Content

Session	Topic	Trainer	Date
1.	**吸毒的趨勢及理論** 1A：Powerpoint file by David Cheung (The Trends of Drug Abuse & Drug Policy) 1B：Powerpoint file by David Cheung (World drug trend) 1C：Powerpoint file by Dr Lo (Various Forms of Addiction) 1D：Reference	David Cheung & Dr Lo Chun Wai	8/9
2	**藥物濫用、治療及驗毒相關之法律、中國禁毒法** 2A：Powerpoint file by Mr. Kong (吸食毒品的禍害、檢測和刑事責任)	Lawyer Mr Kong Chung Yan	8/9
3.	**香港多元化的戒毒治療及匹配服務** 3A：Powerpoint file by David Cheung (The UK Models of care for treatment of adult drug misusers) 3B：Reference--香港為吸毒者而設的治療及治療服務分級多模式架構(二零一零年十二月，第一版) 3C：Reference--Treatment Outcomes Profile(TOP) 3D：Reference--持牌自願性質的住院式戒毒中心及中途宿舍名單	David Cheung	15/9
4.	**藥物濫用做成的傷害** 4A：Powerpoint file by Dr Tse Man Li (Harm of Psychotrophic Substance)	Dr Tse Man Li	15/9
5.	**British Drug Policy and Present situation in Harrow** 5A：Powerpoint file by Dr Rosanna Cowan (Review of Treatment Effectiveness and the Implication on service commissioning and development in England - A Case Study in Harrow)	Dr Rosanna Cowan	22/9
6.	**A review of the Effectiveness of drug and alcohol treatment in England** 6A：Powerpoint file by Dr Rosanna Cowan (British Drug Treatment Policy and its Implementation)	Dr Rosanna Cowan	22/9

7.	**Addiction and offender Management policy in England** 7A：Powerpoint file by Dr Rosanna Cowan (Addiction and offender Management policy in England)	Dr Rosanna Cowan	6/10
8.	**Mobilizing resources-writing Proposals** 8A：Powerpoint file by Dr Rosanna Cowan (Mobilizing Resources by Writing Funding Proposals: the Essentials)	Dr Rosanna Cowan	6/10
9.	**吸毒者家人服務及互累症** 9A：Powerpoint file by Water (吸毒者家人服務及互累症) 9B：Powerpoint file by Water (有關家人之研究) 9C：Powerpoint file by Water (互累症) 9D：Powerpoint file by Water (Satir 不同家庭角色的輔導需要) 9E：Reference--個案討論 9F：Reference--Codependency test pack	Mr Water Lai	13/10
10.	**實證為本服務及研究工作** 10A：Powerpoint file by Dr Shek (Evidence Based Practice and Research Work) 10B：Powerpoint file by Dr Shek (Quantitative vs. Qualitative Research Designs) 10C：Reference	Daniel TL Shek, PhD	20/10
11.	**預防重吸及動機式晤談法** 11A：Powerpoint file by May (Therapeutic Community) 11B：Powerpoint file by May (Relapse Prevention) 11C：Reference -- Incident sheet 11D：Reference --戴托普信條 11E：Reference -- Relapse Prevention 11F：Powerpoint file by Water (動機式晤談法訓練) 11G：Reference --Effective Elements of Brief Intervention 11H：Reference --濫用藥物境況測量表	May Ngai & Mr Water Lai	20/10

12.	**靈性治療及同輩輔導** 12A：Powerpoint file by Eric Siu (靈性治療及同輩輔導) 12B： Powerpoint file by Eric Siu (福音戒毒治療綱要) 12C：Reference --得基輔康會(恩慈之家事工點滴一、二) 12D：Reference --詩歌 (奇異恩典) 12E：Reference	Mr Eric Siu	27/10
13.	**藥物測試及藥物濫用的評估** 13A：Powerpoint file by 政府代驗所 (Forensic Drug Testing of Biological Specimens) 13B：Powerpoint file by Dr S P Leung (Assessment of drug/alcohol abusers) 13C：Reference	政府代驗所 & Dr S P Leung	3/11
14.	**改進參與治療的合作性及降低損害** 14A：Powerpoint file by David Cheung (降低損害的概念) 14B：Powerpoint file by David Cheung (提昇接受治療者的合作) 14C：Powerpoint file by David Cheung (Improving Treatment Compliance) 14D：Powerpoint file by David Cheung& May Ngai (The role of coercion in drug treatment-Probation Order maker a difference)	David Cheung	3/11

Mobilizing Resources by Writing Funding Proposals: the Essentials

Certificate Course on Drug Treatment and Rehabilitation
29th September 2011
Rosanna Cowan

Objectives

- Recognize the challenges of bidding resources in capacity building and workforce development
- Understand the process of funding application
- Able to grasp the skills of writing funding proposals

Principles of Competition and Co-operation

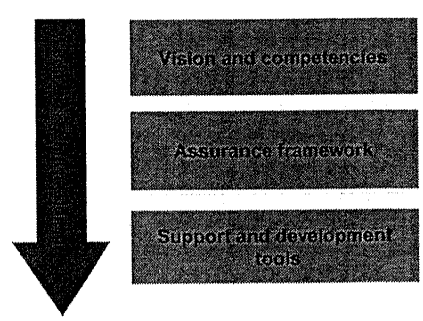
- Public Services Contract Regulations 1993 (a set of detailed rules relating to the procurement of services)d
- Value of the contact, maturity of the market, service types
- 10 Principles of Competition and Co-operation
- Commissioners should commission services from the providers who are best placed to deliver the needs of their patients and population.
- Providers and commissioners must cooperate to ensure that the patient experience is of a seamless health service, regardless of organisational boundaries, and to ensure service continuity and sustainability.
- Commissioning and procurement should be transparent and non-discriminatory.
- Commissioners and providers should foster patient choice and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare.

Competition and Co-operation cont'd

- Appropriate promotional activity is encouraged as long as it remains consistent with patients'best interests and the brand and reputation of the NHS.
- Providers must not discriminate against patients and must promote equality.
- Payment regimes must be transparent and fair.
- Financial intervention in the system must be transparent and fair.
- Mergers, acquisitions, de-mergers and joint ventures are acceptable and permissible when demonstrated to be in patient and taxpayers' best interests and there remains sufficient choice and competition to ensure high quality standards of care and value for money.
- Vertical integration is permissible when demonstrated to be in patient and taxpayers' best interests and protects the primacy of the GP gatekeeper function; and there remains sufficient choice and competition to ensure high quality standards of care and value for money.

World Class Commissioning

A split between Commissioner and Provider in Primary Care Trust



Vision: World class commissioning will deliver

- Better health and well being for all
  - People stay healthier for longer – "adding life to years."
  - People live longer and health inequalities are dramatically reduced – "...and years to life"
- Better care for all
  - Services are of the best clinical quality and evidence based
  - People exercise choice and control over the services that they access so they become more personalised.
- Better value for all
  - Informed investment decisions
  - PCTs work across organisational boundaries to maximise effective care.

How is it different?

- Strategic
- Long-term
- Outcome-driven
- Evidence-based
- Partnership-focused
- Clinically led
- Highly professional

What are competencies?

- Competencies are the skills, knowledge, behaviour and characteristics that underpin effective commissioning

Commissioning Assurance Framework

- Includes an assessment of both outcomes and processes. The three elements of commissioning assurance, outcomes, competencies and governance, reflect this combined approach.
- Outcomes reflect the overall improvement in health and well-being of the population.
- Competencies reflect improvements in the Trust's skills and behaviours as commissioners.
- Governance reflects the underlying grip that the board and the organisation have on their core business.

Market Management

- Understand the operation and performance of existing markets (Quality & Outcomes, access, choice, appropriateness of care, Value for Money).
- Characteristics of demands (patterns of demand, and projected change in demand)
- Characteristics of supply (provider landscape, existing and future capacity, any constraints)

The Bidding Process and its Requirement

- **Identify Project Team**
- **Scope the new service**
- **Report to Board to sign off**
- **Stakeholder Engagement Event**
- **Prepare tender/bid documents**
- **Instructions to Tender**
- **Advertise**
- **Expression of Interest**
- **Pre-qualification Questionnaire**
- **Checklist**
- **Invitation to Tender**
- **Interview and presentations**
- **Presentation to service users/carers**
- **Contract Award Notice**
- **Agree on Details of SLA**
- **Start transitional plan**

- External consultant
- Needs Assessment/ Evidence
- Representation of Board members
- Wider consultation
- Precise service specification
- Advert (a list of preferred providers)
- Deadline
- PQQ evaluation (with clear criteria and scores)
- Health & Safety, finance & insurance, references, reputations
- ITT – acknowledgement of receipt
- Deadline for submission
- Interview (criteria & score, panel members)
- Consultation
- Negotiation
- Management of the transitional process

Resources in terms of outcomes

- **Social capital** - the resource a person has from their relationships (e.g. family, partners, children, friends and peers). This includes both support received, and commitment and obligations resulting from relationships;
- **Physical capital** - such as money and a safe place to live;
- **Human capital** – skills, mental and physical health, and a job; and
- **Cultural capital** –values, beliefs and attitudes held by the individual.

Mobilizing resources

- Understand sources of resources – e.g. external funding committee, professional group, service user group
- Innovation – doing things in different ways
- Organization – joint venture and partnership working
- Team working – sharing ideas, projects, knowledge and skills
- Networking – shared objectives, knowledge (insider), relationship, influence and reputation

The strategic plan of proposal

- Gauging a practicable response to the scale of funding bid requirements'
- Analysing bid issues, options & approaches
- Seeing the bid from the client's side
- Matching work procedures with their cost implications
- Applying project management techniques
- Researching markets and projects
- Understanding client's needs and priorities
- Applying first-hand project experience to bid
- Assessing the risks and the potentials

Guidelines to set your course

- Focus on the client's needs
- Match the bid to the opportunity
- Be honest and realistic about what you can achieve
- Readability makes a difference
- Keep calm and in control

Successful Bid Writers

- Are bright technically
- Know how to write clearly and directly
- Work conscientiously and methodically
- Do what the client asks
- Care about detail
- Perform well in at team
- Understand outputs and meet deadlines

Exercise 1

- Group to learn to write a short proposal
- Ideas, Objectives, outcomes
- Realistic Costing
- Comments from other members
- How do you evaluate the success?
- Any other infra-structure to support the delivery.

A Few Tips to Successful Bidding

- **Suitability** – don't bid for everything; make sure it fits what your organisation is good at and can provide and manage effectively
- **Preparation** – Start as early as you can; high quality bid writing takes a lot of time
- **Guidance** - read the funding guidance notes and any other bid information very carefully;
- **Eligibility** - contact the funder if you want preliminary information before you bid
- **Language** – be concise and specific, use examples to support what you say
- **Style** – try through the guidance notes to get an idea of style of writing that funder prefers
- **Format** – follow the bid format preferred by the funder
- **Order of material** - present what you say in the order requested by the funder to make it easier for them to assess and score your bid
- **Scoring** – check the sections that they give the highest priority to in terms of marks awarded and give your own priority to these sections accordingly
- **Checking** – get someone independent to read over your bid before sending it off; particularly check that the finance information adds up!

Exercise 2: Role of Assessor

- Read the two funding proposals
- Mark the proposals against the criteria
- Share the score with other group members
- Explain your scores
- Reach an agreement of the scores and give the total scores
- Reflection on the process – what have you learnt from the experience as a group?

Online sources to help people through the maze (free or via subscription)

1. www.grantsonline.org.uk
2. www.grants4.info
3. www.governmentfunding.org.uk
4. www.funderfinder.org.uk
5. www.j4bgrants.co.uk
6. www.access-funds.co.uk
7. www.fundinginformation.org
8. www.companyvaiving.org.uk
9. www.governmentfunding.org.uk
10. www.grantsforindividuals.org.uk
11. www.trustfunding.org.uk
12. www.lotterygoodcauses.org.uk
13. www.grantfinder.co.uk (subscription)

吸毒者家人服務及互累症

2011年10月13日

講員：明愛樂協會
資深社工
黎子中先生

我們要解答兩個問題：

1. 為何要有家人服務？
2. 家人有甚麼需要？

為何要有家人服務？

1. 成癮問題初期和復發初期，家人往往有較大的求助動機
2. 齒輪效應 —— 一個家庭成員的轉變可引發濫藥者作出相應之轉變
3. 家人舉動(如：說話、支持、不信任)可對其態度和行為產生深遠影響
4. 家人需要醫治，才可更有效地發揮正面的力量
5. 系統理論——推動和拉動兩股力量(Pull and Push forces)，與濫藥者的朋輩系統互相抗衡
6. 處理深層問題 (治本)
7. 共同面對，一同承擔

有關「家人需要醫治」之解說

家人既是藥物濫用的受害者，同時亦是幫助濫藥者的重要資源——絕對可以是輔導員的良好合作伙伴；然而如果家人的情緒未能適當地獲得處理，家人便發揮不了良好伙伴的角色，甚至可能有相反的效果。

有關「推力和拉力」之解說

推力：	*拉力：*
*對藥物好奇	*藥物的吸引力
*情緒困擾	*朋輩鼓吹
*壓力	*社會風氣
*與家人溝通不到	*毒販策略

家人有甚麼需要？

--- 共同需要

--- 就其身份之需要
(例如：父母、伴侶、兄弟姊妹)

--- 明愛樂協會之經驗

有關家人之研究：

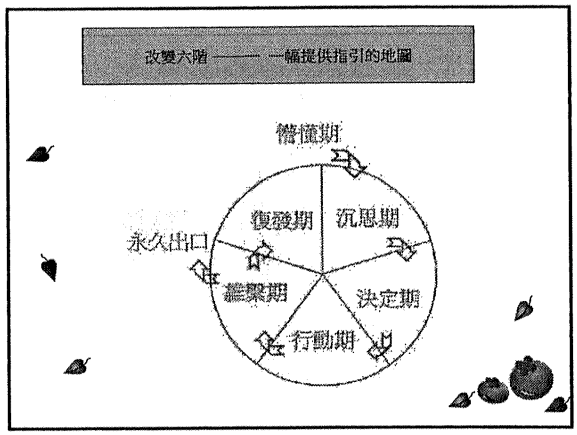
- 1. 觀察家人錦囊小組
- 2. 家人需要探討
- 3. 家人經驗調查

就需要而發展不同的服務——明愛樂協會的經驗分享

- 服務目標的發展——如何發展至家人？
- 家人服務的發展——三層服務：
  1）家人錦囊課程（由小組到講座形式）
  2）家人(家庭)互助小組
  3）家人探訪隊　（附過來人分享）
- 可以家人來開個案
- 增設興趣班、治療小組、親子平衡小組

家人互助組——互勉活動　　家人參觀 Disco

家人探訪隊探訪受困家庭　　藥物測試服務



改變六個階段（簡稱[改變六階]）與樂協會社工給家人的建議

階段	特點	工作員的任務	給家人的建議
懵懂期 Pre-Contemplation	尚未考慮改變	使濫藥者產生疑問－增加濫藥者對目前行為問題所在及危險性的認知	• 金錢管理； • 給如予壓力，讓濫藥者更體會濫藥的代價 • 休息（自己保重健康，為長遠作戰）

改變六個階段（簡稱[改變六階]）與樂協會社工給家人的建議

階段	特點	工作員的任務	給家人的建議
沉思期 Contemplation	內心矛盾，掙扎；感到有問題	促使濫藥者思考需要改變的理由，不改變要受哪些代價，強化濫藥者對自我能力的信心	• 改善關係； • 金錢管理； • 預備行動資料 (例如戒毒機構)

改變六個階段（簡稱[改變六階]）與樂協會社工給家人的建議

階段	特點	工作員的任務	給家人的建議
決定期 **Determination**	- 機會之窗 - 有計劃 - 有決心	幫助濫藥者決定最合適的行動策略	• 配合行動，給予信心和鼓勵 (可陪伴見社工或參與戒毒機構聚會)； • 等待戒毒期間與社工配合，推行減低傷害策略

改變六個階段（簡稱[改變六階]）與樂協會社工給家人的建議

階段	特點	工作員的任務	給家人的建議
行動期 **Action**	- 實行計劃 - 接受戒毒療程中	幫助戒毒者採取步驟，邁向改變	• 關係重建； • 留意探訪時的說話，與戒毒機構同工之配合； • 一起訂立康復計劃

