

JP24, V44-2
NATIONAL
DOCUMENTATION
CENTRE ON DRUG USE

2823

AISLINN ADOLESCENT ADDICTION
TREATMENT CENTRE

EVALUATION REPORT

REGIONAL DRUG

8 * SEP 2002

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AUGUST 2002

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ADULT ADDICTION
TREATMENT CENTRE
EVALUATION REPORT

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AUGUST 2002

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Acknowledgements

Studies of this nature can only be made possible through the dedication and commitment of many individuals. To preserve the anonymity of the young people and families who were involved in the study, individuals who participated in the research have to remain nameless. However, we would like to express our gratitude to all who took part in the study, in particular the young people and families who were undergoing treatment at Aislinn Adolescent Addiction Treatment Centre, during the time of the fieldwork. Without their support and contributions, this research would not have been possible.

We are particularly indebted to the Director and all the staff at Aislinn Adolescent Addiction Treatment Centre for their commitment to this evaluation, and for their complete cooperation throughout the course of the research.

We would like to thank Willie Collins (SHB) Declan Roche (SHB) Tony Barden (SEHB) Tony Whelan (SEHB) and the following members of the Aislinn Management Committee, John McDermot, and Cyril ? for giving of their time.

We hope that the study findings are a fair and accurate reflection of the accounts and experiences of the young people who have participated in the Aislinn Adolescent Addiction Treatment Centre.

E-xecutive Summary⁷

THE STUDY

- The Aislinn Adolescent Addiction Treatment Centre is the only dedicated residential drug free centre for male and female adolescents between the ages of 15 and 21 years in the country. This document reports on the evaluation of Aislinn. The primary aims of the report is to fully define the therapeutic processes involved in the Aislinn Adolescent Addiction Treatment Centre and to examine the effectiveness of the programme in achieving its aims and objectives. Young peoples understanding of the programme and their subjective experiences of progressing through residential treatment and aftercare are integral components of the evaluation.
- In presenting this document we are however mindful that while the health boards have commissioned this report with specific reference to an evaluation of the Aislinn Adolescent Addiction Treatment the interests of the health boards in terms of how Aislinn fits into its existing and prospective services must also be taken into account.

METHODOLOGY

- " Traditionally, evaluation studies have been based on treatment outcomes, where clients are assessed at intake and at one or more follow-up period. Such evaluations pay little attention to the process of treatment, failing to account for client involvement in different aspects of treatment, the quality of treatment provided, and the amount of support provided to clients. Thus a qualitative methodology was employed in this study to provide descriptive accounts of individual perspectives of the programme and the perceived effectiveness of the programme. Rather than relying solely on aggregated summary measure of outcomes, the study focuses on the processes of change during the period of contact. However, ultimately the chosen methods reflect the information needs of the evaluation audience. For this reason quantitative methods were incorporated into the study, in the form of client records analysis and two short surveys.
- At the outset four key stakeholders were identified; the young programme participants, the participant's parents/guardians, the service providers, and health board representatives. Interviews were carried out with a sample of stakeholders from each group regarding their experiences of the programme. To this end 13 young people who were residence in Aislinn at the time of non-participant observation were interviewed and 9 of these young people completed a follow-up interview approximately three months later. In addition, five young people who were in the post treatment aftercare programme were interviewed. In-dept interviews were also conducted with a sample of parents/guardians (n=7) who were participating in the programme at die time of the fieldwork. All Aislinn staff that work directly with clients were interviewed (n=?), as were two members of the Board of Managers. Finally three representatives of the health boards were interviewed. The retrospective experience of programme participants and their parents/guardians were examined by short postal questionnaires.

ADOLESCENT SUBSTANCE USE AND MISUSE

- Adolescent substance misuse differs from adult misuse in many ways. Their drug and alcohol consumption often stems from different causes, and they frequently have multiple and complex difficulties such as depression, poor school attendance, delinquency, current or past histories of abuse and family dysfunction. In treatment, adolescents must be approached differendy then adults because of their unique developmental issues, differences in values and belief systems, and environmental considerations, such as strong peer influences.
- Available Irish data illustrates that tobacco and alcohol are die most widely used drugs. Cannabis is the most commonly used illicit drug, with lifetime prevalence rates ranging from 37% (ESPAD) to 21.7% (National Health and Lifestyle Survey). This is followed by amphetamine and XTC.

- Little is known about the pattern of adolescent substance misuse in Ireland. Research indicates that poly substance use is the norm among many young substance misusers.
- There are few programmes dedicated to the treatment of adolescent substance misusers. A review of the literature illustrates that there is some evidence to suggest that the Minnesota Model and other Twelve-step approaches are successful for adults, however far less is known about their effectiveness for adolescents. Some studies have shown favourable outcomes, however research has been hampered by methodological limitations, and little is known about the processes that govern change among those who derive benefit from Twelve-step treatment

THE AISLINN PROGRAMME

- Aislinn is a subsidiary of Aiseiri, which operates three residential treatment centres in Ireland (including Aisiinn) according to the Minnesota Model, characterised by the use of the Twelve-step philosophy of AA as a foundation of therapeutic change. Aislinn offers a six-week residential programme with two years of aftercare.
- The idea for setting up Aislinn was first proposed in 1994 by an Aiseiri staff member, now Director of Aislinn, who was concerned that there was no similar facility for young people. A study trip to the US confirmed to her the application of the Minnesota Model to young people.
- There are four key tenets to the Minnesota Model's philosophy (Cook, 1988) and consequently to Aislinn. The first is the belief that a substance-dependent individual can modify and change his/her beliefs, attitudes and behaviour. Second, the goals of treatment include abstinence from all mood-altering chemicals and a general improvement in lifestyle. The need for abstinence is rooted in the notion of 'chemical dependency', that is that individuals who are dependent on one particular drug or class of drugs should abstain from all substance, or they are likely to transfer their addiction to another substance. Thirdly, the approach supports the disease concept of substance dependency, characterised by loss of control over use, coupled with the belief that drug dependency is a chronic and progressive condition. Finally, the following components are integral to all Minnesota Model Programmes including Aislinn (1) group therapy; (2) didactic lectures; (3) use of recovering addicts as primary counsellors; (4) use of a multidimensional staff; (5) a therapeutic milieu; (6) family counselling; (7) AA (or when appropriate NA) attendance; (8) daily reading for the AA 'Big Book'; (9) sharing of one's life history, (10) working the first five steps of AA and; (11) recreational and physical activity.
- ^a In recognition of the fact that the needs of adolescent substance misusers differ to adults, Aislinn Addiction Treatment Centre developed its own way of delivering the programme, which is adolescent friendly and includes recreational and creative components. The programme is highly ordered, and daily routine is focused on structured one-to-one, group therapy, group information sessions on the programmes overall philosophy, and step work.
- Family involvement is a crucial component of the programme. From the outset families are part of the screening and intake process. Family members are then required to attend the family programme, each Wednesday from 10am to 5pm, for the six weeks of residential treatment, and to make a social visit on Sunday afternoons. The family day consists of family conference, joint group sessions, step work, and education sessions.
- The importance of aftercare is emphasised to help the young people to sustain a changed lifestyle and adapt to family, school, work, and community following the six-week period of intensive residential treatment. Thus, attendance at meetings provided by Aislinn in four locations and NA/NN is considered an essential component of the programme.

POPULATION PROFILE

- From October 1998 to August 2001 a total of 264 clients presented at and were accepted into Aislinn. Twenty eight percent of the population were female and the remaining 72% were male.

The average age of clients at the time of entering treatment was 17.6 years (range 15-21 years). There was no significant gender difference in the age of programme participants, but females were slightly more likely than males to be in the younger age categories. The majority (69%) reported living with their families prior to entering treatment.

- Over half the population (56%) were unemployed immediately prior to treatment, 17% were in employment and only 13% were in school. The average age at which the clients left school was 15.5 years. Of those that left school (n=229) 39% left with no qualifications, 44% had completed the Junior Cert and only 17% had completed the Leaving Cert.
- All programme participants had tried alcohol. Over half the client group (52%) reported drinking in the week prior to entering treatment. However, only 17% of the population reported that alcohol was their only substance of misuse; the remaining programme participants were poly drug users, consuming a range of substances. Cannabis was the most frequently reported substance — 91% of the population reported its use, and 69% reported cannabis as their primary drug. Over three quarters of the population reported the use of XTC (77%) and 50% reported the use of amphetamine, with 7% and 2% respectively reporting use as a primary drug. Patterns of consumption varied by drug type, as for example, cannabis and alcohol consumption were proportionately more likely to occur on a daily basis. Conversely, XTC and amphetamine use was proportionately more likely to occur at weekends.
- Almost three quarters of the population (73%) reported having been arrested, and analysis revealed that the young men were significantly more likely to report this than their female counterparts (81% Vs 53%). In addition 38% of those arrested (n=72) reported an assault related arrest. Just under half the population (49%) reported that they had charges pending at the time of entering treatment. Young men were significantly more likely to report this than women (58% Vs 26%). In addition, 19% of the young people reported they were attending treatment at the recommendation of the court.
- The majority of young people (84%) reported having no physical health problems. In addition, the majority of clients were not on any medication, however 5% reported being on anti-depressants. 60% of the programme participants reported having attempted suicide at some point in the past. Analysis revealed that the young men were significantly more likely than their female counterparts to report this (66% Vs 47%).
- Over three quarters (77%) of the population had been for counselling in the past and 58% had reported previous contact with drug related services.
- The average length of time on the programme was 29.7 days (Sd=15.2 days; range 1-59 days). Over half the population (52%) completed the residential treatment, and an additional 3% left treatment with staff approval, 25% left at staff request and 20% were self discharges and left against staff advice.
- Overall the young people, who have participated in the Aislinn Adolescent Addiction Treatment Centre, are serious poly substance misusers with complex behaviour, social and legal issues.
- The characteristics of the sample group were comparable to the overall client profile. The gender ratio was the same, the average age of the sample was 17.5 years, and the majority were living in their family home and unemployed immediately prior to treatment. In the sample group the majority (85%) were poly drug users and they reported a range of problems related to their drug and alcohol misuse, including being expelled from school, losing jobs, family problems and health and legal issues.

KEY FINDINGS

The Programme

- Programme participants — both the young people and their parents - did not know what to expect from the Aislinn Adolescent Addiction Treatment Centre. They had a limited understanding of the programme's philosophy, the structure of the programme, its aims and objectives, their role in the treatment process and what was expected of them.
- First contact with the Centre was usually when the young people and their parents/guardians presented for a screening appointment, on site. Potential programme participants are usually screened with the aid of a brief questionnaire and the Jellinke chart - which is intended to assess severity of dependency. Parents and/or guardians participate in the screening process, which was difficult for some young people, particularly when parents knew very little about their sons/daughters drug and alcohol misuse. This may prevent some young people from divulging the exact details of their substance using careers.
- Respondent's first impressions of Aislinn were very positive. Individuals spoke about feeling very welcome, safe and secure. They said that the house was very homely and comfortable and that staff and residents were all very friendly. By and large the young people settled in very quickly and adjusted to the routine of the programme.
- Family involvement in the programme is considered vital. Although parents knew from the outset that they were expected to get involved in the programme, the exact nature, extent and purpose of their involvement was unclear. As parents progressed through the programme and observed others experiences, they learnt what was expected of them, and they got some insight into the therapeutic process.
- Group Work: Respondents spoke about initially feeling uncomfortable in group, because they were unsure of what happens, and what was expected of them. Individuals had to feel safe and trust the other group members before they were prepared to participate, and that took time. Although the young people reported that die group work was very beneficial, they found it very difficult 'opening up' and talking about things they were reluctant to talk about
- Step Work; While in the residential setting the young people usually work through the first five of die Twelve-steps. For many of the young people interviewed the main problem was trying to remember everything, actually concentrating on the step work, and the amount of reading and writing that such a task requires. However the step work was very effective in assisting the young people to focus on the consequences of their drug and alcohol misuse.
- Family Day: All the respondents said that family day was stressful. Moreover, many of the young people spoke about the pain and hurt of being confronted by family members over things that happened in the past. However, everybody interviewed recognised die benefits of this process and the young people spoke about how die process changed their relationship with their parents and siblings. Parents spoke about how difficult it was to confront their sons/daughters, and how emotionally and mentally draining these days were. However, the parents found great support in each other, and comfort in the knowledge that they were not the only people in this situation.
- Abstinences: Most of the young people in-treatment found it difficult to accept the fact that they are expected to abstain from all mood altering substance. In particular, the individual who self identified as drug misusers found it difficult to accept that they needed to stay off alcohol. In their experience, alcohol use was not a problem for them, thus they were reluctant to accept the need for abstinence.

Self reported changes

- While in residential treatment most of the young people reported positive changes in their relationship with their parents, and siblings. Typically the young people spoke about increased

communication between the family members, and individuals within the family getting on better together. The young people also spoke about their growing awareness of the consequences and affects of their behaviour on their family

- Many of the in treatment group reported that being in Aislinn had changed the way they feel about drugs and alcohol. Others reported that their feelings had not changed as they still had a desire to drink or take drugs; rather they were more aware of the consequences of their drug and alcohol misuse.
 - The young people in treatment also spoke about feeling less aggressive, less argumentative, and more prepared to listen to what other people have to say.
 - Nine of the thirteen programme participants interviewed during treatment completed follow-up interviews approximately three months later. All nine were attending aftercare, and only one of the original thirteen had completely ceased to attend aftercare (although two were very erratic in their attendance). Of those interviewed one had returned to school, one had started an apprenticeship, four were doing FAS courses, two had got jobs, and one was looking for work. Six of the young people had returned to their family home, and three had moved into support accommodation away from their city of origin. Only three of the young people interviewed at follow-up had lapsed and all three had spoke about this in the aftercare group and had returned to their recovery. Moreover, only one reported being reported being involved in crime post treatment.
- " However, all of young people interviewed at follow up found leaving Aislinn hard.. They felt very vulnerable and unprepared. Generally speaking the young people found 'recovery' much more difficult then they had anticipated. People reported finding it difficult to cope with incidences and events in their lives without alcohol and drugs. Many spoke about feeling isolated from their peers

Function of Programme

- " There were three identified therapeutic benefits for the young people residing in the rehabilitative environment of Aislinn. Firstly, respite as the programme serves an important function in term of providing young people with respite from street life, from, the drug culture, and obviously from drugs themselves. The important of this should not be underestimated. This respite provides the young people with a freedom from the stresses of their daily lives. Moreover, it provides them with an opportunity to be free from the control of drugs, albeit for a short period of time. In many-instances this represents a major shift in the adolescents life. Secondly, the programme also provides the young people with structure. For the programme participants there was a certain comfort to be found in the predictable structure of the day. Thirdly, the programme also has a positive impact on the family dynamic. The fact that the young programme participants got a chance to sit down in a safe and supportive environment with a counsellor and their family made a difference to them and their relationship. Finally, the programme helps the young people to develop links with stable adult institutions. Many of the young people on the programme, would have had quite negative views of adults, such as teachers. However, their experiences in Aislinn help to dispel some of these views.

Recommendations

- " The Report concludes with a number of recommendations. These recommendations are broken down into a number of sub-sections. Firstly here are general recommendations concerned with the treatment of adolescent substance misusers. This is followed by recommendations which deal with the health boards and Aislinn, and finally there are a number of recommendations that are specifically related to the Aislinn programme that deal with issues such as assessment, programme structure and content, staffing, training, and relapse prevention.

1: Introduction

The Aislinn Adolescent Addiction Treatment Centre established in October 1998 is a non-profit making residential drug free centre for male and female adolescents between the age of 15 and 21. The Centre is the first of its kind in Ireland, and provides 6 weeks highly structured residential treatment followed by two years of aftercare. The programme is based on the Minnesota Model of addiction as practiced at Hazelden, one of the founding treatment programmes of the Minnesota Model¹ (Cook, 1988). At its most basic level, the Hazelden approach is characterised by the use of the 12-step philosophy of Alcoholics Anonymous as a foundation for therapeutic change. The treatment goals are total abstinence from mood-altering substances and improved quality of life.

Briefly, treatment in Aislinn is provided in a residential setting, and consists of group therapy, individual therapy, didactic lectures and group discussion, and individual assignments. The majority of treatment occurs in therapeutic groups, which focus on seeing a broader reality, overcoming denial and gaining a greater acceptance of personal responsibility and hope for change; education about addiction and related factors; an introduction to 12-step philosophy and AA/NA groups; recreational groups; and groups for individuals to tell their stories and receive feedback. Individual therapy is also provided, to review progress and address issues that might be too sensitive for a group setting. The involvement of family is an essential component of the treatment provided at Aislinn and family members are required to attend weekly 'family days', when group sessions with the young people take place, and lectures are also provided. The importance of aftercare is emphasised and is accomplished by attendance at meetings provided in by Aislinn in 4 locations throughout Ireland (Kilkenny, Limerick, Cork, and Dublin) and attendance at AA/NA meetings.

In 2001 the Health Boards involved with the Aislinn Adolescent Addiction Centre, namely the South-Eastern, Mid-Western and Southern, along with the Department of Health and Children decided to undertake an evaluation of the programme. The motivation for the evaluation was to provide feedback to the sponsoring Health Boards and the Department of Health and Children about the purpose and function of Aislinn, the quality of care provided to the adolescents concerned, and to assess the value of the service in the context of the overall addiction and treatment services being provided by various agencies. The Addiction Research Centre, at Trinity College Dublin, received the tender to undertake the evaluation, and the research was carried out over a nine-month period, from July 2001 to March 2002. This paper reports on the evaluation of the Aislinn Adolescent Addiction Treatment Centre.

¹ The Minnesota model was first developed with alcoholics at Willmar State Hospital in Minnesota, and further refined at the Hazelden Foundation, also in Minnesota. For an historical overview of its development and philosophy see Cook (1988).

AIM AND OBJECTIVES OF THE STUDY

The overall aim of the study is to determine how well the programme meets its stated purpose and function in terms of the relative success of the programme.

More specifically the objectives of the study are as follows;

- To identify the aims and objectives of the Aislinn Adolescent Addiction Treatment Centre;
- To identify and profile the client group;
- To fully define the therapeutic processes involved in Adolescent Addiction Treatment Centre including the screening procedure, treatment programme, and involvement of family members;
- To evaluate the effectiveness of the programme in achieving its stated aims and objectives;
- To identify gaps in pre/post treatment provision;
- To review current staffing arrangements, and advise on appropriate staffing requirements in terms of qualifications, training and supervision requirements;
- To examine how effectively the Aislinn Treatment Centre collaborates with other services provided by the Health Boards, with particular reference to coordinating aftercare programme linkage;
- To assess the relevance of the treatment modality to the broad client base in the context of the overall addiction and treatment services being provided by various agencies;
- To identify positive programme practices and;
- To make the necessary recommendations on overall service improvement.

EVALUATING EFFECTIVENESS

This study is intended to examine issues related to the effectiveness of the Aislinn Adolescent Addiction Treatment Centre. Clearly the concept of programme effectiveness may mean different things to different observers. From the inception of this research it was accepted that there are a number of separate but equally valid perspectives on programme effectiveness, which must be taken into consideration in the design of the research, and the generation and analysis of data. These perspectives may coincide in certain aspects, but on the other hand, they might be divergent. The four main perspectives identified are as follows:

- **The Young People:** The perspectives of the programme participants themselves were from the outset considered the lynchpin of this research. Therefore it was necessary to investigate their aims and objectives - what hopes and expectations the young people had when they entered the programme and whether the programme met their needs? It was also essential to explore the young people's satisfaction with the programme, their attitude towards, and relationship with, staff and other young people on the programme.
- **The Young People's Families:** The programme utilises what may be considered a 'family-based' approach to treatment requiring not only the engagement of the young people but also their families. Consequently, the perspectives of the families, who play an essential role in the therapeutic process, and their views on programme effectiveness, were considered vital.
- **The Service Providers:** It is recognised that an understanding of the services own views on programme effectiveness is crucial (Pawson and Tilley, 1997). Particularly, in view of the fact that how the programme functions, and how 'effectively' it works is directly related to the stated aims and objectives of the programme.
- **Health Board Representatives:** One of the primary purposes of the evaluation is to provide feedback to the sponsoring Health Boards and to the Department of Health and Children about the effectiveness of the programme. Therefore, it was deemed necessary to consult with the relevant Health Board representatives, regarding their views on programme effectiveness and to take into consideration their expectations.

There are however a number of difficulties and caveats which must be recognised when evaluating programme effectiveness. As outlined, there are potentially diverse ranges of perspectives on what constitutes appropriate indicators of programme effectiveness, which must be taken into consideration. In addition, it is difficult to attribute any change directly to the programme in the absence of a control group. Moreover, the fact that the effects of the programme may be indirect, or may not be felt for many years is difficult to account for. Inevitably, many questions will remain unanswered, and it will never be possible to arrive at a definitive and non-contentious assessment of the extent to which any residential drug treatment programme is 'effective' in its work with young people.

CHOOSING A METHODOLOGY

Many evaluative studies of drug and alcohol services use what Moos *et al* (1990) call a 'black box paradigm'. Such studies rely on comparing pre and post treatment test results, whereby clients are assessed at intake and at one or more follow-up time period post treatment. Thus., clients are used as their own reflexive control, and the difference between pre and post treatment results are said to be the 'effect' of the treatment, with little consideration given to the treatment processes involved, or to other factors, which might affect the client. Moos *et al* (1990) among others are critical of such an approach to the evaluation of drug/alcohol treatment services, because not only does it fail to examine the influences of specific treatment components on outcomes, but also there is no assessment of how well treatment is implemented. Such an approach to programme evaluation does not help to clarify what actually happens in treatment interventions, such as therapeutic change processes. The lack of qualitative data in programme evaluation research means a lack of descriptive accounts of the methods used within treatment (Keene, 2000).

In addition, focusing solely on behavioural outcomes does not permit an exploration of the viewpoint of the clients about the success of the programme. This individual perspective is essential to judge the acceptability of the programme in the eyes of potential clients, as well as the perceived effectiveness of the programme in giving the clients the tools they need to be successful (Chan *et al*, 1997). While client satisfaction with services is increasingly recognised as an important outcome measure, the literature remains limited. However, one area of consistency in findings about client satisfaction with alcohol/drug treatment service is that the reported levels of satisfaction are almost always high. This appears to hold true regardless of the treatment modality (Cooners and Franklin, 2000) and has led to some concern that client-satisfaction surveys may tend to inflate reports of satisfaction (Perreault *et al*, 1993; Williams, 1994). One way to get a better understanding of service delivery and a truer reflection of client satisfaction with services is through the use of qualitative data collection methods. Moreover, it is recognised that any evaluation method chosen should be based on the concrete information needs of the evaluation audience (Patton, 1990). In this instance, the information needs comprise of multiple perspectives, contextualised meanings, and the experience of service users. To this end a qualitative methodology was considered the most appropriate for the telling of diverse programme stories and to enable an understanding and

interpretation of complex processes. Moreover, it has the advantage of allowing the researcher to evaluate the programme according to the merits and worth of its actual effects, independent of its intended affects (Greene, 1998). However, an element of quantitative data analysis was incorporated into the study, not least because there is greater validity in findings that are derived from more than one method of investigation (Bryman, 1988).

Qualitative data collection

In order to become familiar with the setting, the programme content, and the therapeutic processes involved, the researcher engaged in three days of non-participant observation at the initial stage of the study (21-24th August, 2001). The researcher's presence was explained before hand to all programme participants and their families, and during diat time the researcher observed all activities engaged in by the participants, and informally chatted with the young people and their families. This stage of the fieldwork was vital in terms of establishing rapport with the young people, prior to conducting in-depth interviews.

Immediately after the observation, in-depth interviews were conducted with all young people on the programme (n=13). Follow-up interviews commenced 18 weeks later, and 9 of the original 13 young people were traced, contacted and interviewed the remaining 4 were lost to follow-up. In-depth interviews were also conducted with a sample of parents/guardians participating in the programme (n=7). In addition, 5 young people who were participants in the aftercare group that meets on the Kilkenny premises and 1 participant who had just completed 2 years of aftercare in Limerick were interviewed.

All of these programme participant interviews were carried out by one researcher, which ensured consistency and a grounded approach to data collection. This approach was grounded in that it allowed the researcher to identify and explore themes in the course of individual and subsequent interviews. An open-ended flexible topic guide was used for the interviews, which could be adapted to each respondent's own experience. The interview guide was based on some general themes identified through a comprehensive literature review (See Appendix C1). All interviews were carried out with only the researcher and respondent present Programme participants (including those in aftercare in Kilkenny) and parents were interviewed in a room in Aislinn. Two of the follow-up interviews were conducted in Aislinn, 5 in Cork (in the same location as the aftercare), one in Limerick and one in Dublin. Interviews lasted anywhere between 50 minutes to 90 minutes.

A second researcher was responsible for carrying out in-depth semi-structured interviews with all staff of the Aislinn Adolescent Addiction Treatment Centre (n=?) who work direcdy with clients (see Appendix C3). These interviews were designed to explore the subjective interpretation of staff concerning the treatment model, methods and treatment processes of Aislinn. In addition, two members of the Board of Managers and representatives of the relevant health boards (n=3) were interviewed.

Quantitative data collection

As stated previously, there was also an element of quantitative data analysis. This consisted of analysis of data collected from client's screening/assessment interviews. These data provide information on the **socio-demographic characteristics, drug/alcohol consumption, legal issues and health and well-being of all programme participants (n=264)** who were accepted onto the programme between October 1998 and August 2001 (see Section 4). This process also had the advantage of giving the researcher an insight into, and an understanding of, the client group.

The retrospective experience of former programme participants was considered important to the evaluation. It was decided that the most practicable method of engaging the involvement of as large a number of ex-clients as possible, was through a short postal questionnaire. This approach permitted the researcher to gather data from former clients on their current alcohol and drug use, and on sustained behaviour changes. A short questionnaire (See Appendix C4) was sent to all young people who had participated in the programme (n=258) excluding individuals in treatment at the time of the initial fieldwork. These young people can be roughly divided into the following groups

- GROUP A: Service users who completed 6 weeks residential (n= 138)
- GROUP B: Service users who left with staff approval (n= 8)
- GROUP C: Service users who left at staff request — therapeutic discharge (n= 64)
- GROUP D: Service users who left against staff advice (n= 48)

In addition, a brief questionnaire was also sent to each named parent/guardian or concerned persons for all of these 258 ex-residents (n=380) (See appendix C5). These data were entered into an Excel spreadsheet and analysed using SPSS for Windows.

STRUCTURE OF THE REPORT

Section 2 reviews the available literature on the prevalence of substance use and misuse among young people in Ireland and examines some of the issues around young peoples' drug use. In addition, a brief literature review of effectiveness of treatment services, in particular 12-Step based programmes for young people, is also provided. Section 3 outlines the structure and content of the Aislinn programme. Section 4 provides a profile of the Aislinn client group, based on the data obtained from client records. The study sample is also profiled. Section 5 presents the results from the client interviews, and details programme participants (including parents/guardians) perceptions of the service provided. Section 6 present an analysis of the Aislinn programme and service provision, and the location and function of the programme in the context of the overall addiction and treatment services provided in Ireland is examined. Section 7 pulls together the disparate themes explored in the research, offering conclusions about the efficacy of the Aislinn Adolescent Addiction Treatment Centre and recommendations on how the programme can be improved upon. Appendix A and B present an analysis of the data collected from the questionnaires completed by ex-programme participants, and parents/guardians respectively.

2. Adolescent Substance Use A Review

INTRODUCTION

It is widely recognised that the youth of today have greater access to alcohol and drugs than ever before. For some young people experimentation with drugs and alcohol is merely part of a rite of passage through their challenging teens, and may be seen as reflecting adolescent normative behaviour. The majority fall into a category called 'experimental', 'situational' or 'recreational' consumers, using infrequently and in small amounts to get high, have fun and relax. They generally do not have serious problems with their use or require treatment². For others however, their consumption goes well beyond experimentation, and signals serious adjustment problems. These are usually compulsive, dedicated users with serious personal problems, and they rely on drugs as self-medication to cope with their problems.

