Non-adherence to group therapy in a community drug and alcohol outpatient unit: a thematic analysis.

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ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person or that has been accepted for the qualification of any other degree or diploma of a university or other institute of higher learning, except where due acknowledgement is made in the acknowledgement.

Signed: _____

Dated: _____

Table of Contents

Table of Figures

Thematic Networks

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- To my Lord Jesus Christ; without whom none of this would have been possible, you truly are the lover of my soul, Isaiah 61:1-11.
- Paul my darling husband; your belief and encouragement has allowed me to reach for the stars and beyond, I would never have made it without you.
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Abstract

The aim of this qualitative study was to gain a thorough understanding of non-adherence to group therapy in the context of a community alcohol and drug outpatient service in Auckland, New Zealand. This study explored themes within the participants' experiences of attending group therapy. It identified themes that were supported by existing literature, and novel themes particular to this participant group.

Substance abuse in New Zealand is a major problem, putting a strain on families, communities, and the health and legal systems (Ministerial Committee on Drug Policy, 2007). Studies have shown that attrition rates within the substance-using community is a well documented problem in outpatient units and severely limits the effectiveness of services (Laudet, Stanick, & Sands, 2009). Despite the extent of the problem of substance abuse in New Zealand, there appears to have been little study conducted focusing on the rates of attrition in treatment services in the New Zealand context, and the possible reasons for this.

A qualitative research design was used, where semi-structured interviews were used to collect data. Through thematic analysis the researcher identified themes that contribute to non-adherence in these groups. Interviews were conducted at a Community Alcohol and Drug Services (CADS) unit in Auckland, New Zealand.

Thematic networks enabled the researcher to explore the participants' experiences in depth leading to the subsequent organising of themes for further analysis. Three global themes emerged, Participants, Group Factors and Accessibility. These themes were supported by a variety of organising and basic themes, all of which serve to enhance the understanding of the global themes.

Relevant literature was integrated into the discussion, providing the reader with an understanding of the findings of this study within the context of group attrition.

Key Terminology

Substance abuse and dependence; substance abuse in an New Zealand context; attrition; cognitive behavioural therapy; Maori models of health; group therapy for substance use; motivational interviewing; Community Alcohol and Drug Services (CADS); and Action Group

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Chapter One

Introduction

Attrition rates from treatment within the substance-using community are a well documented problem. This problem severely limits the effectiveness of services (Laudet, Stanick, & Sands, 2009). There are a number of factors that may explain the high attrition rate amongst those with substance abuse problems. These include lack of motivation to change, dissatisfaction with the current program and counsellors, poor flexibility of treatment options, ongoing practical issues, and the high levels of anxiety and depression associated with substance abuse (Stark and Campbell 1988).

As part of the literature study the researcher accessed a variety of sources. Databases such as ProQuest Central were used; e-journals such as Journal of Substance Abuse Treatment, Specialist in Group Work, Counselling Psychology and Specialist in Group work were also investigated. There appears however to be little research completed in a New Zealand context that would explain why people stop attending group based therapy.

Research shows that group therapy is effective only when clients attend regularly (Lowinson, Ruiz, Millman, & Langrod, 2005), and motivation plays an important role in the treatment for those with substance abuse. Motivation would appear to be a critical factor in influencing clients to seek, comply with, and complete treatment (DiClemente, 1999).

Substance abuse in New Zealand is a major problem, putting a strain on families, communities, the health and legal system. In 2007 research was conducted for the Ministry of Health, and estimated the harmful cost of alcohol and drug use in New Zealand at $1,662 million. The report stated that harms related to drug use include a wide range of crime, lost output, health service use, and other diverted resources (Ministerial Committee on Drug Policy, 2007).

Treatment options in New Zealand tend to fall into three main categories. These are self help groups such as Alcoholics Anonymous (AA), a twelve step program that encourages abstinence, and inpatient residential units, which also tend to encourage a goal of abstinence. The third category are outpatient community treatment centres that work from a harm reduction model as recommended by New Zealand's current Drug Policy (Ministerial Committee on Drug Policy, 2007). For the purposes of this study the researcher will be focusing on a community alcohol and drug outpatient unit, Community Alcohol and Drug Services (CADS).

What motivated this research topic?

Over the last twenty years the researcher has been involved in a large number of groups that focused on substance abuse problems, both as a facilitator and a group member. Encounter with these groups was initially due to problems with substance abuse in her family of origin, and more recently due to work. Interest in addiction issues, and the facilitation of change within a group process, was a result of these

early experiences. The researcher has worked as a clinician and group facilitator with Community Alcohol and Drug Services (CADS) since 2000.

What the research is about?

The aim of this qualitative study is to gain a thorough understanding of reasons for a client's non-adherence to group therapy, in the context of community outpatient alcohol and drug services.

Questions similar to those in the study conducted by Laudet et al. (2009) will be asked as part of a semi structured interview. Thematic analysis will be used in this study, focusing on themes and patterns of interpersonal behaviour (Aronson, 1994). It is hoped that this research will offer a clearer understanding of clients' experiences in a group environment, whether they result in continuation or termination of treatment. New practices may be developed within the group environment that support adherence to group attendance within Community Alcohol and Drug Services units.

What to expect

In chapter two the researcher will present existing literature on the criteria for substance dependence/abuse, the cost of abuse/dependence in New Zealand, making particular note of the problems experienced by Maori as tangata whenua the indigenous people of New Zealand. She will also explore the ongoing problem of attrition within the substance abusing/dependant community and bring attention to relevant research regarding the possible reasons for this. The use of cognitive

therapy as well as the use of groups as a treatment option will be discussed, and will highlight the importance of a sound therapeutic alliance between the facilitator and the group members. The importance of motivation will be explored and the groups used in the research will be discussed.

In chapter three the methodology will be presented and the use of thematic analysis and networks explained. In chapter four the participants' data will be presented and thematic networks that have been identified will be discussed. In chapter five the results of this study will be integrated with relevant literature and the limits of the study discussed. Finally recommendations for further research will be made.

Chapter Two

Literature Review

Introduction

In this chapter, the researcher will review the relevant literature that informs and contextualises this study. This includes drug and alcohol abuse from a psychological viewpoint, as well as statistics on drug and alcohol abuse in New Zealand (NZ), and substance abuse within the Maori community. Group attrition within the substance-using community, and the use of cognitive behavioural therapy, group therapy, and the facilitation of groups for substance abuse will be explored. The application of psychoeducational groups, motivational interviewing, and treatment services in New Zealand will be examined. Therapeutic services offered by Community Alcohol and Drug Services (CADS) will be reviewed with particular attention given to the action group.

Drug and Alcohol Use

A substance can be anything that is ingested in order to produce a high, alter one's senses, or otherwise affect functioning. The most common substance in this category is alcohol, although other drugs, such as cocaine, marijuana, heroin, ecstasy, special-K, and crack are also included. Probably the most abused substances, caffeine and nicotine, are also included although rarely thought of in this manner by the layperson (AllPsychONLINE, *n.d.*).

Hulse, White and Cape (2002) describe hazardous use as a repetitive pattern of use resulting in risky behaviours which may cause significant consequences both physically and psychologically. Harmful use is defined as use that actually results in either physical or psychological harm. For the purpose of this study, substance abuse is defined in terms of the DSM – IV-TR (American Psychological Association, 2000). This definition focuses on the social and interpersonal consequences of substance abuse, e.g. failure to meet obligations and problems in social and interpersonal contexts. It is also important to note that substance abuse may be defined when the use of drugs disrupts social norms, which will vary from culture to culture (Hulse et al., 2002).

According to Hulse et al. (2002) dependence exists on a continuum ending in severe dependence associated with drug withdrawal when use has stopped, although this is not necessary for dependence to be diagnosed. “Dependence is described as a psychobiological syndrome that explains this seemingly paradoxical behaviour, it arises from repeated excessive alcohol or other drug use and in turn acts as a driving force for continued substance use” (p. 34).The essential feature of substance dependence, is that a person continues to use despite problems directly attributable to the continued use of a substance (APA, 2000).

Drug use and its associated problems are rooted within a complex evolving sociocultural context (Lowinson, Ruiz, Millman, & Langrod, 2005). The DSM – IV-TR, states there are wide cultural variations in attitudes towards the consumption of substances, patterns of substance use, accessibility of substances, and prevalence

of substance-related disorders. While some groups forbid the use of alcohol, other groups encourage the use of various substances for their mood-altering effects. It is crucial when assessing an individual's substance use that these factors are taken into account. Patterns of medication use and toxin exposure also vary widely within and between countries (APA, 2000; Hulse et al., 2002).

Substance Dependence and Substance Abuse

Alcohol and drug use is not an all or nothing phenomenon, it exists on a gradual continuum ranging from appropriate/non-problematic consumption to inappropriate/problematic consumption, to dependency. There are four different levels of use: abstinence, low risk or casual use, risky use or "substance abuse", and chemical dependence or addiction (Hulse et al., 2002). It is therefore useful to examine the distinction between dependence and abuse in more detail.

Substance Dependence. The DSM – IV-TR describes the essential feature of substance dependence "as a cluster of cognitive, behavioural and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems" (APA, 2000, p. 176). There is a pattern of repeated use that usually results in tolerance, withdrawal, and compulsive drug-taking behaviour. A diagnosis of substance dependence can be applied to every class of substances except caffeine; although not specifically listed as a criteria, "craving" (a strong subjective drive to use the substance) is likely to be experienced by most (if not all) individuals with Substance Dependence (APA, 2000).

Substance Abuse. APA (2000), definition of substance abuse focuses on social and interpersonal consequences of substance abuse, such as failure in role obligations. Substance abuse maybe defined as occurring when the use of drugs or alcohol disrupts prevailing social norms, though these norms may vary with culture, gender and generation. Substance abuse may continue despite negative consequences, even though these consequences may contradict the original reasons of use. For example a person may begin to use substances to manage anxiety; however there may be an increase in the abuser's anxiety due to loss of a job or failed relationships (Hulse et al., 2002).

Etiology. Hulse et al., (2002) state there is evidence that genetic factors play a role in both dependence and abuse (Hulse et al. 2002; Lowinson et al. 2005). Other theories involve the use of substances as a means to cover up or get relief from other problems (e.g. psychosis, relationship issues, stress), which makes the dependence or abuse more of a symptom than a disorder in itself. These theories also apply to other dependencies like gambling, eating disorders or sexual compulsion (AllPsychONLINE, *n.d*.). The following sections will review three of the models recognised in substance abuse/dependence.

The Moral Model. Hulse et al,. (2002) and Ruth (1990) state the moral model was the prevailing addiction/abuse archetype up until the mid-twentieth century, and it still has a wide following. This model views the user as weak-willed and morally bankrupt, someone who should be punished and sometimes pitied. Historically this model emphasized deficits in personal responsibility or spiritual strength as the cause of excessive drinking or drunkenness (Ruth, 1990). This view resulted in the

temperance movement, stating that abstinence was the only way, and alcohol consumption was seen as inherently evil. People who hold to this model generally hold individuals entirely responsible for their substance use.

The Biological (Disease) Model. The disease model represents a significant change of viewpoint from the moral model, and found favour in the 1960's within the academic establishment. This model proposes that drug dependant people are different from non drug dependant people, in that the dependence is caused through a chemical addiction. Therefore the user is not to blame for this disease; abstinence is seen as the only treatment option (Hulse et al., 2002). This model had an immediate advantage for alcoholics as they were able to access humane treatment rather than derision or prison (Ruth, 1990). In the last decade considerable time has been spent gene mapping in the attempt to identify the specific genes that are associated with substance dependence. Qualitative Trait Locus (QTL) has been identified as the novel genes that influence the genetic risk of substance abuse. (Lowinson et al., 2005)

Difficulties in this model include the idea only certain people are at risk of developing dependence/abuse, and while research into genetics has begun to reveal some vulnerability, the biological cause of dependence remains elusive. It is argued while there may be a physical or genetic predisposition, the risk of developing drug and alcohol dependence/abuse has multiple origins. An integration of pharmacological, environmental, psychological, social, cultural, and genetic factors must be considered (Hulse et al., 2002; Lowinson et al., 2005).

The Psychological Model. According to this model people use substances as a way of increasing pleasure or reducing emotional or physical pain. When activated by a rewarding stimulus, such as food, water, chocolate, sex or drugs, the chemical dopamine is released. A message is then sent to the brain that the user has just done something very rewarding and a flood of "feel good" dopamine is released. Because it feels so good there is a desire to repeat this action again and again (Waitemata Health, 2003).

It is often difficult to know whether psychosocial problems are the cause or effect of drug abuse. Those with the most severe problems with substance abuse/dependence are likely to be the ones who report the most significant problems in their family of origin, and their early childhood. In addition those with alcohol and drug problems are more likely to develop relationships with others with similar issues (Hulse et al., 2002).

Having looked at the models of abuse and dependence it is useful to consider the DSM-IV-TR criteria for both substance dependence, and substance abuse. This will ensure that the reader has an understanding of the symptoms present, and problems experienced in those with substance dependence or a substance abuse diagnosis.

Criteria for Substance Dependence. According to the DSM-iv-TR dependence is a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period.

(1) Tolerance, as defined by either of the following:

(a) A need for markedly increased amounts of the substance to achieve intoxication or the desire effect.

(b) Markedly diminished effect with continued use of the same amount of the substance.

(2) Withdrawal as manifested by either of the following:

(a) The characteristic withdrawal syndrome for the substance (refer to criteria A and B of the criteria sets for Withdrawal from the specific substances).

(b) The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.

(3) The substance is often taken in larger amounts or over a longer period than was intended.

(4) There is a persistent desire or unsuccessful efforts to cut down or control substance use.

(5) A great deal of time is spent in activities necessary to obtain the substance (e.g. visiting multiple doctors or driving long distances), use the substance (e.g. chain-smoking), or recover from its effects.

(6) Important social, occupational or recreational activities are given up or reduced because of the substance use.

(7) The substance use is continued despite knowledge of having a persistent or recurrent physical or physiological problem that is likely to be caused or exacerbated by the substance (e.g. current cocaine use despite recognition of cocaine-induced-depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption) (APA, 2000, p. 181).

Criteria for Substance Abuse. According to the –DSM-IV-TR, substance abuse is a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

(1) recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home (e.g. repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children household)

(2) recurrent substance use in situations in which it is physically hazardous (e.g. driving an automobile or operating a machine when impaired by substance use)

(3) recurrent substance-related legal problems (e.g. arrests for substance related disorderly conduct)

(4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g.. arguments with spouse about consequences of intoxication, physical fights).

B. The symptoms have never met the criteria for Substance Dependence for this class of substance (APA,2000,, p. 182–183).

Substance dependence and substance abuse share a number of characteristics; for e.g., the problems experienced in a variety of areas such as health, relationships,

and work. There is however one major distinction between the two, the occurrence of tolerance and withdrawal symptoms in those with substance dependence.

In the following section substance abuse/dependence in New Zealand will be discussed, with attention paid to the prevalence and cost to society.

Substance Abuse in New Zealand.

Substance abuse in New Zealand is a major problem, putting a strain on families, communities, and the health and legal system. In 2007 research was conducted for the Ministry of Health with the aim of estimating the harmful cost of alcohol and drug use in New Zealand. The report stated that, "harms related to drug use include a wide range of crime, lost output, health service use and other diverted resources. Harmful use has both opportunity costs which divert resources from alternative beneficial uses, and psychological or intangible costs, such as reduced quality or length of life" (Slack, Nana, Webster, Stokes, & Wu, 2009, p. 1-2)

The abovementioned study showed that in 2005/06 harmful drug use imposed a substantial cost on New Zealand. The overall cost was estimated to be $6,881 million of social costs and an estimated $4,794 million of diverted resources and lost welfare. Harmful other drug use was estimated to cost $1,427 million, of which $1,034 million were tangible costs (Slack et al., 2009).

The study indicated that joint alcohol and other drug use that could not be separately allocated to one drug category cost a further $661 million. If the joint costs are split proportionately, total alcohol and total other drug costs equate to $5,296 million (over

three quarters) and $1,585 million (just less than one quarter). Using estimates from international research, the study also suggests that up to 50 percent ($3,440 million) of the social costs of harmful drug use may be avoidable. The cost of harmful drug use from a government perspective amounts to an estimated $1,662 million, or almost one third (34.3 percent) of the total tangible costs to society (Slack et al., 2009).

According to the Ministry of Health about one in five people in New Zealand who have used drugs in the past year (18.6%) reported having experienced harmful effects due to their drug use. Drug users reported the most common harmful effects were financial, (10.8%), friendships or social life (8.5%) and home life (8.4%). Furthermore, 7.2% of past-year drug users reported having had one or more days off work or school in the past year due to their drug use. Among past-year drug users, there was some variation by population group in the prevalence of experiencing these harmful effects. For example, there were generally slightly higher rates of harm among younger people and people living in more socioeconomically deprived neighbourhoods. However, these trends were not consistent for all harms (Mason, Hewitt, & Stefanogiannis, 2010).

It is important when considering the problems caused by substance abuse/dependence in New Zealand, that particular attention is given to the effect on Maori. Maori are the indigenous people of New Zealand, and make up about 15% of the population (Huriwai, Robertson, Armstrong & Huata 2001).

Substance Abuse in Maori

Baxter's (2008), study revealed that substance abuse disorders affect many Maori, with 1 in 4 (26.5%) experiencing substance disorder in his/her life before interview and 1 in 11 (0.1%) in the past 12-months. Baxter (2008), states thatl almost 1 in 3 Maori will develop a substance abuse disorder over his or her lifetimes (up until age 75). The age of onset for substance disorder indicate that half of all Maori with substance disorder had the onset of his/her disorder as rangatahi (i.e. around ages 18 or 19 years). This has implications for the high level of need among young Maori with substance use disorders. This also highlights the need for mental health promotion strategies to prevent and address the development of substance use issues in young Maori, alongside the broader contexts associated with the development of substance use disorders (Baxter, 2008).

In the next section the cost of attrition and non attendance to support services has on the substance-using community will be discussed, and some possible reasons for the high rate of attrition in this population will be highlighted.

Attrition

Attrition rates from treatment within the substance-using community are a well documented problem whether in a residential treatment centre, or an outpatient unit. This problem severely limits the effectiveness of services and jeopardises treatment outcomes (Laudet, Stanick, & Sands, 2009). Due to the large cost to government resulting from ongoing substance abuse, it is important that research attempts to discover ways of improving retention for those who access treatment services in

New Zealand. A clear relationship between a client's adherence to therapy, treatment outcome, and long-term stability has been established (Laudet et al., 2009; Monras & Gual, 2000).

Despite the extent of the problem of substance abuse in New Zealand, there appears to have been little study conducted focusing on the rates of attrition in treatment services in the New Zealand context, and the possible reasons for this. According to several studies, there are a number of factors that may explain the high attrition rate amongst those with substance abuse problems. These include motivation to change, dissatisfaction with the current program and counsellors, flexibility of treatment, practical issues, and the high levels of anxiety and depression associated with substance abuse (Laudet et al., 2009; Stark & Campbell, 1988). Other reasons for disengagement have been identified as outside influences, programme expectations, logistical problems, Problem severity and conflict with staff or other clients has also been identified as issues that may impact on attrition. Coulsen, Ng, Geertsema, Dodd & Berk (2009), state that contextual factors to do with work commitments, illness, social and logistical issues may be the most dominant reasons for missed appointments, rather than service dissatisfaction or lack of motivation.

According to Saarnio (2009) it is possible to divide the contributing factors for the early exit from group into two categories - those pertaining to the client and those pertaining to the treatment clinic and therapist. Interpersonal problems and the interpersonal interactions fall into category two. Doumas, Blasey, & Thacker (2005) indicate that what happens between group members plays a large role in the

process of recovery and those who drop out of treatment early. Their study indicates that those presenting for treatment often have significant levels of anxiety and depression, which make functioning in a treatment setting difficult.

According to Small, Curran, and Booth (2010) in addition to the issues already mentioned, there are a number of factors that may specifically hinder women from seeking treatment. They list these as lack of transportation, social stigma, and fear of losing the children. They add for women who live in rural settings that affordability and accessibility are key components; some also identified that the distance to travel to appointments and the times available as a limiting factor. This study further indicates that while living in a rural community can result in social closeness, it does not always serve as a protective factor for those with alcohol and drug problems. In fact it may exacerbate difficulty in accessing treatment, limited economic opportunities, and small social circles.

