A FORMATIVE AND OUTCOME EVALUATION FOR A SUBSTANCE ABUSE TREATMENT PROGRAMME

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EXECUTIVE SUMMARY

Substance abuse is a social problem that has contributed to a burden on the justice system. In South Africa, this problem has been found to be prevalent in Cape Town, the capital of the Western Cape. Methamphetamine, alcohol, cannabis, heroin and cocaine are the most commonly used drugs for which people have sought treatment. These substances are associated with violent behaviour and mental health behaviours which then result in criminal activities.

Treatment however is not easily accessible for some socio-economic groups as it is expensive and geographically inaccessible. Alternate methods of treatment in the form of community interventions have been implemented in response to the need for treatment in these disadvantaged communities. This report is an evaluation of one such intervention based in Hanover Park, Cape Town.

The First Community Resource Centre (FCRC) substance abuse treatment programme comprises of a six week camp as the main component of treatment. The activities of this component were evaluated to assess if they were effective in achieving the stipulated objectives in treating substance abuse. Clients in the programme participate in activities aimed at helping them to detoxify from substance abuse and increase self-efficacy to cease and maintain substance abuse. Clients are required to participate in aftercare upon completion of the six weeks, as a mechanism to sustain the outcomes of the programme. After completion of the programme, it is expected that participants who previously engaged in substance abuse related crime will abstain from this behaviour.

Interviews were conducted with clients who were beginning treatment, as well as a sample of people who had completed treatment ranging between 3 and 20 months ago. The results showed that the programme was successful in leading to the cessation of substance abuse for at least a week after treatment. There was also evidence of some success in maintaining abstinence with 55% of the previous clients, however, 45% had relapsed to substance abuse after treatment. Attendance to aftercare could not be evaluated due to a lack of records. Criminality amongst the participants had also decreased after treatment.

One way in which the programme can be strengthened is to encourage attendance to aftercare by means of support groups such as Narcotics Anonymous (NA) which are situated across different locations in Cape Town. Ways of integrating family support after treatment can also be incorporated as a means of sustaining the outcomes of the programme. Monitoring of the programme attributes as well as the clients after completion of treatment would also help in ensuring the effectiveness of the programme in the long term.

This evaluation provided evidence that community based programmes are effective in treating substance abuse and can contribute to the alleviation of pressure on the justice system by treating substance abuse which is associated with an increase in pro-social habits.

Background

Substance abuse is a social problem that not only affects the people who abuse the substances but also has more widespread consequences. A recent representative study conducted on the South African population reported that 13% of the general population in the country has an untreated substance use disorder (Myers, Louw, & Pasche, 2010). Social problems related to substance abuse are known to be particularly prevalent in Cape Town, the capital of the Western Cape Province, as compared to other parts of the country (Plüddemann, Parry, Donson, & Sukhai, 2004). This has resulted in the province experiencing a greater burden of health, social and criminal problems from the continued substance abuse (Parry, Plüddemann, Louw, & Leggett, 2004). These authors further substantiate that the province has high proportions of trauma patients and arrestees who test positive for alcohol and other illicit drugs. The use of drugs and alcohol is reported to increase the likelihood of unsafe sexual practices, mental health behaviours, trauma related injuries and violent behaviour (Harker, Kada, Myers, Fakier, Parry, Flisher, Peltzer, Ramlagan, & Davies, 2008).

Methamphetamine, cannabis, methaqualone, cocaine, heroin and alcohol are the most commonly abused substances in the Western Cape (Plüddemann, Dada, Parry, Bhana, Perreira, Carelsen, Kitleli, Gerber, Rosslee, & Fourie (2008). Methamphetamine, which is commonly referred to as "tik", has been the primary drug for which a large number of people have sought treatment since 2004 (Parry, Plüddemann, & Bhana, 2009). Statistics from the South African Community Epidemiology Network on Drug Use (SACENDU) show that between January and June of 2010, 34% of the population in treatment reported methamphetamine as their primary drug of abuse (Dada, 2010). This drug first surfaced among gang members involved in criminal activities in the impoverished parts of Cape Town (Parry et al., 2009). However, alcohol is the most frequently abused substance with a lifetime prevalence use ranging between 39% and 64% in the Western Cape (Harker et al., 2008) and second to methamphetamine, 30% of the population seeking treatment report alcohol as their primary drug of abuse (Dada, 2010). Cannabis is also a widely used illegal substance, with 16% of people in treatment reporting this substance as their primary drug of use (Dada, 2010). The prevalence of heroin, as with cocaine,

remain relatively low in the Western Cape, reported at 0.2% and 1% respectively (Harker et al., 2008). In spite of these findings, the use of heroin has also increased in previously economically disadvantaged communities in Cape Town, particularly in what is termed the "Coloured" communities (Parry et al., 2009).

Substance Abuse and Crime

The link between substance abuse and crime is of interest because research has provided evidence that there is a positive correlation between substance abuse and crime which can cause a burden on the criminal justice system. The link between substance abuse and crime has been identified globally: for instance, a study conducted by the Arrestee Drug Abuse Monitoring (ADAM) program in the United States found that in 27 out of 34 states, more than 60% of male and 67% of female arrestees were under the influence of substances during arrest (Taylor, Fitzgerald, Hunt, Reardon, & Brownstein, 2001). In another study conducted on lifetime criminal activity in California, periods of increased narcotic use were also positively correlated with an increase in property crime (Farabee, Shen, Hser, Grell, & Anglin, 2001). They also reported that in a Baltimore study of 354 addicts, it was revealed that crime activity was seven times higher in the times they reported addiction, compared to non-addiction periods.

In a three-metros study conducted on substance use and crime in South Africa, it was found that 23% of arrestees in Cape Town were reported to be under the influence of substance at the time they committed a crime (Parry et al., 2004). Individuals who were arrested for housebreaking and alcohol related offenses were likely to test positive for at least one drug, and the arrestees interviewed in the study indicated that they needed the substance in order to gain courage to be able to commit the alleged crime. Findings also reflected that 50.2% of the individuals who were arrested had a lifetime history of cannabis use and 31.7% reported lifetime use of methaqualone, commonly referred to as mandrax (Parry et al., 2004).

Data collected from South African arrestees who had committed violent offenses such as murder or rape, showed that 49.2% of the individuals reported that they were intoxicated at the time the crime took place (Parry et al., 2004). People who tested positive for any drug at the time of their arrest during the study were also more likely to have prior arrests (Parry et al.,

2004). While the three-metros study was limited in that the research design did not allow for the identification of a causal relationship between substance use and crime, and the police stations in which the data was collected were not representative and so the results could not be generalised nationwide (Parry et al., 2004), it does provide evidence to suggest an association between substance misuse and crime in South Africa.

Need for Substance Abuse Treatment

Farabee et al. (2001) assert that due to the nature of the relationship between substance abuse and crime identified in the literature, it is plausible then to assume that a reduction in crime would result from the treatment of offenders that are substance abusers. The Drug Abuse Reporting Program (DARP) study conducted in the United States to test the effectiveness of substance abuse treatment, found a significant decrease in arrests of the participants over a 12 month follow up period after the study (Simpson & Sells, 1982).

According to Parry et al. (2004) there is a big gap between South African arrestees' need for treatment and those who report actually having received it. From the arrestees in Cape Town in the three-metros study, 8% of these stated that they had in the past received treatment for methaqualone, but 33.2% indicated that they were in need of the treatment (Parry et al., 2004). There is particularly limited access to treatment services in Cape Town. In 2004, statistics revealed that available services can treat approximately 3500 people, yet there was an estimated number of 15 000 users who were in need of the treatment (Parry et al., 2004).

Access to treatment facilities is limited for the disadvantaged Black and Coloured communities in Cape Town, a result of the long history of Apartheid that has left a residue of socio-economic inequities in these communities (Myers, Pasche, & Adam, 2010). Most professional treatment services in the province are expensive and therefore difficult to access for these populations.

There are a number of interventions that can be put in place to reduce the burden that substance abuse causes, and these include different community interventions, treatment programmes in prison and also improving the quality of care that people have access to (Nyabaza & Musekwa, 2010; Parry et al., 2004).

Community based interventions have been increasingly implemented in these disadvantaged communities in an attempt to redress the gap that exists. As people residing in these communities have financial and geographic difficulties in accessing treatment facilities, these interventions aim to accommodate for these constraints (Harker et al., 2008; Myers, Louw & Pasche, 2010). Due to the nature of these barriers, when people in need of treatment do get the opportunity, service providers need to make sure they optimise resources to attain positive treatment outcomes (Myers, Louw & Pasche, 2010). The interventions need to be designed in a manner that facilitates prolonged effective outcomes thereby reducing the likelihood of relapse rates. The interventions that are implemented in these communities mainly target a large number of individuals at any one given period.

Programme Description

Overview

One such community intervention is the focus of this evaluation report. The substance abuse treatment programme that will be evaluated is an intervention which is run by the First Community Resource Centre (FCRC). This is a faith based non–governmental organisation based in Cape Town, South Africa. The programme was launched 7 years ago and revised in 2010, as an initiative to combat crime within the Western Cape Province. Different stakeholders, including the City of Cape Town, the Department of Community and Safety, the South African Police Services, Gun Free South Africa and the FCRC, formed a partnership to implement means through which crime might be reduced.

The need for substance abuse treatment was identified from trends within Cape Town, particularly in the Coloured communities, which reflected that substance abuse played a huge role in facilitating crime activities, and that this was also linked to gang affiliation (C. Engel, personal communication, February 18, 2011). The idea was then to target substance abuse which is viewed as leading to crime, and because research findings suggest that if its use were

to be reduced, it should also lead to a reduction in crime (C. Engel, personal communication, February 18, 2011).

The substance abuse treatment programme takes an holistic approach to the effects of substance abuse. The main component in the programme is a 6-week "camp"; a residential treatment programme conducted at one of the FCRC's sites. A fee for the camp is paid to cover food and accommodation expenses. The Kemoja Youth programme manual, launched by the Department of Social Development in 2005, is used as a guideline for some of the activities in the FCRC programme and every client receives one on arrival to the site. The manual was originally designed to be used as a tool for substance abuse prevention, but the FCRC has incorporated some of its activities as a treatment guide. Different modules are presented throughout the programme in the form of interactive workshops conducted by facilitators. These discussions are the main form of treatment interaction amongst the clients, but other activities are incorporated as will be discussed in a detailed outline below.

Whilst their children are away at the camp, the parents or other family members of the people at the camp are encouraged to attend a parent support group. This is to prepare them to provide the needed support when their children return, as the parents also need to adjust their views and attitudes to suit the difference that the programme is intended to produce in the participants in the programme. These meetings occur once every second week.

Upon returning from the camp, participants are invited to attend an aftercare programme. This helps clients to integrate back into the community. This is mainly achieved by helping the individuals either return to school or work or to find a stable job for those who are unemployed. Contact is maintained with these individuals for up to two years in order to provide a supportive network.

Programme Staff

Five members of staff stay on site to conduct the camp. These are a programme facilitator, two programme monitors, a maintenance manager and a staff member in charge of the kitchen. Additional programme facilitators who do not stay on site conduct site visits to assist in the

workshop delivery. Counsellors from the FCRC conduct at least 3 site visits per week to counsel the individuals on issues that the facilitators may not be able to help with. These sessions are not compulsory. The programme facilitators who run the programme are people who have successfully completed the programme themselves. The programme facilitators and counsellors are trained by the FCRC to equip them on how to achieve the desired objectives of the treatment programme, and they are awarded certificates from the National Board of the Federation of Churches upon successful completion of training (C. Engel, personal communication, March 07, 2011). The monitors are selected from among participants in the programme based on their progress, to mentor newer members in the programme. This happens as the programme is run on a rolling basis: different groups start the programme at different points and someone in week six can then be selected to mentor members in earlier weeks.

Selection into the Programme

People who are accepted into the programme are referred to as clients. They are attracted into the programme through awareness campaigns, marches in the community, brochure handouts and word of mouth. The FCRC, which is located in one of the communities that it aims to serve, is also open to welcome "walk ins" for inquiry. For most clients participation in the programme is voluntary, and clients have to sign a consent and indemnity form before beginning treatment. This is in spite of whether they have been encouraged to seek treatment by a relative or concerned other; signing the form means that they agree to abide by the stipulated rules of the programme. Selection into the programme is done by a counsellor by means of a subjective assessment on the readiness of individuals to partake in treatment. It is preferred to have clients who are willing and actively seeking to change, participate in the programme. This is to avoid having clients who may negatively impact on other clients. During this assessment, a period of time is allowed where individuals attend support group meetings three times a week, from which a counsellor then determines their level of commitment to change. In desperate situations, again determined by the counsellor, the individual is sent directly to the camp. There are however occasions where clients do not enroll voluntarily into the programme. In these

cases, they would have been ordered into the programme by the magistrate as an alternative to completing a required sentence. In this instance, an evaluation form is filled out when the client completes the programme, detailing their progress which then contributes towards determining the outcome of their sentence.

The programme is targeted at people between the ages of 17 and 35 years. There have however been clients up to the age of 50 participating in the programme. The programme can accommodate up to 30 participants at a given period. Clients who have been using heroin are required to detoxify at a certified medical centre before they are permitted entry into this programme; this is a legislative mandate set by government, and the FCRC treatment centre has no medical staff to manage this detoxification process. The only substance that the clients are allowed to use in the programme is tobacco; they are given controlled smoking times and provision of the cigarettes is made by the programme facilitators.

