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Finding a Treatment That Fits: A Grounded Theory of Adolescent Retention in Alcohol and Drug Treatment

A thesis presented in partial fulfillment of the requirements for the degree of

Master of Arts

in

Psychology

at Massey University, Albany, New Zealand.

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2008

Abstract

The present study sought to uncover the process youth go through and the factors that influence their decision to dropout of drug and alcohol treatment. The study reports the experiences of 9 participants from a residential therapeutic community treatment programme in Auckland. Participants' ages ranged from 14 to 17 years. The study utilised a qualitative approach, specifically, a grounded theory approach. Treatment dropout was found to be a complex process that was specific to the individual. A range of client, programme, and other factors were found to influence participants' decisions to dropout of the treatment programme. Recommendations are included for clinicians and suggestions for future research are made.

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Introduction

Statement of the Problem

Alcohol and drug misuse is a significant problem worldwide (Lowinson, Ruiz, Millman, & Langrod, 2005) including New Zealand. The Alcohol Advisory Council of New Zealand (ALAC, 2008) suggests in New Zealand alcohol harm costs somewhere between $1 billion and $4 billion a year. It costs the public health sector $655 million; it costs in crime and related costs $240 million; it costs in social welfare $200 million; it costs in other government spending $330 million, and in lost productivity it costs about $1.17 billion a year. It goes on to say that alcohol is responsible for 70% of accident and emergency hospital admissions and that 75% to 90% of weekend crime is attributable to alcohol. It also posits that 3.9% of all deaths in New Zealand in 2000 were attributable to alcohol consumption, that is, approximately 1040 deaths.

Youth are not exempt from this problem. ALAC (2008) suggests that 125.000 youth under the age of 17 fall into the category of binge drinkers. Illicit drug use amongst New Zealand youth is also extremely common. In fact, in New Zealand and Australia, youth appear to have higher rates of illicit drug dependence than the rest of the developed world with estimates ranging from 2.2% to 12% (Boden, Fergusson, & Horwood, 2006). Youth are at a particularly high risk of negative consequences as a result of their alcohol and drug use as they are at a critical period in their development. Physical, emotional, and neuro-cognitive changes are powerfully evident (Childress, 2006).

Generally, it has been found that treatment is efficacious and improves the lives of adolescents in significantly meaningful ways (Williams, Chang and Addiction Centre Adolescent Research Group, 2000). Treatment has been associated with abstinence (Lewis, Piercy, Sprenkle, and Trepper, 1990; Brown, Vic and Creamer, 1989), a reduction in alcohol and other drug use (Friedman, Glickman, and Morissey, 1986), and a myriad of related domains including criminal activity, employment and educational status, and health outcomes including health behaviour (e.g. HIV risk behaviour) and health symptoms (e.g. psychopathology), as well as a plethora of

physical signs and symptoms (Jainchill, 1997; Spooner, Mattick, and Howard, 2001; Hser, Hubbard, Hsieh, Flethcher and Anglin, 2001).

However, precluding the fact that treatment is efficacious is the fact that retention of adolescents in treatment is typically low (Orlando, Chan, & Morral, 2003). At Odyssey House Youth Residential treatment programme, 66% of youth exit the programme on their own accord within the first week of treatment (Davidson, 2007). It is suggested that stays of 90 days or more is a benchmark for significant changes to occur in residential settings or the equivalent time receiving counselling in outpatient drug free settings (Hser et al, 2001; Simpson, Joe, Broome, Hiller, Knight, & Rowan- Szal, 1997; Hubbard, Marsden, Rachel, Harwood, Cavanaugh, & Ginzberg, 1989).

A number of pre- during, and post- treatment variables have been examined in relation to favourable treatment outcomes. In a thorough review of the effectiveness of adolescent treatment Williams and colleagues (2000) concluded that treatment completion is the *most* consistent predictor of favourable treatment outcomes. The factors contributing to the retention of clients in treatment are not well understood (DeLeon, Hawke, Jainchill & Melnick, 1997; Melnick, et al, 1997; Williams, et al, 2000; Orlando et al, 2003; Jainchill, et al, 2005; Schroder, Sellman, & Deering, 2007). What little research that has been conducted has focussed on *fixed* client characteristics. Despite being given much attention in the past, in general, these studies find no or little association to favourable treatment outcomes (Melnick et al, 1997, Orlando et al, 2003). Moreover, they are of little use as they have no practical value. If the objective is to improve treatment and outcome for all presenting clients rather than to select those most likely to succeed, it is imperative to look at retention predictors that can be influenced by service providers.

Dropouts are undoubtedly problematic. For the consumer, benefits may not be wreaked as the treatment plan was devised according to provider expectations of treatment attendance. From the perspective of the treatment provider, dropouts are costly as high "front end" costs (requirements for initial assessments and treatment planning) occur. As a result, treatment facilities- in effect, operate at low organisational efficiency and effectiveness levels (Simpson et al, 1997). Given the negative perception of treatment dropouts as failures, lowered staff morale

also results (Pulford, Adams, & Sheridan, 2006). Understanding the factors that contribute to low retention is necessary then to improve treatment for adolescents.

Significance of the study

The present study sought to elucidate the issue of retaining youth in alcohol and drug treatment. Specifically, it sought to elucidate the issue of retaining youth in a residential drug and alcohol treatment programme based on a modified therapeutic community. The therapeutic community is fundamentally a self- help approach that views the community of residents itself as the agent of change. It views the substance disorder as a condition of the whole person requiring a new set of values and social skills to support a healthy, pro-active, and drug-free lifestyle. It achieves these tasks through an emphasis on group work, and a variety of teachings on "right living" modelled and taught through a variety of therapeutic groups for example anger management (De Leon, 2000).

By employing a qualitative approach, specifically, the grounded theory approach (Glaser & Strauss, 1967; Glaser, 1978; Glaser; 1992) the study explicates the reasons why youth dropout of treatment. Given that relatively little is known about the reasons why the retention of adolescents in treatment is low, a qualitative approach was deemed appropriate (Glaser & Strauss, 1967; Patton, 2002). A range of client and programme factors related to treatment dropout are reported. By explicating the factors contributing to low retention, the mechanisms contributing to the effectiveness of programs are also addressed.

Recommendations are made for service providers that may increase the retention of youth in substance abuse treatment and respectively, treatment outcomes. A number of suggestions for future research are also made. The research examining the effectiveness of adolescent drug and alcohol treatment lags significantly behind efforts examining the effectiveness of treatment for adults (Williams et al, 2000). If nothing else, more research effort is demanded on humanitarian grounds.

Literature Review

Epidemiology of adolescent substance abuse in New Zealand

Attitude and behaviour in relation to alcohol and drug use amongst New Zealand youth is frightening. Experimentation is extremely common. The latest youth drinking statistics found that 88% of 14-17 year olds have tried alcohol (ALAC, 2003). Boden and colleagues (2006) analysed data collected as part of the Christchurch Health and Development Study (CHDS) and concluded that by 18 years of age 50% of young people had used cannabis on at least one occasion. While alcohol and cannabis are the most commonly abused substances by New Zealand youth, use of other illicit substances is also common. The latest statistics suggest that by age 18, 11% have used other illicit drugs such as hallucinogens, amphetamine- type stimulants, cocaine, sedatives, solvents and opiates (Boden et al, 2006).

Present use of alcohol and drugs is common. ALAC's 2003 youth drinking monitor showed that 66% of 14-17 year olds currently drink alcohol (ALAC, 2003). Similarly, Kalafatelis (2000) concluded that most youth (87%), 14-18 years, define themselves as current drinkers. National surveys comparison found that 4% of young people 15-17 years old frequently use (10 or more times in the last month) cannabis (Wilkins, Casswell, Bhatta, & Pledger, 2002). In the same survey "last year use" of any stimulants was found to be 6% for those aged 15-17 years old.

In regards to attitudes, 47% of young people aged 12-17 years old condone drunkenness- agreeing with the statement "it's ok to get drunk as long as it's not everyday". This is in comparison to the 24% of adults who agreed with the statement (ALAC, 2005). Similarly, Kalafatelis (2000) found that 59% of adults agreed with the statement "It's OK to get drunk as long as it's not too often", while 70% of youth agreed.

Alarming trends in youth substance use are notable. There is evidence that both the frequency of use, and volume of alcohol consumed among New Zealand youth is increasing (ALAC, 2003; ALAC, 2005; Habgood, Casswell, Pledger, & Bhatta, 2001). Comparison surveys showed increases in how often 14-15 year old males and females drink. Increases were also

noted for 16-17 year old men who became on average weekly drinkers by 2000 (Habgood et al, 2001).

In terms of quantity, there were increases in the amount of males and females 15-17 years old that consumed enough to feel drunk at least monthly in the last year. For men this increase was 15%, increasing from 43% in 1998 to 58% in 2001. For women this increase was 17%, increasing from 33% in 1998 to 50% in 2001 (Wilkins et al, 2002). Drinking comparison surveys noted that typical quantities consumed for males increased from 3 drinks in 1995 to 5 drinks in 2000. Typical quantities consumed for 16-17-year-old females increased from 4 drinks in 1995 to 6 drinks in 2000 (Habgood et al, 2001). ALAC's 2005 investigation into "the way we drink" revealed that 37% of young people aged 12-17 years old who are current drinkers, engaged in risky or binge drinking (5 or more drinks is an agreed marker for young people) on their last drinking occasion. Similarly, ALAC's 2003 youth drinking monitor defined 25% of all 14-17 year olds as "heavy drinkers". Two in five, that is, 39% of drinkers drank more than 10 drinks on their last drinking occasion (that's twice ALAC's definition of heavy or excessive drinking) and a significant increase on the 23% measured in 2002 (ALAC, 2003).

Drug use amongst New Zealand youth appears to also be increasing (Boden et al, 2006). New Zealand drug use comparison surveys 1990 and 1998 noted increases in the use of cannabis, hallucinogens, ecstasy, stimulants such as amphetamine, and cocaine amounst young people (Field & Casswell, 1999). New Zealand drug use comparison surveys 1998 and 2001 again noted increases. Experimentation with ecstasy increased from 3% to 5.4%, with current users increasing from 1% to 2.3%. Experimentation with stimulants (amphetamine/ methamphetamine) increased from 7.6% to 11%, with current use increasing from 2.2% to 3.5% (Wilkins, Casswell, Bhatta, & Pledger, 2002)

As might be expected the rates of dependence amongst youth are high. Boden et al's (2006) analysis of the (CHDS) data found 5% of adolescents to meet DSM- 1V-TR criteria for cannabis dependence with an additional 1% meeting DSM- 1V-TR dependence criteria for

other illicit substances. Similarly, the Dunedin Multidisciplinary Health and Development Study found that by age 18 years old 5% had a diagnosis criteria of cannabis dependence (Feehan, Mcgee, Raja, & Williams, 1994). The same study found that 10% of adolescents had a diagnosis of alcohol dependence.

The age at which youth first really start drinking is getting younger. The % of youth 14-17 years old who claimed they "first really started drinking under 15 years old" increased from 34% in 2002 to 42% in 2003 (ALAC, 2003).

Demographic trends are also notable. Gender differences in the way males and females drink is narrowing. Females are now consuming a similar quantity of alcohol as males at a similar frequency. Drug use comparison surveys 1998 and 2001 noted that the % of 15-17 year old females who drank 4+ drinks at least weekly doubled, increasing from 15% in 1998 to 28% in 2000 (Wilkins et al, 2002).

It has long been noted that Maori suffer disproportionately more than Europeans from alcohol abuse and dependence. Maori youth are less likely to be regular drinkers; however the profile of young Maori drinkers matches that of risky drinkers in that when they do drink, they drink heavily. (ALAC, 2003; Kalafatelis, 2000; ALAC, 2002). Similarly, Pacific youth are polarised as either non- or occasional drinkers, or heavy drinkers (ALAC, 2002).

The consequences of adolescent substance abuse

Alcohol and other drug use is associated with numerous negative physical, psychological, and social consequences. Alcohol and other drug use, particularly if used regularly, will wreak havoc on the human body. Although adolescents rarely exhibit the more severe chronic disorders associated with alcohol dependence such as liver cirrhosis, hepatitis, gastritis, and pancreatitis, adolescents who drink heavily, may experience adverse effects on the liver, bone growth, and endocrine development (Alcohol Research and Health, 2004-2005). Cannabis use presents unique health hazards; two of the more commonly cited being respiratory and pulmonary problems. Stimulant drugs are known to place a concerted strain on the

cardiovascular system, and opiate abuse serves to deplete an individual's endogenous painkillers (Walters, 1992).

Emerging research also points to neurocognitive disadvantages among adolescents with alcohol and other drug use disorders. Neuropsychological testing suggests that adolescents with alcohol use disorders demonstrate diminished retrieval of verbal and nonverbal material, and poorer performance on tests requiring attention skills (Tapert & Schweinsburg, 2006). Millsaps, Azrin, & Mittenberg (1994) investigated the neuropsychological effects of chronic cannabis use and found that memory indices were significantly reduced in relation to both intellectual function and attentional ability. They concluded that this profile is a characteristic finding in patients who are recovering from chronic impairment of memory function. Similarly, Grant, Gonzalez, Carey, Natarajan, and Wolfson (2003) found decrements in the ability to learn and remember new information. Verdejo-Garcia, Lopez-Torrecillas, Aguilar de Arcos, and Perez-Garcia (2005) study found that ecstasy abuse affected individuals working memory and abstract reasoning indices. Intellectual development is undoubtedly compromised.

Emotional development is also compromised as individuals become to rely on alcohol and other drugs as a way to cope with everyday problems (Valtonen, Sogren, & Cameron-Padmore, 2006; Hawkins, 1992; Rodrigues, 1999). The achievement of age appropriate developmental milestones is unlikely without such intellectual and emotional development, and indeed it is common to observe developmental ages in adolescents who have abused substances closer to the age at which they began abusing the substance than their chronicological age.

Alcohol and other drug use also wrecks havoc on the human mind. An association between substance use and psychological dysfunction is consistently demonstrated. Substance use has been associated with depression (Davis, Uezato, Newell, & Frazier, 2008; Maddux, Desmond, Costello, 1987; Chinet, Plancherel, Bolognini, Bernard, Laget, Daniele, & Halfon, 2006) anxiety (Valentiner, Mounts, & Deacon, 2004; Norton, 2001), and eating disorders (Blinder, Cumella, & Sanathara, 2006; Dykens & Gerrard, 1986). A New Zealand community survey (Huw, 1996) investigating the adverse effects of cannabis use found a significant number of the 528 subjects to be experiencing aversive effects. The most common were physical or mental

health problems. 22% of users reported acute anxiety or panic attacks following cannabis use and 15% reported psychotic symptoms following use. In the United States, Aarons, Brown, Hough, Garland, and Wood (2001) found that 40.8% of adolescents who were receiving mental health treatment services were diagnosed with a substance use disorder. It can be expected that New Zealand youth statistics would be similar.

Social problems are also a consequence of adolescent substance abuse. Violence is common among adolescents who drink with quantities consumed being positively correlated with extent of violent behaviour (Rossow, Pape, & Wichstrom, 1999; Swaim, Deffenbacher, & Wayman, 2004). Whatsmore, Swahn, Simon, Hammig, and Guerrero (2004) found that adolescents who drink were more likely to engage in physical fighting, be injured, and injure others in fights than non drinkers, even after controlling for drinking frequency and binge drinking

Adolescent substance use is also linked to sexual activity. Substance use has been associated with earlier initiation of sexual activity and engaging in risky sexual practises, including having unprotected sex and having multiple partners (Lynch, 2001; Subin, 1999).

School consequences are also notable. In a review of the literature, Lynskey and Hall (2000) concluded that a number of prospective longitudinal studies have indicated that early cannabis use may significantly increase the risk of subsequent poor school performance and early school leaving. They contend that a possible mechanism underlying the association between early cannabis use and educational attainment is that cannabis use induces an "amotivational syndrome". Lynskey, Coffey, Degenhardt, Carlin, and Patton (2003) prospectively assessed adolescent cannabis use and found that weekly cannabis use was associated with significantly increased risk of early school-leaving. This effect remained after adjustment for a range of prospectively assessed covariates including demographic characteristics, other substance use, psychiatric morbidity, and antisocial behaviour.

Preventable death is perhaps the biggest social problem associated with substance abuse. Winters (1999) reported that motor vehicle accidents are by far the leading cause of death among adolescents, accounting for 29% of all deaths. According to the Centre for Disease

Control (1998), approximately 50% of adolescent deaths resulting from motor vehicle accidents are related to the consumption of alcohol. Furthermore, substance use has been linked to suicide (Miranda, Scott, Hicks, Wilcox, Munfakh, Jimmie Lou, & Shaffer, 2008; Carter, Page, Clover, & Taylor, 2007; Oei, Foong, & Casey, 2006) and murder (Busch, Zagar, Hughes, Arbit, 1990).

Legal problems appear to be an extension of the social problems caused by substance use. According to the Substance Abuse and Mental Health Services Administration (2001), adolescents who use drugs are more likely than those who do not to come into contact with the criminal justice system. In the United States, Aarons, Brown, Hough, Garland, and Wood (2001) found that 62.1% of adolescents in the juvenile justice system were diagnosed with a substance use disorder. It can be expected that New Zealand youth statistics would be similar.

Despite the commonality of alcohol and other drug use amongst adolescents and associated negative consequences, only a handful of adolescents will experience clinical problems and come in contact with service providers.

The etiology of adolescent substance abuse

The etiology of substance abuse is likely to be complex and multifactoral (Kassel, Weinstein, Skitch, Veilleux, & Mermelstein, 2005). However, examining the etiology of substance use is important as it has implications for treatment including why treatment may be unsuccessful. A number of constructs have been identified in the literature that relate to substance use. Hawkins, Catalano and Miller (1992) conducted a thorough search of the relevant literature and concluded that constructs that have empirical support include:

> Laws and norms favourable to drug use; availability of drugs; extreme economic deprivation; neighborhood disorganisation; certain psychological constructs; early and persistent behavioural problems including aggressive behaviour in males, other conduct problems, and hyperactivity in childhood and adolescence; a family history of alcoholism and parental use of illegal drugs; poor family management practices; family conflict; low bonding to family; academic failure;

> lack of commitment to school; early peer rejection; social influences to use drugs; alienation and rebelliousness; attitudes favourable to drug use; and early initiation of drug use. (p. 96)

Three paradigms have been influential in understanding the initiation and maintenance of substance use: the disease paradigm; the learning theory paradigm; and the psychoanalytic paradigm. The disease paradigm has been the dominant influence in treatment approaches since the 1970s (Margolis & Zweban, 1998). In part this has been due to the classification of alcoholism as a medical disease in 1956 by the American Medical Association (Walters, 1992).

The disease model of addiction

The disease model of addiction assumes that alcohol and other drug disorders are in fact medical diseases that share commonalities with other diseases, that is, a condition of primacy, that involves a recognisable set of signs and symptoms, that has clearly established etiological agents and causes, that brings about specific anatomical and physiological changes, and has a predictable and progressive course. Essentially, the model assumes that some individuals have a biological vulnerability to the effects of a substance which progresses from impulsivity to compulsivity and ultimately, the loss of control over the use of that substance (Koob, 2006; Walters, 1992). As such, the disease model implicates abstinence as the primary goal for intervention. The disease model benefits from the fact that it is uncomplicated and relatively easy to understand. It removed the stigma associated with viewing addiction as a moral infirmity. However, it simultaneously downplayed the role of personal responsibility in the development and treatment of drug seeking behaviour.

A substantive body of evidence exists that points toward a genetic or biochemical basis for addictive behaviour that has ensured its popularity. For example, support for the disease model of alcohol addiction comes from family, twin and adoption studies. Family studies find that the rates of alcoholism are substantially higher in relatives of alcoholics than in relatives of non-alcoholics, twin studies find that the concordance rates for illness in pairs of monozygotic twins is higher than that of dizygotic twins, and adoption studies find that disorder is more concordant with biological parents than with surrogate parents, and, exists independent of surrogate

influence. Perhaps the most convincing evidence for a genetic component to the development of alcohol and other drug disorders comes from adoption studies that are able to separate environmental and genetic contributions. Using adoption records from Denmark, Goodwin, Schulsinger, Hermansen, Guze, and Winokur (1973) studied 55 male offspring of alcoholic parents who were adopted during the first few weeks of life by non-alcoholic families. They found that compared to controls, the adult concordance rate was 4:1.

