen, Laippala and Lonngvist (2000) aiming to examine demographic background, psychopathology and psychosocial variables that could be correlated with not completing treatment at an adolescent psychiatric outpatient facility. The variables that Pelkonen, Marttunen, Laippala and Lonngvist identified that correlated with adolescents who did not complete treatment were low socioeconomic status of the adolescents parents, more criminal justice interventions, more sever mood disorders (especially depression), less suicidal behavior and substance abuse issues. The study stated that psychosocial function did not improve for early dropouts and it did dramatically improve for the adolescent that completed treatment. The researchers issue with this study is around the operational definition. The study defines not completing treatment as attending only one or two sessions. The study defines completion of treatment as attending all 14 sessions. There is a very large difference between one or two
sessions and 14 sessions and naturally psychosocial functioning would not improve in the individuals who only completed 1 or 2 sessions. Building rapport and preserving that rapport is difficult for clinician whether they are experienced or just beginning (Pitts & Miller-Day, 2007). The study classified 3-14 sessions as premature dropout and noted that there psychosocial functioning did improve also. However, taking the study by Pelkonen, Marttunen, Laippala and Lonngvist and the study conducted by Baruch, Vrouva and Fearon both thorough studies conducted professionally and adequately however the differences in what it means to not complete treatment is really put into perspective.

**Napa County Demographic Information**

Napa County has a population of 134,000 per the 2009 census with 58% of the population made up of Non-Hispanic Latinos and 31% Hispanic. The Napa County is known internationally for fine wines, award-winning restaurants and world-class resorts. As stated in a study conducted by UC Davis (2000) on Napa Valley and Migrant Farming: Napa County’s economy is rooted deeply in agriculture or wine; Napa's farm sales were $237 million in 1997, and 96% represented the sale of wine grapes and continue to grow. Napa County's 555 growers had 37,500 acres of wine grapes in 1998 and its 230 wineries crushed 102,400 tons of grapes, producing about 6.4 million 12-bottle cases of wine. All of that production comes at a cost. Somebody has to work the fields. Napa has two different kinds of laborers: Directly hired workers and agriculture services workers. The directly hired workers are individuals hired or already possess employment through the wineries year around, but who also participate when the demand
for labor has increased (i.e. during crush= period of time beginning in August when the grapes are being harvested) and the non-employed workers who are hired simply as extra help during crush season many of whom are immigrants from Mexico and only living in Napa 8-10 months a year, returning to Mexico.

The agency that the researcher is collaborating with in conducting this study is Family Service of Napa Valley (FSNV) and they assist in the mental health needs of the uninsured population of Napa. Many of whom are the families who are employed temporarily in the valley during crush seasons; FSNV serves over 500 individuals a year of the Napa County Community with a variety of different services. FSNV works with different agencies in town through a collaborative referral program called bridges; the initial contact agency conducts a single comprehensive assessment that is used by all of the partners and refers to the appropriate agency based on their need for services. Bridges attempts to eliminate redundancy and expedite the helping process. The study that is being conducted here is gathering demographic data from the bridges program to try and get a better picture of the individuals who seek treatment and do not complete. Based on the information already known, a large amount of the client base at FSNV is low-income, Hispanic, single mothers.

**Theoretical Orientation**

This study and the services provided through the agency in collaboration works very much from an ecosystems or ecological baseline. The key components of systems theory are: (Zastro & Kirst-Ashman, 2007) the system itself which is comprised of boundaries, subsystems, homeostasis, input, output, feedback, interface, differentiation,
entropy, negative entropy and equifinality. The system is a set of elements that are orderly and interrelated to make a functional whole. Boundaries are the borders or margins that separate one entity from another. A subsystem is a secondary or subordinate system that is a component of a larger system. Homeostasis is the tendency for a system to maintain a relatively stable state of balance. Role, is the culturally established social behavior conducted by the person in reference to their relationships. Relationships are reciprocal in nature and interpersonal. Input involved the energy out into the other systems. Output, is the response of the system that was receiving the input energy or information. Negative and positive feedback is a form of output from a system. Interface being the point where two systems come into contact with one another. Differentiation is a systems tendency to change in dynamic. Entropy is the tendency of a system to progress toward disorganization and negative entropy being a systems growth and development and lastly equifinality refers to the fact that there are different means to the same end. The different layers of someone’s life have different pertinence depending on time and situation and leading to a strain in the ecosystem as a whole. Sometimes when there is a crisis or a depletion of a layer, intervention is needed to restore the overall homeostasis.