From the outset it is important to be clear about the meaning of terms used to describe the patterns of drug and alcohol consumption by children and young people. Definitions of use, misuse or abuse to some extent depend on a society's acceptance and tolerance of use and indeed of substance related consequences (Health Advisory Service, 2001). For example, in the US, especially regarding illicit drug use among adolescents the term 'abuse' is used, which reflects a view that any use is abuse. Conversely, in the UK the terms 'drug use' and 'misuse' have been adopted. This is in recognition of the fact that one-off and experimental use of drugs and alcohol is not always indicative of personal, psychological or social problems (Health Advisory Service, 1996). Misuse encompasses use that is harmful and is associated with dependency or use that's part of a wider spectrum of problematic or harmful behaviours. For the purpose of this report the definition of '*drug misuse*' is that provided by SCODA (1999) whereby it is defined as being '*drug taking which harms health or social functioning. Drug misuse may be dependency (physical or psychological) or drug taking that is part of a wider spectrum of problem and harmful behaviour. Those who misuse drugs will require a comprehensive assessment and appropriate intervention*'. SCODA (1999) defines '*drug use*' as being '*drug taking which requires a lower levels of intervention and treatment. Harm may occur through drug use, whether through intoxication, illegality or health problems even though it may not be immediately apparent. Drug use may require the appropriate provision of interventions such as education, advice and information and prevention work to reduce the potential for harm*'. The Health Advisory Service (2001) recognises that drug use has different implications at different ages, with use (as defined above) mainly related to experimentation use in older adolescents.

² That is not to say that some young people will not experience problems related to experimental use such as intoxication, excessive use, use of substances in a particular setting or idiosyncratic reactions.

Young people and children who misuse drugs differ from their adult counterparts by characteristic differences in presentation and types of drugs consumed. The current 'pick 'n mix' generation (Parker, Measham, and Aldridge 1994) are more exposed to and consume a greater variety of illicit drugs, display smaller gender differences in behaviour (Melrose, and Brodie, 2000), demonstrate decreasing age of initiation into substance misuse and changing patterns of alcohol consumption (increased episodes of intoxication and attraction to so-called designer drinks) when compared with earlier cohorts. Furthermore, alcohol and drug misuse among adolescents is associated with increased dropout from school, poor educational achievements, early pregnancy, and family difficulties (Health Advisory Service, 2001). There is an extensive body of literature on the issue of co-morbidity of mental illness and drug and alcohol misuse, particularly in adults. However, research has identified a relationship between substance misuse in young people and suicidal behaviour (Wilens *et al*, 1997) depression (Zeitlin, 1999) and conduct disorders (Moss and Lynch, 2001; Whitemore, *et al*, 1997). While prevalence surveys of illicit drugs have sometimes been small and not necessarily representative, the broad pattern and trend is towards increased availability, exposure to, and use of substances across all social strata. For these reasons the use and misuse of alcohol and both licit and illicit drugs among adolescents has become a cause for public and professional concern. This section examines the prevalence of adolescent substance use and misuse in Ireland, and briefly reviews some of the main areas.

PREVALENCE OF ADOLESCENT SUBSTANCE USE AND MISUSE IN IRELAND

Research on the use of illicit drugs by young people in both the UK (Parker, Aldridge and Measham, 1998; Miller and Plant, 1996) and the US (Winter, 1999) suggests a dramatic increase in lifetime prevalence rates during the 1990's. The three main sources of information on young people's illicit drug (mis)use in Ireland are official statistics, social surveys and qualitative studies. The relevant official statistics consist of treatment data contained within the National Drug Treatment Reporting System (NDTRS), which provide an annual national overview of people coming into contact with drug services. These are of limited value in identifying prevalence and trends in young people's drug misuse, however, because of their bias towards certain user groups, such as dependent opiate users. Nevertheless, Table 2.1 illustrates that the number of

Year	Under 15		15-19 years	
	<i>n</i>	% <i>Population</i>	<i>n</i>	% <i>Population</i>
1990	20	1%	319	16%
1991	35	1.5%	335	14.4%
1992	48	1.9%	435	17.2%
1993	35	1.2%	656	22.6%
1994	53	1.8%	826	27.9%
1995	84	2.3%	1361	37.8%
1996	43	0.9%	1446	29.8%
1997	36	0.7%	1269	26%
1998	39	0.6%	1327	22%

Source. National Drug Treatment Reporting System Annual Statistical Bulletins

teenage drug misusers in treatment peaked in 1995, when 40.1% of the treatment population were 19 years and under. Data for the last available year (1998) indicates that just over one fifth of the treatment population (22.6%) were teenagers. However, it is not possible to infer on the basis of these data alone, that there has been a comparable increase or decrease in the number of problematic teenage drug

misusers in the State. It is necessary to take into account factors such as the changes in the number of treatment centres participating in the NDTRS, and the increased numbers of places on methadone programmes. To the authors knowledge there are no treatment data available on the prevalence of alcohol misuse among young people in Ireland. As young peoples drug use and misuse is often inextricably linked with alcohol use, a proportion of the young people who sought treatment, according to the NDTRS were probably alcohol misusers.

Most of the information available on adolescent drug and alcohol use in Ireland is based on social survey research using quantitative techniques, gathering data on young people through the administration of school-based surveys. Although there are problems in comparing the findings of these studies, due to differing objectives, methodologies, data collection methods, questionnaire design, and age criterion, they can provide some useful information on adolescent drug use in Ireland. For example, in 1994 the Western Health Board (VHB) area carried out a survey of substance use among adolescents of school going age (12-18 years), including a sample of early school-leavers (Kiernan, 1995). This study revealed that cannabis and solvents were the most commonly used drugs, with lifetime prevalence rates (have ever used) of 16% and 14% respectively. Ireland has also been involved in the European Schools Project on Alcohol and other Drugs Study (ESPAD), which is concerned with substance use, beliefs, attitudes and risk factors among over 50,000 16 year old in 26 European countries (later extended to 30 countries). To date two ESPAD studies have been carried out, the first in 1995, when participating countries targeted students born in 1979 i.e. in the year of data collection they would have been 16 years (Moran *et al*, 1999). The second ESPAD study targeted students born in 1983 (Hibell *et al*, 2000). In the first study the lifetime prevalence rate for cannabis was found to be 37%, which was among the highest found in all countries participating in the study. However, in the 1999 study the lifetime prevalence rate was found to be 32%.

In 1996 the Midland Health Board (MHB) area carried out a study to examine lifestyles of second-level students. Table 2.2 illustrates that cannabis had the highest lifetime prevalence rate (26%), followed by solvents (17%). The Centre for Health Promotion Studies NUI Galway carried out the Health Behaviours in School-Aged Children (HBSC) study in 1998 (Friel, *et al*, 1999). Respondents ranged from 9 to 17 years, and the lifetime prevalence rate of cannabis was found to be 12% for the total sample and 21.7% for the 15-16 year olds, substantially lower than the findings in the ESPAD study. Finally in 1998 a school survey was conducted in the Eastern Health Board (EHB) area (Rathigan, and Shelly, 1998) and lifetime prevalence rates for cannabis were found to be 21% and 13% for solvents.

Lifetime prevalence is not however an appropriate means of estimating prevalence, as this can refer to once off consumption, or experimental use. Therefore many studies also examine use in the last month. Table 2.3 highlights recent use, in the last 30 days. It illustrates that across all studies cannabis is again the most commonly used drug, and recent use is substantially low than lifetime prevalence.

Table 2.2 Comparisons of School/Youth Surveys of Drug Use:
Lifetime Prevalence of Drug Use by Type of Drug

Survey/Year	WHB	ESPAD	MHB	HBSC	EHB
	(1994)	(1995)	(1996)	(1998)	(1998)
	Local	National	Local	National	Local
Sample size	2,762	1,849	1,654	8,497	6,081
Age Group	13-18	15-16	16-18	9-17	10-18
Drug Type					
Cannabis	16%	37%	26%	12%	21%
Amphetamine	2%	3%	5%	3%	5%
XTC	2%	9%	7%	2%	3%
LSD/ Hallucinogens	9%	13%	9%	4%	3%
Hypnotics + Sedatives	2%	7%	4%	3%	3%
Cocaine — (Crack)	1%	2% - (3%)	NA	2%	2%
Solvents	14%	19%	17%	10%	13%
Heroin	1%	2%	NA	1.0	1%

Sources: O'Brien (2001:48) 'Research Findings on Drug Use' in Moran et al Ed. *Overview of Drug Issues in Inland 2000. A resource Document*. Dublin: The Health Research Board.

Table 2.3 Comparisons of School/Youth Surveys of Drug Use:
Last Thirty Days Prevalence of Drug Use by Type of Drug

Survey/Year	WHB	ESPAD	MHB	HBSC	EHB
	(1994)	(1995)	(1996)	(1998)	(1998)
	Local	National	Local	National	Local
Sample size	2,762	1,849	1,654	8,497	6,081
Age Group	13-18	15-16	16-18	9-17	10-18
Drug Type					
Cannabis	9%	19%	NA	6%	11%
Amphetamine	1%	NA	NA	2%	3%
XTC	1%	NA	NA	1%	3%
LSD	NA	NA	NA	1%	2%
Hypnotics + Sedatives	NA	NA	NA	2%	2%
Cocaine	1%	NA	NA	2%	2%
Solvents	NA	NA	NA	5%	7%
Heroin	0%	NA	NA	1%	1%

Sources: O'Brien (2001:49) 'Research Findings on Drug Use' in Moran et al Ed. *Overview of Drug Issues in Inland 2000. A resource Document*. Dublin: The Health Research Board.

Regarding alcohol consumption, according to the ESPAD only 9% of the young people interviewed never tried alcohol; lifetime prevalence was 91%. In addition, 69% reported use in the previous month, and there was no gender difference in this regard. An attempt was made to measure alcohol misuse, by asking respondents a number of questions about their experiences of feeling drunk including if they had ever felt drunk and if they were drunk in the last month. Sixty seven percent of respondents reported having ever felt drunk, with boys only slightly more likely to report this than girls (96% Vs 65%), and 42% of the young people interviewed reported being drunk in the last month (boy 43%, girls 41%) (Morgan, 1997). The HBSC survey found that 32% of school respondents reported ever having had a drink. Overall, 29% admitted to having a drink in the past month. Of those, boys were more likely to report current drinking than girls, 34% compared to 24% respectively. A similar trend was seen among those who reported having been 'really drunk' with boys proportionately more likely to report having consumed amounts of alcohol, which made them 'really drunk'. For the boys and girls, the majority of those who reported

currently drinking, and ever been 'really drink' were in the 15-17 year age bracket (Friel, *et al*, 1999). Finally a survey of substance use among early adolescents (14-15 year olds) in the Dublin region found that a quarter of the pupils interviewed said that they never drank while 59% said that they sometimes drink and 16% reported drinking regularly (Brinkley *et al*, 1999).

Although not an exhaustive review of school-based surveys (see O'Brien, 2001), the above indicates that a sizable proportion of young people drink alcohol and cannabis is the most commonly consumed illicit drug among adolescents in Ireland. More importantly it highlights the need for comparable methodologies in such surveys to permit meaningful comparisons (O'Brien, 2001). The third source of information on young peoples substance use is qualitative or ethnographic study, which explores young people's own understanding and interpretations of their lives. Due to the nature of qualitative research — resource intensive and more limited in applicability - there are few qualitative studies of young people's drug use in Ireland. Consequently there is a growing need for additional research to flesh out the statistics produced by social surveys and treatment data. Qualitative research (such as Mayock's (2000) study) can help us to understand the meanings and motivations behind the decisions which young people make about their use or non-use of drugs and suggest ways in which personal, social, economic and cultural factors interact to affect such decisions.

To conclude based on the available Irish data it is difficult to state categorically whether substance use and misuse is increasing among adolescents, as in other jurisdictions. It is vital that more research be carried out in this areas, as a clearer picture of the nature and extent of adolescent drug use is necessary in order to plan for future treatment service needs, and to evaluate the effectiveness of current interventions.

PATTERNS OF DRUG MISUSE

Little is known about the pattern of adolescent drug misuse in Ireland. In the previous section it was highlighted that cannabis is by far the most commonly used drug. This is supported by Mayock's (2000) qualitative study of drug (mis)use among young people aged 15-19 in a Dublin inner city community. This study also revealed however, that poly-drug use was the norm among many of the young people interviewed. Research in both the US (Collins *et al*, 1999) and the UK (Measham, Parker and Aldridge, 1998) indicate that combined drug use is common among young people. Such poly-drug (mis)use takes many different forms and serves many different functions, for example one Irish study of a cohort of heroin smokers (n=46) revealed that one third of the cohort had used heroin to come down off ecstasy (Gervin *et al*, 1998). Only a minority of adolescent drug users consume heroin. That said, a sizable proportion of needle exchange attendees are teenagers (25%), and these young people are significantly more likely than their adult counterparts to engage in injecting risk behaviour, to have started illicit drug use and to have initiated IV drug use at a significant younger age (Cox, 2001). Clearly more research is needed on trends and changing patterns of adolescent drugs use and misuse.

RISK FACTORS

A vast body of research has developed on identifying risk and protective factors of adolescent substance misuse. Most of this research relates more to substance misuse and dependency rather than normative/experimental drug use (Health Advisory Service, 2001). The 'risk factors' outlines in Table 2.4 broadly fall into social and environmental factors, and include a wide range of individual, family and social risks. For example, individual risk factors include academic problems, and affiliation with like-minded peers. Many studies document that psychological disturbances tend to predate adolescent drug misuse. Moreover, many of the behaviour traits associated with drug use such as rebelliousness, poor school performance, delinquency and criminal activity have been found to precede the use of drugs.

Table 2.4 Risk and Protective Factors

Domains	Risk Factors
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Individual

- " Learning disability
- Mental health problems
- Early history of child abuse
- Poor academic attainment
- Low commitment to school
- Alienation
- Rebelliousness
- Favourable attitudes towards drug use
- Affiliation with 'like minded' peers

2. Family

- Parent and family drug use
- Poor/inconsistent parental management
- Family conflict and disruption
- Positive family attitude towards drug use

3. Societal

- Poverty
- Neighbourhood disorganisation
- Unemployment

Protective Factors

- Psychological well-being;
- Social connectedness to adults + institutions;
- " Goal directedness in school or vocation;
- " Prosocial peers;
- Academic achievement;
- Problem-solving and coping skills;
- Involvement in religion.

Personality factors such as low-self esteem, anxiety, depression and lack of self-control have also been found to be associated with certain patterns of adolescent drug use. In a US study of high school students, drug users were found to have significantly more psychological symptoms - anxiety, obsessive-compulsive reactions, hostility reactions, agitation-excitement, and violent reactions — and less 'maturity' than students who do not use drugs (Glickman and Utada, 1983). They are more likely to be involved in gang activity, have more problems with the police, and have more problems in school. In short, according to Beschner and Friedman (1985) adolescent drug users appear to be more dissociated from

the adult world and more involved with their own particular peer group.

Research suggests that the severity of adolescent drug use is significantly related to such family factors as disruption and dissolution of family structure, certain family constellation factors, and the number of type of problems which adolescents perceive to be present in their family (Newcomb, 1995). Drug users engage in significantly more negative behaviours within the family (arguments and fights, stealing or taking things from other family members) than nonusers. In addition, absence of a parent, lack of parental closeness, unconventional parents, excessively passive mothers, lack of perceived closeness to parents and

drinking and drug use patterns of parents have been positively correlated with drug misuse (Brooke *et al*, 1980; Kendal, 1982).

VULNERABLE GROUPS

As illustrated the risk of drug and alcohol misuse is not uniformly distributed across the general youth population. Moreover, some groups of young people 'at risk' may not be included in school-based surveys. It is unusual for harmful substance use to arise solely as a result of peer influence and in the absence of a pre-existing major vulnerability (Health Advice Service, 1996). There is a developing consensus regarding the groups of young people who are at particular risk. Among the most vulnerable are runaways (Kipke *et al*, 1997) the homeless (Flemen, 1997), young offenders (Hough, 1996), truant or school 'drop-outs' (Miller and Plant, 1999), those in care (Ward, 1998), young people with concurrent mental health problems (Buksetin *et al*, 1998) and those with co-existing conduct disorders (Whitemore, *et al* 1997). In addition, Melrose and Brodie (2000) reported that young women, compared to males of a similar age, had more problematic and more frequent drug use, initiate drug use at an earlier age and are more likely to be injectors. These vulnerable young people are likely to require interventions from a variety of agencies and professionals to respond to their multiple needs, yet they are faced with a dearth of specialist substance use services.

PROBLEMS PRESENTED BY ADOLESCENTS ENTERING TREATMENT

The patterns, length and intensity of drug consumption among young users entering treatment are considerably different from the patterns of adults. According to US data over half of the adolescent drug users seeking treatment report cannabis as their primary drug, and an additional 20% use cannabis as a secondary drug. Over one third used daily (Weinberg *et al*, 1998). In understanding adolescent drug use one must go beyond the primary drug reported. Most compulsive dedicated users — particularly those requiring treatment - are multiple drug users. Due to the restrictions in age range, adolescents have an earlier onset of substance use and a shorter duration of substance use than adults entering treatment. Similarly, adolescents have less time to experience deterioration in role functioning, (Stewart and Brown, 1995) and have less time to encounter major problems related to their alcohol and drug use (Filstead *et al*, 1989). Despite these characteristics that may limit the manifestation of alcohol and other drug related problems, adolescents have been shown to have a rapid progression from experimentation to problematic use.

Adolescent drug users who seek or are referred to treatment usually present with a multiplicity of problems beyond drug use per se. In any attempt to treat adolescent drug users, attention must be given to these underlying problems and usually to the family situation as well. Family problems are also high on the list of problems reported by adolescents entering treatment; other problems are school-related problems, legal problems, and emotional or psychiatric problems.

TREATMENT FOR ADOLESCENT SUBSTANCE MISUSEKS

Few drug treatment programmes in this country are designed specifically to serve adolescents. Thus, many young people are required to access treatment through adult services. Unfortunately there are no data available illustrating where adolescent substance misusers go for treatment. The National Drug Treatment Reporting System's annual reports do not include an analysis of data by age groupings.

Both the US³ and the UK⁴ have developed treatment protocols/guidelines for adolescent drug users, which outline the importance of basing treatment decisions along a continuum of severity. Accordingly, treatment interventions should range from minimal interventions to long-term residential treatment, depending on the nature and severity of the presenting drug problem, and related issues. More intensive treatment services should be devoted to youth who show signs of dependency - that is a history of regular and chronic use, with the presence of multiple personal and social consequences and evidence of an inability to control or stop using substances (Winters, 1999). However, an individual should never be placed in intensive treatment, such as residential treatment, unless they have had previous treatment. In short, the degree of substance involvement is an important determinant to treatment, as are any coexisting disorders, the family and peer involvement, and the individual's stage of mental and emotional development. Nonetheless, in both the UK and the Netherlands, the overriding principle of treatment placement is 'least intensive treatment first' approach. A working group established by the National Drug Strategy are currently developing a protocol/guidelines for the treatment of under 18 year olds with serious substance misuse problems in Ireland.

There are ranges of psychological therapies (i.e. counselling, brief interventions, individual psychological therapies - such as cognitive and behavioural approaches) and pharmacological therapies, which are utilised in the treatment of adolescent drug users, which have been reviewed elsewhere (Health Advisory Service, 2001; Crome, 1999; Catalano *et al*, 1991). In the US, treatment programmes for adolescents usually take the form of the 12-step approach or family therapy. However, there is a notable lack of research on 12-step based programmes for adolescents, which for nearly three decades have been the most prevalent mode of treatment in the US (Winters, *et al* 2000). Several well-designed studies of adult substance misuser treatment programmes have yielded findings strongly supporting the efficacy of 12 Step orientated programmes (Ouimette *et al*, 1997; Moos *et al*, 1999). However, few studies have examined the efficacy of AA and Minnesota Model programmes among young substance abusers (Kassel and Jackson, 2001). Hazelden's Youth and Family Centre in Minnesota conducted a treatment outcome study of 480 clients who completed treatment in the mid 1980's. However, only 53% of the sample were contacted at 1 year after treatment when 46% reported no use of alcohol and 68% indicated no use of other drugs during the follow-up time period (Keskinen, 1986). Harrison and Hoffmann (1989) conducted an outcome study of several residential adolescent treatment programmes, many based on the Minnesota Model. The study

³ *The Treatment Improvement Protocol, Treatment of Adolescents with Substance Use Disorders* (TIP - Series 32, US, DHSS 1999).

⁴ *The Substance of Young Needs: Review* (2001). The Health Advisory Service.

sample was 924 adolescents; 42% reported total abstinence during the 1-year follow-up period and an additional 23% reported using alcohol and other drugs less than monthly. In addition a range of small-scale evaluations of 12-step programmes reported abstinence rates in the range of 50-60% (Winter *et al*, 2000).

More recently Winter *et al* (2000) carried out an outcome study among 245 adolescents, 73% of whom received treatment with a Minnesota Model approach (residential and out-patients) and the remaining 27% were on a waiting list. The study included samples of individuals who completed treatment, and individuals who did not. The results show that overall significant reductions in drug use were found among treatment completers compared to other subjects during post-treatment period. After a 1-year follow-up, 53% of treatment completers were abstinent (combined abstinent and minor relapse rate), compared with 15% of the non-completers and 27% of the waiting list group. However, the research found that adolescents who received outpatient treatment were more likely than those who received residential treatment to report abstinence at 1-year follow-up, 21.4% compared with 15.4%. In addition the group who received residential treatment were more likely to report lapses (the use of drugs one or two times only during the year) than outpatients, 29.5% and 22.4% respectively. It was expected that residential care, with its presumed enhanced treatment offerings, would out-perform outpatient care. Winter *et al's* study also revealed the treatment retention was an important contributor to outcomes, and indicated that short stays in treatment appear to result in no better outcomes than receiving no treatment at all. It should be noted however, that for some young people the treatment experience (even if not completed) in their youth might indirectly affect future drug use

Unlike 12-step programmes, family-based models, which are relatively new, have been impressively evaluated with controlled studies; Such an approach to adolescent substance use is based on the view that problems related to the whole family often find expression in a young person. Hence, an understanding of the role of the family and, if appropriate, the need for proactive involvement is required (Crome, 1999). Many treatment programmes work with the family members in a component called family-based therapy, family-centred therapy or simply family therapy. Just as the names differ, so have the services differed from one programme to another. According to Winter (1999) some family-focused interventions assume that information about 12 steps philosophy delivered in the context of family treatment is sufficient to affect the drug using behaviour of the adolescent. Other approaches, assume that the interaction within the family and between important family members and other extra familial individuals is critical to making change.

The major objectives of family-based models, regardless of the approach are to reduce resistance to treatment, to re-define the substance problem as a family issue, to improve relationships with parental figures, to develop strategies to change maladaptive patterns of behaviour and to maintain these changes (Crome, 1999). However, Winters (1999) argues that much of what passes as family therapy has lacked a

systematic and disciplined therapeutic approach, and does not reflect an understanding of family dynamics. In addition such programmes frequently lack well-trained and experienced family therapists. Nevertheless, several randomised clinical trials have shown the effectiveness of family-based approaches in increasing client's engagement with treatment and in reducing drug use (Joanning *et al*, 1992; Santisteban and Szapocznik, 1994; Liddle and Dakof, 1995). Moreover, this approach has been shown experimentally to be superior to several alternatives including peer group therapy (Joanning *et al*, 1992; Liddle and Dakof, 1995) parent education (Lewis *et al*, 1990), multi-family intervention (Liddle and Dakof, 1995) and individual counselling (Henggeler *et al*, 1991).

Finally, for many young drug users achieving a brief period of abstinence is a readily achievable goal, although maintaining abstinence or avoiding relapse poses a much greater overall challenge. The rates of post-treatment relapse for adolescent's range of 35% to 85% (Catalano *et al*, 1991) and these rates are based on results from studies using widely varying follow-up periods and methods of data collection. Research has identified three types of variables, which affect treatment progress or treatment outcome (Catalano *et al*, 1991). Firstly, *pre-treatment factors*, which are variables such as age, and drug use prior to admission to treatment. For example, although age is not consistently a predictor of outcome, younger age is associated with better outcomes in residential settings, while older age is predictive of superior outcomes in outpatient settings (Hubbard *et al*, 1985). Secondly, *during-treatment factors* refer to variables such as length of time in treatment, and programme characteristics, which exist during the course of treatment. Thirdly, *post-treatment factors* are those, which occur following the completion of treatment. These include drug cravings, lack of involvement in productive activities, and lack of involvement in active leisure and they have been found to predict relapse among adults (Catalano *et al*, 1991).

SUMMARY

International research illustrates that illicit drug use by young people is widespread (Parker *et al*, 1998; Miller and Plant, 1996; Wright and Pearl, 1990). Moreover, alcohol and illicit drug use is increasingly accepted as part of the youth culture (Parker, 1989). The available Irish data illustrates that alcohol and tobacco are the most widely used drugs among young people. While cannabis is the most commonly used illicit drug. From the available data it is not possible to determine whether substance use and misuse is on the increase in Ireland. However, data from the National Drug Treatment Reporting System illustrates that a proportion, albeit small, of the drug using population are adolescents and young substance (mis)users. These young people have treatment needs that differ from adults. A review of the literature illustrates that there is some evidence to suggest that the Minnesota Model and other Twelve step approaches are successful with adults, but far less is known about their effectiveness for adolescents as studies comparing the effectiveness of such intervention with other treatment alternatives for adolescents are rare. To date few dedicated adolescent treatment services have been established in Ireland, and in the next chapter, the structure and content of the only adolescent residential drug treatment service in the country will be detailed.

3: Aislinn: Background and Programme Structure

INTRODUCTION

Aislinn is the only non-hospital based residential facility in Ireland that is specifically dedicated to treating drug, alcohol and other addictions among young people. Aislinn is a subsidiary of Aiseiri Cahir, which was established in 1983 by St. Eileen Fahey of the Mercy Religious Congregation and managed by a Trust and Board of Managers. Previously members of the Mercy Congregation had a nursing role in staffing county psychiatric hospitals, which included many alcoholics among their admissions. Aiseiri, Wexford opened in 1987 having been requested by the South Eastern Health Board who funded the building and the initial training costs. Thus, Aiseiri operates three residential centres including Aislinn, according to a particular, non-community model of treatment that was originally developed at Willmar State Hospital, Minnesota and was subsequently refined at the Hazelden Foundation. It is known as the Minnesota or Hazelden model and draws heavily from the Alcoholics Anonymous (AA) 12-step programme.

AA 12 STEPS PROGRAMME

The AA 12 Steps Programme is essentially an international mutual support fellowship that is based on an understanding of alcohol problems (and drug, gambling, and other relevant behaviours) as a progressive illness or disease, and promotes recovery through abstinence and regular, voluntary attendance at fellowship meetings. Such meetings are held at several locations: hospital, churches, schools, community centres and treatment centres, depending on the society or community in which they are established. They can be both open (non-addicts, friends or professionals may attend) and closed (members only). Closed meetings involve members discussing and sharing their experience of addiction and working through their programme of recovery. The fellowship is considered as being particularly important in assisting individuals in aftercare, that is helping them to sustain a changed lifestyle and adaptation to family, work and community, following a period of intense treatment, which is provided separately by treatment agencies, who utilise the 12-Steps or other programmes. Because of the importance of these 12 Steps in the Aiseiri/Aislinn programmes, it is worth listing them here;

- | | |
|---------------|---|
| Step 1 | We admitted we were powerless over alcohol - that our lives had become unmanageable. |
| Step 2 | Came to believe that a Power greater than ourselves could restore us to sanity. |
| Step 3 | Made a decision to turn our will and our lives over to the care of God, as we understood Him. |
| Step 4 | Made a searching and fearless moral inventory of ourselves. |
| Step 5 | Admitted to God, to ourselves, and to another human being, the exact nature of our wrongs. |
| Step 6 | Were entirely ready to have God remove all these defects of character. |
| Step 7 | Humbly ask Him to remove our shortcomings. |
| Step 8 | Made a list of all persons we had harmed, and became willing to make amends to them all. |

- Step 9 Made direct amends to such people whenever possible, except when to do so would injure them or others.
- Step 10 Continued to take personal inventory and when we were wrong promptly admitted it.
- Step 11 Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
- Step 12 Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practise these principles in all our affairs.

The Minnesota Model incorporates this AA philosophy. Its application to Aiséiri is documented in an evaluation report that was published in 1994¹.

SETTING UP AND DEVELOPING AISEIRI; AISEIRI

The idea of setting up Aislinn was first proposed in 1994 by an Aiseiri staff member, now current Aislinn director, who was concerned that there was no similar facility for young people. Through both her work with Aiseiri, and her involvement in a schools education programme, she had become conscious of the need for a response to youth drug and alcohol addiction. She prepared a proposal for setting up a separate adolescent residential facility and presented this to the Trustees and Board of Management of Aiseiri. Four main arguments were outlined in support of this proposal.

First, it was argued that there was a widespread increase in adolescent drug and alcohol use potentially leading to major problems including misuse and dependency. The problem of "chemical dependency" was described as being at "epidemic level" and in support of this extracts from a number of localised studies were included in an Appendix², and figures on the number of admissions to psychiatric hospitals by young people for alcohol related problems were also provided³. Second, Aiseiri and other adult treatment centres provided letters in which they reported that their programmes lacked success in dealing with young people primarily because they did not integrate well with adult groups and a more creative approach to treatment was needed. Third, a number of Gardai, judges, juvenile liaison officers and probation officers had indicated (by letter) the need for such a facility⁴. Finally, the directors of three diocesan youth services in southeast region (Waterford, Cashel/Emly and Ossory) indicated (also by letter) the need for such a facility.