Similarly, a study conducted by Bohman (1978) using Swedish adoption records found that the adopted sons of alcoholic parents were three times as likely to be alcoholic as adoptees without alcoholic parents. A smaller, however significant genetic component has also been found with females (see Bohman, Sivardsson, & Cloninger, 1981). Although most research examining the genetic basis of addiction has examined alcohol, the disease model is used broadly to explain the abuse of or addiction to a broad range of substances. Kendler et al (cited in Lin & Anthenelli, 2005) examined twin registers and found that heavy use of cannabis, as well as cannabis abuse and dependence, was largely attributable to genetic factors, with heritability ranging from 62% to 79%.

Support for a genetic basis of alcohol and other drug disorders is also provided by studies examining neurotransmitter and neuropeptide systems within the brain. These studies show that alcohol and drug cravings act through the same pathways as other drive states such as thirst, hunger, and sex. Childress (2006) contends that we are not all created equal in our brains "go" and "stop" system and that hereditability plays a part in determining the balance of this system. Support for this contention comes from animal studies which have shown that it is possible to breed alcohol preferring rats. These animals are noted to have neurochemical differences in dopamine and serotonin levels prior to alcohol exposure. Li, Lumeng, McBride, and Waller (1981) were able to breed strains of mice and rats that engaged in efforts to obtain the drug, showed tolerance to the drug, and became physically dependent on it. The researchers found that once they administered the rats with serotonin and dopamine, drinking behaviour decreased.

Childress (2006) suggests that genetic vulnerabilities may interact with a critical period of development: adolescence. She explains that in normal adolescence changes in the brains "go" system are powerfully evident, with hormonal changes readying the systems response to rewards (e.g. sexual opportunity). However the brains "stop" system is not fully developed. The frontal lobes, that are known to be critical for decision making and impulse control, continue to mature well into individuals 20's.

Several studies have shown that alcohol dependent and non dependent individuals respond to alcohol differently. Schuckit and colleagues (cited in Lin & Anthenelli, 2005) tested a group of high risk and control men's response to a standardised dose of ethanol. They found marked differences between the two groups reported ratings of the intensity of their experience with high risk subjects rating themselves significantly less intoxicated than low risk subjects. He subsequently classified 40 % of the men who were the sons of alcoholics as "low responders" to the alcohol, compared to only 10 % of the participants who were not the sons of alcoholics. Schuckit argued that the low responders would require larger doses of alcohol to achieve the expected desirable effects. Therefore, these men would tend to consume more alcohol, predisposing them to becoming alcoholics.

Ten years later Schuckit and his colleagues contacted the original participants to obtain self-report data on drinking behaviour. The researchers found that among the sons of alcoholics who had been classified as low responders, 56% were themselves classified as alcoholics. This was in marked contrast to the 14% of controls. Overall, genetic researchers find that genetic factors account for approximately 40%- 50% of the variable expression of alcohol and other drug disorders (Lin & Anthenelli, 2005).

Learning theories of addiction

Alternatively, Learning theories insist that all human behaviour is learned through processes of conditioning and modeling. Problem behaviour including substance use is viewed as a "bad habit". Thus these theories all posit- to varying degrees, that substance use can be treated by changing the environment or by changing individuals' reaction to the environment (Margolis & Zweban, 1998). Operant conditioning theorists contend that reinforcement is critical in shaping

behaviour. There are two elements involved in this learning process; positive reinforcement and negative reinforcement. Positive reinforcement involves seeking out rewarding stimuli and negative reinforcement involves escaping from or avoiding unpleasant stimuli. Essentially, this motivational system requires no conscious decision making; it is automatic (West, 2006). Drugs of abuse are known to act through the brains circuitry for natural rewards, however in a much stronger, supernormal way. Dopamine is one such neurotransmitter that has been implicated in underpinning positive reinforcement.

Classical conditioning theorists assume that individuals condition stimuli in the environment to the rituals, paraphernalia, and use of their drug of choice by repeatedly using the drug in specific settings with specific people, and according to a specific ritual. In this way, environmental cues come to elicit urges or cravings involved in the maintenance of substance use. Furthermore, as an individual becomes enmeshed in substance use environmental cues assume greater power- hence the progression of use.

Animal research has shown that drug "cues" become analogous with the brains response to substances and also increase dopamine release (Childress, 2006). Wickler (cited in Margolis & Zweban, 1998) observed that former drug addicts, when talking about their prior drug use, often began to experience actual physiological symptoms of opiate withdrawal. Wickler also found that when heroin addicts injected an inert solution that looked like heroin, they experienced a high from the process. By implication, conditioning related perspectives postulate that treatment techniques need to rearrange the contingencies or responses to substance use (Margolis & Zweban, 1998).

Modeling theories contend that observing others behaviour is central to learning. There are three pieces to this puzzle: cognitive affective theories- that focus on how substance beliefs contribute to substance use; social leaning theories that focus on the causes of such beliefs- that is, imitating the behaviour and attitudes of role models; and conventional commitment and social attachment theories- that focus on the causes of attachment to substance using role models. Theory of Reasoned Action (Ajzen & Fishbein, 1985) is a typical cognitive affective theory that suggests an adolescent's decision to use alcohol and other drugs (like all behaviour)

is a function of their attitudes in regards to the benefits and costs of substance use and their beliefs surrounding the social norms about using the substance. Thus, an individual is likely to use a given substance if they have a favourable expectation of the social, personal, and physiological effects of using the substance, and are less likely to use a given substance if they have a negative expectation of the social, personal, and physiological effects of using the substance.

Theory of Planed Behaviour (Ajzen, 1988) is an extension of Theory of Reasoned action that proposes that an adolescent's decision to engage in substance use is affected by their perception of control over the ability to successfully complete a behaviour in addition to attitudes and normative beliefs. This perception is affected by an adolescent's belief in their ability to obtain a given substance and successfully use the substance (e.g. inhale cannabis) as well as their ability to resist pressure to use a given substance. Support for cognitive affective theories comes from studies that find that use of a particular substance decreases following increases in the perceived risk and social disapproval of that substance (see Bachman, Johnston, & O'Malley, 1990). An obvious shortcoming of cognitive-affective theories is that they do not focus on the cause of substance beliefs; they concern themselves with the effects of such beliefs. Of note, within cognitive- affective theories, use is considered- to varying degrees, a matter of choice; an element of rationality is preserved (West, 2006). Therefore, cognitive-affective theories implicate the need to target adolescents' substance beliefs regarding the costs and benefits of substance use, and to teach skills that increase adolescents' ability to resist social pressures to use substances (Petraitis, Flay, & Miller, 1995).

Although self-selection processes are acknowledged in various theories such as cognitive-affective theories, the literature is dominated by theories emphasising social causation (Moos, 2006). By virtue, these theories explicate the causes of substance use. Social Learning Theory (Bandura, 1977, 1982, 1986) is a cognitive perspective that- like cognitive-affective theories, assumes that substance use originates in the substance specific cognitions of the individual. However, Social Learning Theory goes one step further by suggesting the cause of individuals' substance cognitions- the behaviours and attitudes of those that serve as individual's role models, especially the behaviours and attitudes of parents and peers. An individual is believed

to observe- directly and indirectly (e.g. media portrayals) a variety of contexts, motives, and consequences associated with alcohol and other drug use. An individual then imitates those behaviours that they consider social norms. Thus, an individual is likely to use a given substance if they have role models that model positive social, personal, and physiological effects of the substance, and are less likely to use a given substance if they have role models that model negative social, personal, and physiological effects of using the substance.

Peer Cluster Theory (Oetting & Beauvais, 1987) is an alternative position that contends that an individual's peers are central, and indeed the most salient risk factor, in influencing the decision to use (as well as maintain) substance use. Adolescence is a time period marked by increased peer involvement. Between the ages of 10 and 18, the amount of time adolescents spend with their families' drops on average by a half, and this time, in a large part, is replaced by time spent with peers (Kassel et al, 2005). Of course an alternative position is that "birds of a feather flock together"; that adolescents choose peers whose substance use behaviour is similar to their own. However Kassel et al (2005) assert that the most predominate assumption is that adolescents initiate (and maintain) their substance use as a result of peer influence. The relative influence of families and peers is likely to be determined by the age of the individual. Families most likely have a bigger effect on the development of social norms in children, while peers most likely exert their influence during adolescence (Kassel, et al, 2005).

Support for Social Learning Theory comes from studies which find similarities in the drinking patterns of adults and their children. Similarities have been found in studies examining the drinking patterns of the general population (Barnes & Welte, 1990), and in studies examining the drinking patterns of clinical samples (Penick, Powell, Bingham, Liskow, Miller, & Read, 1987jung). Hasselbrock & Hasselbrock (2006) found that associating with deviant peers tends to promote the acceptance of deviant behaviours including substance use. According to social learning theorists, the key to treatment lies in making substance-using role models less salient and substance-abstaining role models more salient. An obvious shortcoming of social learning theories is that they do not account for why some adolescents have substance using role models and some do not.

Conventional commitment and social attachment theories focus on the causes of adolescents' attachments to such people- weak conventional bonds to society and institutions and individuals that discourage deviant behaviour including substance use. These theories- based in large part on classic sociological theories of control, hold that when adolescents hold weak bonds to conventional society they will feel they have little to lose through attachment to deviant peers. Once attached to deviant peers they are likely to observe, imitate, and be socially rewarded for a variety of deviant behaviours including substance use. Elliott's Social Control Theory (Elliot et al., 1985, 1989) suggests that a discrepancy between an adolescent's aspirations and perceptions of the opportunity to achieve those aspirations, that is, *strain*, is the common cause of weak commitment to conventional society. This strain could be either school related, home related (e.g. wanting a closer relationship with parents), or occupationally related. In addition, social disorganisation may cause a weak commitment to conventional society. Social disorganisation includes disorganised neighborhoods (e.g. where crime and unemployment are common and schools are ineffective), and family disorganisation (e.g. where parents are divorced).

Social Development Model (Hawkins & Weis, 1985) on the other hand focuses more on individuals. Thus, individuals simultaneously influence, and are influenced by, interactions with conventional and deviant role models. When adolescents lack interpersonal and academic skills, or when theses skills are not rewarded by parents and teachers, adolescents feel they have little to lose by becoming involved with deviant peers who use substances. Taken together, Social Control Theory and Social Development Model implicate the need to target: adolescents' academic and occupational expectations; social and academic skills; attachment to parents and other conventional role models; reinforcement opportunities from parents and other conventional role models; and disorganised neighborhoods and families. Common support for these theories comes from studies which find that nonconforming, rebellious, and alienated youth are more likely to use alcohol and other drugs (Jung, 2001: Petraitis et al, 1995).

Psychoanalytic theories of addiction

While early psychoanalytic theories emphasised the use of substances as a regressive pleasurable adaptation, contemporary psychoanalytic thought emphasises the use of substances

as a progressive response to psychological suffering and related problems with self- regulation (Khantzian, Dodes, Brehm, 2005). Although variants exist, psychoanalytic theories share a common assumption that the cause of self-regulatory deficits is early infantile deprivation and maladaptive parent- child interactions. This shift in thinking from viewing addictive behaviour as an attempt to seek infantile pleasure to an adaptive effort for survival has created renewed interest in the school of thought as it appeals to both common sense and clinical observation.

The self-medication hypothesis associated with Khantzian is perhaps the most influential and enduring of the psychoanalytic theories. Put simply, this hypothesis states that individuals use substances to mitigate the effects of unpleasant emotional states. Khantzian based his theory on extensive clinical work. He asserted that drugs are not selected indiscriminately; they are chosen to act as prostheses. In this, the initiation of use and the choice of substance are believed not to be random but instead based on the psychopharmacological effect sought by the individual (Khantzian et al, 2005). According to the self-medication hypothesis, several types of self-regulatory impairments that can lead to substance use: deficits in affect tolerance; self-care; self-esteem, and relationships (Khanzian, 1995; 1997). In regards to affect tolerance, Khantzian noted that some of his patients experienced their affects to the extreme and found their affect confusing or inexplicable. He posited that these individuals turn to alcohol and other drugs to alleviate or block affective responses. In support of the self-medication hypothesis it is notable that theories of motivation consider affect to be a primary force underlying human behaviour (Sturiano, 2003), and various researchers have found that substance use is associated with various unpleasant emotional states such as depression and anxiety (Khantzian et al, 2005).

In terms of self-care Khanzian found that some individuals are unable to self- sooth. He believes this is caused by problems internalising the caring functions of the mother at an early age. A plethora of stress-coping conceptualisations fit Khantzians notion of self- soothing.

Self- esteem- Khanzians third self-regulatory impairment is among the most frequently cited variables in the literature. Self- degradation Theory (Kaplan, 1975) holds that self-esteem is the most salient factor in substance use. The theory argues that adolescents experience low self-

esteem and frequent self-derogation if they repeatedly receive negative evaluations from conventional others or if they feel deficient in any socially desirable attributes. In support of his theory Kaplan (1982) cites a 2-year longitudinal study that found that weak self-esteem directly affected involvement with substance using peers. Underlying low self-esteem Khanzian suggested was a failure to achieve a healthy, stable, cohesive self and a constant representation of mother. He hypothesised that the only way the individual feels they can defend against low self worth is constant abuse of alcohol and other drugs.

The last self-regulatory deficiency suggested by Khanzian is troubled relationships. Khanzian proposed that because of her own need, a mother may foster the idea that her infant should depend on her for all their self-regulatory needs. So later in life it is only natural that the adolescent turn to substances in an effort to re-create the environment of total dependence that existed in the infant-parent relationship.

Although difficult to study in a methodologically rigorous manner, the concept that individuals are attempting to address early disorders of self arising out of impaired object relations has utility. It is common for individuals to speak of wanting to feel normal or avoid painful affective experiences as the reason for their substance use (Walters, 1992). By implication, the psychoanalytic therapist needs to assist the patient in becoming more comfortable with affective states and in developing healthy alternatives to cope with them.

It is worth at this point to highlight the unique period of vulnerability that is adolescence. During adolescence, development takes place in the brain in regions and systems responsible for the regulation of behaviour and emotion, and cognitions of risk and reward. Combined with the developmental milestones that adolescents must complete, this may increase the likelihood that an individual may self-medicate, and seek out substances despite likely negative consequences.

Treatment for adolescent substance abuse in New Zealand

Treatment for adolescents in New Zealand normally fits into one of three treatment modalities: Residential, day, or outpatient (New Zealand Health Technology Assessment, 1998). Within a

particular treatment modality, a variety of treatment approaches are evident. These include 12-step or 12-step based, therapeutic community or therapeutic community based/modified/concept, psychotherapy based, and faith based (Meier & Best, 2006). Each varies in terms of intensity, ranging from a few weeks to over a year. Treatment services also differ in terms of their relative emphasis on individual councelling, group work, psycho-education, skills training (e.g. social skills and coping skills) leisure activities, domestic activities etc. Services also differ in terms of funding structure- being provided by district health boards (DHBs) and non-government organisations (NGOs). This has important implications for service provision and staffing levels and structure, for example number of staff with formal qualifications. A number of services within both DHBs and NGOs operate within a Maori framework including customary Maori cultural values, beliefs, symbols and practises in treatment (Warbrick, 1999- 2000).

Residential treatment encompasses a variety of approaches. The most popular of these approaches has been the therapeutic community. The therapeutic community is fundamentally a self- help approach that views the community of residents itself as the agent of change. It views the substance disorder as a condition of the whole person. A variety of therapeutic groups are routinely held that challenge residents' dysfunctional thoughts and beliefs. The various therapeutic groups also serve to provide healing experiences as residents demonstrate honesty, concern, trust, love, and responsibility for both themselves and others. Staff commonly facilitate such groups and also serve as positive role models for residents. Modified therapeutic communities such as those employed for adolescents usually strive for treatment stays of 6 to 12 months. The approach emphasises the need to isolate individuals from the environment in which the substance use took place so as to maximise the chance of the individual remaining drug free (De Leon, 2000).

Other residential treatment approaches include the Minnesota Model which is the most popular treatment approach in the United States. The Minnesota Model is a 28 day programme that combines the basic principals of psychotherapy with a 12-step approach (Winters, Stichfiels, Opland, Weller, & Latimer, 2000)

Day programmes may operate within the therapeutic community model commonly employed within residential settings amongst others. Day programmes commonly include schooling and recreational activities as part of their treatment programme. This is important as individuals with a history of alcohol and drug abuse usually experience educational difficulties (Lynskey & Hall, 2000; Lynskey et al, 2003). In addition, day programmes allow the adolescent to return to their family home during the evenings.

Outpatient treatment programmes are the most common mode of treatment available for adolescents (NZHTA, 1998). Outpatient treatment services may be provided by a professional therapist, in a group setting including family therapy, and within a structured programme. Given that adolescents are still usually enmeshed in the family environment and under parental influence and dependence, family therapy is a popular option. One such popular approach is Multidimensional Family Therapy (MDFT) (Shanton & Shadish, 1997).

A number of variables affect the choice of adolescent treatment. Variables that are commonly taken into consideration include the severity of the substance use, prior experience with treatment, and whether the family environment is conducive to an alcohol and drug free lifestyle.

The effectiveness of substance abuse treatment for adolescents

Effectiveness research looks at post- treatment outcomes in regards to substance use and related domains including criminal activity, employment and educational status, and health outcomes including health behaviour (e.g. HIV risk behaviour) and health symptoms (e.g. psychopathology) as well as a plethora of physical signs and symptoms. Generally, it has been found that treatment is efficacious and improves the lives of adolescents in significantly meaningful ways. It is noteworthy that this has been the general consensus of researchers despite the fact that relatively little is known about the effectiveness of adolescent treatment. In an extensive review of the literature, Williams, et al (2000) identified 53 studies with sample sixes 20+ examining the effectiveness of adolescent (13-19 years) alcohol and drug treatment. This is in comparison to the 1000+ studies examining the effectiveness of adult treatment for alcoholism alone identified by Miller, Brown, Simpson, Handmaker, Bien, Luckie,

Montgomery, Hester, and Tonigan, in 1995 (cited in Williams et al, 2000). The ability to draw any definitive conclusions regarding the efficacy of adolescent treatment is further compounded by the poor methodological quality that characterises existing studies.

Substance use outcomes have been evaluated in terms of dichotomous abstinent versus not abstinent and reduction in substance use. Brown et al (1989) evaluated treatment outcomes for 75 adolescents attending a residential programme. At 3 month follow-up they found that 36% had been abstinent in the previous 3 months. At 6 month follow-up the proportion abstinent had dropped slightly to 30%. Lewis and colleagues (1990) evaluated treatment outcomes for 84 adolescent probationers attending either 12 sessions of family therapy or 12 sessions of family education. One month prior to discharge, they found that abstinence rates were 39% for those receiving family therapy, and 40% for those receiving family education. McPeake, Kennedy, Grossman, and Beaulieu (1991) evaluated treatment outcomes for 58 adolescents attending a 25-day outward bound programme in the United States. At 6 month follow-up they found that 37% had been abstinent in the past 6-12 months. At 2 year follow-up they found that 43% had been abstinent in the past 1 year. The same researchers found that at both the 6 month follow-up and 2 year follow-up a significant proportion reported decreased use. At 2 year follow-up the proportion of those reporting that their use had greatly decreased was 68%.

Friedman et al (1989) evaluated treatment outcomes for 5603 adolescents attending 30 outpatient programmes in various States of America. They concluded that at the time of discharge substance use had dropped approximately 50% to that of pre-treatment levels. Other studies have noted reductions in substance use from pre to post-treatment however many fail to quantify the extent to which substance use has been reduced (Williams et al, 2000).

In regards to treatment outcomes in other domains improvements have also been found. Again however, the majority of studies simply report whether improvements were found instead of the degree of this improvement (Williams et al, 2000). Jainchill (1997) examined data collected by the Centre for Therapeutic Community Research (CTCR). She found that one year post-treatment, adolescents admitted to a residential facility had significantly less involvement in criminal activity including violent crimes, property crimes, and drug dealing. Utilising data

from the same centre, Jainchill, Hawke, and Messina (2005) found that 5 years post-treatment there was significant reductions in those reporting any involvement with drug possession, drug sales, violent crimes and property crimes. Spooner and colleagues (2001) examined substance use, personal and social functioning and health outcomes for adolescents who attended a residential programme in Australia. The researchers found significant reductions in social dysfunction, criminal behaviour, psychological distress, HIV- risk behaviour, and physical health signs and symptoms at six-month follow-up. Hser et al (2001) found improvements in adolescents' school performance and psychological adjustment, and reductions in criminal activity following both residential and outpatient drug free treatment. Finally, Morral, McCaffrey, and Ridgeway (2004) found that adolescent probationers, who attended a residential therapeutic community, performed better on a range of psychological measures than probationers who attended alternative residential programmes that did not have a focus on substance use.

