

Sade Iyare

Semi-structured interview instrument on client satisfaction for therapeutic community clients

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<p>Therapeutic community (TC) treatment is used around the world to treat drug addicts. Perheiden yhdistetyn hoidon yksikkö (Pyy) unit of Helsinki Deaconess Institute is specialized in drug rehabilitation of the families with children.</p> <p>Based on Cox's Interactive Model of Client Health Behavior (2003) there is a connection between the client satisfaction and the results of the treatment. TC is known to be efficient method of treatment to treat drug addicts, but there is still very little data collected from client satisfaction in TC care. The aim of this study was to develop a semi structured interview instrument on client satisfaction in TC care in Pyy and conduct a pilot study using the instrument.</p> <p>The instrument was developed with Delphi technique, where panel of TC experts commented on the suggested themes of the instrument during two Delphi rounds, ending with the total number of 13 open-ended questions. The pilot interviews were conducted by Pyy staff.</p> <p>There are four main themes in the developed instrument: affective support towards the client, useful health information, client's decisional control over their care and professional-technical competencies of the care provider. The pilot interviews show that this kind of interview instrument can work also in TC setting, and it can bring important information from the client perspective to the personnel on how to develop the TC treatment method in Pyy unit. Since the instrument questions developed are not specific to Pyy care, the instrument could be applied also in other TC settings.</p>	
Keywords	Therapeutic community, client satisfaction, Cox Interaction Model of Client Health Behavior, Delphi method

1 Introduction

Finland is one of the few European countries, where alcohol consumption has been increasing almost continuously during last 50 years. In 2013, the total consumption of alcoholic beverages equaled 11.6 liters of pure alcohol per person aged 15 years or older (Varis – Virtanen 2014). The most recent strong rise in the consumption was noticed after alcohol tax reduction in 2004, when the consumption of pure alcohol was 10 liters per capita. Many characteristics of drinking culture in Finland have remained for a long time, such as drinking on weekends, drinking to get drunk and men consuming more alcohol than women. Probably the biggest change in Finnish drinking habits has been the increase of women's alcohol consumption to six-folded during 40 years. Finnish people drink more alcohol home than before, and men and women drink more alcohol together home and in restaurants. As the alcohol consumption has increased, so have the problems related to drinking alcohol grown noticeable bigger. (Warpenius - Holmila - Tigersted 2013)

Drugs, not even cannabis, have not become very popular among Finns. Anyway the so called second wave brought the drugs more known to Finnish through media publicity. The register-based study conducted by Ollgren et al. (2014) estimated the number of problem amphetamine users in Finland in 2012 at 11,000 – 18,000 and the number of opioid users at 13,000 – 15,000. Based on this study it seems that the amount of problem drug users has increased in Finland in recent years. The usage and home growth of cannabis has also become more popular among young, but in addition also among a bit older age groups. In social- and health care services drug problem can be described as a daily phenomenon. (Warpenius et al. 2013, Ollgren et al. 2014)

Attempts to treat substance abuse have commonly been met with only limited success, with many people failing to enter treatment, dropping out, or relapsing soon after completing treatment (Da Silva – Chan – Berven – Thomas 2003). As an exception to this the therapeutic community (TC) model has shown to reduce both drug use and tendency for relapses, while increasing employment rates, social and emotional functioning, and other variables related to health and quality of life in general and to specific client populations. The TC model is widely practiced in more than 65 countries as one of the most commonly applied methods of substance abuse treatment. (Morgen – Kressel 2010)

The TC model for the treatment of drug abuse and addiction has existed for about 50 years. In general, TCs are drug-free residential settings that use a hierarchical model with treatment stages that reflect increased levels of personal and social responsibility. Peer influence, taken place through a variety of group processes, is used to help individuals learn and understand social norms and develop more effective social skills. (What is therapeutic community 2002)

TCs differ from other treatment approaches principally in their use of the community, which consists of treatment staff and those in recovery, as key agents of change. This approach is often referred to as "community as method." TC members interact in structured and unstructured ways to influence attitudes, perceptions, and behaviors associated with drug use. (What is therapeutic community 2002) As the TC continues to evolve into the mainstream of human services, it is changing, reshaping its staffing composition, modifying its approach and to some extent resetting its goals. These changes are expected and consistent with the TC's own teaching which stresses that the only certainty in life is change itself. But in this evolutionary transition, there is a significant risk that the original model and method will mutate beyond recognition and more importantly lose its effectiveness. This is a risk that requires the TC to hold on to what is unique about its identity and its efficacy. (De Leon 2000)

De Leon (2000) has recognized a need for new type of research in TC. He states that since 1990's research has concentrated in the TC's theoretical perspective concerning the need for long-term treatment to change the "Whole person". De Leon suggests that new research on TC should guide in what ways the TC model and method can be modified, for whom it works best and how to improve the treatment process. Paddock et al. (2007) agree with this by saying that the TC approach to substance abuse treatment is an often-successful yet largely understudied process of individual rehabilitation that involves every aspect of the treatment environment. Ronel et al. (2013) emphasize that routinely assessing client's perceptions is important in understanding which ingredients of treatment contribute the most.

Many studies have shown the efficacy of TC drug dependence treatment in reducing criminal activities and drug use and promoting prosocial attitudes and social functioning. However, our knowledge about how the TC therapeutic process works is still limited. One way to explore this issue is by focusing on how customers view their treatment experience. Customers' subjective perceptions constitute a significant variable that is correlated with treatment preservation, length of sobriety following treatment and

the length of stay which is the largest and most consistent predictor of positive post-treatment outcomes. The perceptions of clients are considered a good predictor of risk of relapse. Despite the significance of this variable as a key to understand the therapeutic process of recovery, studies on customers' perspectives are still limited and less data have been collected. (Ronel – Elisha – Timor – Chen 2013)

There is an increased focus on client satisfaction within health and social care field but to date this has had less impact on drug misuse treatment than on other areas of the field. Morris and McKeganey (2007) found out that higher levels of client satisfaction predict more favorable outcomes. This means that services should aim to satisfy clients in order to maximize effectiveness and that the client satisfaction is an important tool when aiming for improving services.

The aim of this study is to develop semi-structured interview to find out client's views on what elements in TC have helped them in their process of rehabilitation and what could be improved.

2 Client satisfaction in therapeutic community treatment

2.1 Description of therapeutic community treatment

There is agreement that therapeutic communities as a treatment option for drug users largely originated with the establishment of Synanon in California in 1958. Synanon was loosely based on the principles of Alcoholics Anonymous (AA) with recovered addicts as lay therapists, a shift to a residential program and a shift from a God-centred theology to a secular ideology. Glaser traces AA further to the Oxford Group Movement, an explicitly religious organisation aimed at the spiritual rebirth of all humanity. Among the practices of the Oxford Group were “sharing”, “guidance”, “changing”, “making compensation” and the development of “absolute values”. (De Leon 2000)

The TC is one of the major residential treatment methods for addicts with severe substance-abuse disorders. TC treatment is based on the assumption that substance abuse is a disorder of the whole person. Therefore the client's recovery progress involves multidimensional changes in terms of a drug-free lifestyle and personal identity. The social environment and primary treatment agent in the TC is the community itself.