The ecosystem has a whole has a set of elements to make a functional whole that organize the different layers and components as stated above. The elements are Micro, Mezzo and Macro Systems. Micro system is the set of interactions that occur on the individual level which could include a person’s biological or psychological functioning. Mezzo system is the set of interactions that happens with a group which could include
family and friends. Macro system is the set of interactions that happen at the societal and political level. All three elements of the system get intertwined and entangled in a person’s life and can have great impact. Family systems theory as part of ecosystems is a theory that looks at the individual or consumer and places them in a context of who they are in their life. Family systems theory also allows the researcher to take a look at the consumer and their interactions at the different levels as part of a system and not just an individual. The theory is a useful theory especially when working with men and women of multi-cultural backgrounds that place a high importance on the extended families (Corey, 2008). The idea being that you find where a person’s strengths are and you draw upon them while there is a deficit somewhere else in the system. Being a strengths based and eternal optimist, there are always strengths sometimes it just takes a little perspective to locate them.

**Summary**

The most prominent reasons why someone who agreed on treatment as stated in the literature, and then decided not to follow through are age, socioeconomic status, ethnicity, gender and severity of symptoms. Although, the findings across research regarding age are not consistent, different studies stated treatment completers were on average older (Buttell & Carney 2002), and different studies state on average age younger (Gerlock, 2001), age still seems to be a correlating variable as to when looking at the demographics of the dropout population. Another prominent variable across the literature regarding the dropout population is the socioeconomic status of the consumer and that also of the consumer’s parents. It’s no secret that based on your socioeconomic status
comes a certain access to resources and the lack of. Not all the researchers in their studies discussed the component of ethnicity. The studies that did however, the findings were similar. The ethnicities mentioned that were the most at risk for not completing treatment were African American, Native American and Asian American (Vendetti, McRee, Miller, Christiansen, Herrell & The Marijuana Treatment Research Group, 2002; King & Canada, 2004; Rose, Bohlig & Lennox, 2000). The cultural component to not completing treatment should be a topic for further study, especially women of other cultures, as it appears the literature does not go into depth at why different treatment settings are not successful with women or women of color. Women alone have their own component to what correlated with successful treatment. The statistics show and they are alarming, women in treatment and specifically substance abuse treatment are the minority however they are the majority in the population for not completing treatment. The literature regarding women and completing treatment paints a very different picture then that of men. Men appear to be successful in treatment when they received assistance with employment, housing, in many cases assistance through the criminal justice system and the motivation to complete treatment. Women on the other hand appear to be successful in treatment when they gain a support system, when they get validation for their struggles, when the treatment center fits who they are and what they are trying to accomplish with as well as having the motivation to complete. Motivation and insight appear to be uniform across genders, socioeconomic status and age. Without the drive to change for whatever the consumer is seeking treatment for, there outcomes do not appear
favorable. Motivation appears to be a really key aspect when looking at the variables that predict treatment completion.

When looking at the populations of who make up treatment dropout and completion it appears to change with setting and agency. As Keijsers, Kampman and Hoogduin (2001) stated in their study conclusion that with their findings it will still be very difficult to predict the exact dropout risk even amongst what appears to be an identical population and all while using standardized measures, within in their own setting. Dropping out of treatment has vast effects; it affects the direct consumer, the consumers waiting and the agency trying to serve. The studies reviewed in this literature come to a lot of different conclusions however, they have one very important detail in common and that is the agencies and researchers are all trying to serve a population that is hard to reach and with each study comes a better understanding and helpful tools and ideas. In this study the researcher is looking for the variables that identify more specifically to Napa as a community the individuals who are more likely to not complete treatment; what is it in their ecosystem that is failing or is should the treatment approach be more crisis orienting then systems. It could be said the most constant predictor for treatment completion is the treatment completion itself.
Chapter 3
METHODS

In order to provide evidence and insight into the problem of no show and drop-out among potential clients, this study employs both quantitative data from service records and expert input from a group of agency current staff. The quantitative data was a compilation of service records that was completed with the potential client and the helping professional, the service record could also be known as an intake sheet and contained demographic information. The professional focus group included current agency staff: 1) their professional opinion on the research findings, 2) if they felt there were other factors that contribute to premature drop-outs within this population, 3) what they felt would decrease the drop-out rate within this population and 4), if they had unlimited funds create a program that extended services to this hard to reach population—what would they do.