改變六個階段（簡稱[改變六階]）與樂協會社工給家人的建議

階段	特點	工作員的任務	給家人的建議
維繫期 (康復期) **Maintenance**	- 正常生活； - 克服心癮，防止復發 - 若能長久操守，可達致永久出口 (Permanent Exit)	幫助康復者辨識復發的跡象，並採取防範措施	• 家庭關係改進； • 著重信任與溝通

改變六個階段（簡稱[改變六階]）與樂協會社工給家人的建議

階段	特點	工作員的任務	給家人的建議
復發期 **Relapse**	- 重吸	幫助重吸者重新開始，由沉思、決定、而行動，不要因復發而停滯或喪志	• 支持其汲取教訓，再站起來； • 如階段意 (懵懂期)； • 自己情緒要妥善處理

家長經驗分享

1. 當初如何接觸明愛樂協會呢？
2. 你曾參加過家人錦囊課程和家人互助組，學習到甚麼東西？
3. 家長要做些什麼才能幫到自己和濫藥的子女？
4. 樂協會的家人探訪隊帶給你甚麼體會？

供參考之處理方法：

(1) 鬆弛 — 要健康！

(2) 積極 — 把握危「機」！
(信念)

(3) 裝備 — 客觀認識，掌握資源
(有家人錦囊課程)

(4) 找「同路人」— 參加家人組
有共鳴)，
參考中
得啟發、燃希望！

供參考之處理方法：

(5) 找社工 — 合力處理，增方法，得支援

(6) 溝通 — 要學習，避「衝口而出」

(7) 健康的界線 — 別被濫藥者操控，甚至互累！

家庭為本介入手法分享

個案：

1. 家人情緒處理
2. 幫助家人學會表達欣賞小的轉變(嘉言善意)
3. 家庭面談
4. 鼓勵兄弟姊妹之參與
5. 畫家庭圖(重新思索自己在家庭之位置)
   ——借助 Bowen
6. 以藥物測試作輔助
7. 建立較健康的自我價值
   ——借助Satir

家庭為本介入手法分享

小組 / 活動：

1. 家長裝備課程
2. 家長同路人小組 / 探訪活動：比較、正面模範
3. 親子平衡小組
   (主題：快樂人生、學習解決問題、溝通)
4. 一致溝通訓練　　(借助Satir)
5. 學員：家庭重塑活動　(借助Satir)
6. 靜觀 / 正念 (Mindfulness)活動 —
   幫助人感受回自己
7. 敘事治療用於小組 (加迴響團隊)

附錄：快樂七式

招式一： 感謝與讚美
招式二： 健康樂悠悠
招式三： 敬業樂業/投入目標
招式四： 嘉言善意
招式五： 為善最樂
招式六： 常懷寬厚
招式七： 天倫情話

家長的態度應該.....

1. 冷靜
2. 動之以情——溝通與關懷
3. 欣賞其正面改變——即使是一小步
4. 不要譏諷
5. 盡快解決 〈切勿拖延、逃避！〉
6. 也要關注家中其他成員
7. 同時鼓勵其他家庭成員接受及協助濫藥
   子女解決問題

家長如何幫助濫藥子女脫離毒品？

1. 肯定濫藥害處
2. 避免過份保護 (例如：代還債項及隱瞞事實)
3. 小心家庭財物
4. 鼓勵子女求助 (與戒毒機構、醫生及社工聯絡)
5. 避免濫藥朋輩
6. 鼓勵健康活動
7. 合力處理問題 (包括濫藥背後之問題)

吸毒者家人工作的未來發展和出路

一些建議 / 可能性 :

1. 研究——介入手法/架構、成效探討
2. 可跨機構合作—互補
3. 可結合學術機構
4. 聯合家人組 ？
5. 匯聚力量，反映需要
   （社區工作手法？）

《答問時間 》

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謝謝

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有關家人之研究：

- **1.** 觀察家人錦囊小組
- **2.** 家人需要探討
- **3.** 家人經驗調查

STUDY ONE : DRUG EDUCATION GROUP EXAMINED

- ***Sharing of Significant Observations about the Group*** :
  1) many parents described themselves as 'failed' parents; some even blamed themselves that they should not give birth to the children (note the cultural stigma)
- 2) some complained society/government policy --- too loose to put young people in danger of drugs in a youth subculture treating drug use as a fashion

DRUG EDUCATION GROUP EXAMINED

- ***Sharing of Significant Observations about the Group*** :
- 3) the involvement of some siblings and close relatives in the group brought stimulation that they could take positions and roles different from parents in exhorting the drug abusers in a softer way
- 4) some parents revealed their own growing experience & marital problems in sharing (beyond the drug issue of their children)

DRUG EDUCATION GROUP EXAMINED

- ***Sharing of Significant Observations about the Group*** :
- 5) there were parents who kept quiet throughout the process and showed their attitude of 'just coming to listen and to learn'
- 6) mutual support & consolation seen as relationship among members built up in successive sessions

Reflections from the Examination and Observations

- 1) Drug Issue *No Longer* a Private Individual/Parenting Issue
- Family Education not equal to parent education ---- siblings & significant others involved;
- traditional assumption : parents take the sole responsibility for children's misbehavior, resulting in the self-blame;
- when *systemic perspective* adopted, the 'human surround' --- siblings, extended family, church, treatment organization, community, mass media, government policy, cultural notions of parenting etc. all taken into account
  (different systems involved from 'Socio-ecological Model')

Reflections from the Examination and Observations

- 2) Whole-person Development & Lifelong Learning
- Not necessarily focus on knowledge inoculation
- The program can touch the own development of family members (e.g. values, growing history, even marital difficulties & emotional management)
- Mutual learning through the program with reexamination of own values, practices & lives

Reflections from the Examination and Observations

- 3) Role of Family Group Worker : from Professional Expert to Partner
- Worker grow with the family members in jointly tackling the family difficulties
- With parent empowerment perspective
- Building on mutual trust & respect
- A joint venture of discovering new effective means of viewing & handling problems

Reflections from the Examination and Observations

- 4) Constructive Sides of Parenthood to be Explored
- Parents blame their giving birth to drug-taking children
- Can exploration of joyfulness of parents (viewing their children's growth from babies) & non-problem areas/strengths of drug abusers better motivate them face/handle today's difficulties ?

Reflections from the Examination and Observations

- 5) Sensitivity to Social Class Differences
- Certain degree of literacy needed
- Favor the middle class ?
- Working class, though in need of service, may find difficulty to tune in (so keep quiet & do not come next time)
- Can certain adaptations be made possible ?

Suggestions to Family Program in the Field --- the Directions

- 1) A Need-focused Orientation (instead of problem-focused)
- Reduce stigmatization effect
- What are the needs of family members ? Worth studying !
- Counteract negative cultural norms
- Explore needs & support them use their own strengths to fulfill the needs
  e.g. role play in jointly exploring better communication methods with drug abusers

Suggestions to Family Program in the Field --- the Directions

- 2) More Developmental (rather than remedial)
- family members can be encouraged to grow with times, with the world & with their children
- As a process of 'becoming', family members' self-growing can serve as positive model conducive for drug abusers' life changes (e.g. parents' learning youth culture & using new technologies to communicate might be surprising to their children and produce significant impacts on mutual growth)

Suggestions to Family Program in the Field --- the Directions

- 3) Wider Ecological Perspective
- Voices of parents and siblings can be channelized to influence the policy with other systems (e.g. schools, community organizations, health services & mass media)
- Can be mobilized in preventive activities with their heartfelt concern about protecting our youth from being destroyed by drugs
- Transform sorrow into positive input in building a more healthy community with other partners
- Sense of hope & social belongingness cultivated in the process (less 'helpless' & 'failed')

Suggestions to Family Program in the Field --- the Directions

- 4) Adaptations to Meet the Need of Working Class
- More activity-oriented approach (instead of literacy approach)
- Involve mature family members to revise the educational materials and to render live sharing of the materials (*Home Visit Team* has the potential to serve in this aspect !)

Study Two : Situation of Family Members of Drug Abusers

- A simple survey from 2003 to 2004 trying to understand the needs of family members receiving services in Caritas Lok Heep Club
- Opinions from 69 family members collected
- Points summarized :

Points summarized from Survey

- (1) 97% of drug abusers were males but about 80% of family members seeking services from Lok Heep Club were females, indicating the *gender differences* and their *readiness in receiving services*
- (2) The family members got access to the services mostly through *Probation Officers or Welfare Officers (about 30%) & referrals made by non-government organizations (24%)*

Points summarized from Survey

- (3) It took the range from less than half a year (36.4%), 1 to 3 years (20%) to more than 7 years (14%) *before* the drug abuse became *known to the family members*
- (4) While two-third of the family members received services under 3 years, *over 95% found the services helpful, in particular the mutual aid group & counselling services*

Points summarized from Survey

- (5) More *concrete* data on helpfulness of services to family members :
- Over 75% showed *reduction both in their physical and psychological complaints* after receiving the services
- Among them, 29.2% expressed *improvement in financial situation* & 54.4% indicated *betterment in family relationship*
- As a result, *over 90% expressed that they would introduce the services to others in need*

Concluding Remarks

Hoped :

1) The above discussion and findings would shed some light to policy makers and service providers in the field
2) More researches could be conducted to explore and understand at greater depth the needs and voices of these families after the exploratory survey
3) More attention to both the wounds/needs and the potentials of family members as they are first & foremost victims of drug problem but can serve as powerful support in prevention, treatment & rehabilitation of drug abuse when with proper back up

研究三：濫藥者/康復者家人電話調查

- 調查背景
- 時段：2006年8月2日至7日
- 被訪對象：藥物濫用者/康復者的家人
- 被訪人數：70
- 問題與結果：
- 1.子女有濫用藥物問題後，你在以下什麼時候才發現？
- □半年內未能發現 (74%!)
- □二年以上 (19%)　□不確定 (27%)
- (圖一)

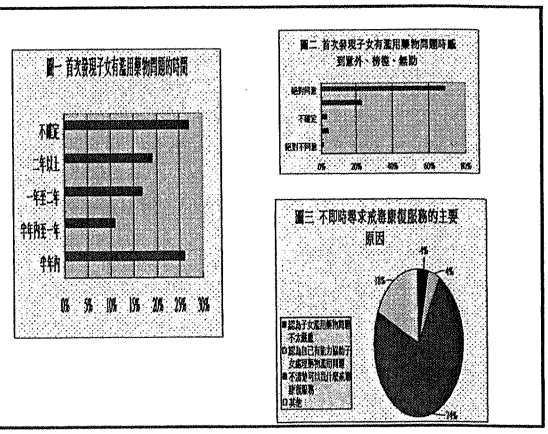
- 2.當你首次發現子女有濫用藥物問題時，你感到意外、徬徨、無助。
- □同意 (92%)　□絕對同意 (69%)
- (圖二)

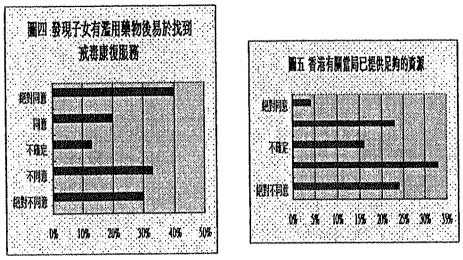
- 3.當你發現子女濫用藥物問題後，你是否即時尋求戒毒康復服務。
- 64%不會即時
(其中74%不清楚找甚麼戒毒服務) (圖三)

研究三：濫藥者/康復者家人電話調查

- 4.當你發現子女有濫用藥物問題後，你十分容易找到戒毒康復服務。
- 絕對不同意　及　不同意：合佔63%
- (圖四)

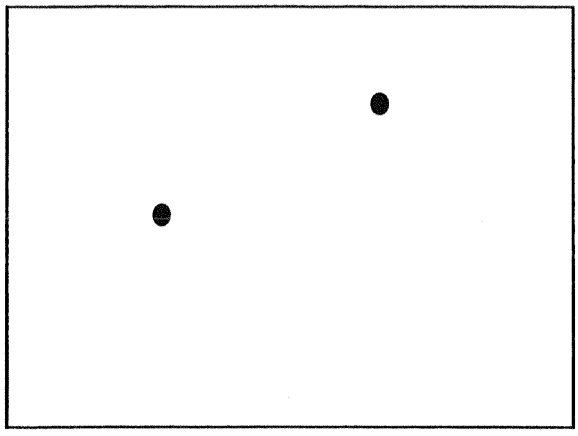
- 5.現時香港有關當局，已提供足夠的資源，協助家長處理子女的濫用藥物問題。
- 絕對不同意　及　不同意：合佔59%
- (圖五)

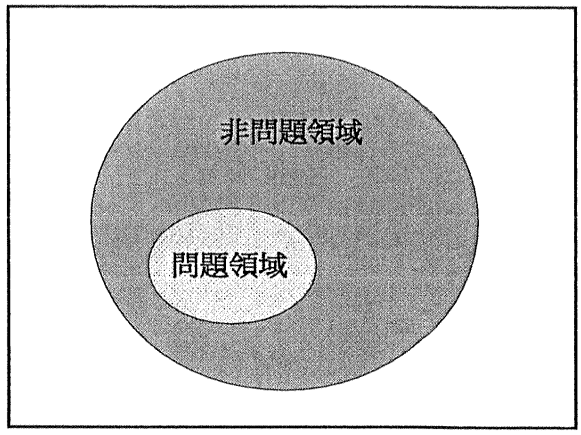




建議：

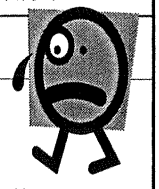
1. 提昇家長對濫用藥物問題的認識並加強與子女溝通
2. 協助家長處理有關子女濫用藥物問題所產生的負面情緒
3. 加強戒毒康復服務的宣傳
4. 提供足夠的資源協助家長處理子女濫藥問題





Satir 不同家庭角色的輔導需要

角色	輔導需要
討好型 (Placating) ——英雄	•建立信任的關係 •真摯地欣賞其美好的本質 （本性，而非所做的事） •家庭系統的探討 •對其角色行為及其後果給予誠實的回饋 •容許其維持角色直到其自尊感提昇至可作改變之地步 •參與小組

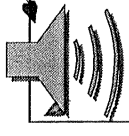


Satir 不同家庭角色的輔導需要

角色	輔導需要
超負責型 —— 維護者 (Enabler)	•建立信任的關係 •由問題和事件導引至感受層次 •協助其釋放感覺 (尤其是憤怒) •給予具了解和同理心之聆聽 •對其角色行為及其後果給予誠實的回饋 •家庭系統的探討 •參與小組 •多導向其集中自己的需要

Satir 不同家庭角色的輔導需要

角色	輔導需要
指責型 (Blaming)	•聆聽其氣憤、傷痛的地方 •發掘當事人潛藏的能量、渴望、希冀、堅持和價值，予以肯定，探討其他途徑可能滿足或達致之 • 教育有關沉溺的特徵 • 對其角色行為提供沒帶有指責含意的回饋 • 參與小組



Satir不同家庭角色的輔導需要

角色	輔導需要
打岔型 (Irrelevant) —— 小丑	• 安靜、舒適的氣氛 • 鼓勵內外一致性 • 確認其價值 (肯定他們是OK的) • 提供資訊讓其知悉需要知道的家事 • 提供專業援助以紓情緒困擾 • 參與小組

參考資料：

- Graves, M. (2007). *Sharing the legacy of Virginia Satir.* Hong Kong : Green Pastures Whole Person Development Centre. (Seminar Notes)

建議之輔導手法 (七大重點)

- 1. 著重找出強項的聆聽
- 2. 小組輔導 (提供參照對象)
- 3. 家庭治療 (著重重建個人自尊、獨立性的)
- 4. 內在快樂的培養——正向心理學 (快樂七式)
- 5. 模範作用 (正面的模範 Positive Role Model, 尤其在*界線設定*、情緒處理及健康的人際關係方面)
- 6. 實際支援 + 配套服務 (如：幫助沉溺者之治療、債務處理輔導、健康檢查服務)
- 7. 靈性治療 (重新感受自己作為一個人之價值、真正接納自己/生命之限制、鼓勵參與12步法)

