Program Evaluation of a Youth Residential Substance Treatment Centre: Using Grounded Theory

By

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A thesis submitted to the School of Community Services in partial fulfillment of the requirements for the degree of Bachelor of Applied Arts in Behavioural Psychology.

St. Lawrence College
Kingston, ON, Canada

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Dedication

To my family- thank you for your constant love and support throughout this journey.

To the late James Kathron who bravely fought his own battles with addiction and mental health.
Abstract

The purpose of the current study was to complete a program evaluation at a youth substance abuse treatment centre. The researcher, using grounded theory, examined youth satisfaction surveys implemented by the centre. The results revealed major and minor trends in the following areas: previous residential treatment, safety of residents in treatment, bullying, changes since arriving at treatment, continuing variables to positive change, nutrition, and contingency management system. A minimum of 3 reoccurring responses was required to denote a trend. The data was considered a major trend if it has 30 or more reoccurring responses. A total of ten major trends were found throughout the data. Similarities and differences were then identified between genders. Areas in which clients wanted change or improvements were identified. The main issue for males was that they would like changes made to the contingency management system while females desired increased consistency between the staff.
Acknowledgements

I would first like to acknowledge my college supervisor Melissa Bolton, who dedicated her time and advice to me throughout the entire thesis process. Your constant support and guidance enhanced my overall experience.

I must also express my gratitude to the Dave Smith Youth Treatment Centre team. I am appreciative to have been able to work along side my facility supervisor Troy Thompson. Your words of encouragement and valuable learning opportunities made this experience successful. Moreover, I am grateful to have had the pleasure of working with, and learning from so many inspiring individuals. Thank you for welcoming me into your residential family and supporting me throughout this process.

A special thank you to Robert Di Fazio and Emma Donovan.
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Chapter I: Introduction

Addiction can be an extremely difficult and debilitating disorder. Unfortunately, there remains certain stigma regarding this class of disorders. Many individuals view addiction as a weakness or character flaw, however substance use disorder (SUD) is a chronic health condition (Mash & Wolfe, 2002). People with SUD must be treated with the same level of treatment and care as any other health disorder. Substance abuse can affect people of all age, ethnicity, race, and gender. However, the youth population of 12-21-years old is particularly at risk for SUD. The number of North American youth seeking treatment for substance abuse continues to increase (Kelly, Urbanoski, Hoeppner, & Slaymaker, 2012). Canadian youth are reporting the highest level of drug use ever before. Youth aged 15-24 years old are five times more likely to report substance abuse compared to all other populations (Kelly, Urbanoski, Hoeppner, & Slaymaker, 2012). Although there are already a number of different methods used to treat addiction, relapse rates remain high.

Residential facilities are becoming a more popular treatment option for SUD. A residential setting is defined as a live-in health care facility. These organizations are colloquially referred to as a “rehab” or rehabilitation institution. A study was completed by Ogborn (1995) to evaluate the factors associated with seeking this form treatment over other courses of intervention. Some treatment facilities require professional referral for a youth to access the residential treatment, whereas other organizations allow youth to self refer. The results of Ogborn’s (1995) research suggested two primary variables distinguish youth who seek residential treatment. First, youth in residential treatment had higher prevalence rates of concurrent mental health disorders. Secondly, these individuals had previously undergone another form of addiction treatment. These results indicated that residential treatment might not be the preferred treatment option among this population. Instead, many individuals within this cohort will first attempt outpatient or day treatment for SUD. If this treatment proves ineffective or relapse occurs then the youth may seek a residential setting.

Mental health is a large contributing variable that often further complicates application for treatment in a residential facility. It is well recognized that substances can be used as a maladaptive coping strategy for emotion dysregulation and concurrent mental health disorders (Mash & Wolfe, 2002). Having both a mental health disorder and SUD is referred to as a concurrent diagnosis.

The current residential treatment facility, the Dave Smith Youth Treatment Centre (DSYTC), examined is a youth organization that catered to clients aged 13-21-years old. The facility had two campuses that were separated by sex. According to statistics taken by the agency, 97% of clients had reported some type of mental health diagnosis (MacGregor, 2015). Demonstrating that almost all of the youth seeking residential treatment have had a co-occurring diagnosis of mental health disorder and SUD. This creates a very complicated and high-risk population in terms of risk to self and risk of relapse in the youth residential addiction treatment environment.

During treatment it is important to ensure this vulnerable population is given the opportunity to discuss both the positives and negatives of their treatment centre. At the DSYTC the treatment policy included the administration of anonymous monthly surveys. The survey encompassed a wide range of questions including how the youth feel about
available groups, staff, daily activities, and food (refer to Appendix A for). This allowed
the organization to be aware of potential perceived limitations in treatment and to ensure
effective delivery of services. This research project evaluated the program at the DSYTC.
The facility is a residential setting for youth aged 13-21-years old. DSYTC uses a harm
reduction treatment model while using Adolescent Community Reinforcement Approach
(ACRA) programing. This organization is also committed to continuous quality
evaluations and improvement. The survey feedback provided clients with a safe and
anonymous outlet to voice their opinions, and this can result in valuable information for
the agency. Exploring participant responses in a scientifically rigorous manner may
reveal trends and common experiences of individuals who have undergone or were
undergoing treatment. Analyzing resident satisfaction surveys provides information on
the program offered and is helpful when making program alterations.

This thesis contains five chapters including: Introduction, Literature Review,
Method, Results, and Discussion. The literature review chapter examines the current
research available on the youth addiction population as well as other researchers who
have used qualitative data analysis. The method chapter explores the specifics of how this
thesis was completed. The results chapter shows the outcomes of data analysis to reveal
trends. Lastly, the discussion chapter reviews the strengths and weaknesses of this thesis.
Further research and important contributions to the field of behavioural psychology will
also be addressed.

Definitions

Addiction. A compulsive need to use substances despite harmful consequences
Substance Use Disorder (SUD). A chronic condition in which the use of one of
more substances causes significant clinical impairment or distress
Stigma. A negative stereotype about a group of individuals
Relapse. Spontaneous recovery or use of a substance after a period of abstinence
Mental health Disorder. A variety of health condition that can affect your
thoughts and behaviours
Externalizing problems. Include acting-out type behaviours such as impulsive,
aggressive, and delinquent acts.
Internalizing problems. Include anxiety, depression, and withdrawn behaviour.
Poly-substance use. Having more than one drug of choice, and often becoming
intoxicated by more than one substance simultaneously.
Chapter II: Literature Review

Youth Addiction and Services

The number of youth reporting substance abuse is at an all time high (Cavanaugh, Kraft, Muck, & Merrigan, 2011). It is recognized that some experimentation with illicit substances can be reflective of societal norms at this developmental stage in life. This experimentation can often occur without prolonged or adverse effects (Mash & Wolfe, 2002). Problematic substance abuse begins with more frequent and prolonged usage, as well as increased tolerance. This increase in substance abuse can interfere with the development of psychological and social skills in youth (Mash & Wolfe, 2002). Some of these under developed characteristics include lower levels of inhibition and a reduction in judgment. This is often paired with increased peer pressure and social desirability to fit in. At this stage of development, youth are often ill equipped to predict the long-term consequences of substance abuse. Mash and Wolfe (2002) state that neurological development can be negatively impacted. For example, an early onset of heavy drinking can affect the brain processes of synaptic pruning and myelination (Mash & Wolfe, 2002). A deficit in these processes can result in underdeveloped attention and memory (Mash & Wolfe, 2002). The age of first use continues to be the most supported risk factor associated with developing SUD. According to Mash and Wolfe (2002), the rate of developing a disorder is decreased by 9% for each year that use is delayed. It has also been found that there is a high comorbidity rate between SUD’s and mental health disorders, specifically ADHD and conduct disorder (Mash & Wolfe, 2002).