Study’s Purpose, Design and Procedures

The populations are the records of individuals who were referred by local service organizations to Family Services of Napa Valley for counseling services and who prematurely dropped out (N= 85 people) in the year 2009. The majority were female, mothers, single income households, Hispanic, Spanish speaking and around the age of 35-45. There was two sources for this study: records of individuals who were referred by local service organizations and the voluntary professional focus group participants. The researcher selected files of clients who prematurely dropped out of counseling services. There is no inducement offered. Since these individuals are not being served by the
agency and the researcher, there is no conflict of interest.

After the initial data analysis, a voluntary focus group was organized. The focus group consisted of ten service providers from inside the agency, collaborative county and community agencies. The service providers were asked to validate research findings and provide program planning recommendations. The focus group is a purposive sample of people who are trained and competent in the topic (Experts). Voluntary experts from outside Family Service of Napa Valley were recruited using the snowball sampling strategy and all experts attending the focus group were given a Focus Group Discussion Guide. The focus group discussed research findings, all information discussed in the focus group is confidential, participation is voluntary and consent is implied based on attendance.

This is a needs assessment using secondary data analysis and a focus group to validate and extrapolate information for service enhancement. The secondary data is referral data in the Family Services of Napa Valley. The data that was collected and organized as service records. This researcher used a Data Collection form to extract the needed information from the records. After all of the data was collected the researcher conducted content analysis and used appropriate statistical analysis to analyze the data. The study aimed to indentify the major contributing issues that are related to the drop out or refusal to utilize services. Based on the findings, literature and focus group recommendation, the researcher will developed recommendations for further study and program adjustments based on the need of the drop out population.
Consent and Ethical Considerations

Because the researcher was placed through the Master of Social Work (MSW) program field placement at the Napa Valley Family Services as a student therapist, the researcher had permission through the agency to use the information provided by the clients on the intake sheets. The information has been organized and stored in the agency database. Only needed information for project research was extracted.

In addition, the focus groups members are expert service providers from Family Service of Napa Valley and other county and community agencies. The expert service providers are practicing professionals. The information and topic being discussed in the focus group meeting is no different than the daily tasks and duties currently being performed. With that said consent is implied based on attendance to the focus group.

As agreed upon by the researcher and agency, all of the information used will be confidential and each client has a client number instead of any names or identifiable information. Furthermore, the researcher had no direct contact with these individuals. As a past intern of this agency, the researcher has completed the internal confidentiality training and abides all agency and county ethical standards in handling of service recipients’ information. Only group data was discussed in the focus group and all information stated remains confidential.

The study was considered “minimal risk” by the Human Subjects Review process and was approved on September, 7th 2010 by the CSUS Division of Social Work Human Subjects Review Committee. There is no direct contact between researcher and the clients whose information is being used. The focus group was done with experts on the
subject, who are practicing professionals in the field related to the research and the researcher was asking question based on the research findings. This study is a needs assessment using secondary data analysis and therefore did not cause clients or experts emotional discomfort.
Chapter 4
PRESENTATION OF DATA

The demographic data that was collected by the researcher included: which collaborating agency was referring the client, the reason as stated on the intake sheet as to why the client did not follow through with services as recorded by service provider (i.e. could not be reached, phone disconnected, no show), the type of client (i.e. individual, couple or family), the identified ethnicity of the client (i.e. Caucasian, Latino, African American), language spoken at home (i.e. English or Spanish), the priority level of the client (i.e. High, Medium or Low), the gender of the client (i.e. Male or Female) and the month the client was referred.

Data Analysis

The average age of the population being examined was 36 and how long these individuals waited on the waiting list before a therapist or agency representative contacted them to make an appointment regarding their referral was 10.4 weeks as stated in Table 1.

