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Pepperdine University

Graduate School of Education and Psychology

THE ASSESSMENT OF ALCOHOL USE DISORDERS AMONG
HOMELESS MEN IN RESIDENTIAL TREATMENT

A clinical dissertation submitted in partial satisfaction of the requirement
for the degree of Doctor of Psychology

by

Stacy L. Pike, M.A.

August, 2014

Cary Mitchell, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

Stacy L. Pike

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

Cary Mitchell, Ph.D., Chairperson

Carolyn Keatinge, Ph.D.

Michelle Margules, Psy.D.

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DEDICATION

I dedicate this dissertation to my wonderful family. I am deeply grateful for your unwavering support and hugs. I am truly lucky.

ACKNOWLEDGEMENTS

I am forever grateful for those who have assisted me through this process and who have encouraged me to follow my dreams. I would like to recognize those who have provided me with endless support, encouragement, and guidance. First, I would like to offer heartfelt thanks to my chairperson, Dr. Cary Mitchell for guiding me through this process and for tirelessly reviewing and editing my work- draft after draft. I have greatly appreciated all of your invaluable feedback. You provided me with the inspiration and determination to move forward with this research. Without you, this would not have been possible. I would also like to extend my gratitude and thanks to my talented committee, Dr. Carolyn Keating and Dr. Michelle Margules. Dr. Carolyn Keatinge, thank you for all of your support and guidance. I have always taken your advice to heart and will continue to carry your wise words with me as I move forward. Similarly, Dr. Michelle Margules has been a tremendous supporter even before I began this doctoral program. Thank you for believing in me and for giving me the extra confidence to apply to this program. I am incredibly grateful that I have continued to have the opportunity to work with you throughout this process and have treasured your feedback and insight. A sincere thank you to Dr. Shelley Harrell, who graciously offered to assist me in analyzing the data. Your passion for statistical analysis was contagious and greatly assisted me in completing this paper. To my wonderful dissertation partner and friend, Brittany Winters, thank you for always motivating me and for making this process feel more manageable. I have always been inspired by your determination and organization. I could not have gotten through this without you, and I am deeply grateful for our friendship. I would also like to thank my wonderful, loving, amazing family. Mom and dad, thank you for always being there to support me through thick and thin. You have always believed in me and encouraged me to follow my dreams. When I need you the

most, you are always there. You are the world's best cheerleaders. Words cannot express how thankful I am to have you as my parents. To my sister Amy, thank you for being a natural listener and for giving the best advice. I am incredibly lucky to have you as my sister and best friend. Your support has kept me going throughout this program. Finally, to my soul mate and husband, Sebastian- Wow, what a road this has been. You have been by my side since day one. Thank you for being my rock and my everlasting supporter who has always kept me grounded. Your optimism, smiles, and lighthearted nature has given me the strength to believe in myself, my capabilities, and my goals. I love you.

VITA

EDUCATION

Pepperdine University, Graduate School of Education and Psychology, Los Angeles, CA
 Doctor of Psychology in Clinical Psychology May 2014
 Dissertation: *The assessment of alcohol use disorders among homeless men in residential treatment*
 (Chairperson: Cary Mitchell, Ph.D.)

Pepperdine University, Graduate School of Education and Psychology, Malibu, CA
 Master of Arts in Clinical Psychology with an emphasis in Marriage and Family Therapy May 2010

University of Colorado at Boulder, Boulder, CO
 Bachelor of Arts in Psychology May 2006

ABBREVIATED SUMMARY OF SUPERVISED CLINICAL EXPERIENCE

Sharp Healthcare, San Diego, CA, Pre-doctoral Internship (APA Accredited) 2013 - 2014
 2,100 anticipated hours in inpatient/outpatient psychiatric hospital setting with children, adolescents, adults, and seniors.

Children's Hospital Los Angeles: Center for Cancer and Blood Diseases, Los Angeles, CA
 Practicum 2012 - 2013
 980 hours in inpatient/outpatient hospital setting with children, adolescents, young adults, and families.

Pepperdine University Counseling Clinic/Union Rescue Mission, Los Angeles, CA
 Peer Supervisor 2012 - 2013
 167 hours supervising first year doctoral practicum students at the Union Rescue Mission.

Pepperdine University Counseling Clinic, Los Angeles, CA
 Practicum 2012 - 2013
 35 hours in university counseling clinic with adults.

Sports Concussion Institute, Los Angeles, CA
 Practicum 2011 - 2012
 577 hours in specialty neuropsychological assessment clinic with children, adolescents, adults, and seniors.

Union Rescue Mission, Los Angeles, CA
 Practicum 2010 - 2012
 565 hours in residential treatment facility with homeless adults and families.

SUPERVISED CLINICAL EXPERIENCE**Sharp HealthCare, San Diego, CA (APA Accredited Internship)**

Pre-doctoral Psychology Intern

August 2013 – Present

Training Director: Lynn Northrop, Ph.D.

General Description:

- Complete three, four month rotations throughout the training year
- Participate in a year-long psychodiagnostic testing rotation for inpatient and outpatient units; including children, adolescents, adults, and older adults
- Present case conceptualizations integrated with literature specific to each rotation during case conference
- Engage in weekly didactic training, weekly psychodiagnostic seminar, and monthly diversity seminar
- Partake in weekly individual and group supervision

Rotation 1: Older Adult Program

August 2013 – January 2014

Rotation Supervisors: Lynn Northrop, Ph.D. and Dara Schwartz, Psy.D.

Description: Inpatient locked unit for older adults ages 55 to 100+

Duties:

- Facilitated and co-facilitated skills-based and process oriented group psychotherapy
- Conducted individual, conjoint, and family therapy with patients using evidenced-based treatments from cognitive-behavioral therapy, acceptance commitment therapy, and dialectical behavioral therapy perspectives tailored in consideration to age, cognitive status, and goals/presenting problems
 - Common diagnoses: mood and anxiety disorders, chemical dependency, chronic pain, psychotic disorders, personality disorders, dementia, suicidality, cancer, and other psychiatric illnesses complicated by medical diagnoses
- Administered, scored, and interpreted empirically supported brief cognitive screens
- Exhibited sensitivity to all diversity issues for each patient
- Provided professional consultation and collaborated with interdisciplinary team on an ongoing basis
- Actively participated in and contributed to weekly treatment team meetings with psychiatry, psychology social work, nursing, nutrition, and pharmacy

Rotation 2: Adult Services

January 2014 – May 2014

Rotation Supervisor: Thomas Lee, Psy.D.

Description: Inpatient locked and unlocked units for adults ages 18 to older adults

Duties:

- Co-facilitated Coping Skills, Process, Psychoeducation, and Distress Tolerance Skills-Based Groups
- Provided culturally sensitive brief individual psychotherapy
 - Common diagnoses: mood and anxiety disorders, psychotic disorders, eating disorders, personality disorders, suicidality, chemical dependency, and traumatic brain injury
- Engaged in chart review to ensure understanding of bio-psycho-social factors that impacted individual functioning
- Participated in bi-weekly treatment team meetings with psychiatry, social work, psychology, nursing, pharmacy, and nutrition

SUPERVISED CLINICAL EXPERIENCE (Continued)*Rotation 3: Child and Adolescent Program*

May 2014 – August 2014 (Expected)

Rotation Supervisor: Jen Wojciechowski, Ph.D.

Description: Inpatient locked unit for children and adolescents

Duties:

- Facilitate Adolescent Cognitive Process Group
- Provide culturally competent brief individual therapy and family therapy from a cognitive-behavioral perspective
 - Common diagnoses: mood and anxiety disorders, psychotic disorders, substance use disorders, eating disorders, disruptive behavior disorders, developmental disorders, and trauma
- Partake in crisis intervention and engage in Child Protective Services reporting if necessary
- Participate in daily multidisciplinary treatment team meeting with psychology, psychiatry, social work, nursing, and pharmacy
- Engage in ongoing assessment, treatment planning, case conceptualization, disposition planning, case management, and thorough charting

Children's Hospital Los Angeles: Center for Cancer and Blood Diseases, Los Angeles, CA

Psychotherapist Extern

August 2012 – July 2013

Supervisor: Betty Gonzalez-Morkos, Psy.D.

- Provided hospital based inpatient and outpatient individual and family psychotherapy to children, teenagers, and family members of all socioeconomic and ethnic backgrounds affected by cancer
- Co-facilitated weekly inpatient process group for adolescent patients diagnosed with cancer to promote social support and expression of feelings
- Co-facilitated bi-weekly outpatient and inpatient process group for patients ages 13 to 20 to enhance healthy coping strategies and support
- Assisted children and teenagers with cancer and blood diseases reintegrate into school by serving as a liaison between the child, medical team, and school administration; provided parents with advocacy skills training and information regarding educational rights
- Presented psychoeducational information related to cancer and blood diseases, socio-emotional needs, and physical needs to school classrooms and to school staff to enhance understanding and support
- Attended weekly didactics, participated in disease team meetings and ground rounds, and collaborated within a multidisciplinary team to provide comprehensive treatment to children and families
- Maintained progress notes to ensure proper documentation of session content
- Engaged in weekly individual and group supervision

Pepperdine University Counseling Clinic, Los Angeles, CA

Psychotherapist Extern

August 2012 – July 2013

Supervisor: Fiona Chalom, Ph.D.

- Provided individual psychotherapy to adults experiencing anxiety, depression, adjustment issues, substance abuse, and relationship dysfunction
- Created weekly progress notes for each client
- Presented and discussed clinical cases during weekly group supervision

SUPERVISED CLINICAL EXPERIENCE (Continued)**Sports Concussion Institute, Los Angeles, CA**

Neuropsychological Testing Extern

September 2011 – July 2012

Supervisors: Tony Strickland, Ph.D. and Mari Davies, Ph.D.

- Conducted neuropsychological evaluations for diverse population including children, adolescents, and adults who presented with sports-induced concussion, mild traumatic brain injuries, learning disorders, and Dementia
- Provided early concussion intervention and prevention (baseline testing) to children and adolescents using ImPACT
- Participated in intake evaluations, accurate scoring, supervised interpretation, feedback to patients and families, and report writing
- Engaged in didactics pertaining to neuropsychological test batteries, cognitive-behavioral therapy, anatomy and processes of the brain, and working with forensic populations

Union Rescue Mission, Los Angeles, CA

Psychotherapist Extern

September 2010 – August 2012

Supervisor: Aaron Aviera, Ph.D.