<< 3C+3P+1S >>

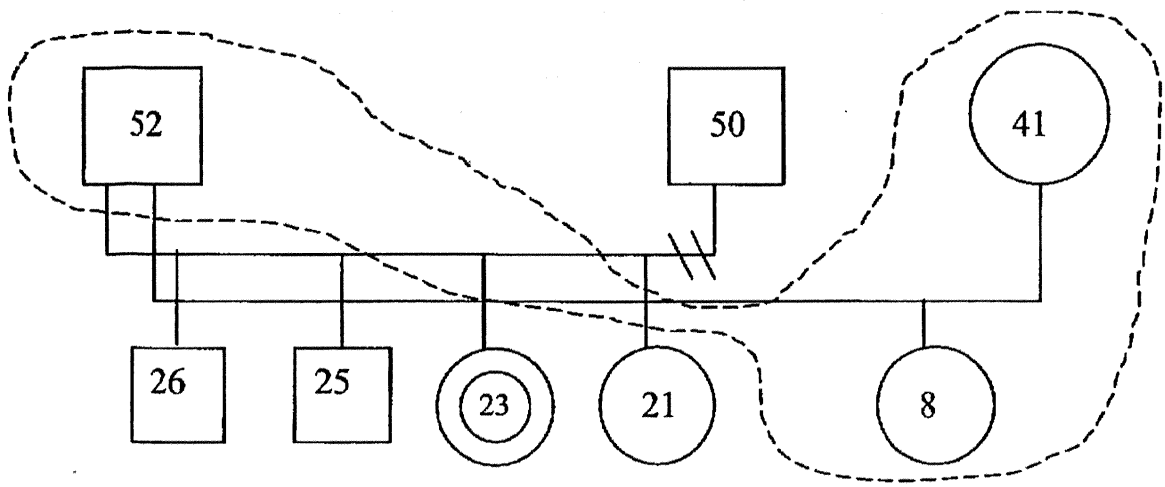
實務輔導經驗分享

- 家規檢閱
- 界線練習
- 接觸個人感受和需要——
  透過歌曲 (例如：問我、愛與痛的邊緣、思念是一種病)的幫助，
  促進自我接納和覺醒自己的失落
- 康復貼士
- 內在快樂之培育 (快樂七式)
- 平靜安穩的祝願

明愛樂協會

個案討論一

姓名：阿慧
年齡：23 歲
教育程度：中三
曾濫用之藥物：白粉，15 歲；大麻，15 歲；冰，21 歲；
搖頭，21 歲；菲仕通，21 歲
濫藥原因：受到朋友影響/想和朋友打成一片
避免因沒有服食藥物而帶來不適
個案背景：從幼起，父母對兒女的關心主要以物質供應爲主，缺乏正確價值觀的培育。童年時的阿慧，因父母妣離，逐漸與母親失去聯絡，父親再娶，阿慧與兄長們開始有明顯反叛行爲。
中學後，阿慧與兄長們因對生母的懷念，常與繼母衝突，在家感缺乏溫暖，故經常與朋黨四處流連、玩樂。
15 歲起，阿慧開始吸食毒品。漸漸地由與朋友打成一片，至因避免身癮而不斷濫藥。輟學後，阿慧因毒癮更趨嚴重，開始了買賣毒品的生活，並藉以應付經濟上的開支。逐漸地，她與家人完全失去聯絡。



資料來源：

基督教巴拿巴愛心服務團(編)(2006)。《結伴同行：濫藥者家人資源錦囊》(頁 15-19)。香港：基督教巴拿巴愛心服務團。

(一) 如何鼓勵濫藥家庭成員戒毒

數年後，阿慧因藏毒被捕。等候聆訊期間，她一直未有決心戒毒的念頭。直至感化官協助尋覓家人，阿慧在還押監房期間見到父親、兄長及繼母一同前來探望自己，更看見父親及繼母爲自己而哭起來，頓然感受到對自己支持及不離不棄，以致上庭時她最終決定接受爲期一年的福音戒毒療程。

給家人的啓示或提示：

(二) 戒毒期間家人如何配合

戒毒期間，阿慧一直得到家人的接納及支持。家人經常透過電話及書信與她保持聯絡，又積極參與家人探訪活動，讓阿慧真正體會家人的愛及支持，從而加強了她的戒毒動機。

給家人的啓示或提示：

資料來源：

基督教巴拿巴愛心服務團(編)(2006)。《結伴同行：濫藥者家人資源錦囊》(頁 15-19)。香港：基督教巴拿巴愛心服務團。

(三) 如何協助濫藥康復者面對重投社會的困難

由於阿慧離家多年，戒毒療程後期，她開始爲重投社會後居住問題而感到徬徨，幸而她的繼母相當體諒和接納，主動邀請她回家與家人同住，讓她能夠再次享受正常的家庭生活。然而，由於長期欠缺正常及有規律的工作生涯，對於新生活上的適應，阿慧常感壓力及無助。過程中，她的家人不斷表達關懷、體諒和鼓勵，讓阿慧由不懂表達、逃避問題，到開始學習面對、嘗試與家人分享感受，以致她能逐漸適應重投社會的生活，更加堅定戒毒的心志。

給家人的啓示或提示：

(四) 如何協助濫藥家庭成員預防重吸

阿慧離開機構後與家人同住，因未找到工作，空閒時會相約以往的朋友見面，及後發現朋友再次濫藥，始決心遠離他們，避免接觸。另一方面，重投社會一個月後，阿慧成功找到工作，任職文員，生活模式相當有規律。由於在工作上日漸與同事熟落，工餘時會與同事相約外出消遣。假日期間，阿慧與男朋友約會之餘，也會抽時間與家人外出用膳，享受與家人共處的時間。

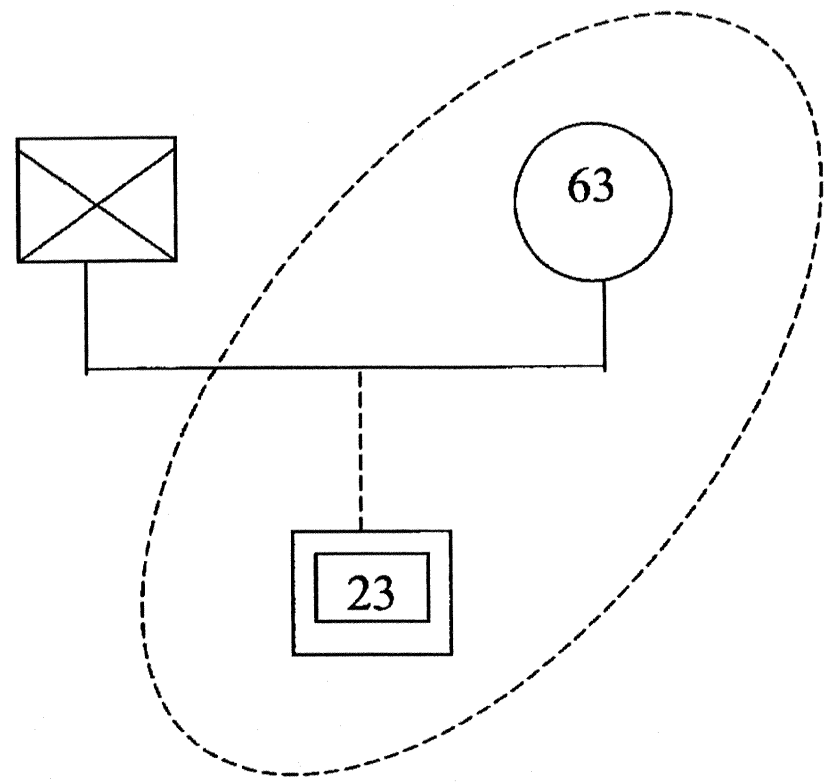
給家人的啓示或提示：

資料來源：

基督教巴拿巴愛心服務團(編)(2006)。《結伴同行：濫藥者家人資源錦囊》(頁 15-19)。香港：基督教巴拿巴愛心服務團。

明愛樂協會

個案討論二



去世時 70 歲
(當時案主 21 歲)

吸食毒品歷史：
案主於 16 歲跟街上之朋輩開始吸食 K 仔。

戒毒歷史：
18 歲因尿道炎被養母送至醫院，後來轉往一間福音戒毒中心住了個半月便中途放棄，很快便重吸，之後一再因藏毒而兩次進入強迫戒毒所。

家庭狀況：
養母天生駝背，是退休教師，自尊感低。
養父在生時十分縱容阿強，不時要給他「零用」，致令阿強無心向學，不務正業，終日和街上之朋輩吃喝玩樂以至吸毒。後來阿強經常向養父母苛索金錢，養父不堪壓力太大而跳樓身亡。養母經常被阿強威脅要給他金錢(不給的話他聲稱亦會跳樓)，擔心他做「傻事」，別人會以爲她不是好養母，或他又再犯法，令之前「幫助」他的努力前功盡廢，她不斷供應他金錢吸毒，自己的積蓄由過佰萬元變爲生活出現困難。

問題：
你會如何協助這個家庭？

個案討論一參考答案：

(一) 如何鼓勵濫藥家庭成員戒毒

1. 坦誠表達感受，讓濫藥家庭成員明白及學習照顧家人的感受。
2. 表達關懷和支持，陪伴濫藥家庭成員尋找戒毒途徑及辦理有關申請戒毒服務的手續。
3. 與濫藥家庭成員保持良好的溝通，耐心聆聽其內心的掙扎、擔心和實際困難，明白他們的感受和難處。
4. 尋求社工或有關專業人士協助。

(二) 戒毒期間家人如何配合

1. 接受戒毒服務初期，濫藥者往往因未能適應入住院舍而輕言放棄，家人宜堅定立場，鼓勵濫藥家庭成員堅持完成整個療程，學習積極面對問題，鍛鍊克服困難的能力和耐力。
2. 家人宜與機構職員保持密切溝通，以了解濫藥家庭成員適應情況，與職員共同配合，幫助他們完成整個療程。
3. 若濫藥家庭成員入住院舍接受戒毒治療，家人需與濫藥家庭成員保持聯絡，可能的話，積極參與機構安排的各項療程活動，例如家庭活動日、探訪日等。透過書信或電話與濫藥家庭成員保持緊密溝通，以表達家人的支持和鼓勵是爲重要。

(三) 如何協助濫藥康復者面對重投社會的困難

1. 家人宜多了解濫藥康復者重投社會的困難(例如自我形象偏低，缺乏自信心，容易感到自卑；缺乏工作經驗，尋找工作困難，容易感到挫折和氣餒)，以致更能明白及體諒他們，對他們有適當的期望，減少對他們造成不必要的壓力，以及減少彼此間因誤會而產生的爭吵。
2. 濫藥康復者對別人是否信任及接納自己容易敏感，家人宜與他們保持良好溝通，增進彼此間的了解和信任，避免不必要的誤會。

(四) 如何協助濫藥家庭成員預防重吸

1. 家人宜主動安排家庭活動，促進家庭成員彼此間的感情，建立良好的關係，營造健康融洽的家庭生活氣氛。
2. 家人之間遇有意見分歧，宜坦誠溝通，避免讓問題惡化。
3. 家人不宜強硬禁止康復的家庭成員外出，但需要關心他們的社交生活，鼓勵他們參加有益身心的活動，培養健康的興趣或嗜好，擴闊健康的社交圈子。
4. 與康復的家庭成員保持良好的溝通習慣，遇到他們面對工作或生活上各種難題時，家人可主動關心和聆聽，鼓勵他們積極面對。
5. 與在康復的家庭的家庭成員一起訂立有規律的生活模式。
6. 家人應樹立良好的榜樣，避免染有沉溺性的行爲，如酗酒、賭博等。
7. 若濫藥康復的家庭成員不幸再次濫藥，家人宜坦誠表達感受和關心，鼓勵及協助他們主動向社工或專業人士尋找協助。

資料來源：
基督教巴拿巴愛心服務團(編)(2006)。《結伴同行：濫藥者家人資源錦囊》(頁 15-19)。香港：基督教巴拿巴愛心服務團。

互累症測試: 請 ✓上大多數時間適當地描述你之句子（請對自己坦誠）。
(Translated from "Let's Stand Up Straight" ,Dr Bruce Litchfield)

.....我有辨認或表達感受之困難
.....我嘗試管理別人或控制他們的生活
.....我對自己和別人有不切實際的期望
.....我關注別人怎樣想我
.....我感到自己對別人的行爲或感受負起責任
.....我需要得到人認同才感安舒
.....我對自己的意見或觀點不信任
.....我曾經爲保護另一個人而說謊
.....我需要照顧人以感到自己有用
.....我嘗試逃避衝突
.....我感到痛楚或有病
.....我對改變我的人生感到無力
.....我做決定方面有困難
.....我的自尊是低的
.....我投入一些對我自己不好的關係裡
.....我把另一人之思想感情與自己的混淆
.....我嘗試閱讀或分析我所愛的人之思想
.....我感到某人當因令我低落而受罰
.....我試圖終止不健康的關係而不成功
.....我一定要夠強、夠好或完美才可被接納

若你有 0 至 5 個 ✓ ，你可能是一個快樂、圓融、懂得就關係作出選擇的人。

若你有 6 至 10 個 ✓ ，你正被一段關係佔據，失去自己 （輕度互累症）。

若你有 11 至 15 個 ✓ ，你有不健康的對人之依賴，集中於別人的問題或關注的東西而逃避自己的感覺 （中度互累症）。

若你有 16 至 20 個 ✓ ，你是跟另一位(些)沉溺者陷入極度不健康的癮癖當中（高度互累症）。

互累症模式

你是否擁有互累症而不自知？ 由互累無名會出版的「互累症的模式與徵狀」，提供一個自我評估的工具：

否認模式：

- □ 我辨認自己的情緒時感到困難
- □ 我嘗試把自己真正的情緒縮小、改變或對它作出否認
- □ 我覺得自己是完全無私及樂於爲他人的幸福而奉獻

自我形象低落模式：

- □ 我做決策時有困難
- □ 我對我所想、所說、所做都很快判斷爲“永不夠好”
- □ 我對得到別人承認、讚美及心意都感到羞怯
- □ 我不會請求他人滿足自己的需要和願望
- □ 我很在乎別人對我的想法、情感及行爲的認同
- □ 我不認爲我是個可愛及有價值的人

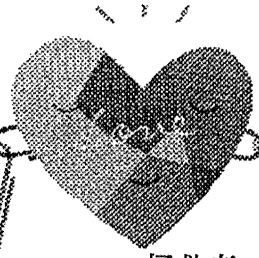
順從模式：

- □ 我調節自己的價值觀以免遭別人排斥或觸怒別人
- □ 我對別人的感受很敏感，自己的感受也很容易受影響
- □ 即使在有危險的情況下，我仍極度保持忠誠。
- □ 我在乎他人的意見及感受多於自己的，同時害怕自己的意見或感受有異於別人
- □ 爲迎合他人所想，我把自己的興趣及嗜好先擱下
- □ 當我想得到愛時，我接受在性方面有所付出

控制行爲：

- □ 我相信大部分人缺乏自我照顧的能力
- □ 我會嘗試說服其他人，他們“應該”怎樣想及他們“真實”的感受
- □ 當別人不讓我幫他們時，我感到不憤
- □ 就算他人沒有問我，我也會向他們主動提出意見及方向
- □ 我對我所愛，在禮物及恩惠上都十分慷慨
- □ 我利用性獲得認同及接納
- □ 要和他人關係良好，我需要“被需要”的感覺

Adapted and translated from Codependent Anonymous,
http://www.codependents.org/foundation-docs-patterns.php on 9 June 2008



拯救者

「我寧願短幾年命代替佢！」

「我可以選擇如何反應，卻控制不了事情的發生。」— 作家米亞

烈士

「***You jump, I jump !***」

「眼睛善於觀察別人的人，一定疏於觀察自己。」— 霍貝斯

受害者

「我成世都被人欺騙，拖累！」

「我們無法改變它，但是我們可以改變自己對它的態度。」— 坎伯

否認型

「我幫佢最後一次！」

「你必須對自己忠實，然後才不會欺騙別人。」— 沙士比亞

自卑型

「我點樣努力，結果都係一樣！」

「每個人都有兩條生命，一條是用是學習，另一條則是用來學習如果失敗、創痛之後，獲得重生。」— 電影《天生好手》對白

遷就型

「*你話點就點，無意見！*」

「別人認爲你該做什麼並不重要，重要的是你自己想做什麼。」— 帕里黎厄斯・席勒斯

操控型

「*我唔幫佢，邊個幫佢！*」、「*無我，佢邊會有今日！*」

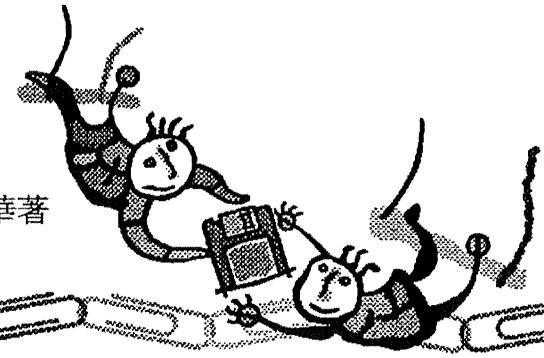
「自大和自信都是欺人的，前者常欺騙自己，後者常欺騙別人。」— 齊麥曼

共通點：1. 了解他人多於自己

2. 能醫不自醫

金句出處 ：《別跟蟑螂打仗》— 王國華著

A. Lau / Codependency / Nov 06



家家有本難念的規 (Family Rules)