Cavanaugh, Kraft, Muck, and Merrigan (2011) reviewed the effective treatment options for youth with SUD. The review observed the findings of a panel of national experts, who determined the functionality of the current treatment systems in place for treating adolescents with SUD. The authors found that this system needs improvement. The experts concluded that the treatment available, both in-patient and out patient, was underdeveloped and provided inadequate services (Cavanaugh, Kraft, Muck, & Merrigan, 2011). During the evaluation, five areas were found to be of critical importance to youth in treatment: collaboration between the youth and agency, improved financing for programs, further development of the workforce, and the use of evidence based practices and family involvement in treatment. In 2005, these changes were implemented into the field.

Once a gap in addiction services was discovered, research was then conducted to further explore where improvements could be made. Researchers have since discovered that early approaches to treatment were modeled after adult substance abuse interventions. This did not take into account the specific needs of the youth such as ongoing development (Cavanaugh et al., 2011). Individuals in this developmental stage are also more likely than adults to experience cognitive problems such as mood swings and disorientation (Mash & Wolfe, 2002). Cavanaugh et al. (2011) demonstrated the potential positive outcomes of conducting a program evaluation. By highlighting areas for improvement, positive changes were implemented into future treatment.

One area of critical importance for youth treatment is collaboration between the youth and agency. In a study conducted by Ogborne (1995) it was found that an important part of developing treatment plans is considering client preferences. This allows the client to be matched with treatment that is consistent with their needs and values. Expanding on Ogborne’s (1995) study, researchers asserted that taking into
account client wants could improve treatment outcomes. This thesis seeks to show that giving the client the opportunity to present treatment preferences will result in valuable information for future programs and clients.

As with any treatment service delivery, one variable to consider is potential barriers to effective treatment. In a study conducted by Wong, Marshall, Kerr, Lai and Wood (2009), barriers to treatment were observed for youth with addiction who were homeless and lived on the streets. Among the 478 participants included in the study 9.8% reported having encountered some barriers when trying to access addiction services (Wong, Marshall, Kerr, Lai & Wood, 2009). The most common of these included: being placed on a lengthy wait-list, having behavioural problems that prevented them from accessing treatment, and not meeting the requirements for a specified treatment. In the article by Wong et al., (2009) participants who had previously received treatment experienced relapse within a year. Another study conducted by Wisdom, Cavaleri, Gogel, and Nacht (2011) examined barriers to treatment for individuals with SUD. Participants included in this study were youth with SUD. All participants were interviewed using semi-structured interviews. The results found that those seeking treatment will experience one or two barriers to treatment. The most common barriers were found to be stigma, lack of awareness, denial, and failed previous attempts at treatment (Wisdom, Cavaleri, Gogel, & Nacht, 2011).

Edokpolo, James, Kearns, Campbell and Smyth (2010) conducted a study that evaluated treatment efficacy with a focus on the sex of the client. The researchers evaluated sex differences in youth attending a drug and alcohol treatment program. Using the Becks Youth Inventory Second Edition (BYI-II) they evaluated the standardized scores of 88 youth. The results showed a difference in psychiatric symptomology between sexes. Female youth were found to have higher rates of internalizing and externalizing psychiatric problems when compared to the male population. This differs from previous research (Gross & McCaul, 1990-1991; Tarter, Kirisci, & Mezzich, 1997; Windle & Barnes, 1988; Whitmore et al., 1997) that states males have higher levels of externalizing psychiatric problems whereas females had higher levels of internalizing problems. Other researchers have suggested that further research is required regarding sex differences in this regard (see Edokpolo et al., 2010).

Residential Treatment

Ogborne (1995) found two distinctive variables for youth who seek residential addiction treatment. The first is having a concurrent diagnosis of severe SUD with a mental health disorder. The second variable is having previously undergone another form of treatment. These two variables support the idea that individuals in this population are vulnerable and experiencing complex emotions and behaviours.

Psychological disorders are often the cause of the initiation of substance abuse, substances serve as a way to cope with the psychological symptomology (Garland, Pettus-Davis, & Howard, 2013). Co-occurring diagnoses of SUD and a mental health disorder can affect treatment outcomes; usually the affect is negative and can seriously harm the effectiveness of treatment for the individual. Tomlinson, Brown, and Abrantes (2004) completed a study that examined the comorbid expression of SUD and mental health disorders. The researchers reviewed the treatment outcomes of 126 youth who had co-occurring SUD and clinical disorders (e.g. major depressive disorder, panic disorder,
schizophrenia). It was discovered that adolescents with co-occurring diagnoses received more treatment than adolescents with only SUD. Despite receiving more treatment adolescents with comorbid SUD and clinical disorders continued to have higher rates of relapse at a 6-month treatment follow-up. Illustrating that although youth with co-occurring disorders often receive more and more intense levels of treatment they continue to have higher rates of relapse. Which may be due to the intensity and complexity of the comorbid expression.

Previous research has suggested that there are barriers to completion of substance abuse treatment among youth, with many of the client’s experiencing relapse. Schroder, Sellman, Frampton, and Deering (2009) conducted a study that aimed to determine which factors are positively correlated with treatment attrition. The study included youth between the ages of 13 to 19-years old who attended a substance abuse treatment centre. The researchers randomly selected 184 participants to analyze in the study. The median length of stay in treatment was 2.7 months. The authors found that client motivation as well as program variables were the biggest factors that affected treatment dropout (Schroder, Sellman, Frampton, & Deering, 2009). Harris, Brazeau, Clarkson, Brownlee, and Rawana (2012) state that there is a need to better understand and examine the barriers to client participation and treatment completion. By allowing for a more comprehensive understanding of youths experience during treatment researchers and treatment facilitators can discover valuable information necessary for improving future treatment measures. In a qualitative research study conducted by Harris et al., (2012) researchers examined the experiential process of youth completing a 5-week residential addiction treatment program. The youth were provided surveys upon completion of treatment and qualitative analysis was conducted on the results. The surveys provided detailed responses to questions the organization had regarding the effectiveness of their treatment program. The responses given by the youth were then analyzed to identify what the youth found most effective in this treatment setting.

A study conducted by Morse and MacMaster (2014) looked at college aged individuals in a residential addiction treatment setting. Participants underwent treatment service reviews at 1-month and 6-months treatment follow-ups. It was found that this population had higher levels of legal and family issues compared to other populations (Morse & MacMaster, 2014). This information proved valuable to the organization, as it helped clarify and prioritize resources. This organization successfully used information given by the clients to evaluate their program. Evaluation of resident satisfaction surveys most likely will lead to discovery of trends and provide useful information that could improve and refine treatment programs at the DSYTC.