¹ See reference - Leane, ?, Powell ? -

² These included extracts from the following:

1. Waterford Regional Technical College (undated) **Survey on need for a Residential Centre for Chemical Dependent Adolescent and Young Adults**, (2 pie charts)
2. University College Cork and Cork Youth Federation (no date) **Smoking, Drinking and Other Drug Use Among Cork City Post-Primary School Pupils** (survey concludes significant polydrug use among young people and advocates a comprehensive school and community education programme).
3. Combined Action Galway (1991) **A Survey of Alcohol Use Among a National Sample of 2nd year 2nd level Students** (indicates age of first drink is declining)
4. Roscommon Regional Youth Service (1993) **Smoking, Alcohol and Other Drug Use**.

³ These figures showed that such psychiatric admissions increased from 78 in 1970 to 295 in 1992. However, the figure of 295 first appears in 1977 and remains high thereafter, and in fact reaches 346 in 1982.

⁴ These indications were provided mainly a letter from one judge and a second letter from a Garda that included the names of criminal justice professionals whom he had canvassed to support the proposal.

Following the presentation of this proposal the proposer's religious community agreed to support her on a study visit to the US, during which time she undertook six week practice study divided between Hazelden Youth and Family Centre Minnesota, and CARON Foundation in Pennsylvania. Both organisations had adapted the 12 steps approach to young substance misusers. This was a successful study visit in that it helped confirm the application of the Minnesota Model to young people. Also the extent to which she was given open access to each element of these programmes provided her with a strong basis for establishing a similar programme in Ireland.

Arising from the visit a proposal for developing an adolescent treatment centre, as a separate entity under the Trustees of Aiseiri but managed through a subsidiary company, was presented. Aiseiri, previously used this model of establishing a subsidiary company to set up a treatment centre in Wexford. The proposal was accepted and committed to in principle pending the location of suitable premises, the raising of £200,000, securing Department of Health funding and cooperation and obtaining the support of the VHI and BUPA. The findings from the US study visit were also presented to the Leaders of the Mercy Sisters of the Southern Province. Support was received from the Order in the form of freeing one member to work unsalaried for three years on establishing the project. In addition the Mercy Congregation provided a house in Ballyraggett, which is now the Aislinn Centre, and \$40,000 to start fundraising. Findings were subsequently presented to the Chief Executive Officers, and Programme Manager of the South Eastern Health Board and they supported the project in principle. Many subsequent meetings followed with the South Eastern Health Board representatives in the following three years. A joint meeting with the South Eastern Health Board, Mid Western Health Board and the Midland Health Board was held in early 1997. Following that meeting, the Midland Health Board withdrew from the project and their place was taken immediately by the Southern Health Board.

Following the decision by the Mercy Congregation to provide a building in Ballyraggett, the way was made clear to appoint a Director, to establish a Board of Management, to engage in an intense programme of fund-raising to assist in the building's refurbishment and to initiate the treatment centre, which eventually commenced in 1998. It is evident that the Director's conviction and the charisma that she brought to her role held great sway with the Board of Management and others and she succeeded in mobilising terrific energies in support of the centre's establishment and development. In the main, the primary role of the Board of Management was, and continues to be, resource acquisition and management. There are two sub-committees: one deals with fund-raising and to date has raised over EURO 600,000 from non-statutory sources, alongside an annual budget of over EURO 300,000 from statutory sources. The other sub-committee deals with personnel issues; recruitment, job descriptions, remuneration, and the development of procedures for complaints and grievances.

AISLINN STAFF

The Board has no involvement in programme design or monitoring and in effect this responsibility lies with the Director and her counselling team. The Director's main initial training is in general nursing. She has worked in midwifery in Ireland and in community health in a developing country. For over fifteen years now she has been involved in addiction work and was initially motivated to be involved in this work as a result of her concerns about a "revolving door syndrome" she encountered in the treatment of alcoholics in hospitals during her nursing training. She undertook training in Aiseiri, which was accredited by Hazelden. She then worked for eight years in Aiseiri until she was assigned to develop and set up Aislinn. The Director's responsibilities are to give overall direction and support to the programme, to manage, supervise and support counselling staff, to lead counselling team meetings and discussions, to work alongside an administrator and to report to the Board of Management. Alongside these management responsibilities, the Director also plays a prominent role throughout the programme, for example facilitating group work and family work, in which she takes a particular interest.

Working alongside the Director is a senior counsellor, who has overall responsibility for the counselling team during the Director's absence. Like the Director, the Senior Counsellor was trained through a Hazelden accredited course in Aiseiri and has four years post-training experience. Next to the Director she is the most experienced (in terms of post qualification years worked) member of the counselling team. Remaining members of the counselling team (n=?) also have similar recent Hazelden training and Aislinn now currently has counselling trainees (n=?) on Hazelden accredited programmes. The Hazelden training clearly provides an important foundation for integrating with and sustaining the programme and staff speak very favourably about its "powerful impact" and the influence it has had on "personal change." A number of staff members formerly had problems arising from drugs or alcohol misuse and are currently in recovery. They are quite open with respect to this and generally speaking being in recovery is viewed as an important asset to the programme. Moreover, this information is not withheld from programme participants. As one counsellor said;

The lads know I am in recovery because they ask and they get told on that basis

In addition to the direct counselling team there is a screening worker who undertakes screening/assessment interviews and also liaises with referral agents and families: a recreational worker and a child care worker who oversee a social and recreational programme; and four night assistants who supervise overnights. The Centre also has a chef and a gardener.

On the administrative side there is a Centre administrator who manages accounts and accounting arrangements/relationships' with health boards and other funding bodies. The Centre's secretary undertakes reception and general secretarial duties. As the first point of contact she also processes initial queries in relation to referral, admission and general information.

PROGRAMME PHILOSOPHY

As previously stated Aiseiri and consequently Aislinn, are based on the Minnesota Model, characterised by the use of the 12-steps philosophy of AA as a foundation of therapeutic change. Accordingly, the treatment goal is total abstinence from mood-altering substances and improved quality of life. Implicit in this view is the notion of *chemical dependency*, that is individuals who are dependent on one particular drug or class of drugs should abstain from all drug use, for fear that they risk relapse to their drug of choice, or transfer their addiction to another substance. Aislinn, retained the main therapeutic components of the parent Aiseiri programme, therefore treatment components include group therapy, individual therapy, family therapy, lectures about the 12 Steps of AA, and a series of AA-based readings and assignments and working through the first five steps of AA. Thus, while in residential treatment, the step work undertaken by the young people focuses on the first five steps of recovery. In lay terms this involves (1) admitting to the power of substances to make one's life unmanageable, (2) believing there is hope for change if you let yourself be helped, (3) learning from the advice of others as you explore making different decisions about your life, (4) taking an in-dept moral inventory of one's life and (5) discussing your past wrongs with a peer, counsellor or significant other (Winter *et al*, 2000). These steps are intended to increase the youths recognition that their substance misuse involvement is causing problems in their life, that a significant life-style change is needed to reverse the current problem, and that support for change can be drawn from several sources in one's home and community.

In recognition of the fact that the needs of adolescent substance misusers differ to adults, Aislinn developed its own way of delivering the programme, which is adolescent friendly, and includes recreational and creative components. For example, all programme participants are required to get involved in recreation, which depending on the weather is carried out outside or in the main building. Participants either play team games such as football, or they do a work out, or circuit training. Other alternative aspects to the programme include art and psychodrama. Outside facilitators are brought in to supervise these groups. In addition a teacher comes in to do career guidance work with the young people. Furthermore the programme is two weeks longer than Aiseiri's four-week programme and residents in Aislinn are within the 15-21-age range, whereas Aiseiri residents are of all adult age groups. Because of its younger age group, the Aislinn programme is conscious of additional care responsibilities in relation to minors, who are never left unattended, and these responsibilities also arise in relation to communications with residents' families.

Despite these differences, which are mainly of a practical nature, there are no philosophical differences between the two programmes. The approach adopted by Aislinn endorses the *disease model* of substance dependency, which represents an explanatory concept encompassing social, psychological, spiritual, but predominantly biological dimensions of alcohol and drug dependency (Sheehan, and Owen, 1999). Thus, like Aiseiri, Aislinn identifies addiction as a disease characterised by gradual loss of control over alcohol or drugs and subsequent deterioration in addicts' physical, emotional and mental health:

It (addiction) hits indiscriminately and is terminal and similar to diabetes. It has to be managed each day and, like cancer, it has a remission and the only difference being that a person in addiction can choose how long they can stay in remission⁵.

From the disease model perspective, individual addicts, it is asserted, have no control over their addiction. **Moreover, substance dependency is a chronic and progressive condition, with no cure. Therefore the view** is that it is particularly important to treat young people at an early age. While their exposure to alcohol and drugs provides a great deal of pleasure and does things for them that they have never experienced before, they are nonetheless losing their self-confidence, losing their self-esteem and becoming increasingly conscious that that they are headed for trouble. Providing an effective treatment intervention while they are still young, can mean that they begin to understand their disease, addiction, and rediscover their confidence in overcoming their problems. Most of the young people treated in Aislinn for substance misuse had no understanding of the 'disease concept of addiction' prior to attending the centre, consequently they did not understand their behaviour. As one counsellor said;

A lot of the lads feel looked-down upon and weak-willed. Whereas they are not: they are diseased and need to be treated on this basis the same as anyone who has this disease.

While there is no cure for addiction Aislinn, like all 12 Steps programmes, emphasises the fact that recovery is possible. However, recovery can only be achieved through abstinence, which is Aislinn's fundamental treatment goal.

We promote abstinence: the way to avoid the illness is to stay abstinent.

The achievement of abstinence, it is believed, can be supported through a lifetime process of spiritual awareness and personal insight, responsibility and change. In this sense, spirituality is not considered a prerequisite for recovery, although on admission clients are asked about their spiritual understanding. It is believed that individual 'addicts' need to acknowledge an external power and to reach out to this in order to make the changes that are needed in their lives.

In order to recover you need to look outside of yourself. Addiction is linked to being in control — recovery is acknowledging that there is something outside of yourself.

There is a process here and people just change. It has a life, philosophy, and spirituality of its own and when you give it your all it seems to work.

Making recovery work involves taking personal responsibility. Although addiction is considered an illness, it has wider family and social consequences and the only way addicts can change the effect of their addiction on others is for them to take responsibility to change. This emphasis on individual responsibility to change is a fundamental principle in Aislinn's overall philosophy and provides everyday guidance to staff in the therapeutic direction of their work with residents.

⁵ Unless otherwise stated quotes in this section are from members of Aislinn Staff

PROGRAMME OPERATION

The main operational component of Aislinn's programme is to provide an induction for young substance misusers into lifetime recovery. Such induction is undertaken through an intensive, concentrated six-week residence. In the initial stages of designing a programme some consideration was given to non-residential options or possibilities, such as day treatment. However, there was a sense in which the residential option became inevitable. The initiative had come mainly from someone who had already spent eight years in Aiseiri and who believed it was possible to make the Aiseiri residential programme work with young people, in a separate setting. With evidence, gained from this US study visit that residential programmes seemed to work elsewhere; there was a clear momentum towards trying this approach as distinct to any other. The residential component it seems is paramount: it is the foundation from which other developments happen rather than the other way around. It is considered "critical" as it provides young people with "time apart" to look at "reality with new eyes".

They need time out in a new environment, away from the environment in which they are under so much pressure ...the addicted person has lost all self-worth and they rebuild it here and it is only through this process that they begin to look at themselves in a positive way.

ADMISSION

Entrance to the programme is through a referral and screening procedure. As there is no uniform funding arrangement between all health board areas, there are variations in the detail in how individual referrals are made. Usually, nominated addiction counsellors from the health boards, which have referral agreement contact Aislinn to make a referral, which is subject to funding confirmation by an authorised senior manager. Alternatively, referrals can be made directly by parents with respect to either private funding (either insurance or direct payment) or subject to further negotiation with respective health boards. The Probation and Welfare Service, G.P.'s, and Gardai also make referrals to Aislinn (see Chapter 4).

Following authorisation or funding agreement, a screening interview is scheduled for the prospective client and their parents/guardians. Parents are present throughout the interview, except in situations where a prospective resident requests a separate interview. The screening interview usually last one and a half hours and focuses*on a range of topics: family, alcohol and drug (mis)use, the consequences of substance misuse, involvement in dealing, school, work, spending and involvement with other services. Questions are also asked about mental health history, violence history, legal history, psychosexual history, friendships and spiritual history. The main focus of interview is a person's alcohol and drug (mis)use and how it impacts on areas of their lives. The screening interview is however, relatively informal, and the young person is encouraged to be open and honest, as are the parents/guardians. This screening is conducted with the assistance of a brief schedule and the Jellinick diagnostic chart (which consists of behavioural items). These instruments are however, not validated and therefore not reliable. There is also doubt concerning the diagnostic value of the Jellinick in determining dependency. Generally, as a result of the screening interview the next available admission to the programme is offered. The young person is shown around the house before they leave, however, they are not able to meet and talk with the other

residents due to confidentiality. On a few occasions prospective residents have been told that they may not be appropriate for admission.

In preparing for admission clients and parents are issued with booklets that comprehensively outline the programme procedures and policies and various processes for dealing with admission, client-family communications during residence and discharge.

DAILY ROUTINES

Once admitted onto the programme clients proceed to adapt to a highly structured programme of therapy:

It's very structured here: most of the time the residents would be in structured activity, so only now and then would there be a free fifteen minutes.

Table 3.1 Typical Daily Routine

Time	Residents	Staff
8.00		Breakfast
8.30	House Chores	< Staff Handover (night staff)
9.00		Meditation
9.30	Free Time	Reflection/daily planning Meeting/handover
10.00	Group Therapy	Group Therapy
	Family Session (Weds)	Family Session (NXeds)
11.30	Free Time/Cigarette Break	Individual appointments
11.45	12 Step assignments- individually	Assist in 12 step assignments
12.20	Cigarette Break	
12.30		Lunch
13.30	Free Time/Cigarette Break	Staff Handover
13.45	Lecture/Family Lecture (Weds)	Lecture/Family Lecture (Wed)
2.15	Cigarette Break	
14.30	Recreation/Art/Family session (Weds)	File Management/Family Session (Weds)
	Family-Visit (Sun)	Individual appointments
16.00	Shower/Free	Staff Handover
16.30	Group Therapy	Group Therapy
	Orientation Group	Orientation group
17.30	Free	Staff Handover
18.00		Tea
18.30	Free Time	
19.00	Big Book Reading	Big Book Reading
	Tea and Meni Plan Review	Tea and Meni Plan Review
19.30	Cigarette Break	
19.45	12-Step Assignments I - Individually Video (Friday, Saturday, Sunday)	Assist with Step Assignments Individual appointments
20.20	Cigarette Break	
20.30	Reflection Sheet	Supervision of Reflection Sheet
21.00		Meditation
21.30	Board Games /Mass (Saturday)	Handover to Night Staff
22.30	Bed	

The programme differs to more familiar (for drug use) Therapeutic Community (TC) programmes, whose residential component is usually 12 months or longer. Unlike TCs, Aislinn does not incorporate routine housekeeping and house maintenance duties as an integral component of daily therapy and treatment. Rather, the daily routine is focused on structured one-to-one counselling, group therapy, group information sessions on the programme's overall philosophy, and instructions on the 12 Steps. There is a social and recreational dimension, but this is strictly timetabled. Residents have no access to distractions such as the radio, the television or newspapers and they are not allowed tape recorders or books. On weekend nights they can view videos that are selected from a limited collection of general releases

THERAPEUTIC FOCUS

Like therapeutic communities, the therapeutic focus in Aislinn is directive, and at times confrontational. Staff routines are highly structured and there is constant attention to 24-hour client supervision; knowing where everybody is; and monitoring changes in patterns of behaviour and communication.

Supervision of clients would be a big thing: constantly doing a head count - always wondering what are they up to. I'm sure clients do find this intrusive.

On a daily basis there are four staff changeovers during which there is an exchange of information in relation to residents' adherence to house rules, their general mood and attitude, their interaction with peers and staff, and their progress in achieving therapeutic objectives.

Most of them have little understanding of rules and boundaries and attending with them is making sure they stay aware of our expectations.

Therapeutic objectives are agreed with clients following consultations - at intake and in subsequent individual and group sessions - but are fundamentally guided by the programme's philosophy.

Our objective is to help residents to give up mood-altering chemicals and also to give up their lifestyles, to change those character defects and failings that get them into trouble and to give them light and hope.

The programme rather than the individual client therefore, primarily governs the determination of need or desired outcome. Provided client aims he within the parameters of the programme's main tenets, or have the potential to do so, they can be agreed. In effect, during the early stages of the programme, residents are being inducted into a philosophy as much as into treatment/recovery:

(We are) promoting a theory with them rather than reflecting on a life experience.

Following agreement, clients receive a great deal of affirmation and encouragement. Each client has a key worker who, in addition to working with the client in groups, is also regularly working in one-to-one sessions, re-assuring them and helping to keep them focused on therapeutic aims and goals. Their progress is discussed at staff meetings and changeovers thus contributing to continuity in attention and treatment. If a client indicates a willingness to explore aspects of their addiction during a morning session there is continuity in keeping them focused on this through the afternoon, the evening and the next day if necessary. Consequently there is a strong sense of being able to witness, acknowledge and share an insight,

a change or an achievement, particularly among other clients. Such developments generate great enthusiasm and help fulfil the programme's belief in a spiritual component.

Somebody has had an internal struggle for so long that finally they are able to reach out:
reflecting something out there that is bigger than all of us.

If however, a client is unable to accept their addiction, their lack of power over it, or to seek a higher power in overcoming it, and make a commitment to a lifetime of abstinence, there are difficulties or complications in reaching agreement about their aims and in sustaining their therapy. They may need to be "cajoled" or "confronted" in order to bring them the extra step towards programme adherence. While these difficulties cause some discomfort, for staff and residents alike, there is also a view that most individual progress is often made during such encounters. Ultimately, failure to achieve progress or programme adherence can result in what is referred to as a therapeutic discharge, whereby clients are asked to leave the programme for the reason that they are not yet ready for it:

Maybe they weren't ready: they might need to hurt more

Other discharges are usually the result of direct client request (against staff advice) or at the request of staff as a result of serious breaches of rules. Procedures for dealing with all discharges or other disciplinary matters are clear, written and adhered to.

Importantly, the programme has a nurturing function in relation to residents. Many come with little nourishment and some lack social skills or have lacked recent opportunities for warmth in family or social relationships. Staff spend a lot of time, particularly during meals, sitting and talking with residents, encouraging them, affirming them and reassuring them.

FAMILY INVOLVEMENT

Family involvement is a crucial component of the programme. From the outset families are part of the referral and intake process. Family members are then required to attend the family programme, each Wednesday from 10am to 5pm for the six weeks of residential treatment, and to make a social visit on Sunday afternoons. Parents are asked to sign contracts in advance of admission committing themselves to this level of involvement. Parents are also requested not to take alcohol or drugs during the course of the six-week programme. The emphasis on family involvement is in recognition of the consequences of young persons' addiction on family members and the need for members to support and adjust to an individual's recovery:

Addiction is recognised as a family illness: family adjusts to cope with the illness. Family has put 99% of their efforts into the addict. Family needs to learn about addiction and themselves and what they need to change in order to allow the addict come home.

The family day consists of lectures, family conference, joint group session, step work and education sessions for parents and concerned others. The purpose is to help support the family and client during transition from addiction to recovery, helping them to break down defence mechanisms, and to improve communication. The family programme over the six weeks consists of the following:

- Introductory Lecture
- Individuals Family Sessions
- Group Family Sessions
- First Step session
- Home Contract and review of relapse track
- " Evening session - educational
- **Lecture** Twelve steps
- **Self Help groups**
 - Effects of Addiction
 - Effects on the whole family
 - Effects of addiction on the addict
 - Relapse, coping with resident going home
 - Spirituality.

Generally, the focus in these sessions is on exploring resident's alcohol and drug history and sharing and reviewing their progress, while at the same time keeping families informed of the philosophy and thinking behind the programme. In family therapy sessions residents share the details of their drug history while parental knowledge and understanding of these is also clarified. Residents account for how they are getting on in their 12 Steps; sharing their personal insights and commitment to change; and exploring how their return home and aftercare is to be managed. Throughout these sessions there is a strong emphasis on communication. In particular, staff facilitate residents to express their ideas and understanding of their addiction to their families, and to help them include their voice. Staff also facilitate family members to ask questions, to seek clarifications or add other insight or other information to the process.

Am HIU:AUK

Another key element in this programme is its focus on aftercare. As already outlined, the main objective of the residential programme is to induct young people with alcohol and drug problems into recovery, which is a lifetime commitment to remaining abstinent and participating in a 12 steps fellowship. By way of supporting ex-residents into continued recovery, Aislinn has set up special two hourly weekly aftercare meetings in four locations: Kilkenny (Aislinn), Dublin, Cork and Limerick. The young people are required to attend the aftercare for two years, following their residential treatment. These meetings follow basic AA principles except that they also include trained facilitators who are themselves in recovery. On a monthly basis a combined aftercare group for the young people and parents is held and there is also a separate monthly meeting in Aislinn, which is for family members only.

S'MMAUY

The Aislinn Adolescent Addiction Treatment Centre was established out of recognition that young substance misusers have treatment needs that differ from their adult counterparts. To this end it was considered necessary (and in accordance with good practice) to establish a Centre specifically for young substance misusers. The 12 Step Minnesota Model approach is one of the most widely practiced approaches to treating serious substance misusing adolescents in the US (Winter *et al*, 2000; HAS, 1999). The Aislinn Adolescent Addiction Treatment Centre uses the basic tenets and philosophy of the

Minnesota Model however the programme has been modified somewhat to cater for the needs of young substance misusers. As outlined in the previous Chapter few outcome studies have been conducted on this treatment approach, and those that have show favourable outcome results for adolescents. However, it is difficult if not impossible to extrapolate on the basis of the research findings, as programmes will vary to the extent to which they adhere to the Minnesota Model, which at its core emphasises life-style changed organised around the AA philosophy.

In the chapter the programme structure, content and philosophy has been described in some detail. As a Minnesota Model programme the Aislinn Adolescent Addiction Treatment Centre combines the principles of the 12 Steps of AA and basic principles of psychotherapy. Chemical dependency is treated as a primary disease with the prescription of abstinence. All clients are involved in a range of treatment components that span the six weeks of the residential programme. Treatment components include group therapy, and individual counselling, family therapy, lectures about the 12*steps, a series of AA based readings, occupational and recreational therapy. Step work focuses on the first five steps of recovery. In addition, families are required to attend sessions on a weekly basis with other family members. Group therapy, lectures and contact with other families and staff offer the participants both information and support. At the conclusion of the residential component of treatment, the young people are expected to enter two years of aftercare. Its purpose is to continue the treatment process, providing ongoing assessment of the young persons progress and assistance as needed. In the next Chapter, the intake characteristics of the population of programme participants are outlined based on programme records.

4: Aislinn Client Profile

Data were collected from client screening and assessment forms, in relation to all young people who presented at and were accepted into the Aislinn Adolescent Addiction Treatment Centre from October 1998 to August 2001 (n=264). The data was entered into an Excel spreadsheet and analysed by SPSS. The data obtained are based on client's self-reported behaviours and provide a comprehensive description of the treatment population at Aislinn. The data presented here represent the total treatment population for the period under investigation; percentages are based on valid responses adjusted for missing data. Missing data includes information not collected and non-responses by clients.

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF POPULATION

Twenty eight percent of the population were female (n=74), the remaining 72% were male (n=190). The average age of clients at the time of entering treatment was 17.6 years (Sd=1.6; range 15-21 years). Analysis revealed that there were no significant gender differences in the age of programme participants. The mean age for females was 17.4 years and the mean age for males was 17.7 years. Figure 4.1 illustrates the age distribution of clients, and show that there were some gender differences in diis regard. It illustrates that 9% of the population were 15 years of age at the time of entering treatment; females were slightly more likely than males to be in this age category (11% Vs 8%). Sixteen percent of the population were 16 years old, and there were no gender differences in this regard. Twenty seven percent of the females were 17 years compared with 21% of the males. Female respondents were less likely than their male counterparts to be in the higher age categories, 18 years (18% Vs 21%) 19 years (14% Vs 16%) 20 years (12% Vs 14%) and 21 years (1% Vs 4%).

Figure 4.1 Age Distribution of Population by Gender

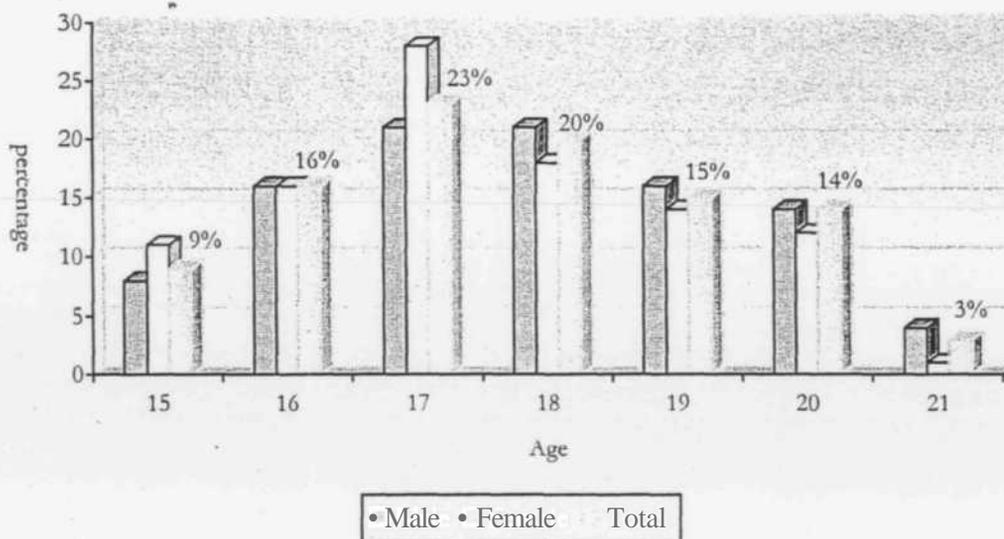
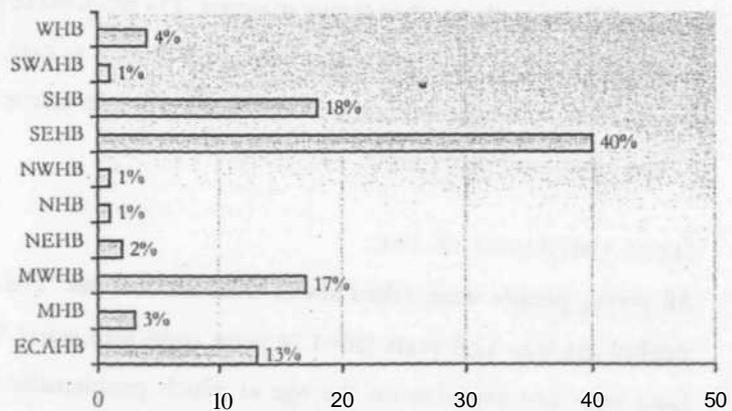


Table 4.1 County of Residents

County of Residence	Number n	Percentage %
Carlow	11	4
Clare	9	3
Cork	37	14
Derry	1	0.5
Donegal	1	0.5
Drogheda	1	0.5
Dublin	26	10
Galway	7	3
Kerry	7	3
Kildare	6	2
Kilkenny	21	8
Laois	3	1
Leitrim	2	1
Limerick	19	7
London/UK	2	1
Longford	1	0.5
Mayo	4	1.5
Meath	4	1.5
Navan	2	1
Offaly	3	1
Sligo	2	1
Tipperary	55	21
Waterford	20	7
West Meath	2	1
Wexford	12	4
Wicklow	6	2
Total	264	100

Table 4.1 illustrates the county of residents of programme participants. It shows that the highest proportion of clients were from Tipperary (21%), followed by Cork (14%) Dublin (10%) and Kilkenny (8%). The health board areas in which the programme participant resided were also recorded. Figure 4.2 illustrates that 40% of clients were residing in the South Eastern Health Board (SEHB), 18% where in the Southern Health Board area, and 17% in the Midwestern Health Board area.

Figure 4.2 Health Board Areas of Programme Participants



The occupation of all participants immediately prior to their entry into treatment was recorded. Table 4.2 shows that over half the programme participants were unemployed (56%), 17% were employed and 13% were still in school. There were some minor gender differences in reported occupation. Female clients were proportionately more likely to be unemployed than their male counterparts (58% Vs 56%). They were also however more likely to be still in school (16% Vs 12%). On the other hand, male clients were proportionately more likely to be on a Youthreach programme (10% Vs 1%) or doing an apprenticeship (6% Vs 1%). There were no gender differences in reported employment.