It is worth noting at this point the methodological weakness that characterises much of the treatment outcome research- that in itself is scant. Many of these studies did not include a non-treated control group. Of those that did, most did not randomly assign participants. Therefore it is uncertain whether the effects obtained where due to treatment characteristics, client characteristics or natural recovery. Inconsistent variable measurements and definitions also limit the validity of the results. Furthermore, earlier research creates uncertainty as to the applicability of the results obtained to present day populations. Drug use patterns have changed significantly since the 1970's, 1980's and 1990's when the large-scale prospective studies where conducted (Simpson et al, 1997; De Leon, Hawke & Jainchill, 2000). Moreover, results conducted overseas may not be applicable to populations in New Zealand. The availability of certain drugs e.g. cocaine makes it's use and dependence less likely amongst the general population- particularly among youth who generally cannot afford the cost of the rare commodity. So although substance abuse treatment appears to be efficacious for adolescents, the mechanisms underpinning the observed relationships are not well known.

A special case in the treatment outcome literature is that of retention. And, among the pre, during, and post-treatment variables that have been examined, retention in treatment and

treatment completion have been found to be consistent predictors of favourable treatment outcomes. A relationship between time in treatment and treatment completion, and favourable outcomes, has been found by numerous researchers evaluating various programmes (for example Sells & Simpson, 1979; Friedman et al, 1986; De Leon, Jainchill, & Wexler, 1982; Melnick, DeLeon, Hawke, Jainchill & Kressel, 1997; Jainchill, 1997; Hsieh, Hoffman, & Hollister, 1998; Winters et al, 2000; Hser et al, 2001). In fact, in a thorough review of the effectiveness research on adolescent treatment Williams and colleagues (2000) concluded that treatment completion is the *most* consistent predictor of favourable treatment outcomes.

Again, it is notable that in addition to the failure of the majority of studies to report degree of improvement from pre to post-treatment, length of stay is, in most cases, not specified. It is suggested that stays of 90 days or more is a benchmark for significant changes to occur in residential settings or the equivalent time receiving counselling in outpatient drug free settings (Hser et al, 2001; Simpson, et al, 1997; Hubbard, et al, 1989) Hubbard, Marsden, Rachel, Harwood, Cavanaugh, & Ginzberg, 1989). Methodological weaknesses are also evident which make it hard to distinguish between the relative contributions of client characteristics, treatment characteristics and natural recovery. It is also possible that the same mechanisms underpinning retention in treatment are responsible for favourable treatment outcomes.

Precluding the fact that retention is related to favourable outcomes for adolescents is the fact that retention, and, respectively, treatment completion is typically low (Hubbard et al, 1989; Stark, 1992; Williams et al, 2000; Hser et al, 2001; Orlando et al, 2003). Whatsmore, dropouts tend to occur in the first few weeks of treatment. Stark (1992) contends that a 50% dropout rate in the first month of treatment for adults is evident, with 25% to 80% dropping out in the first few months. He further states that this relationship is found across a range of treatment modalities. Simpson et al (1997) examined the retention rates for 17 long term residential treatment programmes and 14 outpatient drug free treatment programmes. The researchers found 90 day dropout rates ranging from 21% to 65% among the long term residential treatment programmes and 90 day dropout rates ranging from 16% to 76% among outpatient drug free treatment programmes. In Odyssey House youth residential treatment, the dropout rate is 66%

in the first week of treatment (Davidson, 2007). De Leon (1993) concedes that "dropouts still remain the rule in all treatment modalities" (p. 182).

The factors contributing to the retention of clients in treatment are not well understood (DeLeon et al, 1997; Melnick, et al, 1997; Williams, et al, 2000; Orlando et al, 2003; Jainchill, et al, 2005; Schroder et al, 2007). This is despite it being recognised back in 1989 by Hubbard and his associates who evaluated data collected as part of the Treatment Outcome Prospective Study (TOPS) – a large-scale prospective longitudinal study conducted in the United States examining a variety of treatment modalities and, one of the earliest studies examining the effectiveness of adolescent treatment.

For the consumer, benefits may not be wreaked as the treatment plan was devised according to provider expectations of treatment attendance. From the perspective of the treatment provider, dropouts are costly as high "front end" costs (requirements for initial assessments and treatment planning) occur. As a result, treatment facilities- in effect, operate at low organisational efficiency and effectiveness levels (Simpson et al, 1997). Given the negative perception of treatment dropouts as failures, lowered staff morale also results (Pulford et al, 2006). Understanding the factors that contribute to retention is necessary then to improve treatment. Further, by explicating the factors contributing to low retention it is likely that the mechanisms contributing to the effectiveness of programs will be better understood. Two broad classes of factors have been examined in relation to treatment retention: those related to the client and; those related to the programme.

The first broad class of variables pertains to that of the client. Client related variables can be divided into fixed client characteristics and dynamic client characteristics. A number of fixed client characteristics have been examined in relation to favourable treatment outcomes including retention. These include age (Melnick et al, 1997; Friedman & Glickman, 1987; Blood & Cornwall, 1994; Friedman at al, 1986), gender (Green, Polen, Dickinson, Lynch, & Bennett, 2002; Blood & Cornwall, 1994), ethnicity (Melnick et al, 1997), educational status (Friedman et al, 1986; Blood & Cornwall, 1994), criminality (Friedman et al, 1986; Blood &

Cornwall, 1994), psychopathology (Feehan et al, 1994; Galaif, 2001) referral source (Melnick et al, 1997), substance use, (Blood & Cornwall, 1994; Friedman at al, 1986; Menick et al, 1997; Orlando et al, 1997), and family substance use (Orlando et al, 2003). Despite being given much attention in the past (Melnick et al, 1997, Orlando et al, 2003), in general, these studies find no or little association to favourable treatment outcomes. (For a useful and relative review see Schroder et al, 2007). Moreover, they are of little use as they have no practical value. If the objective is to improve treatment and outcome for all presenting clients rather than to select those most likely to succeed, it is imperative to look at retention predictors that can be influenced by service providers.

In regards to dynamic client characteristics, 3 studies have been conducted that investigate these variables as they relate to adolescents. These studies focus on motivation and readiness-variables that have long been noted by clinicians as critical factors in understanding why individuals both seek and remain in substance abuse treatment. The relationship between these factors and favourable treatment outcomes has been demonstrated on a number of occasions in the adult literature (De Leon, Melnick, & Kressel, 1997). The first of the adolescent studies to examine the effect of motivation and readiness on retention was conducted by Melnick, et al (1997). The researchers examined motivation and readiness of 1097 adolescents attending therapeutic communities using the Circumstances Motivation Readiness Suitability (CMRS) scale. The study also examined scores for an equivalent number of adults. They found that motivation was significantly associated with age (positive relationship) and that higher scores were related to 45-day retention. In fact, for adolescents, those with higher CMRS scores were found to be twice as likely to remain in treatment to 45 days as those with lower CMRS scores.

Similarly, Orlando and colleagues study of court referred youths found that motivation pre-treatment was significantly associated with treatment retention. They did not find a significant relationship between resistance self-efficacy (an individuals belief that they can refuse the substance), and problem orientation (an individuals understanding on the relationship between their substance use and current problems for which they were referred).

Schroder and colleagues recent examination of variables associated with retention of adolescents in the New Zealand context examined a range of dynamic client characteristics. They found that adolescents in outpatient settings which agreed with the statement that "they attended treatment because other people thought they should do something about their alcohol and other drug problem"- thus were externally motivated, were likely to drop out of treatment earlier than those who were not. For adolescents in either day or residential settings, low internal motivation to remain in treatment was associated with treatment drop out. Similarly, for those who were externally motivated, drop out was more likely. Schroder and colleagues also found that adolescents in residential and day treatment programmes were more likely to drop out of treatment if they were less likely to expect that treatment would make them make changes in their life in general, and less likely to expect that treatment would help them make changes in relation to their substance use specifically.

The second broad class of variables pertains to that of the treatment programme. Treatment programme characteristics can be conceived of in terms of treatment programme modality; treatment programme approach within the modality and; unique characteristics within a treatment programme. Treatment programme modality and treatment programme approach are relatively *fixed* characteristics whereas unique characteristics within a treatment programme are relatively *variable* characteristics. In regards to treatment programme modality, 4 studies are notable. Sells and Simpson (1979) analysed data collected as part of the Drug Abuse Reporting Programme (DARP). They compared outcomes for adolescents who had received treatment in a variety of treatment modalities including methadone maintenance, outpatient drug free, and long term residential. They failed to find any differences in outcome between the various modalities at 4- and 6-year follow-up. Hubbard, Cavanaugh, Craddock, and Rachel (1985) analysed data collected as part of the TOPS. They compared outcomes for adolescents who received treatment in outpatient drug free and long term residential. They found favourable outcomes for adolescents attending both treatment modes. Of course, the relevancy of these findings to New Zealand's youth today is questionable.

More recently, Galaif, Hser, Grella, and Joshi (2001) analysed recent data collected as part of the DATOS. They found several differences in the outcomes of the 710 adolescents attending

outpatient drug free and long term residential settings. They concluded that the differences found pertained to the particular setting. For adolescents attending outpatient drug free, severity of substance use pre- treatment was the variable that predicted low treatment retention, while for adolescents attending long term residential treatment programmes, the variables most associated with retention was greater criminal involvement pre-treatment, and having families with greater substance use. This study is significant because it suggests that there is an interaction between client characteristics and programme characteristics that determines outcomes. In contrasts to the findings found by Galaif et al (2001), Hser et al (2001) - analysing the same data, found no differences in outcomes between adolescents attending outpatient drug free and long term residential modalities.

Evidently, there are an insufficient number of studies comparing the efficacy of different treatment programme modalities to draw any conclusions regarding the relative efficacy of one treatment programme modality over another. This contention is echoed by Catalano, Hawkins, Wells, Miller and Brewer (1990/1991) and, more recently, Williams et al (2000), who, in a thorough review of the efficacy literature, concluded that there is no evidence to date that proves that one treatment modality is superior to another. Despite this lack of evidence, it is likely that there is much variation within different treatment programme modalities. Simpson et al (1997) examined retention rates among 17 long term residential treatment programmes and 14 outpatient drug free treatment programmes. They found 90 day drop out rates ranging from 21% to 6% among long term residential treatment programmes and 16% to 76% among outpatient drug free treatment programmes.

In regards to treatment programme approach within the treatment programme modality, several more studies are notable. Hennggeler, Bourdin, Melton, Mann, & Smith (1991) compared a group of conduct disordered adolescents attending either outpatient family therapy or outpatient individual councelling. Four years post-treatment they found that adolescents who attended family therapy had significantly lower drug related arrests. Joanning, Quinn, Thomas, and Mullen (1993) compared 7-15 sessions of outpatient family therapy, to 12 sessions of outpatient group therapy, to 6 sessions of outpatient family drug education. At the time of discharge, they found that those in the family therapy group had significantly lower substance use than the

other two groups. Lewis, et al (1990) compared adolescents receiving 12 sessions of outpatient family therapy to 12 sessions of outpatient family education. At discharge the researchers found greater substance use reduction in the group receiving family therapy, however there were no differences in abstinence rates. At a glance, it appears that outpatient family therapy is superior to that of other outpatient treatment programme approaches. This is the opinion also of Shanton and Shaddish (1997) who, in a meta-analysis found family therapy to be superior to that of other treatment approaches. No studies where found that compared the efficacy of different residential treatment programme approaches. Williams et al (2000) summed up the literature regarding *fixed* treatment characteristics that may affect retention, and respectively favourable treatment outcomes... "There is insufficient evidence to compare the effectiveness of treatment types, [but] outpatient family therapy appears superior to other forms of outpatient treatment" (p. 1)

So, does treatment programme modality and treatment programme approach affect retention in treatment, and respectively, favourable outcomes? It appears that there is insufficient evidence to compare different treatment programme modalities and treatment programme approaches within treatment programme modalities- with the exception perhaps of family therapy. Of significance however, is the efficiency of different treatment programme approaches. Internationally, there has been a trend towards adopting more cost efficient treatment modalities (Pulford et al, 2006) such as the Minnesota model which is a time limited treatment approach- usually 28 days in length, delivered in both residential and community settings. The shorter duration of this treatment likely incurs benefits for both consumers and providers. Recently, Winters and colleagues (2000) compared a group of adolescents attending either outpatient drug free treatment or inpatient treatment. Both modes of treatment utilised the Minnesota approach. He found favourable outcomes for both groups of adolescents. Thus the Minnesota Model may provide effective and efficient treatment.

In regards to unique characteristics within a programme, a few studies are notable. However, like other aspects of adolescent treatment research- insufficient research has been conducted. The studies that do exist are far and few between. Support for the role of programme variables however comes from studies such as that conducted by Simpson et al (1997) which found that

retention rates within both outpatient and inpatient treatment programmes varied significantly for adults.

The earliest of theses studies was conducted by Friedman and colleagues. Friedman and Glickman (1986a) examined programme characteristics associated with successful treatment outcome in 5789 adolescents attending 30 drug free outpatient treatment programmes. They found a number of variables to be significantly associated with a reduction in drug use. These variables included: the provision of schooling and other ancillary services such as vocational counseling and recreational services for drop-outs; employing counselors with at least 2 years experience working with adolescent drug abusers and; being perceived by the clients as allowing and encouraging free expression and spontaneous action.

Friedman and Glickman and Kovach (1986b) examined programme environmental characteristics associated with successful treatment outcome in 244 clients and 131 staff in 30 treatment programmes. They found four variables to be significantly related to a reduction in drug use. These variables were: client rating of "spontaneity"; staff rating of "practical orientation"; staff rating of "personal problem orientation" and; staff rating of "order and organistation".

Friedman and Glickman (1987) examined residential programme characteristics associated with completion of treatment in adolescents attending 22 treatment programmes. They found a number of variables to be significantly related to "case failure" defined as discharge from the programme as a result of client decision or programme decision. These variables included: number of years therapists were employed in the programme (negative correlation); and proportion of clients receiving training in mental and bodily relaxation techniques (negative correlation). Given that these studies are quite old and were conducted in a different cultural and health care setting than New Zealand, the study's generalisability needs to be treated with caution (NZHTA, 1998).

The provision of two ancillary services- schooling (Catalano et al, 1990-1991; Friedman & Glickman 1986a) and family therapy (Catalano et al, 1990-1991; Shoemaker & Sherry 1991;

Orlando et al, 2003), is thought to have a particularly positive influence on treatment outcomes including retention. In regards to family therapy, Shoemaker and Sherry (1991) found that in a sample of 144 adolescents attending 3 residential programmes, more family sessions during treatment and family involvement in the treatment process predicted better outcomes. Orlando et al (2003) found that more than 50% of youths in their study examining retention of 291 court refereed adolescents in 7 treatment facilities reported they needed assistance with family problems. The researchers reported that for those adolescents who reported needing the ancillary service as well as other services (e.g. job training and legal advice) and respectively, not receiving the needed services, dropout was more likely.

In Orlando et al (2003) study they also asked adolescents about their perceptions of counsellors, other residents, and their feelings of safety in the programme. They found that perception of safety contributed significantly to the prediction of retention while ratings of councellor and resident support were marginally significant.

Most recently, Shroeder et al (2007) examined programme factors associated with retention of 79 youth attending 8 treatment programmes. While they found no programme related variables to be associated with retention in outpatient drug free treatment programmes, a highly significant association was found between clients' perceptions of being involved in the process of goal setting and retention. Clients were also found to drop out of treatment if they reported less positive experiences with staff in terms of feeling "safe, comfortable, and supported by staff" and "being able to express themselves openly and honestly with staff". Additionally, they commented that the variables "not feeling connected to the programme" and "not having fun during the programme" showed trends towards being significant. This study is noteworthy as it was conducted very recently utilising New Zealand service providers. One other study worth a mention is that conducted by Meier and Best (2006). The study investigated programme factors that influence the completion of residential treatment. Although limited as it was conducted with a sample of primarily adult service users, it found that the most intensive programmes had the lowest treatment completion rates. The same study found that the more time that was spent on individual counselling the better was the treatment retention, and this was independent of treatment philosophy.

Evidently, there are many answered questions in regards to why retention of youth in alcohol and drug rehabilitation treatment is low. Given that so little is known about the topic-particularly the perspective of the service user (Pulford et al, 2006), it was deemed appropriate to investigate the subject qualitatively.

Methodology

Rationale for qualitative research

The primary consideration when choosing a research method is how the research question/s might best be answered (Robson, 2002). Simultaneously, a research question emerges from ones worldview, as a worldview suggests what is important and reasonable to research (Patton, 2002). In the present study the researcher sought to elucidate the issue of retaining youth in a drug and alcohol rehabilitation programme. Unsatisfied with simplistic explanations that seemed to dominate popular opinion (e.g. "young people drop out of the programme because they experience cravings" or "it's because of a lack of social support") an approach was sought that was holistic and that would account for the inherent complexity in human behaviour. Furthermore, an approach was sought that acknowledged the perspective of the individual; not some grand theory based on "expert opinion".

The qualitative approach met these necessities. Specifically, a constructivist worldview met these necessities and accommodated the researcher's worldview. Constructivist philosophy assumes the relativism of multiple realities, the co-creation of knowledge between the viewer and viewed, and emphasises participants constructed meanings as central to the research process. To elaborate, constructivism holds that individuals create meaningful worlds through dialectical processes of conferring meaning on their realities and acting within them. Constructivists emphasise how individuals construct their realities, what they define as real and the effect on action this has. It is not an ontological doctrine as such, as it does not concern itself with what types of things exist. Constructivists hold that there is no truth to the matter of interpretation, that the viewer creates the ensuing analysis with the viewed. Additionally, constructivists hold that there is no correct method to obtain individuals constructions (Denzin & Lincoln, 2000).

Given the researcher's direct immersion in the field (the researcher is an employee of Odyssey House Youth Residential Programme) it made sense to utilise her experience and insight. A constructivist approach allowed the researcher to draw on such tacit knowledge.

Qualitative research

Qualitative research is lent towards understanding (Denzin & Lincoln, 2000). Qualitative research focuses on the generation of knowledge. The emphasis is on transforming data to theory (Henwood & Pidgeon, 1992). Thus, no priori theory is believed to be capable of encompassing the multiple realities that are likely to be encountered and, that are necessary to achieve understanding (Denzin & Lincoln, 2000). In regards to design, qualitative research is naturalistic. The researcher enters the setting in which the phenomena of interest is occurring. Qualitative research is therefore non-manipulative, non-controlling and non-obtrusive (Patton, 2002). Qualitative designs are emergent; the research design unfolds as the researcher interacts with individuals and becomes increasingly aware of the particularities of the phenomena. Such flexible designs foster creativity and insight (Glaser & Strauss, 1967). Sampling is purposeful in qualitative research. Cases, whether natural (e.g. people) or otherwise (e.g. organisations, events, people) are selected based on their relevance to the emerging theory (Glaser & Strauss, 1967). Such a strategy increases the likelihood that the full array of multiple realities will be uncovered (Lincoln & Guba, 1985).

In depth interviews and close observation are two methods which elicit rich and detailed information about social phenomena. The researcher's personal experience and insight are considered important. The value in such tacit knowledge lies in its ability to give meaning to the nuances in the data (Lincoln & Guba, 1985). One caveat is notable; the quality of data collected in interviews is dependent on the skills and attributes of the researcher to elicit rich and detailed information. The researcher can start by demonstrating respect, neutrality, mindfulness, and sensitivity towards interviewees (Patton, 2002).

In regards to analysis strategies, qualitative research prioritises inductive analysis. The researcher begins with specific observations in order to gain understanding and insight, and then builds towards general patterns. The unique case orientation employed in qualitative research allows an appreciation of idiosyncrasies in the phenomena (Patton, 2002). Qualitative research is holistic. The phenomena understudy is understood in its entirety- as a whole. It is understood as a complex system replete with interdependencies, dynamics and processes (Patton, 2002). Qualitative research is context sensitive. The research is put in its

social, cultural, and historical context. This is part of qualitative researchers holistic emphasis and contributes to an in depth understanding. Also included in a holistic understanding is the documentation of the role of the researcher. This has been referred to in the literature as reflexivity. Put simply, reflexivity refers to the inevitable influence the researcher has on the theory that is generated. Reflexive validity is achieved when the role of the researcher is highlighted and revealed (Henwood & Pidgeon, 1992; Stiles, 1990; Patton, 2002; Denzin & Lincoln, 2000). Patton (2002) contends that while these are not universal themes or characteristics of qualitative research they should be regarded as strategic ideals.