The 6 Week Camp

The use of in-patient treatment where clients are sent to a camp site for 6 weeks is structured to encourage the clients to redefine their "sense of humanity" - their ability to successfully integrate socially in their communities, which is believed to have been altered as a result of substance abuse (A. Matthews, personal communication, October 03, 2011). Facilitators at the camp site enforce rules which the clients follow as signed on the indemnity forms, and this plays a vital role in reinstating the clients' sense of humanity. Detailed activities of the six week programme are outlined below.

Week one.

The first week of the camp is an introduction to the activities which will be conducted throughout the 6 weeks. Workshop sessions are conducted by the programme facilitator who discusses health and hygiene (as most people abusing substances have been found to have deteriorated general health and hygiene standards) and how the clients will need to deal with withdrawal symptoms from substances. They are given time referred to as a "grace period" in

which to deal with their withdrawal symptoms. This is a three day period in which the clients do not engage in any work activities, after which they are assigned four hours of work daily through to the end of the six weeks. Work done includes painting, building, tiling, graphic design, screen printing, beading and gardening.

In the first week, a module based on the idea of how choices have consequences is discussed. Clients reflect on their own experiences as they are led to think about the vicious cycle of destruction resulting from substance abuse. The importance of support groups is also introduced as well as an introduction to devotions which they are required to participate in every morning and evening.

Week two.

At the beginning of a new week, they recapitulate the main themes from the previous week. Physical exercise is introduced within the second week when clients have had an opportunity to adjust from substance withdrawal. The Kemoja manual is used to guide their exercise routines which are maintained throughout the programme. The manual is also used to educate the clients about the short and long term effects of substance abuse to their bodies. The link between HIV/AIDS and substance misuse is discussed in their workshop. This is because people who are intoxicated are more likely to engage in unsafe sexual behaviours whilst under the influence of drugs (C. Engel, personal communication, March 07, 2011). Clients are also encouraged to go for HIV/AIDS testing and a nurse is made available for counselling about how to live with the disease. Discussions around "paradigm shifting" are also incorporated into the week, where the attitudes the clients hold about substance use are challenged and they reflect on them.

At the end of two weeks, the clients are given an opportunity for a home visit. This is viewed as an opportunity for the clients to explore their triggers to substance use and become aware of them.

Week three.

After the home visit where clients are expected to be aware of their substance use triggers, the primary focus of this week is to set goals for themselves. The Kemoja manual is used to help the clients achieve this, in setting goals not just for the programme, but to direct their lives outside the programme as well. Discussions about how to foster plans which will lead to the attainment of the set goals are conducted. Throughout the week different activities are facilitated to help clients engage with this concept.

Week four.

In this week the facilitator leads discussions on communication and anger management. They learn about effective communication as well as managing anger. When discussing anger management, the dangers associated with weapons are demonstrated as well in the form of a paintballing activity. Parent support group dynamics are also incorporated, where they learn the importance of family relationships. Participants are encouraged to reflect and embark on forming more positive relationships with those close to them.

Week five.

In week five clients are prepared for leaving the programme. They are encouraged to form new identities, which entails forming or incorporating character habits which include more positive experiences, utilising the skills they have learned on the programme.

Week six.

In the final week, the clients are encouraged to form support structures for when they leave the programme. This is in the form of "support buddies". They are encouraged to have three buddies, one from the programme, one from outside the programme and one from the centre. Should one not be available, the client can turn to another, reducing the likelihood of relapse when in a time of need. A documented certificate is signed when one agrees to be a support buddy. Discussions are centred on realistic decision making as the clients have been away for a long period of time and will have to adjust to a different lifestyle when they leave the camp.

They also prepare for graduation where each client is awarded a certificate for completing the programme.

Throughout the programme, devotions are held every morning and evening. Clients are encouraged to seek a spiritual connection regardless of what religion they belong to. Counsellors visit the site to discuss issues which the clients may have that may have triggered the substance abuse. Every Saturday a motivational movie is screened and each client is required to write about their understanding of the movie. Their thoughts are shared in the group sessions.

Aftercare

In the aftercare programme, clients attend group counselling sessions three times a week. Help is provided for the clients with developing curricula vitarum, preparing for interviews, setting up electronic mail and networking. This is to aid them to develop pro-social habits as they refrain from previous counter-productive habits. A timeline of 6 weeks is set for the aftercare period, in order to motivate the clients to take steps actively towards being self-reliant in maintaining substance free habits. It is believed that if a timeline is not set, dependency on the centre and the support groups would be encouraged.

The rationale of the FCRC's substance abuse treatment programme is displayed in Figure 1 in the form of a programme theory diagram. A programme theory is a plan of operation which connects activities to an intended outcome (Rossi, Lipsey, & Freeman, 2004). The programme theory contains the activities which are likely to result in the attainment of the long term goals of the programme to help the participants abstain from substance abuse altogether and hence reduce involvement in crime. The activities which take place in the programme have been grouped according to similar themes taking into account the objectives they aim to achieve.

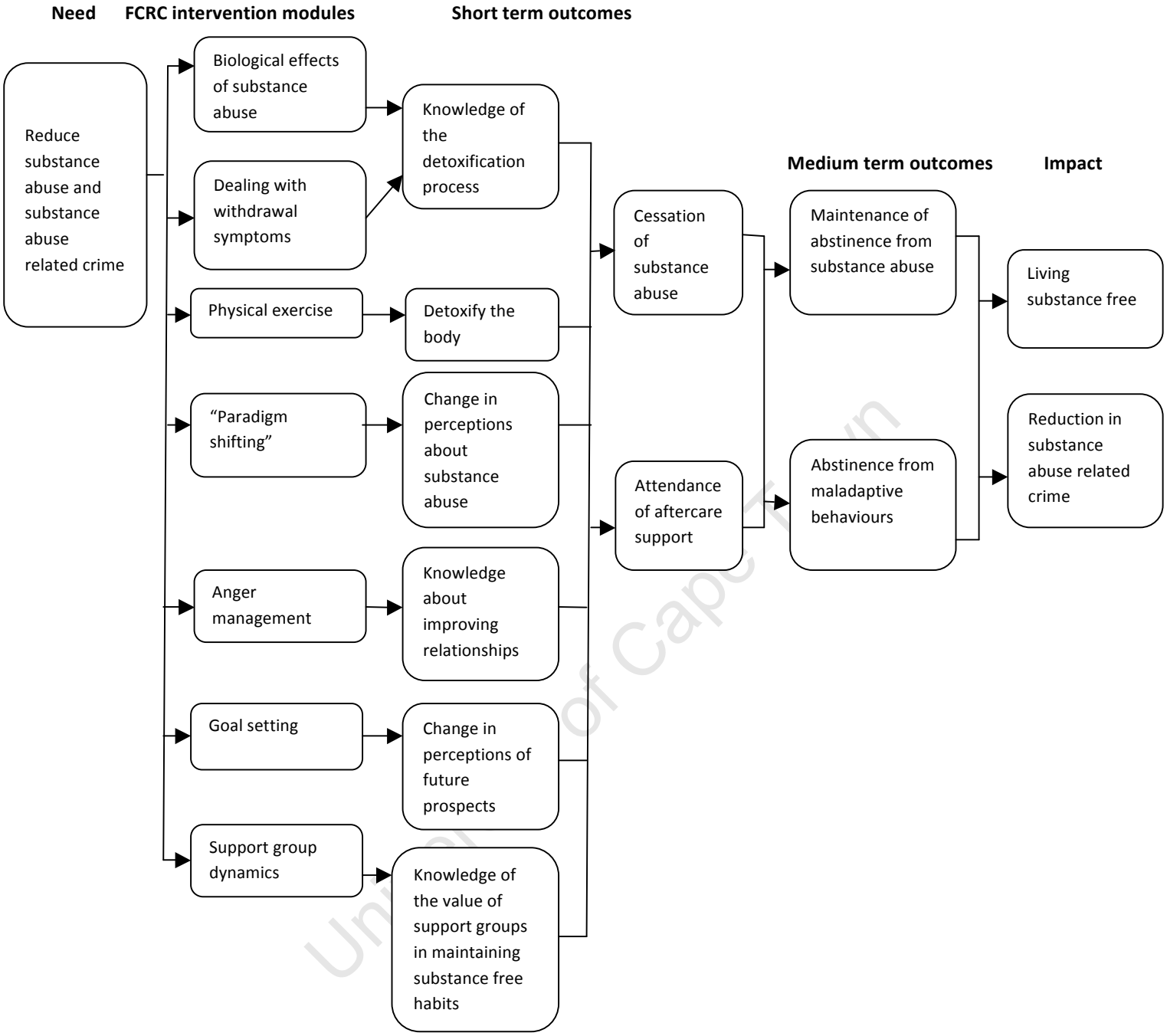

Figure 1 .Programme theory for the FCRC substance abuse treatment programme.

Scope for the Evaluation

The substance abuse treatment programme implemented by the FCRC was not developed as an evidence based intervention but rather as an organic response to an identified community need. Different components have been put together which are believed to result in the desired impact. Two approaches were implemented in the evaluation of the FCRC treatment programme. A formative evaluation in the form of a literature review was conducted to assess whether the components of the treatment programme are likely to result in the desired outcomes. An outcome evaluation could not be conducted extensively due to time and resource constraints, but some outcomes have nonetheless been measured.

Evaluation questions were formulated to provide a focus and direction for this evaluation.

Evaluation Questions

1. Is the programme theory for the FCRC substance abuse treatment programme plausible against literature?

The rest of the questions were formulated based on the expected outcomes in the programme theory.

2. Do the FCRC substance abuse treatment modules lead to:
   - 2.1 Understanding of the detoxification process?
   - 2.2 Detoxification from substance abuse?
   - 2.3 A change in perceptions about substance abuse?
   - 2.4 An understanding of how to work towards improving relationships?
   - 2.5 A change in perceptions towards future prospects?

3. After the programme do participants:
   - 3.1 Cease substance abuse?
   - 3.2 Attend aftercare?

4. After completing aftercare, do participants:
   4.1 Maintain abstinence from substance abuse?
   4.2 Abstain from maladaptive illegal behaviours?

The content and structuring of a programme are important attributes to its being effective and it is therefore important that these be assessed. Moos (2003) stated that individuals engaged in substance abuse have different social forces, such as the environments they reside in, influencing them and these need to be taken into account. The context of treatment needs to encompass not only the biological elements of substance but other interacting factors need to be included. The programme needs to be well organised and structured, encouraging work and social skills development and self-direction (Haaga, McCrady, & Lebow, 2006). This prepares the clients with coping and survival strategies when they leave the programme. In structuring treatment, clients need to have a good understanding of their treatment goals and objectives, as well as access to resources that can assist them in achieving these (Broome, Simpson, & Joe, 1999). Better engagement with the programme is then likely to result.

The content of the FCRC programme has not been empirically tested; however it does contain elements which are similar to treatment programmes that have been researched. These different components and methods will be discussed as part of the formative evaluation to determine the plausibility of the programme theory of the FCRC substance abuse intervention and assess whether it is likely that these activities will result in the desired outcomes.

Programme Theory Plausibility

The first step in assessing whether the FCRC substance abuse treatment intervention might be effective is to assess its programme theory against the standards in literature. A number of studies have been conducted to test the effectiveness of substance abuse interventions. A meta-analysis of 78 studies on different treatment methods revealed that substance abuse treatment is indeed effective in reducing substance misuse (Prentergast, Podus, Chang, & Urada, 2002). Although these different treatment models or methods have different

approaches to treating substance abuse, there is a consensus that most of them use similar process components (Connors, Donovan, & DiClemente, 2001). Furthermore Moos (2003) states that the cognitive and social processes that form the foundation of substance abuse treatment, are likely to have similarities whether they occur in a formal or informal treatment format. This therefore suggests that the effectiveness of treatment interventions is not restricted to the use of a particular model (Simpson, 2004), although he cautions that not all interventions are always effective.

To assess the plausibility of the programme theory for the FCRC substance abuse treatment programme, factors that drive behaviour change will be discussed drawing from the Transtheoretical Model (TTM) of behaviour change developed by Prochaska and DiClemente in 1982. The model, which is an integrative approach developed after an examination of 18 psychological and behavioural theories, incorporates five stages of change, namely pre-contemplation, contemplation, preparation, action and maintenance (Prochaska & DiClemente, 1983). The stages do not represent a linear process of behavioural change; people can in fact move back and forth within the stages, but structuring treatment around this understanding of human behaviour can assist practitioners in better understanding the progress of clients in treatment (Miller, 1999).

The pre-contemplation stage is characterised by a lack of motivation to change due to a lack of awareness that a problem exists (Miller, 1999). In most cases, people who have been forced into treatment fall into this category (Petrocelli, 2002). This suggests a reason as to why the FCRC may find that it struggles with the individuals who are ordered into treatment by a magistrate – clients mandated into treatment may not be ready to engage, whereas those who have volunteered may be in the next stage, contemplation. According to the model, contemplation is the stage characterised by people likely to be aware that a problem exists which requires behaviour change, although they may still be ambivalent about it (Miller, 1999; Petrocelli, 2002). In the preparation stage, individuals have been made aware of how the consequences of their addiction outweigh any positive features and begin to prepare themselves mentally for change. In the action stage behaviour modification begins as

individuals begin to take active steps to modify their habits (Miller, 1999; Petrocelli, 2002). In the maintenance stage, behaviour change has occurred and efforts are directed towards sustaining sobriety and preventing relapse (Miller, 1999). Based on this model, practitioners should therefore seek to cultivate self-efficacy in their clients for them to be able to progress through these stages and overcome addiction.