Table 4.2 Occupation of young people (prior to entry into treatment).

Occupation	Male		Female		Total %
	n	%	n	%	
Employed	30	17	12	17	17
Unemployed	100	56	41	58	56
In School	22	12	11	16	13
College/Third level	2	1	2	3	2
Apprentice	11	6	1	1	5
FAS course	4	2	3	4	3
Youthreach	10	6	1	1	4
Total	177	100	71	100	100

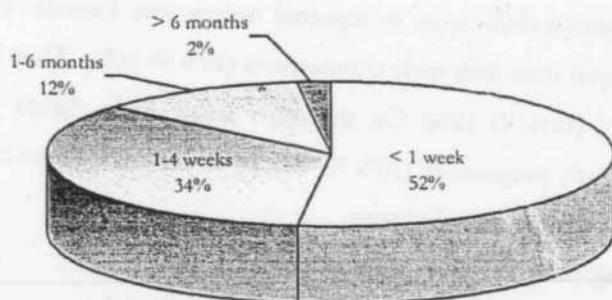
Table 4.2 illustrates that only 13% of the young people were still in school (n=33). The average age at which the remaining clients left school was 15.5 years (Sd=1.44; range 8-19 years) and there was no significant gender difference in this regard. Of those who had left school (n=229) 39% left without any qualifications (n=89), 44% left school having completed the Junior Cert (n=98), and 17% had completed their Leaving Cert (n=37). Of those that completed the Leaving Cert 24% had commenced some type of post-leaving course. Due to the relatively low levels of formal education, it was not surprising that 17% of the population self identified some learning difficulties. Four percent reported that they were dyslexics, 3.5% reported having problems reading, an additional 9% reported problems with both reading and writing, and 1% reported having been diagnosed with ADHD (Attention Deficit Hyperactivity Disorder).

The living circumstances of all the young people prior to entry into treatment were recorded. The majority 69% reported that they were living with their families. An additional 16% reported living with one of their parents, in the majority of such cases (80%) this was their mother. Three percent of the population reported living with another family member, 1% reported living with friends, 3% were living on their own in a flat, 2% reported living with a partner, 1% were in care, and 2% were homeless. Finally 3% reported other forms of accommodation immediately prior to treatment including probation hostels, secure units (Oberstown) and detox units.

DRUG AND ALCOHOL USE

All young people were asked about their alcohol use. The mean age at which the clients reported first alcohol use was 12.8 years (Sd=1.74 years; range 6-18 years); there was no gender difference in this regard. Data were not available on the age at which problematic alcohol consumption commenced. The most common drink consumed was lager (53%) followed by cider (32%), however, it is likely that the young people consume a range of different types of alcohol. Figure 4.3 illustrates that over half the client

Figure 4.3 Last consumed alcohol



group reported consuming alcohol in the week prior to entry into treatment, and one third of the young people drank alcohol in the month prior to entry into treatment. Only 17% of the population reported that the only substance they used was alcohol, the remaining 83% used a range of other substances.

Data were recorded on young peoples self-reported drug (mis)use. The majority of young people (83%) reported poly drug consumption that is the (mis)use of three or more substances. Information was only collated on a maximum of three primary substances used prior to treatment. Therefore, the data presented does not relate to lifetime prevalence of drugs consumed. Most of the young people will have, in the course of their drug using careers, consumed a vast array of different drugs, however, in many instances

their use would have been experimental, or their substance of choice will have changed over time. The data contained within the screening/assessment forms did not permit an accurate analysis of all substances consumed in the course of drug using careers.

Table 4.3 illustrates the total number of programme participants who reported the use of each drug type. For example, it shows that 91% of the programme participants reported the use of cannabis, over three quarters of the population reported the use of XTC and 50% reported the use of amphetamines. The second column shows the programme participants primary drug of use. In this instance primary drug is defined as being *the most frequently consumed drug*, as opposed to the individuals drug of choice. For example it shows that 69% of the

Table 4.3 Self Reported Drug Used

Drug	Total		Primary	
	n	%	n	%
Cannabis	238	91	180	69
XTC	201	77	17	7
Amphetamine	130	50	4	2
LSD	24	9	-	-
Heroin	22	8	8	3
Cocaine	22	8	-	-
Inhalants	12	5	3	1
Benzodiazepines	11	4	-	-
Tranquillisers	9	3	1	0.33
Methadone	6	2	1	0.33
Other opiates	4	2	1	0.33
Magic Mushrooms	4	2	-	-
Alcohol	-	-	44	17
None	-	-	-	-

programme participants reportedly use cannabis most frequently, 17% reported using alcohol most frequently, and 3% of the programme participants reported using heroin most frequently. The most notable differences between the two columns are in related to XTC and amphetamine consumption. This is largely due to the fact that XTC and amphetamine users rarely consume these drugs on a daily basis, rather use is confined to weekends, and cannabis or alcohol is consumed more frequently. This is not to say that the preferred drug is the most frequently consumed.

The average age at which young people initiated use of their primary drug was 13.6 years (Sd=1.8 years; range 7-20 years). Analysis revealed that age of onset of first use varied across drug type. The mean age of first use of alcohol was 13.7 years (Sd=1.6 years; range 9-16 years), the mean age of first use of cannabis was 13.5 years (Sd=1.6; range 7-18 years) and for XTC it was 15.3 years (St=2 years; range 12-20 years). Unfortunately there were no consistent records kept of onset of misuse, or problematic use, therefore the value of the data are limited. Figure 4.4 illustrates when the programme participants last consumed their

primary drug. It shows that 47% use their primary drug within the week prior to entry into treatment, 39% reported use in the month prior to treatment, 12% reported last using between 1-6 months prior to treatment and 2% last used their primary drug more than 6 months prior to treatment.

Figure 4.4 Last consumed Primary Drug

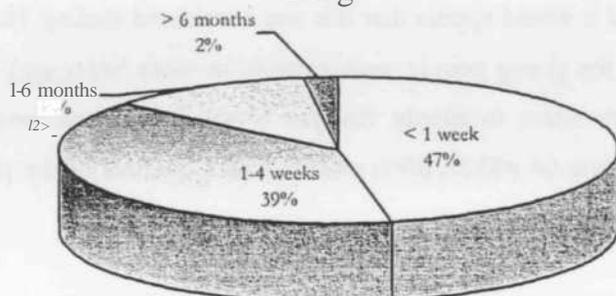


Figure 4.5 Pattern of use of Primary Drug

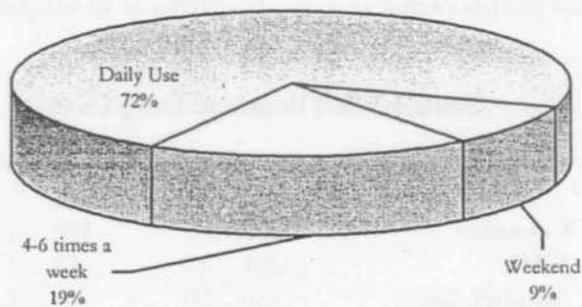


Figure 4.5 illustrates the pattern of use of programme participants primary drug. It shows that 72% of respondents reported using their primary drug daily, 9% reported weekend use, and the remaining 19% reported use 4-6 times a week. Analysis revealed that pattern of use varied across drug type. For example all of the heroin misusers reported daily use, as did 82% of the cannabis misusers, and 54% of the alcohol misusers. On the

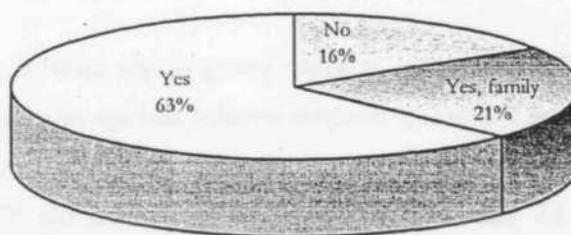
other hand, 56% of the XTC misusers and 50% of the amphetamine misusers reported weekend consumption. While the value of this data is limited, it clearly illustrates that the majority the young people in the Aislinn Adolescent Addiction Treatment Centre are poly drug misusers, consuming a range of substances, and that patterns of consumption varied markedly across drug type. In addition, it is worth noting that 32% of the young people reported that they have had an accidental overdose, and this was not associated with gender or age.

ANTI-SOCIAL Behaviour

Some information was available on the anti-social and offending behaviour of the young people who had been accepted onto the programme. All young people were asked in the assessment procedure whether they had ever stolen for drugs. Figure 4.6

illustrates that 84% of the young people reported that they had, however 21% stated that they had only ever stolen from their family. There was no significant gender difference in this regard, although the young women (22%) were more likely to state that they had not stolen for drugs compared with their male counterparts (14%). In addition all the young people were asked

Figure 4.6 Have you ever stolen for drugs



whether they had ever 'dealt drugs', the majority 69% reported that they had. However, no clear definition of dealing is provided. In many instances the young people bought drugs for themselves and their friends, and it would appear that this was considered dealing. However, as will be seen below, a small proportion of the young people were involved in more heavy end dealing, and had charges pending for possession with intent to supply. Analysis revealed that there was a significant gender difference in self reported dealing ($\chi^2 = 33.33$; $df=1$; $p<0.01$). Three quarters of the young men reported this compared to 51% of the young women.

Almost three quarters of the population (73%) reported that they had been arrested. There were highly significant gender differences in this regard ($\chi^2 = 21.6$; $df=1$; $p<0.01$). Just over half (53%) of the female participants reported having been arrested compared with 81% of the male participants. The average number of arrests per person was 8, however 19 individuals reported in excess of 20 arrests. Programme participants were also asked whether they had ever been arrested for assault, and 38% of those who had been arrested ($n=72$) reported an assault-related arrest. Surprisingly there was no significant gender difference in this regard, with 32% of the females who had been arrested reporting an arrest for assault and 39% of their male counterparts. The vast majority of the young people arrested for assault (94%) reported being under the influence of drink and/or drugs at the time of the incident.

Thirty six percent of the population reported that they were on probation at the time of presenting for treatment. While gender differences were not statistically significant, the young men (38%) were proportionately more likely than the young women (29%) to report this.

Table 4.4 Charges Pending

Charges	H	M
Possession	19	19
Possession with intent to supply	9	9
Drunk and Disorderly	11	11
Drunk Driving	1	1
Breach of the Peace	6	5
Criminal Damage	4	4
Assault	11	11
GMII	1	1
1 .arcenv	13	13
Armed KoMjrrv	2	2
Auo r.hcfr	3	3
Joyriding	1	1
1 res passing	1	1
Breaking and tillering	1	1
Possess ion of wea po n	1	1
2 or more charges pendiiTg	17	17

Just under half the population (49%) reported that they had charges pending at the time of entering treatment. The young men (58%) were significantly more likely than their female counterparts (26%) to report this ($\chi^2=21.24$; $df=1$; $p<0.01$). Table 4.4 illustrates the range of charges that the young people were facing. Over one quarter of the offences were drug related, in that 19% were for possession of a controlled substances, and 9% were for possession with intent to supply.

All programme participants were asked whether they were attending treatment at the recommendation of the court, and 19% reported that they were. It is possible that there was some confusion around this line of questioning. In some cases people reported yes, because their case was adjourned until post-treatment, in other cases the judge or their probation officer recommended that they attend treatment. Finally one fifth of the cohort reported having been to prison (20%) and surprisingly there was no gender difference in this regard. Twenty percent of the females reported having been in prison, compared with 23% of the males. It is likely that this is an overestimate, as individuals may have stated yes, if they were held overnight in police cells. Moreover, there was no distinction made between being remanded in custody and receiving a custodial sentence.

HKAI/TI AND WII.I.-IJKINC

All programme participants were asked whether they had any physical health problems, and 84% reported having none. Twelve percent of the population reported suffering from asthma, and a range of other health complaints were reported including anorexia ($n=1$), epilepsy/seizures ($n=3$) and diabetes ($n=1$). The

vast majority of young people were not on any prescribed medication, however 5% reported being on antidepressants (SRI's) and one respondent reported being on librium to 'stabilise his moods'. Sixty percent of the young people reported having attempted suicide at some point in the past. Analysis revealed that young men were significantly more likely and their female counterparts to report this ($\chi^2=8.8;df=1;p<0.01$). Just under half (47%) of the female clients reported having attempted suicide compared with 66% of the young men. The average number of suicide attempts per person was 2.3, however one young man reported having attempted suicide 10 times. The majority (70%) of the young people reported being sexually active, and gender differences were not statistically significant (males 71%, females 67%). Less than half the cohort, 46% reported having a regular sexual partner.

CONTACT WITH TREATMENT SERVICES

Over three quarters of the young people (77%) had been for counselling (including although not exclusively drug-related counselling). There was no significant gender difference in this regard, however female clients were proportionately more likely (84%) to report this than their male counterparts (74%). Over half of the young people (58%) reported that they had previous contact with a drug related service.

In the majority of cases this contact was for a

relatively short period of time, and it led to a referral on to Aislinn. Analysis revealed that female clients were significantly more likely to report previous treatment contact; 67% of the young women had been in contact with a drug related service compared with 51% of the young men ($\chi^2=3.83; df=1; p<0.05$).

Table 4.5 illustrates the referral sources of the programme participants. It shows that one fifth of the young people were referred by either their Probation Officer or Juvenile Liaison Officer. Parents or other family members referred 18% of the young people. Addiction counsellors were responsible for the referral of 14% of the programme participants and 11% were referred directly by Arbour House (an adult addiction service).

PROGRAMME COMPLETION

The average length of time on the programme was 29.7 days (Sd=15.2 days; range 1-59 days). Figure 4.7 graphically illustrates the length of time individuals stayed on the programme. The blue line highlights the percentage of programme participants who left

Table 4.5 Referral Sources

Referral Source	Number n	Percent %
Probation/JLLO	48	20
Family	44	18
Arbour House	26	11
Addiction Counsellor	33	14
Aiseiri	18	8
G.P.	16	7
Social Worker	14	6
Staff	3	1
Other services	21	9
ARC	1	
Aras Gael	1	
Bernardos	1	
Bushy Park	2	
Cappawhite	1	
Clare Care	1	
Cuan Dara	1	
Ferry House	1	
Hope House	3	
Oberstown	1	
Rutland	4	
St. Dymphna	1	
Tabor Lodge	2	
Wellspring Hostel	1	
Self	3	1
School/Education Off	3	1
Gardai	3	1
Psychiatrist /therapist	8	3
Total	240*	100

treatment at weekly intervals. For example, it illustrates that 14% of the participants left within the first 7 days of treatment, and additional 10% left between the first and second week, and 6% left in the third week of treatment. Figure 4.7 shows that 43% of the programme participants left in their 6th week of treatment. The yellow line illustrates the programmes retention rate. For example, it shows that after 14 days of treatment the programmes retained over three quarters of the young people, and after 35 days of treatment over half its population (52%) were still in treatment.

Figure 4.7 Length of time on Programme

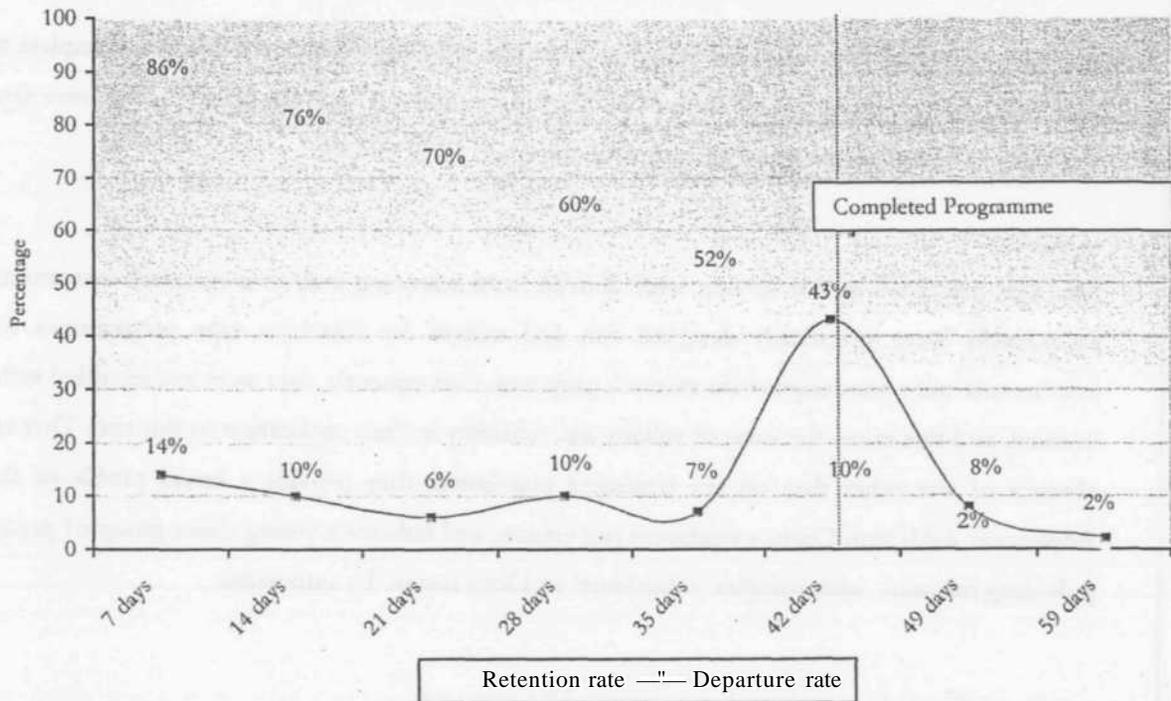
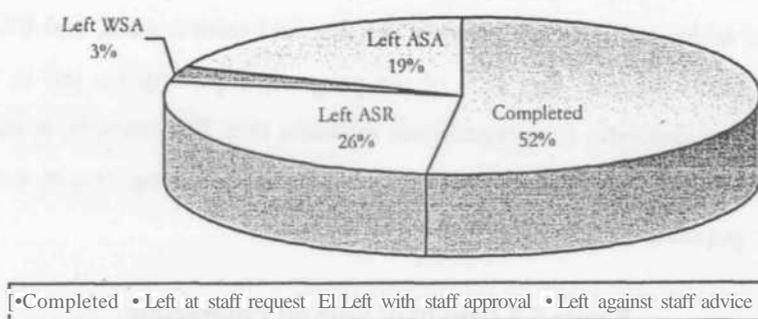


Figure 4.8 on the other hand, shows the outcome of treatment. It highlights that 52% of the population were classified as completing treatment, and an additional 3% left treatment with staff approval. One quarter of the population left treatment at staff request, and one fifth were self-discharges, or those who left against staff advice. Although not statistically significant, analysis shows that young women (61%) were more likely than young men (49%) to complete treatment. Conversely, young men were more likely to have left treatment at staff request (29%) than their female counterparts (16%). Preliminary analysis indicates that age may be an important variable in predicting treatment outcome, or more specifically in predicting whether a programme participant will leave treatment against staff advice. Analysis revealed that programme participants who left treatment against staff advice were significantly younger than those who successfully completed treatment (t -test = 3.57; df =176; p <0.01).

The only other variables found to be significantly associated with treatment completion were being on probation (χ^2 =H.38; df =2; p <0.001) having charges pending (χ^2 =6.3; df =2; p <0.05) and prior arrests (χ^2 =9.38; df =2; p <0.01). All of these variables were seen to impact negatively on treatment outcome. For

Figure 4.8 Programme Outcome



example, individuals who reported being on probation were significantly less likely to complete treatment than those not on probation (40% Vs 64%). Similarly individuals with changes pending were significantly less likely to complete treatment than their counterparts (47% Vs 63%).

COMMKNTS

The data presented in this section were derived from screening and/or assessment instruments. These instruments were specifically designed for, and utilised by Hazelden type programmes thus these instruments were not designed for research purposes. Consequently, data were not recorded with research in mind, and this raises the issue of validity and reliability in their application to this end. That said, in the absence of any other data on the treatment population, they provide a broad profile of the Aislinn Adolescent Addiction Centres treatment population, and indicate a young client group of predominantly poly-drug misusers, with complex behavioural and legal issues. To summarise

- 28% of the population were female; 72% were male
- Mean age of programme participants was 17.6 years
- The highest proportion of clients were from the South Eastern Health Board region
- The majority were unemployed (56%) at the time of screening; only 13% were still in school;
- The majority (69%) live in their family home
- Only 17% of the population reported that alcohol was the only substance they misused
- The majority (83%) reported poly-drug misuse
- Pattern of substance (mis)use varied across drug type:
- 73% reported that they had been arrested, and young men were significantly more likely to report this.
- 36% of the population were on probation and 49% had charges pending
- 77% of the population reported having ever been for counselling
- 58% reported previous contact with a drug service
- 52% of the population completed the programme; and additional 3% left with staff approval

SAMPLE PROFILE

Interviews were carried out with 13 young people who were in treatment at the time, and 6 young people who had completed treatment and were in aftercare. Basic socio-demographic data, together with an overview of individuals drug-using careers, and related problems are presented in this section of the report.

SOCIO-DEMOGRAPHIC CHARACTERISTICS

Of the nineteen young people interviewed 6 were women and 13 were men; of the in-treatment group, only four were women. In relation to those in residential treatment at the time of interview, nine were 17 years of age, one was 18, and three were 19 years old. Those who were in aftercare were somewhat older, one was 17 years old, four were 21 and one was 22 years old.

Regarding the thirteen in treatment, ten were living in their family home immediately prior to entering treatment. The remaining three could be classified as homeless, one was living in a hostel, a second was staying in a B+B and the third had just been evicted from her family home. All the homeless were young women, although one of the young men had been homeless for a period of time. Two of the in-treatment group were still in school, one had been recently sacked from his job, one was working immediately prior to treatment, eight were out of work, and one had recently been expelled from school. One of the respondents was a parent of a young child. The young people were from different parts of Ireland, including Cork, Galway, Pordaois, Wicklow, Dublin Tipperary, Limerick, Kerry, Dundalk and Kilkenny. They all spoke about the fact that drugs were readily available in their areas.

One of the young people interviewed was in her first week of treatment, two were in their second week of treatment, one was in his third week, three were in their fourth week, and two of the young people were five weeks in Aislinn. One young woman had been in Aislinn for seven weeks and was due to leaving the following week, and another was in his last week of treatment. Finally one young man had completed the residential component of the programme and come back to Aislinn to do his 5th Step, and one young woman with 'exceptional circumstances' had been in Aislinn for the previous three months. This young woman had been on the programme in April 1999, had completed treatment and, after a period of being drug free, had relapsed. She explains her situation as follows;

Then I decided that I wanted to come back into treatment again. And eh, [laughs nervously] I was here a week and I got into an exclusive relationship and I were violent towards eh one of the lads in treatment. And we both, well we were both supposed to get sent home. So the head counsellor rang up my mother yea know to come up and collect me and bring me home. And my Mam wouldn't come up, yea know 'cos of everything I did to the house like, and getting her evicted. And, then die head counsellor tried to get me into a different treatment centre, yea know. There was no spaces in any of them! So yea know, she said that I could, that she'd keep me here once I keep away from all the group, and go on a separate programme, on my own! Not having nothing, not even smoking a fag with the group! Doing none of the group activities like, and go down and work in the kitchen every day. With eh, the chef. Eh and I said all right so, and that been going on for three months! [laughs]. (Wendy)

This situation was unique, and for reasons of confidentiality, the young woman in question was not permitted to spend time with the other programme participants. Another of the young women had been on the programme approximately three months previously, and had been discharged after two weeks for taking drugs. She had just come back into the programme, and was starting treatment again.

ALCOHOL AND DRUG USE

Two of the young people interviewed said that they rarely drank, and a third said that her alcohol use was not a problem for her. It was something that she did relatively infrequently, and in a sociable manner. In describing her alcohol use, she said;

Like I do like drink like yea know, but I know when to stop with drink! I know I can have a sociable drink and not, yea know what I mean, it's not going to be a problem. I never have a need [emphasis] to drink, its just E's and hash, yea know like! (Sinead)

Another young man said that alcohol was his 'least favourite drug'. He had used alcohol in his early teens, and as he says;

I don't know I never really got into it! I couldn't, I thought I'd no control, I was kind of happy when I was drunk but I just, it wasn't as over what I was doing when I was drunk. I was loud, yea know, I mean I wasn't aggressive good a buzz for me as we'll say taking speed, or acid, or smoking cannabis. And hangovers were just horrible things, yea know, but then, I suppose in the end hangovers from drugs were a lot worse than drink. But eh, it was my least favourite drug! (Jim)

An additional two of the interviewees said that their primary drug was alcohol, and they reported limited experience with other drugs; having only ever really used cannabis, and even then their use was infrequent. The rest of the young people all had used a range of drugs and reported regular, and frequently excessive alcohol use. As one man had been a regular user of both XTC and hash said;

Alcohol was me main thing before I came here like. I was drinking nearly, some times I could drink every day for about 3 or 4 weeks on the trot like, and then I'd stop for 3 or 4 days and back again like, drinking every day. At the time I was also taking Valium and a bit of hash now and then. (Owen)

Drugs

All of the young people interviewed who reported the use of illicit drug said that they used cannabis. However, cannabis was never the only drug that they consumed, all the drug takers reported using a diverse range of substance, usually stating a preference for a particular drug, which was not necessarily the drug they consumed more frequently. One of the young women interviewed said that glue was her 'favourite drug', although prior to treatment her alcohol use exceeded her use of glue. She had experimented with both XTC and speed but didn't like the physical effects either drug had on her. However, regarding her use of glue, she said;

Every single night I was sniffing glue in the track, or down by the pond. I collapsed like, loads of nights over sniffing it like, yea know. I'd get this buzzing noise in me ear and then I'd know that's me gone like for the night! But eh, I use be sniffing like a fiver bag of glue every single night, without fail....But when I was sniffing glue it had no physical effect, it

took me into another dimension. Yea know, what I mean, it was more like mental, yea know, you'd float off into a different world like and even you'd fall in love with the bag, like, just blowing into it like! Oh, I was just totally like, glue was my best friend, like, yea know what I mean. (Wendy)

Another young woman said that she frequently used inhalants. She said that she started sniffing when she was 11, and progressed onto using other drugs, but continued to use inhalants. She said;

My sniffing was quite bad, I was always sniffing. Mosdy nail varnish, and deodorants. It was stuff like that; it was mosdy the nail varnish now though. I just, even if I was going to paint my nails or something, if I was going out, I'd just get the smell of it and I'd have to do it. ...You'd black out, well I always black out on it, but you just, its not actually a buzz, it's I don't know, it's just like yea know, if you eat something and you just cannot get away from it, that's what its like. When you have the bag and everything in your hand, its stuff like that. But I'd just completely, like I would wake up and I'd be filthy dirty, and I wouldn't have a clue what I did. (Kathy)

The majority of drug takers reported having used XTC, for many their use increased quickly, and became unmanageable. However, as will be seen below, excessive use of XTC was often associated with negative physical effects, and consequently many of die young people could not maintain high levels of use. They would then switch to using somediing else. As one young man said

I was taking 6 or 7 E's, four nights a week like that was going on for a while. Then I substituted that for drink, but I was always heavy on the drink like, but I got heavier on the drink then, to substitute it, yea know that sort of a way. (Colm)

Many of the young drug takers showed a similar pattern, of progression and movement for one substance to another.

When I was ten I started smoking hash....Then from there I started drinking and then I'd my first experience with XTC when I was 13, before my 14th birthday, and then I went on to take XTC and then by the age of 16 I was taking anywhere between 5, 10 to 15 XTC tables in one night 3 to 4 nights a week. Speed as well! ...I smoked a lot of hash too. I used to smoke well over an ounce of hash a week. Drink, I drank phenomenally as well in the end, not as much as, a lot of other people in here... 'cos drink wasn't my forte.. it was drugs for me twenty four seven! (Laurence)

One young man interviewed was an injecting heroin misuser, and another young man who used a range of prescribed medications said;

I was mad to get heroin, to inject heroin, and it was just the opportunity didn't present itself. Yea know, I tried, but I couldn't get it, and I think that would have been die end for me. (Jim)

Thus the majority of the young people interviewed were poly-drug users, consuming a range of substances bodi in die course of their drug using careers, and on a given night out. For some the choice of drug depended on the setting. As one young man said;

The XTC was grand like, for the nightclubs. The dope was grand during the week when I was working, and the beer was grand we'll say on a Friday and Thursday night, or Sunday during the day, and a bit of dope as well, sitting in a pub. (Sean)

Not only was the desired affect of the drug important, for many young people their choice of drug depended on availability; whatever they could get their hands on, at the time. In addition, cost was an important issue, as many of the young people, had limited financial resources.