Table 1

<table>
<thead>
<tr>
<th>Central Tendency Table for Age and Waitlist Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable</td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>Weeks on the Waitlist Before First Contact</td>
</tr>
<tr>
<td>Age</td>
</tr>
</tbody>
</table>
The data that was summarized using frequency distribution, the researcher found that between the months of August and November the Napa Valley’s vineyard community has a high demand for a seasonal labor force to harvest grapes for the wine. The local community calls this “crush”. As stated in literature review, the wineries of the Napa Valley employ many seasonal farm workers who come with their families to work. The Frequency distribution for the category of months referred shows that a high number of individuals were referred during the months subsequent to crush time. The highest months of referrals were March and April. March and April is when there is little work in the valley for seasonal farm workers. October is when the vineyards crush season is at its peak. The majority of the seasonal labor forces that are working the fields during crush time are male. The researcher hypothesized that during the time before crush when work is scarce for the seasonal laborer, causing stress for low-income women, with children and responsibilities could cause an increase in referrals. With the average turnaround time from referral waiting for a phone call to set up an appointment being an average 10 weeks, and possibly as long as 22 weeks, the crisis passed and there is no time for mental health services. When the mental health worker from the agency calls to try and book the appointment the data states that the majority of the women could not be reached. This could mean that there is no one home to answer the phone, resources became scarce and they could no longer afford to pay for a phone and or the prospective client moved (i.e. returning to country of origin). The data displayed a high number of the clients did not show because they were no longer interested (24 clients) and because they did not show up for their scheduled appointment (24 clients). The agency that is providing services has
a number of bilingual (Spanish and English) therapists in order to better serve the cultural
demands of the community. The therapists work flexible work hours 9am- 6pm. The
researcher hypothesized that the no show number was high because the appointments are
during general work hours and the women are working to support their families.
Confliction in scheduling that prevents them from not being able to make the
appointment, which is validated by the data presented in Table 2.

Table 2

*Frequency Distribution Table for Month Referred, Reason for Not Attending Services and Income*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>January: 4</td>
</tr>
<tr>
<td></td>
<td>February: 5</td>
</tr>
<tr>
<td></td>
<td>March: 9</td>
</tr>
<tr>
<td></td>
<td>April: 10</td>
</tr>
<tr>
<td></td>
<td>May: 10</td>
</tr>
<tr>
<td></td>
<td>June: 6</td>
</tr>
<tr>
<td></td>
<td>July: 8</td>
</tr>
<tr>
<td></td>
<td>August: 5</td>
</tr>
<tr>
<td></td>
<td>September: 5</td>
</tr>
<tr>
<td></td>
<td>October: 13</td>
</tr>
<tr>
<td></td>
<td>November: 8</td>
</tr>
<tr>
<td></td>
<td>December: 3</td>
</tr>
<tr>
<td>Reason for Not Attending</td>
<td>Could Not be Reached: 44</td>
</tr>
<tr>
<td></td>
<td>No Show: 24</td>
</tr>
<tr>
<td></td>
<td>Not Interested: 24</td>
</tr>
<tr>
<td></td>
<td>Phone Disconnected: 2</td>
</tr>
<tr>
<td></td>
<td>Referred Out: 4</td>
</tr>
<tr>
<td></td>
<td>Wrong Number: 2</td>
</tr>
<tr>
<td>Income</td>
<td>$0-$24,000.00: 81</td>
</tr>
<tr>
<td></td>
<td>$25,000.00-$35,000.00: 3</td>
</tr>
</tbody>
</table>
The researcher used the statistical program PASW to run cross-tabulations or chi-square ($\chi^2$) and frequency distribution. Chi-square is a test that compares the tallies or counts of categorical responses between two (or more) independent groups as to try and get a better idea where significant and non significant relationships lie. Frequency distribution was used to summarize a group of data and gather mean, median and mode for selected categories within the data set. Chi square analyses were performed across various categorical variables to examine whether significant relationships existed: Ethnicity and crisis priority level, gender and ethnicity, ethnicity and age, gender and crisis priority level, gender and age, and lastly gender and language.