The research study that was primarily used to inform the area of inquiry was conducted by Laudet et al (2009) and concluded that clients fell into two levels of problems: Individual and Program level problems: “Problem-level barriers included dissatisfaction with the program, especially counsellors; unmet social services needs and lack of flexibility in scheduling. Individual-level barriers to retention included, low problem recognition and substance use” (p. 239–240). Inaccurate assessment of a client’s motivation to change and treatment planning has also proven to contribute to a client’s dissatisfaction with treatment services offered (DiClemente, Bellino, & Neavins, 1999)

Cognitive therapy (CT) has increasingly become the treatment of choice for substance abuse/dependence (Lowinson, Ruiz, Millman, & Langrod, 2005). Cognitive processes related to addictions and the use of CT in the treatment of substance abuse/dependence will now be discussed.

Cognitive Therapy (CT)

Cognitive Therapy had its early beginning in the 1960's as a result of Aaron Beck's research on depression. Beck initially began his work to validate Freud's theory of depression. What Beck instead observed was a negative bias in a patient's cognitive processing. It was through these observations that he developed his theory of emotional disorders and a cognitive model of depression (Corsini & Wedding, 2000).

Albert Ellis gave a major impetus to the development of cognitive behavioural therapies. Both Ellis and Beck believed that people can consciously adopt reason, and both viewed the patient's underlying assumptions as target of intervention. While Ellis confronted and persuaded patients that the philosophies they lived by were unrealistic, Beck turned the client into a colleague who researches verifiable reality (Corsini & Wedding, 2000).

Cognitive Therapy focuses primarily on a person's thoughts and behaviours, and is based on the understanding that it is not the event that determines a person's behaviour or response, but their belief, understanding, or perception about the event. CT contends that beliefs and behaviours are learnt and therefore can be unlearnt,

this occurs by identifying and challenging faulty thinking, negative core beliefs, and modifying self-defeating behaviours. Anticipatory beliefs and relief orientated beliefs have been identified by Brook and Spritz (2002) as the cognitive distortions that are most likely to lead to substance use and addictive behaviours (Beck, 1995; Corsini & Wedding, 1995; Lowinson et al., 2005).

Cognitive Therapy is a short-term, focused approach that helps people recognize situations in which they are most likely to use substances. CT's two crucial components are functional analysis and skills training. CT addresses several tasks essential to successful drug treatment, including motivation for abstinence, coping skills, reinforcement contingencies, management of painful feelings, and improved interpersonal functioning and social supports (Caroll, 1998).

Brook & Spitz (2002) state that, Cognitive Therapy for substance abuse is collaborative, to enhance therapeutic alliance and build trust, it is active and based to a large degree on guided discovery and empirical testing of beliefs. CT is highly structured and focused, and attempts to view the drug or drinking problem as a technical problem for which there is a technical solution.

Lowinson et al. (2005), cites Marlot and Gordon's work as one of the first major CT approaches to substance abuse. This work concentrated on relapse prevention techniques, which included identifying and developing strategies to manage high risk situations, and exploring events and decisions that lead to relapse. Relapse prevention helps clients make lifestyle changes, e.g. changing playmates and

playgrounds, that may be necessary to reach goals and prevent future relapse (Lowinson et al., 2005).

in her presentation at the National Conference on Drug Addiction Treatment: From Research to Practice Caroll (1998), stated CT is based on social learning and behavioural theories of drug abuse and the basic approach of CT can be summarized as recognize, avoid, and cope. Treatment is organized around a functional analysis of substance use; i.e., understanding substance use with respect to its antecedents and consequences. Skill training is used to focus on strategies for coping with craving, fostering motivation to change, and managing thoughts about drugs. Problem solving skills are developed, planning for, and managing high-risk situations are explored, apparently irrelevant decisions are identified, and drug refusal skills are cultivated. Principles of CT are that basic skills should be mastered before more complex ones are given. Material presented by the therapist should be matched to patient needs, repetition fosters the development of skills, and practice is needed for mastery of skills. The patient is an active participant in treatment, and skills taught are able to be used in a variety of problem areas.

Beck et al. (1993) cite Mallet's four cognitive processes related to addictions that reflect the cognitive models: Self efficacy, outcome expectancies, Attributions of causality and cognitive decision

Self efficacy: refers to one's judgment about one's ability to deal competently with challenging or high risk situations – e.g. of high self efficacy: I can say no to drugs, I can get through the day without drugs. E.g. of low self efficacy: I can't get

through the day without drugs, I can't cope without drugs or alcohol, I can't manage my problems without the use of drugs or alcohol. A person's level of self efficacy is associated with relapse.

Outcome expectancies: refer to an individual's anticipation about the effects of an addictive substance. Positive outcome expectancies might include the following: it will feel great to party tonight; I won't feel so tense if I use. To the extent that the alcohol/drug user expects the positive rewards to outweigh the negative consequences they will continue to use.

Attributions of causality: refer to an individual's belief that drug use is attributable to internal or external factors. For example, an individual might believe the following: "Anybody who lives in my neighbourhood would be a drug user" – external factor. Or "I am physically addicted to alcohol and my body can't survive without it" – internal factor.

Cognitive Decision: Relapse is a result of decisions made, e.g. going to see friends at the pub, walking down the wine isle at the supermarket, or not using self-care strategies.

Figure 1.1 shows the complete model of substance abuse set out in Beck et al. (1993, p. 47).

Figure 1.1

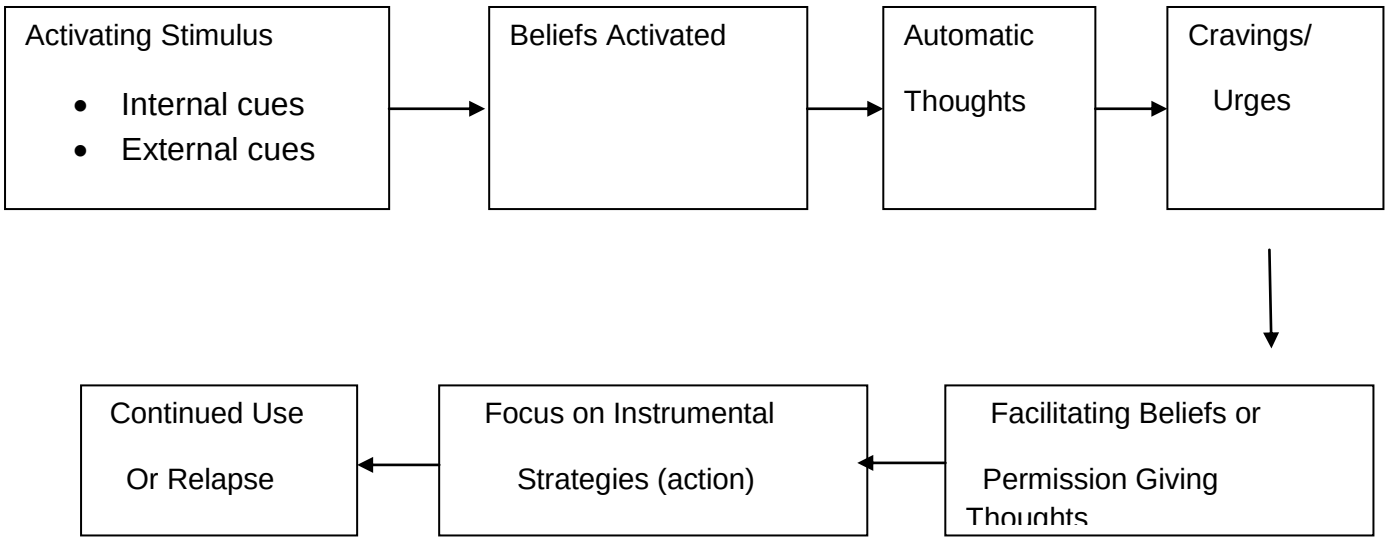
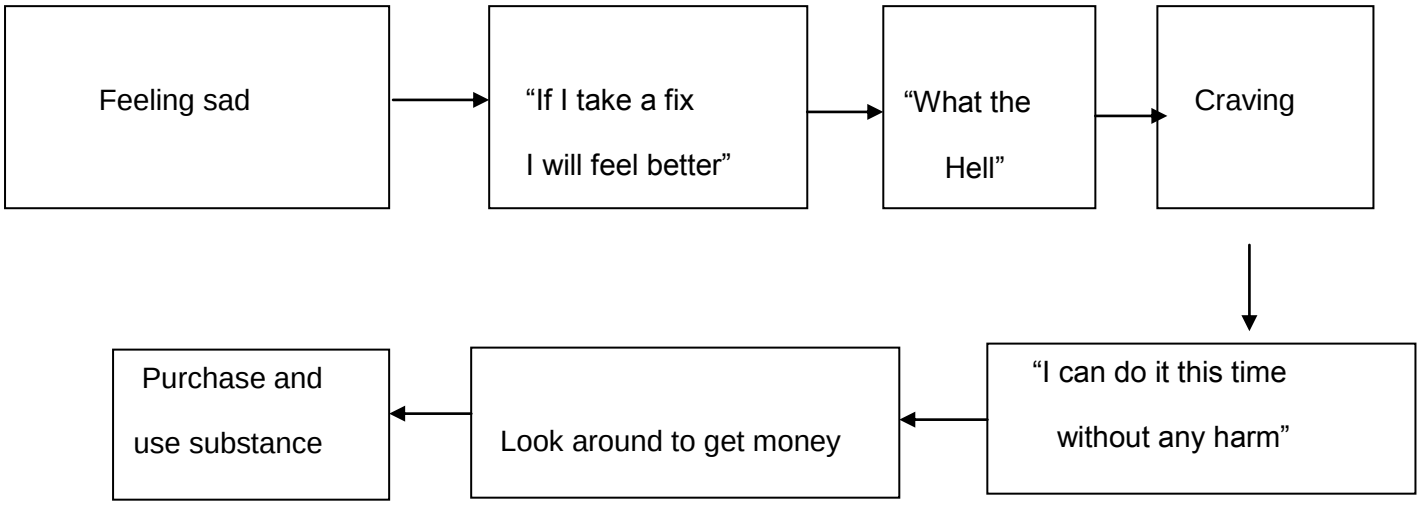


Figure 1.2 An example of substance-using sequence (Beck et al., 1993, p. 48).



Beck et al. (1993) cite research by Brown, Goldman, Inn, and Anderson (1980),

This research states that the those who abuse alcohol believe that drinking will:

- Transform experiences in a positive way
- Enhance social and physical pleasure
- Increase sexual performance and satisfaction
- Increase power and aggression
- Increase social assertiveness
- Decrease tension (p. 33)

Cognitive Therapy approaches emphasise the following:

- The identification and modification of beliefs that exacerbate cravings.
- The amelioration of negative affective states (e.g. anger, anxiety, and hopelessness) that often trigger drug use.
- Teaching individuals to apply a battery of cognitive and behavioural skills and techniques and not just will power to remain drug free.
- Helping individuals to go beyond abstinence to make fundamental positive changes in the ways they view themselves, their future, thus leading to new lifestyles (Beck et al., 1993).

A major thrust of Cognitive Therapy of Substance Abuse is to help the individual in two ways:

- To reduce intensity and frequency of the urges by undermining the underlying beliefs.
- To teach the individual specific techniques for controlling or managing urges.

The aim in a nutshell is to reduce pressure and increase control

(Beck et al., 1993).

Group therapy has for many years been seen as one of the first choices when working with those with chemical dependence. In the following section we will examine the use and nature of groups in the treatment of substance abuse/dependence.

Group Therapy for Substance Abuse

Lowinson et al., (2005), state that one of the reasons that group therapy is supported in the treatment of substance abuse/dependence is the cost effectiveness for inpatient and outpatient units, as more clients may be treated at one time. Peer support and learning from other clients in groups has been reported to be useful. Most professionals would agree that treatment matching to client's needs is vital if client's are to remain in treatment and meet their treatment goals. However in contrast to much of the research supporting the use of groups, there are also some recent articles that question whether group therapy is in fact more cost effective than individual CBT (Tucker & Oei, 2007).

Many substance treatment programs offer a variety of groups that focus on client's problem recognition, stage of recovery and readiness to change. These include groups that educate clients regarding substance abuse and prepare clients for change. Psychoeducational groups which teach skills that help substance abusing

clients to meet their goals, and Relapse Prevention Groups, that focus on helping clients maintain their changes.

The type of group that is appropriate for a client will largely depend on the phase of change the client is in (DiClemente et al., 1999). Therefore an accurate assessment is vital before a referral is made.

Nature of Groups

Groups may be open or closed. Open groups allow new members to join the group at any time or as other members leave; whereas closed groups do not. Groups that are run for substance abusers tend to be open (Lowinson et al., 2005).

Within different theoretical frames, all groups are seen to go through stages regardless of the type of group or style of leadership. Generally there is a beginning stage, middle or working stage, and an ending or closing stage. The beginning stage is characterized by members' anxiety about being rejected, revealing themselves in a group context, meeting new people and being in a new situation. These middle stage sometimes known as the working stage can be characterised by conflict and negative feeling to the facilitator and/or other group members. The ending phase represents the process of termination (Jones & Robinson, 2000).

As clients progress through the various phases of change and move toward meeting their goals, they may be referred to another group that is more focused on meeting their current needs. This can be problematic for some clients, as it can be difficult to leave a group in which they have become comfortable, and may be disruptive to

current group members, due to the ever-changing population. There are many benefits of matching a client to the appropriate group, these include enhanced clinical outcomes and relapse prevention (Lowinson et al., 2005). Group therapy is effective only when clients attend regularly, therefore it is vital that members are successfully integrated into the group (Lowinson et al., 2005).

Psychoeducational groups

Psychoeducational groups use education to promote personal growth, skills training, and lend themselves particularly well to cognitive approaches (McCarthy, Mejia, & Liu, 2000). Psychoeducational groups are designed to help participants develop knowledge and skills for coping adaptively with potential and/or immediate environmental challenges, developmental transitions, and life crises. The distinct feature of a psychoeducational group is its significant educational component. Because of the educational component, structured exercises are used to help facilitate group process (Jones & Robinson, 2000).

There is a significant amount of material written regarding the impact the facilitator has on the outcome of the group process. In this next section attention will paid to the therapeutic alliance, and the required skills of the group facilitator (Ringer, 2002; Wolff & Hayes, 2009).

Group Facilitation

According to Ringer (2002), competency in facilitation of groups is complex, requiring a range of practical skills in the management of group tasks, boundaries, and roles. Achieving these skills competently can be overwhelming, and create a great deal of anxiety for those seeking excellence when leading groups. Group facilitators not only need to have developed skills in managing groups but must also develop personal capacity to manage themselves during challenging times in the group process.

There has been considerable interest regarding the impact that the facilitator has on group outcomes. Research indicates that variability in outcome has as much or more to do with the qualities of the therapist offering treatment as it does on the specific treatment being offered (Wolff & Hayes, 2009).

The client therapist bond is known to play an important part in individual therapy; however this relationship is equally important in a group environment. This bond must encompass the individual's relationship to the group therapist, to other group members, and to the group as a whole (Yalom & Leszcz, 2005).

There has been some debate whether a therapist who is recovering from alcohol and drug problems are advantaged as facilitators over those who are not. Wolff and Hayes (2009), state that theoretically, treatment offered by therapists in recovery may be advantageous as these therapist can draw from their personal experiences to empathize with clients' experiences, and help to build hope for change. On the

other hand, poor boundaries, over identification with clients, and failure to maintain personal goals may be problematic (Wolff & Hayes, 2009).

Wolff and Hayes (2009), also state that existing research has established that therapists who are, and those who are not in recovery tend to yield equivalent outcomes. Much of this research indicates that variability in outcome has as much or more to do with the qualities of the therapist offering treatment rather than the specific treatment being offered

According to Yalom and Leszcz (2005), while there is compelling evidence showing that the strength of the therapeutic alliance predicts therapy outcome, problems with alliance such as disagreement of goals are associated with premature termination. Yalom and Leszcz (2005) cite Bernard and Drob (1989) study of ten clients who prematurely dropped out of group. The following were some of the reasons given for their early exit. The therapist had been unclear about the reasons for placing the client in that particular group. No clear set goals had been formulated with the client, some client's felt wounded by being placed in a group with significantly dysfunctional members. Some client's questioned why they had been placed in that particular group (Yalom & Leszcz, 2005).

Motivation plays an important role in the treatment for those with substance abuse. It would appear to be a critical factor in influencing clients to seek, comply with, and complete treatment (DiClemente, 1999). In the following section the use of Motivational Interviewing in the treatment of substance abuse/dependence will be discussed.

Motivational Interviewing

During the past few years a series of stages have been outlined that describe the stages a person may go through in the process of making change. These stages are: Pre-contemplation – Problem, what problem, i.e. the person sees no need to make changes to their behaviour. Contemplation – Maybe I will, maybe I won't. This stage is described of one of ambivalence. Determination is where decisions regarding change are made. Action is the process of making changes to one's behaviour and Maintenance where the new changes are maintained. The Wheel of Change designed by Prochaska and DiClemente, also includes a phase that recognises relapse as part of the change process (Borg, 1996; DiClemente, Bellino, & Neavins, 1999).

Stages of Change

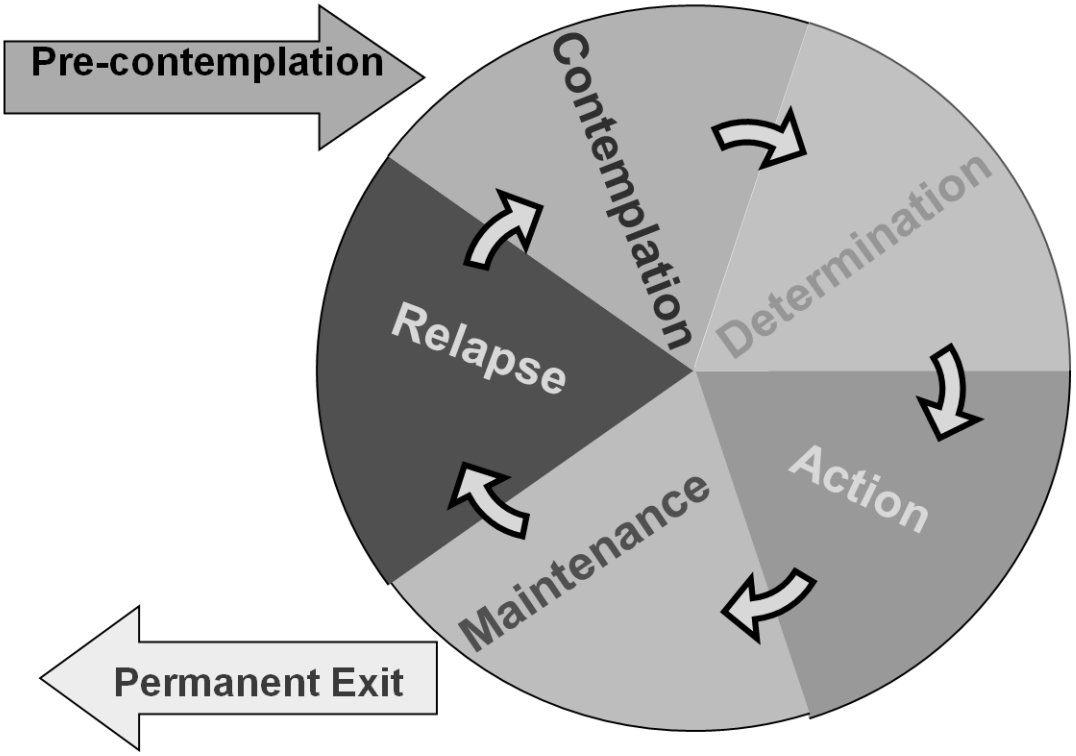


Figure 2 Wheel of Change (Miller & Rollinick, 2002).

Many clients initially present for treatment at the insistence of another person, whether that be a member of the family, employers or the legal system. The presenting clients may not be ready to change their drinking behaviour nor actively participate in treatment. Despite the fact that these clients may be at best contemplative regarding their problem, when they present to treatment centres they

are often referred to groups that are focused on actively making change (DiClemente et al., 1999).

Traditional approaches to treating unmotivated clients with alcohol problems have often used aggressive and confrontational strategies in response to the client's denial. However, research indicates this kind of confrontation can generate more denial, and a stronger resistance to treatment. Therefore clinicians who work with unmotivated clients must develop a less confrontational style and generate a more motivational treatment approach (DiClemente et al., 1999).

When considering the treatment of substance use in a New Zealand context it is vital that this be considered from a Maori perspective (Huriwai, Robertson, Armstrong & Huata, 2001).