PROBLEMS RELATED TO DRUG AND ALCOHOL USE

The young people spoke about a range of problems associated with their drug use. For a number of the young people their drug and alcohol use contributed to them being expelled from school or loosing jobs that they had had. Some of the young people spoke about their loss of motivation and desire to do anything other than take drugs. They spoke about finding it difficult to motivate themselves to either go to work or to school. As one young man said;

I just couldn't do anything, yea know, other than take drugs. I kind of didn't want to go to work, yea know. I'd get up in the morning, so tired from taking drugs all the time, I'd no interest in work, and all my money was spent before I'd even gotten my wages. Yea know, what I mean, it was a mess, yea know, nothing was going right. And to me, it kind of happened over night, yea know. One day, I was yea know, I was just kind of, we'll try out this hash, we'll take these tables, see what they're like, and kind of six years later, that's all I'm doing like! (Jim)

Others spoke about health related problems. Such problems were usually associated with XTC consumption. Respondents talked about rapid weight loss, loss of appetite, inability to sleep, back pains, getting very run down, and generally looking very unhealthy. As stated previously, such negative affects often resulted in the young people switching to another drug of choice. One young man spoke about a particularly negative experience he had had, after taking XTC.

I got put into hospital over XTC tablets. My heart swelled up. I took a heap of them one night and I went home to bed, after I came down, yea know what I mean! Then I woke up the next morning and my chest just swelled out, up there like!....They had me on a heart machine and things, and the heart machine I was on anyway started going beep beep beep and they thought like that I [pause] anyway I went unconscious and I woke up and they had all these things stuck on me, all around me neck and all down there. It was a real shock seeing that like, yea know. I still find it hard to breath sometimes when I'm running (Billy)

For most of the young people, their drug use caused problems at home. The spoke about frequent fights with family members, staying out all night, loosing friendships, and generally making life difficult for their families and friends. As one young man said;

Yea, family problems I suppose, my parents would be arguing all the time wondering where am I and what was I doing, and they started blaming each other for, for, well it's obviously my problem, I'm causing the problem there! (Steve)

The majority of young people interviewed spoke about aggressive behaviour and their inability to control their behaviour, which in turn often lead to the getting involved in fights and eventually the criminal justice system. As one young man said;

I was fighting all the time. like I got into a fight in town, I hit a fella with a buckle of a belt across the eye and he had to get stitches. And I went to court, and I was, well I was drinking and I didn't know what I was doing, and I was on XTC like, and I didn't care what I was doing like! (Paul)

Respondents spoke about robbing from their families, going out robbing cars, selling drugs to get money, and not taking care of themselves or worrying about the consequences. As one young women said;

I'd always either get into a fight with someone, or go away with some fella and wanting to go home and sleep with him like or yea know, and I'd get really ossified drunk that I just couldn't even walk, yea know what I mean like! (Wendy)

Despite the fact that all the young people interviewed reported negative consequences to their drug and alcohol misuse, and a range of related problems, they did not all believe that they were in need of treatment, prior to entering Aislinn. For example, two of the young men stated that one of the main reasons they came into treatment was because of legal problems. Many of the young people interviewed also said that they attended the programme for the sake of their parents rather than for themselves. As one young man whose motivation for attending the programme was largely to avoid a prison sentence said;

A lot of people when they come here first, I think it's, they kind of don't do it, they do it to please others rather than for themselves. But the thing is when they're in here they realise what an enemy they are to themselves. So I think if I had a choice, if I'd a choice, I would have been in here before too long anyway, cos my life was a mess. A complete mess, and I was sick to death of it! So it was a lot of my own choices that brought me in here in the first place. (Laurence)

When parents were asked about problems related to their child's drug and/or alcohol use they all spoke about the upset to family life, the constant arguments, the young persons mood swings, behaviour changes and the fact that they were so difficult to live with. As one parent said;

His behaviour would have been a bit, he was very contrary, and yea know, every day they [the other children] would say is he here, they knew something was wrong! The dinner would be out and your covering for him all the time!___So yea know, it did disrupt family life definitely! I mean because we were so anxious about him, you were kind of snapping at the other children at times, yea know...cos you're so anxious! Over the last 4 months it got worse and worse, it built up, with X it got worse and worse, and it built up with ourselves then! And we were meeting crisis after crisis, it wasn't the case of you know, before then we might have calls from the school or wherever every month or every two months. But this year it just snowballed as he was gradually taking more and more [drugs], there was constandy something going on with X....

Parents also spoke about damage to their relationship, as their son or daughter had created a lot of conflict between themselves, which in turn lead to them blaming each other. A number of parents spoke about how the young person had became the focus of all the attention within the family. As one mother said;

I suppose our reaction was God this has taken over our whole lives for the last few months, yea know, no matter what we were trying to do, he would go missing, or we were looking for him or something! There was always something! He was number one; yea know, over us, over the other three children, over everything!

PREVIOUS TREATMENT CONTACTS

As already mentioned two of the young people had been in Aislinn previously. Most of the other interviewees had had some form of contact with services, albeit limited. This contact was typically with an

addiction counsellor, and either resulted in discontinued attendance or a referral to Aislinn. As one young man said

I was going to [another service] anyway, I went up there for nine weeks I'd say, yea know, going out there weekly. I'd go out every Wednesday, and sometimes twice a week- They do a small bit of counselling, it wouldn't be as much as goes on in here like. They take urines like, but one or two of them came up with XTC in them like, I just couldn't stop taking them like! And I was drinking as well like, when I was going up there, but I was drinking three night before I went out there like, so it was gone out of my system! But I was kind of wasting their time and my time so I stopped going. (Colm)

Two of the young men interviewed had previous been in contact with treatment services. One young man recounted;

I went to, I was in X, I was in there for four weeks, it was a six week programme, a detox and I got thrown out of there. And I've gone to counsellors, and I've gone to NA meetings, and I've tried to get into other treatment centres and just, I didn't think, I didn't think there was no hope for me. (Kieran)

Thus, the majority of the sample interviewed said that attendance at Aislinn was their first significant treatment contact.

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Two of the young people interviewed were referred by counsellors (one of which was a Teen Counsellor). Another young women was attending a drop-in centre and a social worker had told her about Aislinn. Probation Officers referred two of the young men, and one of the young women. The young woman in question had had a Juvenile Liaison Officer until she was sixteen, and was subsequently put on probation and she said that she was 'encouraged' by her Probation Officer to come to Aislinn. While one of the young man recounted;

My Probation Officer ...he told me you've got a choice, you are either going to prison or you are going there [Aislinn] cos I'll put you in prison myself, he said. ..Cos my suspended sentence was up for review, on condition of my Probation Officers' Report. So he could have got the suspension revoked, and got me put in jail for two years if I didn't come! (Laurence)

One young man had initiated contact with AA himself, and after attended a few meetings his sponsor referred him to Aislinn. A past resident referred another young man. For two of the respondents however, the referral to Aislinn was the end of a relatively long process of being involved with a number of Social Welfare, and Youth agencies, and drug services. Although invariable the final referral to Aislinn came for a drug related services, such as Arbour House (which was responsible for 4 of the referral to Aislinn).

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The majority of parents who were interviewed had a different perspective on contact with treatment services, and referral to Aislinn. Although most corroborated what the young people had said, in that attendance at Aislinn was the first meaningful treatment contact, for many their stories were of a long process of attempting to get help for themselves and their child, often unknown to the young person. For

many of the parents their first point of contact was with a G.P., and in one instance this contact was ongoing for four years. One mother spoke in detail about her attempts to get help for her daughter and herself;

I had written, it would have been now 10 months ago, I had written to the Health Board asking for help. Kathy had already gone out on the streets; she then had gone about allegations so she had, to the Health Board, and Kathy was put into a B+B. I did not like her being put into a B+B, she was 16! Now, she had to be there at 10 o'clock at night, so she had the whole day to do what she wanted to do and with nobody supervising her, or taking her by the hand, to be put in at 10 at night. Now unknown to me she wasn't always going to the B+B. So she was still rambling the streets at night.....And I never got a letter back, after seven months! And I couldn't understand why, I'm asking for help, even if they just told me they got the letter, or guided me to somewhere that I could take Kathy. I didn't know where to take her, I hadn't a clue, the Health Board didn't know what to do, a B+B was the only think they could provide! This girl was at risk, and she was a risk to herself and maybe other people as well. At this stage she was joyriding, she had been arrested for joyriding, twice, she was stealing, we had to bail her out, it was starting to get really serious and nobody was listening!___Kathy had made contact with a drop-in centre, I told them I had written to the Health Board. So they got on to the Health Board, and there was" a case conference, and it was a great case conference I have to say, it lasted for a good few hours and I sat in on the whole thing!They mentioned the Aislinn Centre, but we had to engage Kate. I know I wouldn't be able to tell her, cos I knew she'd go mad if I told her about it. I didn't even know exacdy what it was really about, I was told where it was, that was it really! I just though thank God! It was the social worker in the drop in centre who engaged her in the programme, and even though it took, we though it would take 6 months, from the meeting to her actually getting here, but it only took 6 weeks! Kathy wanted to go, and she did!

Parents spoke about feeling helpless, and not knowing where to go for help. This was often compounded by the fact that they were unaware of the extent to which their child was consuming alcohol and/or drugs. Thus, they were in a difficult position, as they did not know what was wrong with the young person. As one father said

We initially thought that Clare was, or that we were and Clare was experiencing major behaviour difficulties! Kind of teenage difficulties compounded by something! Company, etc, etc, drink, drugs, but we didn't realize that Clare was an addict!

SUMMARY AND CONCLUSIONS

In this section a profile of the sample of young people interviewed has been provided. The characteristics of the sample group are comparable to the overall client profile. The gender ratio is similar, but females are slightly over-represented in the sample as 31% of the in-treatment interviewees were female (n=4) compared with 28% of the total client population. The average age of the sample group was 17.5 years, the same as the mean age of the total population of programme participants. As with the population, the majority of the sample group (77%) lived in their family home and were out of work immedLitely prior to entering treatment. Regarding substance misuse only two of the young people interviewed reported misusing alcohol, the majority (85%) as was the case with the total population, reported that they were poly-drug misusers in that they consumed a broad spectrum of drugs, including alcohol. The young people interviewed identified numerous problems related to their alcohol and drug use, including being expelled from school, loosing jobs, family problems, health issues and legal problems. The parent's

perceptions of problems associated with the young persons drug use focused more on the affect on the family unit. The young people themselves spoke of limited contact with drug treatment services, and for many presenting at Aislinn was the first time they had attended a drug treatment centre. Conversely some parents spoke about a long process of seeking help, and accessing services, often unknown to the young person. In sum, the in-treatment group of young people interviewed for the purpose of this evaluation appear to be broadly representative of the overall treatment population. That said, the qualitative methodology is not generalizable as that requires an extrapolation that can never be fully justified; local context and human story are the primary goal of qualitative research and not 'generalizability' (Shaw, 1999). The next section presents the data derived from interviews with programme participant's and presents their perceptions of the programme 'from the inside'.

5: Programme Participants Perceptions of the Service

This section explores the programme participants' (both the young people and their parents/guardians) perceptions of the Aislinn Adolescent Addiction Treatment Centre. From the outset of the evaluation the perspectives of the participants were considered the lynchpin of the research. The interviews addressed respondents' perceptions of all aspects of the programme, including their expectations prior to attending the Centre, their experiences of the screening process, their views on all key component of the residential programme and where appropriate experiences post treatment, and individual's views on aftercare. One of the main advantages of using qualitative methodologies to collect data on participants' perspectives of the service, is that clients are often more honest and critical when interviewed, as they are free to express their concerns about all aspects of care, in a way that is not possible when using surveys.

INTRODUCTION TO TIN-; PKOCHAMMI-

Expeditions

Two of the young people interviewed had heard about the Aislinn treatment programme from past residents. For one of the young men, what he had heard was very positive and it gave him a greater insight into the programme and what was to be expected. He said when speaking of a young man who had told him about Aislinn;

Eh, he said it was great like, yea know what I mean. Like, he said, they thrash out a lot of stuff that would be bothering you, it's not actually the drink and the drugs, they just wreck your head more, yea know. But it's actually where the root of the problem is, yea know, they really get into that. He said it could have been at home where the problem started, or with girlfriends, the way-you started treating young ones like, or whatever! (Sean)

However, one young woman had heard some negative things about the programme that put her off wanting to attend, however she felt that she really had no choice, at the end of the day.

I'd heard stories about the place, that it was a terrible place, that it wasn't a nice place to live in, let's put it that way, that it was too refined like, too much out of the outside world, like! That when you go back out it slaps you in the face! From girls that did, that were in here like! And that kind of put me off a small bit,...but [Care Worker] said, look you've to go to Aislinn House, otherwise we can't take you back and I would have been left with nothing! (Sinead)

However, most of the young people interviewed really did not know what to expect from the programme. They were ill informed by referral agencies, or they did not take in the information provided to them. They had little awareness of the programme content, or of what was expected of them. Some individuals saw it as an easy option, as one young man who faced a possible prison sentence said;

Before I came up here, I thought it was just going to be like, you just sit down, relax like, as if you were at home. It was way different like, going into groups, and all that, I didn't expect any of that! (Laurence)

For others, the prospect was more daunting, and they expected the programme to be set in a more medical and sterile environment. As one young woman said;

I don't know, I just had this idea that it was going to be all clinical and yea know, a bit like a psychiatric ward or something like that! (Kathy)

The majority of the young people had no concept of the programmes philosophy, it's aims or objectives. They were obviously aware that the programme would deal with aspects of their drug and/or alcohol misuse; however, many were unaware that abstinence from all substances was the overall objective. Most of the young people spoke about a desire to control their drinking/drug use, explicitly stating that they did not at the time, expect that they would have to remain drug and alcohol free. For example, as one woman said;

I just, I didn't want to not ever take drink and drugs for the rest of my life like. I just wanted to yea knew, like, I didn't really think that it was my drugs, I think like, I thought my drugs were making me violent and I just didn't want to be violent, and I didn't want to get arrested or anything anymore like, yea know what I mean. So, that's what I thought like, I'd be a good girl, yea know what I mean, I'd be a good girl that'd be able to drink and yea know, and take a bit of drugs. But it hit me with a bang, then when they told me like that there was no more drink or drugs for the rest of your life. So that was kind of like mad! (Wendy)

Some respondents were more pragmatic, and while lacking any in-depth understanding of the programmes' content, they were aware of the possible benefits of an isolated residential environment. For example one young man said;

Eh, the way I saw it was, eh that they lock you up for 6 weeks, and you just can't take drugs because you're away from the whole environment and eh I thought I needed that because I had tried, previous to coming into treatment, to just stop taking drugs, and I just, I couldn't, I literally couldn't stop. (Jim)

Similarly parents did not know what to expect from the programme. They knew little if anything about the programme's philosophy, about the structure of the programme or about their role and function in the therapeutic process. One father said in relation to his son;

I wasn't to sure really, I suppose I ...at the very start I thought he'll go away come off drugs and they'd send him back again! At that stage I mean we weren't calling him an addict, yea know! I remember one day talking about alcohol, fortunately he was never much of a drinker, but, yea know, we were saying that we heard that they don't allow people ever take drink as well as drugs! But we thought he'd be all right with a drink like!

Many parents were just happy that their child was in a safe environment, away from alcohol and drugs. One mother commented on the benefits of not knowing what was 'in store' for her, in terms of the programme structure or content;

I hadn't a clue what it was about, you're not told, you just have to go with the flow! I think that's just as well, because if people were warned beforehand, they'd say no way, I'm not going, and I'll make an excuse.....You learn from each other, not being told, just taking it in your stride!

As outlined in the previous section, many of the young people were referred by addiction counsellors to the Aislinn Adolescent Addiction Treatment Centre for screening and assessment. However, the young people reported a limited understanding of the programme to which they were referred. It appears that **prior to their screening appointment and during the initial stages of the treatment process, the majority of young people and their parents had no idea of the nature or content of the programme, or what was expected of them.**

Screening process

As outlined in Chapter Three, potential programme participants generally present for a screening appointment at Aislinn with their parents and/or guardians. The screening process usually involves going through a brief questionnaire and completing the Jellinek chart - which is 'intended' to assess severity of dependence. Individuals who had been referred by Addiction Counsellors would have previously undergone a somewhat similar process. However, one of the main differences appears to have been that in Aislinn parents/guardians sit in on the screening. Therefore, the young people are required to talk about their drug and alcohol use in front of their parents. For the young people whose parents were aware of the extent and nature of their drug and alcohol use this was not problematic. As one young man said;

Sure they [parents] knew about me drug use, cos like I would have robbed the house, and just, I would have robbed everyone around me, and towards the end of me drug use, I didn't really hide it in anyway. The way I was was, I was that cold hearted, yea know, cos the drugs were after suppressing me feelings, that much, that I didn't really care who heard me business. Me Ma was shattered though [at the screening], and she was crying and all that and me Da was in no good health, but it still didn't bother me! (Kieran)

Others however found it difficult being honest in the presence of their parents, and they did not want to tell them the extent of their drug and/or alcohol use. As one young women said;

No my mother didn't know, no, I lied when I came in here first. I didn't tell them. But as soon as my Mam left I told them what I was really like, yea know, the way you have to give the sample and that, I told them then! It's just, I was afraid to tell my mother at the time. (Kathy)

Generally respondents felt that they were honest about their drug use, to a point. However, respondents spoke about how other residents were not honest, and how they withholding information at their screening, which they said inevitably came out later in the treatment process. Some of the young people said that they found it difficult to confide in a stranger, in such a 'formal' situation, which they felt might have prevented them from being completely open about their drug and alcohol use. Thus, some of the respondents found the screening process difficult, and this was compounded by the fact that often their parents got upset as they spoke, in many instances for the first time in front of them, about their drug and alcohol use.

Three of the young people when talking about the screening process mentioned the use of the Jellinek screening instrument, which scores individuals out of a possible 35. Respondents spoke, with a certain

amount of pride, of the score they got on this aspect of the screening, and the fact that they were told they were for example, 'a chronic addict'. These respondents found comfort in being told that they scored high on the Jellinek chart and being told that they were 'a drug addict'. It provided them with an explanation for why they did what they did, and why they felt the way they felt. For example, one young man said;

For my screening when they kind of assess you to see whether you are an addict or not, I was told I was a chronic addict, I think I scored 32 out of 35. Yea know whether I believed it or not, I'm not sure! But I kind of, I suppose I did, because I didn't know what was wrong with me. Before I came here, I though like yea know, I was stealing and taking drugs, and doing all theses horrible things, yea know, I didn't know I was doing it cos I was a drug addict! And it was nice to be told, look this, yea know, this is a disease and you are a drug addict, and you have no control over it,...Yea know, I though I had a split personality, or schizophrenia! I just didn't know, and it was kind of hard, cos yea know, I just though that I was just a bad apple, yea know, I was a bad person who does bad things! (Jim)

All of the parents interviewed said that they now realise that the young person was not 'totally honest' about their drug and alcohol use, during the screening process. That said, all of the parents reported that they didn't realize the extent to which their child was consuming drugs and/or alcohol until the screening itself. As one mother said;

Yes, I suppose we were surprised to a certain extent, because he added in a lot! He said a lot that day, in the sense that he filled us in on, sort of the amounts and the other drugs he was using. Like that was the first time he mentioned that he had taken acid, but it was all very sort of selective, yea know. So he gave us a little bit, enough to, basically I think he gave us enough for all of us including the assessor, to believe his story.

The parents did feel that the young people would have been more honest about their consumption if they were not present. However, as one father pointed out;

I think the screening here, is for Clare, but I think it was also for us, because we realised that they wanted us in on this as well, so they have to assess us all at that point too! Also to see how much we know, and whether we're actually willing to come here in the first place, and be part of it.

The majority of young people had to wait between 1 to 4 weeks for a place on the programme. For some of the respondents it was very difficult to wait that long, and most found it impossible to remain drug and alcohol free during that time period. On the other hand, one young woman was offered a place on the programme immediately. She was very reluctant to take it, as she felt unprepared to enter treatment, and under pressure to stay. She refused to remain in Aislinn on the day of her screening and returned two weeks later.

There were mixed feelings concerning the screening process, some young people were reluctant to speak in front of their parents, others reported that this was not a problem. The levels of awareness of the parents seem to play an important role in determining how much the young person was prepared to divulge at the screening process. In addition, during the screening little attention is paid to previous assessments carried out in, for example, referral agencies. Thus, many of the young people were repeating what they had already told somebody else.

First Impressions

For most of the young people the first time they saw the Aislinn Adolescent Addiction Treatment Centre was when they presented for their screening, however they did not get much of a sense of the place or the programme at that time. For confidentiality reasons, and to protect the identify of the young people on the programme, potential programme participants only get a brief tour of the building, post screening. Thus, for the majority of the young people, when talking about their first impressions of the Centre, they spoke about when they were actually admitted for treatment. For all young people interviewed their first impressions were very positive. Individuals commonly spoke of feeling very welcome, safe and secure. They said that the house was very homely, and staff and residents were all very friendly.

Similarly, the parents reported very positive first impressions of the Aislinn Treatment Centre. They were anxious and their primary concern was that their child would feel safe and secure in the environment. Thus, upon arriving at Aislinn they all reported being very impressed with the friendly, comfortable and safe environment. As one mother said;

When I first came here, when I was actually being driven down, the day we came down for the assessment, I had a picture of an old house with bars on the windows, a smell of damp inside, yea know, and silence. And I said if I don't like it she's not going there. Even though I know its for her own good, it couldn't have been any worse, but sure then I didn't know what she'd actually done outside! . . . Then driving up I went Oh God I don't believe this! And when we walked in and she was greeted, the first thing she said was this is nice, and she was real nervous, and I said this is nice! [emphasis] And she was fine, and after the screening she said Mam I know I have to be here, and I know I've being sent here for a reason!

Family Involvement

All the parents interviewed were asked about their views on family involvement in the treatment process. For some of the parents, although they were told from the outset that the family was required to participate in the programme, and that they must attend weekly family days, the nature, extent and purpose of their involvement was unclear to them. As one mother said when asked about family involvement in the programme;

Well it was a bit of a shock at the beginning, I suppose, we didn't even realise how important that was I don't think. Until we actually, even after my first child couldn't make it to the first meeting, and after that first meeting, I knew, straight away, I know then, and I say ah, it just has to be all of us, I can see why! Just what was said, generally I felt yea know, I can't be coming home and tell him [husband] this and that, you have to be there to hear it, and as well as that, I think, it involves all of us, we're all a part of it!

Other parents viewed family involvement in the treatment process as being essential, from the outset. As one mother said;

That was very very important, you can't expect a child to do it on their own. No parent can expect that of their own child! They are part of you, they still need you to a certain extent, and they still need your support!

While all considered family involvement important, it was not without it's difficulties. Parents spoke about travelling long distances, some having to stay in B+B's the night prior to family day, the financial pressure

of it, childcare issues, and problems getting time of work. An additional issue was involving the other family members in the treatment process. All parents interviewed had other children, and all reported that the other children in the family attended at least one of the family days. For some it was difficult to persuade them to get involved, other were reluctant to involve them, at first, primarily due to the age of the children in question. For example, one mother spoke about involving her eleven-year-old daughters in the treatment process;

Eh, but the younger ones, we thought they're too young, we'll hold back we thought! We had a number of discussions here, and discussing it among ourselves, and we decided then that, yea know, we better include them! And once we started talking to them we realized that they actually had more experience of what went on then we imagined. Because they were, I suppose, listening to the eh, home arguments, and home hassle that we had, unknown to us, they were listening in, so they knew there was something wrong. They mightn't have realized exactly what it was, but they knew something serious was wrong. . . . To be honest I think it was a good thing because eh, I suppose we were leaving them out really all the time. Treating them maybe a little bit different, because they are our youngest... It was a relief, I think it was for them, to be actually included in the whole family crisis. I think it made them feel a bit more important.

That said, by and large parents knew little of what happened in Aislinn on a daily basis, and they had limited knowledge of the step work that their sons or daughters did on the programme. Their only exposure to this was when they heard their son/daughters first step.

Settling in to the programme

On the whole the young people settled in very quickly, largely due to the fact that they felt comfortable in the environment. However, one young woman did mention that when she entered the programme as the only female there she felt very uncomfortable, until two days later another young woman arrived. The highly structured routine did not prove difficult to adjust to. As one young man said;

It wasn't hard getting use to the routine, yea know, what I find is that this place is like a world of it's own. The outside world doesn't exist for me at the moment, all there is, is this place. So therefore all perceptions of going to bed early and getting up early doesn't exist. There's no outside world to compare it to for me at the moment. It doesn't really bother me.
(Sean) »

However, the majority of young people did speak about feeling very nervous, and scared, at the prospect of what was facing them. Some of the respondents spoke about not thinking very clearly at the time, and feeling quite confused. As one young man said;

I had knots in my stomach - I was really scared cause I, one I wasn't really sure, or aware of the way I was thinking, yea know my head was a bit mixed up like — cause I wasn't eh yea know I wasn't really thinking straight for a long time like! (Steve)

PROGRAMME STRUCTURE

Group Work

Respondents spoke at great lengths about the group work, which is the core component of the Programme. Many respondents felt very uncomfortable at their first group, partially because they were unsure of what happens in the group, and of what was expected of them. As one young man said;

Actually my first experience of group was somebody sharing something very intimate and I was only in the door five minutes. And it was just, I couldn't, obviously I can't say it now, but I just went [laughs] I just had this smothered laugh. And I thought Oh No they are all going to hate me now and I'm only been in the door two minutes, and I thought what am I going to do to cover up! Ah lads I just had to go God and let out a laugh 'cos it was so funny to me to see this kind of thing. (Laurence)

The young people typically said that it took a couple of group sessions before they relaxed and felt comfortable enough to participate, and to 'share with the group'. Individuals had to feel safe and trust the other group members before they were prepared to participate. As one young woman said;

Yea know the first group like, you wouldn't just open your mouth but when you hear people yea know, getting so deep like, and sharing so many personal things about themselves, that kind of gives you, yea know, it kind of makes you think, well Jesus like, they're trusting me, yea know what I mean like! That's kind of like what makes you kind of talk, listening to other people share their experiences and yea know what I mean, that kind of helped me then open up. It took around a week I'd say, cos you only have 6 weeks, so you have to kind of, you want to pull back, but you have to try and get in there as well like, yea know what I mean! (Kathy)

Although all the young people said that the group work was very beneficial, they all found it difficult, as they had to talk about things they were reluctant to talk about. Thus, the young people had mixed feeling when speaking about the group work, on the one hand they talking about how painful the process was, while at the same time recognising the benefits of it. As one young women said about group work;

Yea, it's good, but someday it's very hard. like your been told everything you never wanted to hear like! You're, it's just, I don't know! You're told you've a bad attitude, you're defensive, you're this, and you're that! You'd want ta change it or you can leave treatment or whatever! You've a threat hanging over your head like, and you know yourself you're after being bad, yea know what I mean, and you don't want a big group of people sitting there telling yea! But then at the end of it you do feel better, yea know what I mean! You do like! (Sinead)

STEP WORK

As discussed in Section Xthree while on the programme the young people are required to commence the 12 steps programme. Obviously individuals will progress through their steps at different speeds, and it is rare for anybody to reach their fifth step during the six weeks residential treatment. The following is an account by one of the young men of his understanding of the first five steps:

The life script, that's just getting the group to know you, getting to know about you like. Who you are, what your significant memories growing up were, all that kind of stuff likes. Then you move on to step one, that's just painting a picture of what your past was like, through your addiction. Then you move on to step two, its like, you came to believe that a power, that you're life is a mess like, and they ask that you believe that there's something out there that can bring you out of that mess like! Then step three is like, you made a decision to turn your will and your life over to God like, so what way did you practise this step, and what have you changed and what have you to change. And step four then is sort of, it's like a biography like, with all your shames, your guilt's, and all that I'm on that now at the moment like. And step five is reading it out to another counsellor, like its completely confidential like. They then ask you to go for a bath afterwards, and wash it all away. (Owen)

All the young people said that they found doing their first step very difficult. The young people commonly spoke about their inability to remember things they had done, having difficulties concentrating, having problems with writing, the long list of questions they had to answer, and the length of time it took the to complete it. As one young woman said;

The first step like, it just, it's really, I don't know, it's very difficult like, and I don't know, it's kind of like you're coming in to a treatment centre off drugs and they want you to remember, back as far as you can remember, to the first drink you ever took, how many drinks you had, how many drugs you took, and I mean like I blacked out so many times I just couldn't like, yea know what I mean! I couldn't remember like anything, and, yea know what I mean, I was saying, I can't fucking remember, I can't remember anything, like! And it was really hard like, cos it's the first step you have to do when you come into treatment, and like if it was the last step it would be grand! Because you'd kind of remember, yea know, the fog lifts when your halfway through your treatment like, yea know. But when you straight in the door your head is just cabbaged yea know what I mean. And thinking back like that, just, it had my head wrecked like! (Wendy)

There was also a tendency for some of the young people interviewed to brag to some extent, about the fact that when doing their first step they had to for example break down their drug use or stealing into so many categories (for example, house robberies, car breaking, joyriding, muggings, cash, family-cash etc). Upon completion of their first step, the young people are required to read it out to the group; one young woman who was required to re-do her first step, spoke quite negatively about this process;

Then you do your step one and you come in and you read it out in group and they all tell you what a dickhead you were, that you're spastic like, for what you did, and who do you think you were robbing people! And then they make you, they say, if you don't stay with the feeling, if, you're supposed to cry then for the night, and be all sad and upset by yourself. (Sinead)

Finally one of the young people interviewed had a problem with the concept of a Higher Power. He did not believe in God, and did not like what he felt was an emphasis on God. Having expressed his fundamental opposition to a belief in a higher power, he went on to say it had not caused any problem with his advancement through treatment, and he anticipated that it would not; as he said 'I can always pretend'.