Grounded Theory: A method and theory

Grounded theory methods foster seeing your data in fresh ways and constructing an original analysis of a general problem area that can transcend beyond the obvious (Charmaz, 2000a; Glaser & Strauss, 1967). In grounded theory one begins with an area of study and what is relevant to that area is allowed to emerge (Strauss & Corbin, 1990). Thus, the theory emerges from the research process. The overall aim of grounded theory is to generate a theory that accounts for a pattern of experience, which is relevant for those involved (Glaser, 1978).

In grounded theory there is interplay between data collecting, coding and analysis. The grounded theory method depends on using constant comparative methods and the researcher's engagement (Charmaz, 2000a). The constant comparative method is the hallmark of the approach. As a method of analysis, the constant comparative method involves generating successively more abstract concepts and theories through inductive processes of comparing data with data, data with category, category with category and category with concept. Comparisons then constitute each stage of analytical development (Charmaz, 2000a). Conducting comparative analysis means the researcher consider "all is data". Pre-existing technical (research studies etc) and non-technical literature (newspaper, magazine articles etc), and the researchers own professional understanding of the topic are all viewed as potentially valuable sources of data. This data is given the same analytical treatment, that is, constant comparison as constant comparison reduces the likelihood that researchers merely superimpose their preconceived notions on the data (Glaser & Strauss, 1967). The use of a broad variety of data sources ensures the validity and comprehensiveness of the emerging theory. In fact, the very

nature of the constant comparative method is transcending as it automatically goes beyond the limits of proceeding theories. In other words, successive comparative analysis delimits the boundaries of the existing theory while generating a more general one (Glaser & Strauss, 1967). In sum, the systematic use of comparative analysis gives a broad, rich, integrated, dense and grounded theory.

The success of grounded theory also relies on the theoretical sensitivity of the researcher. Theoretically sensitive researchers are able to conceptualise and formulate a theory as it emerges from the data (Glaser & Strauss, 1967). Glaser and Strauss, among many others, contend that the root source of all significant theorising is the sensitive insights of the researcher him/herself. Theoretically sensitive researchers see nuances in the data. They are able to draw fruitful insights from personal experiences and cultivate such insights. Further, a theoretically sensitive researcher makes profitable use of existing literature and theory rather than letting it predetermine ideas or stifle potential insights (Glaser & Strauss, 1967; Charmaz, 2000a). Glaser & Strauss (1967) suggest one strategy is to literally ignore the existing literature until the theory seems sufficiently grounded and developed and a conceptual framework emerges. Then the literature can be reviewed and integrated into the theory. Additionally this strategy avoids reviewing literature that is conceptually irrelevant to the emerging theory, (Glaser & Strauss, 1967 & Glaser, 1978). Glaser & Strauss (1967) posit:

> When someone stands in the library stacks, he is, metaphorically surrounded by voices begging to be heard....People converse, announce positions, argue with a range of eloquence, and describe events or scenes in ways entirely comparable to what is seen and heard during field work (p. 163).

Grounded Theory: The present

Since their 1967 classic work, Glaser and Strauss have taken grounded theory in somewhat different directions. Glaser continues to define grounded theory as a method of discovery and attribute the development of theory to emergence from comparative analysis. Strauss's method on the other hand contradicts a lot of the fundamental tenets of grounded theory. He concocts a whole new set of technical procedures in his 1990 and 1998 co-authored books with Juliet M.

Corbin. In these books the comparative logic that underscored the grounded theory method is replaced by their new more technical and procedural techniques that move the method towards verification (Charmaz, 2000a). Glaser (1992) contends that Strauss and Corbin's procedures force data and analysis into preconceived categories through their analytic questions, hypotheses, and methodological techniques, rather than letting it emerge from the data. It is a verificational method that does not do justice to the data. The natural participant perspective to theoretical analysis is lost.

My method adheres more closely to Glaser's 1978 and 1992 delineation of the method rather than Strauss and Corbin's 1990 and 1998 manifestation of the method. The reason is that Glaser's method appears to be more amenable to theory development. Adherence to Strauss (1990) paradigm fosters linear reasoning. Constructivism holds that social phenomena are inherently complex. Furthermore, the new technical procedures are too prescriptive and presumptuous, rather than emergent and interactive like their original statement of the method. Moreover, Strauss imparts a behavioural perspective on the method rather than the symbolic interactionism that imbued their earlier statement of the method.

Grounded Theory: Methodological guidelines

In grounded theory there is interplay between data collecting, coding and analysis. I will discuss them as separate processes for the purpose of clarity. In general, data collection is guided by theoretical sampling and analysed by comparative methods and memo writing. Of note, Grounded theory is best described as a style of research delineated by a number of interrelated methodological guidelines that vary in accordance with the aims and context of the research and the topic of inquiry (Strauss, 1987). Glaser and Strauss (1967) posit that precise and exact methodology is not appropriate when theorising about social phenomena as it constrains creativity and insight which are important for developing a sensitive interpretation of the data.

Coding

The relationship between data and theory is a conceptual code. Coding entails conceptualising empirical indicators in the data (Glaser, 1978). A code summarises and accounts for what is

happening in the data (Charmaz, 2000a). There are two levels of coding; substantive coding and theoretical coding, however, most often, these two types of coding go on simultaneously (Glaser, 1978). Substantive codes conceptualise the empirical substance of the problem area. They generate the 'bones' of your analysis. Theoretical codes conceptualise how the substantive codes relate to each other. They assemble the bones – the substantive codes, into a working skeleton – an integrated theory (Glaser, 1978; Charmaz, 2000a).

Substantive coding begins with open coding. In open coding the data is fractured into as many analytical pieces as possible. Line by line coding of transcribed data is characteristic of this stage of analysis. The goal of open coding is to generate an emergent set of categories and their properties. The analysts' job at this stage is to remain open to the data and stay close to it (Charmaz, 2000a). The theoretical sensitivity of the analyst is enhanced by asking certain 'neutral' questions of the data, "what is the data a study of?", "what category or property of a category does this indicate?" and "what is actually happening in the data?" Analysis becomes successively more abstract as data are compared with data, data with category, category with category, and category with concept (Glaser & Strauss, 1967; Glaser, 1978).

When an initial conceptual framework emerges selective or focussed coding commences. During this stage a core variable or variables is selected, that is, the variable or variables that appear to account for most of the variation in the pattern of behaviour. The analyst then delimits coding to only those variables that relate to the core variable or variables in sufficiently significant ways. At this stage of analysis the analyst utilises relevant technical and non-technical literature, and experiential data as a source of comparative analysis (Glaser, 1978).

In theoretical coding the analyst conceptualises the relationships between categories and their properties. Theoretical codes explain how you conceptualise the arrangement of key ideas. Like substantive codes they are emergent (Glaser, 1992). Like substantive codes they are provisional. They may later be reworded to better capture and condense meanings (Glaser, 1978). Theoretical codes are always implicit, however, giving the emergent theory integrative scope (Charmaz, 2000a).

Two types of categories exist, those represented by sociological constructs and those represented by in vivo codes. Sociological constructs are taken or derived directly from the substantive field. They have analytic ability. In vivo codes are codes of participants' special terms. They serve to preserve participants' meanings of their experienced events, views, and actions. Respectively, they have much imagery. In vivo codes tend to be the actual processes and behaviours to be explained, and sociological constructs tend to be the explanations (Glaser & Strauss, 1967; Glaser, 1978).

Theoretical sampling

Initial decisions in regards to data collection are based on theoretical relevance to the general problem area. Theoretical sampling guides further data collection (Glaser & Strauss, 1967; Glaser, 1978). Theoretical sampling is the purposeful collection of data in order to construct full and robust categories and to clarify relationships between categories.

Specifically, theoretical sampling is used to develop emerging categories- making them definitive and useful. The conceptual boundaries of a category are then identified and the properties of a code delineated so that the circumstances surrounding the code can be understood. Theoretical Sampling commences when gaps emerge in the initial data collected. It is therefore controlled by the emerging theory. Comparative methods reveal such gaps in the theory (Glaser & Strauss, 1967; Glaser, 1978). It is a quick, focussed method of gathering specific data (Charmaz, 2000a).

Theoretical sampling continues until categories are 'saturated'. A category is saturated when theoretical sampling reveals no new properties of a category and the same properties continually emerge (Glaser, 1978). Specifically, a category is saturated when the boundaries of the code; the empirical criteria on which it rests; the conditions under which it emerges or is evident and its connections and significance to other codes are explicated (Charmaz, 2000a).

Memo writing

Memos provide the substance of the written theory. Memos are the theorising write up of ideas about codes and their relationships. Through memo writing the analyst elaborates processes,

assumptions and actions that are subsumed under codes (Charmaz, 2000b). They are written up as they strike the analyst when constantly comparing, coding and analysing, (Glaser, 1978; Glaser, 1992). There is no correct way to write a memo. The analyst simply does what works-linking interpretations with empirical reality (Charmaz, 2000a).

Memo-writing serves analytic purposes. Early memos are descriptive. They detail in so far what is happening in the data. Successive memos raise the abstraction of the data to a theoretical level. A conceptual rendering of the data results as the analyst engages with the data, in other words, the analysist achieves intimate familiarity with the data through memoing.

Theoretical sorting and diagramming

Sorting is the final fundamental step in grounded theory. In theoretical sorting memos are sorted into a theoretical outline in preparation for writing the theory. Memos are integrated according to the emerging theory.

Diagramming consists of creating a visual image of the theory. A visual representation promotes understanding of the theoretical integration of the theory. Further, the power and scope of the theory is a made clear.

Rational for Grounded Theory

Pragmatic and ethical considerations drove the decision to use grounded theory methodology. Henwood and Pidgeon (1992) posit that methods are not so much valid in and of themselves, but will be more or less useful for particular research purposes.

Grounded theory is aimed at generating theory that furthers the understanding of social phenomena. Grounded theory allows you to make an original contribution to a substantive field by providing the means to offer a fresh or deeper understanding of the studied phenomena (Glaser & Strauss, 1967; Glaser, 1992; Charmaz, 2000a). Glaser (1978) contends that even in well trodden fields there is still quite enough space if it is grounded. Thus, grounded theory is appropriate for research in which new points of view are sought on a familiar topic as is the case in the present study.

Grounded theory has practical application. It is focussed towards generating middle range theories that are applicable to everyday problems (Charmaz, 2000a). Indeed, much of the popularity of grounded theory is that it deals with what is "actually" going on, not what "ought to be" going on (Glaser, 1978). Charmaz (2000b) suggests that the strength of grounded theory lies in its analytic ability to theorise how meanings, actions, and processes are constructed.

Grounded theory provides rich and detailed information about social phenomena. Grounded theory employs a natural participant perspective to analysis (Glaser, 1992). A unique case orientation allows an appreciation of idiosyncrasies in the data (Patton, 2002). In this, multiple perspectives are accommodated in understanding the phenomena. Furthermore, the complexity of particular world views and actions are acknowledged and accommodated. A natural participant perspective also allows the inner perspectives and emotions caught up in accounts and stories to be revealed (Charmaz, 2000a).

Grounded theory allows research to be conducted from an ethical standpoint. Firstly, grounded theory is non-manipulative and does not use deception (Charmaz, 2000a). Research is undertaken on participants' terms. Secondly, analysis is anchored in participants' worlds (Charmaz, 2000a). The important reality is what individuals perceive it to be (Lincoln & Guba, 1985; Denzin & Lincoln, 2000).

Assessing research outcomes

There is some debate as to what constitutes good qualitative research. This debate is driven in part by ontological and epistemological differences that exist among researchers. One thing is agreeable, appropriate assessment criteria for quantitative research (objective, reliabile and valid criteria) are not appropriate as originally formulated to apply to qualitative research (Glaser & Strauss, 1967; Stiles, 1990; Henwood & Pidgeon, 1992). Multiple criteria compete for attention in the field (Patton, 2002). Criteria have been proposed both for evaluating qualitative research in general and grounded theory in particular. I will address both these criteria in the present study in order to maintain quality in the research process, and the data and theory.

Glaser's (1978) criterion is particularly useful for thinking about the quality of the data and theory. The criteria are to a large extent interwoven. Glaser (1978) posits an effective grounded theory that has practical application will meet four central criteria: *fit, work, relevancy and modifiability.*

A theory that *fits* is one that has been carefully induced from the data. Therefore, there should be an obvious and coherent relationship between empirical indicators in the data and conceptualisations. This criterion is necessitated by the belief that a researcher begins his/her study with certain research interests, background assumptions and disciplinary perspectives. This alerts him/her to look for certain possibilities and processes in the data In other words, the theory should not be based on a researcher's ideals, values and assumptions. Effectively, the criterion of fit is automatically met if constructs are grounded in the data (Glaser & Strauss, 1967; Glaser, 1978).

Work refers to the ability of the theory to explain what is happening in the substantive area (Glaser & Strauss, 1967; Glaser, 1978). A grounded theory that works will provide a conceptual rendering and ordering of the data that explains the studied phenomena. Therefore, the theory needs to be meaningfully related to the empirical substance of the data at every level of abstraction (Charmaz, 2000a). A theory that works will evoke understanding from those who are affected by the general problem area (Henwood & Pidgeon, 1992).

Relevancy refers to the applicability of the theory to the substantive area (Glaser, 1978). A grounded theory achieves relevancy if it offers analytic explanation of actual problems and processes in the research setting (Charmaz, 2000b). A grounded theory automatically achieves relevance if it allows core problems and processes to emerge (Glaser, 1978).

Modifiability refers to the ability of the theory to work the data (Glaser, 1978). Thus, it must be able to accommodate new indicators as further data are collected or conditions change (Charmaz, 2000b). Glaser (1978) contends that this criterion is important as while core problems and processes remain their variation and relevance is forever changing. Thus, the

theory needs to be sufficiently general enough to explain the variation within the phenomena while maintaining a sensitising aspect to the data (Glaser & Strauss, 1967).

Additional criteria have been proposed by Stiles (1990) for evaluating qualitative research in general, and Henwood and Pidgeon (1992) for evaluating grounded theory specifically.

Stiles (1990) suggests researchers should seek information from multiple sources and methods and assess convergence. This process he calls *triangulation*. If a grounded theorist considers "all is data" while constantly comparing to the emerging theory this criterion is met. Charmaz (2000b) echoes this; stressing researchers should gather extensive amounts of rich data with thick description.

Testimonial validity refers to seeking validation of the theory from participants (Stiles, 1990). Similarly Henwood and Pidgeon (1992) suggest the theory should be recognisable to participants. This they term *sensitivity to negotiated realities*. Further to this, Stiles (1990) posits the theory should empower participants. This he refers to as *catalytic validity*. A theory has catalytic validity if it has an impact that engenders change in experience and behaviour.

Both Stiles (1990) and Henwood and Pidgeon (1992) stress the need to be *reflexive* in the research process. A researcher begins his/her study with certain research interests, background assumptions and disciplinary perspectives. This alerts him/her to look for certain possibilities and processes in the data. The underlying notion here is that an interpretation is constructed in concert with participants. Therefore, the researcher has an inevitable influence on the theory that is generated. Reflexive validity is achieved when the role of the researcher is highlighted and revealed. Further to this, Henwood and Pidgeon (1992) posit that all interaction with the data and decisions made in regards to the data should be documented. This process they term *Documentation*. Effectively, a paper trail is laid for an external auditor. It describes how and why the research was done, work processes, decision making processes, and analytic processes. Relevant documentation involves sampling decisions, the context in which the study was conducted, and how theoretical categories were constructed.

Transferability is an additional criteria proposed by Henwood and Pidgeon (1992). This refers to the extent to which the theory is transferable to similar settings. Implicated here is that the researcher is obliged to report on the contextual features of the study so that an external auditor can determine the extent of transferability.

Method

Objectives

The present study sought to uncover the process youth go through and the factors that influence their decision to dropout of drug and alcohol treatment in favour of completing the programme and respectively maximising the chance of being drug and alcohol free in the future. The specific aims of the study were:

- To develop a theoretical framework, grounded in participants' perspective, to holistically understand why the retention of youth in a residential drug and alcohol rehabilitation programme is low.

Participants

The sample consisted of 6 females and 3 males totalling 9 participants. Participants' ages ranged from 15 years to 17 years. All participants attended Odyssey House Youth Residential programme and had a primary diagnosis of drug or alcohol abuse, or both. Participants were recruited for the present study at the premises at the treatment programme. Potential participants, those who had made a decision to leave the treatment programme, were presented with an information sheet (Appendix A) which served as an introduction to the study. If they agreed to participate in the study a date and time was organised to conduct an interview.

Ethics

The study was conducted in accordance with the guidelines and recommendations outlined in the Health Research Council (HRC) and the Massey University Research Ethics Committee. The study received ethical approval from the Health and Disability Ethics Committee (HDEC).

Participants were presented with an information sheet which outlined the nature of the research, the background of the researcher, what was required of the participants and the rights of the participant. Confidentiality was also assured with the exchange of ones name with a pseudonym and the omission of any information that could lead to the identification of the participant. The participant was informed that all information regarding him/her would be

stored in a locked cabinet, accessible only by the researcher at Massey University for a period of 10 years (HDEC guidelines for the storage of health information) before being destroyed. The participant was informed that counselling would be available at any point should it be desired. Further, the details of both the supervisor and the researcher where made available should any questions arise during the duration of the project.

A consent form was issued to the participant prior to the commencement of the interview. A signed consent form indicated that the participant had read and understood the information sheet and had had the project verbally explained to them, including the chance to ask any questions and thereby agreed to participate in the study under the conditions set out in the information sheet.

The method of data collection

Interviews were used to collect data in the present study. Interviews were conducted both face to face and over the telephone. Initially, interviews were largely unstructured. The researcher simply asked participants to talk as much as possible about why they left the programme. Successive interviews became increasingly more structured as the researcher was able to identify gaps in the emergent theory and sample information on the basis of theoretical relevance to the emerging theory. Thus, the interview guide evolved as the research progressed. Once a conceptual theoretical framework emerged technical and non- technical literature, and experiential data were utilised as alternative sources of data. Their role however was subservient to that of the participants' statements and stories.

Rationale for method of data collection

How you collect data affects which phenomena you will see (Patton, 2002; Robson, 2000). Given the present study's objective – to develop a theoretical framework grounded in the participants' perspectives, interviewing was deemed appropriate. Additionally, interviewing is conducive to grounded theory studies natural participant perspective and emphasis on learning about participants' experienced events, views, and actions (Glaser & Strauss, 1967; Charmaz, 2000a). Further, interviewing compliments other methods such as observation (Robson, 2002).

Given the privileged position of the researcher as a youth worker at the centre, the utilisation of such observations was considered beneficial.

In regards to the rationale for an unstructured interview, Glaser (1998) cautions against the use of preconceiving interview guides as it could force data into a preconceived framework rather than an emergent one. Moreover, the use of theoretical sampling supersedes the need for a preconceived interview guide. Therefore, the decision to commence data collection with a largely unstructured interview was deemed appropriate.

The flexibility inherent in interviewing in general, and unstructured interviews in particular, allowed the researcher to go beneath the surface of participants' statements and stories of their experienced events, views, and actions and uncover meanings (Patton, 2002). Thus, nuances in the data can be probed. Further, luminal cues are given in participants tone and flow of speech (Charmaz, 2000a).