The data in the categories of ethnicity and crisis priority level, gender and ethnicity, ethnicity and age, gender and crisis priority level, gender and age, and lastly, gender and language were tested using chi-square test of significance the test rendered that there is no significant relationship between the two independent categories in all categories. This tells the researcher that regardless of ethnicity and crisis priority level, gender and ethnicity, ethnicity and age, gender and crisis priority level, gender and age, and lastly, gender and language there is no relationship between the two categories that could better identify if a potential client is going to drop out of services. Furthermore, this expresses to the researcher that whether or not the client is male or female, Caucasian or Latino, young or old, crisis level priority or age there is still no significant association and the variables. The variables in comparison do not improve an intake workers ability to identify if a client is at higher risk for dropping out as displayed in Table 3.
Table 3

*Chi-square (χ²) and p-value Test Table*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Chi-square (χ²) and p-value</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity &amp; Crisis Priority Level</td>
<td>χ²= .2682, P&gt; .10</td>
<td>None</td>
</tr>
<tr>
<td>Gender &amp; Ethnicity</td>
<td>χ²= 1.13, P&gt; .10</td>
<td>None</td>
</tr>
<tr>
<td>Ethnicity &amp; Age</td>
<td>Ages 20-39: χ²= 1.50, P&gt;.10</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Ages 40-59: χ²=.050, P&gt;.10</td>
<td>None</td>
</tr>
<tr>
<td>Gender &amp; Crisis Priority Level</td>
<td>χ²=.003, P&gt;.10</td>
<td>None</td>
</tr>
<tr>
<td>Gender &amp; Age</td>
<td>Ages 20-39: χ²=.555, P&gt;.10</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Ages 40-59: χ²=.12, P&gt;.10</td>
<td>None</td>
</tr>
<tr>
<td>Gender &amp; Language</td>
<td>χ²= 1.79, P&gt;.10</td>
<td>None</td>
</tr>
</tbody>
</table>

**Findings and Discussion**

The current study aims to identify variables associated with individuals who drop out of treatment. Are there any significant relationships between categories that could better identify someone who is at high risk for not completing or receiving the services?
The researcher was hypothesizing that time of year, ethnicity and gender were variables associated with treatment drop-out because of the seasonal agriculture labor demands of the community. The data very clearly displays that the majority of the clients being referred are low income (96% of clients sampled having an income lower than $24,000 per year). The data shows the prominent gender of the clients are women (76% of clients sampled were female in gender) of Hispanic origin (58% of clients sampled classified self as Hispanic or Latino) and of child-bearing age (Average age of clients sampled was 36 years of age). The data also shows that the majority of the women who decided to not follow through with services could not be reached and waited on the waiting list for an average of 10 weeks.

Limitations

The quality of the data set presented a significant limitation in the statistical findings. What the researcher is indicating by quality of the data gathered is that it came from basic referral forms; there was no access to the client. Little is known about what really happened between the time of referral and the time the worker attempted to make contact. The nature of the existing data set does not provide evidence that could support or deny the research questions. The data helps provide a next step for a further study and what begins to paint a picture of what data needs to be gathered to formulate a data set with statistical quality. It could have been very useful to the study to have been able to access the population and ask them definitively why they were unable to access services, however by the nature of the population being hard to reach and for confidentiality reasons the individuals were not accessible. The data that was available for this study was
not gathered for the intended purpose to answer the research question or the hypothesis of the researcher.

**Focus Group**

The purpose of the focus group was to discuss the findings above with the therapists that are familiar with the population being studied. The focus group consisted of 13 helping professionals and all the therapists concurred that the majority of the clients referred are low income, women, of Hispanic origin and of child bearing. Referred in the months March, April, May and October and waited on the waiting list for an average of 10 weeks. The therapists that are providing the services feel the data represents what they were already feeling regarding this specific drop-out population and that was that there is little to no time for self care. However, therapists were not aware that there was such a strong connection regarding treatment non-completion and the time of year. As the discussion progressed the focus group therapists stated that the time of year made some sense in relationship to potential clients being unable to be reached, their phones being disconnected or no one around to receive a message. Another connection the therapists made with the time of year as being a trigger for non-completion, was that by the time the intake worker calls the clients to come in for an appointment the crisis (problem or reason for clinic visit) has passed, or the clients are back to work and there is no longer time to get help. Some of the assumptions stated by the therapists were that childcare was a major issues why some of the clients did not follow through with their agreed upon appointment and client work schedule.
The therapists felt that there are other factors that contribute to not completing treatment that were not covered in this study. The therapists felt that diagnosis was another key factor that should be incorporated somehow, however diagnosis being a catch-22. How can you diagnose a client if they are not willing to come in and be seen? There is also a need for a motivational scale on the intake sheet; a tool that is used to assess the client’s willingness and readiness to accept change into their lives. The nature of the population makes it difficult to get some of these potential clients into counseling. The population is transient in nature and there are also transportation issues, in conjunction with child care needs. The Latino population, as stated by some of the Hispanic therapists, puts a lot of stigma on mental health. Some of the reasons for not coming into treatment are much more cultural, and systemic to the population being treated and so attempting to relieve stigma regarding mental health services would be beneficial.