Parents had limited experience of the step work done by the young people. However, as mention above the young people are required to read out their step one to their families. All parents said that it was very difficult and upsetting listening to this. As outlined previously, from the parent's perspective, the young people were not honest about their drug use at their screening, thus many at the reading of the first step, were hearing things they had never heard before, and had not expected to hear. As one mother said;

When you hear the step one, you are so shocked and you come out dazed, you really do! You just keep saying, no she has to be saying all that just to keep up with the rest of them! She has to be, she is just making her story better! That's the way you think! Then you say to yourself as the weeks go on, well of course she'd have to be doing those things to feed her habit, how else would she have got the money! I was shocked and horrified!

Family day

As outlined previously family involvement is considered central to the therapeutic process. Once a week family members are required to attend a family day. One young woman provides the following description of what happens on family day;

They are rough! Family days, they are rough! Yea know on the Wednesday they come up at 10 O'clock like and on your first Wednesday you have a conference with your family and a counsellor. And your family say what you were like and you get a bollocking! And then, you go down and you've your lunch they you go in and you write about what they said. They you read it out in group, what they said! Then you get a bollocking off the counsellors for why were you like this at home and that! And you'd be crying and everything. And then you have your tea, then you go out and meet your family from four to half four. Then you come back into group at a quarter to five until six o'clock. It's just a day of work like it's really draining! Everyone dreads family days like! Then Wednesday night, after people have had a stressful day they try and cover it up like. They try and laugh it off and then you're told you're being giddy, you're running from you're feelings yea know! Like you can't win, yea know what I mean! It's just different strokes for different folks. (Clare)

All of the young people spoke about how difficult the family days were for them. They found it a very emotional, stressful and hurtful being confronted by their family members. Respondents said it was very painful hearing what their families had to say about what they were like to live with, and how they behaved. That said, they all recognised the benefits of the process, as one young man said;

Eh, its very stressful, you like, it's good in a way as well, it's very good in a way! Because you're actually sitting there face to face, and they're telling you what you were like, what you did, what you can't do anymore, so it helps you. It lodges into your head and it stays in your head until the next Wednesday when they tell you more stuff about yourself. So you do be thinking back like, Jesus, I was so bad to me mother like, yea know. It's very stressful as well like, but it helps. (Billy)

Moreover, some of the young people said that it changed the way they feel about their parents and/or their siblings, and that it had helped to change their relationships. The support that was shown to the young people by their families' attendance, and their concern and worry, seemed to have been central to this process of change. For example, one young man said;

Since my family have started coming up here, my family used to be afraid to talk to me in case I'd stab them to death or something! But now my family - there's the sense of love that hasn't been there in a long long time. Because they're coming up here, they're talking through their emotions, they're talking about the hurt they've experienced at my hands. I'm taking it up and I'm realizing what I've done to my family and eh we're leaving what's in the past in the past, by talking about it. (Laurence)

All the young people said that they believed the programme would not be as effective if families were not involved in the treatment process. The importance of that day was stressed by all, as was the insight it gave the young people;

I'd say if there wasn't any family group there of a Wednesday you wouldn't, I wouldn't say the programme would be worth doing, yea know. Because you're actually hearing it like, from the people that grew up with yea, what you were like, what yea did and what you put them through like. So that kind of helps like! Stuff, yea know like, when you black out and yea can't remember, you wake up the next morning, and you've cuts and bruises on your face, and you say Oh God what happened me. There's things that me mother was telling me,

that what I'd done to her, and what I'd done to me brothers and sisters like, and I just didn't remember, I only found out about them when I was here. So, ah they help, they help an awful lot, the family days. (Billy)

Parents had a similar view of family day. They all reported finding it very difficult to confront their children about their behaviour. Many of the parents spoke about instinctively wanting to protect their child, and not hurt them. As one woman who had attended Aisiri with her husband said;

For me it was harder, it was hard to go down and confront my husband about his drinking. But it was a lot harder to come in and do it to my own son! I felt that he was down far enough, why should I go in and push him down further! That's the way it was, and that was the attitude I had, before the first Wednesday, and this was going on in my head. And didn't I get a phone call from one of the counsellors here, asking me how I was, and saying that Sean was OK and not to worry about him, and look after myself and was I going over on the Wednesday, and I said I was. And they said that the best gift that I can ever give Sean, what I can give him on Wednesday, is honesty. To be honest, and when I finished talking to them, of course I was trying to sum up the effects of Sean's drinking and drug use on us at home! I was honest, and what didn't come up for me one Wednesday came up the following Wednesday!

Parents reported finding it difficult listening to their sons and daughters stories. This was a painful experience for all of them, and one that led to many unanswered questions. As one mother said;

It's very hard sitting listening to him, God almighty! And apart from that, an awful lot will come up for yourself, it opens up a right can of worms; as to where all this started, where their insecurity started, when they shut down emotionally. It leaves us with more to deal with, but at least once it's dealt with, he's coming home to a better environment!

In addition, all the parents spoke about how emotionally and mentally draining these days were on them. As one mother said;

I came home every Wednesday with a headache, mentally and physically drained. You have said so much, you have unloaded so much, you've got angry, you've cried, you've been happy, you've been a mixture of everything. It's so intense! Being honest and telling them things, this is the place, not outside!

However, the family days also proved to be a great support for the parents. For many, there was a huge relief in knowing that they were not alone, and that others were experiencing the same difficulties. As one father said;

We got a lot of comfort in coming here and talking to other parents, who have gone through similar eh, experiences to ourselves. And talking to them it was amazing how similar their experiences were, and all the things that happened. It was as if we were all reading out of a book. If we knew then what we know now, and watching the slow progression at the start, you can recognise that. It's easy to say now, but eh, what I am saying is that they were so similar, the experiences were so similar, there must be a means of spotting it very early.

In addition, parents helped each other through the therapeutic process, and they spoke about the benefits of talking to other parents who were further on in treatment. This was a great source of comfort and hope.

Lectures

The majority of the young people found the lectures very informative. They felt that they learnt a lot during them, and that by and large they could relate to all the issues covered in the lectures. As one young man said

I didn't think I had a drug problem until they started doing a few lectures and things. Then they were telling me all about my anger like! They did lectures about anger and things and I realised then like, that, how my anger was building up like, and then I was identifying with what other people were saying like. (Colm)

However some respondents felt that it was like being back in school, primarily because of the structure, and it's similarity to a classroom format.

An

Enjoying the art sessions appears to be simply a matter of taste. Some of the young people really liked them, and found art to be a very good means of expressing themselves. One young man highlighted this;

Like yea know, last week he asked us to, he gave us two, he gave use six colours for painting and he goes eh "Right I want you to pick two colours and represent sadness". And I was scratching my head and going how am I going to represent that with two colours? And then in the end you could see everyone's creativity flowing out, and some were very good pictures. I actually thought how am I meant to do this! I was going to pick up the colours and throw them at him, go away! But eh, it was actually, in the end it came out very good. I drew a big Mitsubishi symbol and wrote sadness underneath, a big purple background, a real dour looking yoke and eh. So I was amazed, and then the other one was happiness, what did I do? I made this big spiral, yellow and blue, kind of like a Celtic circle tiling, to represent a spiral some days are happy some days are sad yea know, but it all mixes together to the yellow core which is the happiness. Yea know, it's just funny the way your creativity would actually flow out on something like that, when at the start there is just this mental block, going I don't want to do it! (Laurence)

For others, however, it was a form of expression that they did not feel comfortable with. Some found it difficult, either because they simply didn't like drawing, or because it was too abstract for them. In addition some respondents said that they enjoyed the sessions because it was a time when they could relax and forget about their treatment per se.

Recreation

The majority of respondents spoke very favourably about recreation. For many it provided a welcome break from the therapeutic process, and enabled the young people to get away from treatment for a few hours. In addition, the interviews were conducted during the summer months, when the weather was very good, and recreation was usually conducted out doors, which all the young people enjoyed. Many of the young men particularly enjoyed recreation, as in the past they had been very involved in sport. Only two of the respondents were not enthusiastic about it, primarily because they were not, and had never been into sport.

Psychodrama

As with the art there were mixed responses to the psychodrama. Some of the young people didn't like it, and said that they didn't understand the relevance or purpose of what they were doing. As one young woman said;

I didn't like it, it was stupid, it really was! I don't know what she had me doing! She had me following Owen around, taking to him as if I was his memory and stuff like that! I didn't like it at all. It was weird, and I can't act! Yea know, it would be a good laugh if it weren't about addiction and stuff like that. (Kathy)

On the other hand, others while saying it was 'weird' or 'head-wrecking' felt that it helped a lot. It seemed to be more helpful to the young people who were finishing up on the programme. However, this may be due to the fact that the most recent psychodrama session dealt specifically with issues related to relapse prevention. As one young man about to leave the programme said;

They give you a situation; I was out after finishing treatment. I was acting it like, last week. And I was coming out and my friends were trying to drag me back and there was pubs and there was the drugs, like, yea know! All that kind of stuff! I felt very dreary afterward, I don't know, it just brought up a lot of things for me, I think! It isn't going to be a piece of cake when I finish here like! (Owen)

Meditation

There were mixed views on the meditation. By and large, the young people said that they enjoyed the evening meditation the most. Many felt that the sessions in the morning 'didn't work*. Other respondents found it difficult, as they were unable to concentrate. As one young man said;

It's good in a way, there's times that it does work for me like, you do get a bit of a rush or bit of energy out of it. But there's, most times, as well, eh, you just can't concentrate on it. That's the way I see it now. You're meant to just, your mind's just meant to go black, blank like, but it's fierce hard for me like. I, there's sometimes that it does work, and there's other times then, most times, that it wouldn't work. I can never concentrate, you do be thinking about something else, when you mind should be focused on something else like. (Paul)

Teacher

All, bar one recently admitted respondent, had had some contact with the teacher. The young people spoke very favourably about her, and the fact that she was so helpful, encouraging, and supportive. As one young man said;

She's got me things about going back to school, and she's got me all information I've wanted about mechanical engineering. And she was prepared to go to any lengths I've asked her to go to, just to get information off of companies that probably weren't going to give it in the first place. Yea know, cos she's a very very good-natured person; she'll help yea to the best of her ability. (Laurence)

Many of the young people interviewed had had problems in school with teachers, and other authority figures. Thus, for them to work closely with a teacher who they like and admire is very beneficial.

Staff

All respondents spoke very favourably about the staff. Commonly the young people spoke of the fact that the staff were trustworthy, respectful, easy to talk to, understanding, caring and helpful. The young people quickly learn what was expected of them from the counsellors, as one young man said;

Oh they're good, yea, their good! Yea know, you couldn't open your mouth if you like. You go into group in the morning, all right, you could go in, in a good humour, and you come out pissed off yea know. You go in and sit down in the chair and they do a round of feelings, and you'd be sitting there grand, how are you this morning, I'm good, I'm feeling good, yea know, and what does that mean now, Sean like yea know! You can't actually feel good, you can't feel anyway, cos they're going to drag something out of you, yea know that kind of a way! They just eat into your head like! Then you feel good after a while again! The worst thing to do is to say you're all right! (Sean)

For some respondents, the fact that some staff members had been through treatment themselves was helpful. As one young man said;

Another good thing is that they're all after going through treatment,"well some of them are after going through treatment, and they all know what its like. So, they can talk to you about how they felt, and how they were in treatment, and what they did when they had a problem and all that. (Billy)

Similarly all the parents spoke very positively about the counselling staff. Parents commonly spoke about how good the staff were in understanding the young people. Moreover, they all felt very accepted by the staff, undertook and perhaps most importantly not judged as being 'bad parents'. As one father said;

The staff don't make you feel as if, oh here's another one, or here's more parents who don't know what they're talking about! They don't give that across at all like! They have more faith in our kids then we have in our kids, to be honest with you! We see them as little bastards that are after terrorising us for the last 2 years.

Confidentiality

The young people were not asked specifically about the issue of confidentiality. However the majority of them mentioned this issue in the course of the interviews. They all emphasised the importance of confidentiality, and they all respected this. For some of the young people, the knowledge that whatever they might say would be confidential enabled them to open up and speak in the group session. As one young man said;

Something you say will never be said. Like, if you share something in group and another member of the group wasn't in that particular session for some reason or another, lets say they are doing step four which is a particularly important step, if you are not in the group nothing is said to you, you are not told what is said in the group. It's all around respecting the person that was sharing something, even if you think the person who was out of the group could help them. You don't tell them what happened unless the person who was sharing wants to tell them on a one-to-one basis. (Kieran)

Views on Programme Philosophy

In the course of the interviews with die young people the issue of abstinence frequently came up. This issue more often than not emerged when discussing the programme's views on addiction. As outlined previously, all the young people were unaware when they entered the programme that abstinence for life

was the overall objective. However, they came to quickly realise this. By and large the young people accepted the fact that it was desirable if not preferable, that they stayed away from their preferred drug, be it alcohol, hash or XTC. However some respondents were reluctant, based on their own personal experiences, to accept the programme view on addiction. As one young man said;

Here they say that all drugs, and alcohol is a drug, are addictive if you are an addict, but I mean I didn't find other drug addictive. I found XTC extremely addictive because the high you get from XTC is unbelievable, its, it raises your serotonin levels like up to the roof, so it makes the most boring thing seem amazing! So I don't know! They say in here that if you are addicted to one thing you can be addicted to anything! But I don't believe that, not at the moment like, but I might be proven wrong in the future. Alcohol like, it doesn't even, it's not a big thing to me like yea know. I drink with my parents in the pub, I don't think it would cause a problem for me like yea know, I can take it or leave it! (Steve)

This seemed to be a particular problem for the young people who identified as drug (mis)users, many of whom reported limited or more controlled use of alcohol. Young people frequently spoke of feeling under pressure to say that they were alcoholics and/or admit to having a drink problem, when they believed they didn't. As one young man said;

I'd described myself as an addict, cos I felt that I was addicted to a substance [XTC] yea know! But they're telling me as well, I mean, that I should be labelling myself an alcoholic. I mean, I'd in no way consider myself an alcoholic! It's just that I wouldn't use the label like, no way would I put myself, label myself as an alcoholic, cos I don't think I am! (Laurence)

Similarly one young woman said of her alcohol use;

Like I know that they can call me an alcoholic, but I know in my own heart and soul that I'm not! I know that I could sit in a pub and have a drink, yea know what I mean! But they're saying oh you can't touch drink or anything. But like I'll tell you here and now, I know for a fact that when I go out I will have a drink! And I know that they advise you not to, and I don't give a shit! ... And there's a lot of people in here that don't drink, that have more of a thing for drugs. There are alcoholics in here that drink way more than they use drugs, yea know what I mean. It's just, I never had a problem with drink, and I know now that might seem thick like! Like I know, I would have had a problem with XTC and hash. I know I would have, and like I'm living with that. But drink, no it can sound as stupid but I know I can sit in a pub and if I don't want a drink I'll say no I don't want a drink like, yea know what I mean! (Sin<ad)

Some of the young people were determined to fight against being labelled an alcoholic, others felt that it was not worth it. As one of the young people said;

You see what they do is they turn it around, and what they say is alcohol is a drug and you're a drug addict! Yea know what I'm saying! So you're better off like, some things are best left unsaid yea know what I mean! I'll agree to disagree yea know what I saying! I'll accept half of it like, but I wouldn't.. Sure if I'm going to be bringing it up to anyone I'll be just drawing in myself for a load of grief, and I just keep my head down and do what I have to and. (Steve)

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The young people were asked about whether they felt they had changed as a result of being on the programme. Obviously as the young people interviewed were at different stages of the treatment process, the extent to which they reported changes in their behaviour and their attitude varied. By and large, the

young people spoke about positive changes in their behaviour, their attitude and in their views on alcohol and drugs while in treatment.

Many of the young people spoke about being less aggressive, and more prepared to listen to what other people have to say. As one young man said;

Before I was just all fists, I can talk things out a lot more now. I used be getting into tights and now I can handle situations a bit better like. You can't stop anger, its just I have to find ways to deal with it. Anger's a healthy thing as well like, it's not always a bad thing like. I'll just have to find ways to deal with it like, instead of lashing out and going straight back to the bottle. Finding ways to cope with it! (Owen)

A number of respondents spoke about how their relationship with their family had changed while they were on the programme. They spoke about how they were now getting on better with their families, and of the fact that they had become more aware of the consequences and affects of their behaviour on their family.

I've changed an awful lot like, I'm different with my family now, I always thought my family, I wasn't part of my family and things like, and it wasn't until family days then yea know, it was realising how hurt they were like. I though it was only me that was getting hurt like! I now realised how hurt they were after getting, and all my friends, and my Nan and Grandad, and people like that. And my outlook on people, I was always looking for bad points in people yea know, just so I could laugh at em or mock em or something, and now I look for good points in everyone like. Even if they have bad points like, I try and pass it over onto a good point yea know. Well they have this good point like so, they can't be that bad! (Billy)

Most respondents said that being in Aislinn has changed they way they feel about drugs. As one young man said;

Before I would have thought that XTC, XTC tablets, God XTC wouldn't do a thing to yea! But now I can see the blazing trail of destruction that was my life up until a few months ago. So my perception on drugs, and the thing diat, oh hash is harmless and a bit of speed now and then won't hurt anyone, and the whole thing like all that has changed now, I see all of it as destructive whereas before I saw it as fun! (Laurence)

For others the change was not so much in their view of drugs and alcohol, rather, that Aislinn has provided them with an awareness of the consequences of their drug and alcohol use. As one young woman said;

Not really like because I still get compulsions, yea know what I mean. It's just kind of like, changed the way I look at drink and drugs, yea know what I mean. It doesn't change the way, yea know, I'm always going to get a compulsion to drink, and I know I am, yea know what I mean, I know I am, and that's never going to go like. And I'm always going to want to drink and but I always know that my life is just going to be fucked up if I do drink. Cos there's always consequences when I drink, always, yea know what I mean! (Wendy)

Others felt that being on the programme as such had not changed them, but it had provided them with the motivation and the tools to change themselves. As one young man said;

Yea well it's up to yourself whether you want to change, but it [being on the programme] allows you to see what maybe your defects are, yea know. I suppose that's up to yourself like, I mean if you think OK it's alright to steal, they have told us in here like, you realize that you're disrespecting other people by stealing. You can still go out there and steal afterwards,

if you want to like! Yea know it up to yourself, it just allows you to see that what you are doing is wrong to other people; it's still up to yourself] It's just making you less selfish I suppose, cos that's what we are basically, we just become really selfish and we don't care about anyone, except ourselves! (Steve)

Parents also reported very positive changes in their sons or daughters attitude and behaviour. Moreover, they all said that changes were very visible in all the young people as they progress through the treatment process. Parents also spoke about how their relationship with their son or daughter had changed, and the fact that there was less conflict between them now, fewer arguments, and less resentments and blaming. When parents spoke about changes in relation to themselves, they frequently mentioned how they had learnt a lot about their own behaviour, and how it impacted on the young person, and on the family as a whole. As one mother said;

It's made us look at everything, in the family, at home differently! I suppose, maybe the way, I certainly think the way I reacted to things! I would have reacted an awful lot to X, I would have had a lot of arguments with him. So I know I need to look at that, change that. Even the girls, I was saying to the girls look at where dishonesty basically got X, because you tell your first lie, and then you tell your second, and then you are pulling away from your family and yea know, no matter what they are always going to be there for you. I suppose basically it has changed our parenting!

By and large parents not only learnt about addiction, they also learnt about interaction within the family, and consequently came to see themselves as being important and playing a key role in the family dynamic. As one mother said;

I'm going to see a counsellor now, but she [daughter] didn't like that at first! Cos there were things that I needed to share with somebody who didn't know me! I knew X was getting all the help here, and I was going to support her, but I knew I needed somebody! Now I actually spend time on me. I have actually learnt to say to myself, you are important, because if you're not OK, nobody else can be OK. They have opened that up for me here.

HEALTHY THINGS ABOUT THE PROGRAMME

Respondents were asked to identify what they think is the best thing about the Aislinn Treatment Centre. Some respondents liked the fact that it gave them an opportunity to get away from their homes, which gave them a break from their families, friends, and the environment they were used to. The majority of young people interviewed mentioned the fact that the Centre provided a safe and secure environment. As one young woman said;

Eh, the best things, eh, everything, I don't know. The best thing would be, like having the space out the country and being safe. You feel so safe here, yea know what I mean! It's just safe, you'll never come to harm, there's security like yea know, you feel like you're just wrapped up. That's the best thing of all here like, yea know. (Kathy)

The safety and security of the environment was reflected in the fact that the young people felt comfortable enough to trust the other programme participants and the counsellors. Thus, a number of young people spoke of the fact that they were able to trust people. As one young man said;

It's the way, I don't know, it puts trust into you like. I'd say that's about the best thing like that everyone trusts each other like to open their feelings out like, and what's going on in their lives like and that. That'd be really hard, that's really hard to do like! Yea know, it's just

the way the counsellors put it, yea know, they ask you questions now in the other group, the rest of the group listen to you like and they know that they can trust you then. The best thing is the trust like, and what ever builds onto that like yea know. And it's safe it's really safe!
(Sean)

For others the best part of the programme was getting to know themselves, and starting to like and accept themselves for the first time. For many young people it provided them with a chance to look at their lives, at where they were going and what they have been doing and provides them with an opportunity to start to re-direct their lives. As one young man said;

Like you get your good days and you get your bad days, yea know, when you get your good days, I don't know at the end of the day you're always coming out with smiles or something like that, yea know what I mean! It not all miserable, so it's grand. We're all changing, and getting on with our lived, like we know what we want, and it's just, ah! I don't think I'm changing, but maybe it's easier to see in other people than in yourself. (Paul)

For one young man the best things about the programme was the counsellors. He said;

The best, how helpful the counsellors are! They do, like they go to highs and lows, and no matter what you say or what you did to them, they still come back the next day and treat you as good as anything like. . . . You have so much trust in them like, like I never had any trust in anyone before, like, when I was in me addiction but now I can trust like, all the group like, and I can trust all the counsellors. (Owen)

WOKST THINGS AHOUTTI-IK I'KOGKAMMK

The majority of young people, when asked what they thought was the worst thing about the programme, mentioned the fact that they were not allowed to sing or laugh. Many found such rules too strict, unrealistic, and unnecessary. As one young woman said;

No laughing that's what wrecks me head, no laughing like, the place is a depression house, what are you supposed to do! What are you supposed to do like, no laughing! It's ridiculous like, that really wrecks me head like! You'd want to see some of the groups, they'd be so hard like, and you go through a lot of things, and you'd be in bits, and all you want is a good giggle a good laugh like! It's head wrecking! They come in and say stop being giddy, you're running away from treatment! Ah it's fucking ridiculous. Cos you know some people do be really upset, and you just want to yea know cheer them up a bit, crack a joke and have a giggle and you're running away from treatment, cos you're laughing. You have to have a little bit of a laugh. It's too much! (Clare)

Respondents, who were near completion of the programme and were faced with the prospect of returning home, frequently referred to the fact that whilst in Aislinn they felt too cut off from the rest of the wodd, too closeted, and safe and secure. As one young woman said;

I think it's too kind of cushioned for 6 weeks and then just to be back out there and just slap in the middle of, where all the drugs are again, yea know what I mean! (Wendy)

While for some this segregation from society may have been a problem throughout treatment, in the majority of cases it seemed to be more of a reflection of their concerns around leaving Aislinn and returning home. Not surprisingly, individual's views on what they considered the worst part of the programme tended to be directly related to their experiences while on the programme. For example, one

respondent who had been placed on 'silent reflection' felt that this was the worst part of the programme.

As she explained;

Right so when I did my step one, I did my step one and they turned around to me and said Sinead we want you to. The one thing I hate in the world like is being by myself, and they said we want you to go on silent reflection for two days. They knew very well that I'd hate it, and I wasn't allowed to talk to any counsellors, any staff, I wasn't allowed to talk at the dinner table, from the minute I got up in the morning, till I went to bed! No talking to nobody, just sitting there in silence!....They said they thought it would help me...But it's either, if you don't do it you're not cooperating, yea know, it's kind of a sneaky kind of set up, yea know what I mean! If you don't you're not cooperating, and therefore it's more hassle for yourself! So I went on it and it was the one thing I hated, I was crying for ages when I found out first! (Sinead)

Similarly one of the respondents who had been 'pulled-up' for being in an 'exclusive relationship', when she had previously been in Aislinn felt that this was the worst rule of the programme. She said;

Exclusive relationships, that's stupid, if you're with the same person, if you sit beside the same person at the dinner table for ages and all, or having a smoke with them! The last time I was told I was having an exclusive relationship with this young fella, and he was horrible looking, and I didn't even want to sit beside him. And he sat beside me, and they were telling me I was having an exclusive relationship with him. If you click with someone, cos you'd be excluding people from the group, or something. I don't know, that's so stupid! (Clare)

However, by and large the young people felt that the programme worked, and while there were many aspects of the programme that they did not like, they felt that there were reasons for most of the rules. They had a clear understanding of the reasoning behind rules, thus, while not necessarily liking them, they recognised their possible benefits.

POST TREATMENT

Nine of the 13 programme participants who were interviewed during their treatment completed follow-up interviews approximately three months later. As the young people were interviewed at different stages in the treatment process, they were varying lengths of time out of treatment. All the young people interviewed were attending aftercare, and it was through this service that they were contacted and the interviews set up. One had returned to (a different) school, one had just started an apprenticeship, four were doing FAS courses, two were working, and one was looking for work. Six of the young people had returned to their family and three had moved to supported accommodation away from their city of origin. During the follow-up interview the young people were asked about leaving Aislinn, returning home, attending aftercare, lapses and relapses, and sustained behaviour changes post treatment. Similar questions were asked off the interviewees in the aftercare group.

Returning home

All of the young people said that it was very difficult leaving Aislinn, they felt very unsettled, unsure and basically scared. They spoke about feeling vulnerable and often unprepared for what lay ahead of them. As one respondents said;

The first night I went home, it was so weird, because you're so used to, you're here 6 weeks, and not allowed out in the outside world like, and you looking at the same faces, day in day out and it's like shocking to see so many different faces when you go home. And yea know, you're wrapped up in cotton wool when you're here, and its like your thrown back out there and your next door neighbours are dealers, and your best friends are using and they're calling up and they want to know yea know, are you all right, are you coming back out drinking! And going into like, yea know, the houses out in [name] are real small and going back into my little room, my little box room, and I was just bawling! (Wendy)

Many of the young people also spoke about feeling very lonely when they left Aislinn, and missing the people they were in treatment with and the safe and secure environment provided in the Centre. As one young man said;

To be back in that same environment, with yea know drugs just taken off you, was, I don't know, I felt naked! God, everything looked different yea know! I felt totally alienated from what I had known, it was life a different reality, yea know, it was just totally different! (Owen)

One of the young women interviewed did not have the option of returning home, and a number of them 'chose' not to return home, opting to move on to supported accommodation instead. The young people reported mixed feeling about this decision. Some said that it wasn't what they had expected, as one young woman said;

I don't know, I was just, I wanted to go, like, it's just like, the same thing like, group every day, and yea know what I mean! You still have a bit of your freedom, but not as much as what I thought you would! Yea know what I mean, and the pressure is still on, well not the pressure, but you still have to go into things that you don't want to go into, and yea know, you're repeating step one, and all that kind of stuff again! So my head is quite wrecked at the minute! (Kathy)

For others the continued supervision and support provided in such accommodation was considered if not a benefit, certainly preferable to returning to their home environment. As one young man who went to support accommodation away from hometown said;

I really needed that myself 'cos from where I was coming from, eh, a month wasn't enough to turn me around, I mean I needed a safety net of, yea know a safe house, yea know what I mean! Cos you are here in a treatment centre for a month, this is my own point of view, your in a treatment centre for a month and like you're put back out there like and its very difficult, yea know what I mean. Cos you have to deal with all the friends, and everything straight away, there's so much to deal with like. So for me anyway I definitely needed a half way house for three months, and eh I just started to realise that you could enjoy yourself by staying clean and staying clean wasn't so bad yea know what I mean. (Lorcan)

For other young people the worst part about leaving Aislinn and returning home was the fact that they felt that people had changed in they way they related to them. As one young man said;

It was very hard like, really very hard. I found that people in the family were way different when I got out, then when I went in, yea know that kind of a way. They have changed, towards, I don't know! It's weird enough like yea know! They try and handle you more like, they're very afraid you might do something, yea know that kind of a way! That drives me mad, like yea know! (Mark)

Finally, for a number of respondents the hard part was the fact that tilings were 'no better' then they were before they went into treatment. As one respondents said;

When I came out after a few days I put on the computer, and I had to turn it off yea know, cos it just wasn't the same when I wasn't stoned. It was not good, and everything was, I don't know, there was just no buzz, yea know, I was used to having a buzz all the time, and then when I came out there was no buzz. And, yea know, I think it wasn't good enough for me, it wasn't excited enough, and it wasn't better! That it, like, that it wasn't better then it was before I went into treatment (Jim)

In short all of the young people found it difficult leaving the safe and secure environment provided for them in Aislinn. For some individuals the transition was harder then for odiers, this largely depended on die individual's circumstances. Returning to the home environment was difficult for some, and preferable for others. Similarly moving to a new city was a hard decision for some of the young people, and the only choice for others. They all, however, missed Aislinn and the other residents and staff.