As no one definite treatment model exists in exercising the discussed stages of change, different practitioners employ various means in achieving treatment outcomes. The components incorporated in the FCRC treatment programme will be assessed against methods known literature.

Client readiness for treatment.

Client readiness is an important aspect in the selection of potential participants for the 6 week programme. As previously mentioned, a counsellor assesses the clients as they attend support group meetings, before recommendations are made to join the camp. From this assessment, a judgment can be made about the willingness of the client to take active steps to change their behaviour. This relates to the idea of motivation to change when participating in substance abuse treatment. Haaga and colleagues (2006) describe motivation to change as the 'cognitive and emotional weighing of the perceived harm versus benefits of substance use and abstinence' (p. 678). Ideally, this is a process which has to occur within the client before or as they begin treatment. It is a realisation of the damage that has occurred as a result of substance abuse and is a driver towards wanting to revert from that harm. According to DiClemente, Schlundt, and Gemmell (2004) motivation is an important component that has to exist through the client's recovery process. Furthermore, clients who have internal motivation during treatment are likely to be more participative and have positive views of their experience (DiClemente et al., 2004). The greater the motivation a client has to change, the more likely they are to respond to treatment (Haaga et al., 2006).

Similarly linked to the motivation to change is readiness for treatment. DiClemente et al. (2004) define readiness as 'a willingness or openness to engage in a particular process or to adopt a particular behaviour and represents a more pragmatic and focused view of motivation as

preparedness' (p. 104). As much as readiness for treatment is similar to motivation to change, the two are not interchangeable concepts (DiClemente et al., 2004). The client has to have confidence in their ability to change their behaviour which in turn translates into positive behaviours whilst receiving treatment.

Detoxification

Detoxification is the initial stage of any substance abuse treatment programme (Franken & Hendricks, 1999) and hospitalisation is not always required as was once traditionally believed (Gerstein & Lewin, 1990) to clear toxins in the body which are a product of substance abuse. With the exception of heroin users who need medical attention, physical exercises as well as knowledge of the biological effects of substance use and how to deal with withdrawal symptoms have been included in the FCRC treatment programme as adequate for facilitating detoxification (C. Engel, personal communication, February 18, 2011).

Cognitive behaviour therapy.

Elements of cognitive behavioural therapy (CBT) can be identified in the FCRC intervention. CBT is based on the notion that substance abuse related problems stem from learned behaviours which are initiated and maintained in the context of the affected individual's environment (Waldron & Kaminer, 2004). CBT involves identifying cues in the client's environment that can be triggers to engaging in substance abuse. Once these have been identified strategies to manage these are enforced, and these include self-control and other coping skills training (Waldron & Kaminer, 2004).

The use of CBT can be observed in the FCRC substance abuse intervention. The clients receive what is referred to as "relapse prevention training" where they identify situations or triggers that have led them to engage in substance abuse. Programme facilitators help the clients to formulate or identify strategies that can counter previous behaviour which led to substance use. The clients are also given a chance to visit their homes and in doing so weaknesses or triggers they may not have previously been aware of are made salient.

Group therapy.

The FCRC substance abuse treatment programme is delivered in a group setting format. The term group therapy in the past referred to therapeutic treatment resulting purely from the interaction of individuals, but recent formulations recognise that it can effectively incorporate cognitive behavioural interventions (Weiss, Jaffee, De Menil, & Cogley, 2004). It is when "two or more unrelated patients and a therapist meet together regularly, with the primary goal of reducing or eliminating substance use, or of addressing behaviours related to substance use" (Weiss et al., 2004. p. 339). The use of group therapy has increased mainly due to its cost effectiveness, whereby resources can be used efficiently to target a number of people together as opposed to just one person (Engle & McGowan, 2009). It is useful in providing support for individuals who could easily become isolated, or have become isolated from substance abuse related problems (Washington & Moxley, 2003). Although studies have shown that there are differences between group therapy and individual therapy (Weiss et al., 2004), group therapy has an advantage mainly because of its resource efficiency. According to Simpson (2004), with group sessions the focus is on the social climate which exists as well as how the patients interact with each other, whereas with individual sessions focus is on encouraging personal insight.

Alcoholics Anonymous (AA) is one of the pioneering group therapy treatments for substance abuse and is an example of the effectiveness of group therapy. Based on studies on AA, Morgan-Lopez and Stewart (2007) in fact state that for some addictive substances such as alcohol, group therapy surpasses the use of individual therapy significantly. It is believed that the success of this treatment method lies in the opportunity of the members to develop interpersonal relationships with other members who are experiencing the same issues (Weiss et al., 2004). Benefits of group therapy include the advantages of being able to incorporate different strategies which result in the development of different skills, social support and role change (Engel & McGowan, 2009; Washington & Moxley, 2003). Members of a treatment group can provide support for each other on a non-judgmental basis and can motivate each other as group members can empathise with the other's situation. A context in which alternate forms of

learning are used is created whereby group members can share dynamics on how to overcome their addictions and reflect on their lives simply by listening to one another (Washington & Moxley, 2003).

Although AA is the most widely known group treatment intervention, the structure and systems they employ are not superior to any other group therapy, as shown in a review conducted by Weiss et al. (2004) incorporating 15 different studies. What has been identified as important is the ability to empower individuals to be able to increase their personal efficacy and develop into new roles (Washington & Moxley, 2003). Whatever the content that is used to achieve this outcome, the social interaction that results from group meetings ensures that empowering experiences can be created.

The use of group therapy is then an advantage for the FCRC intervention. Also as the programme is based in a community which is considered to be one of the previously economically disadvantaged communities, resources can be utilised more effectively in such a setting. Although a fee is charged to participate in the programme, it is relatively more affordable than treatment provided on an individual basis because of the efficiencies of group therapy.

The "paradigm shifting", anger management and goal setting modules in the FCRC treatment programme encompass elements of cognitive behaviour therapy and group therapy. Based on the theoretical concepts discussed above and as demonstrated in the programme theory diagram in Figure 1, these are expected to result in the outcomes that encourage a change in the clients towards substance abuse. Another important aspect that these modules build into is that of relapse prevention training which is a technique that enhances behavioural self-control in clients to increase their resilience in situations where they may relapse (Marlatt & Gordon, 1985). The objective of this technique is to establish new thinking patterns in high-risk situations (Simpson, 2004) when they exit the programme.

Efficacy of aftercare.

There is a growing literature which reports that aftercare - continuing outpatient care after intensive treatment or residential outpatient care - results in better treatment outcomes (Lash, Burden, Monteleone, & Lehmann, 2004). The amount of time which individuals spend in treatment can assist in ensuring the effectiveness of a substance abuse treatment programme. Time spent in treatment can refer to the planned intervention itself or continued care after the intervention (Haaga et al., 2006). In a study by Broome and colleagues (1999), patients rated a treatment experience more positively when they attended comparatively more counselling sessions. In addition, follow up studies by Simpson (2004) on substance abuse treatment showed that patient's recovery rates were improved when sufficient time and the appropriate intensity were applied in an intervention. In the event that an intervention is limited in time a long term plan for maintenance of abstinence has to be incorporated as a support mechanism for clients (Haaga et al., 2006). The amount of care clients receive is not as important as the duration of the treatment, suggesting that continued care contributes towards reducing relapse rates of clients (Moos, 2003).

Clients are likely to relapse shortly after completing inpatient treatments, particularly within the first 3 months of abstinence, and this therefore makes it important to have support measures in place which can help them to cope better (Lash, Petersen, O'Connor, & Lehmann, 2001). The average time of most inpatient or intensive outpatient treatments is 1 month due to the expense of maintaining treatment, yet realistically more time is needed to maintain sobriety (Lash et al., 2001). Adherence to aftercare needs to be emphasised during the intervention to increase the likelihood of participation. This was evident in a study where the treatment facilitator provided orientation to aftercare; clients who had received orientation were more likely to attend aftercare than those that did not receive orientation (Lash et al., 2001).

Most aftercare treatments rely on the utilisation of support groups as a support mechanism to reduce the likelihood of relapse shortly after inpatient or intensive outpatient treatment has been completed. Support groups share the same characteristics of group therapy as discussed

above, although with support groups, therapy is just in people sharing their stories, reflecting on them and using them as a support mechanism, rather than provided by a professional. Intervention success rates have been shown to improve with the use of support groups post treatment (Atkins & Hawdon, 2007). Due to the strain of resources on most substance abuse treatment programmes, especially in particular communities in Western Cape, the use of support groups is an advantage as it is a cost effective method that has been proven to complement professional treatment (Atkins & Hawdon, 2007). It is for these reasons that it is plausible that the FCRC treatment programme incorporates the support group dynamics module and the aftercare component.

The literature discussed has outlined components of substance abuse treatment which the FCRC has included in their programme, and how these have been reported to be effective, making their programme theory plausible. The question that remains to be answered is whether or not these components will render the programme effective in achieving its desired outcomes.

Method

This chapter focuses on the methods which were used to investigate whether the FCRC substance abuse treatment programme resulted in the intended outcomes. The evaluation was tailored to assess the short term and medium term outcomes.

Programme Participants

The most ideal research design to show a causal relationship (i.e., that the programme caused the observed changes in substance misuse) between the programme and the outcomes is a randomised controlled trial (Rossi et al., 2004). A randomised control trial is an experimental form of research in which the researcher manipulates treatment between two equal groups so as to be able to draw a conclusion about the effects of the treatment (Leong & Austin, 2006). As this was not possible in this evaluation due to resource constraints – a randomised controlled trial needs a large cohort of clients to be randomly assigned to treatment and control groups - different cohorts of clients who have been through the programme were incorporated. The differences among these groups were used in an attempt to infer causality. The research design emulated the form of a quasi-experimental design.

Clients who were starting the programme at the beginning of the data collection period were included in the evaluation. This group will be referred to as cohort one from this point on. We selected this category to assess how these participants progressed through the programme by comparing their status prior to entering the programme with their status on completion of the programme. This is referred to as a pre-post evaluation where the changes which occur within the group of participants between the pre-test and the post-test are attributed to the programme. The limitation of this design is that there is a possibility that some other independent factor could have resulted in the change in the participants (Babbie & Mouton, 1998) but it would not be able to identify this with this group alone. An equivalent comparison group which does not receive treatment would have been ideal to control for other factors which may have influenced the change in the group which received treatment (Babbie & Mouton, 1998), but was not possible here.

Clients who had completed the programme at least three months previously were selected to attempt to counter for the limitation of the lack of a control group for cohort one. The design selected attempted to replicate the characteristics of a time series quasi-experiment. A time series research design which is used to assess for the effects of an intervention over a period of time, is an alternative method to use which can control for mediating factors which make it difficult to assess a programme's effectiveness (Posavac & Carey, 2007). Table 1 illustrates how a time series design could have been used to assess for the short term and long term effects of the programme.

Table 1

Time series research design

Before treatment	**Treatment**	**3 months after**	**6 months after**	**1 year after**
O_1	X	O_2	O_3	O_4

The evaluation had, however, to be conducted over a short period of time and this did not allow for the implementation of this design. Table 2 shows the actual design that was used in this evaluation. Participants who had been out of the programme for a minimum of three months were used to assess for the long term effects of the treatment programme. This time period was chosen because where relapse occurs; clients are likely to relapse within the first three months after completing treatment (Hunt, Barnett, & Branch, 1971).

Table 2

Research design used for data collection

Data provider	**Before treatment**	**Treatment**	**After treatment**
Cohort one	O_1	X	O_{2*}
Successful group		X	O_{2**}
Relapse group		X	O_{2**}

Notes: *Observation made one week after treatment; **Observation made between 3 months and 20 months after treatment

Seven clients who agreed to participate in the evaluation formed cohort one. This sample consisted of one female and six male participants. Their ages ranged from 19 years to 28 years with a mean age of 24.3 (*SD* = 2.81).

Programme staff members were asked to identify from their programme records, participants who satisfied the criterion of having completed treatment after a minimum of 3 months. Of the 100 participants who satisfied this criterion, 30 people were contacted using convenience sampling as these were the clients who were easily and successfully contacted within the time frame set for the evaluation. A total of 20 people who had completed the programme between 3 and 20 months ago at the time of the evaluation, agreed to participate in the research. After completing the evaluation interview, all participants who reported not having used any illicit substances since completing the programme were classified under the "successful" group and those who had were classified under the "relapse" group. From these 20 participants who were interviewed, 55% (*n* = 11) formed the group of successful clients and 45% (*n* = 9) formed the group of participants who relapsed to substance abuse. In the successful group, 64% (*n* = 7) were male and 36% (*n* = 4) were female. Their ages ranged from 21 years to 40 years with a mean age of 25.3 (*SD* = 5.57). The participants in the relapse group comprised of 67% (*n* = 6) male and 33% (*n* = 3) female participants. Their ages ranged from 19 years to 31 years with a mean age of 23.6 (*SD* = 4.13). The results obtained from cohort one were compared with the ones obtained from these two groups.

Materials

Programme records.

Programme records were used to gather information on the content of the programme which assisted in selecting appropriate measurement tools for the outcomes. The records also provided information on the participants in each identified group, so that participants could be contacted based on the information on their records of when they had entered and completed the programme. Due to ethical considerations, we did not take part in the viewing of the participants' records to select clients to be contacted to partake in the research. This would

have violated the clients' confidentiality. The programme records were also used to identify participants' attendance of aftercare when they had completed their inpatient treatment.

Questionnaires.