- Provided mental health treatment services for the homeless community within a residential treatment facility
- Conducted individual weekly psychotherapy with clients from diverse cultural and ethnic backgrounds presenting with both Axis I and Axis II psychiatric disorders
- Incorporated cognitive-behavioral theory to address presenting issues such as Substance Abuse, Mood Disorders, PTSD, and crisis stabilization
- Managed weekly case notes and ongoing treatment planning
- Participated in ongoing training and didactic seminars pertaining to salient factors within multicultural clientele

PRE-DOCTORAL CLINICAL EXPERIENCE**Comfort Zone Camp, Malibu, CA**

Volunteer/ Big Buddy/Intake Screener

January 2010 – Present

- Act as big buddy throughout the weekend to a child who has experienced the death of a caregiver or sibling
- Participate in healing circles that provide emotional support and containment to grieving children
- Conduct phone intakes with parents to assess for eligibility of camp services for the children in need

Valley Trauma Center, Northridge, CA

Family Preservation In- Home Outreach Counselor/Trainee

January 2009 – March 2010

Supervisor: Clovis Emblen, LMFT

- Assisted families in crisis through in- home therapy while working on areas such as communication skills, anger management, and parenting skills
- Conducted individual psychotherapy with clients
- Facilitated a 20 week parenting group that included instruction of lessons and group discussion
- Maintained open communication regarding client cases with social workers from the Department of Children and Family Services
- Formulated case notes and monthly reports regarding the nature of therapy with clients
- Completed 40 hours of paraprofessional training provided by Valley Trauma Center and earned a California state approved in-home therapy certificate

PRE-DOCTORAL CLINICAL EXPERIENCE (Continued)**Safehouse Progressive Alliance for Nonviolence, Boulder, CO**

Crisis Line and Shelter Volunteer

February 2005 – May 2006

- Answered crisis calls, provided advocacy for female residents and children, conducted intakes, filed paperwork, dispensed medication
- Attained 50 hours of paraprofessional training pertaining to domestic violence

TEACHING EXPERIENCE**Pepperdine University, Malibu, CA**

Graduate Teaching Assistant

January 2013 – May 2013

- Assisted professor and students during graduate level “Techniques of Counseling and Psychotherapy” class with regard to explanation of assignments and comprehensive feedback
- Reviewed students’ written assignments and case conceptualizations and provided detailed feedback to students
- Helped professor devise, administer and score weekly quizzes
- Held office hours each week and maintained scheduled meetings with each student to review progress and questions pertaining to class material and case conceptualization

Pepperdine University, Los Angeles, CA

Peer Supervisor

September 2012 – August 2013

- Met one-to-one with first year Pepperdine University students on a weekly basis to provide support and guidance
- Mentored students with issues pertaining to clinical intakes, diagnosis, psychological treatment, relational dynamics, and case management
- Collaborated with licensed clinical psychologist during group supervision to ensure best treatment practices

Pepperdine University, Malibu, CA

Graduate Teaching Assistant

September 2009 – December 2009

- Helped professor administer weekly quizzes to 250 undergraduate students who were enrolled in “Introduction to Psychology” class
- Graded and filed students’ quizzes each week
- Held office hours each week to assist students with questions pertaining to class material

School District of Lee County, Fort Myers, FL

Instructional Assistant Special Education

January 2008 – June 2008

- Instructed kindergarten through fifth grade students in a Life Skills classroom setting, to develop students’ skills in reading, writing, math, and socialization
- Worked with students individually and in small groups to ensure students received adequate attention
- Enabled students to achieve their individual goals outlined by their Individualized Education Plan
- Prepared and organized instructional aides, materials, and technology used for teaching, and helped the head teacher perform clerical and recordkeeping duties
- Encouraged a classroom environment based on respect for students’ individual differences, cultures, and interests
- Completed twelve weeks of instruction on American Sign Language, presented by Deaf Services Center of Fort Myers

TEACHING EXPERIENCE (Continued)**Las Virgenes Unified School District, Calabasas, CA**

Instructional Assistant Special Education

August 2007 – December 2007

- Aided students with class work
- Guided students to follow the directions of the general education teachers and the special education teachers
- Initiated a positive learning environment, and monitored behaviors and attitudes of the students
- Accompanied students to the cafeteria during lunchtime and assisted with eating
- Had communication with parents regarding the needs of the students
- Implemented Applied Behavior Analysis (ABA) with students throughout the school day, and worked with students on specific goals outlined by their Individualized Education Plan
- Completed 28 hours of “Hands On” training presented by Las Virgenes Unified School District staff and Autism Partnership staff

WORKSHOPS, SEMINARS & TRAININGJulie Wetherell, PhD: *“Are We There Yet? Optimizing Treatment of Anxiety in Older Adults”*Tina Mayes, MA: *“Treatment of Hoarding Disorder”*Veronica Cardenas, PhD: *“Improved Depression and Diabetes Care Management”*Irwin S. Rosenfarb, PhD: *“Empirically Supported Treatments for Psychosis”*Amanda Guterrez, PsyD: *“Emotion Regulation and its Role in Self-Injurious Behavior”*Rafael M. Reyes, PsyD: *“Suicide Assessment Training”*Amanda Guterrez, PsyD: *“Dialectical Behavior Therapy for Borderline Personality Disorder”*Lynn Northrop, PhD: *“Evidence-Based Treatment of Depression in Older Adults”*Kristie Earnheart, PhD: *“Working with Chronic Mental Illness: Thought Disorders”*Lynn Northrop, PhD: *“Recovery and Aging”*Alexis K. Yetwin, PhD: *“Developmental Impact of Hospitalization & Interventions”*Alexis K. Yetwin, PhD: *“An Introduction to Pediatric Pain Management”*Ernest R. Katz, PhD: *“Treatment of Childhood Cancer”*Beth Barber, PsyD: *“Creating Meaning with Pediatric Patients”*Laura Rava, PsyD: *“The World Cup: An Application to Multiculturalism”*Ernest R. Katz, PhD: *“Introduction to Childhood Cancer”*National Summit Conference: *“Sport Concussion and Other Athletic Injuries”*Edward Shafranske, PhD: *“Addressing Religious and Spiritual Issues in Therapy”*Lisa Bolden, PsyD: *“Providing Psychological Services to Homeless Persons who are African American”*Miguel Gallardo, PsyD: *“Providing Psychological Services to Homeless Persons who are Hispanic/Latino”*Robert Scholz, LMFT: *“Motivational Interviewing in Multicultural Settings”*Neva Chaupette, PsyD: *“Drugs and Drug Abuse in Los Angeles’ Skid Row Community”***ASSESSMENT TRAINING**

Emotional Assessment

Doctoral Level

- MMPI-2, TAT, HTP, RISB, Rorschach
- Test administration, interpretation, and report writing

Cognitive and Neuropsychological Assessment

Doctoral Level

- WAIS-IV, WISC-IV, WMS-IV, D-KEFS, WASI, BNT, HVOT, COWAT, RAVLT, Bender Visual-Motor Gestalt
- Test administration, interpretation, and report writing

PROFESSIONAL ORGANIZATIONS

Forensic Psychology Association	November 2011 - Present
American Psychological Association, Member	January 2011 - Present
Psi Chi International Honors Society in Psychology, Member	April 2010 - Present
California Association of Marriage and Family Therapist, Member	January 2008 - Present

AWARDS & HONORS

Pepperdine University Colleagues Grant Recipient	2010 - 2013
University of Colorado at Boulder Deans List	Spring 2004, Fall 2005, Spring 2006

ABSTRACT

Homelessness continues as a grim reality that has devastating effects upon individuals and families from diverse cultures and backgrounds. Alcohol abuse is one of the most common problems reported by homeless individuals in the U.S. Additionally, research has consistently demonstrated a significant relationship between homelessness and mental disorders such as depression. Given the rates of alcohol abuse among homeless persons, it is important that clinicians providing mental health services to the homeless have reliable, valid methods for assessing substance abuse. The main focus of this archival study was to examine the usefulness of the Alcohol Use Disorders Identification Test (AUDIT) among treatment seeking homeless men residing in a faith-based, homeless shelter in Los Angeles. This study also sought to determine the relationship between the AUDIT and the Beck Depression Inventory, Second Edition (BDI-II), a widely used measure of depressive symptoms. The present sample included 86 adult males with a mean age of 43 years. The sample was ethnically diverse, tended to be single, and most participants had at least a high school education. All of the participants were enrolled in a yearlong residential substance abuse recovery program. They all had voluntarily sought individual psychological services from a university-affiliated mental health clinic located within the same shelter that provided the recovery program. In addition to the AUDIT and BDI-II, instruments included the Drug Abuse Screening Test-20 (DAST-20) and an intake application form used at the clinic. The sample obtained a mean AUDIT score of 14.73; internal consistency reliability was .93. The BDI-II and DAST-20 had mean scores of 21.94 and 10.07, respectively. There were no statistically significant differences across ethnic groups in mean AUDIT, BDI-II, or DAST-20 scores. As predicted, significant positive associations were found between the AUDIT and the intake form-based measures of substance abuse problems. There was also a

significant positive relationship found between the AUDIT and the BDI-II. Other findings, clinical implications, limitations, and suggestions for future research are also explored. The results strongly supported the reliability and validity of the AUDIT as a measure of problematic alcohol use among treatment-seeking homeless men.

Chapter I: Problem Statement and Literature Review

Introduction

Homelessness. Homelessness continues to be a grim reality for millions of Americans, and represents a significant problem that negatively affects individuals and families from diverse cultures and backgrounds. Given recent unemployment rates, an increase in property foreclosures, and a decrease of government benefit programs, homelessness is a complex challenge within the United States (Los Angeles Homeless Services Authority, 2011). The U.S. Department of Housing and Urban Development (HUD) includes definitions for unsheltered homelessness and sheltered homelessness within their consideration of what homelessness entails. Unsheltered homelessness is defined as referring to someone who is residing in any area that is not ordinarily meant to be inhabited by humans (e.g., cars, parks, streets, abandoned buildings, under bridges, etc.). Sheltered homelessness, on the other hand, is when someone resides in an emergency shelter or transitional housing center.

With regard to the United States, recent findings suggest that approximately 3.5 million Americans experience homelessness at some point over the course of a year, which amounts to about one percent of the population as a whole (National Coalition for the Homeless, 2009). Furthermore, recent data suggests that on a given night in January 2011 approximately 636, 017 people were homeless (State of Homelessness in America, 2012). The national homelessness trend appears to be decreasing slightly across time, as reflected by a decrease of 1% from 2010. However, these national figures still reflect a massive number of homeless persons and highlight the need for supportive programs, outreach, and concerted efforts to reduce homelessness.

It is important to examine statistics regarding the gender differences pertaining to homelessness as well. On an average night in the United States, it is estimated that

approximately 83% of homeless people are single individuals while 17% are individuals in families, including children (State of Homelessness in America, 2012). However, the National Center on Family Homelessness (2008) reported that the United States has the largest number of homeless women and children among industrialized nations. In addition, the National Center on Family Homelessness (2008) urges caution about the definition of what constitutes single adults. Homeless individuals who are counted as single adults may also have children, although they might not be residing with their children at the present time. In fact, they estimate that families comprise approximately 34% of the total homeless population nationwide.

National data clearly demonstrates that African Americans are disproportionately represented among the homeless. According to the National Coalition for the Homeless (2009), African Americans represented the greatest proportion of homeless individuals in the United States (42%), followed by Caucasians (39%), Hispanics (13%), Native Americans (4%), and Asians (2%). Another staggering finding from this data suggests that 26% of people experiencing homelessness across the United States are considered mentally ill. Similarly, high rates of substance use have been noted within the national data on homelessness. According to the National Coalition for the Homeless (2009), approximately 38% of the nationwide homelessness sample reported problems with alcohol while 26% reported problems with other substances

Given the rates of alcohol and substance abuse among homeless persons, it is important that clinicians providing mental health services to the homeless have reliable, valid methods for assessing substance abuse. The purpose of this study was to examine the usefulness of the Alcohol Use Disorder Identification Test (AUDIT; Babor, Higgins-Biddle, Saunders, & Monteiro, 2001) among homeless men seeking psychological services. Before describing the

proposed study in detail, relevant literature on homelessness, substance abuse, and mental illness will be considered.