This “community as method” approach is composed of a hierarchy of peers and staff who serve as counsellors and role models. (Ronel et al. 2013)

Traditionally, therapeutic communities (TCs) for addiction treatment have been characterized by a treatment philosophy of “right living” and “community as method” delivered in long-term residential programs largely directed and managed by clients. The TC model has emphasized a reliance on confrontational group therapy, treatment phases, and a hierarchy based on tenure in the program and community roles. (Dye – Ducharme – Johnson – Knudsen – Roman 2009)

To use the community to achieve one’s rehabilitative and therapeutic aims is characteristic for the TC treatment. TC is made of the physical and sociological environment and the therapeutic, rehabilitative and educative principles. Community consists of the patients and the staff members. TC treatment supports patient’s rehabilitation and daily living with functional activities and support from the group and staff. Each community creates its own culture and guidelines by following the principles of TC treatment. The patient, who is in the centre of the treatment, unconsciously influences their own recovery and rehabilitation through their actions. (Hännikäinen-Uutela 2004)

Also Ronel et al. (2013) stressed the significance of examining clients’ perceptions and recommended the consideration of client perceptions of treatment in developing correctional programs.

2.2 Customer satisfaction

Customer satisfaction can be defined as a positive reaction towards a product or service. It is always subjective and comparable, unique point of view. If the outcome does not meet the expectations, the customer is dissatisfied. If the outcome meets the expectations, the customer is satisfied. It seems self-evident that companies should always try to satisfy their customers since customer satisfaction is one of the most important measures in analyzing and defining company’s success possibilities. (Rope – Pöllänen 1994)

Customer focus and satisfaction is a driving force for many companies and organizations. Measuring customer satisfaction provides an indication on how an organization is performing or providing products or services. Customer satisfaction has traditionally

been studied within market research and the term customer satisfaction measurement is widely used in particularly business terminology. There are various definitions of customer satisfaction and to actually define satisfaction has proven to be hard because of its multiple dimensions. (Rope – Pöllänen 1994)

Customer satisfaction is generally understood as the satisfaction that a customer feels when comparing his preliminary expectations with the actual quality of the service or product acquired. In other words, customers are typically concerned with the value and quality of the product or service they receive. In addition, customers generally want the best possible product or service for a low cost. The perception of the best product or service and lowest price can, however, vary significantly by customer segment or industry. (Czarnecki 1998)

2.3 Theories of customer satisfaction

Customer satisfaction modelling has become an important tool for setting quality improvement priorities and improving marketing program effectiveness. Satisfaction models provide information regarding how companies perform on various benefits and features as well as the importance, or impact, the benefits and features have on satisfaction and following intentions and behaviours. (Auh – Salisbury – Johnson 2003.)

Professor Noriaki Kano is well-known for his model of customer satisfaction, which he developed in 1984. Kano's model defines the most important features of customer service: meeting the customer's basic needs, adding "extras" to basic service that will make a customer happier, and exciting and delighting the customer with a superior level of service that they did not expect. (Nolan - Bisognano 2006)

Kano suggests that steps to improve the value of any product or service can be divided into three categories:

1. Eliminating quality problems that arise because the expectations of consumers are not met
2. Reducing costs significantly while maintaining or improving quality
3. Expanding the expectations of consumers by providing products and services that they see as unusually high in value. (Nolan - Bisognano 2006)

A. Parasuraman has developed service quality model (also known as gap analysis) which is commonly used to measure service and quality. Gap analysis is the multi-item scale developed to assess customer viewpoints of service quality in a service and retail businesses. (Parasuraman – Zeithaml – Berry 1985)

The service quality model identifies five determinants of service quality which are touchables, reliability, responsiveness, assurance and empathy. Gap analysis is used to identify and correct gaps between the desired level of the customers and the actual level of performance provided by the organizations. Gap analysis shows the weaknesses of the company in fulfilling customer needs. (Parasuraman – Zeithaml – Berry 1985)

Both Kano's model of customer satisfaction and service quality model by Parasuraman are both widely used frameworks to research levels of customer satisfaction, but they do not take in to account the unique features of health care field.

2.4 Client satisfaction in health and social care

To compete successfully in today's consumer-oriented health care market, health care providers must evaluate the outcomes of their services, including client satisfaction. Client satisfaction is important both as a quality assurance measure and as a marketing tool that can give health care agencies and providers a competitive edge when bidding for health care contracts in a managed care environment. (Bear - Bowers 1998)

Healthcare delivery is becoming increasingly competitive. Patients, once regarded as recipients of health care, are now recognized as healthcare consumers. Identifying and understanding what influences healthcare consumers to perceive quality care and be satisfied with the care received is a critical competitive strategy for attracting healthcare consumers to a particular hospital and hence enhancing profits. (Wagner – Bear 2009)

Patient satisfaction is defined as the patients' subjective evaluation of their cognitive and emotional reaction as a result of the interaction between their expectations regarding ideal nursing care and their perceptions of the actual nursing care. Patient satisfaction has become important because of the increasing practice of applying a consumer policy viewpoint to health care while also safeguarding patients' rights and taking their

views into account. Another contributory factor is the knowledge that a patient who is satisfied complies, to a greater extent, with the treatment and advice they receive from health care professionals. A satisfied patient also tends to return more frequently when in need of health care. Moreover, a satisfied patient is more willing to recommend the hospital that provided his or her care to others. (Johansson - Oléni – Fridlund 2002)

Partnership between patients and health-care providers are considered an essential part of quality of health care. Patients in different health-care settings want to assume more control and involvement in decision making. The emphasis on quality of care and outcome measurement led to an increased recognition to the role of patients' perception of care in improving quality of care provided, and therefore, became a significant element in the modern health-care plan and management. Therefore, patients' perceptions related to quality of care provided have been considered seriously in assessing and evaluating health-care services. (Atallah - Hamdan-Mansour - Al-Sayed - Aboshaiqah 2013)

In response to commercial client satisfaction models Cheryl L. Cox developed an Interaction Model of Client Health Behavior (IMCHB) in 1982. This model offers a framework for assessing the unique combination of dynamic personal and background characteristics of a client in order to determine the most optimal way for the nurse to interact with the client to achieve positive health outcomes. (Wagner – Bear 2009)

Since this client satisfaction questionnaire is carried out in the health care setting, I chose to use Cox's IMCHB model as the theoretical framework. The model use is not limited by practice setting, but it can be applied in any type of healthcare atmosphere (Mathews et al. 2008). I am focusing on the client-professional interaction to gather more information of personnel of Pyy how their interaction affects the recovery process of clients.