The participants in cohort one were assessed at two points in the form of a pre and post-test. They received a questionnaire to respond to at the beginning of the FCRC intervention and a week after the end of the inpatient treatment. For the pre-test, scale items adapted from the Alcohol, Smoking and Substance Involvement Test (ASSIST) questionnaire (developed by the World Health Organisation in 1997 and revised in 2008) were used to investigate the substances that participants have abused as well as the frequency. This questionnaire was developed by a group of substance abuse researchers for the purposes of managing and detecting substance abuse in primary and general medical care settings (World Health Organisation, 2011). A score is allocated according to the frequency of use of each substance for the different items on the questionnaire. The scores are totalled and categorised as lower risk, moderate risk or high risk substance use.

The questionnaire was selected because of its reported substantial test-retest reliability. Test-retest Kappa coefficients of agreement (K-values) were calculated for each question and drug category. The obtained K-values ranged from 0.58 to 0.90 for question stems and from 0.61 (sedatives) to 0.78 (opioids) for substance categories (World Health Organisation, 2011). K-levels which are greater than 0.4 are considered to be moderate and those above 0.6 are considered to be substantial (Brenner & Kliebsch, 1996). As tobacco is the only substance the clients are allowed to use in the programme, all question items pertaining to the use of tobacco were removed.

The *Drug Avoidance Self Efficacy* scale which was developed by Martin, Wilkinson, and Poulos (1995) presents different scenarios where people have to indicate how they would respond in situations that might provoke craving to use substances. This subscale was included to assess the participants' perceptions towards their substance use and ability for avoidance. The original 16-item scale was reported to be reliable with a Cronbach's alpha of .91 (Martin et al., 1995).

Participants were asked to respond on a 5-point Likert scale (with 1 = strongly disagree ranging to 5 = strongly agree).

The *How I see my Future* subscale (which was adapted from the modified Social and Health Assessment questionnaire by Schwab-Stone in 1999) was incorporated to assess the perceptions the participants hold regarding their future prospects before entering the programme. The scale was found to have a good internal consistency with a Cronbach's alpha of 0.79 (Ruchkin, Schwab-Stone, & Vermeiren, 2004). Participants were asked to respond on a 4-point Likert-like scale (with 1 = very low ranging to 5 = very high).

Items from the Drug Abuse Treatment Outcome Study (DATOS) questionnaire (developed by the United States Department of Health and Human Services in 1994) were also incorporated. These scale items investigated any substance abuse related crime which the participants have previously been involved in. (See Appendix B for the pre-test questionnaire).

For the post-test (see Appendix C), scale items from Miller and Brown's (1994) *What Did I Get from Treatment* questionnaire which was developed by the Center on Alcoholism, Substance Abuse, and Addictions (CASAA), was included to the same constructed pre-test questionnaire. Participants were asked to respond on a 4-point Likert-like scale (with 1 = strongly disagree ranging to 4 = strongly agree). The DATOS items were removed for the post-test questionnaire because they assess medium to long term outcomes, which were not applicable to participants in this group due to limited time period from which they were measured after completing the programme.

For the rest of the participants who formed the two groups (successfully completed and relapsed), the DATOS questionnaire items were added to same post-test questionnaire that was administered to cohort one, and used with these participants. (See Appendix D)

The use of a questionnaire ensures that the questions are standardised for all participants and it also provides a time-efficient method of compiling this data (Babbie & Mouton, 2009).

Table 3 provides a summary of the methods of data collection from the participants.

Table 3

Summary of the Data Providers and Methods of Data Collection

Groups of clients interviewed	Sample size	Method of data collection
Cohort one - Starting the programme	7	Repeated pre-test and post-test questionnaire
Successfully completed the programme	11	Post-test questionnaire
Completed the programme but relapsed	9	Post-test questionnaire

Structured interviews.

Structured interviews were used to administer the questionnaires. Administering the questionnaires in the form of interviews reduced the likelihood of missing data, and it accommodated for the different levels of literacy that the participants may have had. We could explain or expand on what was not clear to the participants. As the instruments used were developed in the United States, we could also translate some of the terms in the questionnaire which are used differently in the South African context.

Unstructured interviews.

Unstructured interviews were conducted with the programme manager as well as programme facilitators to obtain information on the nature of the programme. Unstructured interviews were used as they allowed for questions to be adapted as the interview was conducted, thereby not restricting the range of responses from the interviewees (Babbie & Mouton, 2009). Four interviews were conducted with the programme manager from which the type of evaluation to be conducted was also established. These unstructured interviews also contributed towards identifying the different categories of clients for the evaluation. The

programme facilitators assisted in clarifying the day to day activities in the programme and the objectives they aimed at achieving.

Procedure

In order to maintain client confidentiality, we could not view client records to identify the participants to be included in the evaluation. Programme staff therefore selected possible participants who met the required criteria as decided for the evaluation. These clients were contacted and asked if they are interested in participating in the research.

Approval to conduct the evaluation was sought from the University of Cape Town's Commerce Faculty Ethics Committee. Upon approval, the questionnaire items were administered through an interview to the participants who agreed to participate in the research. The participants were reimbursed for travelling expenses to the selected site to participate in the research. Cellular phone airtime vouchers were offered to the participants to thank them for participating in the research. The participants in cohort one who were interviewed before they started the in-patient treatment and also a week after they had completed the inpatient treatment received their airtime vouchers after the second interview.

Data analysis

The statistical program SPSS was used to conduct data analysis. Reliability analysis was conducted to assess the consistency of the scales. Descriptive statistics (mean and standard deviation) were used to describe the distribution of the data and inferential statistics (t-tests and anova) were used for statistical comparisons of the data.

Ethics

Participation in the evaluation was voluntary for all participants who were told they were free to withdraw at any point of the evaluation without penalty, and without their withdrawal in any way affecting their relationship with FCRC. All interviews were conducted in the same interview room at the premise of the FCRC. The only people present in each interview were the evaluator and the participant. At the beginning of every interview, the content of the consent letter (see

Appendix A) was read to each participant and the procedure to be followed was explained. Upon agreement and signing the consent letter, the participant was allocated an identity number to maintain anonymity. The names of the participants were not recorded on the interview forms. The same procedure was followed for every participant. The completed questionnaires and consent forms were kept in a secure place where they were locked up for safe keeping and all data was analysed by the evaluator.

Results

Scale Reliability

A reliability analysis of the *What I Got from Treatment, Drug Avoidance Self Efficacy* and the *How I See My Future* scales of the questionnaire was conducted to assess their internal consistency. According to DeVellis (2003), the Cronbach's alpha coefficient of a scale should be above .7 to be considered reliable. Using the whole sample of 27 participants as the unit of analysis, the three scales were found to have a good internal consistency with Cronbach's alphas of .86, .86 and .75 respectively. Table 4 displays the results of the reliability analysis conducted on the ASSIST subscales. The Cronbach's alphas for the Inhalants, sedatives, hallucinogens and "other" drugs subscales could not be displayed because the calculations resulted in the occurrence of zero variance. This is because of participants' responses to the use of these substances, which ranged from infrequent to none use.

Table 4

ASSIST reliability analysis

Subscale	**Cronbach's alpha**
Alcohol	0.6
Amphetamine	0.86
Mandrax	0.9
Opioids	0.97
Cannabis	0.85

Evaluation Question Findings

The results of this evaluation will be reported according to the outcomes evaluation questions that were posed.

Evaluation question 2.1: Do the FCRC substance abuse treatment modules lead to knowledge of the detoxification process?

To answer this evaluation question, participants were asked a question in the *What Did I Get from Treatment* questionnaire on whether they received help in understanding the detoxification process. Participants agreed that they did receive help in understanding the detoxification process and the results from a one-way between-groups analysis of variance shows that there was no statistically significant difference in the responses among the three groups at the $p < .05$ level; F (2, 24) = 0.92. p = .41. Table 1 displays the individual means for each group.

Table 5

Mean scores for knowledge of detoxification

Category	*n*	*M*	*SD*
Cohort one	7	3.7	0.9
Successful	11	3.8	0.6
Relapse	9	3.4	0.73

Evaluation question 2.2: Do the FCRC substance abuse treatment modules lead to detoxification from substance abuse?

Participants were also asked to respond to a question in the *What Did I get from Treatment* scale whether they were presented with methods to help detoxify whilst on the programme. All groups agreed that they did detoxify in the programme and the results from a one-way between-groups analysis of variance showed that there was no statistically significant difference in their responses at the $p < .05$ level; F (2,24) = 0.98, p = .39. The individual means for each group are displayed in Table 2.

Table 6

Mean scores for agreement of detoxification

Category	*n*	*M*	*SD*
Cohort one	7	3.7	0.49
Successful	11	3.1	1.22
Relapse	9	3.3	0.7

Evaluation question 2.3: Do the FCRC substance abuse treatment modules lead to a change in perceptions change of substance abuse?

To assess for this change in perception towards their ability to avoid substance use, a comparison was made from the responses on the pre-test and post-test of cohort one to the five-point Likert *Drug Avoidance Self Efficacy* scale. A paired samples t-test was conducted to assess for a difference in perception before and after the programme. There was a statistically significant increase in the scores from the pre-test (M = 1.74, SD = 1.01) to the post-test (M = 4.63, SD = 0.47), t (6) = -7.4, p < .0005 (two-tailed). This showed that the perceptions of the participants towards substance abuse did change after the programme, in that they felt better able to resist using substances in situations where they might have used them before they went through the programme. The same subscale was administered to the successful and relapse categories as a post-test measure. A one-way between-groups analysis of variance showed that there was a significant difference at the p < .05 level among the three groups; F (2,24) = 3.9, p = .03. Post hoc comparisons using the Tukey HSD test indicated that the mean score for the successful group (M = 4.6, SD = 0.38) was significantly higher than the mean from the relapse group (M = 3.7, SD = 1.3).

Evaluation question 2.4: Do the FCRC substance abuse treatment modules lead to knowledge about how to improve relationships?

Two questions on the *What Did I Get from Treatment* scale asked participants whether they received help in improving relationships, from the programme. The mean scores show that the participants in all groups agreed that the programme helped increase their knowledge about how to improve relationships. A one-way between-groups analysis of variance showed that there was no statistically significant difference among the three groups at the $p < .05$ level; $F(2,24) = 1.2$, $p = .30$. Table 3 displays the individual means for each group.

Table 7

Mean scores for agreement for knowledge about improving relationships

Category	*n*	*M*	*SD*
Cohort one	7	3.6	0.6
Successful	11	3.9	0.3
Relapse	9	3.6	0.5

Evaluation question 2.5: Do the FCRC substance abuse treatment modules lead to a change in perceptions towards future prospects?

To assess for this change in perception, a comparison was made from the responses on the pre-test and the post-test of cohort one on the four-point Likert-like *How I See My Future* subscale. A paired samples t-test was conducted to assess for a difference in perceptions before and after the programme. The results showed that although there was a slight increase in the scores from the pre-test ($M = 3.06$, $SD = 0.25$) to the post-test ($M = 3.4$, $SD = 0.38$), $t(6) = -1.98$, $p > .05$ (two-tailed), it was not a statistically significant increase. This implies that the perceptions that the clients hold regarding their future are not very different before and after the programme. A one-way between-groups analysis of variance showed that there was no statistically significant difference in the responses on the same scale for the other groups at the $p < 0.5$ level; $F(2, 24)$

= 2.1, p = .14. The participants in the successful and relapse groups obtained post-test mean scores of 3.8 (SD = 0.27) and 3.4 (SD = 0.58) respectively, which are similar to the results obtained from cohort one.

Evaluation question 3.1: After the programme, do participants cease substance abuse?

To answer this evaluation question substance use of cohort one before and after the programme was assessed. All seven participants in the group reported to have ceased illicit substance use when interviewed a week after the programme.

The ASSIST questionnaire was used to assess the substance use scores of the participants in cohort one before and after the programme. There was a statistically significant decrease in the scores between the baseline assessment before the programme (M = 60, SD = 22.28) and the post-programme assessment (M = 14, SD = 6.56), t (6) = 6.23, p = .001.

The substance use risk levels of the participants in cohort one were also assessed using the ASSIST guidelines on different substances. Out of a possible maximum score of 39 on the ASSIST questionnaire, participants who had used alcohol and scored within the range 0 – 10 were in the lower risk category, those who scored in the range 11 – 26 were in the moderate risk category and those who scored above 27 were in the high risk category (ASSIST manual, 2011). For all other substances, participants who scored within 0 – 3 were in the lower risk category, those who scored within 4 – 26 were in the moderate risk category and those who scored above 27 were in the high risk category. Figure 1 shows the risk levels before the programme and Figure 2 shows the risk levels after the programme. Figure 2 shows that there is an improvement from Figure 1 in risk levels on all substances.