Homelessness is a particularly grave problem in Los Angeles, California. In fact, Los Angeles County has often been referred to as The Homeless Capital of the Nation (Connery & Brekke, 1999). The January 2011 Greater Los Angeles Homeless Count showed 51,340 homeless persons in Los Angeles County on a given night (Los Angeles Homeless Services Authority, 2011). Although this figure represented a slight decrease in the rate of homelessness since 2009, it still demonstrates a strong need for intervention and support for this vulnerable group of individuals. Similar to the national data on homelessness, research findings from the 2011 Greater Los Angeles Homeless Count indicate that single males represent the majority of the homeless individuals residing in Los Angeles (59%), followed by single women (28%), and children (14%). Findings pertaining to race and ethnicity indicated that homeless African Americans are overrepresented (43%) as compared to the general population of African American individuals that reside in Los Angeles County (8%). Latinos represented 27.7% of Los Angeles County's homeless in 2011, while 24.9% were Caucasians, 2.3% were Asian/Pacific Islanders, and 1.4% were American Indians/Native Alaskans.

In addition, studies have highlighted multiple trends in regards to racial and ethnic identification within the homeless demographic in Los Angeles. Gamst et al. (2006) found that the homeless Latino population appears younger in age as compared to other ethnicities across various cities within California including La Verne, Claremont, and Pomona. Furthermore, researchers found that the Latino population as a whole is less likely than other groups to report victimization and assault while experiencing homelessness. Perhaps this reluctance to report violence originates from fear or insecurity related to one's immigration status, as many Latino

homeless persons tended to identify as first-generation immigrants. This study also highlighted that Caucasian and African American homeless people within these various cities showed higher rates of depression and anxiety than their Latino and Native American counterparts. These findings suggest the need to better understand the experiences and factors that have contributed to life outcomes among homeless individuals from diverse ethnic backgrounds.

Chronic homelessness has been defined in the following terms, “An unaccompanied disabled person who has been continuously homeless for over one year or has had at least four episodes of homelessness in three years; or a family is considered chronically homeless if at least one member meets the definition of chronic homelessness” (Los Angeles Homeless Services Authority, 2011, p. 16). The majority of the chronically homeless in Los Angeles were between the ages of 25 and 55 years-old (62.5%), with approximately 34% over the age of 55 (Los Angeles Homeless Services Authority, 2011). This suggests that the homeless population is aging. Furthermore, 18% of Los Angeles County’s homeless were classified as veterans, a 3% increase from 2009 (Los Angeles Homeless Services Authority, 2011). In Los Angeles, many homeless individuals suffer from disabilities including physical disabilities (22%), mental illness (33%), and substance use related problems (34%). Due to these high rates, it is clear that supportive housing programs and emergency shelters must consider incorporating substance use treatment rehabilitation programs and appropriate treatment surrounding mental health care into the current foundation of care.

A study conducted by the Los Angeles Police Department (LAPD) and the Los Angeles Homeless Services Authority (LAHSA) in 2007 revealed that the greatest concentration of homelessness was located within a fifty block area in the central city area of Los Angeles known as Skid Row, with an estimated prevalence of 5,131 people at that time. Among this portion of

the homeless community, 4,165 persons (81%) were between the ages of 25 and 55 years-old and 2,185 (43%) had problems with substance use. Furthermore, African Americans were disproportionately represented in this part of Los Angeles, accounting for 3,320 (65%) of the homeless residing on Skid Row, followed by 682 Caucasians (14%), 641 Latinos (12%), and 487 multi-racial people (9%). According to the Los Angeles Homeless Services Authority (2011), approximately 78% of homeless people on Skid Row were residing in shelters, with 22% considered to be unsheltered.

Pathways leading to homelessness. Homelessness is a complex multi-determined phenomenon that occurs due to various factors across the lifespan. It is often the result of various interactions between individual characteristics, environmental conditions, and socio-economic circumstances (Toro, Trickett, Wall, & Salem, 1991). Beginning in childhood, familial experiences appear to influence one's pathway into becoming homeless. Recent literature also points to findings that connect salient life experiences in childhood and young adulthood that may relate to risk for homelessness. Nelson, Clarke, Febbraro, and Hatzipantelis (2005) found that previous health issues, unsupportive relationships, and unstable resources were present in many of the interviewed homeless participants' lives before becoming homeless. Additionally, Morrell- Bellai, Goering, and Boydell (2000) found that a majority of participants interviewed in their qualitative study indicated macro-level precipitants to homelessness that included unemployment and micro-level precipitants such as parental alcoholism in childhood, poverty in childhood, substance use, depression, and failed relationships.

For many, themes of unstable households in childhood including witnessing domestic violence, substance use by caregivers, and physical and emotional abuse are present in the narratives of people who become homeless (Kim & Roberts, 2004). For women and children,

domestic violence has been shown to be a significant risk factor for homelessness (Nooe & Patterson, 2010). Browne (1998) reported that a staggering 92% of female homeless individuals endorse experiencing domestic violence at least once during the course of their lives. The burden of having to find stable housing following the escape from domestic violence contributes to homelessness. Many times women and children flee from violent situations with little finances. Lack of finances and additional barriers such as lack of employment history and poor credit make it substantially harder to secure housing (Anti Discrimination Center of Metro New York, 2005). Furthermore, research has suggested that residing in foster care during childhood increases one's chances of becoming homeless in the future, as it has been recognized that many children Age Out of the system before they are ready to take on the complex challenges of independent living (Roman & Wolfe, 1997).

Additionally, lack of employment or low wages has undoubtedly contributed to becoming homeless (United States Conference of Mayors, 2011). According to Wagner and Perrine (1994), unemployment has been identified as a leading factor contributing to homelessness to date. Although unemployment has been shown to be a significant factor leading to homelessness, many homeless individuals are employed (Nooe & Patterson, 2010). However, Nooe and Patterson (2010) report that the low wages obtained from these jobs seldom provide adequate resources for self sustainability, particularly given the high cost of housing in places such as Los Angeles. Finding employment is also more difficult for those individuals who lack adequate schooling (Nooe & Patterson, 2010). Findings from a study conducted in 1999 suggest that approximately 53% of parents within homeless families had less than a high school education (Urban Institute, 1999). It appears that individuals in ethnic minority groups and women also possess fewer employment opportunities than their cultural majority and male counterparts (Anti

Discrimination Center of Metro New York, 2005). Furthermore, low wage jobs do not provide homeless individuals with adequate health insurance benefits, which may lead to increased physical health problems among these individuals (Nooe & Patterson, 2010).

Accessibility to health care is crucial for maintaining both physical and mental health. Unfortunately, jobs that do not offer adequate health care benefits, contribute greatly to the insufficient health care received by both individuals living in poverty and those that are homeless (Nooe & Patterson, 2010). The United States Bureau of the Census (2007) reported that 47 million people living in the United States are without healthcare, while a third of individuals living in poverty are without health insurance. Therefore, lack of adequate health care is both a risk factor for homelessness and may exacerbate health problems experienced by homeless individuals. Physical health problems have been deemed a significant risk factor for homelessness (Nooe & Patterson, 2010). Studies examining the occurrence of health problems in the homeless across the nation have estimated that 46% of individuals have chronic health problems (Rosenheck et. al., 1998), which poses major challenges for these vulnerable individuals and for the health care system. It is also recognized that chronic physical health problems can contribute to the development of mental health issues, as health concerns can lead to stress, anxiety, and heightened vulnerability (Rogers, 2008). Furthermore, the burden of financial strain from chronic and serious health problems and medical conditions may also contribute to inadequate finances and the inability to maintain stable housing (Nooe & Patterson, 2010). The health care disparity demonstrates how multiple factors (housing, finances, medical conditions, health care inaccessibility) can create and maintain a vicious cycle that is difficult to get out of. In today's economy, it is becoming harder to find affordable housing.

The lack of reasonably priced rental properties and housing contributes to and maintains homelessness (Nooe & Patterson, 2010). In fact, it is estimated that 2.2 million low cost apartments vanished across the United States between 1973 and 1993, making it more challenging for individuals and families to find housing that they can afford (Daskal, 1998).

Lack of social support has also been identified as a risk factor for homelessness (Anderson & Rayens, 2004). Perhaps it can be assumed that lack of social support as well as diminished familial contact and relationships can contribute to the increased chance of becoming homeless, as this can hinder one's ability to reach out for assistance if needed.

As will be discussed in later sections, substance abuse, including alcohol abuse and dependence, has been shown to be a significant risk factor for homelessness. According to Johnson and Chamberlain (2008), approximately 45% of homeless individuals within their study endorsed problems with substance use, although two thirds of their sample claimed to begin substance use following homelessness.

Recent studies also suggest that military veterans are at a higher risk for becoming homeless. Statistics show that 41% of homeless men are veterans as compared to their counterparts in the general population (34%) (National Coalition for the Homeless, 2011). Within Los Angeles County, 18% of homeless individuals are veterans (Los Angeles Homeless Services Authority, 2011). Between 2009 and 2011, reports showed a significant decrease of 11% of homelessness among veterans although veterans continue to experience homelessness at a higher rate than the general population (The State of Homelessness in America, 2012). Specifically, it is estimated that there are 31 homeless veterans per 10,000 veterans within the general population (The state of Homelessness in America, 2012). However, military experience alone does not automatically suggest a heightened vulnerability to homelessness. In fact, other

factors seen among veterans including poverty, lack of sufficient housing, and substance abuse, may increase the likelihood of becoming homeless following military involvement (Rosenheck, Frisman, & Chung, 1994). Perhaps the combination of childhood experiences such as familial instability, as well as exposure to trauma, poverty, unemployment, substance abuse or dependence, mental illness, physical illness/disability, discrimination, and other factors all contribute to the pathway into homelessness.

Previous incarceration appears to contribute to the origin and maintenance of becoming homeless. Approximately 630,000 adults are estimated to be released from state and federal prisons each year with the expectation of integrating back into their communities (Luther et al., 2011). Individuals engaging in re-entry into general society are oftentimes unable to obtain basic needs such as housing and employment. Furthermore, the inability to secure such needs disproportionately affects impoverished and ethnic minority populations (Luther et al., 2011). Individuals who have recently been released from prison are also at a higher risk for mental illness and chronic health problems (Luther et al., 2011). It is important to note that almost half of the homeless population in the United States has a history of incarceration (Williams et al., 2010). However, it is unclear whether incarceration is predictive of homelessness or whether it is a consequence of homelessness. Recent findings have suggested, however, that males who have been recently incarcerated face greater challenges to obtaining housing, thus increasing the chances of becoming homeless in the future. As a means to examine this further, Greenberg and Rosenheck (2010) analyzed data from a national sample of incarcerated inmates within the United States. They found that 12.4% of inmates had been homeless during the previous year, while 2.9% were found to be homeless at the time of incarceration. According to the authors of this specific study, the latter finding was considered to be very high, perhaps highlighting the

need for preventative outreach programs for those that are homeless. Furthermore, few jails and prisons comprise programs that offer case management services to link individuals leaving prisons or jails to community services (Steadman & Veysey, 1997). Therefore, supportive programs and organizations, such as the Union Rescue Mission, which offer assistance with basic needs, are greatly needed for individuals who wish to successfully reintegrate back into society.