Treatment for Maori

According to Huriwai et al., (2001), compared with non-Maori, the general health of Maori is considered to be poor in terms of medical disorders and psychiatric disorders – including alcohol and drug use related problems. Alcohol and drug related problems are estimated to be double that of non-Maori (Huriwai et al., 2001). Maori healthcare is often described as holistic and integrates mind, body and spirit.. In contrast reductionist western models of practice have historically separated these areas and concepts of identity and health, and have tended to be based on individual autonomy. Customary Maori health place individual wellbeing in the context of their whanau (family) and hapu (sub tribe), (Huriwai et al., 2001)

Maori Models of Health

*Te Whare Tapa Wha***:** (The four sided house) is a familiar model of health and ensures strength and balance. Te Whare Tapa Wha includes Taha Wairua – Spirituality, Taha Hinengaro – mental health, Taha Tinana – physical health and Taha Whanau – family. (Sullivan, Penfold, Goulding, & Cooke, 2004)

Te Wheke: (The octopus) the tentacles represent the different dimensions of health, the body and the head represent the family unit. The eight tentacles are spirituality, mental health, the physical side, family, uniqueness, vitality, cultural heritage and emotions (Sullivan et al., 2004).

Nga Pou Mana - This model was developed for social policy purposes. The components are family, cultural heritage, environment and land base (Sullivan et al., 2004).

It is evident that all these models encompass a holistic approach to Maori health that fit with traditional values and culture or Maori Tikanga (Sullivan et al., 2004).

Treatment options in NZ tend to fall into three main categories:

- Self-help groups such as Alcoholics Anonymous (AA). This is a twelve step program that encourages abstinence.
- Inpatient residential units that also tend to encourage a goal of abstinence.
- Community outpatient treatment centres that work from a harm reduction model as recommended by New Zealand's current Drug Policy (Ministerial Committee on Drug Policy, 2007).

Treatment Models within the New Zealand Context

The drug policy in New Zealand is based on the principle of harm minimisation. The aim of harm minimisation is to improve social, economic and health outcomes for the individual, the community and the population at large. A harm minimisation approach does not condone harmful or illegal drug use. The most effective way to minimise harm from drugs is not to use them. The harm minimisation approach does recognise that where eliminating high-risk behaviours is not possible, it remains important to minimise the personal, social and economic costs associated with those behaviours. Harm minimisation encompasses a wide range of approaches, including abstinence-oriented strategies for people who use drugs. It also considers the impact of the illegal status of some drugs on the people who use them. Strategies that support harm minimisation can be divided into three groups or pillars:

- Supply control
- Demand reduction
- Problem limitations. (Ministerial Committee on Drug Policy, 2007 p. 5).

At the core of a harm reduction philosophy is the acknowledgment that some people will always be engaged in behaviors that carry risks, like intravenous drug use (IVDU), unsafe sex, and smoking. A harm reduction approach attempts to lessen the consequences of such behaviour when eliminating the behaviour altogether is not realistic. Furthermore, instead of criminalizing these behaviors, harm reduction pursues a social justice response. A harm reduction philosophy supports the idea that people should not be denied health care and social services just because they take risks (Nodine, 2006).

According to Nodine (2006) critics of harm reduction believe that this philosophy condones and may even encourage risky behaviour. They feel these programs are socially destabilizing. Although many of these illegal activities are popularly known as “victimless crimes”, opponents argue that there are indeed victims, such as family members and society at large. Advocates of harm reduction counter that these initiatives are not incompatible with abstinence-based programs. They believe that since risk is a universal part of life, and since change and recovery are processes with many stages, harm reduction is a needed part of public health programs.
Interventions may include controlled use of substance, needle exchange or the methadone program for those with opiate dependence.

For the purposes of this study I will be focusing on the third treatment option, a community alcohol and drug outpatient unit, Community Alcohol and Drug Services (CADS), which is part of the Waitemata District Health Board (WDHB) and offers services in the Auckland region of New Zealand.

Community Alcohol and Drug Services

CADS offer assessments, individual counselling and a variety of groups depending on the needs of those presenting to the service. Support is also offered to the friends and families who are concerned about the substance use of another person.

CADS offer a number of other services to those seeking support with substance abuse or dependence. Specialised support is offered to Pacific Island and Asian

clients, for Youth up to the age of 20, and those who are 65+ years old. Pregnancy and Parental services support clients who are either pregnant or have young children. Designated clinicians are available to Gay and Lesbian clients and a medical detoxification unit is available for those who require medical support while detoxing from alcohol or drug use. Te Atea Marino is a specialised service to cater for the needs of Maori.

Te Atea Marino is a team of Maori workers who work within the CADS service. These clinicians work specifically with Maori clients. Clinicians are available to support Tangata Whaiora (clients) and their whanau (family), with any substance misuse issues (WDHB 2010). Te Atea Marino offer a range of supports, counselling, and consultation options in a culturally appropriate treatment environment.

Te Atea Marino provides specialist services for:

- Rangatahi (youth)
- Kaimanaaki ukaipo (pregnant women and parents with young children)
- Ariari o te oranga (consumers of mental health service with substance abuse issues)
- Whanau (family) of those who have alcohol and drug issues (WDHB 2010).

Groups have become a significant part of the treatment services offered to clients presenting to CADS The following section will explore the groups offered paying particular attention to the action group.

CADS Groups

The researcher has been involved in running groups at Community Alcohol and Drug Services for a period of ten years. During this time she has observed that while some clients complete the eight weeks required for completion, and some continue for many weeks after this, there is a small but significant group that attends for just a few sessions then does not return. The researcher is interested whether there are common themes within this client group.

CADS offer the following groups:

- Facts and Effects: A one-off drug and alcohol information seminar.
- Getting Started: For those at the beginning of the change process – four weeks.
- Maintenance Group: For those seeking support to maintain their changes – ongoing group.
- Managing Mood Group: Learn new skills to manage painful emotions and difficult situations – eight weeks.
- Solution Focused: To learn problem solving skills – ongoing group.
- Friends and Family Group: For those concerned about another's use of alcohol or drugs – ten weeks.
- Action group – eight weeks.

CADS Action Group

The action group meets weekly, and is open to clients both male and female who are over the age of 20, although on occasion clients who are 18 and 19 do attend this gorups. It is open to all who wish to make changes to either their alcohol or drug use. The goals of the clients do not necessarily have to be abstinence from use as CADS supports a harm reduction model, but requires some desire to make changes to their current use.

Action group is both open and ongoing which means members may start at any time and stay until they feel they have reached their goals, or they decide the group is no longer meeting their needs. Members of the group become eligible for a certificate of attendance after eight weeks, regardless of whether they have reached their desired goals; the action group is based on the Prochaska and DiClemente wheel of change.

Many of the group members stay long after they have received their certificate of attendance. However once the members have maintained their goals for a period of time they are encouraged to attend the maintenance group, this is more of a process group that supports them in maintaining the changes they have made. The New Zealand justice system refers people to the action group as part of conditions of sentence; if there have been legal problems due to alcohol or drug use. Clients are required to give their probation officer proof of attendance.

The action group may be described as a psychoeducational group; it has both an educational and process element to it. The goals of the group are to support clients

in the change process. This is achieved by teaching strategies to manage the difficulties that occur when attempting to make change to alcohol and drug use. The group aims to create a safe space where a client can gain personal insights regarding their own use. The participant is encouraged to replace their previously used strategies of alcohol and drugs as a way of managing their problems with alternative more adaptive skills, (see list of these skills below). Facilitators aim to create an environment where group members can become a support for each other by sharing their knowledge and experiences. The group members have an opportunity to learn from each other's experiences, both their perceived successes and failures. Participants are encouraged to see any experiences as an opportunity to learn, and consider a lapse as a chance to make changes to something that may not have worked well. They are encouraged to explore what might have worked better. This is designed to remove the sense of failure and condemnation that many feel after a slip back or "lapse". The group normalises the complex and difficult process of change that many are experiencing, and in doing so reduces the sense of isolation and shame. For many it is a relief to realise that they are not the only people struggling with these issues and they are not alone.

Before attending the action group members are generally required to have completed a Getting Started Group, based on the contemplation phase of the wheel of change. This group is a four-week educational group that covers the facts and effects of alcohol and drug use. This group aims at giving clients a common base of understanding, and help establish goals for future use.

Participants in the action group are often at different stages of the change process; this allows members the opportunity to meet other clients in different stages of managing their issues. While some have already met their goals and are learning to keep the change, others may be experiencing some difficulties reaching their goals. The group encourages members to share their expert knowledge regarding how they managed similar situations, resulting in an increased mastery and connectedness for the members. This can also prove problematic and frustrating for participants who are focused on making change to their use, while others may seem a lot less definite regarding their future goals.

In any week, a group may have a mixture of male and female, those who want abstinence from use and those who want to reduce or control their use. There are those using alcohol and those who are using drugs e.g. cannabis, Meth Amphetamine etc., sometimes both. There are company directors and the unemployed, young or old. The members of the group are self referred, referred by justice as part of their sentencing, they may have come due to an upcoming court appearance or their solicitor has suggested they attend to make a good impression with the judge. There is often a multi-cultural mix of people where for some English may be a second language.

DiClemente and Scott (2006) states that after the decision to make change has been established the focus turns to increasing commitment and making a plan to modify the drug or drinking behaviour. Sometimes that plan is made with abstinence as the goal; however, other times the individual will simply plan to moderate the behaviour. In either case, the implementation of the plan initiates the action stage of the process

of change. It is thought that 3–6 months is necessary to establish either abstinence from drugs and alcohol, or successfully moderate behaviour if the latter is possible.

The recognition of the need for social supports, skills development, behavioural self-control, contingency management, and motivational strategies are required when making change to substance abuse. These processes represent cognitive, affective, behavioural, and environmental activities that appear to account for the principles of change proposed by the major systems of therapy, and that seem to cluster into two larger second-order factors. One represents a cognitive-experiential component and the other a behavioural/environmental component (DiClemente & Scott, 2006).

The Action group covers a variety of topics, these topics are covered in a variety of ways, and they are not necessarily covered in any set order.

Action Group Topics covered

- Self Esteem.
- Self-Care; pacing and strategies to deal with stress.
- Triggers; identifying internal and external triggers that lead to substance use.
- Thought Stopping.
- Boundary setting.
- Problem solving.
- Relapse prevention Strategies.

Action Group Rules

The following group rules are discussed at the beginning of each session in the attempt to create safety within the group:

- Confidentiality: What is said in the group stays in the group.
- Cell Phones Off: (this group rule is generally shared by group members first).
- Group members have the right to pass, but participation is encouraged.
- No sourcing from members: (Unfortunately problems have been encountered in the past regarding clients using each other to source drugs).
- Try to be on time: (The facilitators then state they would rather the group member come late than not at all).
- Please phone if you are not able to attend, just to let the facilitators know you are OK.
- If there have been any safety concerns in the week, or if there are any concerns for current safety, check in with one of the facilitators before leaving (this enables the access of resources to be established if necessary).
- No swearing directly at a person.
- If you need to leave the group early check in with a facilitator before you go (this allows any risk issues to be assessed).
- No judging of each other's experience. Accept each member where they are. A safe place is needed for people to practice new skills without fearing put downs.

Conclusion

Regrettably, treatment completion and retention are a well-documented problem in the addiction services field. "The completion rates from publicly funded programs in 2005 were 44% across modalities, 36% in outpatient settings, the most common form of service delivery in the United States" (Laudet et al., 2009).

Longer participation in groups is associated with improved outcomes and the long term effects of treatment, and may influence remission rates of substance use up to 15 years later. There is a need to understand client's expectations throughout treatment to maximise treatment retention (Laudet et al., 2009).

Chapter Three

Methodology

The following chapter presents a description of the research process used in this study. It introduces and discusses the methodological approach, the reason for choosing a qualitative research approach and the use of a semi-structured interview. This chapter further explains the recruitment process, the selection criteria for participants, and describes the collection and analysis of data.

The aims of the research

This research study focuses on the non-attendance to group therapy in a community drug and alcohol outpatient unit in Auckland, New Zealand. Substance abuse in New Zealand is a major problem, putting a strain on families, communities, and the health and legal system (Ministerial Committee on Drug Policy, 2007). Studies have shown that attrition rates within the substance-using community is a well documented problem in outpatient units and severely limits the effectiveness of services (Laudet, Stanick, & Sands, 2009). Semi-structured interviews have been used to collect data, and through thematic analysis the researcher has attempted to identify themes that have contributed to non-adherence in these groups. This information may inform changes to group practice within the CADS environment.

The researcher's position

The researcher is a qualified counsellor and Cognitive Behavioural Therapist who has worked as a clinician for the past ten years at Community Alcohol and Drug Services (CADS). CADS are government funded alcohol and drug outpatient units in Auckland New Zealand. The researcher was initially employed in a permanent position, but more recently has been contracted to co-facilitate two action groups per week. During the researcher's time at CADS she has been involved in both individual therapy and the facilitation of groups. As a group facilitator she has been aware of the problem of clients who stop attending group before completing the recommended number of sessions, or before the client's goals have been reached.

Research framework

Qualitative research begins with a question to be answered, a problem to be explored, or a situation that needs changing. Research will generally reflect the researcher's interests and will drive the whole research process (Mutch, 2009), and aims at illuminating and generating understanding of situations (Golafshani, 2003). Winter (2000) states that "Qualitative research, arising out of the post-positivist rejection of a single, static or objective truth, has concerned itself with the meanings and personal experience of individuals, groups and sub-cultures and attempts to identify, personal, in depth, descriptive and social aspects of the world" (p. 6). Reality in qualitative research is concerned with the negotiation of 'truths' through the exploration of personal accounts. Quantitative researchers' attempt to distance themselves as much as possible from the research process, where as qualitative

researchers have come to embrace their involvement in the process of research. Quantitative researchers see this involvement greatly reducing the validity of a test, while qualitative researchers believe denying one's role within research in fact threatens the validity of the research (Winter, 2000).

Motivation for using a qualitative research approach

According to Willig (2009) qualitative researchers tend to be concerned with how people find meaning and make sense of the events they have experienced. They aim to understand 'what it is like' to experience a particular situation. Qualitative researchers do not tend to work with variables that are defined by the researcher before the start of the research, as this would lead to predetermined ideas and the imposition of the researchers own meaning.

Most qualitative research projects are guided by the research question and not a hypothesis that is derived from existing theory. A qualitative research question is open-ended and cannot be answered by a simple yes or no answer. A good qualitative research question tends to be process orientated (Willig, 2009). It is with this in mind, the researcher chose to use a semi structured approach to the interview, as this allowed the participants' experience to be told, while at the same time giving the interview some structure.

Three epistemological questions

Willig (2009) describes three epistemological questions:

1. *What kind of knowledge does the methodology aim to produce*? According to Willig (2009), "qualitative research can produce descriptions or explanations. It can aim to give voice to those whose accounts tend to be marginalised or discounted. It may be designed to capture the subjective feel of a particular experience or condition, or it may wish to identify recurring patterns of experience among a group of people" (p. 12).

   As a therapist who has worked in the alcohol and drug sector for ten years, I have developed a number of questions regarding treatment and treatment outcomes for those presenting to alcohol and drug outpatient units. The question I have chosen to focus on for this research study is, why do some clients exit therapy before meeting their goals or completing the required sessions and gain an attendance certificate? The problem of attrition appears to be a problem across alcohol and treatment centres internationally and impacts greatly on treatment outcomes (Laudet, Stanick, & Sands, 2009). While these problems are a well documented fact, there appears to be little research conducted as to the reasons for this, particularly within a New Zealand context.

2. *What kind of assumptions does the methodology make about the world?* This question takes us into the realm of ontology. Ontology is concerned with the nature of the world and the question, 'What is there to know'? Ontological

concerns are fundamental as it is impossible not to make at least some assumptions regarding the nature of the world. Ontological positions can be described as realist and relativist. Willig (2009), states that “a relativist ontology questions the ‘out-there-ness’ of the world and it emphasises the diversity of interpretations that can be applied to it” (P 13).

3. *How does the methodology conceptualise the role of the researcher in the research process?*

   Relativist methodologies see the researcher as the central figure in the research process because it is the researcher who constructs the findings. A helpful metaphor here would be to describe the researcher as a builder who constructs a house. The same bricks (the data) could be used to build a number of very different buildings (Willig, 2009).

Research as a Process

Doing research involves a process or a series of steps, moving from the beginning to the end. While this process is not rigid, there is a chance that the research will be weakened and made more difficult if the initial steps are not executed carefully. The research process is as follows:

Phase 1: Clarifying the issue to be researched

Phase 2: Data Collection

Phase 3: Analysis and interpretation (Bouma & Ling, 2004).

Data Collection

Semi-structured interview: For the purpose of the interview a semi-structured interview was used. According to Willig (2009) semi structured interviewing is a widely used method of data collection in qualitative research. She however cites Potter and Hepburn's (2005) concerns regarding qualitative analysis data generated by interviews. They state that much of the data does not pay attention to interactional features, the status of the conversation between two people, and what stake do the participants in the interview have. They point out it is important to reflect on the meaning of the experience for those being interviewed, and not assume their thoughts and feelings are direct reflections.

While semi-structured interviewing is described as non directive, it is important to acknowledge that the researcher drives the interview by both the questions asked and comments made (Willig, 2009). Cheek (2000) however goes further than this when he states "researchers should become more aware of how their own positions and interests are imposed at all stages of the research process, from the questions they ask to those they ignore, from whom they study to whom they ignore, from problem formation to analysis, representation and writing" (p. 20).

Recruitment of Participants

Clients who began attending action group were given an information handout regarding the research. The handout contained information about the study and answers to frequently asked questions. Clients were able to refuse to be part of the

study by informing the facilitator of the group that they do not wish to be contacted regarding the research.

Clients became eligible for the study if they had attended one or more sessions but did not complete the eight sessions required to receive an attendance certificate. The researcher contacted those clients who made themselves available for the study by phone; the clients were reminded of the voluntary nature of the study, what the study entailed and what would happen to their information. It was explained that the reporting of the results from the study would not be linked to personal identifiers, and that they may return to a group at any time without reprisal. Informed consent was obtained by all those who agreed to take part in the research. This process was initially to be followed until 6-8 participants had been recruited, but due to the difficulty accessing participants only 5 participants were used in this study.

Clients receiving individual counselling, or who attended an action group in which the researcher was involved were excluded for the purpose of this study. This was done to limit factors that may skew the results. Only individuals who were referred to an “Action Group" were included in the study. These groups are open groups where clients may begin at any time.

Research context

This study was conducted in the context of a publically funded community alcohol and drug outpatient unit, Community Alcohol and Drug Services (CADS).

Collection of Data

After gaining consent, data was collected by audio taping semi-structured interviews; these interviews were expected to take up to one hour, but in fact took less time than this, and took place at a Community Alcohol and Drugs Services unit of the participant's choice.

For the purpose of the study, questions similar to those in the study conducted by Laudet, Stanick, and Sands, (2009) on attrition guided the interview format. The questions were:

- What is/are the most important reason(s) why you dropped out of the program?
- Is there anything the program could have done differently so that you would have continued attending? (Dichotomous answer category: yes/no)

Participants who answered the previous question in the affirmative were asked:

- What could have been done differently so that you would have continued attending? (p. 244).

The following questions were also included in the research:

- What were you told about the Action Group before you started?
- What were your expectations before attending the group?

Data Analysis

A thematic analysis approach was used in this study. Thematic analysis is a search for, and a focus on, identifiable themes and patterns of living and/or behaviour. This

process involves careful reading of transcribed conversations, direct quotes, paraphrasing, common ideas and patterns of experiences. Salient themes, reoccurring ideas, and related patterns may then be catalogued and placed into sub themes (Aronson, 1994; Fereday, & Muir-Cochrane, 2006; Mutch, 2005).

The steps that that were followed for the analysis of this research were taken from Attride-Stirling (2001).

Analysis Stage A: Reduction or Breakdown of Text

1. ‘Code Material
    (a) Devise a coding framework
    (b) Dissect text into text segments using the coding framework
2. Identify Themes
    (a) Extract themes from coded text segments
    (b) Refine themes
3. Construct Thematic Networks
    (a) Arrange themes
    (b) Select basic themes
    (c) Rearrange into organizing themes
    (d) Deduce global theme(s)
    (e) Illustrate as thematic network(s)
    (f) Verify and refine the network(s)

Analysis Stage B: Exploration of Text

4. Describe and Explore Thematic Networks
    (a) Describe the network
    (b) Explore the network
5. Summarize Thematic Networks

Analysis Stage C: Integration of Exploration

6. Interpret Patterns (Attride-Stirling, 2001, p. 391).

Validity

Each research paradigm whether quantitative or qualitative, requires paradigm-specific criteria for addressing "rigor". The criteria to reach the goal of rigor are internal validity, external validity, reliability, and objectivity.

Winter (2000) states there is no single or common definition of the nature of validity in regards to qualitative research. It is debated in both educational and social research. Winter (2000) describes the issues surrounding the validity of qualitative research as controversial and many. She argues that "'validity' is not a single, fixed or universal concept, but rather a contingent construct, inescapably grounded in the processes and intentions of particular research methodologies and projects" (p. 1). She states that "understanding the nature of 'truth' is central to any theorisation of 'validity'" (p. 1).