**Working Theories and Models: Grounded Theory**

Grounded theory is currently the most used method to complete qualitative analysis (Strauss & Corbin, 1997). Strauss and Corbin (1990) developed the theory as a way to discover emerging trends and patterns in sets of exploratory data. The primary aim of this method is to develop a working theory. This form of analysis has been extremely influential in the field of social sciences (Hays & Wood, 2011). Once the data is collected it is then organized through a process called coding (Strauss & Corbin, 1990). Coding is defined as conceptualizing the underlying issues in the data (Strauss & Corbin, 1990).
Researchers Kelly and Myers (2007) performed qualitative analysis on youth who participated in 12-step Alcoholics Anonymous (AA) type programs. The authors analyzed the results of eight previous studies to determine positives and negatives of the 12-step model treatment for youth. It was discovered that 90% of substance abuse programs in the United States follow the 12-step model (Kelly & Myers, 2007). It is important to note that the AA model is not considered a professional method of treatment, instead it is perceived as a community service (Kelly & Myers, 2007). The study found many positive results to implementing this model such as low cost, reduced barriers and no wait time; however, the results also suggested some downfalls. Kelly and Myers (2007) asserted that a 12-step program is often not a good fit for youth with SUD. Pertaining to the fact that youth are often overwhelmed by the abstinence approach and prefer a harm reduction model (Kelly & Myers, 2007). Youth may also be uncomfortable incorporating the religious and spiritual aspect, which is a required part of the AA process. This includes incorporating client’s own religion into treatment as well as the daily serenity prayer that is chanted during the meeting. Twelve step programs can be beneficial to youth but only if the youth has previously undergone professional treatment methods (Kelly & Myers, 2007). AA can act as a healthy support system as well as give the youth a social activity to attend however professional methods of treatment are still required (Kelly & Myers, 2007). Through reviewing previous research the authors were able to identify gaps in youth treatment such as the AA model.

Himelstein, Saul, Garcia-Romeu, & Pinedo (2014) discovered grounded theory methodology could be successfully implemented with individuals experiencing SUD. The authors conducted a study that involved 10 incarcerated youth with SUD, which involved a mindfulness-based program. The youth were observed over the course of one year. The participants were then interviewed to evaluate what they found helpful about aspects of the process and program. Grounded theory was used to develop a working theory from the results given. Himelstein, Saul, Garcia-Romeu, and Pinedo, (2014) found that using a short topic introduction followed by a clear description of the technique and a practice exercise to be the most effective way of teaching mindfulness to these youth. The participants reported that mindfulness lead to overall improved psychological well-being and improved management of self (Himelstein, Saul, Garcia-Romeu, & Pinedo, 2014). Himelstein et al., (2014) state that mindfulness skills could result in lowered substance abuse and rates of recidivism.

Grounded theory can also show connection between mental health and substance abuse. Taylor (2011) observed African American youth with SUD residing in public housing units. Using qualitative analysis Taylor (2011) identified that 5% of youth used substances as a way of coping with feeling of depression. Furthermore, Taylor (2011) was able to identify specific life stressors that were negatively affecting that community.

Strauss and Corbin (1990) state that a limitation to grounded theory is that theorists often argue about what is defined as true-grounded theory. Some theorists believe that prior work and literature should be included, whereas others argue that including previous research diluted the roundedness of the results (Strauss & Corbin, 1990).
Chapter III: Method

Participants
Participants for this study include youths ranging from 13-21 years of age, who have been or are currently involved in the Dave Smith Youth Treatment Centre’s residential program. Both male and female participants are included in this study. However genders are separated by different housing facilities. Both subsets receive the same survey questions and similar treatment programming. All participants have SUD (or poly-substance use). Furthermore, 97% of clients at this organization also have another concurrent mental health diagnosis. The majority of clients will come to treatment having already undergone a psychiatric evaluation to determine mental health, however this facility has access to a psychiatrist that can diagnose on-site. It is explained to all participants that the survey results are anonymous. Due to the fact all responses are anonymous and archived data is being used for the purposes of this study, informed consent and limits to confidentiality were not obtained from participants (as they are unknown to this researcher). An exclusion criterion for being part of this study is withdrawing from treatment before completing a minimum of one week. This is because during the first week of treatment a participant is often still adjusting to the facility and may not be familiar with all the rules and regulations. This time is referred too as a “grace period” for the youth.

Data Collection
Data was collected through resident satisfaction surveys by the agency (Dave Smith Treatment Centre- residential program). Surveys occur monthly and are mandatory for all residents to complete. Youth do not have the option to refuse participation in the survey process. If a youth is unable to complete the survey of a specific date completion can be deferred to a different time.

Youth complete the surveys one at a time using an agency computer. The survey was created using a website named SurveyMonkey.com which formats the data into easy to encode and accessible results. The survey is 56 questions long and is comprised of a mixture of closed and open-ended questions. A comments box is provided under the close-ended question to allow the participant to provide additional feedback. All comment boxes do not count as a separated numbered question. The first eight surveys are general information question and do not offer a comment box. The answers given from all questions are then stored in an online data archive. The current study is examining the archival data from 2013 to present. The purpose of this analysis is to evaluate trends in the treatment efficacy and service delivery provided to participants. The results remain separated by genders. This allows for any differences between the male and female locations to be more visible.

Grounded Theory
Once all survey data was collected from the online archive it was then formatted as a hard copy (master copy). The data was pooled amongst all participants. This allows for each question to be evaluated by thematic convergent and divergent data. The evaluator then evaluated and re-evaluated the thematic content, looking for common trends and re occurring words. The male and female results where kept in separate data
pools. However, once the data was evaluated for thematic content, the genders were then compared for the same question. Results where then recorded using a flowchart. This process was repeated for every trend that was found, until data saturation occurred. The results where then re-examined using the same process by a secondary person. This person has no association with the organization. This allows for the results to have higher inter-rater reliability. Questions that cannot be analyzed using grounded theory, questions without enough data to find any trends, and questions that cannot be examined due to reasons of confidentiality will be omitted from the results. A result is considered a trend when three or more reoccurring responses are found. Major trends have 30 or more reoccurring responses.

The data analysis process began with question number 50-56 of the survey. This is because the final six are open-ended questions. Once trends began to emerge in the questions 50-56, all other survey questions where then reviewed to find common trends of re-occurring words in other areas. The first trend observed was that many results spoke negatively about the contingency management system in place at the agency. This was identified through the coding process in question 51,53,55, and 56. Once this was discovered Questions that directly focus on this area where highlighted. These included question 36-40 under the CM ‘Point System’ subsection. Once a trend began to emerge with many questions discussing similar area these trends where then separated into seven overarching themes: previous residential treatment, safety of residents in treatment, bullying, changes since arriving at treatment, continuing variable to positive change, nutrition, and contingency management system.
Chapter IV: Results

The following is a presentation of the most salient emergent themes and trends observed within the data. Several themes have been identified: previous residential treatment, safety of residents in treatment, bullying, changes since arriving at treatment, continuing variable to positive change, nutrition, and contingency management system. Within these themes the occurrence of responses relevant to an emergent trend were documented. Similarities and differences were then identified between genders. Pink boxes represent female-only reoccurring responses. Blue boxes represent male-only reoccurring responses. Green boxes represent reoccurring response or trends found in both male and female answers. The amount of reoccurring responses from the survey data is also listed. A minimum of 3 reoccurring responses is required to denote a trend. The data is considered a major trend if it has 30 or more reoccurring responses. These results are presented in figures that are then further described. A total of ten major trends where found throughout the data. Questions that cannot be analyzed using grounded theory, questions without enough data to find any trends, and questions that cannot be examined due to reasons of confidentiality will be omitted from the results.