Homelessness and mental illness. Past research has indicated at least 20 to 25% of homeless individuals experience mental illness (Blankertz & White, 1990). Deinstitutionalization remains a factor that has contributed to rates of mental illness and homelessness. An increase in deinstitutionalization occurred in the 1980's as an attempt to decrease hospitalization and increase self-sustainability and community living. Although this may have been the result of good intentions, deinstitutionalization also contributed to an increase in homelessness, as these individuals were left with little resources and few occupational and housing opportunities (Nooe & Patterson, 2010). In addition, mental illness may have been exacerbated within these individuals following the trauma of inadequate resources (Koegel & Burnam, 1992). In fact, a study conducted by Kim, Ford, Howard, and Bradford (2010) revealed that experiences of trauma were significant indicators of mental health problems among a sample of 239 homeless men in North Carolina. Furthermore, homeless men who were older than 42 years-old were more than two times more likely to experience mental health problems, suggesting that older adults may be even more susceptible to mental health problems while homeless (Kim et al., 2010).

In addition, many homeless individuals present with both mental illness and substance use issues. According to Staiger, Long, McCabe, and Ricciardelli (2008), the term dual-diagnosis describes individuals who present with both psychiatric illness and alcohol or other substance

use issues. In a study that examined 334 homeless individuals within California cities including downtown Los Angeles, Santa Monica, and Venice, the authors found that homeless individuals with mental illness demonstrated alcohol dependence lifetime rates of 69% and substance dependence lifetime rates of 56% (Sullivan, Burnam, & Koegel, 2000). The findings of this study suggest that homelessness, mental illness, and substance abuse are significantly inter-correlated and relevant treatment and outreach are necessary. In another study, Blankertz and White (1990) found that 57% of homeless persons met criteria for dual-diagnosis. Those that carry a dual-diagnosis often encounter their own unique struggles and challenges as homeless individuals. Not only has it been found that those with dual-diagnoses tend to be older males, they have also been found to be at greater risk for living in harsh conditions, more likely to become incarcerated, and are more prone to victimization (Fischer & Breakey, 1991). In addition, they appear to experience a longer period of homelessness than those who do not identify as having dual-diagnoses (Fischer & Breakey, 1991), and are therefore at greater risk for homelessness. Fazel, Khosla, Doll, and Geddes (2008) found that homeless persons had higher prevalence rates of mental illness as compared to the general population and that alcohol and substance dependence was the most common disorder experienced by the homeless population as a whole. Among homeless young adults, it was found that substance use is exacerbated both by depression and insufficient coping skills (Pluck, Kwang-Hyuk, Lauder, Fox, Spence, & Parks, 2008), showing the inter-relation of risk factors.

According to the Union Rescue Mission (2007), 31% of homeless people are mentally ill in Los Angeles County. Mental illness has been shown to occur within this population at a higher rate than among housed persons. Moreover, mental illness both contributes to and is a byproduct of homelessness. The study conducted by Sullivan et al., (2000) examined factors

associated with becoming homeless and mental illness within two Los Angeles communities. These included the urban downtown Los Angeles area and the coastal cities of Venice and Santa Monica. Sullivan, Burnam, and Koegel found that of the 334 participants, 65% became homeless after the onset of their mental illness, which indicated that homelessness can be one of the consequences of mental illness.

Depression among homeless persons appears to be a significant concern. In a study conducted by Wong and Piliavin (2001), approximately 64% of the 430 homeless individuals in the study were found to be somewhat depressed, which is three times the rate of their housed counterparts. Similarly, another study found that homelessness is a significant factor in the origin and maintenance of depression, as those homeless persons who displayed depressive symptomatology were more likely to have been homeless at least three times as compared to those who did not screen positive for depression (Berg, Nyamathu, Christiani, Morisky, & Leake, 2005). This indicates the importance of identifying and treating depression among homeless individuals, while also tending to other basic needs and stabilization. In Los Angeles, 52% of homeless people in one major study ($N = 3,210$) reported suffering from depression, while only 20% indicated receiving mental health treatment for depressive symptoms (Los Angeles Homeless Authority Services, 2007).

Homelessness and alcohol abuse. As mentioned earlier, alcohol abuse is one of the most common problems reported by homeless individuals. In fact, the National Coalition for the Homeless claims that 38% of homeless people across the U.S. report alcohol problems, while 26% indicate problems with other substances. Despite the high percentage of drug abuse among the homeless, it remains clear that people struggling with alcohol related issues are still occurring at a higher rate (Eyrich-Garg, Cacciola, Carise, Lynch, & McLellan, 2008; North, Eyrich, Pollio,

& Spitznagel, 2004). Furthermore, a study conducted by Fischer and Breakey (1991) found that people residing in homeless shelters are more susceptible to substance abuse in general, suggesting the ongoing need to target this unique population in regard to offering services and substance abuse treatment. In addition, many homeless individuals identify substance use as a key factor that has both precipitated and exacerbated homelessness (McNaughton, 2008). This finding was consistent with another study of 335 homeless persons across Ireland. Specifically, it was found that individuals reported substance use (19%) and alcohol use (13%) as primary reasons for becoming homeless (Lawless & Corr, 2005).

For many, alcohol use has also been identified as a means to cope with the challenges and stressors of homelessness. Specifically, McNaughton (2008) found that many homeless individuals endorsed three key reasons for using alcohol and other substances after becoming homeless. First, they reported wanting to escape from the marginalization and isolation that they had come to experience. Secondly, they used it as a way to assimilate into the environment and culture of homelessness that reflected the social structure of which they were a part. Lastly, use of alcohol and other substances served as a way to manage uncomfortable symptomatology of past experiences pertaining to trauma.

The evidence indicates that alcohol abuse and dependence is interwoven with homelessness at many levels. It may serve as a cause or risk factor for homelessness, it likely serves to exacerbate and prolong homelessness, and it also represents an unfortunate or ill-advised means of attempting to cope with the experience of homelessness (Fountain, Howes, Marsden, Taylor, & Strang, 2003). Moreover, there is evidence that homeless persons may use alcohol and other substances to cope with symptoms of mental illness, trauma, marginalization, discrimination, and other factors associated with homelessness. Furthermore, Greenberg and

Rosenheck (2010) found substance use and mental illness to be independent risk factors for homelessness. Given these complex interconnections, it is essential that mental health professionals working with the homeless have access to reliable and valid means for the assessment of alcohol abuse and dependence and related disorders.

Alcohol Use Disorder Identification Test (AUDIT). The Alcohol Use Disorder Identification Test (AUDIT) is a self- report screening tool for alcohol use disorders that has been utilized in a variety of settings with ethnically, culturally, and socioeconomically diverse populations (Reinert & Allen, 2007). Questions on the AUDIT pertain to the frequency of alcohol use occurrence within the previous year. Responses are weighted on a scale between 0 and 4 (Allen, Litten, Fertig, & Babor, 1997). Total scores on this instrument can range from 0 to 40. A score of 8 or above indicates a possible risk of alcohol use problems (Conigrave, Hall, & Saunders, 1995).

According to Allen et al., (1997), the AUDIT ranks fourth among common alcohol use screening tools and was constructed based on responses from a large multinational sample. In addition, this specific screening tool has been shown to demonstrate high test-retest reliability and strong internal consistency (Reinert & Allen, 2007). In fact, the AUDIT may be the only alcohol use test designed for international use (Babor et al., 2001). Following the development of the AUDIT, many studies have been conducted to assess its validity among clinical and community samples across the world and such studies have typically demonstrated high reliability and validity (Allen et al., 1997). In addition, the AUDIT has been shown to be a valid measure when used among individuals who are unemployed or maintain low income jobs (Claussen & Aasland, 1993; Isaacson, Butler, Zacharek, & Tzelepis, 1994). While other screening measures tend to assess for the presence of alcohol dependence alone, the AUDIT has

been shown to be effective in detecting alcohol use along a spectrum of alcohol misuse, allowing for clinicians to engage in both preventative interventions and treatment for dependence (Donovan, Kivlahan, Doyle, Longabaugh, & Greenfield, 2006). Because there is evidence that the AUDIT can be used with ethnically diverse populations in various settings, it appears to be a promising measure for the assessment of alcohol problems among the homeless.

The purpose of the present study was to examine the use of the AUDIT in a sample of homeless, treatment-seeking men at a major homeless shelter in Los Angeles. This study sought to explore the reliability and validity of the AUDIT in an ethnically diverse sample of homeless men, drawn primarily from a residential substance abuse recovery program. The relationship of AUDIT scores to self-reported substance abuse, as measured by the 20-item version of the Drug Abuse Screening Test (DAST-20; Skinner, Gavin, & Ross, 1989), was also examined. Given the high prevalence of depressive disorders and symptoms among the homeless, the present study also explored the relationship of the AUDIT to scores on the Beck Depression Inventory, Second Edition (BDI-II; Beck, Steer & Brown, 1996).

The following research questions were explored. What are the demographic characteristics of a sample of homeless men seeking psychological services at a homeless shelter in Los Angeles? How do treatment-seeking homeless men perform on the AUDIT? What evidence is there of the reliability and validity of the AUDIT when administered as part of the intake evaluation at a mental health clinic in a homeless shelter? How do AUDIT scores relate to a widely used measure of drug abuse among treatment seeking homeless men? How do AUDIT scores relate to a widely used measure of depressive symptoms among treatment seeking homeless men?

The following hypotheses were addressed: (a) It is hypothesized that AUDIT scores will be positively associated with intake form-based self-report ratings of severity of alcohol abuse (b) It is hypothesized that AUDIT scores will be positively associated with history of legal problems (c) It is hypothesized that higher AUDIT scores will be associated with fewer years of education (d) It is hypothesized that AUDIT scores will be positively correlated with DAST-20 scores (e) It is hypothesized that AUDIT scores will be positively correlated with BDI-II scores.

Chapter II: Method

Research Design

This research study utilized a correlational design as a means to describe the directionality and strength of relationships among the variables of interest. Descriptive statistics were also calculated to describe relevant characteristics of the sample (Mertens, 2010), including age, ethnicity, level of education, legal history, substance use history, and DSM-IV-TR diagnoses, when available. Other psychosocial variables were also collected among a sample of homeless males residing in an inner city mission. An important goal of the study was to examine the usefulness and validity of a self-report measure of alcohol-related problems, i.e., the Alcohol Use Disorders Identification Test (AUDIT). By examining how AUDIT scores correlate with relevant client variables and other psychological measures, its usefulness among treatment-seeking homeless persons with substance abuse problems can be further established.

Setting

This study was conducted at the Union Rescue Mission (URM), a nonprofit, faith-based, Christian organization in the Skid Row area of central Los Angeles that provides emergency and long-term comprehensive services to homeless men, women, and children (Union Rescue Mission, 2012). The average number of men who spent the night at URM on any given night in 2011 was estimated at 924 men, while 217 men obtained transitional housing and program assistance (Union Rescue Mission, 2012). Multidisciplinary services provided at URM include food, shelter, clothing, medical and dental care, recovery programs, religious instruction and worship opportunities, transitional housing, education, mental health counseling, job training, and legal assistance (Union Rescue Mission, 2012). This study utilized data collected at the mission's mental health clinic. The Jerry Buttler-URM/Pepperdine University Community

Counseling Center is staffed by doctoral students from the APA accredited clinical psychology program at Pepperdine University, who are supervised by licensed clinical psychologists affiliated with the University. The Pepperdine Counseling Center, also referred to as the mental health clinic, provides individual and group therapy as well as couple counseling and psychological assessment (Union Rescue Mission, 2012). Although the URM is a faith-based shelter, therapeutic services provided at the mental health clinic are not religiously based and individuals from all faith perspectives and backgrounds are welcome to participate. In 2006, the Pepperdine mental health clinic provided 1,055 therapy sessions to residents of the URM (Union Rescue Mission, 2012).