Some qualitative researchers have argued that the term validity is not applicable to qualitative research, and have at the same time realised the need for some kind of qualifying check or measure for their research (Golafshani, 2003; Winter, 2000). As a result many researchers have promoted their own theories of 'validity' and have often created or adopted what they consider to be more appropriate terms, such as, 'trustworthiness', 'worthy', 'relevant', 'plausible', 'confirmable', 'credible' or 'representative' (Golafshani, 2003; Winter, 2000). Trustworthiness is seen to contain

four aspects: credibility, transferability, dependability and confirm ability (Morse, Barrett, Mayan, Olsen, & Spiers, 2002).

The use of semi-structured interviews helps to ensure the compatibility, dependability and transferability of the research. The use of set questions allows for individual feedback and understanding of each participant's experience. The validity and reliability of qualitative data collected and analysed depends to a great extent on the skill, sensitivity and training of the evaluator. The credible qualitative evaluation of data through observation, interviewing and content analysis may only be achieved with discipline, knowledge, training, practice and hard work by the researcher (Labuschagne, 2003).

When considering validity, Winter (2000), poses the question for whom is the research valid, and whose interest is it in. She highlights the implicit issues of power and control as we try and reduce others to a series of explanations and evaluations, as we try to fit these evaluations into our own "pre-existing conceptual moulds" (p. 8). Winter (2000), states "another problem raised by the concept of 'validity', centres around the use of existing cultural or subject oriented terms when the research is across cultures" (p.9). These cultural differences may result in subtle or wholly different meanings being understood by the researchers and the participants. These classifications could also create problems of subjective misunderstanding within or across native cultures. "Terminology presents problems in the practice and dissemination of research in both qualitative and quantitative methodologies and can present a serious threat to 'validity', however it is conceptualised" (p. 9). The problem of subjective misunderstanding is a real possibility in New Zealand , as it is

a multicultural society, and the participants' of the research may have many cultures influencing their understanding of the question, therefore the researchers' European background may influence understanding of the answers. For the purpose of this study, the researcher will use the definition of trustworthiness by Morse et al. (2002) to describe the processes used in this research; credibility, transferability, dependability and confirm ability.

Reliability

Golafshani (2003), states although the term 'reliability' is a concept used for testing or evaluating quantitative research, the idea is used in all kinds of research. A good qualitative study can help us "understand a situation that would otherwise be enigmatic" (p. 601). The definitions for 'reliability' are as varied and as complex as those for 'validity' (Winter, 2000). Reliability is used to evaluate the quality in a qualitative study and has the purpose of generating understanding.

Golafshani (2003) cites Patton's (2001) article that validity and reliability are factors which are necessary when a qualitative researcher is designing a study, analysing results, and judging the quality of the study.

The term dependability is often used to measure the reliability in qualitative research; this term closely corresponds to the notion of "reliability" in quantitative research. Inquiry audit has been noted as one measure that might increase the dependability of qualitative research. Dependability and consistency will be achieved when the research is verified through examination of such items as raw data, data reduction

products, and process notes. Trustworthiness remains crucial when ensuring reliability of research (Golafshani, 2003). Qualitative researchers are concerned with the meaning of the lived experiences, where there is attention to the social context in which events occur and have meaning. There is an emphasis on understanding the social world from the point of view of the participants (Labuschagne, 2003).

Silverman (2001) states that high reliability in qualitative research is associated with low-inference descriptors; this is achieved by recording information as accurately as possible rather than the researcher's reconstruction. It is for this reason that I have decided to audio tape each face-to-face interview and use the transcripts of these sessions to identify themes. The data analysis and reduction of this study will be completed by two researchers, myself and my supervisor. Process notes will be kept.

Ethical Considerations

In the interest of informed consent, action group clients were given an information handout and informed about this study when they first attended group. They were informed they could refuse to be part of this study, by advising the facilitator.

Once clients met the criteria for the research they were contacted by phone: the study was discussed, and clients were given the opportunity to ask questions. Participants were invited to attend an appointment; if the client agreed to the interview an appointment was made at a CADS unit of their choice.

Care was taken during this research to ensure that all participants' confidentiality was maintained and that participants had a clear understanding regarding their rights and the purpose of the study. This was achieved by reviewing the information handout at the beginning of the interview, going through the consent form and discussing confidentiality. To ensure confidentiality is maintained each participant has been assigned a number that corresponded with the order in which they were interviewed, for example the participant who was interviewed first was assigned Participant 1 (P1).

Interviews were recorded on a digital voice recorder and after the interviews each voice file was transferred on the researcher's password protected laptop and a compact disc (CD). The Researcher is the only one who has access to the laptop. The CD was given to the transcriber and destroyed after the transcript was completed. The voice files were deleted from the recorder after the transfer. To ensure safety, all written information i.e., consent forms and verbatim were kept in a locked filing cabinet at the researcher's office, for which she has the only key. No identifiable information is contained in the final report.

The researcher is currently on contract at CADS, Takapuna, and facilitates an evening action group. As these are open groups, individuals are free to change groups if their personal situations change, for example they gain employment or the time of the group no longer suits them. Participants in this study were made aware of the researcher's involvement in the evening action group, and informed that if for any reason they may want to change and attend the evening group, they would

automatically be excluded from the study as the dual role of researcher and therapist might compromise quality of treatment and research.

Chapter Four

Analysis

The exploration of the personal accounts of the participants' will be presented in this chapter and offer the reader a glimpse into the world of those attending group with substance abuse/dependence issues. Participants' direct quotes will be used throughout the exploration of this chapter, to ensure that their views are represented accurately.

Thematic networks described by Attride-Stirling (2001) as "web like illustrations *(networks*) that summarise the main themes constituting a piece of text" (p. 386) were used in the analysis of this research. These networks were used to structure the themes and enabled the researcher to explore the participants' account of their experience in depth, leading to the organisation of common themes for further analysis. These themes will be discussed, integrated and contrasted in order to deepen the readers' understanding of the participants' experience. A thematic network was developed using the original text.

The reader will be given a short introduction to each of the participants. To ensure confidentiality no personal identifiers will be used, for identification purposes participants have been assigned a number that corresponds to the order in which they were interviewed.

Participants

There were five participants interviewed as part of this research, two male and three female. The participants attended two different action groups. One group is held at CADS North in the centre of Takapuna Auckland, and the other in Red Beach a more rural setting approximately thirty minutes north of Takapuna. Both of these groups are day groups. Red Beach is a semi rural area just north of Auckland. CADS North services Red Beach and other rural areas with satellite units, offering reduced services to its clients.

Participant 1. Is European male, who attended action group voluntarily on three or four occasions at Red Beach. He was enthusiastic regarding his participation in the study, and able to verbalise his experience well. The interview had to be rescheduled on three occasions, due to transport problems and some uncertainty around the appointment time.

Participant 2. Is European male, who was mandated by the court to attend eight sessions of action group as part of his conditions of sentence, due to charges pertaining to his substance abuse. Despite the courts mandate, participant 2 only attended 5 of the eight sessions and realises that he may need to complete the remainder of these sessions at some time in the future. Participant 2 believed he did not need action group as he had made significant changes to his substance abuse prior to attending the first group, and stated that he was in a different stage of making change than the other members in the group. This participant also attended the Red Beach Group.

Participant 3. Is a 39 year old European female, who attended the Takapuna day group on a voluntarily basis for one session. She also began attending another

group offered by CADS North concurrently but stated it was too tiring for her to attend more than one group at a time. Participant 3 describes herself as struggling with anxiety and some physical issues that result in fatigue and believes the other group serves her current needs better.

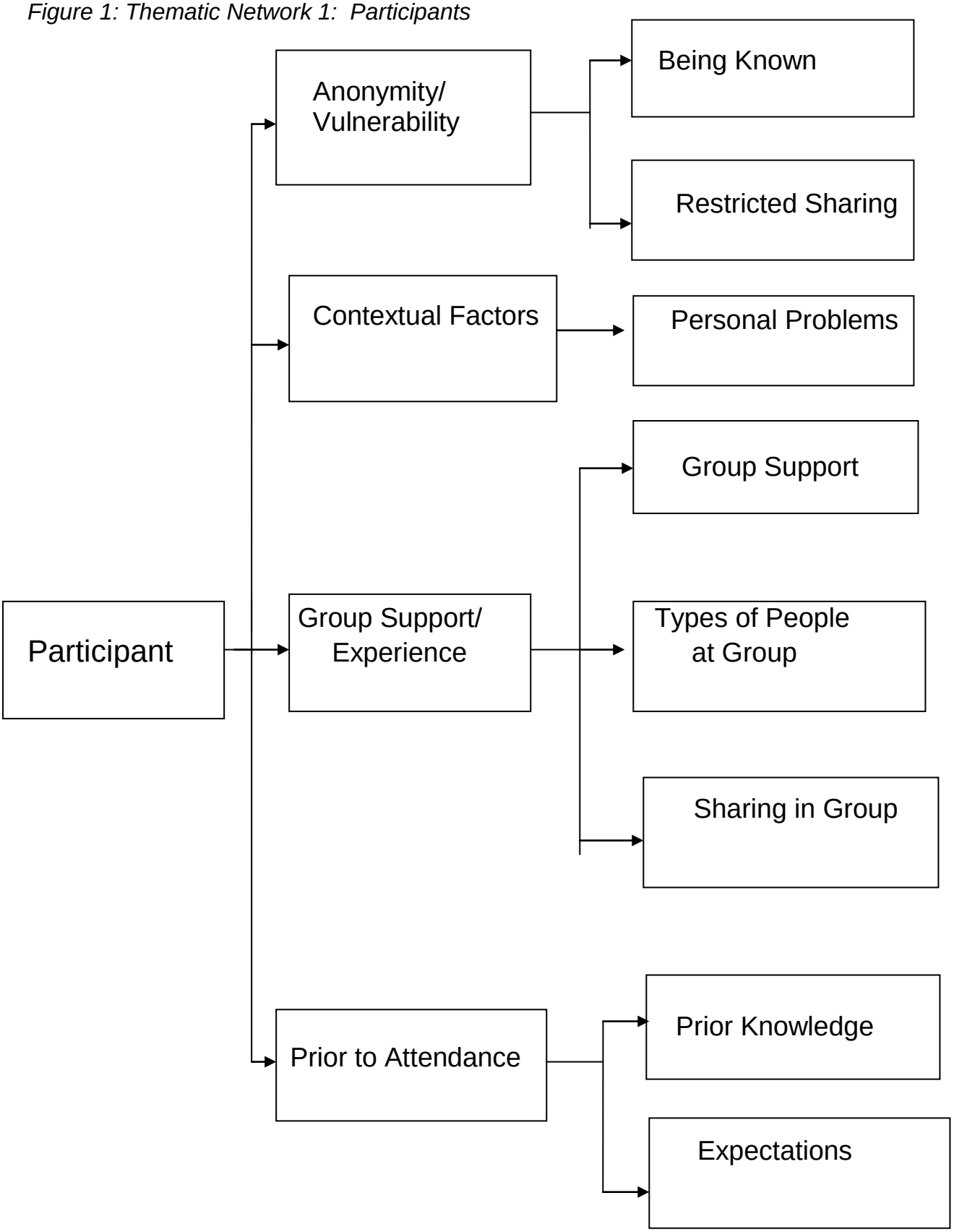
Participant 4 Is a 49 year old European female who voluntarily attended the day group at Takapuna for one session and stated one of the reasons that she initially stopped attending the Action group was due to conflict being experienced at her place of work. She also stated that she did not have the energy to attend the group, and that her motivation to change at that time was not high as she used alcohol to help her manage her emotions. Participant four is also attending an alternative group that she feels caters for her needs better.

Participant 5 is a European female who voluntarily attended the day group at Red Beach. Participant 5 stopped attending this group when it closed due to the small number of participants. She was invited to attend the day group at Takapuna and attended this once, although she does not have any recollection of this. She cited being unable to drive at night as one of the reasons for not attending the night group. Participant 5 stated that she had attended the night group a couple of times when family members had taken her, but there is no record of these attendances.

Data Analysis

Three global themes emerged from the data, the first being “Participants” (see figure 1), the second “Group Factors” (see figure 2) and the third “Accessibility” (see figure 3). Within these global themes a number of organising themes were identified, and within these a number of basic themes were explored.

Figure 1: Thematic Network 1: Participants



Global Theme 1: Participants

The global theme of *Participants* includes the participants' experience during group and their knowledge of action group prior to attending. This theme also integrates the participants individual and contextual factors that had an impact on their group experience. Four organising themes emerged supporting this global theme - *Anonymity/Vulnerability, Contextual Factors, Group Support/Experience,* and *Prior to Attendance.* In turn several basic themes were identified from the verbatim accounts: *being known*, *restricted sharing, personal problems, group support, types of people at group, sharing in group, prior knowledge,* and *expectations.*

Organising Theme 1 Anonymity/ Vulnerability:

This theme identified the difficulties experienced by participants attending the Red Beach group which is situated in a rural setting. Basic themes of *being known* by others in the group, and *restricted sharing* due to feelings of *vulnerability* were identified. These themes were particularly experienced by participant 1 as he expressed how difficult it was attending a group and being known by others,. One of these people was his flat mate. Participant 1 stated a number of times in the interview that he found himself feeling very restricted when sharing in the group. This was such a problem for him that he exited the group after only a few sessions.

Basic Theme 1: Being Known:

P1. "Because there were a few people I knew in the group and one person I actually lived with, a flat mate of mine attends the group. I stopped attending the group mainly because she was there".

P1. “Yeah, I would still be going, it’s a really personal and private thing to say how you feel about what you’ve been doing through the week, and having someone you know and live with”.

P5. “Yes, at the time. And also the fear, it is a small community at Red Beach and I work in the community”. “Definitely, I didn’t go there deliberately because I didn’t want to go somewhere local to begin with”.

Basic Theme 2: Restricted in Sharing/Vulnerability:

P1. “A bit unfair, we’re going there to express how we’re feeling, so if you’re going there with the person you live with there, it’s going to be a bit hard to say certain things. I did feel quite restricted”.

P1. “You can’t exactly say, that person did this and ……This has been going on, because you can’t because that person is there, it’s quite restricting”.

P1. “I did feel quite restricted”.

P5. “I just sucked it in and went well come on why, what’s the problem. Yeah, they’re there for the same reason”.

Organising Theme2: Contextual Factors

Participants identified a number of factors, that were external to CADS or the group process that stopped them attending action group. These factors at the time impacted the participant’s motivation to make change and were included in the basic theme *personal problems.* Both participant three and four are now attending groups that they feel better meet their needs.

Basic Theme 1: Personal Problems

P3:" Yeah, I lost my dear little girl cat, that only happened two months ago and then I got a new cat, a lot has happened this year, I've had problems where I'm living, I've only got enough energy to go to one group".

P3. "I suffer from chronic fatigue and with the anxiety problems and depression problems it's quite a way to come from Torbay".

P4. "Because I went through an employment issue which I was immersed in for about 3 months and probably I was so immersed in it I fell off the wagon a few times during it. I took my ex-employers on a personal grievance and it just about destroyed me emotionally. During the process all I would do would be basically go home, go to the gym or go to a friend's house and bleat and have a drink. It consumed my life; I felt like the nights that I was drinking that I would have been a hypocrite if I had gone. Not heavily drinking, but a few times I would binge drink. I lost so much confidence I would do everything that was familiar to me. I didn't even go to the gym, I was like a robot".

P5. "It was really from my own personal point of view, I possibly wasn't ready for it. I didn't have enough back up behind me. I didn't tell anybody I was going, only my daughter. I do it on my own and don't ask for help until you finally have to ask for help from where ever you can get it".

Organising Theme 3: Group Support/Experience

This theme focused on the group support the participants got from the members of the group, the types of people they encountered and the experience of sharing in a

group environment. Group support appeared to be a positive experience particularly for participant 1, despite his feeling restricted by being known by others. Participant one expressed how supportive he found the environment of group, and that he found it useful to have people who understood his issues and have problems in common. The support participant 1 received from group played no part in his choice to stop attending group. Other participants however experienced some level of frustration due to the differences of group members. These differences included current drug use, age of group members, motivation to change, and goals.

Basic theme 1: Group Support:

P1. "This group is about planning it, planning when you're going to stop and having the support around to do it. And if you fail that's cool but you've got the group to support you".

P1. "You got the support up to that point and after, and if you re-lapse that's ok you come back to the group and it's all right, they understand and they'll support you and you make a new goal and you aim for that".

P1. "Really did, felt like we were all common. Yes, I thought the group was really cool, I did like the group".

P1. "A good group and a bad group, it had a lot more to do about what I was sharing. Everyone was positive, everyone was on track, was on to their goals. Not everyone was oh f*** I had a drink last night, I had a drink last week, everyone's failing and it's all turned to shit. But then the next week it could change and everyone could have been sober for the whole week, then

that would be a good week and we'd get really excited and think yeah we can do this".

P1. "Funny stories, some of them had outrageously funny stories it was kind of nice just to listen to other people and know that other people are going through the same things, it's not just you. You're not poisoned".

P1. "That first day I went back to the group it seemed having that talk and everyone around me listening to how I felt gave me the strength to make the decision".

P2. "Out of all of us in the group, I was the only one who had the meth problem, so it wasn't talked about or anything, so maybe more on that. Maybe if they mixed the class up a bit, not just all alcoholics and one meth user". (Researcher asks the question) Do you think that's a part of why you felt you were different as well? "Yeah definitely, because when it all came up to do with meth the whole class focused on me as well. They all wanted to know this and that".

Basic Theme 2: Types of people at group

P1. "I didn't get to know too much of the personalities in the group, I wasn't there long enough".

P1. "I didn't have any expectations what so ever, I expected it to be shit to be honest. I expected it be a whole group of wasters, drop kicks, bleeding their heartfelt stories out, but it wasn't it was actually really cool, everyone was really cool people, I should learn not to judge next time because they turned out to be cool people".

P1. “Yeah, I’ve been to some meetings out west and stuff and everyone was so depressed, no motivation no one wants to put in, but everyone seemed to want to put in”.

P2. “The other reason was I was in a group with a lot of older people. They were well older than me”.

P2. “Everyone turned out to be a lot older than me it seemed maybe that they knew more than I knew, well that was their understanding but it didn’t work out like that”.

P3. “Another positive part of the action group was that there seemed to be a lot of sadness in the room, a lot of people I could see struggling. I thought I don’t want to keep going down this street, other substances can be a problem for people like meth and marijuana. Also too, I’ve got that addiction trigger in my head and more with the getting started group I found myself inquisitive about the drug “P”. Yeah, because I’m an experimental person, I’ve taken other stuff like “E”, but now I realise how bad it is and I won’t go down that track, but the addiction side of me, I think I was still vulnerable”.

P5. “I felt, I’m not being egotistical, everyone was so different, but there were quite a few in some of the groups that had to be there, I was there by choice. Because of a time limit and you go round and people talk, there were younger people there, particularly young men who didn’t want to be there and they talked a lot, negatively. For me that was a bit of a time waster, I would just sit there and say nothing and thought well it’s nearly time to go home and nothing had been achieved for me. I think I work better one on one”.

P5. “They really didn’t want to be there, they were wasting the facilitator’s time. For me sitting in that large group I just wanted to get on and get some info, get something to sink my teeth into and I’m not talking about a certificate”.

Basic Theme 3: Sharing in group

P2. “Yeah definitely, because when it all came up to do with meth the whole class focused on me as well. They all wanted to know this and that. The researcher asked “what was that like for you? It was ok sort of, it was good, they wanted to know something from me”.

P3**. “**When I first started coming everyone had to say their name and we didn’t get to the nitty gritty. The Facilitator decided everyone had to go around the circle and say there name, very time consuming and I was the only one in the group who had a narcotic problem out of everyone”.

P4. “I found it hard to talk in a group of strangers. I felt bad about myself anyway because of what my ex-bosses were doing to me. I felt so bad about myself, I couldn’t talk”.

Organising Theme 4: Prior to Group Attendance

This theme focused on the participants’ prior knowledge of Action group and what their expectations of group were. There appeared to be a common understanding that the action group is an abstinence based group, when in fact action group is based on a harm reduction philosophy discussed in previous chapters. Participants’ goals in the group therefore ranged from controlled use to abstinence. This prior understanding of the participants resulted in some confusion and frustration. Two of

the questions that were asked of each participant were, “what were you told about the action group before you went”? and “what were your expectations before attending group”?

Basic Theme 1: Prior knowledge of Action Group

P1. “Not a lot, I didn’t know a lot about action groups. It’s about abstinence, the whole goal of the action group is abstinence and I thought that was really cool. That’s what drew me in”.