The therapists agreed uniformly that with this population there has to be a shift in dynamic of services to more of crisis intervention and less on psychotherapy, and the purpose being to be able to fill the gap in services. In addition, the treatment should be addressing women’s needs, because that is who is dropping out if services, but at the same time, there has to be a component that address the men in the family. The therapist state that the majorities of the men in the families of the women they are treating are using substances and display symptoms that could look like depression, there has to be a way to get the men and families involved. The therapists stated that many of the men look at therapy as something for crazy people and is difficult to get them involved so they
can be able to see what therapy is. Many of the women who come in start by saying their reason for coming in and seeking services is to try to help someone else in their lives.

**Implications for Social Work Delivery**

Gender specific services, should be geared towards the women population that has a trend for not following through with services, with that said, there should be a strong component that involves the family. As validated in the focus group, the women are not following through with services for reasons that focus around familial responsibilities. Women would rather work because that contributes to the family as a whole, there is not time to care for self when you have others to care for and the financial demands of a family. It is important as social workers and helping professionals that we understand the demands and the strains of the populations that we serve, but also we should try and understand the demands and strains of the populations that seem to be slipping through the cracks in our communities.

Many of those that seem to be slipping through the cracks are those that are thought to be working or have family members working as seasonal agriculture workers. When it is crush time in the valley, the work days and weeks are long and strenuous, on the worker and the family as a whole. There should be considerations taken by the involved agencies to try and cater to those who have increased responsibilities during this time. The family has to compensate for the loss of a helper around the house (i.e. member of the family working crush) and again there is less time for self, especially if there is a misunderstanding around what mental health services are.
Trying to get the word out about what mental health services are will be a challenge, but educating the local Hispanic population is important to try and decrease the stigma. The focus group brought to light that many of the women who are actively in therapy, have husbands and partners at home who are likely depressed and dealing with substance abuse issues. Many of the men and partners do not see the usefulness in mental health services and it is the job of the worker and those that advocate for mental health to try and change that paradigm. Education is key, there is so much misunderstanding regarding what it is that the agency is trying to help people with and don’t see themselves fitting that misconception.

**Recommendations for Further Study and Service Delivery**

There are two components that the researcher wishes to discuss in regards to the project outcome: topics for further study recommendations and possible structural changes in the services that are provided to the population and incentives for service participation.

In order to study this population better there has to be a more thorough way of collecting the data that is needed to understand the population. For starters on the intake sheets that are being filled out by the referring agency should have questions added regarding motivation for services, readiness for change and possible barriers to completing services. As stated in the literature review one of the key variables that is correlated with treatment participation is having the motivation for change. Being able to accurately gauge in a measurable fashion the clients readiness to participate. That could prove to be a vital component in identifying an at risk client.
The researcher would recommend collaborating with the referring agencies to formulate an intake sheet and referral sheet that measures readiness to change and motivation to participate in services at time of referral and at the time (average 10 weeks later) when the intake therapist contacts the client. The information regarding this specific drop-out population is limited and it would benefit the community, agencies and clients alike to study these topics more thoroughly. This study is a good place to start, however it would have been beneficial to have direct access to the clients that dropped out however, due to the nature of the study and the population that was not an option. In the beginning when the clients are in the office, it is vital to try and get as much information as possible regarding what they need to be successful and the data that is needed to try and explore this topic further: accurate contact information, motivation level, reasons for seeking services and their employment status (i.e. agriculture/ seasonal worker).

Through this study the needs of the populations have surfaced. In order to reach these women and help empower and support them to participate in the services sought out it is important that we help provide things that make participation possible. Some of the services that would be offered would be assistance in transportation. The agency is centrally located downtown and so helping with bus vouchers or cab fares would be a great help and incentive to participate. Another service that would be helpful would be, assisting in child-care, have an on-site daycare for women who are being seen during certain hours, so they have somewhere safe to house their children while they are caring for self. All while, adding a component that got the men involved, either through men’s
groups, and or education workshops. Also, change the dynamic of how certain populations are served, provide home-visits to some of the women who have trouble getting out of the house, and also provide a drop-in clinic for more of crisis intervention. It might be helpful to again collaborate with other agencies that provide more case – management services so that the entire families needs could be managed while the individual who is seeking psycho-therapy could be receiving the therapy and the entire family is onboard towards change. As well as, increase hours of the agency to include evening hours and weekends.