The clinic is available free of charge to all guests and residents at the mission, though the majority of clients come from the Christian Life Discipleship Program (CLDP). CLDP is 12-month residential substance abuse treatment program for homeless men. According to URM, this program assists each individual in understanding the origin of becoming homeless (Union Rescue Mission, 2012). Furthermore, the program identifies with a holistic understanding of the needs of each individual and focuses on physical, mental, spiritual, emotional, and social needs (Union Rescue Mission, 2012). This comprehensive program includes educational classes, religious instruction, worship services, substance abuse recovery groups, financial planning classes, vocational training services, work assignments, and regular meetings with an assigned chaplain. Although psychological services are not required for men in the program, they are highly encouraged to avail themselves of this resource. Therefore, in the vast majority of cases, psychological services and counseling were voluntarily sought out by the clients on whom the data were collected for the present study.

Participants

This archival study utilized de-identified data that were extracted from historical information collected from intake assessments conducted with treatment seeking homeless men at URM's mental health clinic. Eighty-six cases were included in this study. Given that the researcher anticipated a moderate effect size and used the .05 level of statistical significance, 86 participants provided sufficient statistical power to identify the presence of any significant correlations between variables (Cohen, 1988). In addition to relevant demographic, historical, and mental health-related variables from the intake records, scores from the AUDIT, the Beck Depression Inventory- 2nd Edition (BDI-II), and the 20-item version of the Drug Abuse Screening Test (DAST-20) were examined.

The ages of the 86 men ranged from 20 to 64 years, with a mean of 43.08 ($SD= 11.556$). Of the 86, 37 participants identified themselves as being African-American (43%), 21 (24.4%) reported being Caucasian, 18 (20.9%) indicated they were Latino, five (5.8%) reported being Native American, and five (5.8%) identified as multiethnic. The findings pertaining to ethnicity of this sample were similar to the statistics that were recently reported for homeless persons in Los Angeles County (Los Angeles Homeless Services Authority, 2013).

With regard to the highest level of education obtained, out of 85 for whom this information was available, one participant reported his highest education level attained as elementary school (1.2%), 10 reported completing junior high school (11.8%), 19 indicated completing senior high school (22.4%), 30 reported receiving a high school diploma or a General Equivalency Diploma (GED) (35.3%), 18 indicated completing some college (21.2%), and seven reported earning a college degree (8.2%).

With regard to job history, participants reported on their occupational history for up to three years prior to the time of intake. Of the 69 participants who responded to this portion of the intake form, 21 (30.4%) indicated a history of working in the service occupations; 14 (20.3%) reported working in managerial, technical, or professional occupations; seven (10.1%) indicated working in clerical or sales occupations; three (4.3%) reported a history of either processing occupations or machine trade occupations; and one (1.4%) reported a history in structural work. Four (5.8%) individuals fell into the miscellaneous occupations category, and 16 (23.2%) indicated that they were not employed within the three years prior to the time of intake.

Eighty-four participants responded to a question about current marital status. Forty-five men identified as being single (53%), 21 (25.0%) reported being divorced, nine (10.7%) indicated being married, and nine (10.7%) reported being separated. Individuals were also asked to report on their history of military involvement. Out of the 77 participants who responded to this item on the intake form, 13 indicated they were military veterans (16.9%). Of the 73 men who reported on their legal history, 47 individuals (64.4%) reported having been previously incarcerated, while 18 (24.7%) denied having experienced any legal problems. Seven (9.6%) participants reported having been previously arrested with no jail time and one individual (3.3%) described his legal history as *other*.

Eighty-four individuals responded to the intake form question, “Do you have a history of substance abuse problems?” Of the 84, 75 individuals (89.3%) checked the *Yes* option, indicating substance abuse concerns, while nine (10.77%) checked the *No* option. Eighty-five participants responded to an open-ended question that had them identify “the drugs and substances, including alcohol and prescription medications, that you have used and abused the most in your life.” Alcohol was the most frequently listed, as 32 (37.6%) men reported it on this item. Twelve men

(14.1%) indicated crystal meth, 11 individuals (12.9%) listed marijuana, ten men (11.8%) indicated crack cocaine, nine individuals (10.6%) identified cocaine, five (5.9%) listed heroin, three (3.5%) denied having a preference, two (2.4%) cited hallucinogens, and one individual (1.2%) indicated *Other*.

Sixty-three individuals were assigned a psychological diagnosis on Axis I based on specific criteria outlined within the Diagnostic and Statistical Manual Fourth Edition, Text Revision (DSM-IV-TR). Thirty-two individuals (50.8%) were diagnosed with Substance Dependence, six men (9.5%) were diagnosed with Major Depressive Disorder, five individuals (7.9%) were diagnosed with Substance Abuse, four men (6.3%) were assigned a V-Code, three individuals (4.8%) were diagnosed with Schizophrenia, three men (4.8%) were diagnosed with *Other*, two men (3.2%) were diagnosed with Post Traumatic Stress Disorder (PTSD), two individuals (3.2%) were diagnosed with Schizoaffective Disorder, one individual (1.6%) was diagnosed with Depression Not Otherwise Specified (NOS), and one man (1.6%) was assigned a diagnosis of Psychotic Disorder NOS. Two individuals (3.2%) were assigned *No Diagnosis*, one individual (1.6%) was assigned a diagnosis of a *Rule Out*, and one man (1.6%) was assigned *Diagnosis Deferred* on Axis I.

Of the 62 men assigned a diagnosis on Axis II at intake, 25 individuals (40.3%) were assigned *Diagnosis Deferred*, 23 men (37.1%) were assigned *No Diagnosis*, four individuals (6.5%) were diagnosed with Antisocial Personality Disorder, three men (4.8%) were assigned *Rule Out*, two individuals (3.2%) were diagnosed with *Other*, one (1.6%) was diagnosed with Paranoid Personality Disorder, one (1.6%) with Schizoid Personality Disorder, one (1.6%) with Schizotypal Personality Disorder, one (1.6%) with Borderline Personality Disorder, and one (1.6%) with Narcissistic Personality Disorder. Finally, of the 82 participants who responded to

this item, 54 individuals (65.9%) denied past or present psychotropic medication use, while 28 individuals (34.1%) endorsed either currently taking or ever taking psychotropic medication.

Instruments

Intake application form. The Pepperdine University Community Counseling Center Intake Application Form (IAF) is a four page self-completed measure administered to prospective clients prior to beginning treatment services and takes approximately thirty minutes to complete. Demographic information, psychosocial history, substance use history, previous treatment received, and legal history are included within this form. None of the variables obtained for this study included any personally identifying information. All persons seeking services at the clinic are required to complete the intake form, which includes fill-in-the-blank items, Likert-scale items, yes-no/true-false formatting, and a problem checklist. The Mental Health and Substance Use History section allows each respondent to state whether they believe they have a history of substance abuse problems and also targets questions specifically with regard to the past 12 months. For example, respondents are asked to rate how serious their alcohol problems have been within the past 12 months on a 5 point Likert scale 1 (No problems at all/not applicable); 2; 3 (Moderate problems); 4; and 5 (Severe problems). The form includes a parallel item for drug abuse problems in the past 12 months. Respondents are asked to list substances, including alcohol and prescription medication, that have been used/abused by the respondent.

A checklist of 38 problems or concerns is also included on the IAF. The respondent is directed to put a check mark next to each item that is a current concern, and two check marks next to items to indicate the most important concerns. Examples of these items include: feeling down or unhappy, feeling lonely, having a hard time making friends, concerns about staying

clean and sober, and thoughts about taking own life. The IAF assists clinicians in determining salient problems and concerns, encourages clinicians to ask follow up questions by identifying problem areas, and provides a baseline of functioning before treatment. (See Appendix A for copy of IAF).

Alcohol Use Identification Test (AUDIT). The Alcohol Use Disorders Identification Test (AUDIT) was used to assess for harmful and hazardous patterns of alcohol consumption within the year prior to entering the mission (AUDIT; Babor et al., 2001). The AUDIT is a ten-item self-report screening tool for alcohol use disorders and was developed by the World Health Organization (WHO) to assess for excessive drinking. The questions on this measure are organized into three domains which contain items that examine harmful or hazardous alcohol consumption or dependence: (a) Hazardous Alcohol Use (frequency of heavy drinking and typical quantity); (b) Dependence Symptoms (morning drinking and increased salience of drinking); and (c) Harmful Alcohol Use (blackouts, alcohol-related injuries, and guilt after drinking) (Babor, et al., 2001). Scores on this tool can range from 0 to 40. A score of 8 or above indicates a possible risk of alcohol use problems (Conigrave et al., 1995). More specifically, total scores of 8 or more reflect an indication of hazardous drinking, harmful alcohol use, and/or alcohol dependence (World Health Organization, 2001). Generally, a higher score obtained on the AUDIT indicates greater sensitivity towards identifying possible problems with alcohol dependence (World Health Organization, 2001). Responses on the AUDIT include five response options and are on a scale ranging from 0 to 4 on items 1 to 8. On items 9 and 10, three response options are given on a 0, 2, or 4 rating scale. Responses on the 10 items yield a total score ranging from 0 to 40. Specifically, a score from 0 to 4 represents a low degree of alcohol

problems, a score of 8-15 reflects a medium degree of alcohol problems, and a score of 16 and above reflects a high level of alcohol problems (Babor et al., 2001).

The AUDIT was developed and evaluated over a 20-year period and has been found to provide an accurate assessment of risky alcohol use across age, gender, and cultural groups (Allen et al., 1997). According to a systematic review of the literature, the AUDIT is considered the best alcohol use screening tool as compared to other self-report measures including the CAGE or the MAST (Fiellin, Carrington, & O'Connor, 2000). In addition, the AUDIT has been shown to be an effective and valid screening tool among individuals who are unemployed or who maintain low- income wages as well as with individuals with serious mental illness (Claussen & Aasland, 1993; Isaacson, et al., 1994) In a study conducted in Cleveland, Ohio that examined 124 inner city individuals within a medical clinic, researchers found that the AUDIT demonstrated both high specificity and sensitivity for the assessment and detection of recent alcohol problems (Isaacson et al., 1994).

Moreover, the AUDIT has been used to assess for the alcohol use among homeless individuals (Lawless & Corr, 2005; Moriarty, 2011). In a study conducted in Dublin, Ireland, findings suggested that alcohol problems were significant among 247 homeless individuals who participated in this study. Specifically, scores from the AUDIT indicated that 73% of the participants had some level of alcohol problems, while 49% demonstrated higher level alcohol problems (Lawless & Corr, 2005). As noted earlier, 13% of the sample reported that alcohol was the main reason they became homeless (Lawless & Corr, 2005). Moriarty (2011) found that the overall mean score on the AUDIT for 98 homeless, treatment-seeking males in Los Angeles was 13.08 ($SD = 9.79$), indicating a medium level of alcohol problems. Within this sample, scores on the AUDIT ranged from 0 to 34, indicating diverse alcohol related problems among the homeless

individuals in the study (Moriarty, 2011). Furthermore, the AUDIT was positively correlated with five scales from the Trauma Symptom Inventory (TSI; Briere, 1995); including anxious arousal, depression, intrusive experiences, defensive avoidance, and dissociation. This raised the possibility that homeless individuals may use alcohol as a means to cope with trauma-related and depressive symptoms.

As previously mentioned, the AUDIT has been used in various settings among diverse populations. An interesting finding was highlighted in a study conducted with men in Russia between the years of 2008 and 2009. Cook et al. (2011) found that scores obtained from the administration of the AUDIT revealed that alcohol related problems were increased among men who reported less education as compared to men with more education.

