An Effectiveness of a Group Residential Intervention Program for Young Men with Drug and Alcohol Addiction

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Abstract

Recovery from addiction is a complex process and requires a nexus between effective programs, the right support, individual motivation and suitable placement. For young men, continued use of drugs and alcohol can lead to ongoing abuse into adulthood, poorer health outcomes, as well as mental health difficulties and fewer career prospects. The complexity of rehabilitation means that researching what programs are effective and which settings provide a supportive framework for recovery is vital.

Data collected over a six month period in two waves from an initial group of 43 men, was analysed using paired t-tests. Data included depression, anxiety and stress information (DASS-42), general health (SF-36) and psychological distress levels (Kessler-10). In addition to the two wave quantitative data collection, qualitative data by way of a focus group was also collected to examine participant’s perceptions of the intervention.

Results indicated that the treatment reduced distress levels and that participants reported a sense of belonging and hope for a better future. Levels of depression decreased significantly over time. The implications are that services provided for young men need to include life skill education, a supportive framework as well as a therapeutic community. Research on the optimum mix of each element of the intervention is ongoing.

Keywords: Young men; Drug and alcohol addiction; Treatment

Introduction

Among young men, continued abuse of drugs and alcohol is associated with continued substance abuse in adulthood, adverse health effects, academic and vocational difficulties and mental health difficulties [1]. Therefore rehabilitation of young men is an important target group for intervention. One of the more common rehabilitation approaches to addictions is long term residential programs.

Long term residential facilities for young men with control issues involving drug and alcohol use and abuse have been seen in the past as a positive setting for rehabilitation. When the residential facility forms a therapeutic community then research indicates that positive outcomes are likely for the residents [2]. Residential facilities have reportedly had a greater level of retention and lower levels of recidivism [3].

This research was an evaluative study reporting on the outcomes of a long term residential Christian community on the overall well-being and rehabilitation of young men. The residential setting formed a therapeutic community and psycho-education and skill building were essential aspects of the program.

Literature Review

Services for drug rehabilitation have moved in the past 40 years from hospitals to the community [2,4]. Community residential programs became an essential focus of this development. The orientations that are used in these facilities differ with two orientations being either a therapeutic community or psychosocial rehabilitation. Therapeutic community alcohol and drug rehabilitation programs tend to provide more health and treatment options and encourages residents to participate more intensively [2]. Engaging residents in therapeutic programs usually results in greater success in retention as well as in motivation for success by the residents [3].

Many of the young people in residential facilities, as compared to out-patient programs, have been found to have greater addiction problems [5]. Young people are defined here as being in the age range from 18- late 20’s or early 30’s as distinct from the younger adolescent age range. This age range is often seen as being ready for change because they have moved from their early adolescence but their addictive behaviours persist in this young adult age range. This group come before the law as adult offenders and residential rehabilitation facilities are often given a choice rather than incarceration [6]. Research shows that this age group are often treatment resistant in out-patient programs found that retention is higher in residential facilities and retention is often seen as a primary outcome of treatment success. The sense of belonging, the support of other residents and workers as well as a safe environment all support retention in residential facilities. The social climate of the facility in one study was found to be the most significant factor in the rehabilitation of substance addiction [7].

Winters et al. [8] indicate that amongst drug addicted adolescents, education and prior treatment are the best predictors of success in residential programs. Research indicated that adolescents with higher educational levels were more likely to succeed in residential programs [9]. Perhaps this reflects higher educational levels among adolescents are indicative of better coping skills and higher achievement levels lead to greater success in drug treatment programs especially in accessing psycho-education as part of the treatment regimen.

Research studies have shown that a number of factors contribute to the success of residential programs and these include the social

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climate [7], social support of peers and family [10] as well as the length of time that clients stay in the program [11] with personal motivation a further factor [1]. Many residential programs offer a basic six week program of psycho-eduaction about addiction and relapse prevention. One year follow up studies indicated that the length of stay within a residential facility predicted long term benefits and greater outcomes with both better substance use outcomes as well as greater likelihood of employment. The length of time in a program allowed residents to engage in the therapeutic process for longer as well as increasing resident's relationships with staff and experiences in the program and this seemed to reflect their initial motivation. However research indicates that it is the therapeutic community that offers a success rate to residents because of the focus on the development of supportive relationships with other residents and staff [2,7].