Previous Residential Treatment

Survey Question #8 “If yes (you have attended another residential treatment program), how is DSYTC similar or different?” Results from this question revealed that the majority of youth had not attended previous residential treatment. Of the 18.4% of males and 22.9% of females who had previously attended residential treatment centres, a common response stated that they had previously undergone treatment that followed a 12-step or abstinence-based approach. Females had slightly higher levels of previous residential treatment. A common female trend was that Dave Smith Youth Treatment Centre was the first residential treatment centre clients had attended that was not in a hospital setting.

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**Survey Question #9** “Comment on how satisfied you are with the quality of treatment you are receiving.” A trend that emerged often throughout the survey results was positive statements about the staff. The staff was listed as increasing the quality of treatment at the centre, contributing to why youth would recommend DSYTC to a friend, and a major factor in treatment retention. This is listed across both male and female results. The majority of males are satisfied or very satisfied with treatment they are receiving, however, criticisms included finding group counselling not helpful and statement about the contingency management system. The contingency management system is a common theme that emerges throughout the survey. This trend will be further reviewed under the contingency management section of the results.
Male

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Female

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</table>

Figure 2. Survey Question Number 9.
**Survey Question #10 “Would you recommend DSYTC to a friend who was struggling with substance use issues, why or why not?”** The majority of answers to this question yielded a yes response. A total of 71% of males and 77.8% of females would recommend this treatment to a friend. This can be attributed largely to the staff. Positive comments about staff were found across genders. Females also stated that they enjoyed the harm reduction approach to treatment; a major trend was found in males who would recommend the treatment to their friends because they felt it was effective. A common reason listed across genders for why a youth would not recommend this treatment to a friend be due to the age range of treatment. Examples of responses from the surveys include “I think people around my age would do better in an adult treatment centre, rather than a youth treatment centre” and “depends on the age of said friend”.

### Male

<table>
<thead>
<tr>
<th>Response</th>
<th>Chart</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td>71.0%</td>
<td>174</td>
</tr>
<tr>
<td>Somewhat</td>
<td></td>
<td>22.9%</td>
<td>56</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>6.1%</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total Responses</strong></td>
<td></td>
<td><strong>245</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Female

<table>
<thead>
<tr>
<th>Response</th>
<th>Chart</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td>77.8%</td>
<td>158</td>
</tr>
<tr>
<td>Somewhat</td>
<td></td>
<td>20.2%</td>
<td>41</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>2.0%</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total Responses</strong></td>
<td></td>
<td><strong>203</strong></td>
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</tr>
</tbody>
</table>
Figure 3. Survey Question Number 10. A major trend was found in male reoccurring response 1.

Safety of Resident in Treatment

Survey Question #29 “Do you feel safe at DSYTC, if not can you tell us why?” A difference was observed between genders in question 29 which asked about safety in the centre. The most common female response stated that the youth did not feel safe from themselves. This is explained as wanting to self-harm and having suicidal ideation. A response pulled from the survey results states “I self harm and feel like I want to kill myself and staff does not help very much at all.” This response could be related with answers from question 46. The male population had a very different response to question 29. Male youth stated other clients with violent outbursts made them feel unsafe.

<table>
<thead>
<tr>
<th>Male</th>
<th>Response</th>
<th>Chart</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td>96.3%</td>
<td>235</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td>3.7%</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>Responses</td>
<td></td>
<td></td>
<td>244</td>
</tr>
</tbody>
</table>
**Figure 4.** Survey Question Number 29.

**Survey Question #46** “Compared to when you first arrived at the DSYTC do you feel that your mental health is; Much Worse, Somewhat worse, About the same, Somewhat better, Much better. Can you comment on your answer?” When asked about overall mental health since arriving at treatment both males and females had reoccurring responses saying their symptoms of mental illness had increased and attributed this increase to not having access to substances. Substances were being used as a way to cope or ‘block out’ feelings that were surfacing now that the youth was in treatment.

**Female**

<table>
<thead>
<tr>
<th>Response</th>
<th>Chart</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td>94.5%</td>
<td>188</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>5.5%</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total Responses</strong></td>
<td></td>
<td><strong>199</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Male reoccurring responses**

- Male Reoccurring response 1
  Clients who exhibit acts of physical violence (towards others or objects) – 4 responses

**Female reoccurring responses**

- Female Reoccurring response 1
  I feel emotionally unsafe. Still capable of self harm and/or suicidal behaviour – 8 responses

**Male**

<table>
<thead>
<tr>
<th>Response</th>
<th>Chart</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much Worse</td>
<td></td>
<td>2.9%</td>
<td>7</td>
</tr>
<tr>
<td>Somewhat Worse</td>
<td></td>
<td>10.2%</td>
<td>25</td>
</tr>
<tr>
<td>About the Same</td>
<td></td>
<td>29.4%</td>
<td>72</td>
</tr>
<tr>
<td>Somewhat Better</td>
<td></td>
<td>33.5%</td>
<td>82</td>
</tr>
<tr>
<td>Much Better</td>
<td></td>
<td>24.1%</td>
<td>59</td>
</tr>
<tr>
<td><strong>Total Responses</strong></td>
<td></td>
<td><strong>245</strong></td>
<td></td>
</tr>
</tbody>
</table>
Another significant difference noticed between males and females was shown in question 30, which asked if bullying was a problem at the centre. The majority of females answered no, bullying is not a problem, however there is drama and gossiping among the girls.
Figure 6. Survey Question Number 30.
Survey Question #51 “What makes it hard to stay in treatment and working towards your treatment goals?” Relational bullying between clients is also listed in question 51 as a reason it is difficult to stay in treatment. In contrast, males listed bullying as being a significant problem in the centre. Responses included certain clients being targeted by the group and staff not properly addressing the problem. A major trend was found across genders that listed missing family as the main reason it is difficult to stay in treatment.

Figure 7. Survey Question Number 51. Major trends found in female reoccurring response 2, male reoccurring response 1.

Changes Since Arriving at Treatment

Survey Question #44 “Compared to when you first arrived at the DSYTC do you feel that your quality of life is; Much Worse, Somewhat worse, About the same, Somewhat better, Much better. Can you comment on your answer?” Males and females identified ways in which their quality of life has improved since beginning treatment. Both genders identified being happy or happier. When examining the chart results versus the written answers some discrepancies occurred. Males had a majority of positive written responses to this question; however, the graph shows only 39% of this population chose the much better response. Contrarily, females showed trends of negative written responses such as feeling more depressed. When this is compared with the graph information, over half the population (53.3%) chose the much-improved response. This can again be attributed to question 46 in which mental health is discussed as becoming
worse due to not having access to substances. Overall, the majority of both genders stated that their quality of life improved.