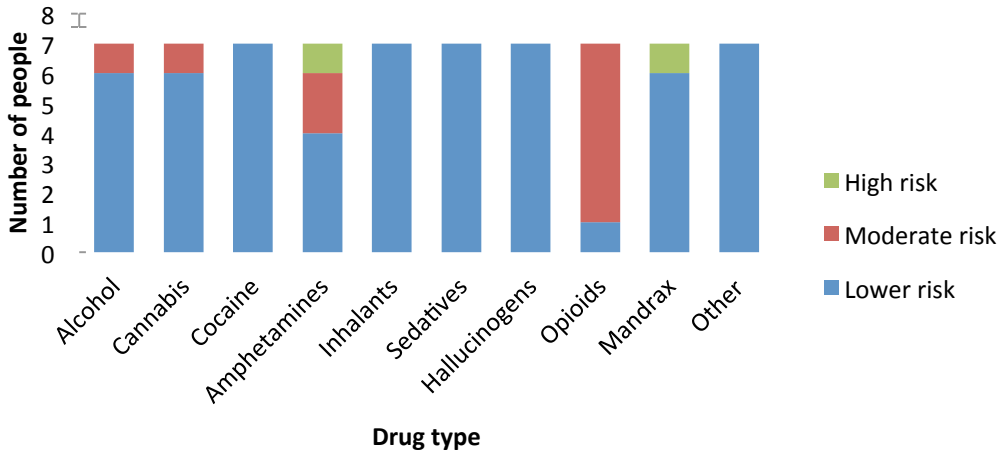

Figure 2. Pre-test substance use risk levels.

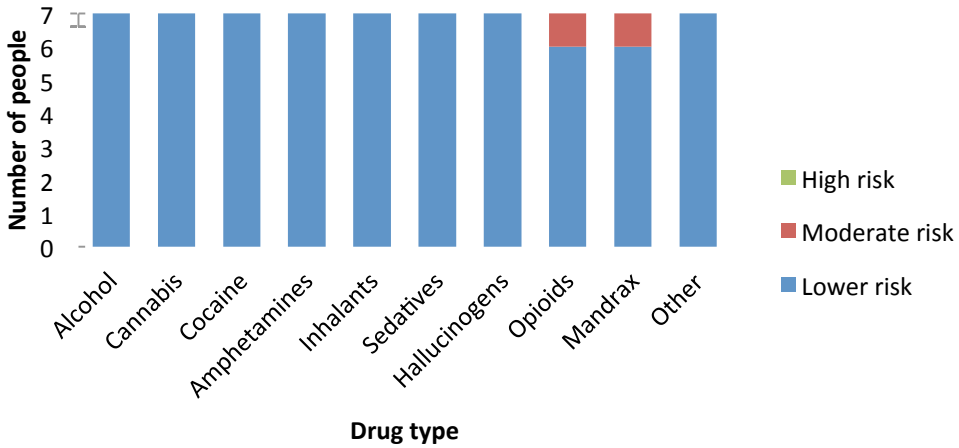

Figure 3. Post-test substance use risk levels.

Evaluation question 3.2: After the programme, do participants attend aftercare?

In order to answer this evaluation question, attendance records of the participants to support group meetings needed to be assessed. However, there were no records available at the time of the evaluation for the three different groups of the participants.

Evaluation question 4.1: After completing aftercare, do participants maintain abstinence from substance abuse?

As this is a medium term outcome of the programme, the participants who had been out of the programme for at least three months were assessed to answer this question. As some participants were identified to have engaged in illicit substance use again after they had completed the programme, there is evidence that not all clients do maintain abstinence from substance abuse. An independent samples t-test showed that there was a statistically significant difference in substance use scores for the successful group (M = 22, SD = 11.05) and the relapse group (M = 43.56, SD = 25.63), t (18) = -2.35, p = .04. In addition, the scores on the ASSIST questionnaire were assessed to compare the differences in substance use risk levels on the varying substances for both the successful and relapse groups. The risk levels of the two groups are displayed in Figure 3 and Figure 4 below.

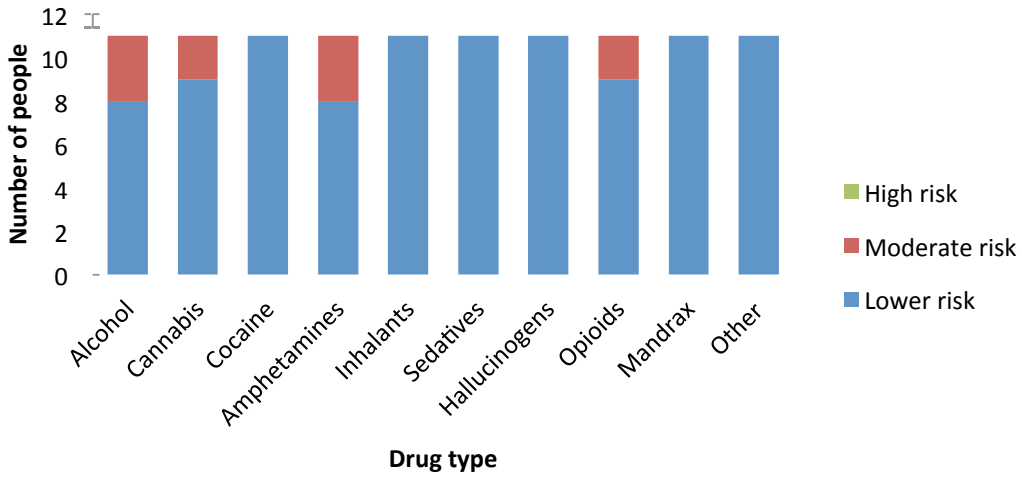

Figure 4. Substance use risk levels for the participants in the successful category.

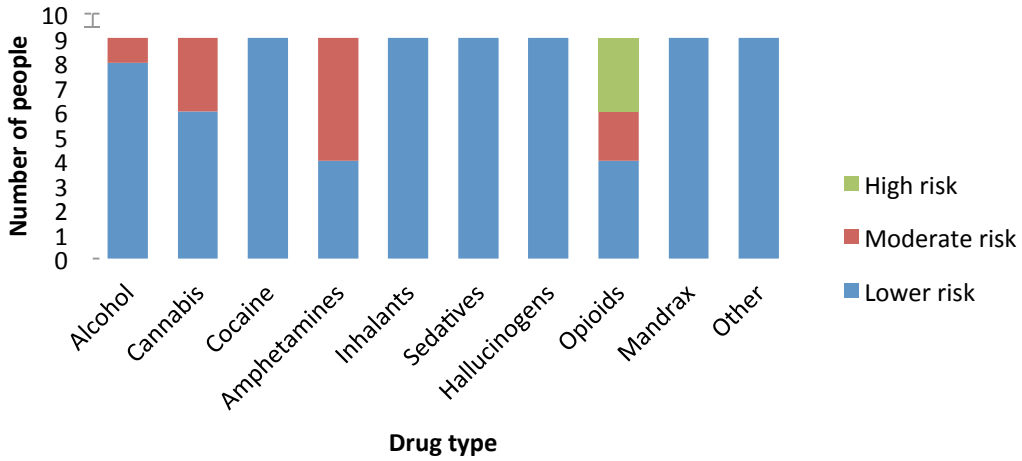

Figure 5. Substance use levels for participants in the relapse group.

From the two charts presented above, there is evidence that the scores between the two groups are not only significantly different, there are more clients in the moderate and high risk categories for cannabis, amphetamines and opioids for the relapse group compared to the successful group.

Evaluation question 4.2: After completing aftercare, do participants abstain from illegal maladaptive behaviours?

It should be noted that the evaluation revealed that the assumption of an association with substance abuse and criminality does not apply to all substance abusers. Of the 27 participants who were interviewed, 78% (*n* = 21) reported being involved in substance abuse related crime and 22% (*n* = 6) reported not.

Of all the 20 participants who had completed the programme three months or more ago, 75% (*n* = 15) reported that they had been involved in substance abuse related crime prior to entering the substance abuse treatment programme, the remaining 25% (*n* = 5) reported that they had not engaged in any form of substance abuse related crime. Only one respondent from

the 15 participants committed a substance abuse related offense after having completed the programme. This participant belonged to the relapse group.

From the participants in cohort one, 86% (*n* = 6) reported having engaged in substance abuse related crime before entering the programme. As the post-test for cohort one was conducted a week after they had completed the programme due to time constraints, they were not re-assessed on this behaviour. Abstinence from these behaviours is an expected medium term outcome and a week is not enough time to yield an accurate measure.

Table 1 provides a summary of the number of participants who reported having engaged in different substance abuse related offenses before entering the programme. The scale had a response option of "other" for participants to report any other offences that were not listed. People who selected this option reported offences involving illegal weapons possession or use. The offense most reported was possession of drugs with burglary reported second most frequently. The offense least reported was pimping/prostitution.

Table 8

Summary of reported substance abuse related crimes prior to treatment (N=27)

Type of Offense	Number	Percentage of people
Possession of drugs	10	37%
Sale of drugs	4	15%
Fraud	4	15%
Burglary	9	33%
Pick-pocketing	8	30%
Pimping/Prostitution	2	0.07%
Bank robbery/Mugging	7	26%
Homicide/Aggravated assault	7	26%
Simple assault	6	22%
Driving under the influence	5	19%
Parole violations	3	11%
Other	5	19%

Participants were asked if there was anything else in addition to the modules presented that they found helpful in their treatment and 18 people indicated that there were other factors which contributed. From these 18 respondents, 72 % (*n* = 13) indicated that the support and encouragement they received from the facilitators and other clients in the programme was beneficial. The remaining 28% (*n* = 5) indicated that establishing a spiritual connection was beneficial for them. Participants in the relapse group were also asked for reasons why they felt they had relapsed, and the four participants who responded indicated that problems which had not been dealt with and lack of family support contributed to their relapse.

Discussion

The results of the evaluation will be discussed according to the evaluation questions that were formulated. As this is the first evaluation that has been conducted on the FCRC treatment programme, its success and methods used will also be discussed against existing literature on treatment and compared to other treatment models.

Evaluation question 2.1 and 2.2: Do the FCRC substance abuse treatment modules lead to knowledge of detoxification and detoxification for the clients?

In response to these evaluation questions, participants indicated that they detoxified in the programme and that they were also informed about the process of the detoxification. Detoxification can be an aversive physiological experience with negative outcomes such as sweating, nausea and cravings which can lead to people avoiding further treatment. It is for this reason that it is important that an understanding of the withdrawal symptoms be emphasised (Franken & Hendricks, 1999). Participants in the evaluation agreed that they had not only detoxified in the programme, but they had been informed about the detoxification process. By doing this, the programme increased the likelihood that participants would stay for the remainder of the treatment. This component is effective in achieving this as all participants, including those in the relapse group completed the six week programme. Detoxification is the initial stage of any substance abuse treatment programme and although it is not effective in itself in ceasing substance abuse, it is referred to as the gateway for treatment (Franken & Hendricks, 1999; Gerstein & Lewin, 1990).

Evaluation question 2.3: Do the FCRC substance abuse treatment modules lead to a change in perceptions of substance abuse?

There was evidence from the evaluation that there was a change in the participants' perceptions of substance abuse avoidance. Before entering the treatment programme, participants in cohort one had low drug avoidance self-efficacy. There was a significant increase in their efficacy after they had completed the programme showing a change in perceptions

towards substance abuse, where they reported that they were able to avoid abusing substance. These perceptions are a possible predictor of maintaining abstinence as their responses were similar to those of the participants in the successful group, who reported that they are able to avoid substance abuse and have managed to do so. These were found to be significantly different from the relapse group who reported lower drug avoidance self-efficacy. Based on these findings, there appears to be an association between reported self-efficacy and abstinence from substance abuse.

Facilitating self-efficacy within a treatment programme equips clients to cease substance abuse (Witkiewitz & Marlatt, 2011). Self-efficacy has been defined as the extent to which individuals feel they can achieve certain objectives (Bandura, 1986). The relapse prevention training modules facilitate this concept.

As with the Alcoholics Anonymous (AA) model, there is a rationale that addictions stem from strong emotional experiences and addiction is used as a way of medicating these. Addicts are therefore likely to suffer rage and anger when they are not using substances (Knack, 2009). Anger management is an example of a relapse trigger module which is presented in the FCRC programme that shares similar concepts used in AA. Acronyms such as “HALT” (hungry, angry, lonely and tired) are used to help clients identify “trigger” emotions, and they are then trained in how to react in healthy ways in situations where they experience these emotions rather than engage in substance use.

The participants in the relapse group reported that they would not be able to avoid abusing substance in high emotion situations in spite of their relapse trigger training. This provides evidence that although it facilitates abstinence from substance abuse, it may not have been sufficient to achieve this objective for all clients. It may be helpful if more time and attention is paid to emotional triggers for substance misuse.

Evaluation question 2.4: Do the FCRC substance abuse treatment modules lead to knowledge about how to improve relationships?

One of the main characteristics of substance abuse is that the addiction leads to a difficulty in managing and tolerating behaviours and emotions (Knack, 2009). Furthermore, people abusing substances are believed to have been alienated from close relationships that once existed. This plays a role in maintaining substance abuse as is the substances provide an escape mechanism for clients with relationship problems (Knack, 2009). On average all participants in the evaluation agreed that they did learn about how to improve relationships and the results showed that the responses from the three groups were not significantly different. The relapse group therefore provided evidence that people can still relapse in spite of this knowledge. The possibility for this anomaly is discussed below.

As with Alcoholics Anonymous which treats alcohol addiction by the facilitation of treatment in a group setting, members have reported that fellowship with people who have similar experiences allows them to relate, reconnect and form relationships after having been withdrawn or having people withdraw from them (Knack, 2009). The participants in the programme reported the support and encouragement from other clients in treatment as being paramount to their treatment experience. When a supportive environment is created within treatment and it is dedicated towards behavioural improvement the experience and outcomes are likely to be positive (Broome, Simpson, & Joe, 2004).

This element is beneficial for the clients in treatment, however they return to the same environment which was associated with substance abuse before treatment. Although families are encouraged to attend parent support group meetings concurrently when the clients are away in treatment, perceptions of the family members and the clients could still be mis-aligned as they did not attend meetings together. This view is supported by some participants who had relapsed: although they reported to have learnt about how to improve relationships, they also reported that not receiving support from their families was a contributing reason for their relapse. Suggestions on how to deal with this element are detailed as part of the programme recommendations further on.