Another way to try and get some of these women who are dropping out to participate in services is through incentives. During the holiday season, coordinate with the food banks and other food charity programs to provide some of your clients with boxes of food. Also, during the hot and cold months coordinating with clothing programs to help provide summer clothes for the family and winter coats. Whatever it takes to help the families and make it worthwhile to come in.
Chapter 5
CONCLUSION

What the researcher was looking to find out was how human service agencies can improve services in our community. Asking questions such as: What good can a social worker be if his/her clients do not show up? What is it about the process that it is deterring your clients from showing up, and how we can change that process so that more people can receive services? Many social workers and helping professionals come across the issue of dropout, premature termination and no shows, and working with different populations will bring about different reasons for not showing up. In our current economic climate, it is important that agencies be as thorough as a possible with services delivered. Digging deeper to get a better understanding of what happens and why some potential clients don’t show up.

There are many implications for social work delivery that are generalized across populations. Lack of follow through with services is not a unique problem to this study as recognized by the literature review in chapter 2. Being able to identify who is high risk in your own specific community is very beneficial to the workers that are trying to increase the well-being of those individuals who seek services. Education on what mental health services are is also important across communities. Many people, those who seek services and those who do not, have misconceptions regarding what exactly mental health services are. The gender specific services recommended are a social work implication and a variable that is specific to the population that was studied here; however, the premise is the same for other communities. There are going to be variables associated with the
The question the researcher was trying to answer with the data collected is what are the variables associated with individuals who drop out of treatment. Are there any significant relationships between categories that could better identify someone who is at high risk for not completing or receiving the services? The researcher was hypothesizing that time of year, ethnicity and gender were variables associated with treatment drop-out because of the seasonal agriculture labor demands of the community. The data very clearly displays that the majority of the clients being referred are low income, women, of Hispanic origin and of childbearing age. The data also shows that the majority of the women who decided to not follow through with services could not be reached, referred in the months March, April, May and October and waited on the waiting list for an average of 10 weeks. In essence, the service demands from the target population are seasonal in the way that coincides with the farming season. Women are the main contact person for seeking outside help. With that in mind, service agencies should focus their outreach efforts to women, particularly during those high demand months.

The majority of the literature focuses on substance abuse. A prominent variable across the literature regarding the dropout population is the socioeconomic status of the consumer. It is no secret that based on your socioeconomic status comes a certain access to resources. The literature show’s women in treatment and specifically substance abuse treatment are the population minority, however they are the majority in the population for not completing treatment. Women do appear to be successful in treatment when they gain
a support system, when they get validation for their struggles, when the treatment center fits who they are, and what they are trying to accomplish, as well as having the motivation to complete. Motivation and insight appear to be uniform across genders, socioeconomic status and age. Without the drive to change for whatever the consumer is seeking treatment for, their outcomes do not appear favorable. Motivation appears to be a key aspect when looking at the variables that predict treatment completion. Age, ethnicity, gender, socio-economic status and type of case (family, individual, couple) are all variables that predict treatment completion. The findings are not generalized.

There were some significant limitations to this study. The limitations in regards to the literature review, the majority of studies had different operational definitions in regards to what does ‘drop-out” mean and how is it measured in that particular study. Each study was catered to the populations being looked into. Also, the literature was really lacking in the field of psycho-therapy/ mental health. The majority of the literature was for substance abuse specific treatments. Furthermore, there were significant limitations in the data. The data collected was sparse in that it was demographic in nature and could only go so far. The focus group was very useful to fill in some of the gaps however, the professionals are as stumped with the population that tends to drop out as the researcher because, they are unable to see them also. So, not having access to the population to ask them directly what happened and what are the reasons beyond speculation was a significant barrier. The study serves the function of an exploratory study to develop more specific research questions. It also highlights the areas that need to be included in the data source for further secondary study. The nature and quality of the
data on drop out and no shows are as important as the data on the success of the treatment outcomes. Proper documentation and data analysis could help service providers to become more effective and successful in meeting the unique needs of our clients.
REFERENCES