Many rehabilitation programs are offered by religious groups or organizations. There is varied literature on the significance and added value of a religious emphasis in rehabilitation and in the retention of residents [12,13]. Shields et al. [13] report that where a program places high emphasis on religion and where the clientele as a whole value the importance of religion, then commitment to treatment tends to be higher and there are positive outcomes for the clientele. There is varied literature to suggest that family disorganization [14] and poor communication [15] can result in poor attachment in infancy and that attachment problems may lead to drug and alcohol abuse [16]. Some researchers [17] believe that in times of crisis, where emerging adults have disassociated attachment from infancy, they can find an attachment to God which sustains them. Having the opportunity in a rehabilitation centre to form an attachment to God may result for some in positive outcomes and in overall improvement in well-being [18].

Research has established that environmental features such as length of stay, treatment setting and engagement with specific programs are important but another important predictor of good outcomes is motivation. Motivation to seek help and reduce substance use has been recognized as an important predictor of engagement with treatment options and with outcomes [1]. Motivation can be either intrinsic or extrinsic. Many individuals reach a point in life where they decide they need help to make significant changes in their life around their substance use. These individuals may choose a residential facility as the option for change. Often this is not their first choice but comes after a series of attempts to change their drug or alcohol habits in other ways with varying levels of success. There are other young people, who are given a choice of a residential rehabilitation facility or incarceration. These individuals can be seen as extrinsically motivated to make changes in their life [19,20]. This extrinsic motivation has the ability to impact on internal motivation through a process that [21] call internalization. This internalization can occur when the external environment impacts on the personal belief system of an individual. External motivation, coupled with internalisation is likely to lead to successful behaviour change for individuals [19]. In an adolescent population [1] indicate that adolescents are less likely than adults to be intrinsically motivated to change their alcohol and drug taking behaviours and often enter rehabilitation facilities because of pressure from family, friends or the law [22]. found that emerging adults are less likely to admit or recognize that their drug or alcohol use is problematic. However, external pressures and then internalisation as described by Deci and Ryan [21] can lead to positive outcomes for young people where sufficient support is in place.

Another factor for success in adolescent populations is the motivation for rehabilitation provided by social networks of friends [1]. In their study they found that for emerging adults and young adults, their social network was influential in both choosing to enter a rehabilitation program as well as remaining in the program. The peer influence according to Breda and Heffinger [23] can be stronger than the family influence especially when the family is disorganized or dysfunctional.

Research indicates that young men are seven times more likely than young women to engage in drug and/or alcohol abusive behaviours [10]. Research is also ambivalent about the best practice for rehabilitation of these young men [8]. Given the prevalence of young men involved in drug abuse and need for successful programs of rehabilitation, best practice requires evaluation of existing programs. In Australia, many residential programs exist for drug and alcohol rehabilitation for young men but relatively few evaluative studies have been conducted [24].

In this study, the aim was (1) to examine the levels of distress before and after treatment (six months apart);(2) to examine their levels of depression, anxiety and stress before and after treatment (six months apart) and (3) to examine participants perceptions of the residential programs effectiveness over the six months period.

Evaluation Method

The quantitative analysis was a test-retest design (Time 1 and Time 2) using the same participants both times and involved collecting data twice at a 6 month interval from a total of 43 resident participants at ONE80TC which is a residential Christian facility. The data was taken from 4 instruments. Three of the instruments were used twice The Addiction Severity Index was only used once as an initial measure of participants drug and alcohol use. Qualitative data from one focus group was also collected in order to examine qualitatively participant's perception of the intervention.

Participants

The participants were men who were residents at a drug and alcohol rehabilitation facility. They were aged from 18-39 with a median age of 24. Forty percent of participants had been in the facility for less than one month while the remainder had been there for more than one month at the first data collection point. They had a mean of 9.8 years of completed formal education.

Instruments used

The quantitative data collected came from 4 questionnaires. These were:

1. The Addiction Severity Index (ASI) [25]. This was used as a questionnaire and covers seven areas of a client's life. It covers medical, employment/support, drug and alcohol use, legal, family history, family/social relationships and psychiatric problems.
2. The Depression Anxiety and Stress Scale-21 (DASS-21) [26]. The Dass-21 is a questionnaire consisting of 21 questions that examine levels and severity of depression, anxiety and stress. It uses a 4 point likert scale and asks respondents to report behaviours based on the previous week.
3. The Kessler-10 questionnaire (K-10) [27]. The K-10 is based on 10 questions about negative emotional states experienced during the 4 week period leading up to the assessment. For each item there is a five level response scale based on the amount of time the respondent reports experiencing the particular problem. The response options are none of the time, a little of the time, some of the time, most of the time, and all of the time.
4. The Short Health Form-36 [28] The Health Survey-36 questionnaire examines an individual's self-report of their state of health using 36 questions. Some require a yes/no response and others require either a 3 or 5 point level of response.