1．家醜不出外傳
2．打死不離親兄弟
3．寧生敗家仔，莫生蠢頓兒
4．血膿於水
5．一生兒女債，半世老婆奴
6．執輸行頭，慘過敗家
7．嫁雞隨雞，嫁狗隨狗
8．無冤不成夫妻，無仇不成父子
9．男兒流血不流淚
10．爛泥扶唔上壁，唔低可憐，自己擺黎衰
11．大人講野，唔准出聲，無大無細
12．我講咩你一定要做
13．我話咁就咁，唔好問咁多，細老哥應該聽大人話
14．再係咁，唔比書你讀，晒米飯，去做乞兒
15．你同我即刻收聲，邊輪到你講野
16．再喊佗衰家，趕你出街唔要你
17．打者愛也
18．再駁嘴就打死你，讀書又唔見你咁叻
19．唔聽話，無飯食
20．生就累人，死就累街坊，當生少個
21．虎父無犬子
22．做大的一定要讓細的

個人權利清單——自主決定權

1.生命不只是爲了存活,還有許多的選擇
2.允許探索童年的經歷
3.允許哀悼一些需要而沒有得到或得到些不需要的往事
4.允許跟隨自己的價值和標準
5.承認和接受適合自己的價值系統
6.在未準備好、不安全和違背自己價值下,允許對任何事說「不」
7.允許尊嚴和尊重
8.允許自己作決定
9.允許自己解決問題和處事的優先主張權
10.允許別人尊重我的需求和願望
11.允許與那些令自己感覺被貶低及侮辱的人終止對話
12.允許不需負責別人的行爲、動作、感受和麻煩
13.允許自己可以犯錯而無需完美
14.允許期望別人對自己坦誠
15.允許自己接觸內心所有感受
16.允許對自己所愛的人表達憤怒
17.允許自己是獨特的,不須感覺自己做得未夠好
18.允許感覺害怕而說「我恐懼」
19.允許經過體驗後而把畏懼、內疚及羞恥一一放低
20.允許自己憑感覺而作出決定,選擇自己的判斷及理由
21.允許任何時間可改變主意
22.允許自己快樂
23.允許自己選擇穩固而健康的關係
24.允許自己有個人空間及私人時間的需求
25.無須笑著而哭
26.自己可以有些時間輕鬆、嬉戲和不莊重
27.允許自己做起事來有彈性和舒服
28.允許自己改變和成長
29.允許自己開放地提高溝通技巧,從而得到諒解
30.允許自己結交朋友,和他們好好相處

31.允許自己逗留在一個非虐待性的環境下
32.允許自己可以比身邊的人更健康
33.允許自己無論發生什麼事,我都可以照顧自己
34.允許自己哀悼各種不同的失落
35.允許信任那些值得自己相信的人
36.允許寬恕別人和寬恕自己
37.允許自己付出和接受無條件的愛

Whitfield, C.(1989). Healing My Child Within. Seefield Beach , Fl.: Health Communications, Inc., pp.115-117.

A. Lau 翻譯

備註:
1. 人生階段
2. 自主決定權
3. 沒有不能解決的事,只有不願解決的人

康復貼士

DEAL WITH CODEPENDENCY 如何治理互累症 (十法)

1. Educate yourself. 自我教育
   a. read books 閱讀
   b. Codependents Anonymous (support group) 參與有關的互助組
   c. individual-group therapy 接受個人及小組的治療

2. Increase self-awareness. 提高自我醒覺：問自己
   a. what am I doing? 我正在做甚麼？
   b. why am I doing it? 因何我這樣做?

3. Take responsibility for yourself. 爲自己各方面負責，包括：
   a. emotions 情緒
   b. goals 生活目標
   c. desires, needs, wants, happiness 渴望、需要和幸福

4. Learn to deal with reality and unpleasant feelings. 學習處理現實及不安情緒

5. Quit covering up and taking responsibility for others. 停止爲別人掩飾及承擔責任

6. Learn assertive communication. 學習自我肯定的溝通

7. Understand the reason(s) behind the choices you make being an enablet.
   了解自己選擇幫對方背後的原因

8. Clarify boundaries. 弄清界線
   a. specifically where you end and someone else begins 自己的底線、對方的範疇
   b. what is truly your responsibility versus the responsibility of others
      甚麼是自己和對方真正的責任

9. If you have children, learn what it means by providing a healthy, stable environment for children.
   如有孩子的話，學習何謂提供健康、穩定的環境供其成長

10. Resolve feelings of anger, hurt, abandonment, and resentment that have built up over the years and prevent you from having the life that you need and want.
    處理自己積存經年的種種憤恨、傷痛及被忽視的情緒(它們阻礙自己擁有理想的生活)

溫馨提示：預防或治理互累症貼士

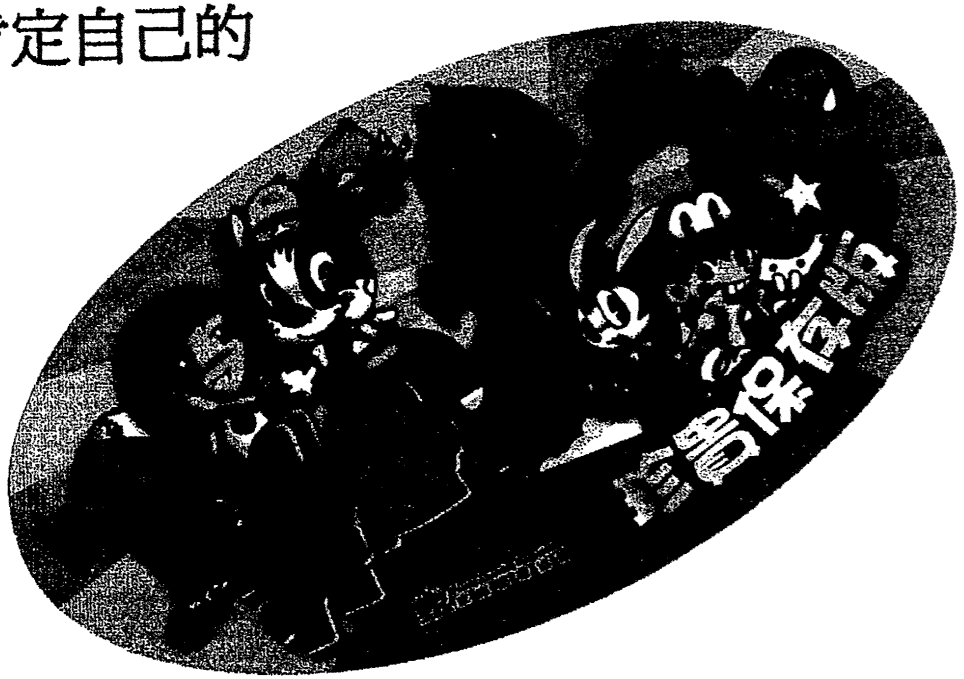
1. *接受自己的限制，幫助人要量力而為*

2. *要學會保護自己*，適當時要 Say No

3. 藉信仰和正向心理學(嘉言善意)肯定自己的價值

4. 遇到困惑要懂得求助，善用資源

5. 擴闊自己的眼光、選擇和社交圈子



Evidence Based Practice and Research Work

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1

Lecture Outline

- Knowledge claims and evidence-based practice
- Quantitative approach to research – experimental designs
- Quantitative approach to research – objective outcome indicators
- Qualitative approach to research – differences between quantitative approach and qualitative approach
- Use of qualitative approach in substance abuse research
- Question of "quality" in qualitative research

2

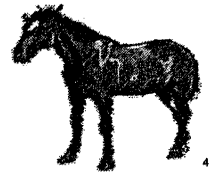
Knowledge Claims - Believe It Or Not?

- "The cranes send the babies to town. When there were more cranes in the town last winter, the number of babies in the next year will increase."
- "Acid in the stomach is the major cause of stomach ulcer."
- "After the Big Bang, the universe has expanded at a slower rate."
- "Gospel drug rehabilitation treatment is better than other modalities"
- Adventure-based counseling is an effective intervention approach in changing the behavior of delinquents.
- "School drug test can prevent substance abuse"

3

The Counting Horse - Believe It Or Not?

- **A horse (Clever Hans) was claimed by its owner that it could count and do simple addition and subtraction (including fractions).**
- **Hans gave his answers by tapping his forefoot or by pointing his nose at different answers displayed to him.**



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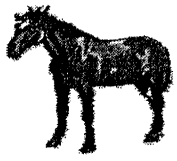
The Counting Horse - Believe It Or Not?

- **A scientific commission was established in 1904**
- **Observation 1: Hans was no longer clever if its master did not know the answer**
- **Observation 2: Hans did not know the answer if it did not see his master**



- **Rational Thinking / Critical Thinking**
- **Systematically varying different conditions and observe the effects**
- **Ruling out alternative explanations**

5

What is Evidence-Based Practice?

- How much do you know about EBP?
- EBP is "the integration of best research evidence with clinical experience and client values." (Sackett et al., 2000, p.1)
  Sackett, D.L., Straus, S.E., Richardson, W.C., Rosenberg, W., & Haynes, R.M. (2000). *Evidence-based medicine: How to practice and teach EBM.* New York: Churchill Livingstone.
- "Use of best current knowledge as a basis for decisions about groups of patients or populations." (Gray, 2001, p.20)
  Gray, J.A.M. (2001). Evidence-based medicine for professionals. In A. Edwars & G. Elwyn (Eds.), *Evidence-based patient choice: Inevitable or impossible? (pp. 19-33).* New York: Oxford University Press.

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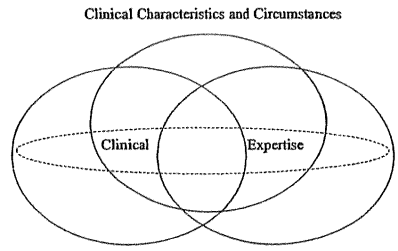
5 Steps of EBP

1. Converting information needs related to practice decisions into well-structured answerable questions.
2. Tracking down, with maximum efficiency, the best evidence with which to answer them.
3. Critically appraising that evidence for its validity, impact (size of effect), and applicability (usefulness in practice).
4. Applying the results of this appraisal to practice and policy decisions (decisions on generalizability of findings).
5. Evaluating effectiveness and efficiency in carrying out. Steps 1 to 4 and seeking ways to improve them in the future.

(Sackett et al., 2000, pp. 3-4)

7

An Updated Model for Evidence-Based Decisions:
Gambrill, E. (2006). Evidence-based practice and policy: Choice ahead. ***Research on Social Work Practice, 16,*** **338-357.**



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Rubin, A., & Parrish, D. (2007). Challenges to the future of evidence-based practice in social work education. ***Journal of social Work Education, 43,*** **405-428.**

- Evidence-based practice as an empowerment process
- Attempts to maximize the likelihood that the clients will receive the most effective intervention
- Associated with a higher probability of treatment success, but not a guarantee (program with higher probability of adolescent drug prevention – carnival; singing concert; curricular-based intervention?)
- **Reflection: What are your feelings and attitudes toward evidence-based practice?**

9

Gambrill (2006): Critical Thinking Values as the Foundation of EBP

Values
- Courage
- Curiosity
- Intellectual Empathy
- Humility
- Integrity
- Persistence

⇨

Honor Ethical Obligations
- Transparency
- Avoiding harm
- Informed consent
- Maximizing autonomy
- Self determination
- Empowerment

10

How to Get the Best Available Evidence?

- **How often do you read social work journals?**
- **Professional and academic journals – A MUST**
- Journal: Evidence-based Social Work
- Journal: Research on Social Work Practice
- **Database: Social Work Abstracts (Social Work and allied disciplines)**
- PsycINFO (Psychology, social work and allied disciplines)
- Medline (Medicine and allied disciplines)
- Sociological Abstracts (Sociology and allied disciplines)
- ERIC (Education and allied disciplines)
- CINAHL Plus (Clinical professions and allied disciplines)
- **Government databases: SAMHSA and NREPP**
- **Campbell Collaboration**

11

The Campbell Collaboration (C2)

- helps people make well-informed decisions by preparing, maintaining and disseminating systematic reviews in education, crime and justice, and social welfare
- an international research network that produces systematic reviews of the effects of social interventions
- voluntary cooperation among researchers of a variety of backgrounds
- Campbell currently has five Coordinating Groups: Social Welfare, Crime and Justice, Education, Methods, and the Users group
- The Coordinating Groups are responsible for the production, scientific merit, and relevance of our systematic reviews
- Campbell's International Secretariat is now located in Oslo and hosted by the Norwegian Knowledge Centre for the Health Services

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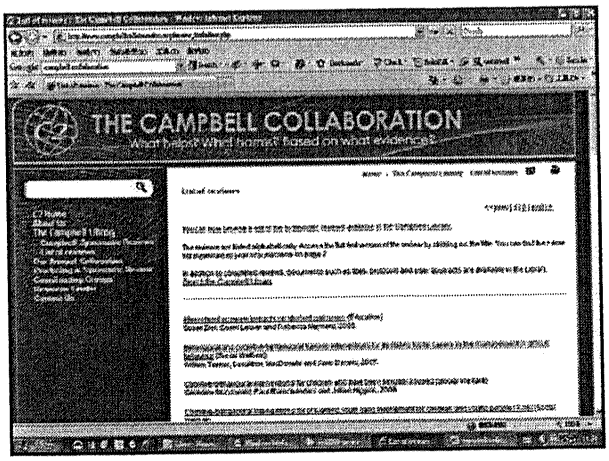

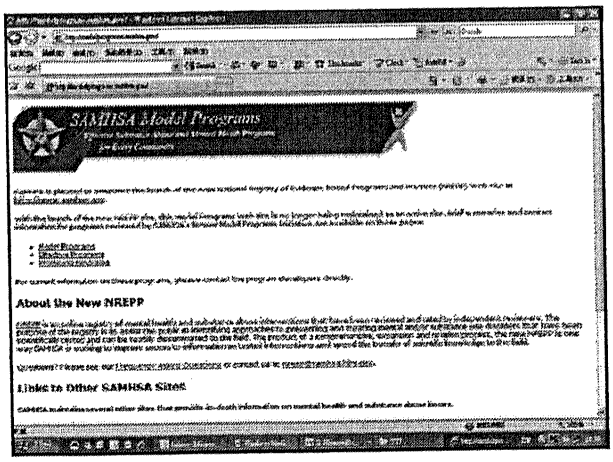

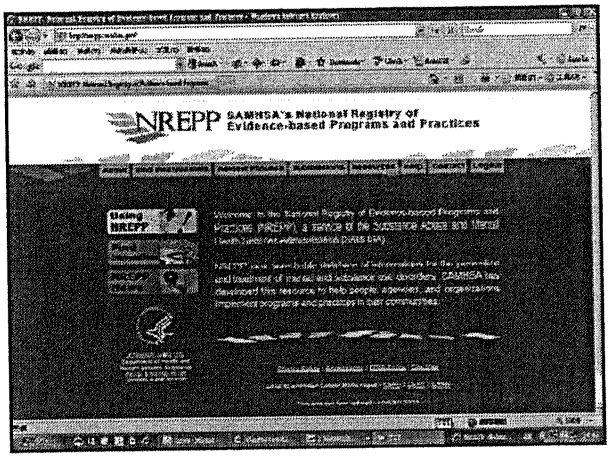

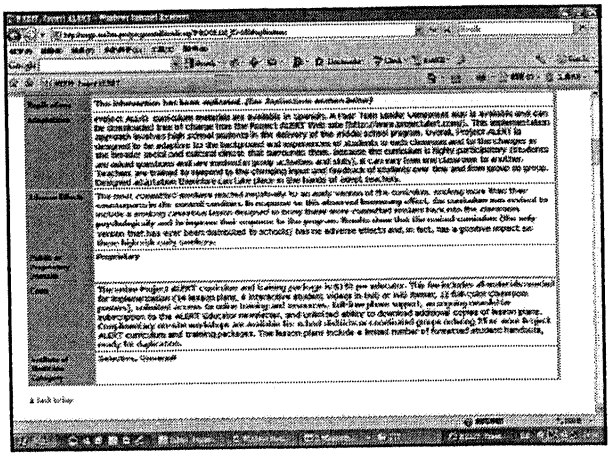

Question for Reflection and Discussion:

It is commonly believed that organizing visits for high-risk youths will lower juvenile crime rates. Based on such a belief, many District Fight Crime Committees, Correctional Services Department and NGOs in Hong Kong organize visits for high risk young people.