P1. “This group is about planning it, planning when you’re going to stop and having the support around to do it. And if you fail that’s cool but you’ve got the group to support you”.

P2. “When I first came here I told them my main problem was both alcohol and drugs but I’ve been off it for over a year now. I was told that the group was in the same place, off it for a while too”. Researcher asks: “You were told that the action group was people like you who had stopped for a while and weren’t using any more”? P2. “Yeah, pretty much but to my understanding none of them were”.

P2. “My understanding of an action group was someone who’s given up drugs and alcohol and was trying to stay sober so they didn’t relapse, but sitting there talking to them, most of them had relapsed the week before, they hadn’t given up, they were all sad at themselves because they had a drink a few days before and all that”.

P3. “I don’t remember that I was told a lot, after getting started you do action group, so I thought I’d be doing 2 *(groups)* at once”.

P4. “Not a lot, action group was the next group up from getting started. To be honest I’m in the solution group. I don’t even know what that was meant for. All I know is action group is one group up from getting started”.

P4. “If anything with the CADS program,, I’d like to know what sort of people, what they do in solution focused and action groups and what is the purpose of each group”.

Researcher asks “You weren’t given any of the pamphlets”?

P4: “Yes, I probably was but I’ve shifted a couple of times in the last 6 months”.

P5. “I was given pamphlets but if I read it. “ I didn’t retain I was a little bit out of the loop mentally at the time too; my memory is not very good at the moment because of my drinking. It was all new to me, if I did get information I wasn’t using it, I wasn’t retaining it and I wasn’t reading everything properly”.

Basic Theme 2: Expectations Regarding Group

P1. “I didn’t have any expectations what so ever, I expected it to be shit to be honest. I expected it be a whole group of wasters, drop kicks, bleeding their heartfelt stories out, but it wasn’t it was actually really cool, everyone was really cool people, I should learn not to judge next time because they turned out to be cool people”.

P1. “I thought it was like you had to go to this meeting. I thought it would be like probation where they make you go to certain meeting”.

P2. “I understand it’s hard and all that but to be in an action group you should at least be sober for so long. They should have been in a group where they’re still classed as drinking every day”.

P2. “I didn’t actually expect too much from it, at the end of the day it’s all up to yourself”.

Researcher comment: “Expectations were around people not drinking, people have the same goals as you? Did you expect particular subjects to be talked about”? P2. “That was just an alcohol one, they didn’t touch on the drugs too much, well they sort of did, but my problem was both drugs and alcohol, but I don’t think I stated that enough that drugs was a factor in my life mainly because of probation but it was pretty much alcohol, alcohol, alcohol”.

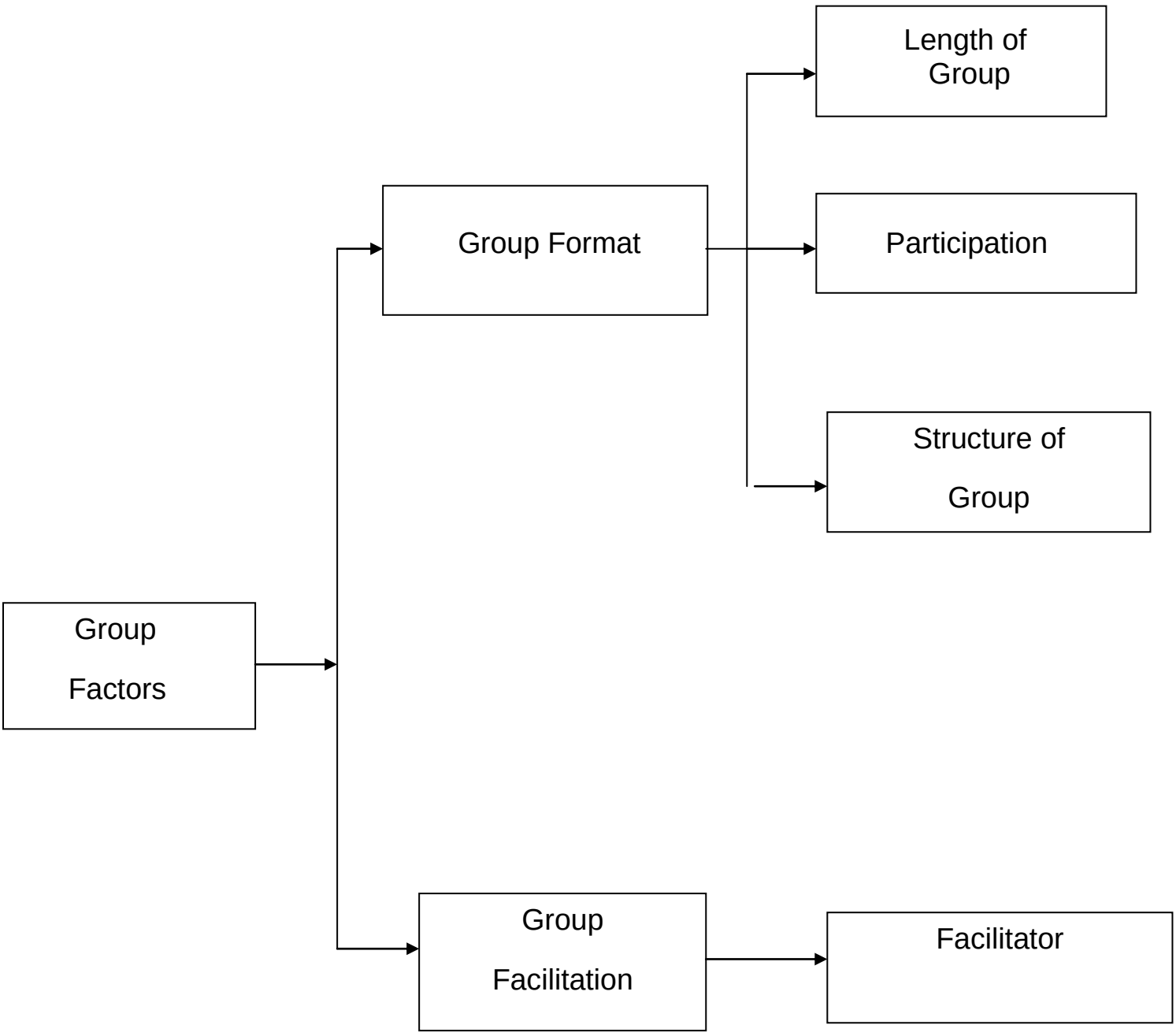
P3. “Well I knew I’d have to stick off my substances, I already had anyway, I know that I can’t go and do anything silly anymore, that’s ok because that is a personal choice I’ve come to anyway, but if you go to action group and you do slip that’s a naughty naughty. I’ve got to be on the straight and narrow which is a good thing”.

Researcher asks “So your understanding of action group is that it’s an abstinence based group”? P3. “A little bit yeah”.

P4. “Sharing, being honest with yourself”.

P5. “Just fear really, fear of the unknown”.

Figure 2 Thematic Network 2: Group Factors



Global Theme 2: Group Factors

The second global theme identified was “Group Factors”. Two organising themes emerged from this global theme; *Group Format* and *Group Facilitation*. *Group format* focused on the way the group was set up, and the experience of being part of action group. *Group facilitation* focused on the facilitation of the group and the participants’ experience of the facilitator.

Organising Theme 1: Group Format

Within this organising theme, basic themes of *length of group, participation, and structure of group* were identified. Some of the participants mentioned that they found the group too long, and while some found participating difficult, they found the activities useful. The participants who commented on group structure appeared to find this positive.

Basic Theme 1: Length of group

P1. “It was quite long, 1 hr 40 minutes, it was quite a long time, I would have preferred something under an hour is good. I felt it was draining, there were some days I would come home and be really energized I’d had a really good group, and other times when I’ve had a bad one and you’re sitting there for 1 ½ hrs through it drags the life out of you”.

P4. “I think it’s an 1 ½, a bit long”.

Researcher asks: “What would an ideal time length be”? P4. “1 hour”.

Basic Theme Two: Participation

P1. “I had no problem with that, it was really cool, had some cool activities”.

P1. “Yeah, I’ve been to some meetings out west and stuff and everyone was so depressed, no motivation no one wants to put in, but everyone seemed to want to put in. We all played the games with the owl, role play games, that was really cool”.

P3. “The action group was really quite good, when my friend went, I met a friend through action group she would tell me about things you people went over and I thought that was really good”.

P3. “I do get nervous when it comes around to saying my name, but I’m getting better at that”.

Basic Theme 3: Structure of Group

P1. “I did like the way that the group was structured”.

P3. “The one during the day wasn’t as structured”.

Organising Theme 2: Group Facilitation

This theme focuses on the facilitation of the group and was supported by the basic theme of facilitators. On the whole the participants’ commented positively on the professionalism and support of the facilitators, finding them warm and helpful. One of the participants however discussed the difficulties experienced when there was a change of facilitators during their attendance of a group. Another participant commented on how difficult they found group when the facilitator did not control the group well. The subject of facilitators sharing from personal experience was raised by one participant, stating they would find it helpful to have some knowledge of the facilitators’ personal experience with alcohol and other drugs.

Basic Theme 1: Facilitators

P1. “I did like that the way that the facilitator introduced, I did like the way the group was done. Yes, he was really good”.

P1. “I came to the group and that’s where I met the facilitator and I was really sick, and they were really kind to me and really understanding and that made me think this is cool, that’s what made me come back”.

P2. “Yeah they were cool, the first one but I only saw him for 2 weeks and then he left and a new guy came. The teachers were good”.

P4. “I went to one action group and she didn’t control it very well, and there was one lady who I think she was drunk and abusive, I think she was a German lady, I thought what am I here for, maybe that was getting started, I thought this is ridiculous, she’s not a very good facilitator”.

P4: “Facilitation of the group is quite important, you need someone who has a bit of presence. The guy who’s a bigger guy, he’s really good. I went to one and then it all started happening and I gave up. The lady with the dark hair (name deleted) I went to one action group and then I stopped. They were all pretty good”.

P4: “I think they’re all great people, I have a lot of admiration for you guys and what you do. I think it’s a great service. I want to keep coming”.

P4: “It would be really good; obviously we look up to the facilitators, the likes of (name deleted) who have given me some one on one sessions. It would be nice to have some more one on one session. You know you have to eyeball someone for an hour”.

P4: “It would be good if the facilitators could share some more of their experience. If they were a heavy drinker or an alcoholic, they could say I might be standing up here now but this was where I was 5 or 10 years ago, it would make them seem like they’re human too. I don’t know if that breaches privacy issues”.

Researcher asks “Do you feel like facilitators don’t really understand”? P4: “A little bit, not that they’re arrogant or proud, you do get a sense of I’m here, I’ve made it but to know that background of facilitators would be helpful. Like if you’re really fat and looking at someone who was 20 stone 10 years ago, they could say this was me then but here I am now, you can do it too”.

P5 “the people (facilitators) seemed very professional and lovely, and informative it was just the fear of being in a group situation, would I know anybody”.

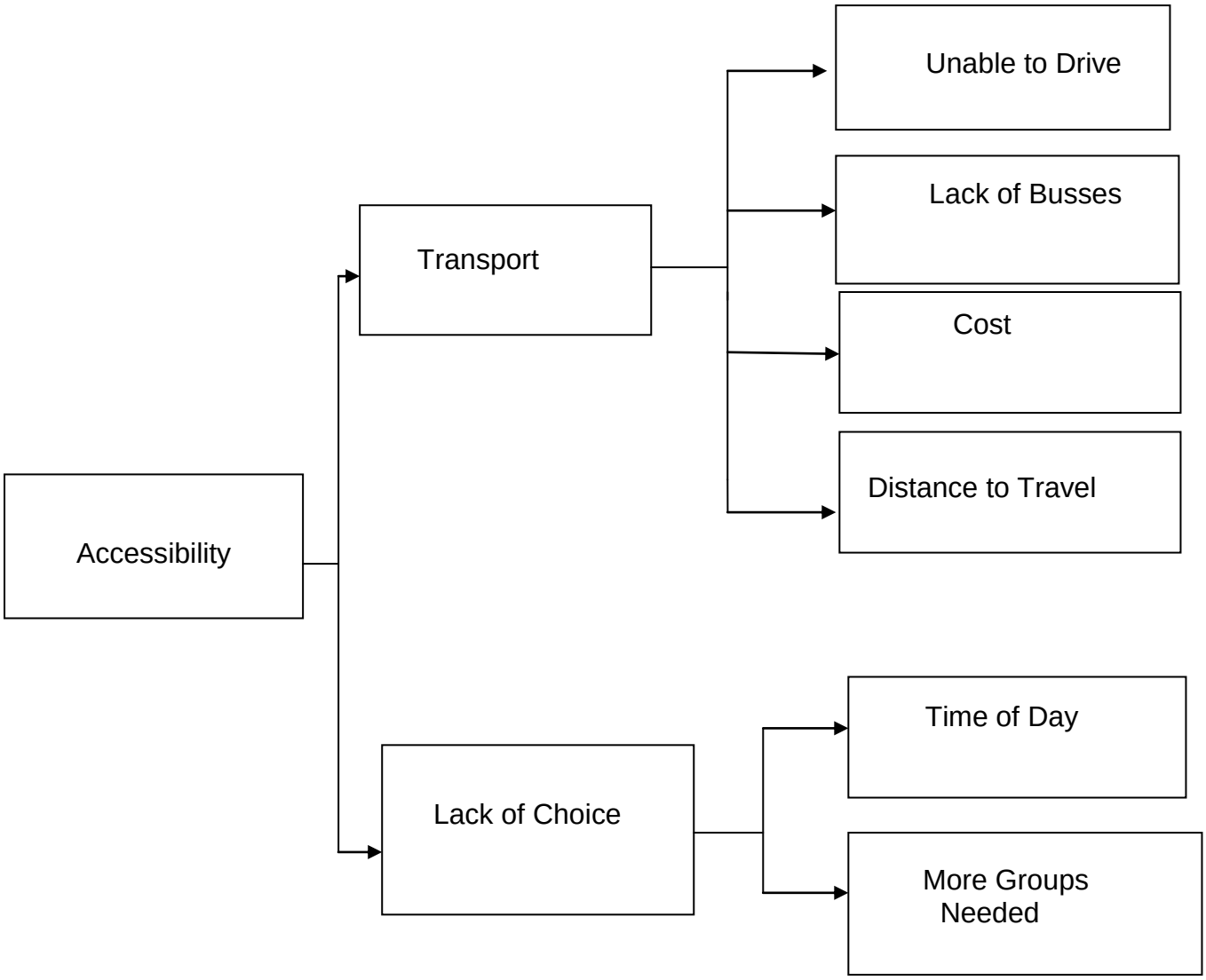
P5. “Honestly, they were very professional the people who were running it, approachable which is really important to me, non-judgemental, they listened to everyone I felt like no one felt they were being treated differently to anyone else”.

P5. “I was followed up, from Red Beach (name deleted), lovely man, he wrote to me, he said that they were going to Takapuna and invited me to come”.

P1. “A consistent facilitator, my flat mates told me that they changed the facilitator; it’s not the same person anymore. I find that a bit disturbing, you gain a kind of bond with the facilitator, a sort of trust in them and if they keep changing everybody. My flat mate’s thinking of not going anymore either

because of that reason, they've changed the facilitator. It's like a whole new process of getting to know that person. Do you like them, don't you like them. Can you tell them certain things, can you trust them"?

Figure 3 Global theme 3: Accessibility.



Global Theme 3: Accessibility

The third global theme that emerged from the data was *accessibility.* This theme identified the difficulty some clients had attending groups particularly in areas that are not well serviced, or serviced at all by public transport. Two organising themes supported this global theme of accessibility - *transport difficulties* and the *lack of choice of groups* to attend.

Organising Theme 1: Transport

There were a number of basic themes that were identified regarding the difficulties of transport. These were *unable to drive, lack of buses, cost,* and *distance.* Transport issues proved to be a significant problem for a number of the participants, and made accessing group very difficult.

Basic Theme 1: Unable to Drive

P1. "It was a bit hard to get to; I'm in Orewa so I couldn't really walk here. I had to drive, and I don't have a fulltime car I've got use of a car, but not fulltime so sometimes it would be not available on those days, so that was another reason I couldn't attend".

P2. "Yeah well most people who are sentenced to it, 9 times out of 10 they've got a drinking problem so more than likely they've lost their license, that's why they're here so they're pretty stuffed in a way of getting here because 9 times out of 10 they're also unemployed".

P2. "Nothing to do with the group, it was transportation. I was on home detention so I could only leave when they told me to. I had a set amount of time to get here and a set amount of time to get back. I was on home

detention for driving charges so I've lost my license and I'm not allowed to drive".

P2. "But the main thing was transportation really".

Researcher comments "Thinking about the transport thing, if you were thinking about which was the bigger issue, the transport or the group not being what you expected, which would be your number one reason for not coming"? P2. "Transport".

P5. "It was mainly to do with getting there, sticking it out really". "Yeah, transport, physically and emotionally, I don't drive at night at the moment, and that's only been a recent thing and it was around about the time that I was going to CADS action group and I couldn't drive at night on my own so I went a couple of times with family members and when it wasn't available I didn't go".

Basic Theme 2: Lack of Buses

Researcher asks "are there buses do you know"? P1. "I've tried but I've never got to Red Beach".

Basic Theme 3: Cost of attending

P2. "Being on the benefit as well, even though a bus fare doesn't sound like much when you've got so many bills it's another bill I can't afford".

P2. "Yeah, but as I said it's only a bus fare but when you're on the benefit and a baby due soon, I've got power bills, rent bills, food bills, it all adds up even

though it might be $6 or $7 for here and back to there but it's $6 - $7 that I need".

Basic Theme 4: Distance to travel

P3. **"**I suffer from chronic fatigue and with the anxiety problems and depression problems it's quite a way to come from Torbay".

Researcher asked "So driving from Red Beach to Takapuna wasn't an option"? P5. "On my own? No".

Organisational Theme 2: Lack of choice

Two basic themes emerged in this organising theme - , *more groups needed* and the *time of day* the groups were offered, participants' found both of these factors limited their access to group. This issue was particularly pertinent to those participants living in the Red Beach area, as the daytime action group was the only action group offered in Red Beach. This group was closed during this research due to lack of clients attending regularly. Takapuna has two action groups operating, one in the day and one in the evening.

Basic Theme 1: Time of Group

Researcher asks "Would it have made a difference if the group had been at night versus in the day"?

P2. "Yeah it would have been for me because my partner could have brought me then because she works during the day, and if it was at night after she'd finished work I could have got here no sweat. And there probably was a night time one".

P3. “I get tired in the evenings and 5:30 in the evening is the time of day when you’re starting to unwind”.

P5. “I don’t drive at night at the moment, and that’s only been a recent thing and it was around about the time that I was going to CADS action group and I couldn’t drive at night on my own so I went a couple of times with family members and when it wasn’t available I didn’t go”.

Basic Theme 2: More Groups needed

P1. But if there was another group that I could attend that we could do separately I would have done that.

P1 If there was another group to attend I would be attending that and I’d probably be more consistent with it because it would be my time away to share or whatever without anyone’s ears that I know in there.

P1. Another group, just another group I think.

P.5 “That was during the day and I went to that, then they said they didn’t have enough people and they were going to form in Takapuna”.

Conclusion

In identifying the global themes of participants, group factors and accessibility a number of factors presented themselves as significant, situated in the larger context of attrition rates in group based treatment for substance abuse/dependence. These themes help to enhance the understanding of the experience of those who attend groups at an alcohol and drug outpatient unit, and then exit treatment early. The various emergent themes were consistent with existing literature and research

findings. In order to discuss the information gathered, the research report will be concluded with an integrative discussion of the data and literature.

Chapter 5

Discussion of Results

Introduction

The exploration of factors that contributed to the early exit of group participants attending a community alcohol and drug outpatient unit will be brought to a close in this chapter. The findings that emerged from the thematic analysis will be discussed within the context of existent literature. In addition, novel themes that arose will serve to enrich the understanding of the experience of those who exited early from treatment in an action group.

Themes

Global Theme 1: Participants

This theme integrated participants' knowledge and experiences of the group process, as well as those experiences and expectations that were external and contextual to the group.

It highlighted the concern by the participants of being known by others in the group, and the difficulty of sharing in a group context. In particular, this experience was shared by participants attending the Red Beach Action Group. Red Beach is a small rural community and the choice of groups is limited resulting in a greater chance of being known by others.

This is supported by Small, Curran, and Booth's (2010) study that focused on what hindered women accessing treatment in rural communities. The results indicated that

living in a rural community can result in social closeness, but it does not always serve as a protective factor for those with alcohol and drug problems. Research further indicated that it may in fact exacerbate difficulty in accessing treatment, and may result in limited economic opportunities, and small social circles. While this study focused only on women, in fact similar factors were identified by both men and women, as will be seen later in this chapter.