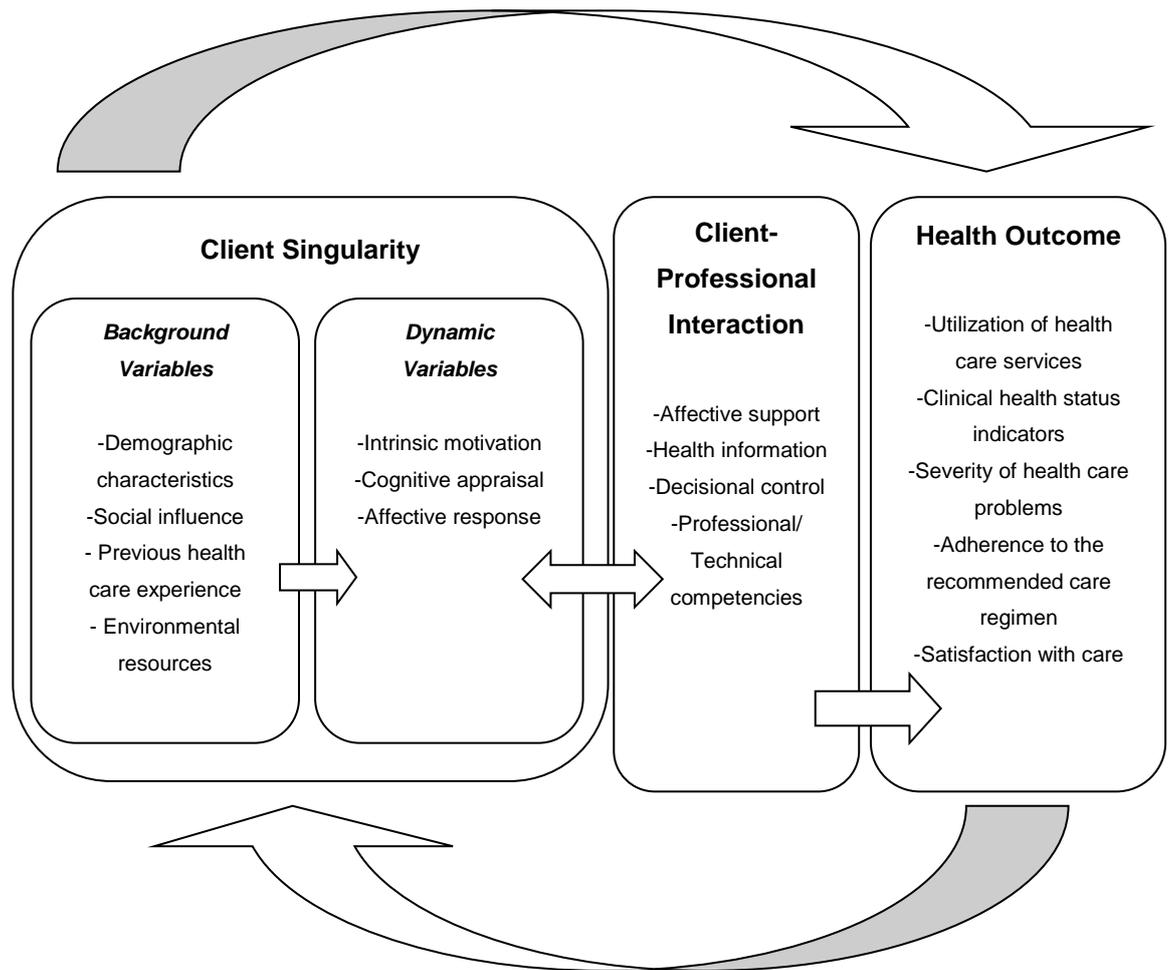


Figure 1. The interaction model of Client Health Behavior. Modified from Cox 2003.

The IMCHB model consists of three elements: client singularity (the unique intrapersonal and contextual configuration of the individual), client-professional interaction (the therapeutic content and process that occurs between a clinician and patient), and health outcomes (the behavior or behaviorally related outcome subsequent to a client-professional interaction). Instead of a one-way direction from client to professional to healthcare outcome, Cox's model proposes a mutual engagement between client singularity, interaction, and health outcomes. (Cox 2003)

The element of client singularity comprises two different sets of factors: background variables (e.g., gender, religion, health history) and dynamic variables (e.g., motivation, knowledge, fear). Selected background variables may change over time, but such change tends to be subtle. These variables can be defined and measured in terms of

many different factors. (Cox 2003) Cox views the client– professional relationship as having a major influence on healthcare behavior. There are four components to this category. The strength of each component will change according to client singularity and healthcare needs. The four components are health information, affective support, decisional control, and professional and technical competencies. (Cox 1982)

Health information: Knowledge can be viewed as power in a client–provider relationship. The provider who presents the knowledge to be used for setting goals and establishing competency in the client may produce successful treatment. If the amount of information is neither small nor large, the information is useful to the client and the client is able to process the information, application of the information could follow (Cox, 1982). The principles of teaching and educating the client should already be nursing's strong point. (Mathews et al. 2008)

The second component of this category is affective support, which is meeting the client at the same level of emotional arousal (Cox 1982). Cox asserts that ignoring affective support of the client or lending heavy affective support, meaning overwhelming the client, yields client withdrawal and dissatisfaction. The interrelationships in this category and client singularity are like a puzzle. For example, if the client's affective response overwhelms the cognitive appraisal of a disease, the provider must help the client by increasing the knowledge base. This therapeutic relationship is the core of nursing itself. (Mathews et al. 2008)

The third component of the client–provider interaction is decisional control. A client who exhibits decisional control will more likely participate in health-related behaviors. Also, the client may exhibit decisional control by letting the provider make the choice for the health behaviors. Decisional control would vary given the client singularity components. However, if a client's cognitive assessment of a disease is incorrect because of a lack of information, then the decisional control is limited (Cox 1982). Therefore, Cox proposes that decisional control needs more emphasis based on the factors of client singularity. (Mathews et al. 2008)

The fourth competency is professional-technical competencies. Cox (1982) focuses on the clients who depend on technical skills from the provider. The more the client depends on the provider's skills, for example, in administering intravenous medicines, the less decisional control the client maintains. As the dependence on the provider's tech-

nical skill decreases, the emphasis on the client's skills should be focused on increasing decisional control. (Mathews et al. 2008)

In terms of the IMCHB model five variables compose the health outcome: utilization of healthcare services, clinical health status indicators, severity of healthcare problem, devotion to the recommended care routine and satisfaction with care. (Wagner – Bear 2009)

2.5 Previous research and development projects in TC treatment

Chan et al. conducted a study in 2007 where TC treatment have demonstrated effectiveness in outcomes and appears suited to the needs of drug-involved offenders, who typically have long arrest histories and severe substance abuse problems. However, clients with different backgrounds or treatment needs may respond to treatment differently and a better understanding of the relationship between TC treatment process and client characteristics is needed to ensure that drug-involved offenders receive treatment that is most effective for them. (Chan – Wenzel – Wallace – Orlando – Ebener 2007)

Using a multidimensional measure of TC treatment process, Chan et al. found that prisoner clients who are older or are poly-substance users had higher Community Environment scores than clients who are younger or are mono-substance users, respectively. Clients with children and clients with fewer arrests had higher Personal Development and Change scores than clients without children and clients with more arrests, respectively. Chan et al. found few differences in process scores between clients in the female and male programs, although we observed stronger associations between treatment process and client characteristics in the male program. (Chan et al. 2007)