<table>
<thead>
<tr>
<th>Male</th>
<th>Chart</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much Worse</td>
<td></td>
<td>2.9%</td>
<td>7</td>
</tr>
<tr>
<td>Somewhat Worse</td>
<td></td>
<td>6.5%</td>
<td>16</td>
</tr>
<tr>
<td>About the Same</td>
<td></td>
<td>13.5%</td>
<td>33</td>
</tr>
<tr>
<td>Somewhat Better</td>
<td></td>
<td>37.6%</td>
<td>92</td>
</tr>
<tr>
<td>Much Better</td>
<td></td>
<td>39.6%</td>
<td>97</td>
</tr>
<tr>
<td><strong>Total Responses</strong></td>
<td></td>
<td></td>
<td><strong>245</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Female</th>
<th>Chart</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much Worse</td>
<td></td>
<td>2.0%</td>
<td>4</td>
</tr>
<tr>
<td>Somewhat Worse</td>
<td></td>
<td>4.0%</td>
<td>8</td>
</tr>
<tr>
<td>About the Same</td>
<td></td>
<td>12.1%</td>
<td>24</td>
</tr>
<tr>
<td>Somewhat Better</td>
<td></td>
<td>28.6%</td>
<td>57</td>
</tr>
<tr>
<td>Much Better</td>
<td></td>
<td>53.3%</td>
<td>106</td>
</tr>
<tr>
<td><strong>Total Responses</strong></td>
<td></td>
<td></td>
<td><strong>199</strong></td>
</tr>
</tbody>
</table>

**Female reoccurring responses**
- Female Reoccurring response 1
  I feel more depressed - 8 responses
- Female Reoccurring response 2
  I am happy - 10 responses

**Male reoccurring responses**
- Male Reoccurring response 1
  I feel healthier since being at DSYTC - 11 responses
- Male Reoccurring response 2
  I can follow a daily routine - 4 responses
- Male Reoccurring response 3
  I am happy - 5 responses

*Figure 8. Survey Question Number 44.*
Survey Question #45 “Compared to when you first arrived at the DSYTC do you feel that your physical health is; Much Worse, Somewhat worse, About the same, Somewhat better, Much better. Can you comment on your answer?” Many similarities were found across the genders in this question. Both groups strongly stated that they enjoyed going out to the gym. This is considered a large factor in why the clients enjoy this treatment centre. A trend found was that both populations had individuals who were gaining weight since arriving at treatment. The majority of the population attributed this to a positive stating “I was too skinny when I was using.” A smaller percent of the population thought of gaining weight as a negative consequence.

Male

<table>
<thead>
<tr>
<th>Response</th>
<th>Chart</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much Worse</td>
<td></td>
<td>0.8%</td>
<td>2</td>
</tr>
<tr>
<td>Somewhat Worse</td>
<td></td>
<td>1.6%</td>
<td>4</td>
</tr>
<tr>
<td>About the Same</td>
<td></td>
<td>9.4%</td>
<td>23</td>
</tr>
<tr>
<td>Somewhat Better</td>
<td></td>
<td>31.8%</td>
<td>78</td>
</tr>
<tr>
<td>Much Better</td>
<td></td>
<td>56.3%</td>
<td>138</td>
</tr>
<tr>
<td>Total Responses</td>
<td></td>
<td></td>
<td>245</td>
</tr>
</tbody>
</table>

Female

<table>
<thead>
<tr>
<th>Response</th>
<th>Chart</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much Worse</td>
<td></td>
<td>0.5%</td>
<td>1</td>
</tr>
<tr>
<td>Somewhat Worse</td>
<td></td>
<td>2.5%</td>
<td>5</td>
</tr>
<tr>
<td>About the Same</td>
<td></td>
<td>13.9%</td>
<td>28</td>
</tr>
<tr>
<td>Somewhat Better</td>
<td></td>
<td>28.9%</td>
<td>58</td>
</tr>
<tr>
<td>Much Better</td>
<td></td>
<td>54.2%</td>
<td>109</td>
</tr>
<tr>
<td>Total Responses</td>
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<td></td>
<td>201</td>
</tr>
</tbody>
</table>
**Figure 9.** Survey Question Number 45.

Survey Question #47 “Compared to when you first arrived at the DSYTC do you feel that your ability to reach substance use goals is; Much Worse, Somewhat worse, About the same, Somewhat better, Much better. Can you comment on your answer?” This survey question found no reoccurring themes that transferred across genders. Females attributed learning new skills to why they believe that they could reach their substance use goals whereas males stated growing confidence as the reason. A trend found in the male population was stating, “I know I will never use again,” “not gonna (sic) touch the stuff.” This type of thinking is known as arrogant euphoria or over confidence in abilities to remain sober. It is known that relapse is often a part of the recovery process and arrogant euphoria can be very damaging to keeping a substance use goal.

<table>
<thead>
<tr>
<th>Male Reoccurring responses</th>
<th>Female Reoccurring responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>I now eat regularly - 4 responses</td>
<td>I have gained weight - 8 responses</td>
</tr>
<tr>
<td>I am exercising regularly and enjoy going to the gym - 23 responses</td>
<td></td>
</tr>
</tbody>
</table>
Female reoccurring responses

Female Reoccurring response 1
I am gaining skills to make them achievable- 3 responses

Male reoccurring responses

Male Reoccurring response 1
I am confident that I can achieve my substance use goals- 15 responses

Male Reoccurring response 2
I never want to use again- 6 responses

Figure 10. Survey Question Number 47.

Survey Question #48 “Compared to when you first arrived at the DSYTC do you feel that your ability to reach life goals is; Much Worse, Somewhat worse, About the same, Somewhat better, Much better. Can you comment on your answer?” This question found the most reoccurring responses in both populations to be feeling more hopeful and confident about reaching life goals. Life goals are incorporated into therapy goals; they are individualized for every client. In males and females, only 10% felt worse about the likelihood of achieving their goals.
**Figure 11.** Survey Question Number 48.

<table>
<thead>
<tr>
<th>Male</th>
<th>Chart</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much Worse</td>
<td></td>
<td>0.4%</td>
<td>1</td>
</tr>
<tr>
<td>Somewhat Worse</td>
<td></td>
<td>3.7%</td>
<td>9</td>
</tr>
<tr>
<td>About the Same</td>
<td></td>
<td>16.8%</td>
<td>41</td>
</tr>
<tr>
<td>Somewhat Better</td>
<td></td>
<td>35.7%</td>
<td>87</td>
</tr>
<tr>
<td>Much Better</td>
<td></td>
<td>43.4%</td>
<td>106</td>
</tr>
<tr>
<td><strong>Total Responses</strong></td>
<td></td>
<td></td>
<td><strong>244</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Female</th>
<th>Chart</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much Worse</td>
<td></td>
<td>1.5%</td>
<td>3</td>
</tr>
<tr>
<td>Somewhat Worse</td>
<td></td>
<td>3.5%</td>
<td>7</td>
</tr>
<tr>
<td>About the Same</td>
<td></td>
<td>17.7%</td>
<td>35</td>
</tr>
<tr>
<td>Somewhat Better</td>
<td></td>
<td>38.4%</td>
<td>76</td>
</tr>
<tr>
<td>Much Better</td>
<td></td>
<td>38.9%</td>
<td>77</td>
</tr>
<tr>
<td><strong>Total Responses</strong></td>
<td></td>
<td></td>
<td><strong>198</strong></td>
</tr>
</tbody>
</table>

**Female reoccurring responses**
- Female Reoccurring response 1
  I am more hopeful/confident that I can achieve my goals - 10 responses

**Male reoccurring responses**
- Male Reoccurring response 1
  I am more hopeful/confident that I can achieve my goals - 20 responses
Survey Question #49 “Compared to when you first arrived at the DSYTC how is your relationship with your family; Much Worse, Somewhat worse, About the same, Somewhat better, Much better. Can you comment on your answer?” The majority of both populations state that relationships with family have improved since attending DSYTC. A trend in female clients who do not state improved family relationships was that they did not have contact with their families. Around the same number of males and females answered that the family situation had remained the same with 23.7% and 22.3% respectively. This response was only revealed as a trend in the male answers.