In addition, this specific screening tool has been shown to demonstrate high test-retest reliability and strong internal consistency (Reinert & Allen, 2007). Specifically, a study conducted by Sinclair, McRee, and Babor (1992) yielded high test-retest reliability ($r = 0.86$). Internal consistency was reported as (.85) in a study conducted by O'Hare et al., 2004. Furthermore, results from a two year review that analyzed a total of 20 studies indicated that the AUDIT was both reliable and valid (Monti, 2007). Specifically, the AUDIT was determined to be easy to score, brief, and generally free of cultural bias (Monti, 2007).

Drug Abuse Screening Test-20 (DAST-20). The Drug Abuse Screening Test (DAST) is a self-report measure with 28 items that was developed to assess problematic substance use (Yudko, Lozhkina, & Fouts, 2007). At the present time, there are three versions of the DAST that vary in the number of items: the DAST-28, DAST-10, and DAST-20 (Yudko et al., 2007). The DAST was originally modeled after the Michigan Alcoholism Screening Test (MAST; Yudko et al., 2007). Although the MAST has been shown to be an effective screening measure

for alcohol use, it does not provide any possibility for the assessment of other substance use (Skinner, 1989). The 20-item version of the DAST (DAST-20; Skinner et al., 1989) is the one that will be used in the present study.

Responses on the DAST-20 are scored as “Yes” or “No.” All “Yes” answers receive 1 point while all “No” answers receive 0 points. Scores of 0 are indicative of no problems with drug abuse; scores between 1 and 5 indicate a low level of problems related to drug abuse; scores between 6 and 10 reflect a moderate level of problems; scores of 11 to 15 indicate substantial drug problems; and scores of 16 to 20 indicate that severe drug problems are likely (Skinner, 1989). Previous research on the DAST-20 showed an almost perfect correlation between this version and the original DAST-28 ($r = .99$; Yudko et al., 2007). According to Yudko et al., (2007), the DAST-20 demonstrates strong face validity and is easy to complete; it takes approximately 5 minutes to answer all questions and is written at a 4th grade reading level.

The DAST has been shown to be an effective assessment measure in diverse community samples. A study conducted in Ireland to assess for substance use among homeless persons showed that 36% of the 355 individuals within the sample could be considered problematic substance users (Lawless & Corr, 2005). A study by Moriarty (2011) of homeless men in residential treatment at the same inner city mission in Los Angeles where the present study was conducted showed a mean score of 12.31 on the DAST-20 ($SD = 5.116$). This indicated that *substantial* substance problems were likely for the 97 men who completed the measure, a reasonable finding given that the participants were involved in a substance abuse recovery program. Overall, the DAST has demonstrated good clinical efficacy, as well as encouraging reliability and validity, among the culturally diverse inpatients and outpatients that have been studied to date (e.g., Carrey, Carey, & Chandra, 2003; Savage, Gillespie, & Lindsell, 2008

Beck Depression Inventory-II (BDI-II). The Beck Depression Inventory, Second Edition (BDI-II) is a 21-item self report measure that assesses for the severity of depressive symptoms (Beck et al., 1996). When responding to questions on this inventory, the participant is asked to answer each statement as it pertains to him or her during the past two weeks, including the day of assessment. Questions reflect diagnostic criteria for a major depressive episode as defined by the DSM-IV-TR. Each question on the measure is weighted on a 4-point scale ranging from 0 to 3. At the end of the measure, the points are summed by the examiner. A total score of 0-13 points is reflective of minimal depression, 14-19 is mild, 20-28 is considered moderate, and 29-63 is reflective of severe depression. According to Beck et al., (1996), the BDI-II has been used for over 30 years and has been found to be highly reliable across a variety of settings and populations. BDI-II internal consistency reliability has been measured at .92 for outpatients and .93 for college students. Test-retest reliability has also been found to be significant, as it was measured at .93 for 26 outpatients who were tested during a first and second therapy session one week apart. Although the BDI-II has demonstrated validity with a broad cross-section of individuals, psychometric data on the BDI-II suggests that it may not be the best measure for elderly patients. Multiple studies have been conducted on the validity of the BDI-II in ethnically diverse populations. For example, Sims (2010) explored the convergent validity of two measures of depressive symptoms in a sample of 100 homeless men in residential treatment in Los Angeles: the BDI-II and the depression scale of the Brief Symptom Inventory (Derogatis, 1993). Her findings strongly supported the validity of both measures and she reported a mean BDI-II score of 18.17 ($SD = 12.07$) for her sample, indicating mild symptoms overall. However, more research is needed on how the BDI-II relates to measures of substance abuse among homeless men.

Procedure

This archival study began by receiving approval from the URM-Pepperdine University Community Counseling Center directors. Next, approval from the Graduate and Professional Schools Institutional Review Board (GPS IRB) of Pepperdine University was obtained. Only de-identified client data was utilized. All clients who receive services at the clinic sign an informed consent document at the beginning of treatment and indicate whether they agree to allow their de-identified information to be used for research purposes. Only the records of individuals who consented for their de-identified data to be utilized were included in the database. Data for the present study was obtained from a de-identified database constructed by graduate student research assistants under the supervision of the clinic director. Data analysis did not take place until after preliminary dissertation orals and after approval was obtained from GPS IRB.

Data Analysis

Descriptive statistics were calculated on all variables collected for this study, including frequencies, means, and standard deviations. Internal consistency reliability coefficients were calculated on the AUDIT, DAST-20, and BDI-II. Other analyses included Pearson product-moment correlations.

A reliability check was conducted by a research assistant on 20 randomly selected cases (23% of the sample) to ensure reliability, accuracy, and consistency of data entries. There were no errors found with regard to the data pertaining to the AUDIT. Similarly, no errors were found with regard to data pertaining to the DAST-20 or to the intake form-based self-report ratings and checklist items regarding alcohol and drug abuse. Twenty-two minor errors (4.8% of BDI-II variables) were found and corrected in the data pertaining to the BDI-II.

Chapter III: Results

The main focus of this study was to examine the usefulness of the Alcohol Use Disorders Identification Test (AUDIT) among treatment seeking homeless men residing in a Los Angeles homeless shelter. In addition, this study explored the validity of the AUDIT by examining how it related to self-reported alcohol use and other relevant variables from the Intake Application Form (IAF) as well as the relationship of the AUDIT to the DAST-20 and BDI-II scores. This section will identify: (a) the descriptive statistics on the self-report measures administered, (b) the reliability and validity of the AUDIT when administered as part of the intake evaluation at the homeless shelter, (c) the relationship between the AUDIT and the DAST-20, and (d) the relationship between the AUDIT and the BDI-II.

Descriptive Statistics

Alcohol Use Disorders Identification Test. The Alcohol Use Disorders Identification Test (AUDIT) was administered to the subjects to assess for harmful and hazardous patterns of alcohol consumption within the year prior to entering the homeless shelter. Scores on the AUDIT ranged from 0 to 40 with an overall mean of 14.73 ($SD = 12.36$). This mean score was indicative of moderate alcohol problems. The findings of this sample were similar to the statistics that were reported on for the mean in the sample from Moriarty's (2011) research, 13.08 ($SD = 9.79$). Of the 86 participants who completed the AUDIT, 32 (37.21%) men reported an absence of alcohol problems or a low degree of alcohol problems (scores of 0-7); 19 (22.09%) indicated a medium degree of alcohol problems (scores of 8-15); and 35 (40.70%) individuals reported high levels of alcohol problems (scores of 16-40). Please see Table 1 for problem severity level findings related to the AUDIT among this sample. The internal consistency reliability of the AUDIT was excellent (Cronbach's $\alpha = .93$).

With regard to ethnicity, 18 individuals who identified as Hispanic/Latino obtained a mean score of 19.28 ($SD = 13.48$); five men who identified as Native American obtained a mean score of 17.40 ($SD = 13.46$); 21 individuals who identified as Caucasian obtained a mean score of 15.67 ($SD = 13.42$); five individuals who identified as Multiethnic obtained a mean score of 14.80 ($SD = 12.64$); and 37 men who identified as African American obtained a mean score of 11.62 ($SD = 10.74$).

Table 1

AUDIT Problem Severity Level

	Frequency	Percentage
Absence/Low (0-7)	32	37.21
Medium (8-15)	19	22.09
High (16-40)	35	40.70
Totals	86	100

Drug Abuse Screening Test–20. The Drug Abuse Screening Test–20 (DAST-20) was administered to participants as a means for assessing for maladaptive, harmful patterns of drug use within the 12 months prior to the time they entered the homeless shelter. Scores on the DAST-20 ranged from 0 to 18, with a mean score of 10.07 ($SD = 5.132$). This score typically indicates an intermediate to substantial level of problems associated with drug abuse, and warrants intensive outpatient treatment according to the authors of the measure. The findings of this sample were slightly lower than Moriarty's (2011) findings, in which the mean score was 12.31 ($SD = 5.116$), indicating substantial drug problems with intensive treatment recommended. Of the 86 participants who completed the DAST-20, two (2.32%) reported no evidence of drug abuse (scores of 0); 18 (20.93%) reported low levels of drug problems (scores of 1 – 5); 22

(25.58%) reported intermediate levels of problems related to drug abuse (scores of 6 – 10); 30 (34.88%) reported substantial problems related to drug abuse (scores of 11 – 15); and 14 (16.28%) reported severe problems related to drug abuse (scores of 16 – 20). The internal consistency reliability of the DAST-20 was very good (Cronbach's $\alpha = .862$). Please see Table 2 for problem severity level findings related to the DAST-20 among this sample.

With regard to ethnicity, 18 individuals who identified as Hispanic/Latino obtained a mean score of 11.06 ($SD = 4.93$); five men who identified as Native American obtained a mean score of 7.40 ($SD = 4.51$); 21 individuals who identified as Caucasian obtained a mean score of 9.90 ($SD = 5.39$); five individuals who identified as Multiethnic obtained a mean score of 8.40 ($SD = 5.50$); and 37 men who identified as African American obtained a mean score of 10.03 ($SD = 5.22$).

Table 2

DAST-20 Problem Severity Level

	Frequency	Percentage
None (0)	2	2.33
Low (1-5)	18	20.93
Intermediate (6 -10)	22	25.58
Substantial (11 -15)	30	34.88
Severe (16- 20)	14	16.28
Totals	86	100

Beck Depression Inventory-II. The Beck Depression Inventory-II (BDI-II) was administered to subjects to assess for severity of depressive symptoms. Scores on the BDI-II ranged from 0 to 52 with an overall mean of 21.94 ($SD = 11.84$). This mean score was indicative of moderate depressive symptoms. This is very similar to the findings of a previous study

looking at depressive symptoms among treatment-seeking homeless males, in which the researcher found a mean BDI-II score of 21.68 (Joy, 2013). The internal consistency reliability of the BDI-II was excellent (Cronbach's $\alpha = .91$). Please see Table 3 for problem severity level findings related to the BDI-II among this sample.

With regard to ethnicity, five individuals who identified as Native American obtained a mean BDI-II score of 23.80 ($SD = 20.25$); 37 men who identified as African American obtained a mean score of 22.30 ($SD = 10.98$); 18 individuals who identified as Hispanic/Latino obtained a mean score of 21.17 ($SD = 11.56$); five men who identified as Multiethnic obtained a mean score of 18.60 ($SD = 12.46$); and 21 individuals who identified as Caucasian obtained a mean score of 17.19 ($SD = 12.17$).