Evaluation question 2.5: Do the FCRC substance abuse treatment modules lead to a change in perceptions towards future prospects?

Results from participants in cohort one, displayed that participants had positive perceptions towards their future prospects before the programme and these did not significantly change after the programme. Participants in the successful and relapse groups displayed similar results of positive perceptions. This is plausible according to the transtheorectical model of change; when clients become aware of a problem that needs changing and they take active steps to achieve this, it is likely then they would have a positive outlook of both the outcomes and their future prospects. The programme would therefore be merely re-enforcing them.

Evaluation question 3.1: After the programme do participants cease substance abuse and 4.1: after completing aftercare, do participants maintain abstinence from substance abuse?

Cohort one, which was assessed both before and after the programme, revealed that all the clients ceased substance abuse after completing the programme. Although this is a good result, these participants were only interviewed once, a week after they had completed the programme. This provides evidence that the programme is effective in achieving substance use abstinence for some participants for at least a week. Being able to maintain abstinence is a better measure of the success of a programme.

Of the 20 participants who were interviewed to answer the evaluation question of maintenance of abstinence, more than half had achieved this objective. Substance abuse treatment programmes aim for abstinence from illicit drugs as the main goal of the programme however there are a number of other factors that play a role in achieving this objective (Simpson, 2004). As with the AA programme, there is an acknowledgement that with addictive behaviours, not everyone will be successful in the programme; the programme aims towards progressing people away from these behaviours and not perfecting them (Knack, 2009).

There is evidence from longitudinal studies which have been conducted in the United States and in other countries that have shown that substance abuse treatment is associated with at least a reduction in substance use and at the same time there is evidence that relapse leading

to readmission is very common. These studies report that, on average, people take 8 years and three or four episodes of treatment before they reach abstinence (Scott, Dennis, & Foss, 2005).

Different authors have different definitions of the term relapse – it can either be a brief period of substance use after treatment which does not necessarily result in negative consequences or it can be a situation where a person returns to substance abuse (Breslin, Zack, & McMain, 2002). The former definition is associated with higher rates compared to the latter definition (Breslin et al., 2002). Although the desired goal by the FCRC is to have all their clients abstain from illicit substances after completing their programme, research shows that it is not always possible to achieve this goal.

The results of this evaluation revealed that the FCRC does have some success in treating substance abuse and maintaining abstinence. Of the 20 participants who were interviewed, 55% had maintained sobriety for 3 months or more. However, 75 former clients could not be contacted or refused to be interviewed. If one assumes that all 75 of these have relapsed, this shows that FCRC has a success rate of 12%. We cannot know the exact relapse rate from this evaluation, because of this high percentage who refused to participate or who could not be found. What is clear is that FCRC can help some people, and those people were able to give us some indication of how the programme might be strengthened. Relapse rates from previous studies are approximated to range between 50% to 90% (Hunt et al., 1971).

Evaluation question 3.2: After the programme, do participants attend aftercare?

Due to the high relapse rate that is characteristic of substance abuse (Grella, Hser, & Hsieh, 2003) it is important that there be a system in place to follow up on the progress and provide support for clients who exit in-patient treatment (Simpson, 2004). The FCRC treatment programme utilises aftercare as a mechanism of support outside of treatment, but its effectiveness could not be evaluated because client records which were required to confirm attendance were not available. This evaluation question therefore could not be answered. This is a program attribute that needs to be managed as the environment that treatment occurs in is different from the environment that the clients return to upon treatment completion (Moos, 2003). They need support in being able to sustain the skills they have learnt whilst in the

programme, to be able to apply them in the outside environment where they are likely to encounter relapse triggers as is discussed as part of the recommendations.

Evaluation question 4.2: After completing aftercare, do participants abstain from illegal maladaptive behaviours?

In support of findings in previous studies, there seems to be an association with attending the FCRC treatment programme and ceasing criminal activities, as it is not only the clients who were in the successful group who abstained from illegal maladaptive behaviours, clients in the relapse category had ceased involvement in criminality as well. Behaviour of people who have gone through some form of substance abuse treatment is reported to be improved compared to people who need and do not seek any treatment (Gerstein & Lewis, 1990). There is evidence that the programme encourages abstinence from these anti-social behaviours and these are maintained even when clients relapse. Possession of drugs, which is the crime that had the highest number of people reporting involvement, is not the only one that decreased after substance abuse treatment - all other crimes that were assessed also decreased. The only participant who reported to have been involved in crime after the programme was charged with the crime of assault, and reported to have been under the influence of substance. These findings support those of previous research on the association of substance use and criminality.

Although research has shown that relapses are likely to happen after treatment, literature does also suggest factors which can make substance abuse treatment more effective to reduce the proportions of clients who do.

Increasing Substance Abuse Treatment Effectiveness

Effectiveness of treatment is not aligned to a certain type of treatment or orientation; both client and programme attributes contribute towards successful treatment. Important client attributes in this regard include the individual's motivation to change, readiness for treatment

and the severity of their substance abuse. Programme attributes which have been cited are the length of the treatment, the type of treatment provider and the structure of the treatment. Client attributes refer to the state of the patient as they begin or undertake treatment. These are attributes that need to be taken into consideration upon admitting individuals into treatment as they are predictors of treatment outcomes. Programme attributes refer to conditions that are ideal to foster positive treatment outcomes.

Client attributes.

The more motivated a person is to change their behaviour, the more likely they are to be successful in achieving this goal. Motivation to change as well as readiness for treatment are important client attributes which have been discussed as the FCRC assesses client levels of preparedness before they begin treatment. The only exception is for clients who have been forced into treatment by the magistrate, for whom treatment may need to be tailored to increase the likelihood of positive outcomes.

In contrast, an inverse relationship exists with a patient's severity of substance abuse and response to treatment (Haaga et al., 2006). Severe substance abuse is defined as frequent substance misuse over a long period of time (Boyle, Polinsky, & Hser, 2000). Clients' severity of substance abuse is related to such problems as frequency of use, type of drugs used and the client's risk environment (Scott et al., 2005). Clients with severe substance abuse levels may be suffering from severe medical conditions that make it difficult to envision beyond those circumstances (Haaga et al., 2006). Without a clear positive outlook due to irreversible damage, these patients may not be as driven to change as patients engaged in less severe substance abuse.

Programmes which specifically deal with clients who have severe substance abuse levels are believed to have a more difficult task at treatment making poor outcomes more likely (Simpson, 2004). A study conducted with cocaine patients showed that patients with severe abuse levels require more intensive care with longer term treatment (Simpson, 2004). Consideration has to be awarded to clients with more severe problems as they are likely to experience greater withdrawal symptoms as well as have a longer recovery path (Franken &

Hendricks, 1999; Scott et al., 2005). In the evaluation, there was no indication of an assessment of the severity of substance abuse of clients before they enter treatment. This is a factor that could account for variations in the treatment outcomes for the FCRC programme where some clients were successful yet others relapsed.

Programme attributes.

The type of treatment provider is a programme attribute which influences the effectiveness of the treatment. Specialists in addiction treatments are believed to yield more positive outcomes (Haaga et al., 2006). This is because they are better equipped and skilled to deal with specific issues pertaining with substance abuse. Linked to the type of treatment provider, is the therapeutic relationship that exists between the provider and the patient. As based on the concept birthed by Carl Rogers in 1959, the alliance formed in the therapeutic relationship is of importance. The treatment provider has to establish rapport with the patient reflecting genuineness and warmth, as the quality of this relationship determines the success of counselling (Simpson, 2004). Authors have expressed concern that counsellors or facilitators need to be trained in order to assist clients with addictive behaviours. A study conducted by McLellan, Woody, Luborsky, and Goehl (1988) which compared the efficacy of different counsellors, however, found that what was important was not the person's education or background, but the content and process they used. Being able to empathise with the clients in treatment is an advantage as a rapport is established and clients feel that the facilitators are being genuine.

As with the AA programme, the FCRC uses a similar behaviour modelling system. AA utilises sponsors in facilitating treatment, as does the FCRC treatment programme whose facilitators are all previous clients. These people are believed to be good role models as they have gone through the steps required and been successful in treatment and can therefore guide other clients on how to achieve the same (Knack, 2009). The facilitators in the FCRC treatment programme can become 'support buddies' for the clients when they complete treatment and can maintain personal contact with them should they feel distressed and in need of help. Monitoring of the facilitators can help increase the effectiveness of the programme as they are

not formally qualified, but are trained by the organisation to achieve the programme objectives.

The length of treatment is a programme attribute that has been discussed which the FCRC encompasses in the form of aftercare. Treatment also has to be structured to accommodate the progress that the clients make. The modules in the FCRC treatment programme build upon each other (C. Engel, personal communication, February 18, 2011) and have been structured sequentially such that one module needs to be completed before clients can engage in the next. This also helps in facilitating the theorised changes in behaviour which occur according to the transtheoretical model of behaviour change.

In a study by Broome and colleagues (1999) both patient and programme attributes were found to be important in determining treatment outcomes, however the client attributes were vital to fostering commitment to treatment. Client attributes are those elements that are necessary to set the foundation and prepare the patient for recovery. This commitment is what drives the client to successfully complete the programme with positive outcomes. Program attributes are still essential to setting the ideal environment and could have a negative effect on the client's attributes. As an example, without a good therapeutic alliance or a defined structure to a programme, clients' motivation to change can be reduced as they would lack goals and a vision to work towards. The implication is that these need to be present before programme attributes can take effect. The two can be seen to co-exist as without the other, one attribute would not be as effective in resulting in successful treatment. Programme staff and resources need to be well organised to be able to meet client needs.

Recommendations

Programme improvements.

As discussed, there are a number of factors, both client and programme attributes that mediate treatment outcomes. The ASSIST questionnaire is a tool that the FCRC could use to assess the nature of substance use of their clients prior to commencing treatment. This provides a more objective method of selection into the programme as opposed to relying solely on the

perception of a counsellor. Different levels of severity require different levels of treatment. From this assessment, treatment can either be tailored for individuals with more severe substance abuse if resources allow, or they can be referred to more equipped facilities.

Substantial time should be devoted to role-playing during the relapse prevention modules, so that clients can practice alternative behaviours in high-risk situations. Knowledge of how to change behaviour and having the self-efficacy to do so contribute towards behavior change, however it is also important that clients be equipped with the skills to be able to do so (Michie, Johnston, Francis, Hardeman, & Eccles, 2008).

For client monitoring purposes, different drug screening methods can be incorporated to assess whether the participants are indeed free of substance. Table 9 shows an illustration of the time periods in which different substances can be detected using different screening methods. The substances reported to have been more frequently used in the evaluation have been included. The time periods are dependent on the severity of use.

Table 9

Substance detection periods

Substance	**Urine**	**Hair**	**Blood/Oral**
Alcohol	6-24 hours	up to 2 days	12-24 hours
Amphetamines	1-5 days	up to 90 days	12 hours
Cannabis	2-30 days	up to 90 days	2-14 days
Heroin	1-4 days	up to 90 days	1-2 days

As clients from different geographical areas attend the FCRC treatment, not all of them can access support group meetings which are conducted at the premises as part of the aftercare treatment. Narcotics Anonymous (NA) meetings are a suitable alternative as they are located in various areas in Cape Town and the meetings are free of charge. Information regarding these

meetings can be given to clients whilst still on the six week programme as part of their module on the importance of support groups for maintaining abstinence.

Monitoring data in the programme is important. This data can provide information on the progress of the clients and can also address any factors that need to be improved for more positive outcomes. The lack of updated records on aftercare attendance prevented accurate assessment of client progress outside of the residential programme. It is recommended that more attention be given to ensuring that aftercare records are kept up to date, even for clients who attend aftercare meetings at other sites.

When clients complete the six week programme at the camp, it is recommended that they attend support group meetings together with family members who constitute their support system. The programme can strengthen its work with families, and strengthen work with the clients to help them cope with unsupportive and undermining families. As previously discussed, this increases the likelihood of the clients effectively utilising the knowledge and skills they would have been taught, about how to improve relationships.

The client and programme attributes which the FCRC treatment programme does not already incorporate can be taken into consideration in the implementation of their programme as they are reported to increase the likelihood of positive outcomes.

Future monitoring and evaluation.

A time series research design can be used as a monitoring or evaluation tool by the FCRC where they can observe the progress of their clients over time. This provides a more accurate measure of the outcomes. The sample size used in conducting evaluations can be limited by budget and time constraints, however it is recommended that the help of a statistician be sought to determine an appropriate sample size to increase the statistical power of the findings in subsequent evaluations.

Limitations

There are a number of limitations in the evaluation that affect how conclusive the results were. Firstly the sample used in the evaluation was a relatively small number compared to the population which has completed the programme. This reduces the statistical power of the findings and caution has to be exercised in making inferences from the findings. The larger the sample size, the better the conclusions that can be drawn pertaining to the effectiveness of the programme. (Leong & Austin, 2006).

The groups in the evaluation were also not comparable due to the lack of random assignment meaning other factors could have mediated the outcomes. There is also a possible bias in the participants who were selected in the evaluation, as contact was established with clients who were easier to contact because communication had been maintained. These participants are likely to have abstained from substance abuse and therefore may not be representative of all clients who have been through the programme.

Using a post-test only research design has the limitation of not knowing whether there are any pre-existing conditions in the participants that could have influenced the results.