### Male

<table>
<thead>
<tr>
<th>Response</th>
<th>Chart</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much Worse</td>
<td></td>
<td>1.2%</td>
<td>3</td>
</tr>
<tr>
<td>Somewhat Worse</td>
<td></td>
<td>4.9%</td>
<td>12</td>
</tr>
<tr>
<td>About the Same</td>
<td></td>
<td>23.7%</td>
<td>58</td>
</tr>
<tr>
<td>Somewhat Better</td>
<td></td>
<td>31.4%</td>
<td>77</td>
</tr>
<tr>
<td>Much Better</td>
<td></td>
<td>38.8%</td>
<td>95</td>
</tr>
<tr>
<td><strong>Total Responses</strong></td>
<td><strong>245</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Female

<table>
<thead>
<tr>
<th>Response</th>
<th>Chart</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much Worse</td>
<td></td>
<td>1.5%</td>
<td>3</td>
</tr>
<tr>
<td>Somewhat Worse</td>
<td></td>
<td>3.6%</td>
<td>7</td>
</tr>
<tr>
<td>About the Same</td>
<td></td>
<td>22.3%</td>
<td>44</td>
</tr>
<tr>
<td>Somewhat Better</td>
<td></td>
<td>25.9%</td>
<td>51</td>
</tr>
<tr>
<td>Much Better</td>
<td></td>
<td>46.7%</td>
<td>92</td>
</tr>
<tr>
<td><strong>Total Responses</strong></td>
<td><strong>197</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 12. Survey Question Number 49.

**Contributing Variables to Positive Change**

Survey Question #32 “How satisfied are you with the individual therapy session at DSYTC? Do you have any comments about them?” A large contributing factor to the aforementioned improvements is counselling sessions. Youth have two individual counselling sessions a week with an addiction therapist. These session work through the ACRA model of treatment that is in place at the centre. In question 32 the majority of both males and females listed being satisfied or very satisfied with individual counselling prevalence rates are 81.6% and 87.4% respectively. A major trend was found in females saying they are extremely satisfied with counselling session. A major trend was also found among males who stated individual counselling is helpful and gives me an outlet to speak openly. These youth also stated that because they found individual therapy extremely helpful they would prefer more than two sessions a week. Group sessions are also a large part of the ACRA program. A difference was found between males who do not find group sessions very helpful and females who enjoyed group sessions.
Male

<table>
<thead>
<tr>
<th>Response</th>
<th>Chart</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Satisfied</td>
<td></td>
<td>52.9%</td>
<td>129</td>
</tr>
<tr>
<td>Satisfied</td>
<td></td>
<td>28.7%</td>
<td>70</td>
</tr>
<tr>
<td>Neutral</td>
<td></td>
<td>12.7%</td>
<td>31</td>
</tr>
</tbody>
</table>

| Unsatissfied    |       | 4.5%       | 11    |
| Very Unsatisfied|       | 1.2%       | 3     |
| **Total Responses** |       |            | **244** |

Female

<table>
<thead>
<tr>
<th>Response</th>
<th>Chart</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Satisfied</td>
<td></td>
<td>59.8%</td>
<td>119</td>
</tr>
<tr>
<td>Satisfied</td>
<td></td>
<td>27.6%</td>
<td>55</td>
</tr>
<tr>
<td>Neutral</td>
<td></td>
<td>10.1%</td>
<td>20</td>
</tr>
</tbody>
</table>

| Unsatissfied    |       | 2.0%       | 4     |
| Very Unsatisfied|       | 0.5%       | 1     |
| **Total Responses** |       |            | **199** |

**Figure 13.** Survey Question Number 32. Major trends found in female reoccurring response 1, male reoccurring response 1.
Survey Question #34 “What group sessions are the most helpful to you?” In question 34 a major trend was found among females that listed Seeking Safety as being the most helpful group. Males listed Aggression Replacement Training as being their most helpful group; however, there were an equal number of male answers that stated group sessions were not helpful. This was due to other clients being disruptive, making it difficult to pay attention.

<table>
<thead>
<tr>
<th>Female Reoccurring responses</th>
<th>Male Reoccurring responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Reoccurring response 1</td>
<td>Male Reoccurring response 1</td>
</tr>
<tr>
<td>Seeking Safety Group - 62 responses</td>
<td>Find group sessions not helpful because it is hard to pay attention and other youth are distracting - 12 responses</td>
</tr>
<tr>
<td>Female Reoccurring response 2</td>
<td>Male Reoccurring response 2</td>
</tr>
</tbody>
</table>

Figure 14. Survey Question Number 34. Major trend found in female reoccurring response 1.

Survey Question #50 “What helps you to stay in treatment and committed to working towards your treatment goals?” The staff was listed again as a reason to remain in treatment. This was a trend that was found throughout the survey across both genders. Both genders also attributed familial support as a positive for treatment retention. Support from family was found to be a major trend across genders. Conversely, both genders also listed having nowhere else to go (lack of family) as a large contributing factor to staying. Females enjoyed the idea of reaching a treatment graduation date. A large trend found in the male population was remaining in treatment due to legal reasons: “if I leave I go to jail.”
**Figure 15.** Survey Question Number 50. Major trends found in female reoccurring response 2, male reoccurring response 1.

**Survey Question #35 “Are there any group session topics you think should be added to the program?”** When clients were asked in question 35 what group topics should be added to the program, females listed groups to improve self-esteem, and groups about avoiding/escaping sexual exploitation. The male population listed sexual education as a group topic to be added. Both populations listed wanting more education about the use of substances.
Survey Question #52 “What has been the most helpful to you so far at the DSYTC?” Staff continues to be monitored throughout the survey as a large contributing factor to success. Both genders praised the staff for being kind, available, and supportive. Staff was found to be a major trend occurring across genders. The two populations also strongly correlated treatment success with individual counselling sessions. Individual counselling was found to be a major trend in females. A major trend was also found in males, who listed other clients as being the most helpful so far.

### Female reoccurring responses
- Groups to improve Self-esteem and body image- 13 responses
- Education about the effects of substances- 10 responses
- Groups about avoiding or escaping sexual exploitation- 5 responses

### Male reoccurring responses
- Education about the effects of substances- 8 responses
- Sexual Education- 7 responses
- Other clients- 23 responses
- Individual counselling- 18 responses
- The gym- 14 responses

**Figure 16. Survey Question Number 35.**
Figure 17. Survey Question Number 52. Major trends found in female reoccurring response 1, female reoccurring response 3, male reoccurring response 1, male reoccurring response 3.

Nutrition

Survey Question #43 “Comment on how satisfied you are with the food provided.” According to the graph, female clients were more satisfied with the food they were receiving. They enjoyed that the food was often a healthy option. Both genders suggested that there be an alternative option offered in order to support more picky eaters.