2.6 Instruments used in therapeutic community

There are already some existing instruments to use for survey in TC settings. One of them is The Dimensions of Change Instrument (DCI) which was designed to assess aspects of the TC treatment process from the client's perspective. The instrument was developed to examine whether client responses to process dimensions are able to pre-

dict outcomes, to gain a greater understanding of components of TC treatment, and thus to improve treatment quality. (Miles – Wenzel – Mandell 2008)

The DCI has eight subscales: Community Responsibility; Clarity and Safety (CS); Group Process; Resident Sharing, Support, and Enthusiasm (RSSE); Introspection and Self-Management; Positive Self-Attitude, Problem Recognition, and Social Network. (Miles – Wenzel – Mandell 2008)

In 1993 De Leon developed Therapeutic community scale of essential elements questionnaire (SEEQ) which assesses the extent to which a program has the generic characteristics of TC. The SEEQ measures the TC perspective, treatment approach and structure, community as therapeutic agent, education and work activities, formal therapeutic elements, and process. (De Leon 2000)

3 Purpose and aims of the study

Purpose of this thesis is to develop client satisfaction survey methods to use for TC care. The aim of this thesis is to study client satisfaction in TC.

Specific objectives are

1. To develop semi-structured interview instrument measuring client satisfaction for PYY community clients.
2. To make a pilot study for PYY clients in Helsinki Diakonissalaitos (Helsinki Deaconess Institute)

4 Research environment

The pilot of this study will take place in Perheiden yhdistetyn hoidon yksikkö. The unit is part of Helsinki Deaconess Institute. This Drug-Rehabilitation Residential Unit for Families (PYY) offers rehabilitation to families with drug-abuse problems. This form of care aims to support substance abuse-free parenting and to secure the child's development. A further objective is to prevent children from being taken into custody and to promote the termination of custody arrangements.

The treatment in PYY is based on Therapeutic community model. Clients can use medication maintenance treatment when needed. The clients have a history of alcohol and/or drug abuse. PYY aims to restore functional family dynamic and children's well-being is highly considered in PYY. Approximately 9-12 families go through the rehabilitation process in a year.

5 Materials and methods of the study

5.1 Design

The semi-structured interview instrument was developed by using a Delphi method. The Delphi method was named after the ancient Greek oracle at Delphi from which prophecies were given. An oracle refers to a statement from someone of unquestioned wisdom and knowledge or of infallible authority. It was first developed in early 1950's by Olaf Helmer and his associates at the Rand Corporation while working on the defence research project. (Kuusi 1999)

Delphi method is developed to use as a special tool in-between survey and qualitative research. The Delphi method is a systematic process through which experts reach consensus. This method is typically used when there are a small number of researchers in a particular area, such as the lack of research competencies in the field of counselling. The Delphi method involves selecting a panel of experts, who remain anonymous to one another, to provide their opinions and ratings through multiple structured steps. Usually the survey is mailed to experts of research topic. (Wester – Borders 2014) (Linstone –Turoff 2002)

The Delphi method has three central characteristics: anonymity, repetition, and feedback. The anonymity factor separates the Delphi method from other expert methods but it has its advantages and disadvantages (Kuusi 1999). Linstone and Turoff (2002) have also described the anonymity as being one of the most important factors when performing a Delphi research. The goal is to obtain genuine opinions and ideas without the experts feeling pressure from their employer or from their competitors.

There are different ways to apply Delphi method in a development work, and there is not one right way to do it. In this study Delphi process followed the process plan described by Ojasalo et al. (2009):

- 1) The problem is identified and the main aim of the study is defined.
- 2) A panel of experts is assembled. Experts in the problem area are identified and contacted.
- 3) Development of the first round questionnaire. In this study a set of questions for the questionnaire were built based on the Cox's IMCHB theoretical framework.
- 4) The questionnaire is sent to each member who anonymously and independently comments on the questions and sends it back to the author.
- 5) The results of this questionnaire are compiled and analyzed and on the basis of the responses received.
- 6) A second version of the questionnaire is developed.
- 7) Second version of the questionnaire is mailed back to participating members. The members are asked again to comment, suggest and answer the questions, possibly generating new ideas and solutions.
- 8) The responses to this second version of the questionnaire are compiled and analyzed.
- 9) Steps 6 to 8 are repeated as long as desired or necessary to achieve stability in the results. The above process is repeated until a consensus is obtained.
- 10) Then the final report is prepared.

5.2 Sampling and data collection

The selection of a representative panel of experts is critical to the validity and strength of the Delphi method. Panel members should be considered successful and knowledgeable in the area of study in order to make a valid contribution. In addition, a heterogeneous group of individuals with differing opinions, skills, and perspectives on the problem is needed to generate more comprehensive and full-bodied results. (Wester – Borders 2014) According to Metsämuuronen (2000) nobody can actually tell how many experts should be included or who is “good enough” to be part of the panel. There have been panels with more than thousand panelists, but already panel of 150 experts is considered big. Anyhow it is not agreed what would be the benefits of a big panel.

Purposive sampling design was used to choose the experts for the Delphi panel. This was necessary in order to make sure that experts have a wide knowledge and experience on TC care. Experts (n=5) were chosen to work as a panel for developing the client satisfaction interview instrument to use in Pyy TC setting. More experts were contacted to participate in the study, but all of them were not able to follow the planned schedule. Metsämuuronen (2000) mentions to take into account that all panelists may not reply, especially if the Delphi round is executed by mail. In this study panelists were contacted by e-mail to give the participants time to go through the suggested questions and consider their answers.

These experts chosen are skilled professionals who have a sound theoretical and empirical understanding on using TC treatment in the rehabilitation context. The experts work in the TC field in different kind of professions. Panel was aimed to build as very heterogeneous, and workers from different levels were included: from a practical nurse to a senior TC trainer.

In this research Delphi method was used to ensure that the most relevant aspects of the TC treatment will be taken into consideration in development of the questionnaire. A semi-structured interview was developed based on Cox's IMCHB model and then a panel of participants went through two rounds using e-mail, where they were able to comment on the planned customer satisfaction questionnaire. To try out the developed instrument a pilot interview was conducted with two Pyy clients. To ensure the clients were suitable for this study, clients who have stayed in the unit six months or longer were chosen.

5.3 Pilot study

Pilot study was conducted with two Pyy clients. Each interview was conducted by different staff member in order to get more feedback on the usability of the questionnaire. In the interview a staff member had a face-to-face meeting with the client in the quiet office. Staff member had the printed semi structured interview instrument and took notes when the client replied for the questions. The whole questionnaire was gone through by interviewing. The questions were asked in the same order as they are written down in Table 2.

6 Description of the Delphi rounds and results

A Delphi study was performed to seek consensus on the nature, wording, and number of the questions to include in the instrument. Metsämuuronen (2000) suggests that the opinions and the views of the experts are reached by the third round. In this study consensus was already found on the second round, although Metsämuuronen (2000) questions even the definition of “consensus” in Delphi study. In this study it was considered a consensus when panellists did not suggest changes on the questions of the instrument any longer.