The process of data collection through interviewing

Initially the researcher spent time ensuring the participant was comfortable and relaxed. Establishing rapport was not necessary as the participant was already familiar with the researcher as a staff member at the treatment programme. Prior to the execution of the interview, participants' rights were reiterated including the right that they could stop or pause the interview at anytime. Due to the nature of the study – examining stigmatised behaviour, it was important that the participant understood that their comfort level was more important than gaining interesting data. Interviews ranged from 15 minutes to 65 minutes with 40 minutes representing the average length of an interview. Throughout the interview the researcher listened attentively. The researcher attempted to put questions in a straightforward, clear, and non-threatening way. The researcher also sought to eliminate cues which could lead interviewees to respond in a particular way e.g. "are you against engaging in illegal activities"? (Robson, 2002). To address reflexivity issues, the researcher consulted with her supervisor regularly. She also addressed reflexivity by continuously relaying data back to participants to ensure correct understanding. Empathy was conveyed with both verbal and non verbal cues e.g. nodding and conveying appropriate facial expressions. Open questions and probes (e.g.

giving and inquiring glance and mmhmm) were used to gather further information on an area and closed questions were used to elicit specific information within an area. Often, the emotion expressed by the participant, rather than their words determined the meaning of events. Had the researcher not listened attentively and inquired into this salient factor important information would have been missed. Closing questions were slanted towards eliciting positive responses as to end the interview on a positive note. The participant was thanked for their time and reminded the researcher would send them a copy of the transcribed interview should they desire to alter or withdraw any statements or stories.

Later on in the study when a theoretical framework had emerged the researcher utilised experiential data and existing literature - using them as empirical indicators to be subject to comparative analysis and integrated into the emerging theory.

Transcription

Interviews were transcribed by the researcher in verbatim. Participants' names were then replaced with a pseudo name with all other identifying information being omitted. The transcripts were then posted to the individuals homes (if they had elected this option) along with a stamped addressed envelope to alter or withdraw any statements or stories they saw necessary. No transcripts were amended.

Data analysis

Data was analysed for meaning using grounded theory as proposed by Glaser and Strauss (1967) and Glaser (1978) and (1992).

Interviews were conducted and transcribed by the researcher in verbatim. Open coding of the first four interviews was conducted line by line. The focus during this stage of analysis was to identify substantive codes. The researcher fractured the data into as many analytic pieces as possible. The researcher constantly compared each piece of data within each interview. The researcher asked, "what is this data a study of"? and "what is actually happening in the data"? Each piece of fractured data was given a conceptual code to reflect its tentative classification. These codes were often in vivo as to preserve participants' special terms. Memos were largely

descriptive at this point in the analysis- detailing in so far what was happening in the data. For the purpose of clarity the researcher drew a pyramid. Substantive codes represented the bottom tier of the pyramid. (See appendix D).

As gaps in the emerging theory became evident theoretical sampling commenced. That is, the researcher sought to develop themes that were suggested in the data- themes often bought to light by memoing. The researchers focus at this point was to develop the emerging theory. Specifically, the researcher sought to delineate codes under broader categories. That is, to delineate experienced events, views, and actions that appeared more frequently in the data and that had explanatory power. Theoretical codes were among these categories- generated as the researcher began to hypothesise about the relationships between the substantive codes. (See appendix D).

Categories and their properties soon began to emerge. These categories represented the second tier in the pyramid. At this stage of analysis, data was compared with category and category with property. The researcher asked "what category or property of a category does this data indicate"? Memos focused on identifying core categories that would become the third tier in the pyramid.

As analysis progressed categories and their properties began to saturate. When an initial conceptual explanatory framework became visible the researcher delimited coding to only those variables that seemed related to the theory in sufficiently significant ways. These variables were promoted to higher order variables and represented the third tier of the pyramid. (See appendix D). These variables are referred to as concepts or core variables. At this stage of analysis the researcher compared experienced events, views, and actions to the concepts or core variables. Additionally, at this stage the researcher began to sample relevant technical, non-technical, and experiential data as a source of comparative analysis. Memo writing focused on refining the theory at this stage of analysis. Once categories were saturated the researcher focused on sorting memos into a theoretical outline in preparation for writing the theory. The emerging theory as a process dictated logical integration of memos.

Results

Participant descriptions

David

David is a 14 year old European male from Auckland. He was referred to the service through the legal system. He was referred for cannabis and alcohol misuse. David has a history of suicidal gestures including one previous attempt. He also has a history of criminal offences that include pending charges for possession of a weapon and assault against his mother. David had been expelled from school prior to his admission to the treatment programme for cannabis. He spent approximately 2 weeks in the treatment programme .

Beverly

Beverly is a 15 year old Maori female from Wellington. She was referred to the service through the legal system. Prior to her admission to the service she spent 7 months in youth detention. She was referred for alcohol, cannabis, and methamphetamine abuse. She has an extensive criminal history that includes stabbing a police officer, 5 aggravated assaults, and aggravated robbery. Her history also includes 3 suicide attempts. She has an extensive trauma history that includes sexual abuse. She has spent the majority of her life in CYFS care and protection. Her family is heavily involved in gang culture including drug dealing. She spent two weeks in the treatment programme before absconding.

Lisa

Lisa is a 15 year old Maori female from Auckland. She was referred to the service through the legal system. She has spent the last 2 years of her life in and out of youth detention. She was referred for cannabis and methamphetamine abuse. She has an extensive criminal history including burglary and aggravated assault. She has had one previous suicide attempt. Lisa is currently unable to return home as CYFS have deemed it as an unsafe environment. Her mother is also a heavy drug user. She spent 3 days in the treatment programme before absconding.

Sophie

Sophie is a 16 year old European female from Nelson. Her referral was self-motivated. Her drug of choice was alcohol. She has a history of criminal behavior while intoxicated. She narrowly escaped youth detention prior to her admission to the service. She also has a psychiatric history that includes depression and psychosis. She has had several suicide attempts in the past. She spent approximately 4 months in the treatment programme.

Jane

Jane is a 16 year old Maori female from Auckland. Her referral to the service was self-motivated. Her drugs of choice were alcohol and cannabis. She has a history of trauma. Her family home was a high risk environment where drug use was common. She was expelled from school for truancy prior to her admission to the service. She has no known criminal or psychiatric history. She spent approximately 4 months in the treatment programme.

Amy

Amy is a 17 year old European female from Whangarei. She was referred to the service by her councellor. She has an extensive history of drug use that includes ecstasy, methamphetamine and alcohol. She has a psychiatric history that includes depression and an eating disorder. She has no known criminal history. She spent 3 days in the treatment programme.

John

John is 15 year old Maori male from Auckland. He was referred to the service through CYFS. He was referred for cannabis use. He has no known psychiatric history. He reported a history of criminal behaviour however has no known record. John has a history of abuse and neglect. He spent approximately 2 months in the treatment programme.

Adam

Adam is a 17 year old European male from a small rural town in the North Island. He was referred to the service by his family. His drug of choice was cannabis. Prior to his admission to the service he had been engaging in a number of criminal activities including stealing cars

however has no known criminal record. He has a history of depression. He spent approximately 2 weeks in the treatment programme.

Joanne

Joanne is a 15 yea old European female fro Wellington. She was referred to the service by CYFS who have protection of her. She was referred for alcohol abuse. She has a history of unspecified mental illness. Her mother is also actively psychotic. She has no known criminal record. She has an extensive trauma history that includes sexual abuse. She spent 2 weeks in the treatment programme before absconding.

Dynamic client characteristics

Client factors related to dropout

Motivation

Many of the participants cited motivation as a contributing factor in why they left the treatment programme. This was particularly true for participants who had been in the treatment programme for a limited time- generally under 2 weeks. Motivation can be divided into low internal motivation and external motivation. In each case, the client's motivation influenced their decision to leave the treatment programme. Note, this distinction is necessary as motivation to engage in treatment as a result of self or others had differential effects on treatment retention and other treatment outcomes such as abstinence- albeit not the focus of the present study. Motivation is also discussed as it relates to treatment dropout and treatment retention. This is because the same factor e.g. external motivation, can affect both treatment dropout and retention.

Internal motivation

John talked about wanting to come back (no time frame specified) and graduate the programme. I asked him why he left then. He told me he had "a lack of motivation". I asked him what it would take in order for him to want to come back and complete the programme. He replied, "I would just need to get stuck into it". Thus, John feels he could complete the treatment programme if he just put more effort in. *Note: John's interview was the first interview I conducted in the present study.*

Memo: Do young people come to realise the time and effort involved in alcohol and drug rehabilitation and feel that it is a problem best tackled later on in their life (for whatever reason)? Thus, is retention in the programme low because young people feel that some time in the future is a better time to seek alcohol and drug treatment? Moreover, is retention in the programme low because young people feel that some time in the future is a better time to be alcohol and drug free?

David talked about the present not being a good time. He said, "I'm not saying I don't want to be alcohol and drug free ever, just not at this point in my life". David also went one step further and suggested that in some cases treatment is redundant. He remarked, "they (the staff) couldn't teach me anything I didn't already know". He went on to say, "there is no valid excuse for my actions". In saying so, David suggested that the ability to be alcohol and drug free resides from within. It is suggested that the same ability affects treatment retention.

Joanne said, "giving up drugs is not exactly top of my priority list". She said, "I am young" and later, "I like drugs so sue me". She went on to tell me that no one can make her give up drugs if she didn't want to.

When I asked Jane why she thinks people stay in the treatment programme as opposed to dropout, she suggested, "they [treatment dropouts'] probably don't want it that bad; some people want it and end up not wanting it". She asserted, "if you want it, you just got to put your mind to it".

Sophie suggested that the reason why retention is low is because "they [treatment dropouts'] are court ordered and they don't want to be there; they don't want to change". Therefore, she suggested that treatment retention is low because people don't want to be in the treatment programme or change their drug use lifestyle. *Note: the premise that those who leave treatment are court ordered is not supported.*

External motivation

David explained to me that others were his motivation to be in the treatment programme. He asserted, "I love alcohol and drugs", and, "it [pleasing others] just wasn't worth the pleasure of alcohol and drugs". Thus, for David, the wishes of others were not sufficient enough to deter him from using alcohol and other drugs and remain in treatment.

For Amy, being externally motivated was also related to treatment dropout. She said, "I really only went [to the treatment programme] because my councellor and family kind of expected

me to go and I didn't want to let them down". This external motivation was obviously not sufficient enough to keep Amy in the treatment programme either.

Coping

Many of the participants talked about not being able to cope with various things while in the treatment programme. This was particularly true for participants who had been in the treatment programme for a limited time- generally under 2 weeks. Coping is dived into a) cravings, b) missing home, c) accepting authority and, d) decision making. Each of these factors impacted on participants' ability to engage in the treatment programme.

Cravings: "I love alcohol and drugs"

Beverly spoke about being tempted to leave the programme when a female she knew from her past joined the programme. She told me that the female told her they had mutual friends living close by and that these friends would "have the goods" (alcohol and drugs). Beverly talked about thinking about the things she "used to get up to" ("doing drugs, stealing cars" etc), and being tempted to leave the programme to engage in these activities with the other female. She said, "I thought I might just go and get stoned with them, take some drugs, and do the stuff I use to get up to". She went on to say, "I just can't say no to that kind of thing".

Memo: This is something that is somewhat of a common occurrence. That is, two or more young people make friends in the programme and conspire to leave together. I assume that they 'negrave' (therapeutic community term which means to negatively rave) together about alcohol and drugs and other negative behaviours including criminal behaviours, and become 'triggered' (therapeutic community term that refers to craving something because of some kind of reminder in the environment) and are unable to suppress their urges.

Lisa told me that her and Beverly (the above female) were "scheming to leave from day one". She said,"I couldn't stay because my mate was there". She implied that having Beverly in the treatment programme was simply too much of a distraction for her; she could not focus on her treatment.

Memo: It is interesting to note that both girls tell me that it was the other ones decision to leave the treatment programme. It is also possible that these two girls felt they had a reputation to uphold. Both girls are very familiar with the criminal justice system and heavily invested with substance using peers. I also wonder if they were afraid of losing their rebellious, substance using image in that it would leave them without an identity that is so important to young people.

Joanne told me that the first thing she did when she left the treatment programme was "go get drunk and stoned". She told me that she had "missed it a lot".

David also talked about missing alcohol and other drugs. He said, "I love alcohol and drugs". He said once he made the decision to leave the treatment programme he "couldn't wait to get high".

Missing home: "Getting upset because I was homesick"

When I asked Lisa why she left the treatment programme, the first thing she told me was "I "just missed my mum".

Amy said, "I kept on getting upset because I was homesick; I missed my family, my councellor, and my area. I just couldn't handle it". I asked Amy what she did initially to try and handle it (cope). She replied, "I tried to keep busy. I tried to talk to the others and get involved in the programme, and I tried to talk myself into it". She went on to tell me that "it worked in the beginning then started not to work".

Accepting authority: "Getting into trouble"

"Getting into trouble" was amongst the first things mentioned when I asked John why he left the programme. He said "being challenged" [by staff and other residents] was hard and that it "frustrated" him.

Memo: John found it hard to cope with getting into trouble. This made me think, given that many individuals come from environments where there has been a lot of neglect and where they have largely been left to their own devices, was the experience of authority too much; alien for some young people? Were they unable to cope with being challenged and reprimanded for negative behaviour and attitude?

Similarly, Adam contended that he "was constantly getting in trouble for little things". He went on to say he couldn't cope with this. He suggested that he would have done better in the treatment programme (cope) if he just "got over it". For Adam, this was clearly easier said then done.

Lisa talked about being on limbo as a difficult time for her. She said, "being on limbo was kind of sucky". (Limbo is one of a number of consequences in the programme for negative behaviour and/or attitude. It is normally a time period of 4 days for the individual to reflect whether or not they wish to be in the treatment programme. During this time they are not allowed to converse with other community members. They do not partake in regular activities such as schooling and extracurricular activities. Instead, they spend a lot of time doing menial tasks such as cleaning toilets and cleaning windows). She said, "being on limbo made me want to leave".

When I asked Jane why she thought that others dropout of the treatment programme, she said, "probably because of the rules and stuff, they just can't take it".

Decision making: "Now that I think about it, I'm gutted that I left the programme"

Beverly told me that she "actually liked the programme". She said, "now that I think about it, I'm gutted that I left the programme.

Memo: This is something I have seen many times, that is, a young person leaves the treatment programme only to want to return several days later. In some cases these individuals are re-admitted into the programme a week later, however in some cases (e.g. they absconded from the treatment programme, large waiting lists, already second

admission into the programme) these individuals adhere to their exit plan which could involve anything from returning to their family home to mandated youth detention. I wonder what makes young people make such rash decisions they later regret. It seems most likely that these young people become frustrated (for whatever reason) and then self-discharge. In other words, they use emotion-focused coping.

I asked Lisa what she didn't like about the treatment programme. She told me she "didn't not like anything". She went on to say that given the opportunity she would happily return to the treatment programme. (Sadly for Lisa she was not eligible as she had absconded from the treatment programme).

Joanne told me she would like to come back to the programme one day. She said she wished she hadn't of left the treatment programme because now she is in a girls home and "everyone is real catty there".

Client factors related to retention

Motivation

Many of the participants cited motivation as a contributing factor in why they stayed in the treatment programme. This was particularly true for clients who had been in the treatment programme for a number of months- generally over 2 months. Motivation can be divided into high internal motivation and external motivation. In each case, the client's motivation influenced their decision to stay in the treatment programme.

Internal motivation

When I asked Sophie why she thought she was able to stay in the treatment programme longer than most people, she replied, "it was the right time for me; I was in the right frame of mind. I came in wanting to change". She spoke of a light bulb moment where she realised her drinking was out of control.

Similarly, when I asked Jane why she thought she was able to stay in the treatment programme longer than most people, she said, "I really wanted to get my life back on track".

When I asked John if he was currently alcohol and drug free, he replied "yes". I inquired into this apparent irony. I asked him why he would want to come back to the treatment programme then (he talked earlier about wanting to come back and complete the programme). He replied, "well it would help me in a way". I gave an intrigued glance. "Coming back to the programme will help me with alcohol and drugs as it will make me think I can do something". He added, "it would just make me happier" and, "it would just be good to finish something" (implies he has never really finished something). In this statement John addresses the mechanisms underpinning his motivation to stay in the treatment programme, that is, self-esteem.

Memo: I have had this impression from several clients who are in the programme. That is, the reason why they want to complete the programme is because it would make them feel good about themselves; give them a sense of achievement. I have also heard this statement expressed in regards to pleasing others, that is, "if I complete the programme so and so will be proud of me". In this regard I am assuming there must be some degree of happiness dependent on the happiness of others.

Amy explained, "if I hadn't of gone to the programme I would have ended up dead or in prison". She said that her drug use and current lifestyle was spiraling viciously out of control.

External motivation

I asked Adam to explain the circumstance surrounding his admission to the treatment programme. He said, "mum kind of suggested it, and I just went along with it". He said, "I didn't really think I had a problem". I asked him what was in it for him then. He told me "bribes and stuff". Adam went on to tell me that despite those circumstances, he "planned on staying a while". (He implies the reason for him dropping out of the treatment programme was largely attributable to programme factors). Thus for Adam, being externally motivated was sufficient enough to keep him in the treatment programme.

Sophie told me that a lot of her motivation for staying in the treatment programme so long was her family. She said, "the big thing for me was my family. I really just wanted to make them proud, and I just wanted to show everyone I could do it".

Similarly, Jane explained, "people thought that I wouldn't last very long so I really wanted to prove them wrong".

Beverly told me that she was under a supervision order so attending the treatment programme was one of a number of mandated residential options she had. She was enthusiastic about attending the treatment programme though as she understood that she needed help with her alcohol and drug use. In addition, she had heard the treatment programme was holistic in that it provided a range of activities from schooling to extracurricular activities like horse riding and rollerblading.

Lisa explained to me that she was court ordered to attend the treatment programme. However, she was thankful to have the chance to attend the treatment programme as she thought "it was way better than lock up". (Lisa's alternative option was youth detention).

Joanne's motivation was also largely external. She explained to me that her options were the treatment programme or "yet another girls home". She said that the treatment programme represented a much better option than a girl's home.

Programme characteristics

Programme factors related to dropout

Programme mode

Several of the participants cited the programme's mode as a contributing factor in why they left the treatment programme. This was particularly true for participants who had been in the treatment programme for a limited time- generally under 2 weeks. Programme mode was divided into a) Being away from home: "A better way to do it" and b) Feeling institutionalised: "Like another world". In each case, the mode of the programme influenced the participants' decision to leave the treatment programme. Being away from home is discussed as it relates to treatment dropout and treatment retention. This is because the same factor that is, being away from home affected both treatment dropout and retention.

Being away from home: "A better way to do it"

Amy said, "I kept on getting upset because I was homesick; I just missed my family too much". She explained, "I couldn't see how I could do it [the treatment programme] without the support of my family". She felt that "there was a better way to do it".

Lisa also told me that the reason she left the treatment programme was because she "just missed mum too much".

Feeling institutionalised: "Like another world"

David told me that the treatment programme made him feel institutionalised. He explained, "when I was in Odyssey House it felt like I was in another realm; it was like another world; Odyssey House was like a cell". He said he found the programme "constrictive", and that "there was no freedom". He went on to say, "when I left I was free". He told me when he left the treatment progamme he "just ate and slept, and watched T.V".

Memo: This echoes some of my earlier premises that residential treatment is profoundly different to many young people's previous living arrangements and indeed, anything they

have ever experienced before. It seems that those young people who have come from the family home experience the most difficulties with residential treatment. Young people who come to the programme via youth justice facilities or Child Youth and Family (CYFS) residences are more comfortable with the arrangement. However, I feel that what David is referring to here is more than just the living arrangement. It is the all the terminology, the rules and regulations. There is regiment and routine. There is a process for everything, a proper procedure, a right and a wrong. It is in a sense an institution. I begin to think about the nature of treatment in general and residential treatment in particular. Is the treatment programme's mode and/or approach too intense for some young people?

Similarly, Adam remarked, "there was no trust" and "constant supervision". This was echoed by Lisa who said, "I hated having no privacy". Thus for Adam and Lisa, the treatment programme resembled something like a corrective institution.

Programme approach

Many of the participants cited the programme's approach as a contributing factor in why they left the treatment programme. Programme approach was divided into a) Programme length: "I just got sick of it" and b) Programme structure: "The level system was hard". While the programme's structure influenced participants' decisions that had been in the treatment programme for a limited time- under 2 weeks, programme length equally influenced participants' decisions. In each case, the approach of the programme influenced the participants' decision to leave the treatment programme. The programme's approach is also discussed as it relates to retention however, different aspects of the approach are emphasised.

<u>Programme length: "I just got sick of it"</u>

John talked about time and the programme being slow. He talked about continuously getting set back (held back on a level; prevented from progressing to the next level). Getting set back made him think "it was going to take a while to get higher up" (ultimately complete the programme). This frustrated him. He felt that ultimately, he had given as much time as he

could at this point in his life. Time is the first factor mentioned when I asked John the reason he left the treatment programme.