Table 3

BDI-II Problem Severity Level

	Frequency	Percentage
Minimal (0-13)	28	32.56
Mild (14-19)	14	16.28
Moderate (20-28)	18	20.93
Severe (29-63)	26	30.23
Totals	86	100

Relationship of Ethnicity to AUDIT, DAST-20, and BDI-II.

The relationship of ethnicity to the primary measures used in this study was examined through analysis of variance (ANOVA). According to the findings, there were no statistically significant group differences related to ethnicity on the AUDIT, $F(4,81) = 1.30, p = .28$; the DAST-20, $F(4,81) = .62, p = .65$; or the BDI-II, $F(4,81) = .73, p = .57$.

Intake application form. The Intake Application Form (IAF) used at the mental health clinic included two 5-point rating scale items that asked the respondents, “During the past 12 months, how serious have your alcohol problems been?” and, “During the past 12 months, how serious have your drug problems been?” The instructions asked participants to circle one number that corresponded to perceived severity of alcohol and drug problems. Circling “1” indicated “No problems at all/not applicable,” circling “3” indicated “Moderate problems,” and circling “5” indicated “Severe problems.” Of the 83 individuals who responded to the alcohol problems question, 33 (39.8%) circled option “1,” indicating “No problems/not applicable”; five (6.0%) individuals circled option “2,” suggesting mild problems; 21 (25.3%) circled option “3,” indicating “Moderate problems”; nine (10.8%) circled option “4,” suggesting moderate problems; and 15 (18.1%) circled option “5,” indicating “Severe problems.” The sample obtained a mean of 2.61 on this rating scale item ($SD = 1.54$).

With regard to participants’ self report ratings on perceived severity of drug problems, of the 82 individuals who responded, 30 (36.6%) circled option “1,” indicating “No problems/not applicable”; six (7.3%) circled option “2,” suggesting mild problems; 15 (18.3%) circled option “3,” indicating “Moderate problems”; eight (9.8%) circled option “4,” suggesting moderate problems; and 23 (28%) circled option “5,” indicating “Severe problems.” The sample’s mean value on this item was 2.85 ($SD = 1.66$).

The IAF also provides prospective clients with a checklist of common problems or concerns for which people seek therapy, and asks the individual to rate his/her current problems and reasons for seeking treatment. The subject has the option of not checking an item, placing one check to indicate the item is of concern, or placing two checks to indicate that particular problem is a serious concern at the present time. Two of the “current problems” listed are

“Use/abuse of alcohol or drugs,” and “Concerns about staying clean & sober.” These two checklist items were summed to provide an additional IAF measure of concern about substance abuse. Each check on one of these two checklist items was coded in the database as one point. Scores on these two summed IAF checklist items therefore ranged from 0 to 4. Of the 83 participants who responded to the IAF checklist, 34 (41.0%) checked neither substance-related item and had a summed score of 0; 12 (14.5%) checked one item for a score of 1; 28 (33.7%) obtained a score of 2 on the summed checklist items; four (4.8%) obtained a summed score of 3; and five (6.0%) obtained the maximum score of 4 on the summed items. The mean value for the summed items was 1.20 ($SD = 1.21$). Please see Table 4 for problem severity level findings related to the IAF among this sample.

Table 4

IAF Substance-Related Checklist Items

	Frequency	Percentage
0 Checks	34	41.0
1 Check	12	14.5
2 Checks	28	33.7
3 Checks	4	4.8
4 Checks	5	6.0
Totals	83	100

Correlations

The first research hypothesis was that the AUDIT would be positively associated with the intake-based, self-report measures of the severity of alcohol abuse. As predicted, a strong positive correlation was found between the AUDIT and the IAF self-report rating of the severity of alcohol problems $r(81) = .723, p < .001$. This indicated that the higher the AUDIT score, the

greater the IAF self-report rating of alcohol problems for the past 12 months. This finding supported the validity of the AUDIT as a measure of alcohol concerns.

Also consistent with the first hypothesis, AUDIT scores were positively correlated with the summed, substance-related IAF checklist items, $r(81) = .355, p < .001$. As expected, higher AUDIT scores were associated with endorsing checklist items that reflected substance-related concerns at intake (“Use/abuse of alcohol or drugs” and “Concerns about staying clean & sober”).

The second hypothesis was that alcohol problems as measured by the AUDIT would be positively associated with history of legal problems. Of the 72 men who reported on their legal history, the seven men who reported being previously arrested without jail time obtained a mean score of 27.71 ($SD = 12.96$) on the AUDIT. Forty-seven individuals who reported being previously incarcerated obtained a mean score of 14.57 ($SD = 12.43$) and 18 men who did not endorse any significant legal history obtained a mean score of 8.78 ($SD = 8.24$) on the AUDIT. The findings suggest that men without a significant legal history obtained the lowest scores on the AUDIT as compared to those who endorsed being arrested with no jail time and those who endorsed history of previous incarceration. Analysis of variance (ANOVA) indicated a significant overall relationship between the different levels of legal history and scores on the AUDIT, $F(2,69) = 6.75, p = .002$. Tukey’s HSD indicated that the men who were arrested only (without incarceration; $n = 7$) scored significantly higher on the AUDIT than men who have previously been incarcerated ($n = 47$) and than men who denied any legal history ($n = 18$). The difference between participants with incarceration histories ($M = 14.57$) and those without ($M = 8.78$) was in the predicted direction but did not reach the .05 level of statistical significance, according to Tukey’s HSD. The researcher’s hypothesis therefore received only partial support.

Given these findings, it appears that past legal history is certainly associated with AUDIT scores, but more research is needed with larger samples and greater statistical power.

The third hypothesis was that the AUDIT would be significantly associated with fewer years of education. Contrary to the prediction, there was no significant relationship between levels of education and the AUDIT, $r(84) = .063, p = .562$.

The fourth hypothesis was that the AUDIT would be significantly and positively associated with the DAST-20. There was no significant relationship between the AUDIT and the DAST-20, $r(84) = .188, p = .083$. Clearly the trend was for a positive association between the two measures, but the relationship did not reach the .05 level of significance.

The fifth hypothesis was that there would be a positive correlation between the AUDIT and the BDI-II. As predicted, a modest but statistically significant positive relationship was found between the AUDIT and the BDI-II, $r(84) = .248, p < .05$. In other words, more severe alcohol problems were in fact associated with greater severity of depressive symptoms. Please see Table 5 for correlational findings between the AUDIT, DAST-20, BDI-II, and IAF-based measures of substance-related problems.

Table 5

Correlations Between the AUDIT and DAST-20, BDI-II, IAF Checklist Items, and IAF Alcohol Problems Rating

		AUDIT
DAST-20	Pearson Correlation	.188
	Sig. (2-tailed)	.083
	N	86
BDI-II	Pearson Correlation	.248
	Sig. (2-tailed)	.021
	N	86
IAF Checklist Items	Pearson Correlation	.355
	Sig. (2-tailed)	.001
	N	83
IAF Alcohol Problems Rating	Pearson Correlation	.723
	Sig. (2-tailed)	.001
	N	83

Chapter IV: Discussion

Summary and Implications of the Research Findings

This study sought to examine the demographic characteristics of treatment seeking homeless men residing in a Los Angeles homeless shelter. The sample was composed of ethnically diverse individuals with the mean age being 43.08. The majority of the men were single or divorced. With regard to education, most of the men received a high school diploma or higher. Finally, nearly all of the men evidenced substance abuse problems. The demographic characteristics were very similar to what has been reported for homeless men in Los Angeles County (Los Angeles Homeless Services Authority, 2011). The high level of reported substance abuse concerns was expected since the study drew from a residential substance abuse recovery program.

This study primarily sought to examine the usefulness of the AUDIT among treatment seeking homeless men residing in a homeless shelter. Results of this study indicated both strong reliability and validity of the AUDIT when utilized among an ethnically diverse sample of homeless men in residential recovery, suggesting the utility of this assessment tool among homeless, treatment-seeking men. The average score on the AUDIT among this sample was indicative of moderate alcohol problems. However, nearly half of the sample (41%) reported a high level of alcohol problems. Given these findings, it may be beneficial for clinicians at the shelter where this study was conducted, as well as at similar shelters providing recovery services, to provide simple advice combined with motivational interviewing which targets the identification of the risks and consequences of alcohol consumption. Additionally, further assessment and treatment of alcohol use may be warranted as well.

This study also examined the convergent validity of the AUDIT by looking at its correspondence with self-reported ratings of alcohol and substance abuse concerns from the IAF. As predicted, AUDIT scores were positively associated with the alcohol-related items from the intake form. The greater the self-reported rating of alcohol problems on the IAF, the higher the AUDIT score was among men in this sample. The strong positive correlation (.723) between the AUDIT and the IAF's rating scale item of alcohol problems in the past 12 months was especially noteworthy. This study supports the AUDIT as a valid and useful measure of alcohol related concerns within this population. It also provides some general affirmation that self-report measures of alcohol problems can be utilized as reliable and valid assessment tools within residential treatment programs for the homeless. The lack of any significant differences on the AUDIT across ethnic groups was also noteworthy. This further confirmed the potential usefulness of the test in diverse settings. It also appeared consistent with the test developers' original intent to create an alcohol scale that could be used in multicultural settings.

With regard to the relationship of legal history to alcohol problems, the results partially supported the researcher's hypothesis. The analyses showed a significant overall relationship between legal history and AUDIT scores. In looking at specific mean contrasts, the small group of men who reported being arrested but never incarcerated had a significantly higher mean AUDIT score than the men who had been incarcerated and than the men who denied any legal history at all. While those with incarceration histories had a higher mean AUDIT score than those without any legal history, the difference did not reach the .05 level of significance. In general, there was some evidence that greater alcohol problems were associated with more serious legal histories. However, more research is needed with larger groups of subjects. It was surprising and somewhat unexpected that the men with histories of arrest only scored so much

higher than the other two groups. Given that the finding was based on a small number of persons, it needs to be replicated in future research to see if it is a reliable finding.

It would seem reasonable to expect that future research would show a link between AUDIT scores and legal problems among homeless men. This would be consistent with other research that has shown an association between substance abuse and legal difficulties. Of course any research that uses a correlational design would not allow the researcher to identify any cause and effect relationship between alcohol problems and legal concerns. However, it would appear safe to expect that alcohol abuse contributes to risk taking behaviors, compromised judgment, and alcohol-related offenses such as public intoxication, driving under the influence, and open container violations to name a few, making an individual more prone to arrest and/or experiencing legal problems. The present study provided some evidence that alcohol abuse and legal problems went together for the men in this sample.

Contrary to the researcher's hypothesis and previous research, no significant relationship was found between years of education and AUDIT scores. The researcher had expected that fewer years of education would operate as a risk factor for alcohol problems. Instead, the present findings suggested that alcohol use and abuse can be acquired by individuals despite education level. These results need to be interpreted with caution, as the majority of the participants (55 of the 85 men who provided this information) reported having at least a high school diploma or GED.

Additionally, although the correlation between the AUDIT and DAST-20 showed a positive trend (.188), these two assessment measures were not related at the .05 level of statistical significance. This suggested that alcohol and drug problems were relatively independent of one another for men in the present sample. More research is needed on the extent

to which alcohol and drug problems covary among homeless persons seeking treatment.

Certainly it is important to assess for both alcohol use disorders and drug problems in residential treatment facilities such as the one where this study was conducted.