In two rounds of request of comments, a panel of experts was consulted to provide feedback about the evolving set of items. The Delphi method consists of a repetitive process that aims to combine the perspectives of a panel of experts into a group consensus. It was decided to conduct two Delphi rounds, in anticipation of competing priorities and time constraints of relevant participants in the field of TC. Metsämuuronen (2000) emphasizes especially the importance of the suitable questions imposed on the first Delphi round. It can be considered crucial to make a successful study.

In the Figure 2 development process of the instrument is described as it was realized according to process described in Ojasalo et al. (2009).

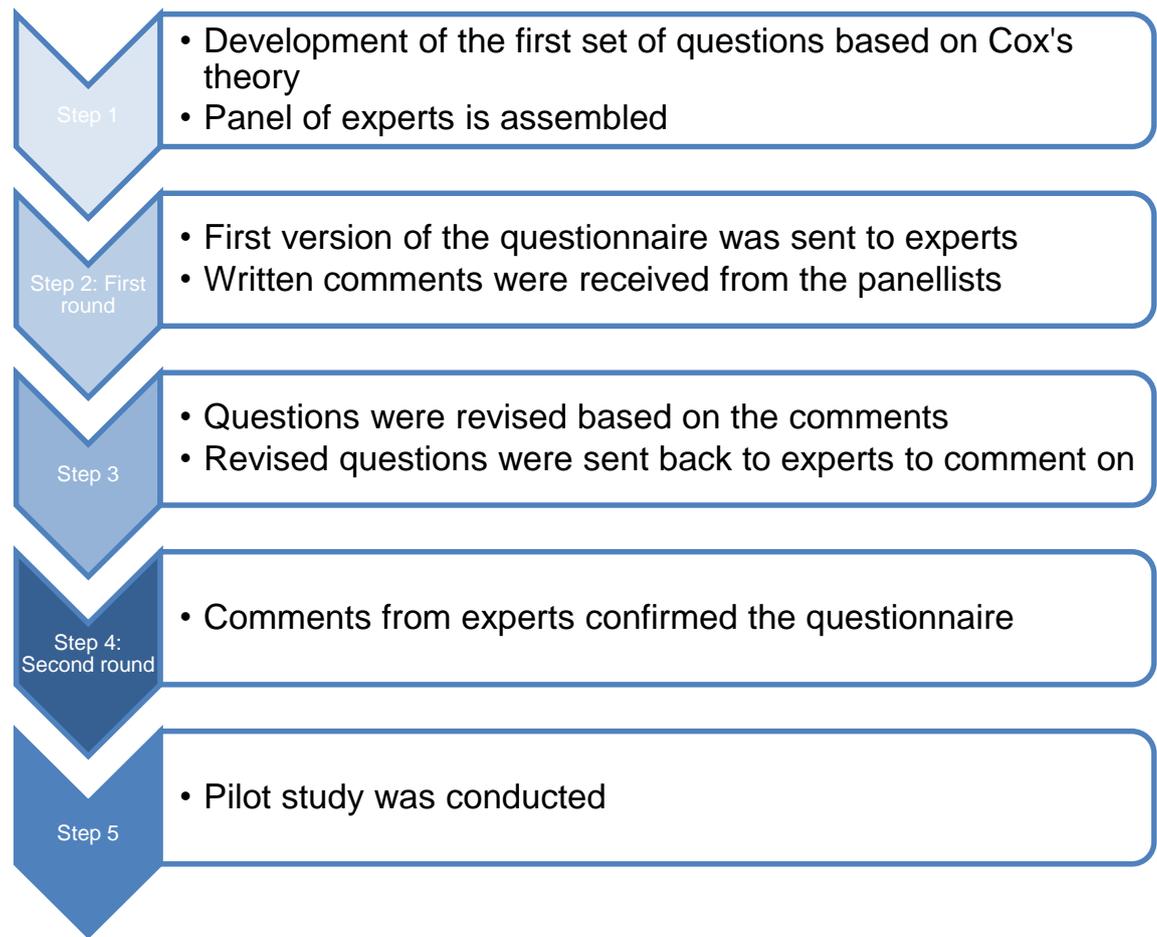


Figure 2. Delphi procedure and development of the instrument

6.1 Developing the instrument: Round one

The first set of interview questions was created based on client-professional interaction – category of Cox's IMCHB model. (See step 1 in Figure 2) There are four components to this category: affective support, health information, decisional control, and professional and technical competencies. (Cox 1982) The original set of suggested interview questions in Finnish is available as attachment 1.

The first interview questions that arose from affective support factor from client-professional interaction were (freely translated): "What helped your rehabilitation in Pyy-care?" and "How has the community influenced your rehabilitation?" Secondly the questions related to health information were created: "How did you get information of your addiction disorder?" and "What kind of things that are important for your rehabilitation you have learned during Pyy-care?" Then questions related to decisional control

were built. “In what ways you have been involved in your care process?” and “How have you participated in your rehabilitation?” Last, the questions regarding professional competencies were constructed: “How have the TC components of Pyy (such as groups, work responsibilities and so on) have advanced your rehabilitation?”

Five TC treatment experts were contacted to join the panel of experts in this study. (See step 1 in Figure 2) Four of them were invited orally and one panelist was contacted by e-mail. Four experts were willing to join the first Delphi round and one panelist said due to challenges with the schedule they would join the second Delphi round. The round one questionnaire was e-mailed to four experts. (See step 2 in Figure 2) Three experts replied with comments and suggestions. The sent mail included the first version of instrument questions a brief introduction to the aim of the study and a summary of the theoretical framework. The first version of questions freely translated in English is in the left column of table 1. The comments received suggested to put more emphasis on personnel’s role in client’s rehabilitation in the questions: two experts proposed asking an additional question about personnel’s role in client’s rehabilitation. Another suggested addition to the questionnaire was “What would you like to change/add in Pyy TC so it would aid your rehabilitation even more?”

Two panelists wanted to point out the question concerning the addiction disorder because they assumed likely not everyone who is in the Pyy treatment recognizes them having a disorder. A suggested question to replace this was “Has the community been able to add your understanding of your drug usage?” It was also suggested that instead of asking “What kind of things that are important for your rehabilitation you have learned during Pyy treatment?” the question should ask “what kind of important things you have learned and what important you have experienced”. Because only one expert brought this up, the question of learning and experiencing was put in two separate questions for the second Delphi round.

Two of the experts questioned whether two of the questions related to decisional control were too similar to ask, so the instrument for the second Delphi round was left with only one question concerning client’s own participation. In addition it was recommended to add two questions about the clients’ roles in TC. According to DeLeon (2000) one of the defining elements of the TC model is the use of peer roles for social learning. Suggested questions were about client’s role as a helper and receiver of help: how he has performed in these roles and how he experienced them. For the question concern-

ing how the components of Pyy have advanced client's rehabilitation, it was suggested to ask also how client has experienced them.