<table>
<thead>
<tr>
<th>Male</th>
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<td>5</td>
</tr>
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<td>Total Responses</td>
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Contingency Management System

Survey Question #39 “Do you change your behaviour to get points/avoid losing points? If yes, can you give an example?” A trend that came up often throughout the survey was the contingency management point system. This system was put into place at the male and female facility as a way to hold clients accountable for negative behaviour and reward them for positive behaviour. Youth often debate that the point system is ineffective; however, when asked in question 39 if the contingency management system was effective in changing behaviours most youth reported favourably. Both males and females said the contingency management system made them more aware of their communication and inappropriate language. Youth would attempt to reduce swearing to avoid losing points. Females seem to be more open to the contingency management system, saying if they received a significant point loss they learned not to repeat the behaviour and wanted to gain points to receive rewards. Males, however, stated that the system made them feel as though they were treated like children.

Male

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<td>61.9%</td>
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<tr>
<td>No</td>
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<td>38.1%</td>
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Figure 19. Survey Question Number 39.

Survey Question #53 “What has been the least helpful to you at the DSYTC?” The contingency management system appeared again as a trend for both males and females as a reason it was difficult to stay in treatment. This finding is contradictory to question 39, which showed that clients adapted their behaviour to receive points. This result shows that the point system was effective in managing behaviour; however, the clients did not like the method. Males also stated that other clients made it difficult to remain in treatment. This is elaborated on in the answers as clients being mean and not caring about the program.
Survey Question #55 “What needs to be improved or changed at the DSYTC?” No trends were found across genders. Males listed the contingency management system as the main area needing improvement. Males stated it is difficult to earn points. Males also stated not being satisfied with the food. This response is contradictory to results found in question 43 where only 3.4% of clients chose unsatisfied with the food offered. Females listed the main area needing improvement as, creating more consistency between staff’s administration of the contingency management system.

Survey Question #40 “Do you have any suggestions for contingency management privileges that clients could earn?” No overlapping trends were found between genders in this question. Females stated that having phone privileges was very reinforcing to them and they would adhere more to the point system if this were included. Males found it more difficult to earn points and stated that can be discouraging. A trend in the male population was found that allowing more opportunities to receive points might be helpful in encouraging adherence to the point system.
Figure 22. Survey Question Number 40.

Female reoccurring responses

- Female Reoccurring response 1
- More phone time - 7 responses

Male reoccurring responses

- Male Reoccurring response 1
- Give more opportunities to earn points especially for new clients - 3 responses
Chapter V: Conclusion/Discussion

Evaluating resident satisfaction surveys using grounded theory provided trends and themes of data patterns. These patterns were observed to identify emerging themes. Many themes were discovered in the survey question with a total of 10 major trends emerging. Under the Previous Residential Treatment subheading, clients articulated that they enjoy the harm reduction approach to treatment. Within the Bullying subcategory males identified other clients as a reason it is difficult to remain in treatment. However, a major trend showed that a main factor making it difficult to remain in treatment was missing family, friends, and/or significant others. This major trend occurred across both genders. Within the Contributing Variables to Positive Change category, a major trend was found across genders that showed the most helpful aspect of treatment was individual counselling. Both genders also listed family and friends as what helped them stay in treatment and work toward achieving their goals.

In conclusion, this evaluation was effective in analyzing resident satisfaction surveys in order to find trends. Multiple trends also appeared across genders. Areas in which clients want change or improvement were identified. The main issue for males was that they would like changes made to the contingency management system. Males also said that improvements could be made to the system by providing more opportunities to earn points. Males further stated that it was very discouraging for them to lose points and they found it frustrating to not have the same privileges as their peers. Females were more accepting of the point system; however, they stated that they became frustrated when staff did not all administer points in the same way. Females would like to see the point system improved by creating more consistency between the staff. Although youth often complain that they do not like the contingency management system in place, by examining the survey results it is clear that the system is effective at managing and improving behaviour. It also helps clients create routine and learn what is expected of them. Using grounded theory also found re-occurring trends of how the system could be improved to better fit the specific clients.

Clients also stated that their primary support for remaining in treatment was family and peers. Clients listed throughout the survey the desire for more communication with their supports outside of the treatment facility. Both males and females wanted healthy, pro-social peers to be allowed on their call list.

The results found in this study show the potential benefits of giving the client the opportunity to present treatment preferences. This resulted in valuable information for future programs and clients. This idea builds upon a study done by Ogborne (1995) who states, an area of critical importance for youth treatment is collaboration between the youth and agency. In Ogborne (1995) study it was found that an important part of developing treatment plans is considering client preferences. This allows the client to be matched with treatment that is consistent with their needs and values. Expanding on Ogborne’s (1995) study, researchers asserted that taking into account client wants could improve treatment outcomes. Evaluating resident satisfaction surveys was affective in discovering the effectiveness of the contingency management system, possible improvements that could be made, and factors that increase treatment retention.
These findings are important to the field of behavioural psychology because they can encourage other treatment centres to begin giving their clients the opportunity to voice treatment preferences.

Multi-Level Challenges

Client Level. It can be challenging to work with clients in a residential setting. Many of the youth at this organization had co-occurring substance abuse disorder and a mental health disorder. When attempting to work with a client on a problem regarding substance abuse, mental health often became the focus. This is due to the severe nature of mental health disorders such as anxiety, depression, and borderline personality disorder that could cause the client to make dangerous decisions. Client safety must always be the primary focus of the staff. If a client began engaging in suicidal or self-harm behaviour, those behaviours would take priority over work on substance abuse disorders.

Clients would occasionally refuse to come to programming or leave group sessions early. This would be disruptive to staff and to other youth. Refusing to come to treatment would also result in youth missing valuable skills and information. In term of residential survey, some clients did not want to complete the survey. This could result in partially finished results as well as, many results found throughout the survey stating, “I do not want to be doing this.”

Program Level. The organization is run on a two or three staff model. If more than one client is in crisis at the same time, it is extremely difficult to control. This causes staff to have to deal with client crisis situations without other staff support. This can also result in one staff being left alone with the rest of the house.

Organizational Level. The organization has three different staffing shifts including morning, evening, and overnight. In between each shift change a meeting occurs with the staff that are leaving and beginning work. During this time staff discuss what occurred during the previous shift and highlight youth who may be struggling. Currently one staff must stay on the floor to supervise the youth. This individual can miss valuable information about what is going on in the house.

Societal Level. Dealing with members of society can be difficult with this population. Many individuals hold negative stigma about youth with substance abuse disorder. It is an important part of the agency treatment process that youth are engaged in positive pro-social activities. These often involve going out into the community. Occasionally clients will break the rules, or become engaged in an altercation while in the community. After such event an organization will often turn away these clients and ask them not to return. Therefore it can be difficult to find places that will accept a youth.

A limitation to this study is that survey data goes back to year 2013. Throughout the years changes have already been implemented to the program. Survey results could be showing a result that is no longer relevant at the agency. Another limitation includes agency staff not distributing the survey. If the staff forgets or does not have time the survey could be forgotten for that month. This could potentially result in missing data or trends not becoming apparent.
References


Dave Smith Youth Treatment Centre Residential Client Experience Survey

Hello! We are asking for your help to evaluate the programming at the Dave Smith Youth Treatment Centre. We want to know what we are doing well and what we could be doing better. We want your honest opinions. Please note: Your name does not appear on the survey. Your answers are kept confidential and are only seen by the Quality Improvement Manager. Your specific answers will not be shared with staff. How you answer the questions will not affect the services you receive here. The responses from all clients will be put together to continuously improve our programs for clients. Thank you for participating!