All data except the Addiction Severity Index were collected twice at six month intervals.

The qualitative data was collected from an in-depth semi-structured interview format as a focus group. Eight participants were asked about their experiences of the program and perceptions from their involvement.

Procedure

Human research ethics approval was sought and granted from the UWS Human Research Ethics Committee (Approval No H8992).

Explanation of the research was made to all residents at ONE80TC by the researcher speaking with the group of men, handing out information sheets and participant consent forms. Invitations to be involved were given to the residents. One week after the initial information session, written consent was obtained from willing participants. All participants were given the four questionnaires to complete at ONE80TC at a mutually appropriate time, by the researcher. Staff and the researcher were available to answer questions or help to read the questions during this process.

All materials were then collected and later coded and entered into a statistical package (SPSS 17.0). Descriptive statistics were determined.

Six months later, a second wave of data was collected in a similar way to the first data collection procedure. This wave of data was obtained from the same group of participants but there had been a 35% attrition rate of participants for Time 2 data collection. Some of the attrition was due to original participants having left the residential placement but some participants chose not to be involved in Time 2 data collection.

The Addiction Severity Index was not repeated because it was used as a measure of drug or alcohol use as a pre-entry measure. Any evidence of drug or alcohol use by the participants while in residence resulted in them being asked to leave. This data was also coded, descriptive statistics obtained and analysed.

For the qualitative data an in-depth semi-structured interview format was used to conduct the focus group. All participants were asked about their experiences of the program and perceptions from their involvement. In the focus group, the following broad questions were used to guide the interview discussion:

• What is your contribution and involvement in the ONE80TC program?
• What are the positive aspects of this program?
• What are the changes you observe in the resident students here?
• What would you do differently if you could?
• What are the negative aspects of this program?
• What else would you like to implement in this program?

The interview was recorded by a digital recorder and later sent to a transcribing service and transcribed verbatim.

Data analysis and interpretation

All data from questionnaires was coded and entered into the statistical package SPSS 17.0. Descriptive statistics were obtained and graphed or tabulated. Time One data was compared to Time Two data to determine if scores have changed over time.

Interview data was thematically analysed into dominant themes. The analytic process was both inductive and deductive [29]. This was done by reading and re-reading the data to tease out similar themes expressed by the participants. Data were manually coded to obtain the main ideas, concepts and themes. Categories of responses were determined. The relative importance of categories and relationships between them were established. As suggested by Matthew and Huberman [30], other researchers also examined the qualitative data and independently determined themes and then comparisons were made to minimize data bias. Interview data were manually coded and organised. A content analysis was conducted with the frequency of responses coded thematically.

Results

Demographic information

Some general demographic information about participants is contained in the (Table 1)

The demographic information indicates that the majority of men in this residential facility were single Caucasian men with no specified religion.

Addiction severity index

All men who completed this questionnaire had already been part of the rehabilitation program and hence the valid use of this instrument needs to be challenged. For this reason it was not repeated for Time 2. Nevertheless it produces valuable information about past behaviours and present status.

The results from this addiction severity scale indicate that 37% of the men reported serious levels of alcohol and drug (dual addiction) as the main problem, with 23% reporting polydrug abuse as their most serious problem of addiction, with heroin, cocaine and cannabis individually reported by 4.7% of participants. One participant reported just alcohol as a serious problem of addiction.

Table 2 below shows lifetime use of drugs by individuals, their

| Relationship Status | N  | %   |
|---------------------|----|-----|
| Single              | 31 | 72.1*|
| Married / De Facto  | 6  | 14  |
| Separated / Divorced| 5  | 11.6|
| Children            |    |     |
| No Children         | 24 | 55.8*|
| Children            | 16 | 37.2|
| Race                |    |     |
| Caucasian           | 30 | 69.8*|
| Asian or Pacific Islander | 14 |
| Hispanic            | 2  | 4.7 |
| Aboriginal          | 1  | 2.3 |
| Religious Preference|    |     |
| Protestant          | 10 | 23.3*|
| Catholic            | 6  | 14  |
| Islamic             | 1  | 2.3 |
| Not specified       | 22 | 51.2|**

*Percentages do not add to 100% because of missing data

Table 1: The demographic information indicates that the majority of men in this residential facility were single Caucasian men with no specified religion.
individual histories of abuse and their self-reported psychiatric status.