All data collected and analysed in the evaluation is based on self-reports. When dealing with a sensitive issue such as substance abuse, social desirability is a possible form of bias that may affect the accuracy of the results.

The lack of data from participants who have dropped out of the FCRC treatment programme is another limitation to the evaluation. Based on the views provided by this group of people, factors attributable to the programme that hinder treatment outcomes could have been identified. This group could have also been used as a comparison to those who have successfully completed treatment.

Evaluation Contribution

The evaluation was conducted to look for evidence that the grassroots community intervention run by the FCRC is effective in achieving its intended outcomes. From the programme theory,

the elements that held true in the expected outcomes where identified. As there is a difficulty in accessing treatment for some socio-economic groups in Cape Town, community interventions that are put in place need to be monitored and assessed to establish whether they are effective in treating substance abuse. This evaluation added value to understanding the effectiveness of this and similar community interventions which have had little exposure to evaluation and has set ground work upon which future evaluations of this nature can build on. Suggestions on elements to incorporate in future evaluations were also presented to compensate for the shortcomings of this evaluation.

Conclusion

Community based interventions are a good resource for providing alternate treatment methods for people in need of substance abuse treatment from disadvantaged communities. This evaluation has provided evidence that interventions of this nature do result in positive outcomes towards treating substance abuse and reducing illegal maladaptive behaviours which not only creates safer social environments, but can also reduce strain on the justice system. Although the programme theory of the FCRC treatment programme did not hold in its entirety as there were clients who relapsed to substance abuse, there are improvements which can be made to ensure progress towards the attainment of these objectives. Both the formative and outcome evaluation have demonstrated the challenges involved in treating substance abuse. This evaluation has contributed towards answering some questions on the effectiveness of community based interventions, but it has also raised further considerations that need to be investigated in future large scale evaluations.

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Appendix A

Consent to participate in a research study

Dear respondent

I am studying towards a Masters degree in Programme Evaluation. For my dissertation and with the assistance and support from Craven Engel from the FCRC, I am evaluating the FCRC's substance abuse treatment programme. You are invited to take part in the evaluation. Your input is valued and will benefit the FCRC to determine if the treatment is effective and whether any changes need to be made to the programme. The interview process will not take longer than 15 minutes to complete.

The interview will assess:

- Your pattern of substance abuse
- Your experience in treatment
- Any substance abuse related crime involvement

The data collected will help to identify how much the treatment has benefitted those who have been through the programme and also identify any changes that might need to be made to the programme. Please answer all questions as accurately and honestly as you can.

Please sign below to show that you have provided your consent to participate in this research

Signature…… **Date**……

APPENDIX B: PRE-TEST QUESTIONNAIRE

Interviewee I.D.....

Gender..... **Age.....**

SECTION A

Introduction*(Please read to patient)*

Thank you for agreeing to take part in this brief interview about alcohol, tobacco products and other drugs. I am going to ask you some questions about your experience of using these substances across your lifetime and in the past six weeks. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills (show drug card). Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

Question 1

In your life, which of the following substances have you ever used? ***(NON-MEDICAL USE ONLY)***	No	Yes
a. Alcoholic beverages (beer, wine, spirits, etc.)		
b. Cannabis (marijuana, pot, grass, hash, etc.)		
c. Cocaine (coke, crack, etc.)		
d. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)		
e. Inhalants (nitrous, glue, petrol, paint thinner, etc.)		
f. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)		
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)		

h. Opioids (heroin, morphine, methadone, codeine, etc.)		
i. Mandrax (methaqualone)		
j. Other - specify:		

Question 2

In the past six weeks, how often have you used the substances you mentioned *(FIRST DRUG,SECOND DRUG, ETC)*?	Never	Once or twice	Monthly	Weekly	Daily or almost daily
a. Alcoholic beverages (beer, wine, spirits, etc.)					
b. Cannabis (marijuana, pot, grass, hash, etc.)					
c. Cocaine (coke, crack, etc.)					
d. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)					
e. Inhalants (nitrous, glue, petrol, paint thinner, etc.)					
f. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)					
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)					
h. Opioids (heroin, morphine, methadone, codeine, etc.)					
i. Mandrax (methaqualone)					
j. Other - specify:					

Question 3

During the past six weeks, how often have you had a strong desire or urge to use *(FIRST DRUG, SECONDDRUG, ETC)*?	Never	Once or twice	Monthly	Weekly	Daily or almost daily
a. Alcoholic beverages (beer, wine, spirits, etc.)					
b. Cannabis (marijuana, pot, grass, hash, etc.)					
c. Cocaine (coke, crack, etc.)					
d. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)					
e. Inhalants (nitrous, glue, petrol, paint thinner, etc.)					
f. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)					

g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)					
h. Opioids (heroin, morphine, methadone, codeine, etc.)					
i. Mandrax (methaqualone)					
j. Other - specify:					

Question 4

During the past six weeks, how often has your use of *(FIRST DRUG, SECOND DRUG, ETC*) led to health, social, legal or financial problems?	Never	Once or twice	Monthly	Weekly	Daily or almost daily
a. Alcoholic beverages (beer, wine, spirits, etc.)					
b. Cannabis (marijuana, pot, grass, hash, etc.)					
c. Cocaine (coke, crack, etc.)					
d. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)					
e. Inhalants (nitrous, glue, petrol, paint thinner, etc.)					
f. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)					
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)					
h. Opioids (heroin, morphine, methadone, codeine, etc.)					
i. Mandrax (methaqualone)					
j. Other - specify:					

Question 5

During the past six weeks, how often have you failed to do what was normally expected of you because of your use of *(FIRST DRUG, SECOND DRUG, ETC*)?	Never	Once or twice	Monthly	Weekly	Daily or almost daily
a. Alcoholic beverages (beer, wine, spirits, etc.)					
b. Cannabis (marijuana, pot, grass, hash, etc.)					
c. Cocaine (coke, crack, etc.)					
d. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)					

e. Inhalants (nitrous, glue, petrol, paint thinner, etc.)					
f. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)					
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)					
h. Opioids (heroin, morphine, methadone, codeine, etc.)					
i. Mandrax (methaqualone)					
j. Other - specify:					

Question 6

Has a friend or relative or anyone else ever expressed concern about your use of *(FIRST DRUG, SECOND DRUG, ETC.)?*	No, never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Alcoholic beverages (beer, wine, spirits, etc.)			
b. Cannabis (marijuana, pot, grass, hash, etc.)			
c. Cocaine (coke, crack, etc.)			
d. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)			
e. Inhalants (nitrous, glue, petrol, paint thinner, etc.)			
f. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)			
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)			
h. Opioids (heroin, morphine, methadone, codeine, etc.)			
i. Mandrax (methaqualone)			
j. Other - specify:			

Question 7

Have you ever tried and failed to control, cut down or stop using *(FIRST DRUG, SECOND DRUG, ETC.)?*	No, never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Alcoholic beverages (beer, wine, spirits, etc.)			
b. Cannabis (marijuana, pot, grass, hash, etc.)			
c. Cocaine (coke, crack, etc.)			
d. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)			

e. Inhalants (nitrous, glue, petrol, paint thinner, etc.)			
f. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)			
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)			
h. Opioids (heroin, morphine, methadone, codeine, etc.)			
i. Mandrax (methaqualone)			
j. Other - specify:			

Question 8

Have you ever used any drug by injection? (**non-medical use only**)	YES	NO

SECTION B

Question 9

NOW, I'd like to ask about your involvement with the police, courts, and illegal activities. Let me remind you that this information will remain confidential.

A. In the 12 months before admission to this program, how many times were you arrested **or** sent to juvenile court regardless of the charge?

[ ] Times

B. Were you high or under the influence of drugs or alcohol at a time when you did things that led to your arrest or being sent to juvenile court?

YES	NO

C. In the 12 months before admission, did you have any police or legal problems because of using drugs or alcohol?

YES	NO

D. If you answered **YES** above, please respond to the chart history below:

Offense Chart History

Type of offense	Have you been involved in any of these offences before enrolling into the programme?	
Use or possession of marijuana, drugs, liquor law violation, drunk and disorderly	YES	NO
Sale or manufacture of drugs	YES	NO
Forgery, fraud, embezzlement (including till-tapping, bad checks); buying, receiving, or possession of stolen property (including fencing	YES	NO
Burglary-breaking and entering, unlawful entry, housebreaking, or safecracking	YES	NO
Larceny-theft such as pickpocketing, purse snatching (without force), shoplifting, theft from motor vehicles, theft of parts and accessories, theft from buildings or coin machines	YES	NO
Pimping, prostitution, or commercialised vice	YES	NO
Robbery-bank, mugging, armed robbery, or purse snatching with force	YES	NO
Attacks on persons such as homicides, manslaughter, aggravated assault, forcible rape, or kidnapping	YES	NO
Other offenses where people may be injured such as simple assault or offenses against family and children	YES	NO
Driving under the influence or driving while intoxicated	YES	NO
Statusoffenses such as running away, curfew violations, truancy, etc	YES	NO

Any other offenses such as gambling (including numbers and bookmaking), weapons offenses, probation parole violations, contempt of court, vagrancy, suspicion, disorderly conduct**,** or loitering, etc. **(SPECIFY)**_____	YES	NO

APPENDIX C: POST-TEST QUESTIONNAIRE

Interviewee I.D.....

Gender..... **Age.....**

Question 1

In your life, which of the following substances have you ever used? ***(NON-MEDICAL USE ONLY)***	No	Yes
a. Alcoholic beverages (beer, wine, spirits, etc.)		
b. Cannabis (marijuana, pot, grass, hash, etc.)		
c. Cocaine (coke, crack, etc.)		
d. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)		
e. Inhalants (nitrous, glue, petrol, paint thinner, etc.)		
f. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)		
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)		
h. Opioids (heroin, morphine, methadone, codeine, etc.)		
i. Mandrax (methaqualone)		
j. Other - specify:		

Question 2

In the past six weeks, how often have you used the substances you mentioned *(FIRST DRUG,SECOND DRUG, ETC)*?	Never	Once or twice	Monthly	Weekly	Daily or almost daily
a. Alcoholic beverages (beer, wine, spirits, etc.)					
b. Cannabis (marijuana, pot, grass, hash, etc.)					
c. Cocaine (coke, crack, etc.)					
d. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)					
e. Inhalants (nitrous, glue, petrol, paint thinner, etc.)					
f. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)					
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)					
h. Opioids (heroin, morphine, methadone, codeine, etc.)					
i. Mandrax (methaqualone)					
j. Other - specify:					

Question 3

During the past six weeks, how often have you had a strong desire or urge to use *(FIRST DRUG, SECONDDRUG, ETC)*?	Never	Once or twice	Monthly	Weekly	Daily or almost daily
a. Alcoholic beverages (beer, wine, spirits, etc.)					
b. Cannabis (marijuana, pot, grass, hash, etc.)					
c. Cocaine (coke, crack, etc.)					
d. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)					
e. Inhalants (nitrous, glue, petrol, paint thinner, etc.)					
f. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)					
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)					
h. Opioids (heroin, morphine, methadone, codeine, etc.)					
i. Mandrax (methaqualone)					
j. Other - specify:					

Question 4

During the past six weeks, how often has your use of *(FIRST DRUG, SECOND DRUG, ETC*) led to health, social, legal or financial problems?	Never	Once or twice	Monthly	Weekly	Daily or almost daily
a. Alcoholic beverages (beer, wine, spirits, etc.)					
b. Cannabis (marijuana, pot, grass, hash, etc.)					
c. Cocaine (coke, crack, etc.)					
d. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)					
e. Inhalants (nitrous, glue, petrol, paint thinner, etc.)					
f. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)					
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)					
h. Opioids (heroin, morphine, methadone, codeine, etc.)					
i. Mandrax (methaqualone)					
j. Other - specify:					

Question 5

During the past six weeks, how often have you failed to do what was normally expected of you because of your use of *(FIRST DRUG, SECOND DRUG, ETC*)?	Never	Once or twice	Monthly	Weekly	Daily or almost daily
a. Alcoholic beverages (beer, wine, spirits, etc.)					
b. Cannabis (marijuana, pot, grass, hash, etc.)					
c. Cocaine (coke, crack, etc.)					
d. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)					
e. Inhalants (nitrous, glue, petrol, paint thinner, etc.)					
f. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)					
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)					
h. Opioids (heroin, morphine, methadone, codeine, etc.)					
i. Mandrax (methaqualone)					

j. Other - specify:					

Question 6

Has a friend or relative or anyone else ever expressed concern about your use of *(FIRST DRUG, SECOND DRUG, ETC.)?*	No, never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Alcoholic beverages (beer, wine, spirits, etc.)			
b. Cannabis (marijuana, pot, grass, hash, etc.)			
c. Cocaine (coke, crack, etc.)			
d. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)			
e. Inhalants (nitrous, glue, petrol, paint thinner, etc.)			
f. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)			
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)			
h. Opioids (heroin, morphine, methadone, codeine, etc.)			
i. Mandrax (methaqualone)			
j. Other - specify:			

Question 7

Have you ever tried and failed to control, cut down or stop using *(FIRST DRUG, SECOND DRUG, ETC.)?*	No, never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Alcoholic beverages (beer, wine, spirits, etc.)			
b. Cannabis (marijuana, pot, grass, hash, etc.)			
c. Cocaine (coke, crack, etc.)			
d. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)			
e. Inhalants (nitrous, glue, petrol, paint thinner, etc.)			
f. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)			
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)			
h. Opioids (heroin, morphine, methadone, codeine, etc.)			
i. Mandrax (methaqualone)			

j. Other - specify:			

Question 8

Have you ever used any drug by injection? (**non-medical use only**)	YES	NO

INSTRUCTIONS

We would like to know what you received from treatment, from your own viewpoint. Many possibilities are listed. For each one, please indicate how much you actually received this as of your treatment here. You can do this by selecting one number (1, 2, 3 or 4) for each item. This is what the numbers mean:

Example:

I received detoxification.