Staying Clean

All respondents, except one, said that they found it very difficult staying away from alcohol and drugs. Many of the young people spoke about the fact that alcohol was so readily available and that they were constandy faced with opportunities where they had to resist the temptation Jo have a drink.

There's a lot of drink around, I think it's worse out in the country. Out in the country they do it all the time, cos there's not many Guards around yea know. The Guards would be in the pub even, drinking, so a lot of the young people have nothing to do so they go drinking and smoking hash and all that! So there is a lot of that around like! (Shay)

Generally speaking, the respondents found 'recovery' much more difficult then they had anticipated. This in turn often made them resentful toward particular staffs members. This was typically expressed as follows;

They made it sound so easy in Aislinn! I remember [staff name], Oh now if I could get my hands on them, [name] said when you go out a new life and all that! I was going yea, they made it sound like, yea know, I'd won the lottery or something! It's different when you go out though! It's very hard, even if you move somewhere, it's very hard! I find it that way anyway! (Mark)

Some of the young people said that they found it difficult coping with things in the absence of alcohol and drugs. They were finding themselves having to deal with situations, emotions and/or feeling diat they would have previously dealt with, with the aid of drink and/or drugs. As one respondents said;

To be honest with you, at die minute I'm not liking recovery! I'm liking it in a sense, but in another sense I can't! I'm not used to dealing with pain, and all the emotions and feelings, I'm just not used to it! And I would love, and like I really do miss my hash, to relax me, cos I'm getting very hyped up about different things, and they could be the smallest things! I feel my temper is coming back an awful lot! I felt like snapping at home, I just, ah I couldn't listen to it! That's why I couldn't be at home cos I'd end up taking it out on my family! And I would go back drinking and that! (Kathy)

Other respondents reported feeling different to their peers, and complained about not being 'normal'. The young people said they were no longer able to do the things they used to do like going to pubs, clubs or just simply hanging out with their friends. Many found this difficult and very isolating, as one young man said;

But I miss all that, yea know, parties and yea know the whole lot! Just going for a nice drink with friends, having a chat, meeting girls and all that like! But now I'm labelled [an alcoholic] yea know what I mean! (Mark)

Some of the respondents mentioned the fact that it was difficult to hide the fact that they were in recovery from people they worked with or were in school with. As one young man said;

I mean a lot of people like myself, I stayed out of pubs and clubs for the first year. ..It was difficult cos your, cos on the course you'd be talking to people like, and they'd be there what are you up to and what are you doing this weekend, and I had to make up some mad excuse or something! (Lorcan)

One young man spoke about not being able to going out drinking with his peers in school.

It is like, yea know when, especially in school like, when all they talk about is fucking getting pissed and getting stoned, and yea know, what your going to do next weekend, and yea know. ...And it's hard to listen to it like, cos in a way you feel that what they're doing now you've done already, yea know that kind of way. And like we'd say I did all that between the age of 13 and 16, and they're doing it now when they're turning 18 and stuff like that like! And it's just strange that I can't go out and experience it with them. (Shay)

For others life seems a bit 'boring' after treatment. They equate the absence of alcohol and drugs with the absence of fun and excitement in their lives. Of those interviewed, the young women seemed to find it more difficult, as the young men were more likely to have found a social outlet through other activities, such as going to the gym, playing pool, boxing etc. None of the young women were involved in any of these activities. As one young woman said;

I really miss the adventure of it [taking drugs], cos I love facing dangerous things, and yea know, reality is the same thing day in and day out, boring, going to meetings, or stay in, like that's, I don't want a life like that! (Wendy)

Finally, a number of young people spoke about the fact that what was difficult was knowing that being in recovery was for the rest of their lives. The knowledge that they could not drink or take drugs ever again did not sit well with some of them. As one young woman said;

I can't believe I'm only 18 and Jesus, the rest of my life, what if I get married, I still won't be able to drink at my wedding! It's yea know, all that kind of thing! I know I'm thinking away ahead of myself but, people say it, but that's the way it is!... You can't keep it in your own day.... I think that's impossible to do! And it does bug me when people say it to me, like, keep it in the day and all this kind of, it's all recovery talk, and it just drives my head wild, it does! (Kathy)

However, it should be mentioned that the follow-up interviews were carried out just before Christmas. Thus, many of the respondents spoke of the fact that it was a time of year normally associated with getting drunk, going out, and having a good time. They were not looking forward to the holidays and to New Year in particular.

Aftercare

The aftercare component of the programme is designed to help former programme participants to remain sober and establish drug free lives. As stated previously all the young people interviewed were attending

Aislinn's aftercare in one of the four locations. By and large the young people spoke very favourably about the aftercare. They felt very comfortable there, able to talk and liked the fact that there were with people who had been in the same treatment centre. One young man described aftercare as follows;

You just come in basically and talk about how your week is going and eh, you know you'd be talking about different situations that come up in your life. Sometimes you might be given, you might make a commitment to the group, yea know you might get out of this situation, a certain situation, say you might be hanging out with our old friends again, right so, you might be asked if you want to make a commitment to the group that you'll do something about this. That helps you yea know what I mean, I find that helps a lot! And eh, so yea, it's just listening to other peoples stories, cos you're just gaining trust, and you're all trying to do the one thing cos you're all out there, trying to live clean, and we all have the one goal because we want to stay clean. And there is another group for people who have relapsed yea know what I mean, it another part, it happened, yea know what I mean! (Lorcan)

A few of the respondents said that they did not find attendance at aftercare particularly helpful; these individuals invariably mentioned the fact that it was not the same as group work in Aislinn was. In addition, the fact that some respondents had to travel long distances to get to their aftercare did not help.

As one young man said;

It's OK, but sometimes I walk out thinking what's the point in going to that like! Yea know, I'm the same as when I went in like! I'd have a better talk with my Auntie at home like yea know! It's all right like! But I don't really like coming down here all the time like! ...Aislinn was better group like! I suppose cos your with each other more like! (Mark)

One respondents who was involved in group work in another settings during the day, found that at the time of the interview she was getting very little out of Aftercare, but anticipated that in the future it would play more of a supportive role. The young woman said;

It's good, I found it very hard at the start because I'm getting group therapy every day up in [place name], and eh, then coming down here and having to get more counselling like, yea know what I mean! It would fucking fiy your head like, yea know what I mean. So like, I just go in like, I just listen like, and I don't know if I'm getting much out of aftercare now, but I know I will when I leave [place name] because I wont have anything like, only my aftercare and I know it will come in handy then. But now like, I'm not really getting that much out of it! I know when I go out I'll be glued onto aftercare! (Wendy)

However, it much be said that while some of the young people said that the benefits of aftercare were limited they were still attending on the weekly basis. Respondents who had been attending aftercare for a while frequently pointed out the fact that, as with treatment, it is essential that attendance is voluntary, and they said that people would get limited benefit from aftercare if they were going to keep their families or other concerned persons happy. As one young man said;

If you're going to aftercare and going to meetings you have to want to go. I was just going for other people to keep my parents, happy and to keep other people happy, yea know. That's just not, it's going to work, you can't, you can't do it for everyone else. That what I've learnt anyway, no matter how many people want you to not drink, if you want to drink you'll drink. That's the way it is. (Lorcan)

AA/NA

Upon completion of the programme the young people are required to not only attend weekly Aislinn aftercare meetings, they are also required to attend twice weekly AA and weekly NA meetings, or as appropriate. The respondents had mixed feeling about these meetings. Frequently respondents spoke about feeling worse when they come out of these meetings. As one young man said;

I don't like it to tell you the truth! It's all older people! Yea know, you come out of it like, you'd come out of it depressed, yea know! I come out of them depressed, listening to all the stories like! Yea know, they're only living for this AA meeting like! Yea know they can't go on with this that depresses me that would! Yea know, they can't get on in life without this meeting, like yea know! (Billy)

Others found what they saw as being hypocrisy difficult to deal with. More specifically the fact that individuals may one week attend meetings clean and sober and the next week they may come in drunk. As one young woman said;

I think it's just, like everybody says that the meetings are this, that and the other! Like at the start, I'd walk into a meeting all right, and I'd walk out depressed and wanting to drink. I even saw a man who said AA saved his life or what ever, and the next time I seen him, he had relapsed yea know what I mean! So that just put me off it altogether! Yea know, he could say that one-week and the next week he comes in scattered off his brain like! (Wendy)

The issue of age was mentioned by a few of the young people. They said that individuals in AA were a lot older than themselves, which made them feel uncomfortable. Moreover, a few respondents said that people at meetings had said to them that they were 'too young to be alcoholics', this they found difficult to deal with, particularly as they shared this view. However, when the members of a meeting accepted them, it made all the difference. As one young woman said;

Eh, I hate it, I hated the meetings! But like last night I went to a meeting and I really enjoyed it, it was AA! But I really enjoyed it and it was the first time I shared as well, and I felt more comfortable and it was a small group! I think it was just the atmosphere, because I have this thing about old men, I just don't like them, I feel uncomfortable around them! Don't ask me why! They're all staring and that, but I think it's just because, what's going through my head is, that they either want something off me or, they think I'm too young to be an addict! This is what's going through my head! But last night like your man who was doing the chair, he turned around and he said he thinks it's great when he sees young people coming into the thing, cos you're catching the addiction at an early age! Which put me in a good mood! (Kathy)

Despite the fact that NA had a somewhat young attendance age, generally speaking the young people preferred going to AA meetings. As one young woman said;

I like AA because, the only reason I go to AA is because there is a lot of clean time, or sober time, some people are 30 years clean, and there's a lot of wisdom in there like yea know! But in NA they are a lot younger, but like yea know, people would be only 3 or 4 years clean like, or like maybe 10 years max clean, that's only because the meetings are only starting! (Clare)

However the longer the young people were attending AA or NA the more they seemed to find the meetings beneficial, the more comfortable they felt and the more prepared they were to participate. Although the respondents frequently mentioned that the NA/AA meetings were different to both the

aftercare and group work in Aislinn, the programme had prepared them for these meetings. As one young man said;

I go to 4 or 5 NA [meetings] a week...I was a bit edgy at the start cos you're thinking ah Jesus, now I have to talk now in front of these people, and they don't know me. But it's good in a way too, that you can eventually feel comfortable, yea know like, and you can talk to people after it and before it and you don't feel out of place or whatever. I was at meetings before, but like, Aislinn has prepared me cos like before I came here, I didn't want to speak in meetings, cos I was afraid of offending somebody, or saying something that probably didn't come out right to whatever! But Aislinn taught me that I'm just there for myself, yea know what I mean! I'm there to get me better! (Owen)

Lapses/Relapses

Three of the treatment group had lapsed since they left treatment, and two of the young people from the aftercare groups had relapsed. As one young man said;

I did, well I didn't relapse, I slipped yea know! A relapse would be like progressive yea know. But eh, I only smoked half a joint at [place name] yea know, just smoked it like, cos me mind set like, it was about 8 weeks ago! But I was thinking to meself, ah fuck this like, what will my friends think like, yea know all the image coming up like, Jesus ydu've turned queer soft and all! But eh I smoked it anyway and I was pissed off when I did smoke it yea know. I was just zombied out, and wrecked! But eh, I still get fierce close, cos I was rolling joints there the other day, yea know two days ago! (Billy)

All the young people who reported drinking or taking drugs after treatment, said that it wasn't very enjoyable. They spoke about feeling of guilt, shame and disappointment. As one respondent said;

And I remember, being told that a relapse was worse then before, before you knew the programme existed. And for some reason it was yea know, I just wanted more and more and more, then I did before. After going through family days here yea know, and having your family say what you were like and just finding out some much about yourself and what you were like in addiction, all the things you did, it makes it very hard to enjoy a buzz afterwards, because you know you're an addict, you know all the ins and outs of the drug, and the addiction, and the relapse. You know your not taking drugs your in a relapse. Yea know, its just its just, the fun's gone out of it. The fun's just gone out of it. And then there's all the feeling of guilt and shame, I suppose. Yea know, there was no good feelings really! (Jim)

For some the relapse was planned, it had been something they had been thinking about for a long time, rather than just a response to a situation. As one respondent said;

Na, I think it was a bit planned in me head, without me even thinking yea know! And that's what I'm afraid of at the moment like! I think there's something being planned in my head, yea know! Especially for going home at Christmas I think there's a big huge scheme in my addiction, so I do. But I don't know what it is you see, and that's what frustrating me a bit yea know. Cos for some strange reason, I haven't go a craving for drink yea know, but I could be thinking ah sure wait till you go home yea know what I mean like! (Billy)

Many were quite philosophical about their 'slip', and saw it as being a good thing. For some of the young people it made them realise that they could not 'handle' drink/drugs at that moment in time. Others felt that is was just part of the recovery process. As one young man said;

Some slips like they help you in your recovery yea know what I mean! It does help you cos when you just realise, you have so much expectation over this joint, then you realize that your back to square one, you won't go near it again, you'll go fuck that shite like, yea know

what I mean! But sometimes people will progress from that yea know what I mean, but I didn't like! (Lorcan)

For those who had not (re)lapsed post treatment, it was proving very difficult. These young people interviewed at follow-up spoke frequently and at great lengths about drugs, alcohol, and their desire to use again. As one young woman said;

And I always think that somebody relapses in their life! And that gives me the urge to relapse, I want to! Do you know what I mean! I want to see what it's like, I want to see if I can handle it! And even though I know, deep down in my heart that I can't, I just want to, yea know what I mean! Cos I see people and they relapse and they come back, yea know! But knowing me, I wouldn't be able to get myself back! (Kathy)

Similarly another respondent said;

You feel sad for them [people who have relapsed] eh, but I also want to do it myself! I still would love to just test it, and they say it's harder and this and that and the other, if you ever go back drinking its never the same cos, you feel guilty and that! But I want to try! (Audrey)

For many who had not (re)lapsed it was the fear of the consequences that had stopped them from going out and using. This seemed to be particularly the case for the young people who were living in support accommodation, as there was a very real risk that they would become homeless if they returned to drug and alcohol use. As one young woman said;

The last time I got out of treatment I was going to pubs and clubs the whole time and I relapsed, yea know what I mean. The fear is there like, yea know what I mean, and I've fucking nothing to fall back on this time! I had my family there the last time, yea know what I mean, I had a house and I had a bit of sanity and if I go back out this time, I'm dead or in prison like, yea know what I mean. That's scary like! (Wendy)

Involvement in Crime

Only one of the young people interviewed at follow-up reported being involved in crime post treatment. However as she explained the sense of guilt led to her owning up to what she had done and attempting to make amends;

Second weekend home then, and it went all right....But I ended up robbing when I was in [place name] and I robbed a phone and when I went back up to [place name] I had a phone and all the counsellors were saying where did you get the phone, and I was saying I got it off my sister like! But then, I just got pure guilty like yea know what I mean, so I just said it to her then, I said I robbed the phone I said, and I'll post it back like, yea know to the coffee shop! So I posted it back like! Then I did a load of stuff around robbing yea know, cos I'm always picking up stuff and yea know what I mean. I just think it's grand like, pick up a tube of make-up or a bottle to perfume like yea know! But I didn't like saying it, yea know at the start like, yea know in group therapy, at the start you introduce yourself and I say my name's Wendy and I'm an addict, an alcoholic and I had to say I've a problem with stealing! Then one of the girls started calling me a robber, and I freaked one night, like who is she to tell me I'm a robber like! (Wendy)

Others, who were no longer involved in crime, simply felt that they had out grown it, and didn't necessarily see their involvement in crime as being directly related to their drug/alcohol use. As one young man said;

But I'm getting older now, like yea know, so I know certain things, so, that was when I was younger yea know! You kind of mature, you drink differendy, and when you come out of a nightclub now like, you won't go, oh I'm going robbing! I'm finding that now! I got into trouble, yea, when I was younger I go into trouble like!The crime and all that grows out of you like, you done that for a laugh like as well! It wasn't all over drink, and the money for drink! You like to have money, yea know that kind of way, going off with the girls and all that like! Showing off, and all that. Robbing the cars to have a laugh with your friends! It was different feelings besides drink, like, yea know! You just do stupid thinks sometimes like!
(Mark)

The majority of the young people also said that they were less aggressive than they had been before they entered treatment. However that said, the young people who were struggling with recovery did report that they were beginning to feel angry and aggressive again. These respondents frequently mentioned the fact that their 'temper was starting to come out again'.

Family relationships

The vast majority of respondents said that they were now getting on much better with their parents and other family members. They said that their relationships had improved while they were in treatment, and they had managed to sustain these changes. As one young woman said;

They've made [Aislinn] they've actually saved my life, and that's the truth! And I would do anything for them! Eh, they've saved my relationship with my Mum! ...And my sister, like, she talks to me now, and tells me what's going on, and it's great! (Kathy)

Many of the young people spoke about the fact that not only had their relationship with their parents improved, but they were now also getting on much better with their siblings. As one young man said;

...but when I stopped taking drugs, she [sister] was always nice to me, but I always pushed her off, but now, if she has something bothering her, it's me she'll come to before anyone else. For her to come to me, I'm the person she'll come to! I suppose it's a normal duty for a big brother to help but it's great! Now I get on really well with my two little sisters as well, they kind of sensed that I was not a nice person to be around, you know children, they just, I don't know! (Jim)

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To conclude, for most of the young people life after treatment was difficult, and in their view it was more difficult than they anticipated. They often referred to the fact that all they wanted was to be 'normal', and 'like other people'. The young people frequently felt very isolated from their peers, which in turn led to boredom, and frustration. Moreover, they had limited social lives, and many, in particular the girls, seemed to find it difficult to separate a social life, from drinking and using drugs. As one young woman said;

I don't really go out that much, I hate going out at the weekends! I went out one Saturday night, I was in town with my friends, eh it was actually one of the girls up in the house, and we went into town just to look around or whatever and have a cup of coffee! And we seen everybody all dressed up, in their outfits going out, and drink and singing and all that, and I was just, oh, I'm never going into town again! I was mad, one hundred girls could have jumped on top of me, and I probably would have teared through every single one of them! That's how bad it is! All I'm doing is eating! (Clare)

All the young women and three of the young men spoke about wanting to find a boyfriend/girlfriend, which for them represents the end of isolation and loneliness. As one young woman said;

People are saying not to get into relationships and all that, I haven't, but I want to! Like I haven't done nothing like yea know, but it is so hard! And I just, I really would love to, I feel like I need a fella in my life at the minute! Like they say you can't have a relationship for 2 years, that wont happen! That will not happen! And I know it's a risk, it is a big risk to have a relationship in early recovery and all this kind of shite! But sure there are loads of things that depress people and get them back on the drink, like, if some fella, like just say, some fella we were getting on so well and something happened there right, and like, and it didn't work out, and I'd be depressed, and I'll still have a phone call, I'll still my meetings, do yea know! But if it worked out well, do yea know what I mean! (Kathy)

For other respondents life after Aislinn was difficult due to their circumstances, and while they acknowledge that they have learned a lot both about themselves and about addiction, they are still living in very stressful and difficult situations and have to deal with painful issues. As one young woman said;

I still sometimes like, yea know if I think like, of the situation I'n\in now yea know what I mean, I'm still practically homeless yea know what I mean, I haven't my mother talking to me, yea know she doesn't want to have anything got to do with me like! My Nana's dying, and yea know what I mean, when I think this like yea know what I mean, its all running thought my head like, yea know, and still about the Gardai and the time I was in the abusive relationship, and that still effects me to this day like, yea know what I mean. Yea know, when I'm looking at myself in the mirror, and think like about everything, I just fucking get so pissed off, and sometimes I just say, did that fucking really happened like! And yea know, sometimes when you having a really fucking bad day you just say yea know, I'd just live if this was all a fucking dream and I just work up and I was fucking normal! (Wendy)

That said all the young people said that Aislinn had prepared them for leaving treatment in as far as they could. They said that the relapse tracks that they had completed were very beneficial and it increased their awareness, but at the end of the day they had to leave Aislinn and face the 'real world'. As one respondent said;

They [Aislinn] could have done nothing else; this is the way it is like! And this is the way it's always going to be! I could be in Kilkenny for 2 years, and I'd still have to come out and I'd still have to face reality! It was different in there, in treatment because that kind of a place you felt so safe! Like out here your back out in the world, yea know what I mean! It's like your lost in a big jungle, yea know its jus mad! But like you get over it after a while! (Lorcan)

Only one of the young people interviews regretted having been to Aislinn. That said the individual in question was at the time of the follow-up interview experiencing great difficulty dealing with being labelled an 'alcoholic' and coming to terms with the disease concept of addiction. All the other respondents interviewed post treatment spoke very favourably about their experiences in Aislinn. As one young man said,

Aislinn has taught me a new way of thinking, that's what helped me. Yea know, you can look at things from a different point of view, yea know what I mean! I'm open to things that people say to me now, yea know! And I can sit down and talk to people. Six months ago I wouldn't sit down here and talk, I was mad, well not mad, but I was just very snappy and violent and all that! If someone came to me and said about the evaluation, I would have said fuck off, I wouldn't have been able to sit down here and talk to you! (Owen)

SUMMARY

A qualitative evaluation provides a distinct but coherent perspective on policy, programme and practise evaluation (Shaw, 1999). In this section a richly descriptive account of programme participants experiences of the Aislinn Adolescent Addiction Treatment Centre was provided. The qualitative approach enabled the researchers to give a voice to the normally silenced young people who seek treatment for substance misuse. By and large the young people interviewed spoke very favourably about their experience of Aislinn and all 13 young people interviewed while on the programme completed the residential aspect of their treatment. Moreover, only one of the 13 interviewees had completely ceases to attend Aftercare at the three-month follow-up (to individuals were attending infrequently). That said, many of the young people found the therapeutic process demanding and 'recovery* harder than expected.

The screening process was difficult for many because the programme participants were required to speak about their drug and alcohol misuse in the presence of their parents, often for the first time. The extent to which this was a problem seemed to vary depending on how much the parents knew about their son or daughters drug and alcohol misuse prior to treatment. It is good practice to have parents involved in the screening/assessment of a young person, as the information given by parents can help the assessment by providing a fuller picture of the young person and an understanding of the family relationship (SCODA, 2000). However, when the parents are involved, it is essential that the young person be given the opportunity to be assessed alone. It is paramount that the young person provides a detailed history of their drug and alcohol consumption and that the counsellor has an understanding of their difficulties and their past and present life story to enable them to determine the appropriate of the Aislinn Addiction Treatment Centre to their needs.

The majority of the young people interviewed did not know what to expect from the Aislinn when the first arrived. They had a limited understanding of the programme's aims, objectives and the overall programme philosophy. Although all the young people would have been made aware of the focus on sobriety and abstinence prior to entry into treatment, it took time for the implications of this to sink in. Thus it was later in the treatment process diat the young people began to address this reality, either by stating that they do not have a problem with a particular substance, usually alcohol, or saying that they are capable of controlled usage. It is essential that young programme participants make an informed decision to enter treatment therefore they must be made fully aware of the programmes structure, content and what exacdy is expected of them. There were somewhat mixed views on the programmes philosophy regarding 'addiction'. Some of the young people were not too perturbed by being described as 'an addict' and its implications. That is not to say that they necessarily agreed with it, rather they appeared to accept it. Others completely refused to accept being labelled a 'drug addict' or 'alcoholic'.

In term of programme content and the day-to-day activities, the young people settled in quickly and soon learnt what was expected of them. By the end of the first week, the young people had settled into group;

6: Linking Aislinn with Local Models of Drug and Alcohol Treatment

INTRODUCTION

Previous sections of this report have summarised Aislinn's programmes and operation and reviewed participants' perceptions of programme's suitability and impact. The next section draws together a discussion of this material leading to an analysis of the programme's overall efficacy and impact. Before proceeding to this discussion however, it is necessary, here in section 6, to consider the wider service environment within which Aislinn operates. Currently, the broad thrust of stated public policy on drug and alcohol treatment is to support the development of community services within a framework where specialist, residential services operate as a back-up. There is a need therefore to provide some account of the circumstances in which such back up would be required and the likely expectations of a service such as Aislinn in providing such back up.

THE EMERGING COMMUNITY MODEL OF TREATMENT

Traditionally, alcohol treatment in Ireland, as in many other jurisdictions, was based on specialist intervention in psychiatric hospitals involving set periods of in-patient detoxification and care in highly controlled and supervised environments. Since the 1970s however the appropriateness of this approach has been questioned and policy has supported a shift in the direction of community models of care.

Criticisms of the specialist approach are summarised in the report *Planning for the Future*, 1984, which argues that specialised services operate a "separatist" approach - drawing people "away from the community and family", potentially excluding the "contribution of primary care and community, medical and social services" and running "counter to the principle....that help to individuals and families should be as near to their communities and homes as possible."

Since the publication of *Planning for the Future*, stated policy for the management of alcohol problems has supported a community rather than a specialised, in-patient approach. Conceptually, this community approach advocates earlier intervention and greater involvement of family members, within the context of primary health care and personal social services, and with access to specialist psychiatric services, as appropriate. In some respects this community approach is envisaged as an ongoing support system for those who experience problems with alcohol consumption. It acknowledges that alcohol problems do not

they were aware of the procedures, the level of participation expected and what they were required to do. Many of the young people spoke about how difficult the group sessions were, however at the same time they were aware of their benefits and on some level appeared to enjoy the group. Central to the group sessions is the step work that the young people undertake. The extent to which the young people understood the 12 Steps varied. They are however guided through their step work at each stage with lists of questions that they must answer, or issues that they must address. The down side of this approach is that individual step work is at risk of becoming somewhat formulaic and the possibility of competition between people when undertaking the individual steps.

The young people all viewed family involvement as central to the programme. Similarly the parents interviewed felt that their participation in the programme was vital to the process of change. That said family groups were painful for both the young people and their families. The young people had differing views on the programme content. For example, some liked art, while others did not enjoy expressing themselves in this manner. Respondent's views on such aspects of the programme were largely a matter of taste. All of the young people spoke very positively about the staff. They were liked and respected by the young people and their parents.

The young people reported a range of behaviour and attitudinal changes including feeling less aggressive, and more prepared to listen to what other people have to say. Most of young people reported positive changes in the relationship with their parents, and family. The young people reported being more aware of the consequences and affects of their behaviour on their family. Both parents and young people reported that there was less conflict between them now, fewer arguments, and less resentments and blaming. However, the majority of young people found life after treatment very difficult, and staying 'clean and sober' was harder than they had envisaged. That said, at the second round interviews, approximately 3 months post treatment; one/ three of the in-treatment group had lapsed. However, the young people who had managed to remain drug and alcohol free spoke in great detail about drug and alcohol use and their desire to 'see what it's [relapse] like' and basically to use drugs and alcohol again. The findings highlight the importance of aftercare and the importance of post treatment services to help maintain recovery.

lend themselves to curative treatment, that many such problems are continuous, with problem highs and lows, and draw different levels and forms of intervention at different stages.

In addition to these issues. *Planning for the Future*, also argues that specialist services are hugely expensive as compared to non-specialist interventions, a point that is emphasised further in the *National Alcohol Policy, 1996*:

....the present state of knowledge suggests that out-patient models of treatment are no less effective than in-patient care and they have the advantage of being less expensive (p39).