Table 2 shows clearly some of the areas of problem for these young men both within the past month as well as in their lifetimes. There is a self-reported history of varied drug and alcohol use and a background of abuse and co-morbid psychiatric illness as well as medical problems.

Table 3 shows clearly positive and negative activities that participants have been involved with. Difficulties with the law are obvious from the table. The table also clearly shows the social supports that they use. Friends are partners are the most usual supports that these participants reported.

The depression, anxiety and stress scale-21 (DASS-21)

All participating residents completed the questionnaire on two occasions approximately six months apart. There was a level of attrition (35%) of participants from Time 1 to Time 2.

Table 4 below shows the results of paired t-tests conducted on the DASS-21 for the three sub-scales

At Time 1 on the Depression scale (DASS-21), 9.3% of participants reported severe levels of depression, with 27.9% reporting moderate levels of depression and 9.3% reporting mild levels of depression. At Time 2 on the Depression Scale (DASS-21), 6.7% reported severe levels of depression, with 13.3% indicating moderate levels and 6.7% reporting mild levels of depression. This reflects a significantly lower level of depression at Time 2 compared to Time 1.

| Drug Use by Type | Lifetime Use (%) | Use Within Past Month (%) |
|------------------|------------------|---------------------------|
| Alcohol          | 79               | 25                        |
| Cannabis         | 74               | 14                        |
| Amphetamines     | 67               | 7                         |
| Alcohol to intoxication | 65       | 23                        |
| Cocaine          | 41               | 4                         |
| Heroin           | 39               | 6                         |
| Hallucinogens    | 37               | 2                         |
| Other opiates / analgesics | 30        | 2                         |
| Other sedatives /tranquilisers | 20    | 4                         |
| Inhalants        | 11               | 7                         |
| Methadone        | 11               | 0                         |
| Barbiturates     | 9                | 2                         |

| History of Abuse | Lifetime (%) | Past month (%) |
|------------------|--------------|----------------|
| Emotional Abuse  | 33           | 5              |
| Sexual Abuse     | 9            | 2              |
| Physical Abuse   | 28           | 4              |
| No Abuse         | 34           |                |

| Self-reported psychiatric history | Lifetime (%) | Past month (%) |
|----------------------------------|--------------|----------------|
| Depression                       | 35           | 25             |
| Anxiety / Tension                | 30           | 35             |
| Hallucinations                   | 14           | 2              |
| Trouble concentrating /memory    | 16           | 39             |
| Trouble controlling violent behaviour | 26        | 28             |
| Serious suicidal thoughts        | 28           | 14             |
| Attempted suicide                | 23           | 2              |
| Prescribed meds for psychosis    | 16           | 14             |
| No reported psychiatric problems | 16           | 14             |

| History of Medical problems | Lifetime (%)* | Past Month (%) |
|-----------------------------|---------------|----------------|
| Medical problems            | 58            | 41             |
| No medical problems         | 25            | 44             |

*some participants chose not to answer

Table 2: Below shows lifetime use of drugs by individuals, their individual histories of abuse and their self-reported psychiatric status.
learning new ways. The facility was a fresh start for them. Five participants who had previous experience of other rehabilitation programs, both residential and outpatient service spoke of a tangible difference of care that they experienced in this residential program.

The overwhelming theme that was evident in the interview was that this program provided the participants with opportunity for change in a safe and supported environment where skills were taught but where the example and modelling from adults was testimony to everyone's commitment to the participants.

There were two dominant themes; the first was the opportunity for a new beginning and the second was opportunity to plan for the future. Sub themes within each main theme revolved around support and skill building. The new beginning theme under the support umbrella included sub themes of being loved, understanding themselves while the skill building sub theme included learning about addiction, learning life skills, communication skills and daily living skills. Around the theme of planning for the future, under the sub theme of support, there was a theme of making positive contacts, feeling safe and in the learning skills sub theme there were themes of wanting to give back to the community, making plans for positive re-entry into society (Figure 1).

In answer to the broad question of what are the positive aspects of the program, the students’ perspective related:

- opportunity for a fresh start,
- a chance to get the body clean, with
- a possibility for growth and being more confident in a safe environment

Some direct quotes:

- “I had a chance to get chemicals out of my body” (P2)
- “I’ve been able to get help here” (P5)
- “I’m more confident in the person I am now” (P1)
- “I came in for drugs but now I’m doing anger courses and relationship courses” (P3)
- “… it’s a good support network, being right within a community” (P7)

A sub theme that was evident was that there is awareness from the participants that they are loved and cared for by the staff

- “there’s a lot of love” (P3)
- “this place is different to other places, just more caring and they’re here because they love us boys” (P2)

Participants are aware that they want to change and that this program provides a strong supportive network. The theme of wanting a fresh start is evident in all the participants’ talk. They describe being given opportunities to learn skills and to make plans for the future.