Interactions within the group and the perceived support that existed in the group also emerged as important factors to consider. This is supported by Doumas, Blasey, and Thacker (2005), who state that interpersonal problems and interactions that happen between group members play a large role in the process of recovery and those who drop out of treatment early. The study further indicated that those presenting for treatment often have significant levels of anxiety and depression, which make functioning in a group treatment setting difficult.

One participant stated she had found sharing in group particularly difficult due to negative feelings about them self, and did not want to be judged by others. A number of participants mentioned that it had been difficult to share in the group due to feelings of anxiety.

Other participants found the support positive, as discussed by Doumas, Blasey, and Thacker (2005), but found the problem of being known by others a greater issue, as discussed in Small, Curran, and Booth (2010), and stopped attending the group.

The participants' experiences were also impacted by feeling different from the other group members, due to the type of drug used, their age, and stage of change they were in. Yalom and Leszcz (2005) state that while there is compelling evidence showing that the strength of the therapeutic alliance predicts therapy outcome,

problems with alliance such as disagreement of goals are associated with premature termination. There may be problems if the therapist has been unclear about the reasons for placing a client in that group, no clear set goals had been formulated, or if they feel wounded by being placed in a group with significantly dysfunctional members.

Treatment matching to a client's needs is vital if clients are to remain in treatment and meet their treatment goals (Lowinson, Ruiz, Millman, & Langrod, 2005). Motivation plays an important role in the treatment for those with substance abuse, and type of group that is appropriate for a client will largely depend on the phase of change they are in. However, it would appear that those who present to treatment centres are often referred to groups that are focused on actively making change, despite the fact that these clients may be at best contemplative regarding their problem (DiClemente, Bellino, & Neavins, 1999), or in this case one of the participants was in fact in the maintenance phase of the wheel of change. Therefore an accurate assessment is vital before a referral is made.

Action group is a psychoeducational group and is based on cognitive theory which is used to develop skills, and focuses on strategies for coping with craving, fostering motivation to change, and managing thoughts about drugs. Problem solving skills are developed, planning for, and managing high-risk situations are explored (Caroll 1998), While the aim of the action group is to focus on the teaqching of skills to manage contextual issues, the participants did not attend the group long enough for these skills to develop.

Low self efficacy and outcome expectancies (Beck 1993), were both factors in the participants' decision to continue using substances to manage their problems. Self

efficacy refers to one's judgment about one's ability to deal competently with challenging or high risk situations. The participants in this study did not think they would manage the current problems without the use of substances. Outcome expectancies refer to an individual's anticipation about the effects of an addictive substance; participants viewed the use of substance as a way of managing their anxiety, work problems, and other contextual factors. Beck et al. (1993) state that when the alcohol/drug user expects the positive rewards of using to outweigh the negative consequences, use will continue,. While a number of participants stated that they wanted to make changes to their alcohol use, they continued to use alcohol to manage their negative emotions such as stress, grief and lack of support. They stated that the use of alcohol helped them get through difficult times, and it was too hard to make change when they were experiencing a number of problems.

Accommodation, health and work related problems emerged as external and contextual factors that impacted on the early termination of group treatment for a number of the participants. This is supported by Coulsen, Ng, Geertsema, Dodd, & Berk, (2009) who state that "extraneous factors to do with work commitments, illness, social and logistical issues may be the most dominant reasons for missed appointments, rather than service dissatisfaction or lack of motivation" (p. 376).

Participants were asked what they had been told *prior to attendance* of action group, and what their *expectations* from the group were. As previously stated Yalom and Leszcz (2005) identified some of the reasons for early exit from group as disagreement of goals, no understanding of why they were referred to that particular group, and not having clear goals. Each of the participants in this study knew little about the group before they attended, a number believing that it was an abstinence

based group. There was considerable frustration felt by some of the participants when this was not the case. A number of the participants accepted that information and handouts may have been given, but stated they were either not read or the information not retained. Surprisingly, the participants had no real expectations before attending the group, just accepting that the action group is automatically attended after the previous group which is called 'Getting Started'. A number of participants did not appear to know there were other groups being offered at CADS.

Global Theme 2: Group Factors

This theme integrated information on group format and facilitation. Participants had different experiences of the duration and structure of the group, but as previously stated, extraneous factors were reasons given for the missed appointments, rather than service dissatisfaction (Coulsen et al., 2009).

Facilitation also proved to be a key theme in this study; participants commented on the professionalism and support of the facilitators. Participants also discussed the difficulties experienced when the facilitators running the group changed during their attendance of a group or did not control the group well. Wolff and Hayes (2009), state there has been considerable interest regarding the impact that the facilitator has on group outcomes. Their study indicates that variability in outcome has as much or more to do with the qualities of the therapist offering treatment as it does on the specific treatment being offered (Wolff & Hayes, 2009). Despite the overall positive regard of the facilitators, this did not prove enough of a factor to keep the participants attending the group. Accessibility and extraneous problems proved to be a greater factor in the decision not to attend group.

The subject of facilitators sharing from personal experience was raised by one participant. She was particularly interested if the facilitators had experienced similar problems with substances, stating it would make them seem more human. However, according to Wolff and Hayes (2009), existing research has established those therapists who are, and those who are not in recovery tend to yield equivalent outcomes.

Global Theme 3: Accessibility

Issues around accessibility highlighted the difficulties participants encountered when attempting to attend group and the number of groups being offered. These factors included participants' lack of transportation, a poor bus service, the cost of getting to group and the distance from home to group being too far. A number of participants also reported that they found getting to group difficult as they did not have a current license to drive, or they could not drive at night. This theme proved to be a key factor for the early exit from group and was mentioned by all the participants in some form. Accessibility also highlighted the lack of groups offered particularly in the Red Beach area. Time that groups were held was also mentioned by three of the participants.

The previous problems identified by the participants is supported by the Small et al., (2010) study that stated lack of transportation, social stigma and fear of losing the children were listed as reasons that women did not access treatment. This study also indicated that for women who live in rural settings affordability and accessibility were key components; some women identified distance to travel for their appointment and the times available a limiting factor. As previously mentioned while this study was conducted with women only, the factors identified in this study were equally relevant to the male participants.

What does all this mean?

In the planning of this research it was hoped that in identifying the salient themes in the data, insight may be gained of the factors that have contributed to the early exit of participants from action group. While there was a number of factors identified some of these would be difficult to change due to staffing and funding issues. However, there were a number of factors that may be modified by examining the way groups are structured, communication is given, and referrals are made. These changes may result in the enhancing of the group experience for clients, increase attendance, and ultimately improve treatment outcome. This would be an important part of the process as a clear relationship has been shown to exist between a client's adherence to therapy, treatment outcome, and long term stability (Monras & Gual, 2000).

Laudet, Stanwick and Sands (2009), research concluded that clients fell into two levels of problems: individual and program level problems. "Problem-level barriers included dissatisfaction with the program, especially facilitators; unmet social services needs, and lack of flexibility in scheduling. Individual-level barriers to retention included, low problem recognition and substance use" (p. 239–240).

According to Saarnio (2009), contributing factors for early exit from group fall into two categories: those pertaining to the client, and those pertaining to the treatment clinic and the therapist. In this research, the themes could be categorised according to these levels of problems and factors:

Issues pertaining to the treatment clinic and the facilitator:

- Participants were not aware of the different groups available at CADS,, although the information may have been given out at the time of the assessment it had either been forgotten or lost. Clients often present to the service when they are either in crisis or feeling very anxious. Clients are given various types of information at the time of assessment and are given a number of handouts with information to help in the initial stages of change. It is possible that much of this information remains unread.
- A number of the participants lacked information about the action group prior to attendance, or had incorrect information regarding the group. They did not understand the aims and the purpose of the group, e.g. action group is based on harm reduction, and not necessarily abstinence. Action group is designed for clients who wish to make change to their substance use. This resulted in feelings of frustration for some clients.
- Three of the five participants did not feel that action group was the right group for them. One of these participants felt quite frustrated with this, feeling he did not fit in with the other group members. There appeared to be a perception from a number of the participants that action group automatically followed the Getting Started group, when in fact there are a number of groups available. After leaving action group two of the three participants began attending another group at CADS that they felt better met their needs.
- A number of participants identified a lack of services available in rural areas as a major problem. These included both program level problems and contextual problems. Since the beginning of this study the Red Beach group

has been closed, leaving only one group operating, which exacerbates this problem.

There were a number of extraneous problems and contextual issues experienced by the participants that contributed to their decision to stop attending action group.

Issues pertaining to the client:

- Accommodation difficulties were experienced by two of the participants. One due to ongoing problems with their landlord resulting in high levels of stress, and the other as they were living with one of the other group members and found it difficult to be transparent with them in the group.
- Anxiety and stress were experienced by a number of the participants. Some of this stress was due to the group process but a lot was due to contextual issues e.g., work related problems, or pre-existing anxiety issues.
- This study identified accessibility as a major contributing factor to the early exit from group. This problem included participants who no longer had a car license due to court sentencing, poor public transport, and the cost of bus fares.
- The court system mandates that a client attends action group as part of his or her conditions of sentence, however, this may not be the appropriate group that matches the clients' current stage of change.

Possible suggestions based on results

- Improving clients' awareness regarding groups available.
- More information could be given regarding the group process.
- Better awareness by clinicians of contextual issues that may hinder the attendance to group. This may be done at assessment phase.
- Better matching of clients to the appropriate group.
- Awareness of the difficulties experienced for those living in rural areas to access services.
- Improve channels of communication with client at the time of referral to the group. When a client is referred from one group to another, some dialogue about a client's motivation and stage of change would be beneficial. This would help identify the appropriate group for group members. A quick conversation may be useful at the beginning of each group to explain the goals of the group, e.g. that action group has a harm reduction philosophy, and is for those who wish to make change to their substance use.
- The ongoing development of groups that meet the needs of clients.

Reflections and Limitations

There were a number of difficulties experienced while completing this study. There was an attempt on the part of the researcher to access participants from three action groups, two from CADS North and one from CADS West. However, the researcher experienced difficulty accessing suitable participants from the CADS West group due to time constraints. This resulted in only two groups being used in this study. After a number of changes to facilitators in the group at Red Beach, both groups were

ultimately facilitated by the same facilitator from the same CADS unit. This may have skewed the final results pertaining to the comments regarding facilitation.

One of the groups used in this study was temporarily adjourned for six months and the other group closed down altogether. This made accessing participants difficult, resulting in only five participants being interviewed and not the original six that were planned.

This is a limited sample size, and it would be interesting to see if the same themes would be identified with a larger sample. It is important to note that all participants in this study were European; New Zealand is however a multi cultural society and Maori are the tangata whenua (indigenous people of the land). Maori may be less represented in this study as they are offered a separate service at CADS focusing specifically on Maori models of health. More studies are required to see if the factors identified in this study are consistent cross culturally and across CADS units.

Efforts were made to ensure the participants felt comfortable to share their experiences freely by assuring them their confidentiality would be maintained. Participants however were aware of the researcher's role in CADS, being informed through both the handout and before the interview began. This may have had some impact on the freedom participants felt to be completely open and honest regarding their experience attending action group.

Interviews were conducted in a CADS unit of the participant's choice; this may have resulted in some difficulty in sharing openly their experience of action group and with CADS.

A semi-structured interview was used to bring some framework to the study, and efforts were made to capture the participants' unique experience of group. While semi-structured interviewing is described as nondirective, it is important to acknowledge that the researcher drives the interview by both the questions asked and comments made (Willig, 2009). Cheek (2000) however goes further than this when he states "researchers should become more aware of how their own positions and interests are imposed at all stages of the research process, from the questions they ask, to those they ignore, from whom they study, to whom they ignore, from problem formation to analysis, representation and writing" (p. 20). It is therefore important to consider how much of the participants' sharing was in response to the questions asked and the comments ignored. While analyzing the data the researcher became aware of a number of comments made by the participants that the researcher did not clarify, for e.g., where did the participant get the understanding that the action group was an abstinence based group. As follow up contact was not part of the agreement the researcher was unable to contact the participants regarding this information.

Conclusion

In conclusion, while findings in this study yielded results similar to existing literature on group attrition, there appears to have been little study conducted focusing on the rates of attrition in treatment services in the New Zealand context, and the possible reasons for this. Therefore more research is needed to investigate whether there may be factors influencing attrition rates that are particular within the New Zealand culture.

This is important as there is a clear relationship between a client's adherence to therapy, treatment outcome, and long term stability (Monras & Gual, 2000) It remains an important goal for those working with substance abuse/dependence to develop treatments that encourage client's adherence to therapy.

There were a number of extraneous factors that resulted in clients exiting group. These fall outside the domain of CADS. However, there were certain factors where change may be considered to improve the client's experience of group. Improved communication regarding: available groups, group processes, and client matching to the appropriate group, is necessary to ensure that all clients at CADS have the best opportunity to make changes to their substance use.

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Appendix 1

Verbatim

R: Researcher

P: Participant

Participant 1

R: “So just for the purpose of the tape, I’m going to say that you have signed the confidentiality, and that I have explained about the research and that you are feeling okay about that, and that you understand that everything you say will be held confidential and the information won’t be accessed by anybody but myself or my supervisor”.

P: “Yes I do”.

R: “So really what I’m interested in is the experience that you had. I’ve got a series a questions to get a start from, but if there’s any other information that you would like to give me that aren’t covered in those questions, feel free to give that”.

“The first question I’ve got is”:

What was the most important reason why you stopped attending action group”?

P: “Because there were a few people I knew in the group, and one person I actually lived with, a flat mate of mind attends the group. I stopped attending the group mainly because she was there, but if there was another group that I could attend that we could do separately I would have done that. And a few other people in the group I knew, from down at the chemist”.

R: “Is that because it’s quite a small community”?

P: “Yeah, it’s really small”.

R: “Were you told about the groups at Warkworth and at Takapuna, that there are evening groups there”?

P: “I have been told that there are groups there, but I thought there should still be groups in Orewa, like an NA group or something, that’s what I would have ideally liked to go to, an NA group, but I chose this group because it is the only group that they had here”.

R: “NA group being a 12 step programme that’s not run through Waitemata”.

P: “No”.

R: “So basically the main reason you stopped attending was that you knew people there”?

P:” I knew people there, my flat mates attend, I felt like she was there before me. A bit unfair, we’re going there to express how we’re feeling, so if you’re going there with the person you live with there it’s going to be a bit hard to say certain things”.

R: “So you felt quite restricted”?

P: “I did feel quite restricted”.

R: “So if there had been another action group”?

P: “I’d be there”.

R: “Like an evening group, or another kind of group, you could have attended, you would have attended that”.

P:”I did like the way that the group was structured, I did like that the way that the facilitator introduced, I did like the way the group was done. I had no problem with that, it was really cool, had some cool activities”.

R:” Is there anything that the programme or the group could have done differently that would have made it”?

P: “Another group, just another group I think, a consistent facilitator. My flat mates told me that they’ve changed the facilitator; it’s not the same person anymore. I find that a bit disturbing. You gain a kind of bond with the facilitator, a sort of trust in them and if they keep changing everybody. My flat mates thinking of not going anymore either because of that reason, they’ve changed the facilitator. It’s like a whole new process of getting to know that person”.

“Do you like them, don’t you like them. Can you tell them certain things, can you trust them”?

R: “So they’ve stopped going because of that”?

P:” No she hasn’t stopped going, as far as I know she’s still going but she’s had some issues because of that”.

R: “But for you, when you were there, the facilitator was always the same”?

P: “Yes, always the same”.

R: “And you found the facilitation of the group went well”?

P: “Yes, he was really good”.

R: “And you liked the content”?

P: “Yes, I did”.

R: “So basically if you could have gotten another group that you could have attended, or if there’d be nobody attending the group that you knew, you’d still be going”?

P: “Yeah, I would still be going, it’s a really personal and private thing to say how you feel about what you’ve been doing through the week, and having someone you know and live with there, you can’t exactly say, that person did this and ……”

R: “This has been going on, because you can’t because that person is there, its quite restricting”.

P: “Yeah, quite restricting”.

“Are there any other reasons that you may have stopped attending the group other than that”?

P: “It was a bit hard to get to. I’m in Orewa so I couldn’t really walk here. I had to drive, and I don’t have a fulltime car I’ve got use of a car, but not fulltime so sometimes it would be not available on those days, so that was another reason I couldn’t attend”.

R: “So access”?

P: “Yes, access”.

R: “Are there buses do you know”?

P: “I’ve tried but I’ve never got to Red Beach”.

R: “So maybe there isn’t even a bus”?

P: “I’m not even sure to be honest”.

R: “Access is an issue, the fact that there’s only one group is an issue, anything else that you can think of”?

P: “At this moment right now, I’ve gone a bit blank. I know there was one more but I can’t think of it, I think we should move on”.

R: “What were you told about the action group before you went”?

P: “Not a lot. I didn’t know a lot about action groups. It’s about abstinence, the whole goal of the action group is abstinence and I thought that was really cool. That’s what drew me in. When you have the 12 step programmes you don’t have to stop now, you just need to listen and do it in your own time, but this group is about planning it, planning when you’re going to stop and having the support around to do it. And if you fail that’s cool but you’ve got the group to support you”.

R: “The goal was to be abstinent at some point”?

P: “You got the support up to that point and after, and if you re-lapse that’s ok you come back to the group and it’s all right, they understand and they’ll support you and you make a new goal and you aim for that”.

R: “So you felt like the group was understanding”?

P: “Really did, felt like we were all common.

R: So that was a good thing about the group”?

P: “Yes, I thought the group was really cool, I did like the group”.

R: “Access, the number of groups, planning & action, anything else talked about the group, anything that you were prepared for”?

P: “Not really, I didn’t attend that many times, maybe 4 times all up – 4 weeks. It was quite long, 1 hr 40 minutes, it was quite a long time, I would have preferred something under an hour is good. I felt it was draining, there were some days I would come home and be really energized I’d had a really good group, and other times when I’ve had a bad one and you’re sitting there for 1 ½ hrs through it drags the life out of you”.

R: “What do you think was the difference between a good group and a bad group”?

P: “A good group and a bad group, it had a lot more to do about what I was sharing. Everyone was positive, everyone was on track, was on to there goals. Not everyone was oh f*** I had a drink last night, I had a drink last week, everyone’s failing and it’s all turned to shit. But then the next week it could change and everyone could have been sober for the whole week, then that would be a good week and we’d get really excited and think yeah we can do this”.

R: “So even if you hadn’t had such a good week, there was a lot of support there which was good, but if you’d had a good week there were a lot of people to celebrate with you and that was really good too”?

P: “It sounds like you really enjoyed the personalities of the group too?

R: “I didn’t get to know too much of the personalities in the group, I wasn’t there long enough. But I did get to know the facilitator of the group. When I came to the group I was detoxing off methadone. I’d come off at about 30 mgs and I lasted about 10 days and it was 10 days of hell. I came to the group and that’s where I met the facilitator and I was really sick, and they were really kind to me and really understanding and that made me think this is cool, that’s what made me come back. Then obviously after 10 days I couldn’t handle it any more and thought I’m going to get back on the methadone. I went to Takapuna and the facilitator was there, he was sitting in on the process of how the whole methadone thing works and he told me he was going to become a methadone worker, so I thought what’s going to happen to the group, they’re obviously going to get someone else in. I probably went for 4 weeks after that, then I stopped, I got back on the methadone and my life started getting to get back together. When you start feeling better you start wanting to do other things”.

R: “So is that another thing that doing other things, you got quite busy”?

P: “I’ve found myself really busy lately, doing nothing, I’m not exactly achieving much but I’m so busy all the time, its awful, it’s awful. I don’t have time for my friends. I’m running around doing nothing”.

R: “So is that part of the reason you’re not attending? Or no, not really”?

P: “It is a bit of the reason, my flatmates still encouraging me to come to the groups. But I know that now I’m not there she’s getting so much more out of it. As I told you, I said I might still go, my flatmates saying come back to group, but I noticed she’s been coming back so much better since I haven’t been there. I know it’s got nothing to do with me, but me not being there might be that little bit of extra time away for her, because we do live together”.

R: “One of the reasons you’re still not going or might not go back, is once again your flatmate? That sounds like it’s been quite a catalyst”?

P: “It has, if there was another group to attend I would be attending that and I’d probably be more consistent with it because it would be my time away to share or whatever without anyone’s ears that I know in there”.

R: “If things changed and your flatmate stopped going or completed, would you think about going back”?

P: “Yes I would, transport would be an issue though”.

R: “So that stays an issue”?

P: “Yes that stays an issue”.