1 Strongly Disagree	2 Disagree	3 Agree	4 Strongly Agree

The fact that you received help does not necessarily mean that your treatment was successful. We would like to know, on this questionnaire, what kind of help you got in treatment, whether or not it worked.

Section 1: Addictive behaviours

Did you get this from treatment?	**1 Strongly disagree**	**2 Disagree**	**3 Agree**	**4 Strongly agree**
1. I received detoxification, to ease my withdrawal from	1	2	3	4

alcohol or other drugs.				
2. I received help in understanding the detoxification process.	1	2	3	4
3. I was given help to decrease my use of drugs (including alcohol)	1	2	3	4
4. I was given help to stop using drugs (including alcohol).	1	2	3	4
5. I learned more about alcohol/drug problems.	1	2	3	4
6. I learned some skills to keep from returning to alcohol/ drugs	1	2	3	4

Section 2: Other concerns

Did you get this from treatment?	**1 Strongly disagree**	**2 Disagree**	**3 Agree**	**4 Strongly agree**
7. I got help with angry feelings and how to express them.	1	2	3	4
8. I was given help to have healthier relationships.	1	2	3	4
9. I was shown how to express my feelings in a more healthy way.	1	2	3	4
10. I got help with problems in my marriage or close	1	2	3	4

relationship.				
11. I got help in setting goals and priorities in my life.	1	2	3	4
12. I received help in getting motivated to change.	1	2	3	4

Section 3: Drug avoidance self-efficacy

	1 Certainly No	**2 Probably No**	**3 Really can't say**	**4 Probably Yes**	**5 Certainly Yes**
1. Imagine that you are going to a party where you will meet new people. You feel that drug/alcohol use will relax you and make you more confident. Could you avoid drug/alcohol use?	1	2	3	4	5
2. Imagine that you have just blown a good job, you are home alone and depressed. Would you resist the urge to take drugs/alcohol that are in the house	1	2	3	4	5
3. Imagine that you are home with a loved one, and feeling angry after a fight. You want to make up, but at the same time you want to get stoned/loaded. Could you resist the urge to take drugs/alcohol?	1	2	3	4	5
4. Imagine it is late, you cannot sleep and drugs/alcohol are available in the house. You have decided not to use drugs. Could you resist the urge to use drugs to help you get to sleep?	1	2	3	4	5
5. Imagine that a new job is starting tomorrow, you are going out with friends and expecting a	1	2	3	4	5

good time. Could you resist the urge to celebrate with drugs/alcohol?					
6. Imagine that you are home with your loved one and very angry after a fight. You are tempted to get back at your partner by getting stoned/loaded. Would you resist the temptation?	1	2	3	4	5

Section 4: How you see your future

What are the chances that:

	Very Low 1	Low 2	High 3	Very High 4
a. You will have a job that pays well?	1	2	3	4
b. You will have a happy family life?	1	2	3	4
c. You will stay in good health most of the time?	1	2	3	4
d. You will find a job you will enjoy?	1	2	3	4
e. You will succeed in doing what is most important for you?	1	2	3	4

THANK YOU FOR YOUR HELP!

Is there anything else that you would like to say about what you got or did not get from treatment?

APPENDIX D: PREVIOUS CLIENTS QUESTIONNAIRE

Interviewee I.D.....

Gender..... **Age.....**

SECTION A

Introduction *(Please read to patient)*

Thank you for agreeing to take part in this brief interview about alcohol, tobacco products and other drugs. I am going to ask you some questions about your experience of using these substances across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills (show drug card). Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

Question 1

How long has it been since you completed the programme?

Question 2

In your life, which of the following substances have you ever used? ***(NON-MEDICAL USE ONLY)***	No	Yes
a. Alcoholic beverages (beer, wine, spirits, etc.)		
b. Cannabis (marijuana, pot, grass, hash, etc.)		
c. Cocaine (coke, crack, etc.)		
d. Amphetamine type stimulants (speed,		

diet pills, ecstasy, etc.)		
e. Inhalants (nitrous, glue, petrol, paint thinner, etc.)		
f. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)		
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)		
h. Opioids (heroin, morphine, methadone, codeine, etc.)		
i. Mandrax (methaqualone)		
j. Other - specify:		

Question 3

In the past three months, how often have you used the substances you mentioned *(FIRST DRUG,SECOND DRUG, ETC)*?	Never	Once or twice	Monthly	Weekly	Daily or almost daily
a. Alcoholic beverages (beer, wine, spirits, etc.)					
b. Cannabis (marijuana, pot, grass, hash, etc.)					
c. Cocaine (coke, crack, etc.)					
d. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)					
e. Inhalants (nitrous, glue, petrol, paint thinner, etc.)					
f. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)					
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)					
h. Opioids (heroin, morphine, methadone, codeine, etc.)					
i. Mandrax (methaqualone)					
j. Other - specify:					

Question 4

During the past three months, how often have you had a strong desire or urge to use *(FIRST DRUG, SECONDDRUG, ETC)*?	Never	Once or twice	Monthly	Weekly	Daily or almost daily
a. Alcoholic beverages (beer, wine, spirits, etc.)					
b. Cannabis (marijuana, pot, grass, hash, etc.)					
c. Cocaine (coke, crack, etc.)					

d. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)					
e. Inhalants (nitrous, glue, petrol, paint thinner, etc.)					
f. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)					
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)					
h. Opioids (heroin, morphine, methadone, codeine, etc.)					
i. Mandrax (methaqualone)					
j. Other - specify:					

Question 5

During the past three months, how often has your use of *(FIRST DRUG, SECOND DRUG, ETC*) led to health, social, legal or financial problems?	Never	Once or twice	Monthly	Weekly	Daily or almost daily
a. Alcoholic beverages (beer, wine, spirits, etc.)					
b. Cannabis (marijuana, pot, grass, hash, etc.)					
c. Cocaine (coke, crack, etc.)					
d. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)					
e. Inhalants (nitrous, glue, petrol, paint thinner, etc.)					
f. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)					
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)					
h. Opioids (heroin, morphine, methadone, codeine, etc.)					
i. Mandrax (methaqualone)					
j. Other - specify:					

Question 6

During the past three months, how often have you failed to do what was normally expected of you because of your use of *(FIRST DRUG, SECOND DRUG, ETC*)?	Never	Once or twice	Monthly	Weekly	Daily or almost daily

a. Alcoholic beverages (beer, wine, spirits, etc.)					
b. Cannabis (marijuana, pot, grass, hash, etc.)					
c. Cocaine (coke, crack, etc.)					
d. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)					
e. Inhalants (nitrous, glue, petrol, paint thinner, etc.)					
f. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)					
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)					
h. Opioids (heroin, morphine, methadone, codeine, etc.)					
i. Mandrax (methaqualone)					
j. Other - specify:					

Question 7

Has a friend or relative or anyone else ever expressed concern about your use of *(FIRST DRUG, SECOND DRUG, ETC.)?*	No, never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Alcoholic beverages (beer, wine, spirits, etc.)			
b. Cannabis (marijuana, pot, grass, hash, etc.)			
c. Cocaine (coke, crack, etc.)			
d. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)			
e. Inhalants (nitrous, glue, petrol, paint thinner, etc.)			
f. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)			
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)			
h. Opioids (heroin, morphine, methadone, codeine, etc.)			
i. Mandrax (methaqualone)			
j. Other - specify:			

Question 8

Have you ever tried and failed to control, cut down or stop using *(FIRST DRUG, SECOND DRUG, ETC.)?*	No, never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Alcoholic beverages (beer, wine, spirits, etc.)			
b. Cannabis (marijuana, pot, grass, hash, etc.)			
c. Cocaine (coke, crack, etc.)			
d. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)			
e. Inhalants (nitrous, glue, petrol, paint thinner, etc.)			
f. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)			
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)			
h. Opioids (heroin, morphine, methadone, codeine, etc.)			
i. Mandrax (methaqualone)			
j. Other - specify:			

Question 9

Have you ever used any drug by injection? (**non-medical use only**)	YES	NO

SECTION B

Instructions

I would like to know what you received from treatment, from your own viewpoint. Many possibilities are listed. For each one, please indicate how much you actually received this as of your treatment here. This is what the numbers mean:

Example:

I received detoxification.

1 Strongly Disagree	2 Disagree	3 Agree	4 Strongly Agree

The fact that you received help does not necessarily mean that your treatment was successful. I would like to know, on this questionnaire, what kind of help you got in treatment, whether or not it worked.

Part 1: Addictive behaviours

Did you get this from treatment?	1 Strongly disagree	2 Disagree	3 Agree	4 Strongly agree
1. I received detoxification, to ease my withdrawal from alcohol or other drugs.	1	2	3	4
2. I received help in understanding the detoxification process.	1	2	3	4
3. I was given help to decrease my use of drugs (including alcohol)	1	2	3	4
4. I was given help to stop using drugs (including alcohol).	1	2	3	4
5. I learned more about alcohol/drug problems.	1	2	3	4
6. I learned some skills to keep from returning to alcohol/ drugs	1	2	3	4

Part 2: Other concerns

Did you get this from treatment?	1 Strongly disagree	2 Disagree	3 Agree	4 Strongly agree
7. I got help with angry feelings and how I express them.	1	2	3	4
8. I was given help to have healthier relationships.	1	2	3	4
9. I was shown how to express my feelings in a more healthy way.	1	2	3	4
10. I got help with problems in my marriage or close relationship.	1	2	3	4
11. I got help in setting goals and priorities in my life.	1	2	3	4
12. I received help in getting motivated to change.	1	2	3	4

Part 3 : Drug avoidance self-efficacy

	1 Certainly No	2 Probably No	3 Really can't say	4 Probably Yes	5 Certainly Yes
1. Imagine that you are going to a party where you will meet new people. You feel that drug/alcohol use will relax you and make you more confident. Could you avoid drug/alcohol use?	1	2	3	4	5

2.Imagine that you have just blown a good job, you are home alone and depressed. Would resist the urge to take drugs/alcohol that are in the house?	1	2	3	4	5
3.Imagine that you are home with a loved one, and feeling angry after a fight. You want to make up, but at the same time you want to get stoned/loaded. Could you resist the urge to take drugs/alcohol?	1	2	3	4	5
4. Imagine it is late, you cannot sleep and drugs/alcohol are available in the house. You have decided not to use drugs. Could you resist the urge to use drugs to help you get to sleep?	1	2	3	4	5
5.Imagine that a new job is starting tomorrow, you are going out with friends and expecting a good time. Could you resist the urge to celebrate with drugs/alcohol?	1	2	3	4	5
6. Imagine that you are home with your loved one and very angry after a fight. You are tempted to get back at your partner by getting stoned/loaded. Would you resist the temptation?	1	2	3	4	5

Part 4: How you see your future

What are the chances that:

	Very Low 1	**Low 2**	**High 3**	**Very High 4**
f. You will have a job that pays well?	1	2	3	4
g. You will have a happy family life?	1	2	3	4

h. You will stay in good health most of the time?	1	2	3	4
i. You will find a job you will enjoy?	1	2	3	4
j. You will succeed in doing what is most important for you?	1	2	3	4

Is there anything else that you would like to say about what you got or did not get from treatment?

_____

_____

_____

_____

_____

SECTION C

Question 10

NOW, I'd like to ask about your involvement with the police, courts, and illegal activities. Let me remind you that this information will remain confidential.

A. Since you completed this programme, have you been arrested **or** sent to juvenile court regardless of the charge?

YES	NO

B. Were you high or under the influence of drugs or alcohol at a time when you did things that led to your arrest or being sent to juvenile court?

YES	NO

C. Since completing the programme, have you had any police or legal problems because of using drugs or alcohol?

YES	NO

D. Please indicate which crimes (if any) you have been involved in, in the past:

Offense Chart History

Type of offense	Have you been involved in any of these offences before enrolling into the programme?	
Use or possession of marijuana, drugs, liquor law violation, drunk and disorderly	YES	NO
Sale or manufacture of drugs	YES	NO
Forgery, fraud, embezzlement (including till-tapping, bad checks); buying, receiving, or possession of stolen property (including fencing	YES	NO
Burglary-breaking and entering, unlawful entry, housebreaking, or safecracking	YES	NO
Larceny-theft such as pickpocketing, purse snatching (without force), shoplifting, theft from motor vehicles, theft of parts and accessories, theft from buildings or coin machines	YES	NO
Pimping, prostitution, or commercialised vice	YES	NO
Robbery-bank, mugging, armed robbery, or purse snatching with force	YES	NO
Attacks on persons such as homicides, manslaughter, aggravated assault, forcible rape, or kidnapping	YES	NO
Other offenses where people may be injured such as simple assault or offenses against family and children	YES	NO
Driving under the influence or driving while intoxicated	YES	NO
Status offenses such as running away, curfew violations, truancy, etc	YES	NO

Any other offenses such as gambling (including numbers and bookmaking), weapons offenses, probation parole violations, contempt of court, vagrancy, suspicion, disorderly conduct**,** or loitering, etc. **(SPECIFY)**_____	YES	NO