Some quotes:

- “You come here because you want to change” (P8)

|                      | Mean | SD  | Sig. |
|----------------------|------|-----|------|
| Depression T1        | 15.67| 10.54|      |
| Depression T2        | 7.21 | 8.37| 0.004*|
| Anxiety T1           | 11.68| 8.1 | 0.092 |
| Anxiety T2           | 7    | 7.95|      |
| Stress T1            | 17.45| 11.03|      |
| Stress T2            | 9.13 | 7.52| 0.005*|
| Kessler Psychological Distress Scale (K-10) | | | |
| K-10 T1              | 24.88| 9.69|      |
| K-10 T2              | 17   | 6.12| 0.001*|

*Significant at the p<.05 level

Table 4: Depression Anxiety and Stress Scales-21 (DASS-21).

On the anxiety scale (DASS-21), at Time 1, 16.3% of participants reported severe levels of anxiety, with 18.6% in the moderate range and 4.7% in the mild range. At Time 2, 13.3% reported severe levels of anxiety, 20% reported moderate levels of anxiety and 6.7% reported mild levels of anxiety. There were no significant differences in levels of anxiety from Time 1 to Time 2.

On the Stress Scale (DASS-21), at Time 1, 20.9% of participants reported severe levels of stress, 14% reported moderate levels of stress and 7% reported mild levels of stress. At Time 2, not one participant reported a severe level of stress, 13.3% reported a moderate level of stress and 13.3% reported a mild level of stress. There was a significant decrease in stress levels from Time 1 to Time 2.

On the Kessler Psychological Distress Scale (K-10), at Time 1, 27.9% of participants reported a severe level of psychological distress, 14% reported a moderate level of psychological distress and 27.9% reported a mild level of psychological distress. At Time 2, no participants reported a severe level of psychological distress, 13.3% reported a moderate level of psychological distress and 6.7% reported a mild level of psychological distress. There was a significant lowering of psychological distress from Time 1 to Time 2.

The health survey-36

The Health Survey-36 (Ware et al. [28]) questionnaire results indicated that at Time 1, 7% of participants reported poor health, 18.6% reported fair health, 42.9% reported good health with 18.6% with very good health and 11.6% responding with excellent health. At Time 2, poor health was reported by 6.7%, fair health by 13.3%, good health by 40%, very good health by 26.7%, and excellent health by 13.3%. Statistical analysis did not show a significant difference in reported general health from Time 1 to Time 2.

Focus group results

The rationale for conducting the focus group was to examine participant’s experience of the intervention program. This focus group called for willing participants to be involved and one group of eight participants was conducted over two hours. This incorporated all participants who volunteered and within the group all participants made a contribution to the group, with active participation in the discussion and an overwhelming desire to speak of their experiences of the program and the staff. All participants reported that the residential facility was a fresh start for them. Five participants who had previous experience of other rehabilitation programs, both residential and outpatient service spoke of a tangible difference of care that they experienced in this residential program.
A lot of us come from pretty messed up families so (we learn) just basic skills – relating to people, basic life skills" (P3).

Under the dominant theme of opportunity for the future the participant's relate that the program gives them a chance to make future plans and to deal with hurt slowly.

"you can leave here with a plan to work on in the future" (P4).

Each participant also talked about wanting to give back to the community in some way while they were at the residential facility but also beyond that into the future. There is a focus in the program on helping the young men learn to be men, to lead and to be part of strong families and this was evident from one young man

"I'm going to go out there a man, more of a man than what I was and be stable to raise a family in the long run and achieve my goals that I've set out to do" (P6).

A similar theme was expressed by another participant in this way "I came in here first and foremost to fix myself because I can't help anyone until I do that, but I'm also here because I need fixing myself, to be a better dad and to be a better son, brother, friend" (P3).

As a Christian organization, participants agree to going to Church on Sunday and that is part of their commitment. Many of the participants expressed their commitment to a Christian lifestyle and awareness that church life in the future would be part of their support network. Talking about support one participant said "Church life would be a big part of it.... building relationships with those type of people" (P4).