Although, since the 1980s, public policy on alcohol has supported a shift in the direction of community services, progress in developing these, no less than other areas of 'community care' has been slow. In some respects the new model fell victim to public expenditure cutbacks. In such circumstances, where such problems are considered *everybody's* responsibility they can, in the absence of funding, end up being *nobody's*. In practice therefore, new community models of care remain at an early stage of development and it is only in recent years that substantial funding for such developments have become available. Meanwhile, the absence of well-developed community services has contributed to a higher demand for specialist interventions. In particular there has been a growth in the demand and provision of specialist residential treatment in non-hospital (psychiatric) settings. In effect this has meant that in some circumstances, back-up, residential facilities are available, prior to, and not as a consequence of, an engagement with, or demand from, local services. And, as already outlined earlier, the demand for setting up Aislinn emerged not from within the community but from within existing specialist service provision. There is little evidence that this demand was articulated from among health board field personnel, although, as is clear from our earlier discussion, there is also little evidence of health board personnel being deployed in sufficient numbers such that adequate local assessments of drug and alcohol needs could be made.

SERVICES FOR YOUNG PEOPLE

Alcohol problems

The community approach to treatment is also evident in the emergence and development of services for young people. Official responses to alcohol problems among young people tend to emphasise the role of secondary prevention: targeting specific groups of vulnerable young people, offering counselling, peer-help and other supports in programmes for vocational preparation, responding to early school-leaving and crime diversion. Generally, it is envisaged that emerging community-based alcohol treatment services be provided to young people in the same generic model as to other groups. The *National Alcohol Policy, 1996*, does not advocate the need to provide separate alcohol treatment interventions, specifically for young people.

Drug problems

As the drug problem tends to be associated with young people (under 25 years), many treatment, as well as secondary prevention responses, were developed with a focus on this particular target group. Initially, following the onset of this problem in the late 1960s, treatment services were provided centrally through specialist personnel. However, as a result of local epidemics and public health concerns with HIV/AIDS the main treatment provision is now community-based, within a similar, albeit separate and more-funded, model as alcohol. Specific treatment interventions for young people under the age of 18 years are limited. The National Drug Strategy, *Building on Experience*, highlights the need for adolescent-focused treatment and sets the provision of "geographically accessible" services for this group as one of its forthcoming targets. A Working Group to develop a protocol for the treatment of young people under 18 years has been set up by Government and is due to report in May 2002.

COMMON ELEMENTS OF A LOCAL FRAMEWORK

An important consequence of the National Drug Strategy, *Building on Experience* is it has brought a new momentum to implementing a local framework for drug and alcohol misuse, across the regions. As already indicated, a wider policy framework incorporating the necessity of local strategies has been advocated now for almost 20 years. The new impetus to move towards implementation emerged from widespread public concern with drug problems as well as the availability of public funds, and in 1996 this led to focused strategies in worst affected areas. With *Building on Experience*, such localised strategies have now been extended, potentially across all geographic areas, and also potentially, with a more effective integration of drug and alcohol treatments. Needless to say, such developments are hugely reliant on the continued availability of robust funding, and in light of recently heralded pressure for health expenditure cutbacks, it remains to be seen whether these initiatives can be sustained.

In the context of this evaluation, this increased momentum towards implementing a local framework for alcohol and drug misuse has important implications with respect to the integration of these services with other non-localised services, including Aislinn. These issues are explored here within the context of discussions held with representatives of two of the health boards who between them account for nearly 60% of Aislinn's admissions. In this exploration, there is a need to identify the main features of the health boards' adaptation to a local framework; while at the same time there is a need to examine how Aislinn's particular model of care and treatment fits into this emerging local framework.

Given the historical context of a traditional system of institutional care that is only in recent years begun to make way for a community system, a variety of pathways to developing this new system is likely. Differences here are quite apparent in the approach of the two health boards concerned. For example, in one health board area its drug and alcohol services are being developed through incorporating a number of core, non-residential services that were previously provided through a voluntary agency. These services are now provided directly through the health board and are being augmented by an increasing number of

satellite services operating at various geographic locations, as required. In the second health board area, the focus is on building localised services from a green field situation, drawing together existing personnel carrying a drug or alcohol brief and linking these together with new members of an expanding number of locally-based teams. It is likely that an examination of a larger number of health boards would indicate an even broader disparity of development models. In due course however according as the number of personnel and services reach a critical mass, we would expect that these developments should show clear signs of model convergence. An appraisal of their differences here therefore, is not so important as that of highlighting the common thinking of two health boards as to what should constitute the main elements of a new local framework.

The first common element in the approach of both health boards is their desire to develop *local professional teams* within the overall structure of a county or community care area. The central idea here is to have a team of drug and alcohol counsellors who can provide therapeutic and non-therapeutic services and supports, as required. Teams would be structured to have 3-4 counsellors per senior member and there would be a strong emphasis on professional support, supervision and direct accountability. The services provided should be relatively accessible and capable of being provided at health centres, community centres or various other local centres with a health / counselling focus. Even though the core components of such services might be provided at central locations it would be important that they have outreach capabilities.

A second common element of an emerging local framework is that an *array of therapies and interventions* needs to be available through this community team. These might include behavioural therapy, psychotherapy and family therapy. While drug-free interventions would be (and are) provided, potentially linking in with locally available AA and other self-help groups, it is important that "non-abstinent" options, such as programmes for controlled drinking or drug-substitution, are also available. The following comments from a health board representative summarises its intentions in this regard.

Within two years it is likely that we will have a system, through an expanded team, that will allow for more intensive interventions at a local level, with the back up of an addiction specialist psychiatrist.

In this emerging local team structure it would be important that team members understand and appreciate the varying circumstances under which different types of programmes operate. Clearly, it is hardly possible for each member of such a team to be able to provide multiple intervention types, but the overall team itself should be able to maximise such availability and individual members should be particularly competent in at least one type or approach. Furthermore, it would seem important that team members have good knowledge into the range of treatments that can be provided, to have insight into the treatments that work well in particular situations or circumstances and to have the ability to assess prospective clients' suitability for different treatments. It would also be important that they be able to

refer-on, as appropriate, for either further specialist assessment or for treatments (including hospital-based or other residential treatments) not currently available from within the local team.

A third common element relates to the way in which it is envisaged that these emerging teams comprehend the *widely-ranging needs and potential* of persons with drug and alcohol problems. It is considered **that many users of drug and alcohol services have multiple problems and are likely to avail of several** specialist and generic services over a long term. Many will be part of families who similarly have regular, long-term contact with helping services and the utilisation of family models for addressing complex, multiple problems, will often take precedence over specific alcohol or drug-use issues. Others will have little contact with families and may be quite isolated and vulnerable within their own communities and neighbourhoods. In these circumstances it would be envisaged that most persons presenting with drug and alcohol problems need to be dealt with, in the first instance, through a primary care system, and through an approach that seeks to modify the proximal conditions in the person's social environment (family, school, workplace and social relationships), as it does to change drug and alcohol-related behaviours.

Each service user is of course an individual with a unique set of circumstances and needs and an important aspect of a community-based response is flexibility and adaptability to these needs. In so far as it is practicable it is important that the response preserve rather than jeopardise individual uniqueness. In many respects therefore, this involves undertaking an appraisal of needs in order to ascertain the combination of services that may be appropriate for any particular individual, rather than simply assessing an individual's suitability for a particular service. This point is emphasised by a health board official as follows:

Assessment is not for a service but for a treatment plan and there are many options available in this treatment, such as non-residential 12 Steps, brief therapy, family conferencing, individual motivational therapy, etc.

Coordinated casework management is an important aspect of this type of response and provides an opportunity to ensure service users have regular, ongoing assessments of their health and social needs. It also ensures they have long-term treatment goals, alongside contingencies for dealing with particularly high-risk or other once-off situations, as and when required. Essentially, service users need a keyworker who would provide both support and continuity across a range of services: assessment, practical support, therapeutic support, crisis intervention and support in developing plans for vocational, educational and social rehabilitation. Clearly key workers would also need to be highly involved in making referrals to residential settings, in supporting placements, in dealing with case management issues in placement as these arise, and in developing and supporting an after-care plan, as appropriate.

Alongside a knowledge of treatment types and competencies in particular interventions, a fourth common element of this community approach, is that members of the local team need to be able to successfully *integrate with other community care personnel* who are involved with providing health or social service inputs.

They need to be able to liaise directly with GPs and pharmacists in relation to pharmacological treatments, as appropriate. They need to be able to deal directly with social work colleagues in relation to child protection or other family welfare issues. Beyond the health board they need to be able to link up with agencies who provide vocational training, education, youthwork and other support services, and in particular they need to have meaningful relationships with agencies involved with secondary prevention drug and alcohol programmes, with particular, targeted groups. They also need to be able to link in directly with back-up, residential supports. These residential supports would include both hospital and non-hospital residential services. Clearly, local drug and alcohol personnel would need to be able to network efficiently with a range of professional and non-professional bodies who interact with their shared service population.

At this particular juncture a missing component of this developing framework is health board policy towards the treatment of young people and the extent to which services for young people need to be separate, integrated with adult drug and alcohol services, or linked in with child and adolescent services. Obviously there are many other issues that need to be considered also. The actual position of health boards in relation to these matters is likely to become more clear following the report of the Working Group on a protocol for the Treatment of Young People, which was set up as a result of the report, *Building on Experience*.

It needs to be emphasised that the above common elements do not directly describe particular services as provided by either one, other or both health boards. Rather they reflect a common understanding of how these services would best function on the assumption that progress towards such functioning continues to be made.

It is important to consider how this emerging community framework links up with a residential service such as Aislinn. Bearing in mind the earlier cited principle that "help to individuals and families should be as near to their communities and homes as possible" it behoves both community and non-community based drug and alcohol professionals to ensure that, prior to referral to Aislinn, or to any other residential service, there are distinct components to an individual's treatment plan that suggest the need for a residential placement. These distinct components need to be appraised in two separate ways, and two linked questions arise here: First, are there components of treatment, necessary in a particular case, that can only be provided through residential placement and if so, what are these components? Second, are there individual case factors that suggest the necessity for residential placement and what are these factors?

Dealing with the first question concerning programme elements: As outlined in previous sections of this report, the main objective of the Aislinn residential programme is to induct young people with drug and alcohol problems into a lifetime of recovery, whereby they would remain abstinent and continuously linked in with a 12 Steps recovery plan. The main components of this induction are group and individual

therapy, and an educational content, and these are delivered within a very tight daily routine. On the face of it there is nothing about these main components that require the programme to be delivered from within a residential setting. In some circumstances, health boards have indicated, that such programmes are already provided on a daily attendance basis, although clearly these cannot be delivered with the degree of intensity available through a residential programme. Indeed *intensity* is Aislinn's main distinct component and is perhaps best explained by the following excerpt from an Aislinn document:

...(A) residential placement, even a brief one of six weeks, gives respite to the resident and space from family and peer pressures. The resident is in a deliberately nurturing and safe environment. The quality of surroundings and good food help residents to feel cared-for and protected, leaving them free to engage with the process. In a residential setting maximum use can be made of quality time and positive relationships between the residents and counsellors are fostered, while the staff in general provide good role models for the residents outside of therapy sessions. In addition the day is highly structured and focused which gives a sense of security. It is a period of enforced stability during which a group of peers with similar problems live together, challenge one another and strive towards a common goal.

Clearly, the programme's intensity provides for a safe, nurturing and secure environment. But perhaps, more importantly, the programme's intensity is linked to its "strive towards a common goal" which in this case is towards a common state of abstinence from drugs and alcohol. The goal is not unique as many other non-residential and community-based programmes share this objective. However, it differs to these latter programmes in that local community teams who arrange or operate such programmes need also to be able to make available or refer clients onto other, non-abstinence programmes, or indeed to operate in an environment where such programmes are also available. In the case of Aislinn, this is not the case. Here, a further distinct component of Aislinn is evident and that is that it comprehensively embraces and adheres to an abstinence ethos, suggesting therefore that Aislinn is indicated as a place of referral in the case of persons who are at a stage of being able to make this dedication. Where it is assessed that persons are unable or not yet ready to make this commitment, given that they fully understand what exactly they are committing themselves to, then referral to Aislinn might be considered inappropriate. This issue is returned to later in considering individual case factors that indicate the necessity for residential placement. In the meantime, there is a need for further discussion of components of Aislinn's treatment programme that are described as distinct and two in particular, relating to family programme and after care, are proffered.

Aislinn has a high level of commitment to its family and after care programmes. Alongside the weekly involvement of family members in both therapeutic and educational group sessions and lectures, their participation also forms part of screening, preparation for induction, ongoing management and monitoring, and discharge. The two-year after-care programme involves trained facilitators providing structured opportunities for persons to engage in group sessions in addition to their attendance at AA or NA groups. Despite this high level of commitment to these programmes however, it would be difficult to argue that these are either distinct or that a person might be referred to Aislinn because such components

are not available elsewhere. There is an argument indeed that, in many instances, both the family and aftercare components of drug and alcohol treatment, generally, can be more effectively sustained, in the long-term through non-residential, community-based programmes. In this latter case the necessary contacts and networks for building these components would be developed close to the family's home and community, thus lessening the inconvenience and cost, and potentially linking the young person and their families to indigenous networks of natural support. Within family programmes, in particular, the day centre model, rather than residential centres, offers better opportunities for in-depth intervention and therapy, especially in the case of a structural approach, wherein the family system is being treated. Family interventions built around weekly, day-long engagements with a residential programme might become over-focused on the resident, and their individual problems and behaviours. Potentially, these interventions lack both a sufficient knowledge base and a treatment plan for responding to more deeply-rooted family dynamics and traumas, of which an individual's addiction is but one symptom. Such problems might be overcome through the whole family or one or two key members moving into residence and certainly in such circumstances there is a robust argument in favour of a residential referral. However, such arrangements are rarely possible and the choice, in a family-focused approach therefore, is between engaging the family as a support to an individual's in-residence treatment, or engaging the family in its own direct treatment through a more prolonged, if less intense, community response. Within the latter programme, the whole family (or at least the agreed participating members) can potentially, be dealt with more effectively as a unit. The young person, parents, and other family members all, potentially have similar and equal opportunities to participate in individual sessions or group sessions away from other family members and to come together as a family unit to untangle family dynamics and deal with family problems, as appropriate. In the former approach, the family is mobilised to lend support and authority to the individual's residential treatment plan, although this plan may fall short of being able to directly engage the family in dealing with deeper systemic issues. In this context, it would be important that where deep family problems and traumas are indicated that measures are taken to ensure that a referral is made, either during or post-treatment, to an appropriate family service.

Similarly, in relation to aftercare, there is an argument that following a period of residence in Aislinn, continued support should be provided not directly by it, but by community services, who would obviously need to be linked to Aislinn for referral and other purposes, through a keyworker. Critically, it would be envisaged that a keyworker have the primary role in assessing an individual's suitability for a residential placement, in preparing the individual for this placement, in linking in with them during placement and in providing a follow-up post-placement. Such arrangements are developing in relation to hospital care. They are not in place in relation to Aislinn although there is some indication that changes in relation to an involvement in assessment are forthcoming. The need for an involvement during a residential and in aftercare is pressing.

This issue leads on to discussing exactly what are the specific case circumstances where it might be appropriate to refer a young person from a community setting to a residential programme such as Aislinn. Given the age group involved here, and again bearing in mind the principle of providing care as close as possible to a person's family and social environment, there is a case for minimising out-of-home placements. Indeed, only in exceptional circumstances should consideration be given to placing young people outside their home or community. A case needs to be established that such placements have a strong likelihood of achieving outcomes that otherwise would not be attainable within the context of community or day programmes. Comments from health board officials indicate the exceptionality of such placements:

Family circumstances usually dictate a persons need for residential care. The family and local situation is too problematic.

Unless there were pressing social or psychological events it would be unusual to consider a residential option for a young person at first referral / assessment.

The priority therefore needs to be to ensure that the options of intervening-within a community situation are in place and that a person is not referred to Aislinn, simply because little else is available. There are indications from Section 4 of this report that this, in fact, does happen. While almost 60% of cases had previous contact with a drug or alcohol related service in the majority of cases this contact was for a very short period. More services and options need to be available for treating these problems within a community context.

There are of course circumstances where community-based treatment is no longer appropriate and that the option of a residential placement needs to be explored prior to linking the person back into a community service. Such placement could be in Aislinn or alternatively in a hospital-based or other residential programme. The likely circumstances given rise to the need for such a placement would be periods of crisis or respite and / or when opportunities for intense therapeutic input are presented. As explained by a health board official:

These might be issues of family breakdown, no indigenous supports in the community. Or the young person is compulsively in use and completely unable to stay away from a drug-using peer group. There might be a psychological breakdown. Or, the level of psychological dependence might require reflective time, and in these circumstances it could be indicated that a residential service might be useful.

Aislinn is in a position to respond to some of these situations. However, as already outlined, it is best able to respond to these situations in circumstances where those who are being referred are able to make an informed commitment to an abstinence model.

A further issue that arises is the involvement of the families of persons considered suitable for a residential placement. It is riot always the case that family members of persons in this situation can make the type of commitment to Aislinn that is required for programme participation. As explained by a health board official:

People who get to Aislinn have family support whereas a lot of the people we deal with will not have this and to a degree they get excluded further from the system.

Indeed, it might be argued that some of those who are most in need, according to the above criteria, are in such circumstances primarily because they have become isolated from their families or other concerned person. If they had this support, it might be more possible to undertake the necessary interventions from within the community thus avoiding the necessity of a residential placement. An issue that arises here is that Aislinn, at some levels, is perceived as dealing with young people who could be dealt with quite effectively from within the community. And, they are perceived as not dealing with those who, because of the extent of their addiction, their difficult family backgrounds, their social and peer networks and psychological traumas, are potentially more challenging.

There is a major challenge here for the Aislinn programme. Often the persons who best fit the description of those who need a residential placement — persons who are perceived as most challenging from the perspective of a community-based worker - are least able to make the necessary commitment to an abstinence model. Some young people may have reached the point where they are ready for an intense therapeutic input, but not yet ready to make a long-term commitment to abstinence. If such persons succeed in being admitted too soon to Aislinn they would likely be given a therapeutic discharge for the reason that they are still not yet ready to make the necessary commitment to the programme. For those who work with such a person in the community it could be that they might never, ever be more ready to deal with their drug and alcohol problems. A referral to Aislinn therefore could be an opportunity lost. A better alternative may be for the young person to participate in a community-based induction programme prior to taking up a place in Aislinn, or indeed to participate in some other residential programme (not currently available) in which a lifetime commitment to abstinence does not form such a key part of the treatment process. At a later stage they might then be ready for Aislinn.

The issue here in this discussion is not the requirement that residents abstain from alcohol and drugs during the residential programme. That requirement has an inherent logic given both the nature of a residential programme and the responsibilities that go with providing a safe, healthy and nurturing environment. The issue that potentially gives rise to difficulties is the requirement that residents demonstrate a willingness or ability to commit to a lifetime of recovery. A therapeutic discharge for failure to make such commitments would be possible in both residential and day/community programmes. However, in the latter, community personnel are more likely to be in a position to place such persons onto an alternative, non-abstinence programme, which, under current circumstances, is not an option that would be available to Aislinn. It is particularly important that Aislinn is working in close collaboration with such person's community-based keyworker in order that they be involved in making these linkages and referrals. Clearly, such referrals can only be made in circumstances where a wider range of services (both community and residential) are available. This is an important issue for health board planners. A shortcoming of discussing how Aislinn integrates with other health board services is that a dearth of

alternative services means that the discussion can become too-focused on Aislinn. In reality, there needs to be more discussion about alternative services, about how these are to be set up, who is going to provide them and about how they are link in with existing local services and Aislinn?

SUMMARY

This section of the report has provided a brief account of the wider, institutional context within which drug and alcohol services operate with particular attention to how Aislinn might more effectively integrate with local services. It is evident that a major limitation of this discussion is the dearth of drug and alcohol services for young people and clearly more initiatives need to be taken in order to respond to this void. It is imperative that young persons who are perceived as in need with respect to their drug and alcohol problems, have some opportunity to avail of publicly-funded programmes. Clearly, a greater number of treatment programmes need to be available, at both community and residential levels and it would be important that these adhere to an agreed treatment protocol. The health boards, of course, need to become more directive in assessing needs and appraising the various types of services that are required. In making these assessments they should bear in mind the underlying principle that such services should be provided as closely as possible to where they are needed and through the direct involvement and input of primary care personnel. At a minimum, young people need to be able to access counsellors and to be able to participate in day and family programmes within the community. In situations of chronic problems they need to be able to access residential or other specialist services. While, it would seem obvious that attendance at such services would be on a no drugs, no alcohol basis, it would be hard to justify that all available services operate on the basis of a lifetime commitment to abstinence. Clearly, availability, accessibility and choice need to be important considerations in relation to service provision.

Obviously the position of Aislinn needs to feature in an appraisal of how different services fit into an overall framework. In the above discussion varied perceptions and indeed, problem conceptions, between health board and Aislinn personnel are evident. These need to be reconciled, in order to achieve a more effective utilisation of treatment for the young people concerned. Clearly, there is little room for manoeuvre with respect to Aislinn's overall ethos. Its mission is a clearly stated residential, 12-Steps, abstinence programme and it is inconceivable that operational adjustments be made to this programme that would undermine its overall ethos. However, there is plenty of room for further modifications and adjustment and more importantly, there is a need for greater flexibility with respect to how Aislinn operates in conjunction with community-based services. In particular, community services need to have a greater involvement in screening and assessing persons for Aislinn, in being part of the monitoring structure, in playing a role in the family component and in supporting after-care.

The issues discussed above commence an analysis of the efficacy of Aislinn's programme within the overall context of an emerging framework for developing locally based drug and alcohol services. The issues are quite complex and by necessity need to be explored primarily at an abstract level. This report is

not an evaluation of community services and neither has it collected empirical data from community-based services. There is a limit therefore, to how far it can go in discussing these issues in a more definitive manner. The next chapter, drawing as it does, more from the data as collected directly from the Aislinn programme, provides a clearer basis for exploring these issues further.

7: Conclusions and RRecommendations

INTRODUCTION

It is generally accepted that adolescent drug and alcohol misusers differ from adult misusers in a number of ways, which have important implications for treatment. They tend to have shorter drug using histories, less involvement with opiates, more involvements with alcohol and cannabis, greater levels of binge drinking and more poly-drug use. Differences related to developmental and social factors include rapid social and physical changes, and the normative nature of high-risk behaviour (Jessor, 1991). In addition, adolescent substance misusers have a wider range of co-existing life problems which complicates the treatment process. Because adolescent treatment programmes are generally derived from the traditional adult models, they are often ill equipped to deal with the mental health problems, behavioural disorders, developmental lags, poor social and academic functioning, and family problems associated with adolescent substance misuse. Nevertheless unequivocal support exists for dedicated adolescent programmes, as young people do better in treatment orientated towards their development needs and in services dedicated to their age group (Health Advisory Service, 2001)

In recent years some progress has been made in evaluating treatment programmes for adolescent substance misusers. However, generally speaking outcome research on substance misuse has been unable to distinguish between treatment models in terms of effectiveness. Comparative outcome studies in the substance misuse field as a whole are hampered by problems in the identification of criteria for baseline, outcome and follow-up measures. Research has not produced enough evidence to demonstrate that any one approach is superior, as all treatment models seem to be equally effective in reducing the severity of dependence and/or drinking behaviour (Project MATCH, 1997; Keene *et al*, 1999). In light of these findings researchers have tried to identify individual characteristics that predispose some people to do better within particular treatment models. There has been much controversy about the identification of predictors of treatment outcome and indeed of the usefulness of treatment outcome as a measure at all (Edwards, 1988). Research indicates that although specific treatment variables may be significant for immediate behaviour change, many variables mediate treatment effects. This is further complicated by variables influencing maintenance of change at follow-up, such as personal and social functioning (Moos *et al*, 1999).

Consequently this study focused less on the behavioural outcomes, as it explores the viewpoint of the clients and staff on the treatment process and the perceived effectiveness of the programme. To this end, the research primarily employed a qualitative methodology, with less emphasis on the quantitative

components (analysis of client programme records and short postal questionnaires). Qualitative research meets quite different objectives from quantitative research and provides a distinctive kind of information. In a way that quantitative evaluations cannot the researchers in this study gained a holistic overview of the culture and context under investigation. The study employed ethnographic methods of non-participant observation to explore the methods staff used, including counselling sessions and group therapy, together with team meetings and staff interaction with clients. The researcher also undertook participant observation of the general activity of the centre. The aim of the analysis was to examine closely the interactions between staff and clients throughout the treatment process, from initial assessment to treatment termination, in order to give an account of what takes place during the treatment process and the actual methods used by staff. The semi-structured interviews were designed to explore the subjective interpretations of staff and clients concerning theory, methods and treatment process, that is the meanings, beliefs and understanding they employ to make sense of and account for particular social contexts.

FINDINGS

Previous research has highlighted the fact that there is not necessarily a relationship between treatment methods used and treatment theory (Keene, 2000). However, analysis revealed that the therapeutic model used in Aislinn, the Minnesota Model, influences the way in which staff conceptualises and define the problems experience by the young people on the programme, and therefore also the client assessment process, and what staff considered to be a successful treatment outcomes. The strong belief in a disease concept, whereby the disease is seen as the primary cause of all other problems or 'symptoms' means that the 'addiction' is of primary importance to the staff. It is absolutely essential for clients to accept the programmes conceptualisations and definition of their 'problems'. This means that if clients do not accept the staff interpretation of their problems then staff often feels unable to work constructively with them.

The assessment process for any treatment intervention will vary depending on differing definitions of the presenting problems. In the assessment for Aislinn 'the problem' is seen in terms of any (or all) type of substance misuse together with particular attitudes and behaviours, and consequently success is evaluated in terms of these criteria. The assessment focuses on health and social harm, as well as degree of dependency (Jellinck); they also include moral and spiritual deterioration and a clear-cut definition of addictive disease. The assessment is used partly as an educative technique, but it also has a therapeutic purpose, and an important function in term of persuading clients to accept staff definitions of problems. The clients usually present a view of themselves and their substance misuse that is challenged in the initial weeks of treatment. In short, treatment for these young programme participants takes place in a context where, it is largely staff that decide what the problem to be treated is.

In sum, Aislinn tends to conceptualise the heterogeneous population of young substance misusers as homogeneous ('addicts'), multiple interacting problems as a single problem ('the disease') and finally it

conceptualise successful treatment outcomes in terms of a single treatment goal (abstinence). But the importance of therapeutic theories as an integral part of the therapeutic change process should not be underestimated. Keene (2000) argues that the therapeutic utility of a model or theory can be understood in terms of its effectiveness as a therapeutic ideology. That is, a set of beliefs which serve to bond together client and therapist and enable a non-judgemental relationship, positive and negative reinforcement and the maintenance of constructive cognitions and behaviour. In addition, it may allow the development and maintenance of constructive values, beliefs and rituals. Research indicates that therapists are more effective when they work within a clearly structured therapeutic model, as the MATCH research group demonstrated (Project Match, 1997). Therefore while therapeutic models are an integral part of effective therapy they also appear to distort both diagnosis and definitions of success. It is possible that therapeutic models of addiction and dependency may be counterproductive for clients with a range of problems, such as adolescent substance misusers. In such instances multiple diagnosis, interventions and goals are probably more appropriate than single diagnosis, a single treatment and a single goal (Keene *et al*, 1999).

That said, in terms of outcomes the study revealed excellent completion rates. All 13 of the young people interviewed completed the residential aspect of the programme. The data derived from programme records illustrates that over half (52%) of the young people who entered the programme completed the residential component. Moreover, only one quarter (26%) of the admissions left at staff request. In addition, all young programme participants interviewed entered into aftercare and the majority (n=12) were still attending aftercare at the time of the follow-up interviews (albeit two were attending infrequently) approximately 3 month later. Of the sample group, only one young person was unemployed at follow-up, the remaining had either returned to education, or were working. At follow-up only 3 of the young people had lapsed, and all had, with the support of aftercare group stayed in recovery. In addition, it is important to note that the treatment experience may indirectly affect the future drug and alcohol use of the young programme participants, by influencing changes in behaviour that promote recovery, such as changing peer relations, that eventually manifest as reduced drug involvement later in life.

Compliance with a residential programme such as Aislinn is easy to measure, however it is not always a marker of behaviour change, with regard to the target problem behaviour. Treatment involvement is more difficult to assess, but it is often a better indicator of the engagement in the process of change. An individual who is involved in treatment is actively engaged in the treatment process, has bought into the treatment rationale, and has formulated treatment goals consistent with the programme's philosophy. In short, treatment involvement can act as a valuable intermediate measure of treatment outcome. Chapter Five of this document examined programme participants involvement in the programme, and the processes of change. As with diagnosis and outcomes, the therapeutic model influences the process of change a clients undergoes during treatment, as the importance of specific strategies and activities to promote change differ significantly from one treatment modality to another. For example most modalities