6.2 Developing the instrument: Round two

After receiving the comments from the first round changes were made to the questionnaire the second version was e-mailed to five panellists and three of them replied. (See step 3 in Figure 2) The original set of suggested interview questions for round two in Finnish is available as attachment 2. The questions freely translated in English are available in table 1.

Table 1. The development of the instrument.

Questions based on theory	Revised questions
What helped your rehabilitation in Pyy-treatment?	What helped your rehabilitation in Pyy-treatment?
How has the community influenced your rehabilitation?	How has the community influenced your rehabilitation? - What has been the meaning of peer support in your rehabilitation? - What has been a role of the staff in your rehabilitation? - Is there anything to develop in staff's function?
How did you get information of your addiction disorder?	Was the community able to increase your understanding of your drug usage?
What kind of things those are important for your rehabilitation you have learned during Pyy-treatment?	What kind of things those are important for your rehabilitation you have learned during Pyy-treatment? What kind of things those are important for your rehabilitation you have experienced during Pyy-treatment?

In what ways you have been involved in your care process?	How have you participated in your rehabilitation?
How have you participated in your rehabilitation?	How have you performed in the role of a helper? How you have experienced it? How have you performed in the role of receiving help? How you have experienced it?
How have the TC components of Pyy (such as groups, work responsibilities and so on) advanced your rehabilitation?	How have the TC components of Pyy (such as groups, work responsibilities and so on) advanced your rehabilitation and how did you experience them? - What would you change in Pyy-treatment so that it would better aid your rehabilitation?

The panel almost fully agreed with the second version of suggested questions for the instrument. (See step 4 in Figure 2) One expert brought up the language used in the questionnaire and proposed whether it would have been more suitable to discuss “recovery” instead of “rehabilitation”. Anyway it was decided to stay with the original term “rehabilitation” since when clients come to Pyy TC word “rehabilitation” is used daily in group meetings and everyday conversation. In Pyy treatment it is not common to refer to “recovery”, and this could confuse the clients interviewed.

One expert suggested a change in the wording for the question about drug usage “Was the community able to increase your understanding of your drug usage?” Suggested version was “Were you able to increase your understanding of your drug usage with the help of the community?” This change was made for the final version because it makes the question more personal to the client.

Another proposal for change was in the wording concerned about peer roles in TC. In the revised questionnaire were two questions about the role of helper and role of help receiver. After second Delphi round panelist suggested following questions:

- How have you helped other members of the community? How did you experience this role?
- How have you received help from other members of the community? How have you experienced the role of a help receiver?

This proposal was supported by another panelist who also thought that probably clients would not recognize themselves as “helpers” or “receivers of help”. These changes to the wording were made. Since the panelists did not bring up new ideas to the questions, there was no reason to carry out another Delphi round. The final questions of the instrument is seen in Table 2. The final set of questions in Finnish is available in attachment 3.

Table 2. Final instrument.

Final questions in English (freely translated)	Final questions in Finnish
1. What helped your rehabilitation in Pyy-treatment?	Mikä Pyy-hoidossa auttoi kuntoutumistasi?
2. How has the community influenced your rehabilitation?	Kuinka muu yhteisö on vaikuttanut kuntoutumiseesi?
3. What has been the meaning of peer support in your rehabilitation?	- Mikä on ollut vertaistuen merkitys kuntoutumisessasi?
4. What has been a role of the staff in your rehabilitation?	- Mikä on ollut henkilökunnan rooli kuntoutumisessasi?
5. Was there anything to develop in staff's function?	- Oliko henkilökunnan toiminnassa kehitettävää?
6. Were you able to increase your understanding of your drug usage with the help of the community?	Pystyitkö lisäämään yhteisön avulla ymmärrystäsi päihteiden käytöstäsi?
7. What kind of things those are important for your rehabilitation you have learned during Pyy treatment?	Minkälaisia kuntoutumisesi kannalta tärkeitä asioita olet oppinut Pyy-hoidon aikana?
8. What kind of things those are important for your rehabilitation you have experienced during Pyy treatment?	Mitä kuntoutumisesi kannalta tärkeää olet kokenut Pyy-hoidon aikana?
9. How have you participated in your rehabilitation?	Miten olet itse osallistunut kuntoutumiseesi?

10. How have you helped other members of the community? How did you experience this role?	- Kuinka olet auttanut muita yhteisön jäseniä? Miten olet kokenut tämän auttajan roolisi?
11. How have you received help from other members of the community? How have you experienced the role of a help receiver?	- Kuinka olet ottanut apua vastaan muilta yhteisön jäseniltä? Miten olet kokenut avun vastaanottajan roolisi?
12. How have the TC components of Pyy (such as groups, work responsibilities and so on) advanced your rehabilitation and how did you experience them?	Millä tavoin Pyy rakenteet (ryhmät, vastualueet jne.) ovat edistäneet kuntoutumistasi ja miten olet ne kokenut?
13. What would you change in Pyy treatment so it would better aid your rehabilitation?	- Mitä muuttaisit Pyy-hoidossa, että se palvelisi kuntoutumistasi vielä paremmin?

The final instrument consists of thirteen interview questions. In the final questionnaire questions number 1 and 8 might echo from any of the four components from Cox's (2003) IMCHB model's "Client-professional interaction" category: affective support, health information, decisional control or professional/technical competencies. The answers to these questions would determine the component it reflects. Questions number 2, 3, 10, and 11, echo from affective support component of Cox's (2003) model. Question 9 addresses the issue of client's decisional control over their treatment. Questions number 4 and 5 address the component of professional/technical competence in IMCHB model (Cox 2003). The last question number 13 does not arise clearly from any of the four components mentioned, but it came along with the first Delphi round. Nevertheless it is very suitable open-ended question, just like nearly each question of the instrument, which gives respondents the freedom to respond in their own words, provide as much detail as they wish, and offer illustrations and explanations (Polit – Beck 2004).

6.3 Pilot interviews

Following the two Delphi rounds the semi-structured interview instrument was ready to try out in a pilot study in Pyy TC. (See step 5 in Figure 2) After conducting the interviews, interviewers commented that the instrument was clear to follow and questions were simple and easy to use. Although they mentioned that there was not proper place on the form to take notes. According to the interviewers some questions required additional questions or further explanation from the interviewer to get understood by the interviewee. One question gave an option to answer yes or no. Interviewees gave feedback that the instrument included many similar questions. On the other hand the interviewers observed that when repeating the similar questions the client had a chance to mention new information to the interviewer, or deepen the information already received. Interviewees found some of the questions difficult to answer, and both clients left one question unanswered each.

7 Discussion

The Interaction model of client health behaviour IMCHB (Cox 2003) gave a suitable foundation to develop client satisfaction questionnaire for TC context. Based on the comments from Delphi panel, all major points were already covered from the start. It seemed to be a good approach to concentrate on the client-professional aspect from the model, since while customers are staying in TC care in Pyy unit, the staff cannot have influence on the component of background variables of IMCHB model (Cox 2003) and it would be too early stage of the treatment to use health outcome aspect.