Memo: Is retention in the programme low because the programme is too slow/ not progressive enough?

David talked a lot about time. He said, "the whole thing just dragged on and it was a huge waste of time; a waste of my life". He said, "it's like you're in a hole, each day is longer than the last". David also said that the treatment programme was not progressive enough. He said, "its 1 step forward and 2 steps back- it is just not progressive enough". He added, "the programme is pointless and slow".

When I asked Jane why she left the treatment programme, the first thing she said was, "I just got sick of it". She went on to tell me that "graduating (completing the treatment programme) would have been cool, but it wasn't worth staying just to graduate".

Similarly, Sophie told me that she would have liked to have graduated, however did not want to stay several more months "just to graduate".

Programme structure: "The level system was hard"

David talked about the need for individualised treatment. He suggested, "they need to look at everyone as individuals". David did not care to elaborate. I feel what David is referring to here is the structure of the treatment programme whereby each individual is expected to accomplish the same tasks as each other in order to progress in the programme.

Memo: I empathised with David, I remember him constantly arguing with the staff at the programme. He was contesting the rules and regulations- many which are dictated by policy, and the need to revise what he thought were injustices due to individual needs. I agree somewhat with David's assertion. I remember something I was told by a school teacher. She was explaining to me the difference between fairness and equality. She described a scenario that was somewhat like a test. So there's a short person and a tall

person. She needs them to get a book off a high shelf. She offers the short person a chair that brings him up to the same height as the tall person. The tall person says "that's not fair". The teacher replies, "no it's not equal, but it's fair", that is, endeavouring that both children had the same opportunity to meet their potential. I wonder whether David thought that the treatment programme was suitable for him. I wonder how many clients had left the treatment programme because they thought that it was not suitable to their needs.

David also talked about what he sees as problems inherent in the treatment approach. He felt that "they [the approach] look at people as part of a machine". He said he "found the level system degrading in that there are less rights the lower the level". (Odyssey House is a level system programme whereby individuals move up levels as they complete increasingly difficult questions. Progressive levels are associated with increased responsibility and privilege. A new admission in the programme has the right to daily phone calls home and water and medication anytime). He said he found the level system "dehumanising and degrading".

Echoing both these points, Lisa said she also found the level system hard and that it was unfair she couldn't have her walkman and journal as these are a safety blanket for her- a coping mechanism. She said, "the only thing I didn't like about the programme was not being on a level". She went on to say, "all I wanted was my walkman and to be able to write in my journal in privacy". (Note: the only private time new residents have is when they sleep. Walkmans are also a privalige new residents are not entitled to). Lisa also told me that being on limbo was "really sucky because no one is allowed to talk to you and stuff".

Programme specific characteristics

Many of the participants cited programme specific characteristics as a contributing factor in why they left the treatment programme. Programme specific characteristics were divided into a) Programme intensity: "The programme is like a boot camp", b) Programme routine: "Too much in one day", c) Programme environment: "Feeling safe and secure" and, d) Programme staff: "The staff were not very nice". In each case, the specific characteristics of the programme influenced the participants' decision to leave the treatment programme.

Programme specific characteristics influenced equally participants' decisions to leave the treatment programme. Programme specific characteristics are also discussed as they relate to retention, however different aspects of the programme are emphasised.

Programme intensity: "The programme is like a boot camp"

When I asked Sophie why she left the treatment programme, the first thing she said was, "probably because I got frustrated at like the consequences". She told me that prior to leaving the treatment programme she had been busted back a level in the treatment programme because she "was trying to tell a casual staff member the rules". She said when the full time staff came back on Monday they told her she shouldn't have "put [her] point across". She said, "so I was busted back, the house had lost its privileges, and we were just getting bossed around- do this, do that". She went on to tell me, "then we had to scrub walls and it was just a bit overboard". She said, "you work so hard to get up the levels and then [management] clicks their fingers and your busted back". She commented, "no one can be that perfect, we all make mistakes". She added, "the programme is like a boot camp".

Adam explained that although he was externally motivated to attend the treatment programme, he "was planning on staying a while". However, he said, "the programme wore thin". He "was sick of getting into trouble for little things". I asked Adam whether he thought that graduating the treatment programme was an attainable goal. He replied, "in a brainwashed way". He said the programme "made robots out of people" and he "was not willing to make that sacrifice". Adam asserted that the other residents in the programme (the ones that had been in the treatment programme for some time) "were not normal"; that "they did not behave in teenage ways or talk about teenage things". (Adam is referring here to the rules of the programme that require residents not to talk about drugs, criminal behaviour, sexualized behaviour etc. These rules also mandate residents to hold each other accountable for all instances of behaviour that the treatment programme deems as negative e.g. discussing any of the above behaviours, swearing, sharing belongings, talking negatively about the programme and its staff).

Memo: I begin to think about the stark contrast in environment the treatment programme must be from some young peoples' previous experience. It is in effect an institution that shares some properties of cult's e.g. not talking negatively about the programme and its staff. It also shares some of the properties of prisons e.g. scrubbing walls.

Memo: I do want to make clear that the programme had become a lot more intense than when I first started. This is why I have chosen to put this code under programme specific characteristics as opposed to programme approach as this intensity is certainly not universal of therapeutic communities. A change in management is likely the biggest causal factor.

David also talked about the programme being "emotionally draining". He said, "they try to break you down and change you". He said he "felt tired and worn out".

"Getting into trouble" is amongst the first things mentioned when the researcher asked John why he left the programme. He associated this as the reason why he was getting set back and ultimately why "things were taking a while". John talked about the programme being "real structured" particularly the 'groups'. (I feel John is referring here to the nature of the 'groups'. He is referring to 'groups'- the kind which often accompanies negative behaviour and/or attitude. Groups are formal in nature and are often very challenging. The individual is questioned on issues such as motivation, intention, and remorse. It was obvious John found such groups too intense.

When I asked Jane why she left the treatment programme, she said, "because I got sick of it, I couldn't take it anymore; just so much pressure and expectations, and they [the staff] push you too much". She said, "I kept on getting punished and consequenced for stupid things, I couldn't seem to move up and that was making me think I couldn't do it [complete the programme] anymore". Jane added, "they [the staff] kept on busting me back just before my home pass". She went on to say, "the rules are way over the top". I asked Jane what rules she felt were over the top. She said, "well I think its stupid that we get consequenced if we forget

to get a receipt when we are on pass (the residents are required to show staff evidence of every purchase while they are out on a pass from the treatment programme), even if its for a coke-yea that's pretty stupid". She told me that the last time she forgot a receipt she was prevented from going on a home pass as she lost all her privileges. She said she also thought "it was stupid that now no one is allowed to touch the radio in the van and that you have to listen to the same station the whole journey". She also explained to me that now the clients are not allowed to wear slippers in the house apart from when it's free time. She went on to tell me, "and then like when its job function you forget and you're consequenced again". I asked Jane at that point whether she thought graduating the treatment programme was achievable. She replied, "I use to think it was, but then began to think it wasn't".

Programme routine: "Too much in one day"

Jane explained, "there was just too much in one day". She said, "the schedule was too busy; we never got any free time".

Similarly, Sophie said, "it was go from the moment you woke up till you went to bed". She said, "half the time we were still doing evening meeting at 9.00pm". (9.00pm was bedtime). She said, "like during the holidays we were doing so much physical stuff and we were exhausted, and then it was like we were just expected to get up the next day and do it all again, and people had sore muscles and stuff from the day before".

Moreover, David talked about monotony in the programme. He said, "I hated routine, I couldn't handle it". David implied that routine was boring. He said, "it really did my head in".

Programme environment: "feeling safe and secure"

John talked about feeling uncomfortable while he was in the treatment programme. When questioned what he meant by this he found it hard to articulate a reason. He simply mentioned that "people (his co-residents) did not make [him] feel comfortable".

Memo: I empathised with John, I knew very well what he meant. I would notice that others would often become inpatient with John. I suspect this was because of the long

time it would take John to articulate something. This was evident in comments directed at John such as "do you want to respond John" and, "do you even understand what we are talking about"- they were subtle, passive aggressive comments. In a society which values speed and efficiency John was not at home. It was not hard to understand why John felt "uncomfortable" amongst his co-residents (and also why they were frustrated with him- they had internalised as a result of socialisation with modern society that this behaviour was not normal and that it must be associated with some shortcoming). John undeniably comprehended this opinion cast on him. I think back to an incident which saw John into an emotional outburst. Later it came to light that that he was reacting towards what he thought was everyone laughing at him. Sadly for John this time it was not the case. He was later given a consequence for this behaviour.

Amy said, "part of the reason I left was Joanne- the way she was talking to me- it really got me down". She said that she did not feel "safe and secure" like she should have. Thus, Amy implied that she was getting bullied in the treatment programme.

Programme staff: "The staff were not very nice"

David talked about not liking the staff at the treatment programme. He said, "the staff were fat heads". (I don't know exactly what this means but assume it is derogatory given the tone and content of the conversation). He went on to say, "they really should get some better staff". He said, "the staff were not very nice".

Memo: I remember something I heard back in my early days of studying psychology, that is, treatment success is 90% attributable to the client-therapist relationship and only 10% to the specific mode of treatment. I begin to ponder this. I wonder whether young people size up the staff and ask themselves whether the staff are going to be able to help them with their alcohol and drug problem. Is retention in the programme low because young people feel that the staff are unable to help them with their alcohol and drug problem?

Lisa talked about not feeling respected by the staff. She said, "nobody listened to me".

Adam told me that he "seemed to always be getting in trouble for little things". He said he felt the staff were "picking" on him as "they did not like [him] for whatever reason".

Jane said she thought "some of the staff were too strict". She also suggested that the staff where not very empathetic. She said, "a 10 minute phone call to your family is not very much, especially when your like stressing that you want to go home". She said that she understood that there wasn't always time because of the schedule however felt that in some circumstances they should allow time. She also said that "some of the casual staff didn't know what they were doing". She said they [management] need to tell them [the casual staff] the rules so that everyone's on the same page". She also suggested that it would be better "if they [the casual staff] got to know the [young] people".

Sophie said that she was constantly being "bossed around" by a particular staff member when she was in the treatment programme. She recalls the staff member making her "scrub walls" and thought it was "unnecessary". She said she later snapped at this staff member and then received another consequence. She said, "it was too much". She also explained to me that during the school holidays everyone was doing a lot of exercise. She went on to tell me that when they told management they had sore muscles they were told they were lazy.

Programme factors related to retention

Programme mode

Several of the participants cited the programme's mode as a contributing factor in why they stayed at the treatment programme. Programme mode is discussed in terms of a) Being away from home: "Getting away from it all". In all instances, it affected participants decisions to stay in the treatment programme who had been the programme 2 months plus.

Being away from home: "Getting away from it all"

Amy suggested that although for her being away from her home was hard, it may be beneficial for others. She said, "I think that some people just need to get away from it all".

Sophie said being away from home enabled her to focus on treatment. She explained, "there were no distractions like people ringing up and wanting me to go out with them".

Jane also said that being away from home enabled her to focus on treatment. She explained to me that there was always drugs lying around at home and that this was too tempting for her. She said, "when other people are doing drugs it makes you want to too".

John told me that "drugs is just life at home". He explained that the treatment programme was the first environment he had ever been in where there was not direct access to drugs and alcohol. He said, "being in the programme was good because I couldn't even have done drugs if I wanted to".

Programme approach

Many of the participants cited the programme's approach as a contributing factor in why they stayed in the treatment programme. Programme approach is discussed in terms of a) Programme environment: "The support that is provided", and Programme breadth: "I would have never... without". Programme environment and programme breadth equally influenced participants' decisions. In each case, the approach of the programme influenced the participants' decision to stay in the treatment programme.

Programme environment: "The support that is provided"

When I asked Beverly what exactly she liked about the programme she told me that she liked the support the young people and the staff gave her. (Inherent in the therapeutic community is a peer orientation. Each person is his brother's keeper- a therapeutic community term which denotes an individual's responsibility for his/her peers. In fact, being responsible for others is a focal task an individual must achieve before they graduate the treatment programme at Odyssey House).

Joanne told me she thought of the other young people and the staff in the treatment programme as her family.

Memo: I wonder about the nature of the therapeutic community. Did the therapeutic community represent a pseudo family to her? I know from her history that this has been something she has never really had.

Similarly, when I asked Amy why she thinks the programme works for some young people and not others, one of the reasons she mentions is the support that is provided. Jane and Sophie both said that they had received a lot of support from their peers throughout the course of their stay in the treatment programme.

Programme breadth: "I would have never... without"

Sophie told me that she liked her councellor and that she helped her work through "issues". She said that councelling had helped her a lot and she "began to look forward to the future and wanted to concentrate on making up for lost time". She also explained that through councelling she became confident in herself and decided what she wanted to do in the future- a Maori art and design course. She said the experience of being able to do art class made her realise how much she enjoyed it and that she had talent. Sophie also said that she had become a lot more conscious of the need to exercise. She said she is continuing to run and keep fit.

John told me that the programme made him "hygienic and stuff". He talked about now knowing the importance of washing daily, and changing his clothes and linen.

Jane said that when she went home on pass she "just got out the vacuum and cleaned the whole house". She told me that she told her mum that she "didn't like mess anymore". Jane also told me that she really liked art class. She said that her art work "looked professional" and that the art teacher was even going to organise an exhibition for all the young peoples art work to be displayed.

Sophie told me that when she went home on pass she made dinner for her family. She said she enjoyed cooking at the programme and would like to be a chef one day. She said that cooking at the programme every night had made her into a much better cook and that she would not have had the opportunity to be creative in the kitchen at home. (Understandably, a lot of food gets wasted when young people with no previous cooking experience are left to cook in the kitchen!).

Joanne told me that she "got to do some real cool stuff in the programme". She said that she couldn't remember the last time she "got to do fun stuff".

Similarly, Sophie, Jane, and John said that they enjoyed the paid challenges and that prior to their admission into the treatment programme their time and money had gone on drug related activities. (Paid challenges occur every fortnight in the treatment programme. They include activities such as horse riding, rollerblading, sea biscuiting, and ice skating).

Beverly told me that she had made a relapse plan while in the treatment programme. She said that she "learnt about drugs and stuff and how they get you". Beverly explained to me that the treatment programme she attended prior to Odyssey House hadn't taught her about relapse. She had found this information most helpful. She also was grateful for the extracurricular activities she got the chance to partake in.

Jane, Sophie, John, Adam, and David, said that attending school at the treatment programme was very beneficial. Jane, Sophie and John told me that they had gained credits to count towards their NCEA. They all insisted that if it wasn't for the treatment programme they wouldn't have received any further education. David told me that school was the only good thing about the programme and that if he was in charge of the programme he would have school go all day. (School currently runs from 9.30am- 12.30pm). Adam said he liked the fact that everyone worked to their own pace through schoolwork. He said, because of this, he had been able to complete a lot of work in a short amount of time.

Programme specific characteristics

A few participants cited programme specific characteristics as a contributing factor in why they continued to stay in the treatment programme. Programme specific characteristics are discussed in terms of a) Programme staff: "Not needing drugs and alcohol to be happy". In each case, the programme's specific characteristic influenced participants' decision to stay in the treatment programme.

Programme staff: "Not needing drugs and alcohol to be happy".

A few of the participants had positive things to say about the staff. John told me that Khan (a staff member at the treatment programme) had made him realise that "he did not need drugs and alcohol to be happy". He went on to tell me that "Khan really helped [him] a lot".

Jane also agreed that the staff had made her realise that she did not need drugs and alcohol to be happy.

Sophie said that her councellor was "really nice" and that "she was onto it" (knew what she was doing).

Other factors associated with treatment drop out

Problem resolution

Problem resolution: "Everything's all good now"

Many of the participants said they were generally happy with their treatment outcome. Thus, a contributing factor in why they left the treatment programme was that their initial presenting problem for which they sought treatment had largely resolved. This truism extended to a participant who had been in the treatment programme 3 days.

Amy told me that she was enlightened while at the treatment programme and that's why she wasn't worried about her alcohol and drug use and future anymore (she had earlier told me that if she hadn't have gone to the treatment programme she probably would have ended up dead or in prison). She said, "being down there really opened up my eyes. I was thinking a lot about my future and stuff, and seeing the adults from Bollard (name of Odyssey House's adult facility) - I didn't want to be like that" (an adult seeking alcohol and drug treatment as opposed to an adolescent). I later ask Amy if she would consider coming back to the treatment programme. She replied that she "would if things got bad again".

John also talked about what he gained from the programme. He talked about a future without alcohol and drugs and what that future would look like. He talked about hope. He said that Khan made him realise that he did not need alcohol and drugs to be happy.

Memo: I begin to think about the staff as role-models and the programme as education in regards to alcohol and drugs. Had John had any other role models in his life? What did he know about alcohol and drugs? What did the staff and/or the programme teach young people about alcohol and drugs? Is retention in the programme low because young people believe there is no pleasure in/hope of them stopping alcohol and drugs?

Similarly, when I asked Sophie if she would consider coming back to the treatment programme she said, "yea, if I needed to, (implies that she currently has no need for treatment) and I've always said that".

When I asked Jane if she would consider coming back to the treatment programme she said, "If I needed to get my life back on track again I'd consider the option, but everything's all good now". Thus both Sophie and Jane feel that there alcohol and drug use is under control and they have no present need for treatment.

Finding a treatment that fits

All of the participants spoke about finding a treatment that fits. For some participants, the treatment was not a fit. These participants cited a range of client and programme factors as contributing factors in why they drooped out of the treatment programme. For some of these participants, client factors were more pertinent in why they dropped out of the treatment programme, and for others, programme factors where more pertinent. However, in all cases, there was an interplay of client and programme factors.

For some participants, the treatment was a better fit. For these participants, another factor- problem resolution, contributed to why they dropped out of the treatment programme. However, in all of these cases, client and/or programme factors were also cited and thus had a contributory role in why they dropped out of the treatment progamme.

A poor treatment fit

For Adam, the treatment was a poor fit. Although he was sufficiently externally motivated and found school beneficial, he spoke about feeling institutionalised, finding the programme too intense, and not liking the programme staff as the reason for his dropout. Additionally, 2 client factors- low internal motivation and experiencing trouble accepting authority can be considered to be associated with his dropout from the treatment programme.

For David, the treatment was a poor fit. Although he had some degree of internal and external motivation and found school beneficial, he spoke about feeling institutionalised, experiencing the programme as too long, too structured, and too regimented, and not liking the programme staff. Additionally, 3 client factors- low internal motivation, external motivation, and experiencing trouble accepting authority, can be considered to be associated with his dropout from the treatment programme.

For Beverly, the treatment was a poor fit. Although she was sufficiently motivated- particularly external, and enjoyed the support provided and programme's breadth, she spoke about experiencing cravings and bad decision making. These client factors affected her ability

to engage in the treatment programme and consequently she dropped out. This was despite her alternative option being youth detention.

For Lisa, the treatment was a poor fit. Similarly, she was sufficiently motivated (external) and liked the programme's breadth, however spoke about missing home, experiencing cravings, and bad decision making. In addition, 4 programme factors also weighted on her decision. She spoke about having trouble being away from home, feeling institutionalised, experiencing the programme as too structured, and not liking the programme staff. Lisa dropped out of the treatment programme despite her alternative option being youth detention.

For Joanne, the treatment was a poor fit. Although she was sufficiently motivated (external) and found aspects of the programme beneficial- the programme's breadth, she spoke about low internal motivation, experiencing cravings, and bad decision making. These client factors affected her ability to engage in the treatment programme and she consequently dropped out. This was despite her alternative option being a girl's home.

A better treatment fit

For Jane the treatment was a better fit. She spoke about being generally happy in that her alcohol and drug problem had largely resolved. However, 4 programme factors also contributed to her treatment dropout. She spoke about experiencing the programme as too intense, too regimented and too long. Jane dropped out of the treatment programme despite being highly motivated, liking the support provided, the programme's breadth, and some of the staff.

For Amy, the treatment was a better fit. She spoke about being generally happy with her treatment outcome as she felt that the problem for which she sought treatment had largely resolved. However, 2 programme factors, and 1 client factor also contributed to her treatment dropout. Amy spoke about experiencing trouble being away from home, and not feeling safe and secure in the treatment programme. Additionally, she spoke about not being able to cope with feeling homesick.