General information
1. What year is it?
   - 2014
   - 2013
   - 2015

2. What month is it?
   - January
   - February
   - March
   - April
   - May
   - June
   - July
   - August
   - September
   - October
   - November
   - December

3. Which Dave Smith Youth Treatment Centre (DSYTC) Campus are you at?
   - Carp Campus (Female Campus)
   - Carleton Place Campus (Male Campus)

4. How long have you been in residential treatment at the Dave Smith Youth Treatment Centre?
   - Less than one week
   - More than a week but less than one month
   - More than one month

5. How old are you?
   - Between 13-17 years old
6. Is this the first time you have been a residential client at the DSYTC?
   ○ Yes
   ○ No

7. Have you ever attended another residential treatment program (other than DSYTC)?
   ○ Yes
   ○ No

8. If yes (you have attended another residential program), how is DSYTC similar or different?

Your Experience at the Dave Smith Youth Treatment Centre
9. How satisfied are you with the quality of treatment you are receiving?
   ○ Very Satisfied
   ○ Satisfied
   ○ Neutral
   ○ Unsatisfied
   ○ Very Unsatisfied
   Comment

10. Would you recommend the Dave Smith Youth Treatment Centre to a friend who was struggling with substance use issues?
    ○ Yes
    ○ Somewhat
    ○ No
    Why or why not?

I feel that the staff at Dave Smith Youth Treatment Centre

<table>
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<th>11. Do a good job</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<td>12. Are fair with clients</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>13. Explain the rules of the program</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>14. Respect clients</td>
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<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>15. Agree with you on what your problems are</td>
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<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>16. Explain what your treatment is supposed to accomplish</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>17. Ask for your opinions about your problems and how to solve them</td>
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<td>18. Agree on what to do about your substance use</td>
<td>○</td>
<td>○</td>
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<td>○</td>
<td>○</td>
</tr>
<tr>
<td>19. Help you do something about</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
your substance use
20. Agree on what to do about your other problems (e.g. mental health, family.)
21. Help you do something about your other problems (e.g. mental health, family)
22. Are sensitive to your cultural background
23. Give you enough help for now
24. Are available when I need them
25. I felt welcomed by staff when I arrived at DSYTC.
   o Strongly Agree
   o Agree
   o Neutral
   o Disagree
   o Strongly Disagree
   Why or why not?

26. I felt welcomed by the other clients when I arrived at DSYTC.
   o Strongly Agree
   o Agree
   o Neutral
   o Disagree
   o Strongly Disagree
   Why or why not?

27. The Peer Buddy program is helpful.
   o Strongly Agree
   o Agree
   o Neutral
   o Disagree
   o Strongly Disagree
   o Not applicable
   Why or why not?

28. Staff and I agreed on my goals and treatment plan.
   o Strongly Agree
   o Agree
   o Neutral
   o Disagree
   o Strongly Disagree
Comment

Your Safety at the Dave Smith Youth Treatment Centre
29. Do you feel safe at the Dave Smith Youth Treatment Centre?
   o Yes
   o No
   If not, can you tell us why?

30. Do you think bullying is a problem at the Dave Smith Youth Treatment Centre?
   o Yes
   o Somewhat
   o No
   Comment/example

Academic Program (school)
31. How satisfied are you with the academic program or 'school' at Dave Smith Youth Treatment Centre?
   o Very Satisfied
   o Satisfied
   o Neutral
   o Unsatisfied
   o Very Unsatisfied
   o Not applicable
   Any comments about academic program or 'school'?

Individual Therapy Sessions
32. How satisfied are you with the individual therapy sessions at Dave Smith Youth Treatment Centre?
   o Very Satisfied
   o Satisfied
   o Neutral
   o Unsatisfied
   o Very Unsatisfied
   Any comments on your individual therapy sessions?

Group Sessions
33. How satisfied are you with the group sessions at Dave Smith Youth Treatment Centre?
   o Very Satisfied
   o Satisfied
   o Neutral
   o Unsatisfied
   o Very Unsatisfied
34. What group sessions are the most helpful to you?

35. Are there any group session topics that you think should be added to the program?

Contingency Management 'Points System'

36. How do you feel about the 'points system'?
   - Very Satisfied
   - Satisfied
   - Neutral
   - Unsatisfied
   - Very Unsatisfied

37. When you gain or lose points, do you understand why?
   - Yes
   - Sometimes
   - No

38. Do you change your behavior to get points/avoid losing points?
   - Yes
   - No

39. If yes, can you give an example?

40. Do you have any suggestions for CM privileges that clients could earn?

Prosocial Activities (Recreation)

41. How satisfied are you with the prosocial activities at Dave Smith Youth Treatment Centre?
   - Very Satisfied
   - Satisfied
   - Neutral
   - Unsatisfied
   - Very Unsatisfied

42. Are there any prosocial activities you feel should be added to the program?

Food Services

43. How satisfied are you with the food provided at the Dave Smith Youth Treatment Centre?
   - Very Satisfied
   - Satisfied
   - Neutral
   - Unsatisfied
   - Very Unsatisfied

Comments
Are you being helped?

44. Compared to when you first arrived at the Dave Smith Youth Treatment Centre, do you feel that your quality of life is
- Much Worse
- Somewhat Worse
- About the Same
- Somewhat Better
- Much Better

Comment/example

45. Compared to when you first arrived at the Dave Smith Youth Treatment Centre, is your physical health now
- Much Worse
- Somewhat Worse
- About the Same
- Somewhat Better
- Much Better

Comment/example

46. Compared to when you first arrived at the Dave Smith Youth Treatment Centre, is your mental health now
- Much Worse
- Somewhat Worse
- About the Same
- Somewhat Better
- Much Better

Comment/example

47. Compared to when you first arrived at the Dave Smith Youth Treatment Centre, how do you feel now about your ability to achieve your substance use goals?
- Much Worse
- Somewhat Worse
- About the Same
- Somewhat Better
- Much Better

Comment/example

48. Compared to when you first arrived at the Dave Smith Youth Treatment Centre, how do you feel about your ability to achieve your life goals?
- Much Worse
- Somewhat Worse
- About the Same
- Somewhat Better
- Much Better
49. Compared to when you first arrived at the Dave Smith Youth Treatment Centre, how is your relationship with your family?
   - Much Worse
   - Somewhat Worse
   - About the Same
   - Somewhat Better
   - Much Better

50. What helps you to stay in treatment and committed to working towards your treatment goals?

51. What makes it hard to stay in treatment and working towards your treatment goals?

52. What has been the most helpful to you so far at the Dave Smith Youth Treatment Centre?

53. What has been the least helpful to you at the Dave Smith Treatment Centre?

54. Have there been particular staff who have been especially helpful to you? What do they do that makes them so helpful to you?

55. What needs to be improved or changed at the Dave Smith Youth Treatment Centre?

56. Is there anything we didn't ask but you would like us to know?