Originally seven experts were contacted for the panel and four were able to participate. The consensus of the nature of the client satisfaction questionnaire for TC treatment was achieved without a struggle. Based on the comments from the pilot interview's interviewers this kind of open-ended semi structured interview form requires active interviewer. The interviewer's role is remarkable and the interviewer should carry their responsible to make the interview conversation-like. Based on the pilot interviews the language used in the questions was probably too professional-like, and sometimes difficult to understand for the clients.

7.1 Ethical issues

The researchers must follow three major ethical principles in the study: autonomy, beneficence and justice. The principle of autonomy ensures that informants have a right to decide voluntarily whether they want to participate in the research. The principle of beneficence protects informants from psychological and physical harm. The principle of justice ensures that informants are treated with dignity and respect. (Polit – Beck 2004)

Based on the right to privacy, the data collection procedure should be done with absolute confidentiality and the collected data should be used strictly for the study purposes. The informants should be protected through anonymity or other confidentiality measures. (Polit – Beck 2004) This study was approved by the Ethical committee of Helsinki Deaconess Institute. All panellists remained anonymous and all clients remained their anonymity. All participants volunteered to be part of the development work, and they were aware they can drop out anytime during the process.

7.2 Reliability and validity

The validity of this research will depend on the truthfulness of the result, which also rely on the data usefulness. If Pyy TC treatment unit is unable to use the data then it is invalid (Silverman 2005). For this study Pyy unit of Helsinki Deaconess Institute has already expressed their interest to take the instrument as a routine part of their treatment and the personnel has shown interest to develop their work and methods based on results. Also other TC workers in Finland have shown interest to apply the instrument in TC settings.

Content validity is concerned with the sampling adequacy and efficacy of the content being measured. (Polit – Beck 2004) Since there were carefully chosen experts in the Delphi panel, the validity of the content was ensured during the process. The panellists paid special attention to the wording of the questions. Still, despite of the careful reviews, a yes-or-no question was left on final questions. Some multiple questions are left on the final version of the instrument, and these might reduce the validity of the data gathered. During the Delphi process attempt was made to avoid leading questions.

When considering the choice of the experts, it would have been beneficial to make the instrument more relatable and the language used more customer-friendly if at least one client would have been included in the Delphi panel. In this study the panel was made up only from TC professionals. Although the instrument is about client satisfaction, a client was not involved in the develop process from the beginning.

In this pilot study the instrument was tried out in person-to-person interview, but it could be also conducted in group interview. In-person interviews can be expensive and time-consuming and perceived anonymity by respondents is possibly very low. In this study the clients knew the interviewers before. This can be seen as strength in the study if it makes it easier for the client to open up and share more in-depth stories. On the other hand it can be seen also as a limitation of the study if low anonymity restricts the client to bring up openly criticism towards the TC unit and personnel. In group interview group interactions may accentuate members' similarities and differences and give rich information about the range of perspectives and experiences. Also when similar questions are administered simultaneously to a large number of people the obtained data are more identical, correct and standard. (Lambert - Loisel 2008)

Triangulation could enhance the credibility of the instrument in the future. Triangulation is the process of using multiple referents to draw conclusions about what represents truth and it has been said that triangulation helps to capture a more complete and contextualized portrait of the phenomenon under study. This semi-structured instrument could be tested for example at different times with the same client: for example after 6, 9 and 12 months of rehabilitation in Pyy TC treatment. As already mentioned above, the instrument was now piloted by person-to-person interviews, but to add its credibility it could be also tried out for example for couples, families or for the whole community in Pyy. (Polit – Beck 2004)

Metsämuuronen (2000) challenges the reliability of Delphi study, and questions whether the results of the study would have been different with other experts in the panel. The basic principles of TC care are clear and they have remained the almost the same since the beginning of TC from 1960's (DeLeon 2000). Therefore it is reasonable to assume that the instrument developed would most likely look very similar with other panellists. Even the fact that consensus was found effortlessly within two Delphi rounds supports this idea of clear standards.

To add the internal validity of this study it could be easily peer examined. Some TC experts could go through the instrument and give comments on its usability. In the ideal situation those peers would have not been involved in the Delphi process. To increase the external validity of this study the instrument would be recommended to test also in other TC unit. The questions developed are not very specific for Pyy but they are rather covering key points of TC treatment generally.

7.3 Own reflection

Although this study used a theoretical framework from nursing context, Cox's IMCHB (2003), through Delphi panel it was able to achieve the essence of TC care to the instrument: the primary treatment agent is the community itself. Majority of the questions address the role of community in relationship to client's own personal rehabilitation process. On the other hand this instrument lacks the perspective of the special quality of TC treatment in Pyy, the parenthood. Pyy TC is specialized in rehabilitating parents with drug addiction. The limitation of the instrument is that it concentrates now solely on the drug addiction and the TC, not on supporting the parenthood or parent-child-relationship.

It has been known that the TC treatment method works well for drug addicts, but there are only few studies which aim to actually show how or why. Since the instrument is not tightly attached to Pyy, but it follows more the general guidelines of TC method and Cox's (2003) theoretical framework, it could be also tested in different TC settings: for example in prisons or in mental health care settings. If the instrument is used as it is now developed: semi structured interview questionnaire, then later assumedly some general themes would rise from clients' answers. Taking advantage of these themes, instrument could have potential to evolve to use to gather also quantitative data on client satisfaction in TC.

The final version of the instrument is developed for assessing client satisfaction care in TC setting, but it in fact covers nearly all aspects of Parasuraman's service quality model, too (Parasuraman – Zeithaml – Berry 1985): tangibles, reliability, responsiveness, assurance and empathy. The aspect of tangibles is not mentioned as its own question in the instrument, but questions based on professional and technical competencies can also belong to this category. (See page 22) The aspect of reliability can be found in several questions about the staff and community. Responsiveness refers here

especially to staff according to Parasuraman, so questions about personnel would cover this aspect. The questions that were categorized to the component of affective support of Cox's IMCHB (2003) can also refer to assurance and empathy. So even if service quality model was not the original framework for the instrument, it still somewhat covers all the five determinants of service quality. (Parasuraman – Zeithaml – Berry 1985)

Kano's model of customer satisfaction is based on satisfying customer's need in different levels: basic needs, "extras" and superior level service. (Nolan – Bisognano 2006) The instrument does not itself follow Kano's model, but client's answers could be interpreted accordingly to these three levels. First the basic needs must be defined in order to be able to assess if the expectations are met or are they exceeded. On the other hand if the main idea of this instrument was to assess client satisfaction, why the question "Have you been satisfied with Pyy TC treatment" was not in the questionnaire? Obviously yes-or-no questions are not highly recommended, but that short and clear question could have offered important information right to the point.

Ronel et al. (2013) emphasized the significance of examining clients' perceptions of the TC treatment, and this instrument answers that require by trying gaining understanding from customers' experiences. The open-ended questions leave lots of space for clients' thoughts and ideas, but if the client gives short answers, the interviewer has a big responsibility to ask further questions. Therefore if the instrument is used exactly as it is now, its reliability could be compromised based on interviewer. This can be avoided by giving detailed instructions how to make the interview conversational and leave space for the client to express their thoughts. The interviewer should not interrupt and they should be respectful.