Do you think such programs are really effective in reducing juvenile crime rates?

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Reality

A study in Campbell Collaboration (similar to Cochrane Collaboration) showed that visits to correctional institutions did not reduce juvenile crimes. In contrast, compared with control participants, those who joined the visits had a higher chance of committing crime.

- **Read:** Shek, D.T.L. (2008) Enthusiasm-based or evidence-based charities: personal reflections based on the Project P.A.T.H.S. in Hong Kong. *TheScientificWorldJOURNAL: TSW Holistic Health & Medicine 8,* 802–810.

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- Petrosino A, Turpin-Petrosino C, Buehler J. "Scared Straight" and other juvenile awareness programs for preventing juvenile delinquency. Campbell Systematic Reviews 2004.2 DOI: 10.4073/csr.2004.2
- We conclude that programmes like 'Scared Straight' are likely to have a harmful effect and
- increase delinquency relative to doing nothing at all to the same youths. Given these results,
- agencies that permit such programmes must rigorously evaluate them not only to ensure that
- they are doing what they purport to do (prevent crime) - but at the very least they do not
- cause more harm than good.

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Rosenbaum, D.P., & Hanson, G.S. (1998). Assessing the effects of school-based drug education: A six-year multi-level analysis of Project D.A.R.E. Journal of Research in Crime and Delinquency, 35(4), 381-412.

- Drug Abuse Resistance Education Program (DARE) – reaching 25 million students in the US, adopted in 44 foreign countries.
- 18 pairs of elementary schools in urban, suburban and rural areas of Illinos
- Matched for school characteristics, random assignment
- Pretest and posttest measurement (6 years), with data collected from students and teachers

20

- Outcome measures – drug use behavior; onset of alcohol use; general attitudes toward drugs; Attitudes toward the use of specific drugs; perceived benefits and costs of using drugs; self-esteem; attitude towards police; peer resistance skills, school performance, delinquent and violent behavior
- Multi-level analyses with seven waves of posttreatment data showed that D.A.R.E. had no long term effect on a wide range of drug use measures

21

Conclusion

"...Can this popular school-based program prevent drug use at the stages in adolescent development when drugs become available and are widely used, namely, during the high school years? Unfortunately, the answer to the question is 'No' ..."(p. 404).

Personal reaction to this study? Implications for social workers in Hong Kong?

22

Obstacles to EBP:
(Gambrill, 2006; Shek, Lam & Tsoi, 2004)

- Preference for authority-based practice
- Non-availability of relevant databases
- Self-deception
- Justificatory approach to knowledge
- Time constraints
- Chinese culture (face, interpersonal harmony)
- Professional culture of social work (non-critical thinking; non-existence of continuing professional education))
- Shek, D.T.L., Lam, M.C., & Tsoi, K.W. (2004). Evidence-based practice in Hong Kong. In B. Thyer and M.A.F. Kazi (Eds.), *International perspectives on evidence-based practice in social work (pp. 167-181)*. London: Venture Press.
- **Reflection: How to overcome these problems?**

23

The Quest for Effective Drug Prevention and Treatment Program

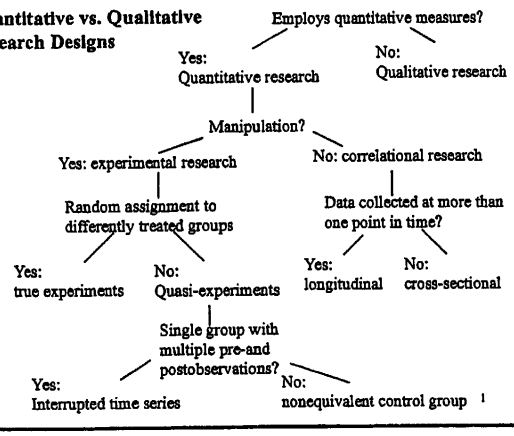
6 Possible types of programs:

1. Ineffective or harmful intervention
2. Intervention unlikely to be beneficial
3. Intervention with unknown effectiveness
4. Intervention with both benefits and adverse effects
5. Intervention likely to be beneficial
6. Intervention is effective reflected by clear evidence

Shek, D.T.L. (2008) Enthusiasm-based or evidence-based charities: personal reflections based on the Project P.A.T.H.S. in Hong Kong. *TheScientificWorldJOURNAL:* **8**, 802–810.

24

Quantitative vs. Qualitative Research Designs



1

Experimental Approach and Objective Outcome Evaluation

- Most widely used strategy in medical and mainstream social sciences: Why?
- Most scientifically credible – Gold Standard: Reactions?
- Randomized clinical trials
- Meaning of "cause" and "effect" in human service intervention?
- Examples in Hong Kong?
- Experimental studies are very rare in the substance abuse field in Hong Kong. Why is it the case? What can be done in future?

2

Emphasis on Manipulation Through Experimentation

Experiment: Aims to establish the effect of the independent variable(s) on dependent variables(s) – causal relationship

Independent variable (IV): Variables manipulated or varied by the experimenter (Types of intervention; Examples?)

Dependent variable (DV): Variables measured or observed by the experimenter (Mental health; Examples?)

Extraneous variables (EV): Variables which might affect the causal inference of the findings

Experimental group or treatment group: Condition in which the experimental treatment (or level of a treatment) is applied

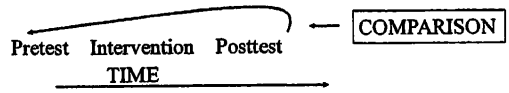
Control group: Condition in which the experimental treatment (or level of a treatment) is withheld

3

Pre-experiment Design: One-group pretest-posttest design

Measure the dependent variable in a single group, administer the intervention, and then re-assess the dependent variable. Compare pretest and posttest results.

Examples? Problems?



4

Quasi-Experimental Design: Non-equivalent Control Group Design

Observation 1 → Treatment → Observation 2

Observation 1 ——————→ Observation 2

Salient of point: No random assignment of participants; Rigorous use of statistical methods to control extraneous factors

Examples: Project ASTRO

5

Project ASTRO: Quasi-Experimental Design

- Lam, C.W., Shek, D.T.L., Ng, H.Y., Yeung, K.C., & Lam, O.B. (2005). An innovative drug prevention program for adolescents: The Hong Kong Astro Program. *International Journal of Adolescent Medicine and Health, 17*, 343-353.
- Project ASTRO: a psychosocial primary prevention program for high-risk youth, focusing on peer and other influences on youth to use drugs, and on the development of skills to resist those pressures
- Three sequential and developmentally appropriate programs: Astro Kids, Astro Teens and Astro Leaders
- Programs for parents and community leaders are also included in the design of the Astro Program

6

Content of the Astro Programs

Program	Astro Kids	Astro Teens	Astro Leaders	Astro Club
Age range	10-13	13-16	Graduates of Astro Teens	Graduates of Astro programs
No. of sessions	10	12	3 + 1 community involvement project	---
Content	Stress and coping, family relationship, smoking, drug education, puberty, friendship, refusal skills, self understanding, pressure from media	Stress and coping, decision-making, gateway drugs, drug education, teenage sex, self-image, refusal skills, peer pressure, life planning	Self-image, life planning, community involvement project	Healthy activities and building up of support network among members

- Objective outcome evaluation based on longitudinal data collected from an experimental group (N = 356) and a control group (N = 414) utilizing a non-equivalent group design: mixed design
- Independent variables: Treatment (experimental group) vs. no treatment (control group); time (pretest, posttest 1 posttest 2, posttest3)
- Dependent variables: included indicators of knowledge, attitude, behavioral intention and refusal skills related to substance abuse and early sexual behavior
- Extraneous variables: gender, delinquency at pretest, drug abuse level at pretest – analysis of covariance technique

8

Results (Evaluation Area 1: Objective outcome evaluation)

- The findings are generally positive
- Using different time points as reference points, there is evidence showing that the experimental group performed better than the control group in terms of drug knowledge, sex knowledge, social skills, and refusal skills in different samples
- Experimental group participants found fewer benefits of abusing drugs and they had a stronger intention of not abusing drugs when compared to the control group participants

9

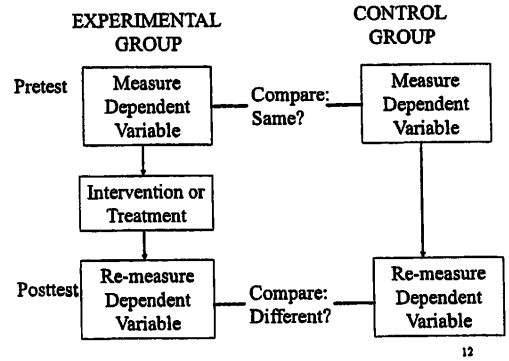
	Post-1 - Post 2 Mean		Scale Direction	Main effect: Between subject factor Group effect		Interaction effect: Group X Time	
	Experimental	Control		F	Sig	F	Sig
Combined Sample (N = 339)							
Social skills	18.06	17.80	H	12.519	***	NS	
Refusal skills (Marijuana)	8.39	8.28	H	5.751	*	NS	
Teens Sample (N = 192)							
Social skills	17.99	17.98	H	6.147	*	NS	
Drug Knowledge	13.74	13.30	H	7.170	**	NS	
Kids Sample (N = 147)							
Social skills	18.19	17.50	H	6.726	*	NS	
Behavioral Intention (Sex)	3.63	3.57	H	5.273	*	NS	
Attitude ("Ice")	10.61	10.82	L	4.781	*	NS	
Refusal skills (Ecstasy)	8.51	8.31	H	4.837	*	NS	
Refusal skills ("Ice")	8.45	8.31	H	5.641	*	NS	
Refusal skills (Marijuana)	8.54	8.27	H	4.327	*	NS	
Refusal skills (Gateway)	7.93	7.67	H	4.479	*	NS	
Refusal skills (PS)	16.15	15.63	H	4.290	*	NS	

Threats to Internal Validity in Quasi-Experiments

- Time threat (different time → different effect) High vs. Low delinquency season
- History (different history → different effects) Pretest differences in experimental and control subjects
- Maturation (positive change because of developmental maturation)
- Test reactivity (Bad experience in pretest → affected scores in posttest)
- Regression to the mean (extreme scores will change anyway)
- How to rule out alternative explanations?

11

Basic Experimental Design



12

Objective Outcome Evaluation

Participants recruited from 24 pairs of schools matched in terms of banding and other school characteristics randomly drawn from the participating schools by the EMB, with one school randomly assigned to the Experimental Group and one school randomly assigned to the Control Group)

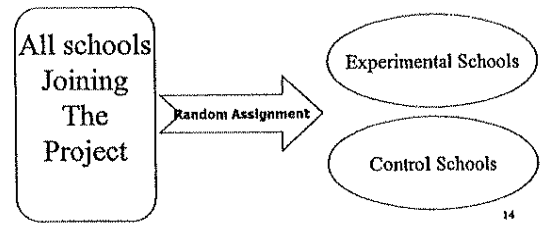
Pretest : Measures of positive youth development, including the Chinese Positive Youth Development Scale (Shek, Lee & Siu, 2007).

Posttest: Measures of positive youth development, including the Chinese Positive Youth Development Scale (Shek, Lee & Siu, 2007) and subjective outcome evaluation measure.

13

Randomized Group Trial: Experimental and Control Schools

- **24 pairs of experimental and control schools were randomly chosen from the schools participating in the project**

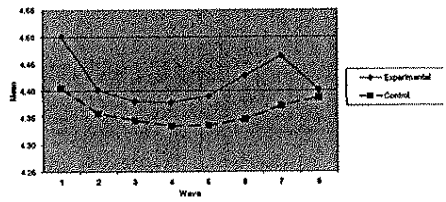


14

	Experimental Schools	Control Schools
Participants	Secondary 1 students cohort admitted in Sept. 2006	Secondary 1 students cohort admitted in Sept. 2006. They WILL NOT join the P.A.T.H.S.
Data Collection	Sept. 2006 to August 2011 (2 years' follow-up): 8 waves	Sept. 2006 to August 2011: 8 waves
Program Duration	Sept. 2006 to August 2009	Sept. 2007 to August 2010 (Secondary 1 students admitted in Sept. 2007)
Content of Evaluation	•Objective outcome evaluation •Subjective outcome evaluation •Qualitative evaluation •Process evaluation	•Objective outcome evaluation

Differences between Experimental[a.] and Control Group participants in their growth curves

Clear and positive identity



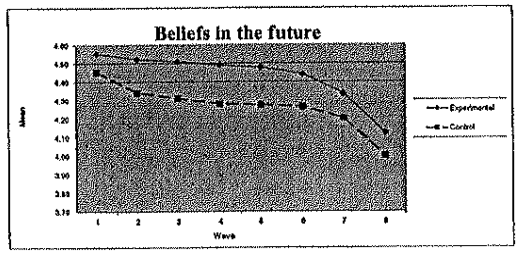
* Cases participated in Tier 1 program only

^ one item from clear and positive identity subscale

Group X Time[2] interaction effect ($p < .05$) after controlling the initial age and gender

Differences between Experimental[a.] and Control Group participants in their growth curves

Beliefs in the future

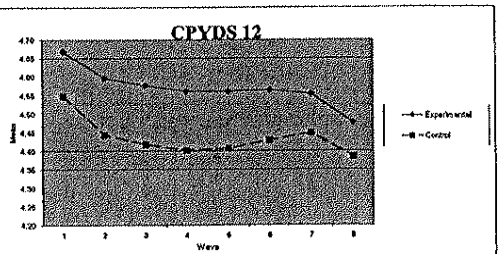


[a] Cases perceived the program positively

Group X Time[2] interaction effect ($p < .01$) after controlling the initial age and gender

Differences between Experimental[a.] and Control Group participants in their growth curves

CPYDS 12

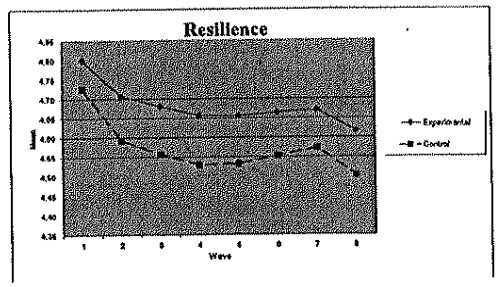


[a] Cases perceived the program positively

CPYDS 12 = 12 subscales of the CPYDS

Group X Time[2] interaction effect ($p < .01$) after controlling the initial age and gender

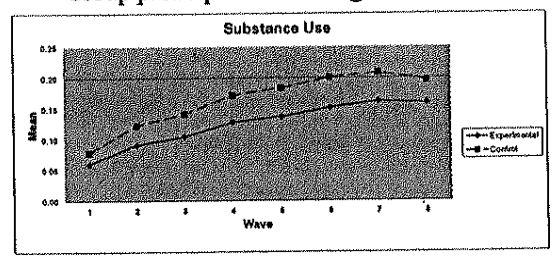
Differences between Experimental[a.] and Control Group participants in their growth curves



[a] Cases perceived the program positively

Group X Time[3] interaction effect ($p < .05$) after controlling the initial age and gender

Differences between Experimental[a.] and Control Group participants in their growth curves