Discussion

The aim of this study was to examine the levels of distress expressed by participants over a 6 month period as well as to determine levels of depression, anxiety and stress. There was also an aim to obtain participants perceptions of the effectiveness of the program offered. The key findings include that participants level of psychological distress lowered significantly over a period of six months in residential care. This is consistent with findings from other residential facilities [15]. The second finding was that participant's level of depression and stress decreased significantly over the 6 month period. Dakof et al.[10] found that participants who engaged in the treatment program made significant gains in rehabilitation and these results show that participants who remained engaged in the therapeutic process made significant gains in mental health and well-being.

Results from the demographic information and the Addiction Severity Scale indicate that the participants had severe and complex presentations of addiction. This is in line with many other studies of young people with substance abuse issues where the symptoms are complex and there is a degree of comorbidity with other mental health problems [11,31].

Most participants reported both alcohol abuse as well as drug use with varied prescription and illegal drugs used over time. This finding is consistent with previous findings with this population [2,32]. Alongside this were reported levels of abuse, physical, emotional and sexual and lower levels of school retention and higher levels of unskilled work or lack of consistent work. Goodman et al. [1] in their research point to all these outcomes as indicative of problematic substance use in youth.

Results of t-tests indicate significant differences in levels of depression and stress over the time of their residency. As stated over the six month period levels of depression and stress decreased. Statistically significant lower levels of psychological distress over the six month period were also recorded by the K-10. Given that these young men were in the residential program for this period of time it is clear that the program had significant positive effects on the young men. Spooner et al. [33] found in their research of a residential program that multiple improvements were significantly more prevalent in their intervention group.

Teeson, et al. [24] report that in an Australian population alcohol and other drug use disorders are an important mental health issue and those that seek treatment usually make positive gains. The focus group data indicates that this is also the case in the present study with many positive gains articulated in the focus group not only related to residents being able to make better choices around their drug and alcohol use but voicing skills they had acquired as well as recognising ways they had grown generally. For many of the participants who remained in the program for the 6 month period, there was evidence that they had embraced Christianity and that this had become another element of support for them. McDonald et al. [18] report that this attachment to God results when adolescents are seeking support.

Motivation for change was spoken about in the qualitative focus group and indicated that the residential program offered residents an opportunity for a fresh start as well as an opportunity for growth and change within a safe environment. The sense of belonging, feeling safe and loved allowed many of the participants to value what the program had to offer. The program allowed them opportunity to learn new skills and for many these were basic living skills such as anger management and better communication. This led to hope for the future. Clark [34] referred to his research in which an integrated system of person and process focus yielded the best addiction rehabilitation outcomes. There was a degree of internal motivation for change that became adopted even if they were initially mandated to be at this facility. This internal motivation has been obvious in other studies where youth seek help for addiction problems [1]. Encouragement from peers seemed to make a difference in seeking change behaviours.

Recovery from substance abuse is a complex process and as concluded by Wisdom and Gogel [32], requires a partnership between the treatment staff, family and significant others as well as a good program of skills and specific recovery related goals. The value of the therapeutic community cannot be underestimated because for many of the residents, significant relationships are built with case workers and others in the community and these relationships help to restore hope and build confidence for the future. The Christian aspect of many recovery programs adds a dimension of support that residents have reportedly rarely experienced in the past. There is a sense of being loved and cared for which meets needs for belonging. As reported by Nordjaern et al. [7] the social climate factors in a residential program may be of significant importance for treatment motivation and persistence. This represents a more holistic approach which results in better treatment outcomes in the short and long term

Limitations

This study could have been stronger if each participant could have been given the questionnaires prior to rehabilitation entry. That did not occur and hence it is difficult to have a total picture of pre-program condition. The level of attrition was also problematic in that the participants who left the program may have changed the results. The positive outcomes obviously relate to those participants successfully remaining in the program and therefore providing a positive slant to results. Having only one focus group is also a limitation. The invitation went to all participants but many were reserved about taking part in this
type of interview process. Clearly this is a weakness of the qualitative data in that it may not be representative of the whole group.

Conclusion

This residential rehabilitation community, operating as a therapeutic community, provided a program that for those participants who remained in the program, gained skills, mental health, emotional well-being and opportunity to change their addictive behaviours. There is need for after care support for these participants for the future. The fact that one of the focus group main themes was a future orientation spoke clearly of the positive outcomes that these participants had for themselves. The quantitative data of better mental health and well-being was also a positive outcome for these young men. As Dakof et al. [10] indicate engagement with a program is the essence of success.

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