The results of this study showed a modest relationship between the AUDIT and the BDI-II, which suggests the more severe an individual's alcohol use problem, the more likely he was to experience symptoms of clinical depression. It is not surprising that mood symptoms and alcohol use would go together among homeless men in residential treatment who are also seeking out psychological services. These results highlight the importance of continuing to assess for both clinical depression and alcohol use problems in settings such as URM. Additionally, treatment following the assessment phase might focus on treating both depression and alcohol use problems concurrently. Furthermore, individuals might benefit from psychoeducation pertaining to the risks of experiencing both alcohol use problems and clinical depression simultaneously and the bi-directional nature of these two disorders among treatment seeking homeless men.

Limitations

All the data for this study was collected from a single setting, and the results were reflective entirely of treatment seeking homeless males who resided at one shelter and participated in an abstinence-based residential substance abuse rehabilitation program. Therefore, the findings may not be generalizable to homeless individuals in other settings or with other presenting complaints. It cannot be assumed the results would generalize to homeless men who are not seeking mental health treatment services, or to those who do not report substance-related problems. In addition, because the sample was relatively small in size, the findings may not be representative of homeless individuals in general. The findings may also not generalize to homeless women or to minors.

As mentioned, URM is a faith-based organization. The vast majority of persons seeking services at URM identify themselves as Christian (Moriarty, 2011). Due to this, the findings of the present study may not generalize to settings that have greater religious diversity.

Although various ethnicities were represented in this study, Asian or Pacific Islander persons apparently were not. The findings may therefore not generalize to men from those communities. Additionally, English was used as the primary language for the study. Given this, the results may not be applicable to non-English speakers.

A limitation of any archival study is that the researcher does not have the opportunity to alter the original procedures or to introduce new measures. Limitations also arise when self-report measures are administered, as reporter biases may result in problems such as under-reporting or over-reporting of symptoms and substance use. In addition, the correlational nature of the research design did not allow the researcher to identify any causal relationships. A small percentage of minor coding or entry errors were noted and corrected among the BDI-II scores in the 20 cases that were randomly selected for accuracy/reliability checks. To the extent there were similar errors among the BDI-II records among the remaining cases, the results could have been impacted in unknown ways.

Suggestions for Future Research

Given the limitations of this study that impact generalizability, it may be beneficial to replicate this study with a larger sample that includes both men and women. Additionally, to investigate the utility of the AUDIT, researchers might consider replicating this study within various homeless shelters and settings, including those that have no religious affiliation. With regard to legal history, more research is needed to shed light on the factors associated with an increased risk for alcohol use among individuals who have been previously arrested with no jail

time. In addition, future research is needed to examine the specific types of legal problems that may be associated with greater alcohol use as well as the nature of the causal relationship between alcohol use and legal problems. The relationship between alcohol use and education should also be considered as an area that could benefit from closer examination within future studies. Specifically, researchers might consider replicating this study where there are more individuals with lower levels of education. More information about the exact nature of prior educational experiences might be helpful as well, including the types of educational institutions attended, the recency of post-high school education or training, and other defining characteristics. Future studies would also be strengthened by incorporating methods other than just self-report in the measurement of issues such as drug and alcohol problems, depressive symptoms, and other relevant variables.

Finally, future studies would be strengthened by examining the unique needs of homeless individuals who have been previously incarcerated. It may be beneficial to explore what services or programs are needed by individuals reintegrating into the community after being incarcerated. This could assist in decreasing rates of homelessness and substance abuse among at-risk persons in the community.

Conclusion

Homelessness continues to be a grim reality for many Americans and alcohol abuse is one of the most common problems reported by homeless individuals. Given the grave problems related to homelessness and widespread substance abuse associated with being homeless, this study sought to examine the usefulness of the AUDIT. Practical implications of this study include that homeless, treatment-seeking men should be screened for alcohol related problems. Findings suggest that the AUDIT was found to perform quite well among homeless, treatment-

seeking men in a residential treatment facility. Specifically, the AUDIT represents a clinical tool that clinicians can utilize to address the serious problem of alcohol abuse among homeless men. Utilizing the AUDIT in a therapeutic setting can also help to ensure that alcohol-related concerns are accurately assessed and understood. Results of the AUDIT may also inform treatment planning to help ensure that goals of treatment correctly reflect presenting problems related to alcohol abuse.

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APPENDIX A

Intake Application Form

Union Rescue Mission – Pepperdine Counseling Center Intake Application

This form is intended to gather basic information in the interest of providing you with the best service possible. All information on this form is considered confidential. If you do not wish to answer a question, just leave it blank or speak to the Clinic Coordinator.

Applicant Name: _____ **Date:** _____

Age: _____ **Birth date:** _____ **Sex: Male** _____ **Female** _____

URM Program Name: _____ **Room/Bed #** _____

Chaplain/Case manager: _____ **Referred By:** _____

**If not living at the Union Rescue Mission, please provide the following information-
Address:** _____

Telephone number: _____

Personal Information:

Ethnicity (please check): African American _____; Asian/Pacific Islander _____;
Caucasian _____; Hispanic _____; Native American _____; Multi-racial _____;
Other (please indicate) _____

Marital Status: Married _____; Separated _____; Divorced _____; Widowed _____;
Never married _____; Currently in a relationship _____; Living together _____

How long have you been a part of the Union Rescue Mission program? _____

Have you served in the U.S. armed services? _____ **Specify Branch:** _____

If living outside of the Union Rescue Mission, please list the people living with you:

<u>Name</u>	<u>Relationship</u>	<u>Age</u>	<u>Occupation</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Person to be contacted in case of emergency:

Name: _____

Address: _____

Telephone: _____

Relationship to you: _____

Medical History:

Last medical exam: _____ Current Physician: _____

Last visit to physician: _____ Where: _____

Current medical and physical health problems (e.g., diabetes, high blood pressure, headaches, etc.): _____
_____Medications being taken: _____
_____**Mental Health and Substance Use History:**

Do you have a history of substance abuse problems? Yes _____ No _____

During the past 12 months, how serious have your alcohol problems been? (circle one)

1	2	3	4	5
No problems at all/ not applicable		Moderate problems		Severe problems

During the past 12 months, how serious have your drug problems been? (circle one)

1	2	3	4	5
No problems at all/ not applicable		Moderate problems		Severe problems

Please list the drugs and substances, including alcohol and prescription medications, that you have used and abused the most in your life: _____

_____List other recovery programs you have attended. For example: AA, NA, prison, drug programs, other Missions. Please state where and when: _____

_____What are the main concerns you are seeking help for in the counseling center?

_____Have you ever been in therapy before? _____ If so, please describe: _____

Are you now or have you been on any medications related to emotional or mental difficulties? _____ If so, please list: _____

Have you ever made a suicide attempt? _____ If so, when and how many times?

Please list any previous hospitalizations (medical or psychiatric):

<u>Date</u>	<u>Hospital Name</u>	<u>Reason</u>	<u>Length of stay</u>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other serious illnesses:

<u>Date</u>	<u>Nature of condition</u>	<u>Duration</u>
-------------	----------------------------	-----------------

_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous history of mental health care:

<u>Date</u>	<u>Type of services</u>	<u>Describe problem</u>	<u>Duration</u>
-------------	-------------------------	-------------------------	-----------------

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any past Legal Problems (arrests, incarcerations, etc.)

Are you currently court mandated to attend counseling? _____

Family Data:

Is Father living? _____ If yes, his current age: _____ His residence _____

His occupation: _____ How often do you have contact? _____

If he is not living, his age at death: _____ Your age at his death: _____

Cause of death: _____

Is Mother living? _____ If yes, her current age: _____ Her residence _____

Her occupation: _____ How often do you have contact? _____

If she is not living, her age at death: _____ Your age at her death: _____

Cause of death: _____

Children:

<u>Name</u>	<u>Age</u>	<u>Current Residence</u>	<u>Contact how often?</u>
_____	_____	_____	_____
_____	_____	_____	_____

Brother and Sisters: _____

List any other people you lived with for a significant time period during childhood:

<u>Name</u>	<u>Relationship to you</u>	<u>Still in contact?</u>
_____	_____	_____

Educational and Occupational History:

Highest grade or year of education completed _____

Please list any professional, technical, or vocational training:

Are you currently in school? _____ School/Location: _____

Current and previous jobs:

<u>Job Title</u>	<u>Employer Name</u>	<u>Dates/Duration</u>
_____	_____	_____
_____	_____	_____

Please check boxes to indicate which of the following areas are current problems for you and reasons for counseling. Place TWO check marks to indicate the most important concern(s).

Feeling nervous or anxious

Under pressure & feeling stressed

Needing to learn to relax

Afraid of being on my own

Feeling angry much of the time

Difficulty expressing emotions

Feeling inferior to others

Lacking self confidence

Feeling down or unhappy

Feeling lonely

Experiencing guilt feelings

Feeling down on myself

Thoughts about taking own life

Concerns about emotional stability

Difficulty with school or work

Concern about finances

Having difficulty being honest/open

Trouble communicating sometimes

Having a hard time making friends

Having a hard time keeping friends

Feeling pressured by others

Feeling controlled/manipulated

Pre-marital counseling

Marital problems

Family difficulties

Difficulties with children

Break-up of relationship

Difficulties in sexual relationship

- | | |
|--|--|
| <input type="checkbox"/> Feeling cut off from emotions | <input type="checkbox"/> Feeling guilty about sexual activities |
| <input type="checkbox"/> Wondering "Who am I?" | <input type="checkbox"/> Concerns about physical health |
| <input type="checkbox"/> Difficulty controlling my thoughts | <input type="checkbox"/> Feeling fat even if weight is average |
| <input type="checkbox"/> Being suspicious of others | <input type="checkbox"/> Use/abuse of alcohol or drugs |
| <input type="checkbox"/> Getting into trouble | <input type="checkbox"/> Concerns about staying clean & sober |

Additional concerns (if not covered above):

APPENDIX B

Non-Human Subjects Determination Form

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

May 30, 2013

Stacy Pike
[REDACTED]
[REDACTED]

IRB# P0413D03

Project Title: The Assessment of Alcohol Use Disorders Among Homeless Men in Residential Treatment

Dear Ms. Pike,

Thank you for submitting the Non-Human Subjects Verification Form and supporting documents for your above referenced study. As required by the Code of Federal Regulations for the Protect for Human Subjects (Title 45 Part 46) any activity that is research and involves human subjects requires review and approval by the Graduate and Professional Schools IRB (GPS-IRB) prior to initiation.

After review of the Non-Human Subjects Verification Form and supporting documents, GPS IRB has determined that your proposed research¹ activity does not involve human subjects. Human subject is defined as a living individual about whom an investigator (whether professional or student) conducting research obtains

- (1) Data through intervention or interaction with the individual, or
- (2) Identifiable private information. (45 CFR 46102(f))

GPS IRB review and approval of your above referenced research is not required as it does not involve human subjects. We wish you success on your non-human subject research.

Sincerely,



Doug Leigh
Graduate School of Education & Psychology
6100 Center Dr. 5th Floor
Los Angeles, CA 90045
[REDACTED]
[REDACTED]

cc: Dr. Lee Kats, Associate Provost for Research & Assistant Dean of Research
Ms. Alexandra Roosa, Human Protections Administrator
Dr. Cary Mitchell, Graduate School of Education and Psychology

¹ Research means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported un-der a program which is considered research for other purposes. (45 CFR 46.102(d)).