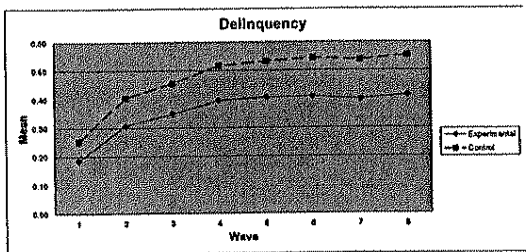


[a] Cases participated in Tier 1 program only

Group X Time interaction effect ($p < .01$) after controlling the initial age and gender

Group X Time[2] interaction effect ($p = .01$) after controlling the initial age and gender

Differences between Experimental[a.] and Control Group participants in their growth curves



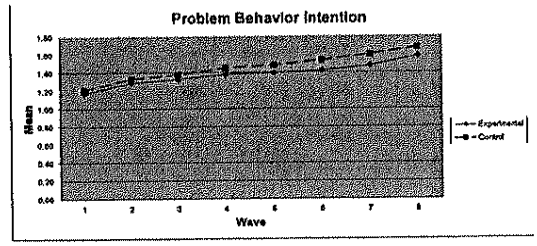
[a] Cases participated in Tier 1 program only

Group X Time interaction effect ($p < 0.5$) after controlling the initial age and gender

Group X Time[2] interaction effect ($p > .05$) after controlling the initial age and gender

Group X Time[3] interaction effect ($p > .05$) after controlling the initial age and gender

Differences between Experimental[a.] and Control Group participants in their growth curves



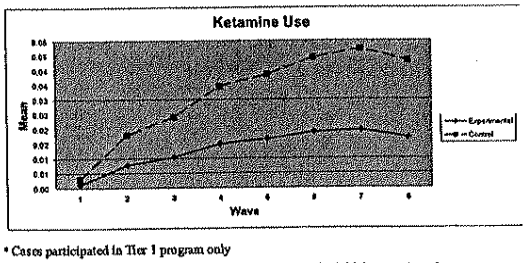
[a] Cases participated in Tier 1 program only

Group X Time interaction effect ($p > .05$) after controlling the initial age and gender

Group X Time[2] interaction effect ($p < 0.5$) after controlling the initial age and gender

Group X Time[3] interaction effect ($p < 0.5$) after controlling the initial age and gender

Differences between Experimental[a.] and Control Group participants in their growth curves



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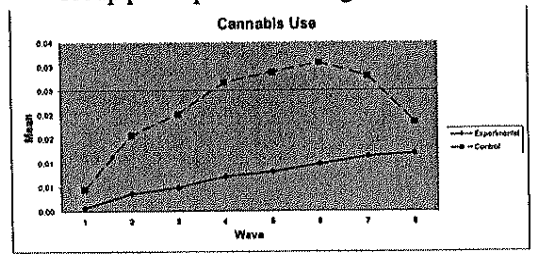
Group X Time interaction effect ($p < .05$) after controlling the initial age and gender

Group X Time[2] interaction effect ($p > .05$) after controlling the initial age and gender

Differences between Experimental[a.] and Control Group participants in their growth curves



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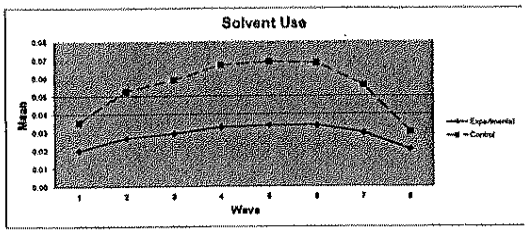
Group X Time[2] interaction effect ($p < .05$) after controlling the initial age and gender

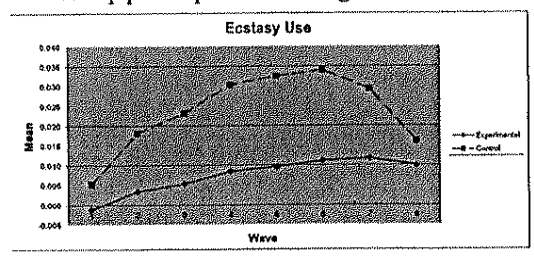
Differences between Experimental[a.] and Control Group participants in their growth curves



[a.] Cases participated in Tier 1 program only

Group X Time interaction effect ($p < .05$) after controlling the initial age and gender
Group X Time^2 interaction effect ($p < .05$) after controlling the initial age and gender

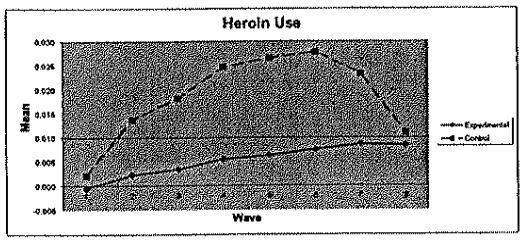
Differences between Experimental[a.] and Control Group participants in their growth curves



[a.] Cases participated in Tier 1 program only

Group X Time interaction effect ($p < .05$) after controlling the initial age and gender
Group X Time^2 interaction effect ($p < .05$) after controlling the initial age and gender

Differences between Experimental[a.] and Control Group participants in their growth curves



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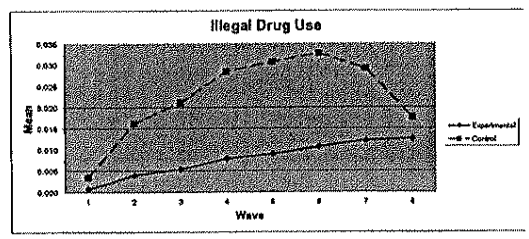
Differences between Experimental[a.] and Control Group participants in their growth curves



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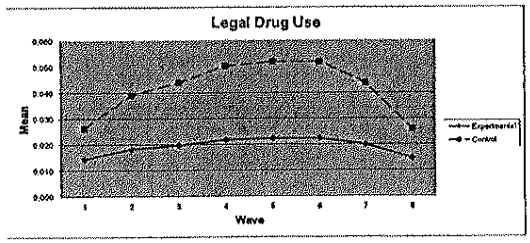
Differences between Experimental[a.] and Control Group participants in their growth curves



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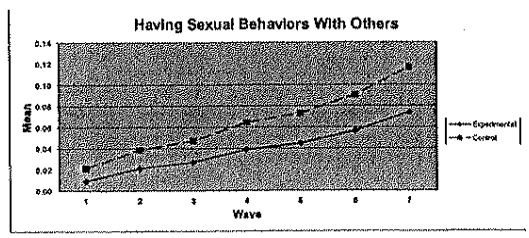
Differences between Experimental[a.] and Control Group participants in their growth curves



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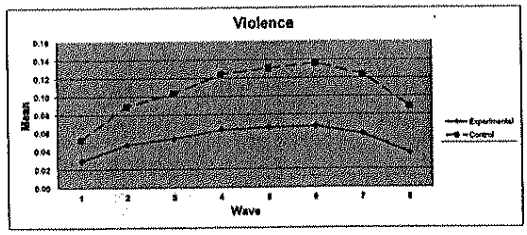
Group X Time interaction effect ($p < .05$) after controlling the initial age and gender

Differences between Experimental[a] and Control Group participants in their growth curves



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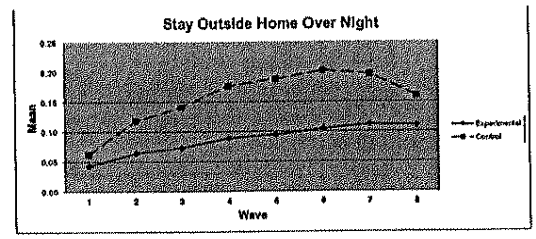
Group X Time^2 interaction effect ($p < .05$) after controlling the initial age and gender

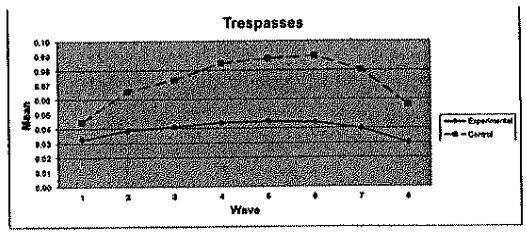
Differences between Experimental[a] and Control Group participants in their growth curves



[a] Cases participated in Tier 1 program only

Group X Time interaction effect ($p < .01$) after controlling the initial age and gender
Group X Time^2 interaction effect ($p < .01$) after controlling the initial age and gender

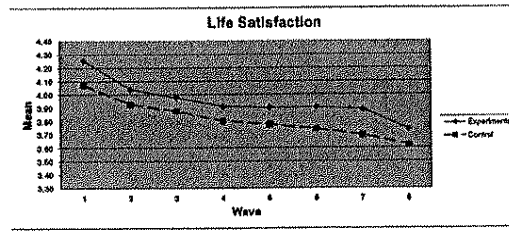
Differences between Experimental[a] and Control Group participants in their growth curves



[a] Cases participated in Tier 1 program only

Group X Time interaction effect ($p < .05$) after controlling the initial age and gender
Group X Time^2 interaction effect ($p < .05$) after controlling the initial age and gender

Differences between Experimental[a] and Control Group participants in their growth curves



[a] Cases participated in Tier 1 program only

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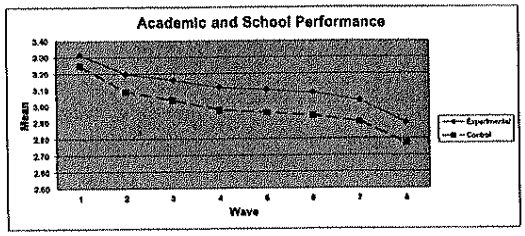
Group X Time^2 interaction effect ($p < .01$) after controlling the initial age and gender
Group X Time^3 interaction effect ($p < .01$) after controlling the initial age and gender

Differences between Experimental[a] and Control Group participants in their growth curves



[a] Cases participated in Tier 1 program only

Group X Time interaction effect ($p = .05$) after controlling the initial age and gender
Group X Time^2 interaction effect ($p > .05$) after controlling the initial age and gender
Group X Time^3 interaction effect ($p > .05$) after controlling the initial age and gender

Experimental Evaluation of a Community Drug Prevention Education Program

- The District Board funds a preventive education program to prevent substance abuse (e.g., talks, carnivals, growth groups) in Tuen Mun
- How can we demonstrate the effectiveness of such a campaign using an experimental or pre-experimental approach?
- Independent, dependent and extraneous variables?
- Intervention?
- Experimental group(s) and control group(s)?
- Outcome measures?
- Statistical analyses to assess change?
- How to rule out alternative explanations?

36

Core Feature of Quantitative Research: Objective Measurement

- **Concept**: Abstraction formed by generalization from particulars - "red"/ "poverty"; Examples?
- **Construct**: A construct is a concept, but deliberately and consciously invented or adopted for a special scientific purpose (e.g., intelligence / self-consciousness / self-esteem); Examples?

Conceptual Definition (Constitutive Definition):

- Constitutive definition defines a construct with other constructs (e.g., weight = heaviness of objects)

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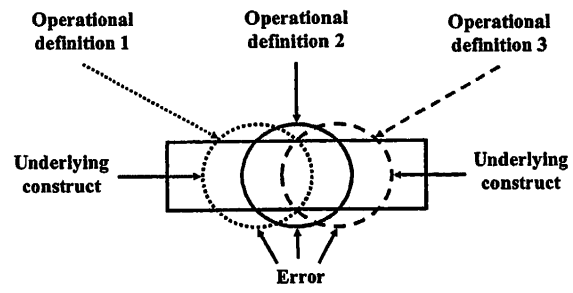
Operational Definition

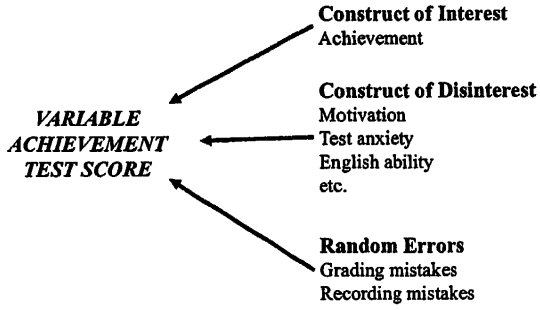
- Defining a construct or variable by specifying the activities or "operation" necessary to measure it
- Length: Concept measured by a ruler and the process of measurement
- Social class: Educational attainment/ income / occupation
- Academic achievement: G.P.A., percentile points
- Mental health: Psychiatric observations/ scales
- Relapse in drug addiction
- Substance abuse? Addicted to drugs?
- "Effective" vs. "Ineffective" programs?
- Assumptions and problems of operationalization

38



Operational definitions include irrelevant components and fail to include all relevant portions of the underlying construct

39



Three Components of a Variable

40

Problem

A social worker wishes to assess family life quality among the residents in a drug rehabilitation agency. He/she has designed some items to form a scale that assesses family life quality. How can he/she know whether the scale constructed can assess family life quality in an objective manner?

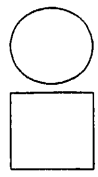
What are the characteristics of an objective measure of family life quality in a drug rehabilitation context?

41

Reliability and Validity: Measurement Components and Construct Operationalization

a. **Unreliable**

X = E



(Construct)

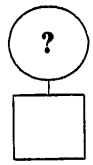
(Measure)

Measure unrelated to any concept

42

b. Reliable

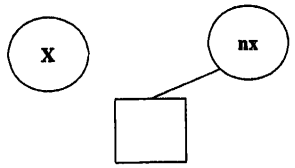
$X=T_x+T_{nx}$



Measure related to some construct

c. Invalid

$X=T_{nx}$

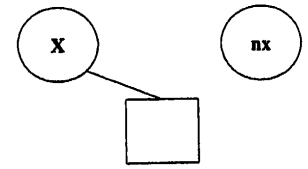


Measure related to unintended construct

43

d. Valid

$X=T_x$



Measure related to intended construct

44

Problem

Your agency is interested in understanding the attitudes of substance abusers towards "Ice" and you are asked to design an assessment tool to assess this construct.

How would you do the task?

What steps will be involved in designing such as a tool?

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Hierarchy of Evidence

Grade

1. Grade 2 is met plus evidence of effectiveness when the preventive intervention is implemented in its intended setting with adequate training of personnel and monitoring of implementation and outcomes.
2. Evidence based on multiple well-designed, randomized, controlled trials or multiple well-designed, interrupted time-series experiments that were conducted by two or more independent research teams.

SOURCE: Biglan, A., Mrazek, P.J., Carnine, D., & Flay, B.R.(2003). The integration of research and practice in the prevention of youth problem behaviors. *American Psychologist, 58*, 433-440.

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Hierarchy of Evidence

Grade

3. Evidence based on multiple well-designed, randomized, controlled trials or multiple well-designed, interrupted time-series experiments that were conducted by a single research team.
4. Evidence based on at least one well-designed, randomized, controlled trial or an interrupted time-series design that was replicated across three cases.

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Hierarchy of Evidence

Grade

5. Evidence based on non-equivalent group design (i.e., comparisons between groups that were not effectively randomized to conditions).
6. Evidence based on pre-post evaluation with no comparison group or multiple posttests (i.e., pre-experimental design).
7. Evidence based on clinical experience by respected authorities (researchers and practitioners), descriptions of programs, and case reports.

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Characteristics of Qualitative Research

1. Holistic - begins with an understanding of the whole or large picture (quantitative reductionism)
2. Looks at relationships within a culture/system
3. Personal, face to face, immediate
4. Understanding rather than prediction
5. Demands the researcher to stay in the setting over time
6. Demands time in analysis = Time in the field
7. Demands the researcher to develop a model of what occurred
8. Requires the researcher become the research instrument.
9. Response to ethical concerns
10. Incorporates room for description of the role of researcher and description of researcher's own biases and ideological preference.
11. Requires ongoing analysis of the data

Your reactions to these characteristics?