For John, the treatment was a better fit. He spoke about being generally happy in that his alcohol and drug problem had largely resolved. However, 3 programme factors can also be considered to have had a substantial contributory role in his dropout as John was highly motivated to complete the treatment programme. John spoke about experiencing the programme as too intense and too long, and not liking the programme's environment. He dropped out of the treatment programme despite also having liked the programme's breadth and some of the staff.

For Sophie, the treatment was a better fit. She spoke about being generally happy with her treatment outcome as she felt that the problem for which she sought treatment had largely resolved. However, 4 programme factors also contributed to her treatment dropout. She spoke about experiencing the programme as too intense, too regimented, and too long, and not liking some of the programme's staff. Sophie dropped out of the treatment programme despite being highly motivated and liking the support provided, the programme's breadth, and her councellor.

In retrospect, it is apparent that each participant was trying to find a treatment that fitted their specific and unique needs. This was a process that took some clients longer than others- ranging from a few days to several months. The degree of fit differed for each client, however, was not an ideal or best fit in any case.

Finding a Treatment That Fits

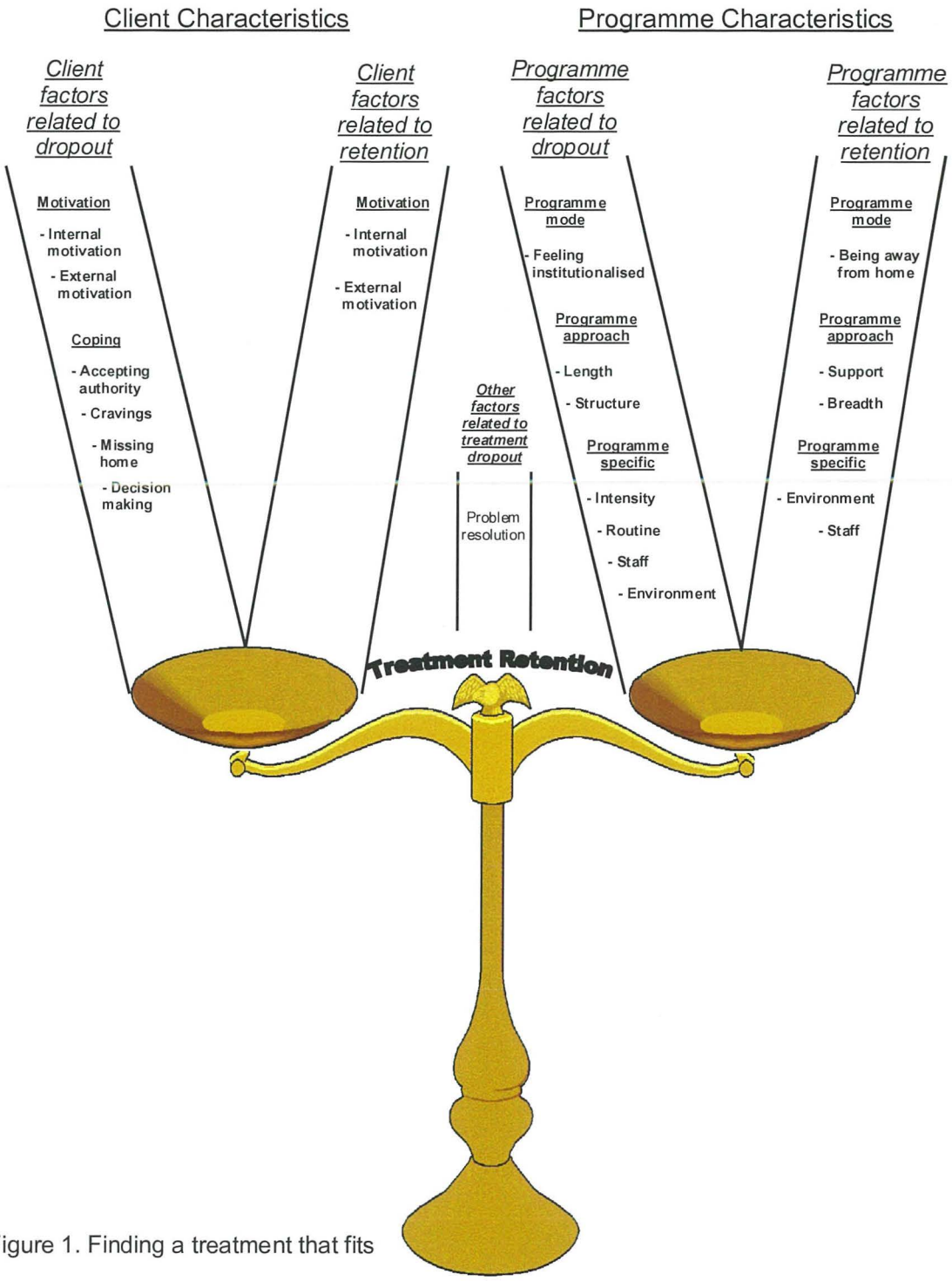

Figure 1. Finding a treatment that fits

Discussion

Discussion of client factors

Motivation

Many of the participants spoke of motivation as a factor contributing to treatment dropout. However, other participants spoke of motivation as a factor contributing to retention. Thus the same factor- motivation, had a differential affect on participants decisions. Specifically, low motivation was found to be associated with treatment dropout while high motivation was found to be associated with treatment retention. Motivation was found to be divisible into internal and external motivation. Both internal and external motivation had an affect on participants decisions to stay in the treatment, and leave the treatment programme. This highlights the complexity of motivation as a factor in influencing clients' decisions.

Internal motivation

Internal motivation can be seen as a powerful indicator of treatment retention. 5 participants spoke about low internal motivation as a factor contributing to treatment dropout. David and Joanne had particularly low internal motivation to stay in the treatment programme. David said that he did not want to be alcohol and drug free at this point in his life, and Joanne said that being alcohol and drug free was not exactly top of her priority list. David and Joanne both stayed in the treatment programme less than 2 weeks. So it appears that low internal motivation is associated with treatment dropout. On the other hand, 5 participants spoke about high internal motivation as a factor contributing to treatment retention. Sophie, John, and Jane were all highly motivated to stay in the treatment programme. Sophie spoke of a light bulb moment where she realised that her drinking was out of control, Jane said that she really wanted to get her life back on track, and John said that completing the programme would give him self-esteem. Stephaie, John, and Jane had the best retention rates out of all the participants. Thus, it appears that high internal motivation is associated with treatment retention.

External motivation

External motivation can also be seen as a powerful indicator of treatment retention. 2 participants spoke about external motivation as a factor contributing to treatment dropout. David said that he loved alcohol and drugs and that sobriety was too big of a sacrifice just to please others, and Amy said that she really only went to the treatment programme because others expected her to go. David stayed in the treatment programme less than 2 weeks while Amy stayed less than a week. Thus, it appears that being externally motivated is associated with treatment dropout. However, 6 participants spoke about external motivation as a factor contributing to treatment retention. Sophie and Jane had particularly high external motivation to stay in the treatment programme. Sophie said the biggest motivating factor for her was her family. She said she really wanted to make them proud and show everyone she could do it. Similarly, Jane said that people doubted her ability to stay in treatment and be drug free so she really wanted to prove them wrong. Sophie and Jane had the best retention rates out of all the participants. Thus it appears that external motivation is also related to treatment retention as well as treatment dropout.

The implications of these findings are that service providers need to target clients' motivation levels. They can do this by increasing external pressure and thereby motivation to remain in treatment or by increasing internal motivation to remain in treatment or, preferably both. In terms of external motivation it seems necessary to get significant others on board. In Amy, Adam's, and David's case, this external pressure was sufficient enough to bring them in the hands of a service provider. In Beverly, Lisa, and Joanne's case, legal pressure was sufficient enough to bring them in the hands of service providers and have good intentions to stay in the treatment programme. This does not imply that other positive outcomes such as a reduction in alcohol and other drug use will result, simply that the youth will be retained in treatment. This is all we can do as service providers and hope that our efforts to engage youth in the treatment process will be successful.

In terms of internal motivation, it must be a focal task of service providers to nurture this type of motivation- if it is there, and hope that it will grow. If it is absent it is up to service providers

to plant a seed- to educate the young people that present to their service about the costs of substance use and the benefits of sobriety.

The significance of motivation as a factor associated with treatment retention is consistent with existing research that has been conducted in the field. It is consistent with Melnick et al's (1997) study which found higher scores on the CMRS scale to be related to 45-day retention, Orlando et al's (2003) study which found motivation pre- treatment to be significantly associated with treatment retention, and Schroder et al's (2007) study which found that clients who had low internal motivation to remain in treatment and who were externally motivated, dropped out of treatment earlier than their peers.

Coping

Many of the participants spoke about inadequate coping skills as a factor contributing to treatment dropout. Specifically, they spoke about coping with cravings, missing home, accepting authority, and decision making. They are all grouped under the heading of coping, as they impacted on the clients' ability to engage in the treatment programme.

Cravings: "I love alcohol and drugs"

Cravings can be seen as a powerful indicator of treatment retention. 4 participants spoke of cravings as a factor contributing to treatment dropout. For example, Beverly said she couldn't stop thinking about the stuff she use to get up to such as doing drugs and stealing cars when a substance using peer was admitted into the treatment programme. When an opportunity presented itself, Beverly could not say no and she absconded from the treatment programme to engage in the above activities. Similarly, David said there was no pleasure in sobriety as there is in alcohol and drugs. All 4 participants who mentioned cravings left the treatment programme within a month. Two of these four participants left within a week. Thus experiencing cravings is a factor associated with treatment dropout, and one that appears to have its biggest effect in the first few weeks of treatment

Missing home: "Getting upset because I was homesick"

Missing home can be seen as a predictor of treatment retention. 2 participants spoke about missing home as a factor contributing to treatment dropout. When I asked Lisa why she left the treatment programme, the first thing she told me was she just missed her mum. Similarly, Amy said that she couldn't cope with feeling homesick. In fact, for both these participants, missing home was the factor they most contributed to the reason why they left the treatment programme. Both these participants remained in the treatment programme less than a week. Thus, missing home appears to be associated with treatment dropout.

Accepting authority: "Getting into trouble"

Having trouble accepting authority can be seen as a powerful indicator of treatment dropout. 4 participants spoke about trouble accepting authority. For example, Adam said he couldn't cope with constantly getting in trouble for little things and Lisa said she wanted to leave the treatment programme when she was put on limbo. Both these participants left the treatment programme within a week. Thus, an inability to accept and cope with authority can be seen as a factor associated with treatment dropout. It appears that these clients get frustrated when they are punished by authority and consequently decide to leave the treatment programme as a result of their frustration and inability to cope with it.

Decision making: "Now that I think about it, I'm gutted that I left the programme"

Decision making can be seen as a powerful indicator of treatment dropout. 3 participants spoke about making the decision to leave the treatment programme and later regretting it. Beverly said she was gutted she left the treatment programme, Lisa said given the opportunity she would come back to the treatment programme, and Joanne said that she wished she hadn't left the treatment programme. Beverly, Lisa, and Joanne all left the treatment programme within 2 weeks. Thus decision making appears to be associated with treatment dropout. It appears that some clients have problems making good decisions and lack consequential thinking processes. It seems most likely that these young people become frustrated (for whatever reason) and then self-discharge. In other words, they use emotion-focused coping. Wanting instant gratification- a property of alcohol and drugs, is likely to be typical of this client.

Although on this occasion the clients coping was associated with treatment dropout, coping is generally considered a factor amenable to change. The implication of these findings is that service providers need to target clients' coping skills. Although this is often an element of effective treatments (MacEwan, 1999), the present study has implicated the need to prioritise this skill training in the treatment process. In fact, the present study suggests coping skills may be one of the most crucial determinants of treatment retention. The power of coping skills to affect clients ability to engage in a treatment coping is demonstrated in Lisa and Beverly's case. For these participants, dropout occurred despite their alternative option being youth detention. For Joanne dropout occurred despite her alternative option being a girls home.

It is somewhat ironic that substance abusers are known to lack effective coping skills (Valtonen, et al, 2006; Hawkins, 1992; Rodrigues, 1999; Khantzian, 1995; 1997) and that coping skills training has been identified as an element of effective interventions (MacEwan, 1999), yet no research to date that the researcher knows of has cited coping as a factor affecting treatment outcomes including retention. A gap is evidently clear in the research literature.

Discussion of programme factors

Programme mode

Being away from home: "A better way to do it"/ Being away from home: "getting away from it all"

Being away from home can be seen as powerful indicator of treatment retention. 2 participants spoke about being away from home as it relates to treatment dropout. Amy said she couldn't see how she was supposed to complete treatment and be alcohol and drug free without the support of her family, and Lisa said that she needed her mum to help her through the treatment process. Amy and Lisa both left the treatment programme within a week. Thus being away fro home appears to be associated with treatment dropout. On the other hand, 4 participants spoke about being away from home as it relates to treatment retention. For example, John said that being away from home removed the temptation to use alcohol and drugs, and Sophie and Jane

said that being away from home enabled them to focus on their treatment. John, Jane, and Sophie had the best retention rates out of all the participants. Thus, it is apparent that the same factor that is, being away from home is related to both treatment dropout and treatment retention.

It is necessary that further research is conducted to determine the mechanisms underpinning these relationships. It is suggested that it may be beneficial to remove adolescents from their family home if they are enmeshed in drug culture. This includes being heavily invested with substance using peers and/ or adults who use or condone alcohol and drug misuse. It is suggested that it may be aversive to remove adolescents from their family home if they are heavily dependent on their family and/ or other significant others. It may also be aversive if the adolescent has never experienced being away from home in the past.

As far as the researcher is aware, the significance of residential treatment- specifically being away from home, as a factor contributing to treatment retention has not been investigated in the past. Further research is needed to elucidate the role of residential treatment and being away from home in influencing clients' decision to stay or leave treatment.

Feeling institutionalised: "Like another world"

Feeling institutionalised can be seen as an indicator of treatment retention. 3 participants spoke about feeling institutionalised as a contributing factor in why they left the treatment programme. David said when he was in the treatment programme he felt like he was in another world in that there was no freedom. Similarly, Adam disliked the fact that there was no trust and constant supervision of the young people. Lisa said she didn't like having no privacy. David, Amy, and Lisa all left the treatment programme within two weeks. Thus feeling institutionalised appears to be associated with treatment dropout.

As far as the researcher is aware, this aspect of the treatments mode has also not been investigated in the past. It would be beneficial if its relationship to treatment retention could be explicated. It is suggested that residential treatment is profoundly different to many adolescents previous living arrangements and indeed, anything they have ever experienced

before. Adolescents who have experienced a similar living arrangement e.g. those who have been incarcerated or spent time in a foster home or other temporary residence may be more comfortable with the arrangement.

It seems necessary that service providers incorporate as many elements as possible of the outside world into residential treatment. This may be as simple as allowing adolescents free time to watch television, eat and sleep. This was certainly the case with David who told me that when he left the treatment programme he "just ate and slept, and watched T.V".

Programme approach

Programme length: "I just got sick of it"

A programme's length can be seen as a powerful indicator of treatment retention. 4 participants spoke about the programme's length as a contributing factor in why they left the treatment programme. David said the treatment programme dragged on and on and that each day felt longer than the last, and John, Jane, and Sophie all said they would have liked to have completed and graduated the treatment programme but were not willing to give that much time in pursuit of some abstract measure of treatment rehabilitation when they felt that they already possessed the ability to abstain from alcohol and other drugs. Thus it is apparent that the programme's length contributes substantially to clients decisions to leave a treatment programme.

This has several important implications. Firstly, the present study suggests that the designated length (6-12 months) of therapeutic communities may be unnecessary to effect positive changes in young people lives. This was certainly the case with Amy, John, Jane and Sophie. Indeed, I have witnessed the opposite case where an adolescent has completed and graduated the treatment programme only to return to alcohol and other drug use the same day!

It is also apparent that service users demand treatment that is of significantly shorter duration. It is important to remember that each client presents to a treatment programme with some degree of motivation- if they had no motivation they would not have presented to the treatment

programme in the first instance. When service providers devise adolescent treatment plans according to their expectations of treatment tenure they stand to negatively impact young people as more judicious use of time actually spent in the treatment programme could have occurred.

The significance of treatment length in influencing client outcomes including retention has been suggested elsewhere in the literature. Pulford et al (2006) posited that the necessity of a 3-month attendance minimum cannot withstand critical inquiry in the psychosocial treatment context as treatments of a considerably shorter duration have been proven effective in the alcohol treatment sector. The finding that treatment approaches vary only slightly in their overall effectiveness (Williams et al 2000) provides evidence of this contention.

It is also suggested that service providers need to ensure that their treatment programme's are sufficiently progressive. If they fail to achieve this they may fail to engage young people in their treatment programme's and they may consequently dropout. This was the case for both David and John. John specifically stated that he was sick of getting set back in Odyssey House's treatment programme.

The present study highlights the importance of graduating a treatment programme to clients. Regardless of whether clients feel they posses the ability to remain alcohol and drug free, they leave the treatment programme as dissatisfied customers. This dissatisfaction extends beyond their own self-esteem to the expectations and hope of their families and other significant others. The message is clear- if service providers fail to offer treatment of significantly shorter duration they may simply fail to retain young people in their treatment programme's.

Thus it appears that treatment providers need to reconsider the length and nature of their treatment programmes. This may require thinking twice about an adolescent's placement in a therapeutic community residential setting as therapeutic community research suggests that adolescents may require longer periods in residential treatment than adults to produce similar positive outcomes (Melnick et al, 1997).

Programme structure: "The level system was hard"

A programme's structure can be seen as an indicator of treatment retention. 2 participants spoke specifically about the programme's structure as a contributing factor in why they left the treatment programme. Both these participants said they did not like how the programme did not take their specific needs into consideration. For example, Lisa said she thought it was unfair that she couldn't have her walkman and journal as these are a safety blanket for her- a coping mechanism.

By not individualising treatment to the specific and unique needs of clients, service providers may simply fail to retain young people in their service. Clients are heterogeneous in their abilities and capacities. Thus it seems unrealistic to expect that clients are able to achieve and perform equally. The message is simple, service providers need to be realistic in their expectations of young people. If clients feel that the programme is not able to fit their needs they will dropout of treatment. This was certainly the case for David and Lisa. The relevance of this latter point is echoed by Shroeder et al's (2007) study which found that clients were more likely to dropout of treatment if they thought that a treatment programme would not be likely to help them make positive changes to their life in general and alcohol and drug use in particular.

By implication service providers need to assess the needs, abilities and capacities of adolescents in their treatment programme and devise treatment plans accordingly.

Programme environment: "The support that is provided"

A programme's environment can be seen as a powerful indicator of treatment retention. 4 participants spoke about the programme's environment as a contributing factor in why they stayed at the treatment programme. Joanne said she thought of the other young people as her family, Beverly said she liked the support the staff and the other young people gave her, and similarly, Jane and Sophie said that they had received a lot of support from their peers throughout the course of their stay in the treatment programme. Thus support can be considered a factor associated with treatment retention.

Client ratings of support have been only recently investigated in the literature. Orlando et al's (2003) study reported that client ratings of resident support showed trends towards being significantly related to treatment retention. Similarly, Shroeder et al's (2007) study found client ratings of staff support to be related to retention.

It seems necessary then that service provider's endevour to create an atmosphere whereby clients feel supported by both staff and other residents. It seems obvious that service providers need to assess clients' needs in terms of support and ensure the ensuing environment is conducive to rehabilitation.

Programme breadth: "I would have never... without"

The programme's breadth can be seen as a powerful indicator of treatment retention. All bar 1 of the participants spoke about the programme's breadth as a contributing factor in why they stayed at the treatment programme. These participants cited a range of activities as beneficial. For example, Sophie said that councelling had really helped her a lot, John said he had learned a lot about health, and Jane, Sophie, John, Adam, and David said they though attending school in the treatment programme was very beneficial. Most of the participants also really appreciated the extracurricular activities such as horse riding and rollerblading. Sophie, Jane, and John told me they had forgotten how enjoyable these types of activities are. Thus it appears that having a treatment programme that incorporates a variety of other services is associated with treatment retention.

The significance of the programme's breadth in affecting treatment outcomes is consistent with Friedman and Glickman (1986a) study which found that the provision of schooling and other ancillary services such as vocational counseling and recreational services was significantly associated with a reduction in drug use, Orlando et al's (2003) study which found adolescents who reported needing ancillary services such as job training and legal advice and not receiving the needed services were more likely to dropout of treatment, and Shroeder et al's (2007) study which found that dropout was more likely if adolescents reported not having fun during a programme.