Previously there has been The Dimensions of Change Instrument (DCI) in use in some TC settings. This semi-structured interview instrument will address a different perspective of TC treatment. DCI is built up to assess aspects of the TC treatment process from the client's perspective, and it estimates the received treatment from the shorter period of time. The recommended usage is every three months. (Miles - Wenzel – Mandell 2008) The instrument from this study is developed to give a more holistic view from the longer period of time, to evaluate the received TC treatment as a whole. The other questionnaire used in TC settings SEEQ is much longer instrument (140 multiple

choice questions) that aims to assess if the TC has the generic characteristics of TC. SEEQ instrument does not ask about personal experiences or individual's stories.

On their research about TC treatment effectiveness Chan et al. (2007) brought up how clients with different backgrounds may respond to treatment differently. This instrument's limitation is that it does not take into consideration the background variables or dynamic variables which Cox (2003) calls client singularity factor. It was also unfortunate that all panellists did not have a chance to participate, but that was expected. It was surprising that experts found consensus already after two rounds. Some experts were very doubtful about combining nursing-based theory of client satisfaction to the instrument on TC treatment where also client to client interaction plays a big role, but it actually fitted smoothly.

During the study no special attention was paid on the outlook of the instrument. The interviewers gave feedback on its practical usability, and reported that there was not sufficient space to take notes. If the instrument should be used regularly, it should be modified also to be functional for the staff to use. After the instrument has been tried out for a while, it could be assumed that similar themes of what works in TC care will rise up. For further development a thematic map could be drawn from most common answers, and instead taking written notes in the future, the interviewers could mark on the thematic map the issues brought up during each interview.

8 Conclusions

This study focused only on one section of Cox's IMCHB theory (2003), and in the future the instrument could be expanded also to the other segments of the theory. Questionnaire on client singularity-section could be developed and done in the beginning of rehabilitation or regularly for example quarter yearly. Semi structured interview on health outcome could be conducted once at the end of TC treatment and then perhaps again 6 - 12 months after leaving TC.

The data collected with the instrument could be analyzed for example with Webropol, an online survey and analysis software. Using such software would make it easier to gather and analyze data. The data from this instrument could be used several purposes, such as

- for marketing purposes to show how satisfied the customers are with the TC treatment or to show that the unit does routinely quality assurance by following client satisfaction
- a developmental tool for nursing. The information collected would show where clients would need more support and what kind of support they wish to receive
- within TC the results could be discussed in group meetings, by assessing why clients are so satisfied (or dissatisfied)

This study developed showed a new kind of interview form to begin gathering information TC drug rehabilitation treatment method. This instrument could be first used as framework for a qualitative study, and later those results could be developed to a quantitative study on TC. Another way how the instrument could be evolved further is to test this with some new questions concerning Client singularity aspect. (Cox 2003) This questionnaire showed to be fairly simple to conduct, and clients can give valuable information about their TC treatment to the personnel. I would recommend for drug rehabilitation and mental health TCs to test this instrument. This instrument can work for both inpatient and outpatient centres.

This instrument is a valuable new tool for TC settings and especially in TCs in Finland. Previously there was not a proper instrument to measure customer satisfaction in TC, especially not in Finnish. The foundation to develop TCs is to evaluate its functions. It has been rarely done systematically previously. The elements of this instrument are the key elements of TC treatment: personnel, peer support, client's own role and own actions and "TC as method". This instrument can become a major aid in marketing TC services in future. It brings to transferability to TC settings: the treatment is continuously evaluated and developing. The results from using this instrument will bring new information from the clients that cannot be gathered from elsewhere.

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Attachment 1

HAASTATTELUKYSYMYKSET, versio 1.

- Mikä Pyy-hoidossa auttoi kuntoutumistasi?
- Kuinka muu yhteisö on vaikuttanut kuntoutumiseesi?

- Kuinka sait tietoa päihdesairaudestasi?
- Minkälaisia kuntoutumisesi kannalta tärkeitä asioita olet oppinut Pyy-hoidon aikana?

- Millä tavoin olet ollut osallisena hoitoprosessissasi?
- Miten olet itse osallistunut kuntoutumiseesi?

- Millä tavoin Pyy-rakenteet (ryhmät, vastualueet jne.) ovat edistäneet kuntoutumistasi?

Attachment 2

HAASTATTELUKYSYMYKSET, versio 2.

- Mikä Pyy-hoidossa auttoi kuntoutumistasi?
- Kuinka muu yhteisö on vaikuttanut kuntoutumiseesi?
 - Mikä on ollut vertaistuen merkitys kuntoutumisessasi?
 - Mikä on ollut henkilökunnan rooli kuntoutumisessasi?
 - Oliko henkilökunnan toiminnassa kehitettävää?

- Pystyikö yhteisö lisäämään ymmärrystäsi päihteiden käytöstäsi?
- Minkälaisia kuntoutumisesi kannalta tärkeitä asioita olet oppinut Pyy-hoidon aikana?
- Mitä kuntoutumisesi kannalta tärkeää olet kokenut Pyy-hoidon aikana?

- Miten olet itse osallistunut kuntoutumiseesi?
- Kuinka olet toiminut auttajan roolissa yhteisössä? Miten olet tämän roolin kokenut?
- Kuinka olet toiminut autettavan roolissa yhteisössä? Miten olet sen roolin kokenut?

- Millä tavoin Pyy-rakenteet (ryhmät, vastualueet jne.) ovat edistäneet kuntoutumistasi ja miten olet ne kokenut?
- Mitä muuttaisit Pyy-hoidossa, että se palvelisi kuntoutumistasi vielä paremmin?

Attachment 3

HAASTATTELUKYSYMYKSET, lopullinen versio.

- Mikä Pyy-hoidossa auttoi kuntoutumistasi?
- Kuinka muu yhteisö on vaikuttanut kuntoutumiseesi?
 - Mikä on ollut vertaistuen merkitys kuntoutumisessasi?
 - Mikä on ollut henkilökunnan rooli kuntoutumisessasi?
 - Oliko henkilökunnan toiminnassa kehitettävää?

- Pystyitkö lisäämään yhteisön avulla ymmärrystäsi päihteiden käytöstäsi?
- Minkälaisia kuntoutumisesi kannalta tärkeitä asioita olet oppinut Pyy-hoidon aikana?
- Mitä kuntoutumisesi kannalta tärkeää olet kokenut Pyy-hoidon aikana?

- Miten olet itse osallistunut kuntoutumiseesi?
- Kuinka olet auttanut muita yhteisön jäseniä? Miten olet kokenut tämän auttajan roolisi?
- Kuinka olet ottanut apua vastaan muilta yhteisön jäseniltä? Miten olet kokenut avun vastaanottajan roolisi?

- Millä tavoin Pyy:n rakenteet (ryhmät, vastuualueet jne.) ovat edistäneet kuntoutumistasi ja miten olet ne kokenut?
- Mitä muuttaisit Pyy-hoidossa, että se palvelisi kuntoutumistasi vielä paremmin?