Source: Janesick, V.J. (1998). The dance of qualitative research design. In N.K. Denzin and Y.S. Lincoln (Eds.), *Strategies of qualitative inquiry*. Thousand Oaks, Calif.: Sage. 1

Themes of Qualitative Inquiry (Patton, 1990): General Qualitative Research Attributes

1.	Naturalistic inquiry	Studying real-world situations; non-manipulative, unobtrusive, non-controlling; openness to whatever emerges, lack of predetermined constraints.
2.	Inductive analysis	Discover important categories, dimensions, and interrelationships; begin by exploring genuinely open questions.
3.	Holistic perspective	The whole is more than the sum of its parts; focus on complex interdependencies not reduced to a few discrete variables and linear, cause-effect relationships.
4.	Qualitative data	Detailed, thick description; inquiry in depth; direct quotations capturing people's personal perspectives and experiences.
5.	Personal contact and insight	Direct contact with and gets close to the people, situation, and phenomenon under study; researcher's personal experiences and insights are an important.[2]

6.	Dynamic systems	Attention to process; assumes change is constant and ongoing.
7.	Unique case orientation	Each case is special and unique; the first level of inquiry is capturing the details of the individual cases being studied; cross-case analysis follows from and depends on the quality of individual case studies.
8.	Context sensitivity	Places findings in a social, historical, and temporal context; dubious of the possibility or meaningfulness of generalizations across time and space.
9.	Empathic neutrality	Complete objectivity is impossible; pure subjectivity undermines credibility; the researcher includes personal experience and empathic insight as part of the relevant data, while taking a neutral nonjudgmental stance toward whatever content may emerge.
10.	Design flexibility	Open to a adapting inquiry as understanding deepens and/or situations change; avoids getting locked into rigid designs that eliminate responsiveness; pursues new paths of discovery as they emerge. 3

	Quantitative	*Qualitative*
(1) Role of qualitative research	Preparatory	Means to exploration of actors' interpretations
(2) Relationship between researcher and subject	Distant	Close
(3) Researcher's stance in relation to subject	Outsider	Insider
(4) Relationship between theory/concepts	Confirmation	Emergent
(5) Research strategy	Structured	Unstructured
(6) Scope of findings	Nomothetic	Ideographic
(7) Image of social reality	Static and external to actor	Processual and social constructed by actor
(8) Nature of data	Hard, reliable	Rich, deep

Question: Are quantitative and qualitative researches incompatible? 4

Quantitative Model

Knowledge as Accumulation of Facts (agreed?)

Correspondence theory of truth		Nomothetic
Objectivity (free form subjectivity i.e. researcher bias)	PERSON AS MACHINE	Scientific
Error Elimination		Erklären
Explanatory		Reliability + Validity
Rules		Generalisations
Unilateral Control		Non Interactive

Reductionist

5

Qualitative-Interpretative Model

Knowledge as Construction of Reality (Agreed?)

Coherentist theory of truth		Idiographic
Subjectivity (objectivity = social agreement)	PERSON AS SCEINTIST	Scientific
Reflexive		Verstehen
Descriptive		Authenticity
Praxis		Utility
Bilateral Control		Interactive

Holistic

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Dimensions of Competing Methodological Paradigms

Qualitative/Naturalistic Paradigm	*Quantitative/Experimental Paradigm*
Qualitative data (narratives, descriptions)	Quantitative data (numbers, statistics)
Naturalistic inquiry	Experimental designs
Case studies	Treatment and control groups
Inductive analysis	Deductive hypothesis testing
Subjective perspective	Objective perspective
Close to the program	Aloof from the program
Holistic contextual portrayal	Independent and dependent variables
Systems perspective focused on interdependencies	Linear, sequential modeling
Dynamic, ongoing view of change	Pre-post focus on change
Purposeful sampling of relevant cases	Probabilistic, random sampling
Focus on uniqueness and diversity	Standardized, uniform procedures
Emergent, flexible designs	Fixed, controlled designs
Thematic content analysis	Statistical analysis
Extrapolations	Generalizations

Patton, M.Q. (1997). Utilization-focused evaluation: The new century text. Thousand Oaks, Calif.: Sage. Your familiarity with these paradigms before graduation?

Reflection

A review of the literature shows that there are comparatively more qualitative research studies than quantitative studies in the social welfare field and substance abuse field.

1. Why is it the case?
2. What are the consequences of this trend?
3. Is qualitative study a "weaker" form of research?

8

EVALUATION SITUATIONS FOR WHICH QUALITATIVE METHODS ARE APPROPRIATE

- Under situations would you use qualitative evaluation, quantitative evaluation or mixed-method evaluation? Are there any definite guidelines?

- Patton, M.Q. (1980). Qualitative evaluation methods. Beverly Hills, Calif.: Sage.
- 1. Does the program emphasizes **individualized outcomes** (i.e., different participants are expected to be affected differently)? Religious rehabilitation ... other examples?
- 2. Interested in the **internal dynamics** of a program - program strengths, weaknesses and processes? Examples?

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- 3. **In-depth information needed** for certain cases or sites (e.g., most successful cases, most difficult cases, critical cases, politically sensitive cases)?
- 4. Interested in the **diversity and uniqueness** of the program participants vs. standardized and uniform measures? Participants' reactions to role-play. Examples?
- 5. Is information needed about the program implementation via **subjective views** of the clients' program experience? Whose view is more important - evaluators or the stakeholders? Subjective construction of the participants? Examples?
- 6. Interested in collecting detailed and descriptive information about the program for the purpose of improving the program? **Formative evaluation?** Distinction between formative and summative evaluation?

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- 7. Any need for the **descriptive information** on the quality of the program activities and outcomes, not just levels, amounts or quantities? Self-esteem levels, conflict levels ...etc?
- 8. Administration of quantitative measures **overly obtrusive**? Demand characteristics; social desirability; embarrassment. Examples?
- 9. Are **valid and reliable quantitative measures** available? How about the situation of Hong Kong and China?
- 10. Do decision-makers who lack the observing and listening skills of the trained evaluators want some **"surrogate eyes and ears"**? Why such eyes and ears are important? Examples?

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- 11. Are the goals of the programs vague, general and non-specific so that it is desirable to gather **information about what effects the program is actually having**? Adventure-based counselling; innovative projects. Examples?
- 12. Interested in assessing the **unexpected and unanticipated effects** of the program? Negative impacts? Examples?
- 13. Interested in breaking the old routines and generate some **new insights** about the program? Examples?
- 14. Interested to use methods that are more **"humanistic" and personal** - the method is feel natural, informal and understandable to participants? Powerless clients that would be shaped to be more powerless in quantitative evaluation context. Examples?

12

- 15. Do decision-makers and evaluators have any **ideological biases** that make them prefer qualitative methods?
- 16. Are decision-makes and evaluators interested in increasing their understanding of the program by developing a grounded theory of program action and **effects that is inductively derived** from a holistic picture of the program? Examples?
- Examples: Cough medicine abuse
- Examples: Project Astro
- What are the strengths and weaknesses of qualitative evaluation and the related techniques?
- Will you use qualitative evaluation in your work?
- Why or why not?

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Varieties of Qualitative Approaches ☺

- Terminology jungle
- Different types of qualitative research depending on what criteria are used to classify the approaches
- Classification based on strategies (Denzin & Lincoln, 1998).
- Classification based on methods (e.g., Wolcott, 1992)
- Classification based on sources of influences. Patton, M.Q. (1990). *Qualitative evaluation and research methods.* Newbury Park, CA: Sage.
- Classification based on disciplines (anthropology, qualitative sociology, qualitative social work, phenomenological theories)
- Classification based on philosophical orientations: grounded theory (critical realists), social constructionism (relativists)
- Reflection: state clearly what is your position in qualitative research!

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"General" Process of Qualitative Research

1. Develop a general area of inquiry based on previous knowledge (personal experiences research and theory)
2. Brainstorm possible research questions (alone or with others)
3. Think about, write down, or discuss your own theoretical perspectives, ideologies, and biases (self-critical)
4. Review the literature
5. Formulate a list of questions based on Step 2 to Step 4. Allow them to change as you collect and analyze data
6. Develop an idea of parameters of your study (e.g., time, informants, and settings). These can be changed
7. Enter the field as open-mindedly as possible and be aware of the effects of your personal ideologies

Gilgun, J.F. (1992). Definitions, Methodologies and Methods in Qualitative Family Research in J.F. Gilgun et.al (Ed.) *Qualitative Methods in Family Research.* Newsbury Park: Sage.

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8. Observe the first case, literally through observation or through combinations of observations and interview questions. Generate further questions if needed
9. Write field notes. Include observer comments.
10. Write memos in the field notes (Memos are speculative and wide-ranging comments about the relevance of emerging findings to existing bodies of research and theories.)
11. Develop initial definitions of emerging concepts and speculate on the connections among concepts (e.g., poor family relationship predisposes drug abuse)
12. Observe the second case, and as you do, many of your questions will be based on emerging findings
13. Write field notes, including observer comments and memos as with the first case.
14. Compare patterns (hypotheses) within the second case and with patterns in the first case

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15. Change hypotheses to fit both cases
16. Continue these process, choosing cases through theoretical sampling – to explore themes further either with similar cases or dissimilar cases
17. When you have some confidence that you have developed some hypotheses, review the literature you think might be relevant to your emerging findings
18. Link literature to the empirically grounded hypotheses.
19. Test the theoretical formulation on other cases
20. Change the theoretical formulation to fit the empirical patterns of this subsequent case
21. Continue this process until you have developed findings that are linked both to phenomena of interest and to theoretical formulations

Reflection: How to use these steps in your research?

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Data Collection Methods in Qualitative Research

- Basic Issue: How to get the **real lived experiences and social interactions in the natural world** (versus survey method which generate artificial and non-contextual findings)
- Interviews: Respondents are encouraged to offer their own definitions of particular activities
- Observation: The aim is to gather first-hand information about social processes in a 'naturally occurring' context
- Textual Analysis: Media reporting; literature description (e.g., news, journals, diaries)
- Transcripts: Audio and video tapes of interviews and observations as sources of data (e.g., tapes on staff meetings)
- Personal Experience Method: Self as informant (own diaries) and participant

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Data Collection Approaches (Your Choice)

- Gather observational notes by conducting an observation as a participant
- Gather observational notes by conducting an observation as an observer
- Conduct an unstructured, open-ended interview and take interview notes
- Conduct an unstructured, open-ended interview, audiotape the interview, and transcribe the interview
- Keep a journal during the research study
- Have an informant keep a journal during the research study
- Collect personal letters from informants
- Analyze public documents (e.g., official memos, minutes, archival material)
- Examine autobiographies and biographies
- Examine physical trace evidence (e.g., footprints in the snow)
- Videotape a social situation or an individual/group
- Examine photographs or videotapes
- Have informants take photographs or videotapes
- Collect sounds (e.g., musical sounds, a child's laughter, car horns honking)

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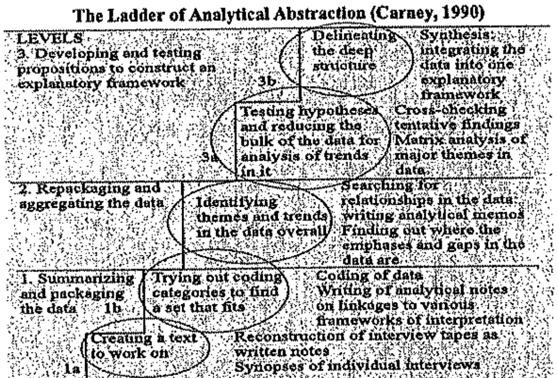
Characteristics of Qualitative Data Analysis

- Non-linear process, circular processes
- Data collection and data analysis processes inter-related
- Complexity involved in data analysis
- General vs. approach-related strategies
- Within-case analysis and cross-case analysis
- Data management and documentation systems

The Ladder of Analytical Abstraction (Carney, 1990)



Carney, T.F. (1990). Collaborative inquiry methodology. Windsor, Ontario, Canada: University of Windsor, Division of Instructional Development.

Qualitative Evaluation Based on Focus Groups

1

Shek, D.T.L., Ng, H.Y., Lam, C.W., Lam, O.B., & Yeung, K.C. (2003). *A longitudinal study of a pioneering drug prevention program (Project Astro MIND) in Hong Kong.* Hong Kong: Beat Drugs Fund and the Hong Kong Youth Institute.

Chapter [illegible]
Results of Evaluation Area K:
Qualitative Evaluation

Analysis of the Qualitative Data

[illegible]

[illegible]

[illegible]
TheScientificWorldJOURNAL

Implementation Quality of a Positive Youth Development Program: Cross-Case Analyses Based on Seven Cases in Hong Kong

Daniel T.L. Shek[1,2,3,*] and Rachel C.F. Sun[3]
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Cross-case analyses of factors that influence the process and implementation quality of the Tier 1 Program of the Project P.A.T.H.S. based on seven cases were carried out. Systematic and integrative analyses revealed several conclusions. First, several factors related to policy, people, program, process, and place (5 "P"s) were conducive to the successful implementation of the Tier 1 Program in the schools. Second, there were

TABLE 3
[illegible]

Aspect		Obstacles Affecting the Quality of Implementation	A	B	C	D	E	F	G
(a) Program	•	[illegible]	✓						
	•	[illegible]	✓	✓					
	•	[illegible]	✓						
	•	[illegible]	✓						
	•	[illegible]		✓				✓	✓
	•	[illegible]		✓					
(b) People	•	[illegible]	✓	✓					
	•	[illegible]	✓		✓			✓	
	•	[illegible]	✓						
	•	[illegible]	✓						
	•	[illegible]		✓					
	•	[illegible]	✓	✓	✓		✓	✓	
	•	[illegible]		✓			✓		
	•	[illegible]			✓		✓		
	•	[illegible]			✓				
	•	[illegible]			✓		✓		✓
	•	[illegible]					✓		
	•	[illegible]					✓		
	•	[illegible]				✓			
(c) [illegible]	•	[illegible]	✓	✓		✓		✓	
	•	[illegible]	✓	✓					
	•	[illegible]	✓						
	•	[illegible]						✓	
	•	[illegible]						✓	
(d) Policy	•	[illegible]	✓	✓	✓				
	•	[illegible]		✓					
	•	[illegible]		✓					
	•	[illegible]			✓	✓			
(e) Place	•	[illegible]		✓					✓

Reflective Questions on Qualitative Research (Beginning or Ending)

- What are the basic characteristics or assumptions of qualitative studies? (Mentioned?)
- Does the researcher know the differences between qualitative and quantitative approaches? (Mentioned?)
- What specific type of qualitative design is used in the study ? Why? General vs. approach-specific qualitative studies? (Mentioned?)
- Does the researcher reveal his or her values and biases brought to the research? (Mentioned?)
- What steps will be taken to gain entry and approval to collect data at the research site? (Mentioned?)
- What are the procedures for collecting data mentioned and discussed? Justifications for the steps? (Mentioned?)

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7. How information during the data collection procedure would be recorded? (Mentioned?)
8. How data analysis would be carried out? (Mentioned?)
9. General vs. approach-specific data analyses (e.g., ethnographic approaches, grounded theory, case study, phenomenology) used? (Mentioned?)
10. What are the steps that can be taken to verify the information (validity and reliability) mentioned? How to address the limitations of qualitative designs in terms of generalizing and replicating the findings? (Mentioned?)
11. What steps have been carried out to address the issue of biases and ideological preoccupation? (Mentioned?)
12. What are the ethical issues to be addressed? Benefits to the participants?

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Criteria Governing Qualitative Evaluation Studies

- Shek, D.T.L., Tang, V., & Han, X.Y. (2005). Evaluation of evaluation studies utilizing qualitative research methods in the social work literature (1990-2003): Evidence that constitutes a wakeup call. *Research on Social Work Practice, 15*, 180-194.

- Statement of the philosophical base of the study **(Criteria 1)**
- Justifications for the number and nature of the participants of the study **(Criteria 2)**
- Detailed description of data collection procedures **(Criteria 3)**
- Discussion of the biases **(Criteria 4)**
- Description of the steps taken to guard against biases or arguments that biases should and/or could not be eliminated **(Criteria 5)**
- Reliability measures **(Criteria 6)**

Criteria Governing Qualitative Evaluation Studies

- Shek, D.T.L., Tang, V., & Han, X.Y. (2005). Evaluation of evaluation studies utilizing qualitative research methods in the social work literature (1990-2003): Evidence that constitutes a wakeup call. *Research on Social Work Practice, 15*, 180-194.
- Triangulation **(Criteria 7)**
- Peer checking and member checking **(Criteria 8)**
- Audit trails **(Criteria 9)**
- Alternative explanations examined **(Criteria 10)**
- Negative evidence accounted for **(Criteria 11)**
- Limitations of the study examined **(Criteria 12)**

Questions to be Further Considered

- Which paradigm (quantitative approach versus qualitative approach) do you like most? Why?
- Compared to quantitative research, qualitative research is a weaker form of research. Agree?
- Will you use qualitative research in your evaluation? Why?
- Qualitative research is homogeneous in nature. Agree?
- What is the difference between personal constructivism and social constructionism?