R: “What were your expectations about the group”?

P: “I didn’t have any expectations what so ever, I expected it to be shit to be honest. I expected it be a whole group of wasters, drop kicks, bleeding there heartfelt stories out, but it wasn’t it was actually really cool, everyone was really cool people, I should learn not to judge next time because they turned out to be cool people. Funny stories, some of them had outrageously funny stories it was kind of nice just to listen to other people and know that other people are going through the same things, its not just you. You’re not poisoned”.

R: “So you expected it to be rubbish”?

P: “Yeah, I’ve been to some meetings out west and stuff and everyone was so depressed,

no motivation no one wants to put in, but everyone seemed to want to put in. We all played the games with the owl, role play games, that was really cool".

R: "Your expectation was that people were going to sit around and complain"?

P: "I thought it was like you had to go to this meeting. I thought it would be like probation where they make you go to certain meetings".

R: "So what made you go"?

P: "I was so sick, I was coming off methadone and I was drinking really heavily at the time and my flatmate just dragged me along and I agreed to go, I didn't actually know, I was just beside myself and my flatmate said I might get something out of it and I did".

"That was the decision I made to go back on methadone, I realized its ok to go back on methadone. It was like it was ok to go back on meth. I talked to everyone about it. I've had a lot of shit in the past. My partner left me because I didn't get off the methadone, I've lost friends because I've been on methadone. People judge you and I found that when I was there people didn't judge. I made the decision that I would go back on methadone at a really low dose and that I would come off really slowly, instead of jumping off at 30 and going down to 1 and try that again. In the beginning I was going to tough it out, I thought there's no way I could go back on methadone, I didn't think I was worthy of anything, I thought I was a piece of crap. That first day I went back to the group it seemed having that talk and everyone around me listening to how I felt gave me the strength to make the decision, which in the end saved my relationship for another 2 months but that still fell through, and that's part of the reason I had to come back here. I had to ask myself was I doing it for myself or my partner".

R: "The group supported you in making a critical decision at that moment"?

P: "Yes they really did".

R: "Well it helped you anyway".

"Is there anything else that you feel like you'd like to say about the group or the way the organization is run"?

P: "Not really, more input from the people in the group as to what activities you do, we'd have arguments, we didn't want to do this activity we wanted to do that activity. That was a bit of an issue".

“I feel like I’m nit-picking, I didn’t think there was anything wrong with the group”.

R: “I’m just asking your opinion, its not nit-picky, its not negative, it’s an opportunity for you to have an input and say what worked for you and what might have worked better and what didn’t work for you. I’ve heard what worked for you and what didn’t work for you, but I’m just wondering what might have made it a better experience for you”.

P: “If I kept going I think it definitely had more to offer me”.

R: “So there’s no more information that you think would be useful”?

“What would you have liked to have known about the group that you didn’t know”?

P: “That it wasn’t a 12 step group. I thought it was a 12 step program when I first started”.

R: “Did you get given a pamphlet”?

P: “No, I just turned up one day. I didn’t actually sign up, my flatmate just brought me along one day. I was thrown into it”.

R: “So in actual fact people didn’t actually have an opportunity to tell you much about the group”?

P: “No but they all had to vote when I was there, if they wanted me to be in the group. Which I found awful, I was really nervous, I didn’t like that very much”.

R: “Do you know why they would have done that”?

P: “Because at first you have to ring up and tell them that you want to come to the group, then they’ll bring you in, but first of all they’ll tell the group look group we’re going to have a new person, this is a bit about the person, do you want them, is that ok with everybody, but

instead I was there on the day and they had to vote if I was to stay in the group or not, and of course they all voted yes".

R:"Do you think that was a good process"?

P: "No way, what if they'd said no, I would have felt awful. How bad I was feeling that day and if I'd gone home after they'd said no we don't want him in the group and I left feeling like that it would have made my day so much worse".

R: "So it was a difficult situation because you just turned up"?

P: "Yes it was a difficult situation".

R: "I think that is just about all. I want to thank you because it's been really helpful. It is about identifying themes, it's not good or bad, right or wrong we're just looking for common themes".

Participant 2

R: “So just for the purpose of the tape, I’m going to say that you have signed the confidentiality, and that I have explained about search and that you are feeling okay about that, and that you understand that everything you say will be held confidential and the information won’t be accessed by anybody but myself or my supervisor”.

P: “Yes I do”.

R: “it is really informal; I have a couple of questions. You can answer anything you want. There is no expectation on this interview pushing you back into group. All we want to do is find out why some people don’t come back and if there is anything as an organization that we can do to make this a better experience for you. I’ve got a series of questions to get a start from, but if there’s any other information that you would like to give me that aren’t covered in those questions, feel free to give that”.

“The first question I’ve got is”:

“What was the most important reason why you stopped attending action group”?

P: “Nothing to do with the group, it was transportation. I was on home detention so I could only leave when they told me to. I had a set amount of time to get here and a set amount of time to get back. I was on home detention for driving charges so I’ve lost my license and I’m not allowed to drive. Being on the benefit as well, even though a bus fare doesn’t sound like much when you’ve got so many bills it’s another bill I can’t afford”.

“The other reason was I was in a group with a lot of older people. They were well older than me. My understanding of an action group was someone who’s given up drugs and alcohol and was trying to stay sober so they didn’t relapse, but sitting there talking to them, most of them had relapsed the week before, they hadn’t given up, they were all sad at themselves because they had a drink a few days before and all that”.

R: “What was that like for you sitting in with a group of people who have just lapsed”?

P: “I understand it’s hard and all that but to be in an action group you should at least be sober for so long. They should have been in a group where they’re still classed as drinking every day”.

R: “What was your understanding, what were you told initially about action group”?

P: “When I first came here I told them my main problem was both alcohol and drugs but I’ve been off it for over a year now. I was told that the group was in the same place, off it for a while too”.

R: “You were told that the action group was people like you who had stopped for a while and weren’t using any more”?

P: “Yeah, pretty much but to my understanding none of them were”.

R: “So what you thought you were coming to turned out to be quite different”.

P: “Yeah, but the main thing was transportation really and that everyone turned out to be a lot older than me it seemed maybe that they knew more than I knew, well that was there understanding but it didn’t work out like that”.

R: One of the biggest issues was transport and the next issue was around understanding what the group was about and the reality for you was quite different and you were told before you went to action group that’s what you were going to find there”?

P: “Yeah, pretty much”.

R: “Is there anything that the program could have done differently that would have helped you decide to keep coming”?

P: “I don’t know if I can answer that question. No not really, as I said the main thing was transportation”.

R: “Did the courts know that you were having that much trouble with transport”?

P: “No, they don’t even know that I missed that many days either, so that might turn around and bite me in the bum yet”.

R: “You were told by the court that you needed to attend”?

P: “Yeah, it was part of my sentencing conditions. But then I got told that even though it was an 8 week program that if you missed a couple it was ok. That wasn’t told by the teacher, that was told by other people I’m not to sure how that will work out. Nothing has been said by my probation officer but I completed everything else and they pretty much know because it was historic charges to, they were driving charges from over 18 months ago and they’ve only just got dealt with through the courts”.

R: “That might still be an outstanding issue”?

P: “It could be, but it shouldn’t be because I’ve completed my other sentences and all that”.

R: “Other than the fact that you expected people not to be drinking, what else did you hope to get from the group”?

P: “I didn’t actually expect too much from it, at the end of the day it’s all up to yourself. Nothing really, honestly the only reason I was there because I had to be. If I didn’t have to be there, more than likely I wouldn’t have been there”.

R: “It was the fact that you were sent”?

P: “Yeah it was more that I was sent there, I wasn’t there on my own accord. At the end of the day it’s all up to yourself. They can tell you whatever but you only want to change if you want to change”.

R: “What you are saying is that you are well through the action stage, you have given up now for over a year, that’s more of maintenance phase isn’t it”?

P: “Yeah, the only reason it’s like that it was more of a lifestyle, as soon as I got away from that lifestyle, different people I hung out with now, everything changed”.

R: “We call that the play mates and play ground; you change those and your lifestyle changes”.

P: “Yeah, that’s what I did, even changing the partner because of the drug problem, so that all helped”.

R: “It sounds like you’ve done an awful lot of work outside of the group anyway”?

P: “Well yeah, I had to”.

R: “Thinking about the transport thing, if you were thinking about which was the bigger issue, the transport or the group not being what you expected, which would be your number one reason”?

P: “Transport”.

R: “I’m thinking about probation and them setting you up with a group that you need to go to and not necessarily giving you the wherewith all to get there”?

P: “Yeah well most people who are sentenced to it, 9 times out of 10 they’ve got a drinking problem so more than likely they’ve lost their license, that’s why they’re here so they’re pretty stuffed in a way of getting here because 9 times out of 10 they’re also unemployed”.

R: “Would have it made a difference if the group had been at night versus in the day”?

P: “Yeah it would have been for me because my partner could of bought me then because she works during the day and if it was at night after she’d finished work I could have got here no sweat. And there probably was a night time one”?

R: “Yes, there’s a night time one in Takapuna”.

P: “Yeah, but that’s a long way away too”.

R: “So part of it is the location, it is quite out of the way, outside of Auckland”?

P: “If I did have the night time one that’s pretty much $20 in gas to get down and back”.

R: “It’s a lot to expect someone to drive you down and wait around for a couple of hours”?

P: “Yeah, especially if she’s been working all day, the last thing they want to do is sit around and wait for me”.

R: “Apart from transport and that it wasn’t really what you were expecting, another issue is the timing of the group”?

P: “Yeah, the timing”.

R: “It’s good for us to know, some things the organization can do something about and some things unfortunately because of where you live out here it makes things a little more difficult”.

“Is there anything else you’d like to tell me about the group, or anything else you’d like me to know or the organization to know”?

P: “No not really, it was ok really, but as I said at the end of the day it’s all up to yourself if you want to change”.

R: “What about the facilitator, how did you find them”?

P: “Yeah they were cool, the first one but I only saw him for 2 weeks and then he left and a new guy came. The teachers were good”.

R: “Did you find it difficult having one leave and a new facilitator come”?

P: “No not really, I was sort of new to it anyway, maybe if I was on for awhile it would have been”.

R: “How many groups did you actually attend, do you remember”?

P: “About 5”.

R: “At the end of the day the parol officer said you need to do it then you’ve only got 3 left to complete”?

P: “I was thinking of trying to finish it anyway, but it’s all a time thing and transportation”.

R: “Do you live near a bus stop”?

P: “Yeah, but as I said it’s only a bus fare but when you’re on the benefit and a baby due soon, I’ve got power bills, rent bills, food bills, it all adds up even though it might be $6 or $7 for here and back to there but it’s $6 - $7 that I need”.

R: “Is it $6 - $7.00 both ways”?

P: “Here and back is about that, it would be different it I worked but being on the benefit doesn’t help”.

R: “If you worked it would be difficult for you to come to a day group anyway”?

P: “Yeah, exactly so there’s no winning”.

R: “Part of that is living up here unfortunately, but I see your dilemma”.

P: “No way would I live back on the Shore, I grew up on the Shore”.

R: “So it’s safer for you up here”?

P: “In the way of re-offending, drinking, carrying on, yeah”.

R: “Expectations were around people not drinking, people have the same goals as you. Did you expect particular subjects to be talked about”?

P: “That was just an alcohol one, they didn’t touch on the drugs too much, well they sort of did, but my problem was both drugs and alcohol, but I don’t think I stated that enough that drugs was a factor in my life mainly because of probation but it was pretty much alcohol, alcohol, alcohol”.

R: “You felt like there was a very strong emphasis on alcohol and not such a strong emphasis on drugs”?

P: “Yeah, because I had a meth problem, and meth is a lot worse than anything else I reckon, even though alcohol is very bad, alcohol was the worse but in the last few years mainly the meth, how to get the money. All that went with that”.

R: “So what would have you liked to see in the group that would have felt like you had that catered for”?

P: “Out of all of us in the group, I was the only one who had the meth problem, so it wasn’t talked about or anything, so maybe more on that. Maybe if they mixed the class up a bit, not just all alcoholics and one meth user”.

R: “Do you think that’s a part of why you felt you were different as well”?

P: “Yeah definitely, because when it all came up to do with meth the whole class focused on me as well. They all wanted to know this and that”.

R: “What was that like for you”?

P: “It was ok sort of, it was good, they wanted to know something from me”.

R: “So you had a bit of a feeling of having the expertise”?

P: “Yeah, exactly”.

R: “That was good”?

P: “Yeah”.

R: “So the facilitators were happy to draw on the knowledge of the group”?

P: “The teacher would ask me the question, if it came to meth, that was sort of cool”.

R: “That was one good thing about the group, you had a sense of having some knowledge that was useful”?

P: “It was good really, they were telling me what I knew anyway, everyone knows right from wrong”.

R: “Are there any skills that you learnt there that you took out of it and been using”?

P: “No not really, I’ve done a lot of courses, in prison you do a lot of drug and alcohol classes like straight thinking, stuff like that, I already knew what to do to stop me from drinking. I’ve been off drinking and drugs for quite a while, longer that what is on there, but when these charges came about I had a stressful time and relapsed, ex-partner and everything that is going on”.

R: “It sounds like you have done really well and continuing to do really well. Congratulations on your upcoming baby, when is the baby due”?

P: “January 22nd, went for the scans today and saw the little heartbeat, hands and foot, bouncing around”.

Participant 3

R: “I need to confirm that you have had the confidentiality explained to you, that you have signed the consent form and you’ve agreed to be a part of the research”?

“We are trying to find common themes about why people might stop attending action group, and if there are common themes is there something as an agency that we can do to make it a better experience. As an agency if we tweak this it might be a different experience for people”.

“You attended action group and then you stopped attending. What was the most important reason that you stopped attending action group”?

P: “The group was really big, really large and I get tired in the evenings and 5:30 in the evening is the time of day when you’re starting to unwind and also it was such a big group, when I first started coming everyone had to say there name and we didn’t get to the nitty gritty. *name deleted* decided everyone go around the circle and say there name, very time consuming and I was the only one in the group who had a narcotic problem out of everyone”.

R: “So you felt a little bit different”?

P: “Yeah”.

R: “You attended a day group as well”?

P: “Yes, I did, that wasn’t as well structured. I liked to go to ‘managing mood’ I get a lot out of it and know its worth my time, I suffer from chronic fatigue and with the anxiety problems and depression problems it’s quite a way to come from Torbay”.

R: “So you felt like the action group, the day that you started going wasn’t as well structured and you think the managing mood is better focused to your needs”?

P: “Very good, it covers a lot, I get in there, the action group is too big and the one during the day wasn’t as structure.

R: “So size is an issue to you, the size of the group because of being a little anxious and structure is important to you”?

P: “I used to pick up on everyone’s energy and I was getting anxious”.

R: “Is that because there were so many people in the room”?

P: “So many people I felt overwhelmed”.

R: “So the day group was not as many people, but not as structured”?

P: “Yeah, I felt more comfortable in the day group but it was a long way to come, it’s a double edged sword, the night group was more structured and I got something from it, but the first 45 minutes was saying people’s names, the second ones we did get into things but I didn’t feel like I was going to get as much out of it as the night one the second half”.

R: “The managing mood sounds like it fulfils both that criteria for you”?

P: “Yeah, it was really good”.

R: “So although the action group hasn’t worked, the service has provided a group that does fit for you”?

P: “The action group was really quite good, when my friend went, I met a friend through action group she would tell me about things you people went over and I thought that was really good. I think too, I’ve been a bit fluey and tired”.

R: “So tiredness and winter is a bit of an issue as wel”?

P: “Yeah, I didn’t want to go out”.

R: “So you’re coming regularly to managing mood and that is filling the need for you”?

P: “Yeah”.

R: “Is there anything that the action group could have done differently that would have helped you continue attending”?

P: “The size - not so big, also getting around our names and substance quicker”.

R: “What about during the day”?

P: “We didn’t do that, maybe we did but it wasn’t so big”.

R: “So was there anything that program could have done”?

P:” It seemed like it was more a getting started group, the stuff during the day was a lot of what was said by the counsellor was a lot of what the getting started group was, the evening at the end was good though, that anxiety that I felt beforehand became overwhelming for me”.

R: “When the focus came off the people and onto the learning you were able to relax a little more, is that what you were saying. You didn’t get that in the day group because it wasn’t so big but you didn’t feel like you got as much learning out of it. If we could have combined a smaller group with the structure and the learning you would have found that better”.

P: “Yes, definitely”.

R: “If you had found a group like that you would have continued attending the action group, or you still think managing mood is better for you”.

P: “I still think managing mood”.

R: “What were you told about action group before you started attending, did you do the getting started group first”?

P: “Yes I did, after doing getting started you do the action group so it was like the next group you went to. Also, I thought I had a really bad drinking problem but I’ve got on top of that and I hadn’t been taking my benzo so I felt like too I was ready for the maintenance and I think one of the facilitators said you need the maintenance, it hadn’t been an issue for 6 months, I felt like too that was a reason I didn’t need to come”.

R: “So one of the facilitators told you, you don’t need to come”?

P: “No they just said that was more maintenance”.

R: “So you felt like you got a get out of action group card”?

P: “Yeah”.

R: “So what were you told about action group? Were you told anything”?

P: “I don’t remember that I was told a lot, after getting started you do action group, so I thought I’d be doing 2 at once. I thought I could handle doing 2 at once, but I realise it takes a lot out of me, its a lot of mental and emotional stuff that I have to face”.

R: “So that’s another key theme for you”?

P: “One group seems to be enough”.

R: “2 groups is too much”?

P: “Yeah, I lost my dear little girl cat, that only happened two months ago and then I got a new cat, a lot has happened this year, I’ve had problems where I’m living, I’ve only got enough energy to go to one group”.

R: “Initially you thought 2 groups would be ok, whereas one group is enough and you chose managing moods as its servicing your needs better”?

P: “Yeah”.

R: “Having not been told that much about action group before you went, did you have any expectations”?

P: “Well I knew I’d have to stick off my substances, I already had anyway”.

R: “So there was an expectation that you had to be off”?

P: “I know that I can’t go an do anything silly anymore, that’s ok because that is a personal choice I’ve come to anyway, but if you go to action group and you do slip that’s a naughty naughty”.

R: “Is it”?

P: “A little bit I’ve got to be on the straight and narrow which is a good thing”.

R: “So your understanding of action group is that it’s an abstinence based group”?

P: “A little bit yeah”.

R: “So that was one of your expectations that you thought is was an abstinence based group and if you slipped from your goals you got a bit of a slap on the hand”?

P: “Yeah, it was a little more pressure for me for myself”.

R: “Was that a difficult pressure to hold”?

P: “Well I certainly wanted to smoke a joint when I lost my cat”.

R: “Did the fact that you were part of the group help you not slip”?

P: “Another positive part of the action group was that there seemed to be a lot of sadness in the room, a lot of people I could see struggling. I thought I don’t want to keep going down this street; other substances can be a problem for people like meth and marijuana. Also too, I’ve got that addiction trigger in my head and more with the getting started group I found myself inquisitive about the drug P”.

R: “Because you had other people talking about it”?

P: “Yeah, because I’m an experimental person, I’ve taken other stuff like e, but now I realise how bad it is and I won’t go down that track, but the addiction side of me, I think I was still vulnerable”.

R: “Other than the expectation that it was an abstinence based group, did you have any other expectations of attending action group or what the group was about”?

P: “No, I did notice though that the evening facilitators were very supportive compared to the day one, both of the facilitators, especially you, I’m not just saying this to make you feel better, but they seem to be a lot more supportive and they take interest, and that is one think I did like about it, and I think that is important for someone going through this and I didn’t get that during the day one”.

R: “And you’re getting that through managing mood”?

P: “Yes I am but we are dealing more with scenarios which is good because it’s making me, even though things are hard I’m getting to the crutch, the support of other people in that group is quite good to”.

R: “Is there anything else that you would like to give about your experience at action group that I haven’t asked about or haven’t covered”?

P: “I do get nervous when it comes around to saying my name, but I’m getting better at that”.

R: “So anxiety is quite an issue for you around going to group”?

P: “Yeah, well there’s a lot of people in the room”.

R:” My wondering is how many people experience that anxiety around going to group”?

P: “Yeah, I did notice know that both *name deleted* and *name deleted* were a lot more supportive than the day time group and they seem to be more interested in what we were doing, you couldn’t put anything past them, they saw straight through me like how many vodkas exactly is that, I noticed the skills that both of them have, they got around me”.

R: “So no other information that you want to give”?

P: “If it wasn’t so big, whipped around the names and substances quicker, didn’t make it so easy for people to come in when they wanted to and got down to the nitty gritty faster”?

R: “Can we go back to ‘make it so easy for people to come in when they want to”’?