Thus it appears necessary that service providers provide a range of ancillary services for adolescents including fun activities which may serve to engage them in the treatment process.

Programme specific characteristics

Programme intensity: "The programme is like a boot camp"

The programme's intensity can be seen as a powerful indicator of treatment retention. 5 participants spoke about the programme's intensity as a contributing factor in why they left the treatment programme. In fact, for 3 of the participants, the programme's intensity was the most pertinent factor in why they left the treatment programme. Adam said he was sick of getting into trouble for little things and thought the staff were trying to brainwash him into thinking that his beahviour and attitude in the programme was abnormal, David said that the treatment programme was emotionally draining, John said he was always getting into trouble and that the programme was too challenging, Jane said the rules were way over the top and there was too much pressure and expectations, and Sophie said the staff expect you to be perfect and are constantly bossing you around. Whatsmore, 2 of these participants stated they thought completing the programme was not achievable.

The present study points to some strong evidence that young people leave a treatment programme because it is too intense for them. This was certainly the case for Adam, Jane, and Sophie. The specific issues raised by the young people in this study should be taken into account by service providers. If treatment services are too demanding of the young people in their programme's they may fail to retain them. If they are continuously punished they will lose hope in their ability to complete a treatment programme and be alcohol and drug free. It seems necessary that as service providers we are realistic in our expectations of young people. Each client deserves to be treated with compassion and understanding. This includes not being made to scrub walls as punishment. The bottom line is this; adolescents present to service providers with the hope of seeking help for their alcohol and drug use and other problem areas. They do not desire or require a boot camp as one participant said.

Although not conducted with adolescent service users, it is worth reiterating the finding of Meier and Best's (2006) review. That is, the most intensive programmes have the lowest treatment completion rates.

Programme routine: "Too much in one day"

The programme's routine can be seen as a powerful indicator of treatment retention. 3 participants spoke about the programme's routine as a contributing factor in why they left the treatment programme. Jane said the schedule was to busy and she never got any free time, Sophie said the treatment programme was physically exhausting, and David said he hated the routine in that it was the same thing day in day out.

It is implicated that service providers need to balance their schedules so that there is time for the young people to relax and unwind. Treatment should be holistic in that it recognises a balance between the mind and body. If young people are physically exhausted it is likely that there treatment will be compromised. This is not to say that treatment shouldn't be structured and all encompassing, simply that it needs to include down time. It also seems apparent that service providers need to arrange their schedules so that there is variety and diversity in order to engage young people such as David. If service providers fail to engage young people in the therapeutic process it will most certainly lead to treatment dropout.

Programme environment: "feeling safe and secure"

Feeling safe and secure can be seen as an indicator of treatment retention. 2 participants spoke about the programme's environment as a contributing factor in why they left the treatment programme. John said that the other young people in the treatment programme made him feel uncomfortable and Amy said that she was getting bullied by another female in the programme. Amy specifically stated that part of the reason she left the treatment programme was because she was getting bullied. Thus it appears that not feeling safe and secure is associated with treatment dropout.

The implications seem obvious; service providers must create a safe environment for their clients. This must also be demanded on humanitarian grounds.

The importance of having a safe and nurturing environment for adolescents was also demonstrated in Orlando et al (2003) study. The researchers found that clients' perception of safety in a treatment programme contributed significantly to the prediction of retention. It certainly was indicative of retention in Amy's case.

Programme staff: "The staff were not very nice"/ Programme staff: "Not needing drugs and alcohol to be happy".

Some of the participants cited the programme's staff as a contributing factor in why they left the treatment programme. However, other participants cited the programme's staff as a contributing factor in why they stayed at the treatment programme. Thus the same factor- the programmes staff, had a differential effect on participants decisions.

5 participants said the programme's staff contributed to the reason why they dropped out of the treatment programme. David said that the staff were not very nice, Lisa said that the staff did not listen to her, Adam said the staff picked on him, Jane said some of the staff were too strict and at times were not very understanding, and Sophie said she was constantly being bossed around by a particular staff member. Jane also commented that she didn't like it when casual staff were on shift as they did not know the young people or the rules of the programme.

On the other hand, 3 participants said the programme's staff contributed to the reason why the stayed in the treatment programme. Note, 2 of these participants also cited the programmes staff as a reason why they dropped out of the treatment programme. This is because the dynamics cited by the young people between themselves and the staff often pertained to just one staff member. Thus, it is apparent that the programme's staff can have a powerful affect on clients decision whether or not to stay in a treatment programme.

The significance of programme's staff in influencing client outcomes including retention has been noted elsewhere in the literature. Friedman and Glickman (1987) study found number of years therapists were employed in a programme to be significantly related to treatment dropout, similarly, Friedman and Glickman (1986a) found that employing counselors with at least 2

years experience working with adolescent drug abusers was associated with favourable treatment outcomes, Orlando et al (2003) study found that clients' ratings of councellors showed trends towards significantly affecting client retention, and Shroeder et al's (2007) study found that clients were more likely to drop out of residential treatment if they reported less positive experiences with staff in terms of feeling "safe, comfortable, and supported by staff" and "being able to express themselves openly and honestly with staff".

Thus, it seems crucial that service providers invest in qualified staff that are experienced in working with young people with alcohol and drug problems. Staff also need to possess relevant personal attributes that allow them to relate to young people and engage them in the therapeutic process. Williams et al (2000) contended that the therapeutic relationship between a councellor and client is probably more important than therapists training or experience. The researchers suggest that good therapeutic relationships are fostered through therapist qualities of flexible/intelligent thinking, good interpersonal skills, and genuine empathy.

One other suggestion seems necessary, service providers need to concert effort to retain staff in their programmes so that their programmes are well staffed. This would likely include endevouring staff are well remunerated and feel safe and supported in their work environment.

Discussion of other factors

Problem resolution

Problem resolution: "Everything's all good now"

Problem resolution can be seen as a powerful indicator of treatment retention. 4 participants spoke about problem resolution as a contributing factor in why they left the treatment programme. Amy said being in treatment and seeing the adults at the adult treatment programme really opened up her eyes, John said that he had come to realise that he did not need alcohol and drugs to be happy, and Jane and Sophie both said that there was no current need for them to be in the treatment programme.

Thus it is apparent that in some cases the initial presenting problem for which clients seek treatment resolves. It is important to note that this is not a phenomenon that occurs only in the latter stages of treatment as one participant who had been in the treatment programme 3 days cited this as a contributing factor in why she left the treatment programme.

This is important for service providers to know. Additionally, it may provide further evidence for the effectiveness of adolescent alcohol and drug treatment and consequently attract more funding from government departments to put towards a worthwhile venture, and on the other hand it may provide support for abstract concepts such as natural recovery. Further research examining the mechanisms underpinning problem resolution is urgently required.

Discussion of finding a treatment that fits

Finding a treatment that fits was found to be the underlying process in the present study in that it accounted for all participants experience in the treatment programme. Fit was determined by participants as they engaged in the treatment programme and experienced its mode, approach, and other specific characteristics. Simultaneously, the programme interacted with participants' motivation levels and source (internal/ external) as well as coping ability, to produce a treatment outcome.

The treatment was not a fit

For 5 participants, the treatment was not a fit. For some of these participants client factors were more pertinent and for others, programme factors were more pertinent. In most cases however, there was an interplay of client and programme factors that contributed to their dropout from the treatment programme.

Each of these participants gave a different account of why they dropped out of the treatment programme. Evidently, there is much variation in why clients dropout of a treatment programme. There is no variation however in the outcome, that is, treatment dropout. The

immediate implications are that these clients leave without receiving an adequate dose of treatment and are consequently likely to continue there alcohol and other drug use. Two points of intervention are implicated. Firstly, service providers need to determine the likely degree of fit for clients by assessing their needs prior to admission into a treatment programme. Service providers should utilise findings such as those reported in the present study to give them some idea of the clients they are most likely to retain. In addition, service providers can provide potential clients with information regarding their programme's approach and other specific characteristics and allow them to make up their own minds as to their likely fit in the programme. This option is unfortunately not accorded to clients who enter a service as a result of legal influence. However, legal services can and should provide alternatives for young people if they want them to have favourable treatment outcomes such as retention. This represents a proactive approach.

Secondly, service providers can be reactive to the needs of young people who present to their service. This would likely involve continual case monitoring whereby service providers meet with young people at regular intervals to assess their needs. Within this, treatment providers should give clients the opportunity to voice their opinions in regard to the specific characteristics of the programme as well as those of the programme's approach. Although it is unlikely that a treatment programme will change its treatment philosophy and method, many aspects of the treatment programme are amenable to change. Treatment is a process and as such clients' needs are likely to change throughout the therapeutic process.

It seems necessary that service providers take both a proactive and reactive approach to enhance the likeliness of treatment fit and thereby retention. Clients are heterogeneous in their needs. And, although services continue to evolve to meet the needs of young people, it is unlikely that a treatment exists- in its raw form, which is right for the needs of all clients.

The treatment was a better fit

For 4 participants, the treatment was a better fit. For these participants, problem resolution in addition to client and programme factors contributed to their dropout from the treatment

programme. These participants, - by implication, were more satisfied with their treatment outcome.

Additional recommendations are implicated for clients such as these participants who for the most part were happy with their treatment outcome. Firstly, is recommended that service providers change their definition of case failure. These participants did not view their treatment as a failure and indeed were generally happy with their treatment outcome. However, as it currently stands, these clients do not leave a treatment programme as successes according to provider expectations. The discrepancy between provider and consumer definitions has recently been given attention in the treatment outcome literature. Pulford et al's (2007) recent examination investigating adult treatment users' satisfaction post treatment is notable. The researchers found that although short term service use was not an intentional strategy of treatment dropouts, the majority of the dropouts reported significant levels of service satisfaction and problem improvement that was at a level comparable to their longer term peers. Thus, if clients are heterogeneous in their needs than it is reasonable to expect that they are also so in terms of their response to treatment provided.

If brief treatment was provided to all clients as a matter of course than the very concept of treatment dropout would be redundant as by implication these clients would have left a service according to mutual goals. Not to mention, this would do away with the costs of premature treatment dropout currently accorded to service providers.

Treatment retention for adolescents is likely to remain low. The suggestions put forward in the present study are unlikely to solve this complex problem however are certainly a start.

Limitations of the present study

A constructivist epistemology makes it necessary to acknowledge that data and theory is a construction; an interpretation. A different researcher could come up with a different interpretation- although it would likely be similar given that the ensuing data and theory is based on a close conceptual rendering of the data. Thus, data are narrative constructions; they are reconstructions of experience, not the original experience. A researcher's disciplinary perspective and guiding interests shape the research process. They give the researcher ideas to pursue and sensitise him/her to ask particular types of questions and look for certain possibilities in the data (Charmaz, 2000a).

Furthermore, dynamics of power, professional status, gender, and race, affect the data that is given by participants and gathered by researchers. Thus we do not construct our interpretations in isolation, but against a backdrop of shared understandings, practices, language and so forth (Denzin & Lincoln, 2000).

Of particular significance, the experience of the researcher as an interviewer may have affected the quality of the data. You don't become a good interviewer by reading about it; skills are involved which require practice (Robson, 2000).

It is also notable that subjects are seldom able to give full explanations of their actions and intentions; all they can do is offer stories or accounts of what they did and why (Charmaz, 2000b).

One further caveat in notable. The present study was restricted by the boundaries imposed when working within a Masters thesis. As such, the study was conducted using a relatively small sample. The study also utilises participants from one residential setting. The generalisabilty of the study to other samples in other settings needs to be treated with caution.

Assessing research outcomes

In the first instance a study can be judged on whether it met its objectives. Such pragmaticism means judging the quality of a study by its intended purposes, available resources, procedures followed, and results obtained (Patton, 2002). The present study sought to understand why the retention of youth in a drug and alcohol rehabilitation programme was low. It was important for the researcher and for the advancement of knowledge, that the research was holistic and anchored in participants' worlds. In its most general sense the objectives of the present study were fulfilled by utilising a qualitative approach, specifically, a grounded theory method.

It was also important to the researcher that the research was conducted from an ethical standpoint. This was achieved by being open and honest about the aims and objectives of the study, obtaining informed consent, building rapport with the participant, demonstrating empathetic neutrality and mindfulness (e.g. paying close attention to non-verbal cues, active listening, and continually validating participants experienced events, views and actions), keeping participants involved throughout the research process (e.g. negotiating constructions), acknowledging the value of their contribution to the ensuing theory (e.g. offering the opportunity to amend transcripts), and keeping participants informed throughout the research process (e.g. providing participants with a summary of the research findings).

In regards to Glaser's (1978) criteria pertaining to the quality of the data and theory, that is, *fit, work, relevancy and modifiability,* each can be considered met. Fit was achieved by grounding constructs in data. Adherence to Glaser and Strauss (1967) and Glaser's (1978) and (1992) criteria- emphasising emergence, ensured analytic questions, hypothesis, and methodological techniques were not forcing data into preconceived categories. Specifically, the use of comparative analysis, negative case analysis, and delaying the literature review contributed to achieving fit. Respectively, relevancy was achieved as core problems and processes were allowed to emerge. Work was also assumed as an explanation of what was happening in the substantive area was obtained. Modifiability is also assumed given that the study was based on extensive amounts of rich data.

In regards to Stiles (1990) and Henwood and Pidgeon, (1992) criteria for evaluating research, *triangulation, testimonial validity or sensitivity to negotiated realities, catalytic validity, reflexivity, documentation,* and, *transferability* were met.

Triangulation was met by the utilisation of multiple methods- interviewing and observation, and multiple sources- participant accounts, researcher accounts, and the use of technical and non-technical literature. Congruence was then assessed by comparative analysis.

Testimonial validity or sensitivity to negotiated realities was met by seeking validation of the ensuing analysis form participants. The researcher received comments such as "yeah that pretty much sums it up", and "so true". The researcher also received comments such as "I never really thought about it that way…." and, "next time I guess I won't…." Thus, catalytic validity was also met.

Wherever possible I sought to be reflexive. The researcher revealed her assumptions regarding the data throughout the study in memos (see results section). It is notable at this point to highlight some information regarding the reseacher. The researcher's disciplinary perspective is psychology. The researcher is a European middle class female who is a youth worker at Odyssey House's Youth Residential Alcohol and Drug Treatment Programme. This may have affected the information that was given by participants and gathered by the researcher.

It is hoped that how and why the research was done, work processes, decision making processes, and analytic processes are clear to the reader throughout the methodology, method and results section- achieving the criterion of documentation.

The researcher is reluctant to comment on the extent of transferability given the researchers constructivist epistemology however, it is hoped that the reader is able to judge such an extent through the researcher's report of contextual factors. It is however assumed that a certain degree of transferability is possible given the fact that the study was based on various experienced events, views, and actions.

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Appendix A: Information Sheet

PARTICIPANT INFORMATION SHEET

Why is Retention in Youth Drug and Alcohol Rehabilitation Residential Settings Low?

The researcher, Heather McKenzie can be contacted through Odyssey House on [redacted]. Alternatively, Heather McKenzie is contactable by e-mail: [redacted]

The supervisor of the project, Heather Buttle, can be contacted on [redacted]. Alternatively, Heather Buttle can be contacted by e-mail: h.buttle@massey.ac.nz

Introduction

My name is Heather McKenzie and I am a Masters student at Massey University studying Psychology. My supervisor is Dr. Heather Buttle.

This is an invitation to volunteer to take part in the project described here. Participation is entirely voluntary. You may choose to take part in the study at any point during your treatment. You may withdraw from the study at any time and for any reason. Participation or otherwise in the study will not affect your treatment at Odyssey House in any way.

Purpose of the study

This study comprises the final requirement of my Masters degree. This study aims to identify the reason/s why people decide to leave the programme at Odyssey House instead of complete their treatment.

If you decide to participate in the study, you will be asked to complete up to 3 interviews with the researcher, Heather McKenzie. Each interview will take approximately 15 minutes in duration. Interviews will be audio taped.

In the interview you will simply be questioned on your reason/s for choosing to stay in the programme (if you are currently in the programme), the reason/s why you are contemplating leaving the programme (if you are contemplating leaving the programme), or, the reason/s why you left the programme (if you have left the programme). General areas the interviews may include: The participants drug of choice and their history of drug taking, beliefs about drug use, motivation for abstinence, attachment to the

programme, the staff and co-clients, background and historical information, and general personality characteristics. Note: Questions on previous drug use will pertain to *what* drugs have been taken and for *how* long. Question that may incriminate the individual or anyone they know will not be sought.

You do not have to answer all the questions, and you may stop the interview at any time. You may withdraw from the project at any time.

The study will be held at Odyssey House, Goodman Centre. The study will begin in August and end in February. A summary of the results will made available to you at the end of the study. Alternatively, you may access the full published study through the Massey University library from June 2008.

Benefits, risks, and safety

If you decide to participate in the study you will have the opportunity to express what it is exactly that you like about the programme and don't like about the programme. By sharing this information you are informing all the people who are concerned with your treatment and giving them the opportunity to change those things you don't like about the programme, and to keep those things you do like about the programme.

There is a chance that emotional discomfort may arise during or after the interview as a result of the information you have just shared with the researcher, Heather McKenzie. Support for this discomfort may be sought from the researcher at any time. Alternatively, support may be sought from another staff member if this is deemed desirable by you.

In the unlikely event of a physical injury as a result of your participation in this study, you may be covered by ACC under the Injury Prevention, Rehabilitation and Compensation Act. ACC cover is not automatic and your case will need to be assessed by ACC according to the provisions of the 2002 Injury Prevention Rehabilitation and Compensation Act. If your claim is accepted by ACC, you still might not get any compensation. This depends on a number of factors such as whether you are an earner or non-earner. ACC usually provides only partial reimbursement of costs and expenses and there may be no lump sum compensation payable. There is no cover for mental injury unless it is a result of physical injury. If you have ACC cover, generally this will affect your right to sue the investigators. If you have any questions about ACC, contact your nearest ACC office or the investigator.

No costs are attached with taking part in the study, and no payments will be made to participants.

Confidentiality

No material which could personally identify you will be used in any reports on this study. All information about you will be stored in a locked cupboard at Massey University where only the researcher, Heather McKenzie and her supervisor, Heather

Buttle will have access to the information. The information will be stored safely and securely there for a period of 10 years before being destroyed.

If you have any queries or concerns regarding your rights as a participant in this research study, you may contact an independent Health and Disability Advocate. This is a free service provided under the Health and Disability Commissioner Act:

Telephone (NZ wide): 0800 555 050
Free Fax (NZ wide): 0800 2787 7678 (0800 2 SUPPORT)
Email: advocacy@hdc.org.nz

This study has received ethical approval from the Northern X regional Ethics Committee.

Version 3, 31/10/7

Appendix B: Consent Form

PARTICIPANT CONSENT FORM

Why is Retention of Youth in Drug and Alcohol Rehabilitation Residential Settings Low?

This consent form will be held for a period of ten (10) years

I have read and understand the information sheet dated 31/10/07, and have had the opportunity to discuss this study with the researcher, Heather McKenzie or a family/whanau member or friend. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time. I understand that taking part in this study is voluntary and I may withdraw from this study at any time and this will in no way affect my treatment at Odyssey House.

I agree to participate in this study under the conditions set out in the information sheet.

I have had sufficient time to consider taking part in the study.

I have had the opportunity to use family/whanau support.

I agree to the interview being audio taped.

I am aware that the exception to confidentiality will be if the researcher, Heather McKenzie has significant concerns about the safety of others or myself.

I consent to my transcript being posted to my home address.....Yes/No.

Signature: ..... **Date:** .....

Full Name- printed: .....

Project Explained By: ..... **Date:** .....

Full Name- printed: .....

Version 4, 31/10/7

Appendix C: Authority for the Release of Tape Transcripts

AUTHORITY FOR THE RELEASE OF TAPE TRANSCRIPTS

Why is Retention in Youth Drug and Alcohol Rehabilitation Residential Settings Low?

This form will be held for a period of ten (10) years

I confirm that I have had the opportunity to read and amend the transcript of the interview/s conducted with me.

I agree that the edited unidentifiable tape transcript and extracts from this may be used by the researcher, Heather McKenzie in reports and publications arising from the research.

Signature: ..... **Date:** .....

Full Name- printed .....

Version 3, 12/9/7

Appendix D: Example of Coding

Example of Coding