Questions to be Further Considered

- How structured should the interview schedule be in a qualitative research?
- How should we determine the sample size in a qualitative research?
- What does the term "researcher as an instrument" in qualitative research mean?
- Focus group is not a scientific method for collection data. Agree?
- Weekly diaries generate biased data. Agree?
- How can we be sure that coding is valid and reliable?

Shek, D.T.L., & Lam, C.M. (2006). Adolescent cough medicine abuse in Hong Kong: Implications for the design of positive youth development in Hong Kong. ***International Journal of Adolescent Medicine and Health, 18,*** **493-503.**

Beliefs about the Cough Medicine Abuse

	十分不同意	頗為不同意	少許不同意	少許同意	頗為同意	十分同意
1. 我相信服用咳藥水會損害健康。	1	2	3	4	5	6
2. 我相信服用咳藥水會前途盡毀。	1	2	3	4	5	6
3. 我可以控制服藥的習慣，因此咳藥水不會令我上癮。	1	2	3	4	5	6
4. 我覺得與濫用咳藥水的朋友來往亦無妨。	1	2	3	4	5	6
5. 今時今日，服用咳藥水與吸煙無異，只是一種嗜好。	1	2	3	4	5	6
6. 我的好朋友覺得服用咳藥水是很平常的事情。	1	2	3	4	5	6
7. 我相信服用咳藥水令我更有自信。	1	2	3	4	5	6
8. 我相信服用咳藥水後，我的煩惱會消除。	1	2	3	4	5	6
9. 我相信服用咳藥水後可以令我和朋友更容易相處。	1	2	3	4	5	6
10. 我相信服用咳藥水會令我玩得更開心。	1	2	3	4	5	6
11. 如遇到不如意的事，我會服用咳藥水。	1	2	3	4	5	6
12. 我相信如果經常濫用咳藥水，我的工作或學業會有麻煩。	1	2	3	4	5	6
13. 我相信服用咳藥水可減低我緊張的情緒。	1	2	3	4	5	6
14. 我相信服用咳藥水的青少年可受到異性的歡迎。	1	2	3	4	5	6
15. 我相信服用咳藥水可幫助我更融入身處的環境。	1	2	3	4	5	6
16. 我相信濫用咳藥水是愚蠢的。	1	2	3	4	5	6
17. 我相信青少年服用咳藥水可證明他們是堅強的。	1	2	3	4	5	6
18. 我相信服用咳藥水的青少年容易惹上麻煩。	1	2	3	4	5	6
19. 我相信服用咳藥水可令我的表現(創作力、生產力）更佳。	1	2	3	4	5	6
20. 我相信服用咳藥水是不會上癮的。	1	2	3	4	5	6

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SOCIAL BEHAVIOR AND PERSONALITY, 2008, 36 (1), 135-144

BELIEFS ABOUT COUGH MEDICINE ABUSE AMONG CHINESE YOUNG PEOPLE IN HONG KONG

DANIEL T. L. SHEK AND CHING MAN LAM
The Chinese University of Hong Kong, Shatin, Hong Kong

Beliefs about cough medicine abuse among Chinese young people were examined using the Beliefs about Cough Medicine Abuse Scale (BACMAS; developed by Shek). A total of 225 Chinese young people, including 160 cough medicine abusers and 65 noncough-medicine abusers, participated in this study. Results showed that the scale was internally consistent, and was able to differentiate between those who did and did not abuse cough medicine. Higher BACMAS scores were related to higher levels of endorsement of cough medicine abuse and severity of consumption, thus providing support for the concurrent and construct validities of the scale. The respondents abusing cough medicine generally did not perceive the benefits of abusing cough medicine and they recognized the harmful effects of such abuse. However, 40.7% of them believed that cough medicine was not addictive and 57% believed that there was no harm in associating with friends who abused cough medicine. Results suggest that it is important to understand the beliefs of cough medicine abusers regarding cough medicine abuse.

Keywords: cough medicine, cough mixture, Chinese, young people, addiction, drug abuse, substance abuse.

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Review
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Enthusiasm-Based or Evidence-Based Charities: Personal Reflections Based on the Project P.A.T.H.S. in Hong Kong

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In charitable foundations throughout the world, different approaches are used to allocate funding. As many projects with good will (i.e., enthusiasm-based charity) actually fail to help those who really need it, it is argued that the evidence-based approach (i.e., charity guided by scientific evidence) represents the best strategy to support projects that can really help the needy. Using this approach, scientific research findings are systematically used to (1) understand the nature of the problem and/or social needs, (2) design appropriate intervention programs based on the best available evidence, and (3) systematically evaluate the outcomes of the developed program. Using the Project P.A.T.H.S. funded by the Hong Kong Jockey Club Charities Trust as an example, the characteristics underlying this approach are outlined. The systematic use of scientific evidence in the Project P.A.T.H.S. is exemplary in different Chinese societies. This project provides much insight for charitable foundations and funding bodies locally and globally.

KEYWORDS: evidence-based practice, scientific evidence, charitable foundations, funding allocation, Project P.A.T.H.S.

INTRODUCTION

In different parts of the world, charitable foundations have been set up by businessmen, corporations, and the public in order to help people in need. Most of the time, such foundations are seen as a sign of corporate social responsibility and an act of the company to serve society. Some charitable organizations outside Hong Kong include the Bill and Melinda Gates Foundation[1], Ford Foundation[2], and Rockefeller Foundation[3]. Similarly, there are many charitable foundations established in the private sector to meet the social needs of Hong Kong. Some examples include the Li Ka Sing Foundation, Hong Kong Bank Foundation, and Sun Hung Kai Properties-Kwok's Foundation. There are also foundations established by the Government to support welfare, education, and community projects, such as the Beat Drugs Fund and the Quality Education Fund.

Another important charitable organization in Hong Kong is The Hong Kong Jockey Club Charities Trust of The Hong Kong Jockey Club[4]. As one of the largest racing organizations in the world, The

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Review
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Implementation Quality of a Positive Youth Development Program: Cross-Case Analyses Based on Seven Cases in Hong Kong

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Cross-case analyses of factors that influence the process and implementation quality of the Tier 1 Program of the Project P.A.T.H.S. based on seven cases were carried out. Systematic and integrative analyses revealed several conclusions. First, several factors related to policy, people, program, process, and place (5 "P"s) were conducive to the successful implementation of the Tier 1 Program in the schools. Second, there were obstacles and difficulties with reference to the 5 "P"s that impeded the quality of implementation. Third, policy support and people (especially commitment and passion of the principals, senior school administrators, and program implementers) are two main groups of factors that influence the quality of program implementation. Fourth, although there were different arrangements for program implementation, incorporation of the Tier 1 Program into the formal curriculum was a sound and viable strategy. Fifth, implementation of the Tier 1 Program in schools that admitted students with high or low academic achievement was viable. Sixth, the program was generally perceived positively by the program participants and implementers. Finally, the program implementers perceived the program to be beneficial to the program participants.

KEYWORDS: adolescence, positive youth development, implementation quality, cross-case analyses, Project P.A.T.H.S.

What are the factors that affect the success or failure of positive youth development programs? Nation et al.[1] pointed out that there are many factors that determine the success of an adolescent prevention program. Among these factors, process variables, such as varied teaching methods (i.e., use of a wide range of teaching methods that help the program participants to become aware and understand problem behaviors and acquire the related skills) and positive relationships with adults (e.g., workers), are important factors to be considered. There are also research findings that show that teaching practices and program implementation attributes influence the extent of program success. Harachi et al.[2] reported findings to support some of the propositions of the social development model that instructional strategies

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Evaluation of Evaluation Studies Using Qualitative Research Methods in the Social Work Literature (1990-2003): Evidence That Constitutes a Wake-Up Call

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Objective: This study examines the quality of evaluation studies using qualitative research methods in the social work literature in terms of a number of criteria commonly adopted in the field of qualitative research. Method: Using qualitative *and* evaluation *as search terms, relevant qualitative evaluation studies from 1990 to 2003 indexed by* Social Work Abstracts *were examined, and their quality was evaluated. Results: The review shows that the quality of published evaluation studies using qualitative research methods in the social work field is not high and that many of the reviewed studies are not sensitive to the following issues: philosophical base of the study, auditability, bias, truth value, consistency, and critical interpretations of the data. Conclusions: Social workers using findings arising from published evaluation studies using qualitative research methods in social work should be cautious and social workers conducting qualitative evaluation studies should be sensitive to the issue of quality. Adequate training for social workers on qualitative evaluation should also be carried out.*

Keywords: *qualitative research; evaluation; social work literature; evaluative criteria; criteriology*

Is social work intervention effective? A review of social work literature shows that the answer to this question has changed with time. In the 1970s, several reviews of quantitative social work evaluation studies suggested that social work intervention was not effective (Fischer, 1973; Segal, 1972). However, with the growth of quantitative outcome studies showing that social work intervention programs were effective (Reid & Hanrahan, 1982; Rubin, 1985), this gloomy picture changed in the 1980s. Besides, there were attempts to develop guidelines that govern the quality of quantitative evaluation studies. Thyer (1989) outlined a series of first principles governing social work practice research, and Thyer (1991) further proposed guidelines for evaluating social work outcome research reports. With the publication of new social work journals, such as *Research on Social Work Practice*, quantitative studies documenting the effectiveness of social work have gradually accumulated.

Although there is a growing effort to evaluate the effectiveness of social work intervention via quantitative methods, there has also been a growing literature on qualitative studies in the social work context. A review of *Social Work Abstracts* in June 2004 showed that although there were 513 publications when the search term *quantitative* was used, there were 1,338 publications when the search term *qualitative* was used. In a review of social work research dissertations and theses, Dellgran and Hojer (2001) found that of the 89 Ph.D. theses covering the years 1979 to 1998, half of them were qualitative studies, 14% were quantitative studies, and 36% were mixed-method studies.

With the growing number of qualitative evaluation studies in the social work literature, one important question that should be asked is whether the qualitative evaluation studies paint an optimistic picture of social work intervention as effective. In response to the growing emphasis of qualitative research in the social work profession, Thyer (1989) argued that "the advocates of qualitative research are urged to provide the profession with similar positive examples of research on the outcomes of

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Prevention of Adolescent Problem Behavior: Longitudinal Impact of the Project P.A.T.H.S. in Hong Kong

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The present study attempts to examine the longitudinal impact of a curriculum-based positive youth development program, entitled the Project P.A.T.H.S. (Positive Adolescent Training through Holistic Social Programmes), on adolescent problem behavior in Hong Kong. Using a longitudinal randomized group design, six waves of data were collected from 19 experimental schools (n = 3,797 at Wave 1) in which students participated in the Project P.A.T.H.S. and 24 control schools (n = 4,049 at Wave 1). At each wave, students responded to questions asking about their current problem behaviors, including delinquency and use of different types of drugs, and their intentions of engaging in such behaviors in the future. Results based on individual growth curve modeling generally showed that the participants displayed lower levels of substance abuse and delinquent behavior than did the control students. Participants who regarded the program to be helpful also showed lower levels of problem behavior than did the control students. The present findings suggest that the Project P.A.T.H.S. is effective in preventing adolescent problem behavior in the junior secondary school years.

KEYWORDS: adolescent problem behavior, longitudinal study, positive youth development, prevention, Project P.A.T.H.S., randomized group trial

INTRODUCTION

Adolescent problem behaviors, such as alcohol use, delinquency, teenage pregnancy, violence, and different types of substance abuse, are always of concern to health professionals and researchers. In the past 2 decades, the strategy to prevent adolescent problem behaviors has evolved from problem monitoring to the use of strength-based approaches that focus on the promotion of positive youth development[1]. Researchers have pointed out that problem-oriented programs did not engage the motivations and capacities of young people, failed to address complicated personal and social antecedents of problem behaviors, and did not consider youth development as a gradual and cumulative process in

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Chapter 5
Results of Evaluation Area 3: Qualitative Evaluation

Analyses of the Qualitative Data

The content of the interviews for the workers (N=15) and program participants (N=30) was transcribed. To facilitate analyses, a pre-structured case approach with reference to the interview questions or areas of interview questions was adopted (Miles & Huberman, 1994). Our unit of analysis was a meaningful unit instead of a statement. For example, the statement that "the program helps me to gain more knowledge on substance abuse and develop more positive attitudes to substance abuse" would be broken down to two meaningful units or attributes, namely, "the program helps me to gain more knowledge on substance abuse" and "the program helps me to develop more positive attitudes towards drug abuse" (Shek, 2001; Shek & Chan, 1991). To examine the reliability of the coding schemes for some of the questions (particularly those questions regarding the effectiveness and benefits of the program), a certain proportion of the protocols were randomly selected and coded by another rater to generate measures of inter-rater reliability (i.e., triangulation by researchers).

Qualitative Interviews with the Workers (N=15)

Context Evaluation

The questions in the interview guide for the workers were designed with reference to the CIPP model (Stufflebeam & Shinkfield, 1985). As far as context evaluation concerned, 11 workers (73.33%) expressed that they had not conducted any systematic drug prevention programs before. Amongst those who indicated they had provided drug prevention programs before, analyses of the responses showed that most of the activities were relatively short and unsystematic, such as drug talks, carnivals and adventured-based counseling camps. The findings are shown in Table 5.1. Regarding the mode of evaluation for drug prevention programs held previously, some of the informants had used case analysis and client satisfaction questionnaires. However, 4 workers (26.67%) indicated that they had not conducted any systematic evaluation for such programs. With reference to the question of whether they knew the structured drug prevention programs developed in the West, 8 workers (53.33%) indicated that they did not know, 2 workers (13.33%) said that they had heard of but they did not know much and 3 workers (20%) said that they had only consulted local materials only.

Input Evaluation

Regarding the selection of program participants, 12 workers (80%) indicated that the participants were either selected by them in terms of severity of problems or recommended

by the school. Only 3 workers (20%) indicated that they recruited members via open recruitment. Regarding the question whether the workers encountered any difficulties in the recruitment plan, various difficulties were included. In particular, 4 workers mentioned the difficulty of recruiting participants in the experimental and control groups and another 4 workers mentioned the problem of labeling. The findings can be seen in Table 5.2. Regarding the question of whether the implementation of the program had affected the normal work of the workers, 5 workers (33.33%) indicated that the related work was additional and 7 workers (46.67%) indicated that the program was part of the normal workload. Concerning the question of whether adequate resources had been planned and arranged, amongst the 23 responses from the workers, 18 responses (78.26%) were positive. For those responses that were not positive, the problems included difficulty in planning meeting time and inadequate manpower coordination. As far as the cooperation among the school, agency, research team and community, 15 responses out of the 20 responses were positive. In particular, 4 workers (26.66%) expressed that the arrangement where research team members led the groups was a good arrangement.

Process Evaluation

Regarding the workers' impression of the program, most of the workers were positive about the program (Table 5.3) and they felt that there were many positive features of the program (Table 5.4). In addition, over half of the responses supported the applicability of the program, although the workers also mentioned some obstacles hindering the applicability of the program (Table 5.5). Concerning the special experiences of the workers, most of the narrated experiences (12 responses out of 17 responses) were positive in nature. For responses related to negative experiences, 4 responses were related to the discipline of the members and 1 response was related to the members' challenge of the worker. The workers also perceived that the participants were positive about the program. Amongst the 38 responses, 27 responses were positive (Table 5.6).

With reference to the difficulties encountered, 37 responses were recorded. The informants expressed the following difficulties: cognitive understanding of the members (N=3), discipline problems (N=4), interaction problems among the members (N=5), timing problem (N=7), venue problems (N=1), too many group members (N=2), coordination problems (N=6), manual problems (N=7) and prolonged collection of evaluation data (N=2). Regarding the workers' views on the evaluation of the program, amongst the 37 responses, 31 responses were negative, such as the length of the questionnaire was too long and it took much time to complete the questionnaires.

In short, most of the workers were generally positive about the implementation of the project. They had positive perceptions and experiences about the program and they felt that the members had good responses. They were also generally positive about the coordination between the research team and the workers and the related arrangements. However, they expressed concern about the difficulties encountered and the lengthy evaluation mechanism of the project.

Product Evaluation

Most of the informants perceived that the project was different from the "conventional" drug prevention programs. A summary of the 20 responses showed that the workers perceived the program to be systematic (N=6), rich and continuous (N=3), educational in nature (N=2),

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