P: “Just that who wants to go next with saying there name and substance, it should just go round the circle”.

R: “Anything else”?

P: “Get to the nitty gritty quicker, lovely to have a snack if you’re a bit low on blood sugar at that time of night, that’s an excellent thing”.

R: “In summary attending the night was hard because it was at night, a big group and you felt that because it was so big it didn’t get to the nitty gritty quick enough. The day group for you wasn’t meeting the need because it wasn’t structured enough, then when you started attending 2 groups because you thought it would be ok you found that it was really tiring and

a sap on your energy and your emotional energy and you made a choice around which was going to meet your needs more and clearly managing moods is doing that. Do you feel like you could return to the action group if you wanted to? Do you feel like that's a place that is still open"?

P: "I think I need to be in a better place, I need to move out of where I'm living. To be in more of a settled place in my head and then I think I would have the energy for that, but other things have just zapped it, like the death of my cat, but it's just the size of the group that really got to me".

Participant 4

R: “So just for the purpose of the tape, I’m going to say that you have signed the confidentiality, and that I have explained about search and that you are feeling okay about that, and that you understand that everything you say will be held confidential and the information won’t be accessed by anybody but myself or my supervisor”.

P: “Yes”.

R: “It is really informal, I have a couple of questions. You can answer anything you want. There is no expectation on this interview pushing you back into group. All we want to do is find out why some people don’t come back and if there is anything as an organization that we can do to make this a better experience for you. I’ve got a series of questions to get a start from, but if there’s any other information that you would like to give me that aren’t covered in those questions, feel free to give that”.

“The first question I’ve got is”:

“What was the most important reason why you stopped attending action group”?

P: “Because I went through an employment issue which I was immersed in for about 3 months and probably I was so immersed in it I fell off the wagon a few times during it. I took my ex-employers on a personal grievance and it just about destroyed me emotionally. During the process all I would do would be basically go home, go to the gym or go to a friend’s house and bleet and have a drink. It consumed my life; I felt like the nights that I was drinking that I would have been a hypocrite if I had gone”.

R: “What I hear you saying is that for you there was a conscious choice to focus on your employment, and part of managing that was drinking at that time”?

P: “Not heavily drinking, but a few times I would binge drink. I lost so much confidence I would do everything that was familiar to me. I didn’t even go to the gym, I was like a robot”.

R: “So your confidence got so knocked that you didn’t even want to come out and do anything challenging? It sounds like at the time it was quite a conscious decision to not attend group knowing at that moment you weren’t being able to do what you wanted to do? You didn’t want to be a hypocrite”.

“Were there any other contributing factors to you not attending”?

P: “I found it hard to talk in a group of strangers. I felt bad about myself anyway because of my ex-bosses were doing to me. I felt so bad about myself, I couldn’t talk”.

R: “So the idea of sharing in the group was scary, one step too far. Do you normally find talking in a group a problem for you”?

P: “I don’t really like public speaking, but I’m in advertising and media so I do a lot of presentations in my day to day work. I was in auto pilot mode”.

“Even to the point that when it was all done and dusted and I got a new job and I started going back to the gym, I didn’t go to the Zumba class because the instructor would say you’re not doing that right, I couldn’t handle it. I couldn’t handle any public criticism”.

R: “Before what happened with work, would have you been able to go to group”?

P: “Yeah”.

R: “What I hear you say is presentation at work was hard but it wasn’t personal, where as coming in to group was personal”?

“Were there any other contributing factors that you can think of”?

P: “Time, I don’t know, no”.

R: “Is there anything the program could have done differently that you would have continued to attend”?

P: “I went to one action group and she didn’t control it very well, and there was one lady who I think she was drunk and abusive, I think she was a *name deleted*, I thought what am I here for, maybe that was getting started, I thought this is ridiculous, she’s not a very good facilitator”.

R: “That was getting started not action group”?

P: “Facilitation of the group is quite important, you need someone who has a bit of presence.

The guy who’s a bigger guy, he’s really good”.

R: “Did you get that at action group”?

P: “I went to one and then it all started happening and I gave up. The lady with the dark hair, *name deleted,* I went to one action group and then I stopped. They were all pretty good”.

R: “So is there anything that they could have done that would have helped you continue attending”?

P: “I think an 1 ½, a bit long”.

R: “What would an ideal time length be”?

P: “1 hour”.

R: “So if it had been an hour and controlled differently you would have kept on going”?

P: “Possibly, but not likely at that time I couldn’t have taken the risk of being pulled out and having someone talk to me”.

R: “So what I hear you saying is that you were very vulnerable at that time, I really can understand that. You needed to protect yourself. It can take everything to keep going”.

P: “It was psychological warfare what they did, I didn’t want to get my lawyer in but I did”.

R: “In the end that’s how it came, there’s a long process to get there”.

P: “You know they’re gunning for you, you have to be monitoring everything they’re doing and write it all down”.

R: “What were you if anything told about action group before you started? Did you have expectations”?

P: “Not a lot, action group was the next group up from getting started. To be honest I’m in the solution group. I don’t even know what that was meant for”.

“All I know is action group is one group up from getting started”.

R: “Did you have any expectations when you went then”?

P: “Sharing, being honest with yourself”.

R: “So you had no sense of let down, as you weren’t told a lot, basically after getting started you went into action group”?

P: “If anything with the cad programs I’d like to know what sort of people, what they do in solution focused and action groups and what is the purpose of each group”.

R: “You weren’t given any of the pamphlets”?

P: “Yes, I probably was but I’ve shifted a couple of times in the last 6 months”.

R: “On the wall is pamphlets which tell you what all the groups do”.

“Would it have been useful at getting started to be told what the other groups are doing. Would have it been helpful to know”?

P: “Yeah, to have the facilitators say this is action group, here’s what we do, this is our purpose, a lot of people come to cut down completely, and solution based is this……. Da, da ,da”.

: “At some point at the end of each session that could be explained”.

R: “I’ll take that on board, I think it’s important you have some idea what you’re walking into”.

“Is there anything else you’d like to say about the group , the facilitator, any other thoughts that you might have about action group”?

P:” I guess being a bit more sort of, no I think its fine. I think you do everything right except for the prefacing of what it’s all about”.

R:” It is a really good point that is something that certainly I will put in as a recommendation that’s come in”.

“Is there anything else you’d like to say before we finish the interview”?

P: “I think they’re all great people, I have a lot of admiration for you guys and what you do. I think it’s a great service. I want to keep coming”.

R: “So you’re enjoying solution focus”?

P: “Yeah I am, So that’s a step down”.

R: “Step down in what way”?

P: “Is that before you get to action group”?

R: “I wouldn’t call it a step down, I would call it a sideways step”.

P: “It would be really good, obviously we look up to the facilitators, the likes of *name deleted* who have given me some one on one session. It would be nice to have some more one on one session. You know you have to eyeball someone for an hour”.

“It would be good if the facilitators could share some more of their experience. If they were a heavy drinker or an alcoholic, they could say I might be standing up here now but this was where I was 5 or 10 years ago, it would make them seem like they’re human too. I don’t know if that breaches privacy issues”.

R: “Do you feel like facilitators don’t really understand”?

P: “A little bit, not that they’re arrogant or proud, you do get a sense of I’m here, I’ve made it but to know that background of facilitators would be helpful. Like if you’re really fat and looking at someone who was 20 stone 10 years ago, they could say this was me then but here I am now, you can do it too”.

R: “Do you think that goes on in action group because there are people who have already made the changes and they’re already a bit further on than you”?

P: “Yeah, I think they’re pretty open”.

R: “Do you think that openness inspires people who are new to the group”?

P: “Yeah I do”.

Participant 5

R: “So just for the purpose of the tape, I’m going to say that you have signed the confidentiality, and that I have explained about search and that you are feeling okay about that, and that you understand that everything you say will be held confidential and the information won’t be accessed by anybody but myself or my supervisor”.

P: “Yes”.

R: “It is really informal; I have a couple of questions. You can answer anything you want. All we want to do is find out why some people don’t come back and if there is anything as an organization that we can do to make this a better experience for you. I’ve got a series questions to get a start from, but if there’s any other information that you would like to give me that aren’t covered in those questions, feel free to give that”.

“The first question I’ve got is”:

“What was the most important reason why you stopped attending action group”?

P: “It was mainly too do with getting there, sticking it out really”.

R: “Transport? When you say getting there what do you mean”?

P: “Yeah, transport, physically and emotionally, I don’t drive at night at the moment, and that’s only been a recent thing and it was around about the time that I was going to CADS LT action group that I couldn’t drive at night on my own so I went a couple of times with family members and when it wasn’t available I didn’t go”.

R:” Red Beach Group was during the day though”?

P: “That was during the day and I went to that, then they said they didn’t have enough people and they were going to form in Takapuna”.

R: “So the reason you stopped going to Red Beach was because they closed it down”?

P: “Yes, I wanted to carry it on, by that time I realized it could help me. I did try to organize car pooling there were a few local people that transport was a problem and I had a car. I wanted company and I thought also monetary wise it would help others, but no one took me up on it so I didn’t go”.

R: “So driving from Red Beach to Takapuna wasn’t an option”?

P: “On my own, no”.

R: “Any other reasons that you stopped”?

P: “No”

R: “So you basically stopped because they closed it, and there wasn’t another option at Red Beach for you”?

P: “There is AA but I wasn’t considering AA at the time”.

R: “If there had been another group at Red Beach would you have looked at attending that”?

P: “Yes”

R: “Is there anything the program could have done differently? I suppose that answers the question really, if they had a group at Red Beach you would have attended it, or a big enough group to come down to Takapuna, you would have come down to Takapuna”?

P: “Yeah, I would of”.

R: “So, what were you told about the action group before you started attending”?

P: “I was a little bit out of the loop mentally at the time too; my memory is not very good at the moment because of my drinking. It was all new to me, if I did get information I wasn’t

using it, I wasn't retaining it and I wasn't reading everything properly. I was going with the flow, if I could get there I would sit there and answer questions if I was asked, I was on auto pilot.

R: "So, you don't remember being given a pamphlet or anyone telling you what to expect"?

P: "I was given pamphlets but if I read it, I didn't retain".

R: "So you arrived at action group not really knowing what to expect"?

P: "Yeah, just winging it".

R: "Had anyone else talked to you about action group"?

P: "I think they did when I was at CADS, it was discussed, but because it was so new I was just feeling by touch really".

R: "As you said where you were emotionally and mentally at that stage, you were on auto pilot".

P: "Nothing was going in really".

R: "Nothing at all"?

P: "Oh, little bits, I knew there was something there, it was a straw to grasp but that was about it really. Then I obviously carried on with other areas".

R: "And so if you had been told anything you didn't really remember. Did you have any expectations"?

P: “Just fear really, fear of the unknown and although the people seemed very professional and lovely, and informative it was just the fear of being in a group situation, would I know anybody”?

R: “So you were quite anxious before you went”?

P:” Yes, very”

R: “So when you say the people were professional is that the facilitators”?

P: “Yeah”

R: “What was your experience like at the group”?

P: “I felt, I’m not being egotistical, everyone was so different, but there were quite a few in some of the groups that had to be there, I was there by choice. Because of a time limit and you go round and people talk, there were younger people there, particularly young men who didn’t want to be there and they talked a lot, negatively. For me that was a bit of a time waster, I would just sit there and say nothing and thought well it’s nearly time to go home and nothing had been achieved for me. I think I work better one on one”.

R: “So that was another consideration for you as to why you didn’t go back because you work better one on one”?

P: “I work better that way, but one on one is not free”.

R: “Part of the issue with you is the group was mixed with people who were voluntary also with those who were being mandated”?

P: “They really didn’t want to be there, they were wasting the facilitator’s time. For me sitting in that large group I just wanted to get on and get some info, get something to sink my teeth into and I’m not talking about a certificate”.

R: “So for you it wasn’t about just finishing the eight weeks”?

P: “No, I just needing some answers, someone to talk to.”

R:” Is there anything else you would like to tell me or anything else you think would be useful for us to know about action group or about your time there”?

P: “Honestly, they were very professional the people who were running it, approachable which is really important to me, non-judgemental, they listened to everyone I felt like no one felt they were being treated differently to anyone else”.

“It was really from my own personal point of view, I possibly wasn’t ready for it. I didn’t have enough back up behind me. I didn’t tell anybody I was going, only my daughter. I do it on my own and don’t ask for help until you finally have to ask for help from where ever you can get it”.

R: “So eventually when the Red Beach action group closed down that’s when you looked for help outside of that”?

P: “The ball had started rolling, the Dr was on to me, and the counsellor was pushing me, not pushing me but pushing for me. So I had more people, the ball had started rolling; people were ringing me up to see if I was coming”.

R: “So you were followed up”?

P: “I was followed up, from Red Beach *name deleted*, lovely man, he wrote to me, he said that they were going to Takapuna and invited me to come. I hadn’t heard back from anyone else in the group that they wanted a lift. I had vocally told him that I would ask around and I would come if I could find people who would carpool”.

R: “So it feels like a long way from Red Beach to Takapuna”?

P: “Yes, at the time. And also the fear, it is a small community at Red Beach and I work in the community”.

R: “So that was another issue for you about going to that group”?

P:” Definitely, I didn’t go there deliberately because I didn’t want to go somewhere local to begin with”.

R: “Eventually it was Red Beach or nothing because of transport issues but you went”?

P: “I just sucked it in and went well come on why, what’s the problem”.

R: “They’re there for the same reason”.

P: “Yeah, they’re there for the same reason”.

R: “But it is pretty tough walking into that room for the first time”.

P: “Well sure, I walked in to here after 2 weeks in detox and I know 2 people here. When you get to our age you know a lot of people”.

Appendix 2

Consent Form

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Project title: Non-adherance to group therapy in a community drug and alcohol outpatient unit: a thematic analysis

Project Supervisor: Elizabeth du Preez

Researcher: Bev Monahan

English	I wish to have an interpreter	Yes	No
Māori	E hiahia ana ahau ki tetahi kaiwhaka Māori/kaiwhaka pakeha korero	Ae	Kao
Cook Island Māori	Ka inangaro au i tetai tangata uri reo	Ae	Kare
Fijian	Au gadreva me dua e vakadewa vosa vei au	Io	Sega
Niuean	Fia manako au ke fakaaoga e taha tagata fakahokohoko kupu	E	Nakai
Sāmoan	Ou te mana'o ia i ai se fa'amatala upu	Ioe	Leai
Tokelaun	Ko au e fofou ki he tino ke fakaliliu te gagana Peletania ki na gagana o na motu o te Pahefika	Ioe	Leai
Tongan	Oku ou fiema'u ha fakatonulea	Io	Ikai
	Other languages to be added following consultation with relevant communities.		

- I have read and understood the information provided about this research project in the Information sheet

- I have had an opportunity to ask questions and to have them answered

- I have had the opportunity to use whānau support or a friend to help me ask questions and understand the study.

- I understand that taking part in this study is voluntary (my choice), I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

- I understand that my participation in this study is confidential and that no material that could identify me will be used in any reports on this study.
- I have had time to consider whether to take part in the study.
- I am not suffering from any mental or physical illness or injury that impairs my performance,
- I agree to take part in this research.
- I wish to receive a copy of the report from the research (please tick one): Yes○ No○
- I understand there will be some delay between data collection and my receiving a copy of the report.

I consent to my interview being audiotaped. Y ☐ N ☐

Participants signature: .....

Participants name: .....

Participants Contact Details:

.....

.....

.....

.....

Date:	
Signature:	
Full names of researchers:	Beverley Monahan
Contact phone number for researchers:	0275 357 375
Project explained by:	Beverley Monahan
Project role:	Principle researcher

Signature:	
Date:	

Approved by Northern Regional X Ethics Committee 26/04/10. Ethics Reference number NTX/10/EXP/Note:

The Participant should retain a copy of this form.

Participant Information Sheet

6th April 2010

Project Title

Non-adherence to group therapy in a community drug and alcohol outpatient unit a thematic analysis

An Invitation to take part in a research study

My name is Bev Monahan, I am a psychology student completing a Masters of Health Science Psychology at AUT University. As part of my Masters degree I am required to complete a research project, as a result of this research it is hoped that I will complete the research practice paper for my Masters of Health Science.

I would like to invite you to be a part of my research to explore why people stop attending group.

This research is completely voluntary, and you may withdraw from the project at any time without fear of prejudice to your ongoing contact with CADS. Participating in this research will not prevent you from returning to action group if you choose to do so?

What is the purpose of this research?

The purpose of this research is to gain information and understanding from group participants who choose not to continue attending action group. This in turn may inform changes to group practice within the CADS environment. The confidential information gathered will be used in my research, as part of this I am required to present this research to other students and members of the AUT faculty, but no personal identifiers will be used in this report

How was I chosen for this invitation?

All participants who miss three sessions of the Action group have been contacted by a member of CADS and invited to tell me, the researcher, more about their experiences at CADS. Participation is voluntary and anonymous, only people who chose to go ahead with the interviews will become part of this study.

What will happen in this research?

A face to face interview will be completed with you at a CADS unit nearest to you, which will take approximately one hour, this interview will be audio taped. After all the interviews have been completed I will attempt to identify common themes and experiences that emerge. A report will then be written, and presented to the management team at CADS, the AUT faculty and to yourself if you wish. Due to current laws your tapes and will be kept securely for a period of 10 years at AUT University, then destroyed

What are the discomforts and risks?

The aim of this research is not aimed at getting you back into group, but to gather information that may improve the group process at CADS in the future.

How will these discomforts and risks be alleviated?

Should you wish to speak with anybody during the process of the research or after the research is completed, you may contact either the clinical team leader or the clinical supervisor at CADS. If for any reason you do not wish to speak to either of these people my supervisor at AUT may be contacted, her details are found later is this handout

What are the benefits?

It is my hope that as a result of this research, experiences and themes may be identified that will give a better understanding why clients may leave group before the required number of sessions for completion. These themes may in turn bring a greater understanding of a client's needs in a group environment. Where possible new practices may be developed, resulting in improved adherence to group attendance, and a better experience for client's within Community Alcohol and Drug Services units.

How will my privacy be protected?

No material that could personally identify you will be used in any reports on this study'. The reporting of the results from this study will not be linked to any personal identifiers. The management team at CADS will have access to the final report and possible recommendations only. Your tapes and transcripts will be kept securely in locked cabinets until the end of the research and then at AUT University

Interviews will be audio taped; participants will be given a code to identify them. Tapes will be kept in a locked filing cabinet except when being transcribed. Tapes and Raw data will be kept at AUT Psychology Department in locked filing cabinets for 10 years and then be destroyed

What are the costs of participating in this research?

The interview will take approximately one hour of your time, plus your travel time and cost to and from the appointment. As a way of compensating you for this cost a $20.00 petrol voucher will be offered.

What opportunity do I have to consider this invitation?

You will have been given information regarding this research when you first attended Action Group. After having been contacted by phone you will be given one week to consider your participation. You may remove yourself from this research at any time prior to the completion of data collection, without being disadvantaged in any way. All relevant information including tapes and transcripts, or parts thereof, will be destroyed.

What if I need support

You may have a friend, family or whānau support to help you understand the risks and/or benefits of this study and any other explanation you may require.'

How do I agree to participate in this research?

Your agreement to participating in this research will be both verbal, and by signing the necessary consent form.

Will I receive feedback on the results of this research?

You will be offered a copy of the report, to be given at the completion of this research project.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Elizabeth Du Preez Senior lecturer,

Email: edupreez@aut.ac.nz

Phone: 09 921 9999 ex 7692

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, *madeline.banda@aut.ac.nz* , 921 9999 ext 8044.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact an independent health and disability advocate:
Free phone: 0800 555 050
Free fax: 0800 2 SUPPORT (0800 2787 7678)
Email: advocacy@hdc.org.nz'

To ensure ongoing cultural safety Nga Kai Tataki - Maori Research Review Committee Waitemata DHB encourage those who identify themselves as Maori and who are participating in health research or clinical trials to seek cultural support and advice from either Mo Wai Te Ora – Maori Health Services or their own Kaumatua or Whaea.

For assistance please contact the Services Clinical Leader for Mo Wai Te Ora –

Maori Health on 09 486 1491 ext: 2324 or the Maori Research Advisor on 09 486 1491 ext: 2553

Whom do I contact for further information about this research?

Bev Monahan: Research Student

Researcher Contact Details:

Bev Monahan: Research Student 0275 357 375

Project Supervisor Contact Details:

Supervisor, Elizabeth Du Preez Senior lecturer,

Email: edupreez@aut.ac.nz

Phone: 09 921 9999 ex 7692

This study has received ethical approval from the Northern X Regional Ethics Committee; ethics reference number NTX/10EXP/055

Please feel free to contact the researcher if you have any questions about this study.'