A SITUATION ANALYSIS OF THE TREATMENT MODELS USED IN REGISTERED INPATIENT ALCOHOL AND DRUGS REHABILITATION CENTRES IN AND AROUND NAIROBI

A PROJECT REPORT SUBMITTED IN FULFILMENT FOR THE AWARD OF MASTERS OF SCIENCE DEGREE IN CLINICAL PSYCHOLOGY OF THE UNIVERSITY OF NAIROBI

BY:

CATHERINE MAWIA MUSYOKA

DEPARTMENT OF PSYCHIATRY

SCHOOL OF MEDICINE

COLLEGE OF HEALTH SCIENCES

UNIVERSITY OF NAIROBI

June 2013

DECLARATION

I CATHERINE MAWIA MUSYOKA hereby declare that this dissertation is my original work and has not been presented for the award of a degree in any other University. All sources of information have been acknowledged by means of references.

Signature.....

Date.....

SUPERVISORS' APPROVAL

This dissertation has been submitted with our approval as university supervisors:

Prof. David Ndetei
Department of Psychiatry
University of Nairobi
Signature ……..... Date …….....

Dr. John Mburu
Lecturer
Department of Psychiatry
University of Nairobi
Signature ……..... Date …….....

Dr. Muthoni Mathai
Lecturer
Department of Psychiatry
University of Nairobi
Signature ……..... Date …….....

TABLE OF CONTENTS

DECLARATION 2
SUPERVISORS' APPROVALS 3
TABLE OF CONTENTS 4
LIST OF ABBREVIATIONS 7
DEFINITION OF TERMINOLOGIES 8
ABSTRACT 10
CHAPTER 1: INTRODUCTION 11
1.0 Background 14
1.1 Statement of Research Problem 14
1.2 Study Justification 14
1.3 Research question 15
1.4 Study Objectives 15
1.4.1 Broad Objective 15
1.4.2 Specific Objectives 15
CHAPTER 2.0 LITERATURE REVIEW 16
2.1 Studies on 12-Step Model 16
2.2 Evidence on Cognitive-Behavioural Approaches 17
2.3 Evidence on the Biopsychosocial model 18
2.4 Studies on Harm reduction 19
2.5 Studies about Therapeutic Communities 221
CHAPTER 3.0 METHODOLOGY 22
3.1 Study Design 22
3.2 Study Area 22
3.3 Study Population 22
3.4 Inclusion and Exclusion Criteria 22
3.4.1 Inclusion Criteria 22
3.4.2 Exclusion Criteria 22
3.5 Sampling Procedures 22
3.5.1 Sampling Technique 22
3.6 Data Collection instrument and Procedure 22
3.6.1 Data Collection Process 23

3.7 Anticipated Obstacles/Limitations 23
3.8 Ethical Considerations 23
3.9 Data Management, Analysis and Presentation 24
CHAPTER FOUR ..... **Error! Bookmark not defined.**
DATA ANALYSIS AND INTERPRETATION ..... **Error! Bookmark not defined.**
4.1 Introduction ..... **Error! Bookmark not defined.**
4.2 Structured processes 32
4.2.1 Admissions 32
4.2.2 Assessment 33
4.2.3 Planning 33
4.2.4 Client Management 34
4.2.5 Duration 34
4.2.6 Discharge 36
4.2.7 Follow up 37
4.3 Therapy 38
4.4.1 Individual 38
4.4.2 Group 39
4.4.3 Family 39
4.3.4 Medical 40
4.3.5 Christian 40
4.4 Model 41
4.5.1 12 steps model 442
4.5.2 Therapeutic communities 443
CHAPTER FIVE 44
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS 44
5.1 Introduction 44
5.2 Summary of findings 44
5.3 Conclusions 46
5.4 Recommendations 46
5.5 Recommendations for further studies 47
6.0 TIMELINE OF EVENTS 48
6.1 Organisation of the Study 49
6.1.1 Work plans and Budgets 49

7.0 REFERENCE.....50
8.0 APPENDICES.....51
Appendix 1: Rehabilitation Centre In-charge Consent Explanation.....52
Appendix 2: Rehabilitation Centre In-charge Consent.....53
Appendix 3: Participant Consent Explanation.....54
Appendix 4: Consent by Study Participants.....55
Appendix 5: Socio-Demographic Questionnaire for Staff.....56
Appendix 6: Types of models used tool for counsellors offering drug rehabilitation services.57
7.0 FLOW CHART.....58

LIST OF ABBREVIATIONS

AA	Alcoholics Anonymous
CBT	Cognitive Behavioural Therapy
CBTM	Cognitive Behavioural Therapy Model
DSA	Drug and Substance Abuse
MAT	Medication Assisted Treatment
MGH	Massecheutes General Hospital
NACADAA	National Campaign against Drug Abuse Authority
NA	Narcotic Anonymous
NCSACW	National Centre on Substance Abuse and Child Welfare
OLITA	Outpatient Long-term Intensive Therapy for Alcoholics
PFR	Partners for Recovery
Rehab	Rehabilitation
RCSP	Recovery Community Services Program
RP	Relapse Prevention
SSPS	Statistical package for social sciences
TC	Therapeutic community

DEFINITION OF TERMINOLOGIES

ABUSE: The misuse or overuse of a substance in a way different from the way it is generally used, medically or socially. Also the continued use of a substance even though it is causing problems in one's life.

ADDICTION: Loss of control and compulsive use of a mood or mind-altering chemical or chemicals along with inability to stop the use in spite of the fact that such use is causing problems in one's life. It means having a physical and/or psychological dependence on a substance.

AFTERCARE: Also known as continuing care: Follow-up care that offers continuing ongoing support to maintain sobriety/abstinence, personal growth and integration into family/community.

ALCOHOL : A colorless volatile flammable liquid, C2H2OH, synthesized or obtained from fermentation of sugars and starches and widely used, either pure or denatured, as a solvent in drugs, cleaning solution, explosives, and intoxicating beverages. Alcohol is mind and mood altering substance with a depressant effect to the brain

ALCOHOLIC ANONYMOUS (AA): The original Twelve-Step recovery program, begun in 1935 by two alcoholics to provide mutual help and support for people who have a desire to stop drinking.

ASSESSMENT/EVALUATION: The systematic identification of a patient's/client's condition and needs within a framework based on professionally accepted best practice guidelines.

CENTRE: Substance dependency treatment facility

CLIENTS: People dependent on or addicted to a substance who have been admitted to a treatment centre.

DRUGS: Any chemical agent that when introduced into the body alters the biochemical and physiological processes of body tissues or organism

DRUG DEPENDENCY: A physical and/or psychological need for a mood altering substance.

PSYCHOACTIVE SUBSTANCES: Any drug that when ingested, affects the central nervous system and alters consciousness and/or perceptions e.g. cognition

DRUGS AND SUBSTANCE ABUSE: A mal adaptive pattern of drug use

REHABILITATION: Relearning or re-establishing healthy functioning, skills, and values as well as regaining physical and emotional health

TREATMENT: Application of planned procedures to identity and change patterns of behaviour that are maladaptive, destructive or injuring; or to restore appropriate levels of physical, psychological or social functioning.

ABSTRACT

Background of the study

Drug and substance abuse is a global threat that causes serious ramifications on people's health, security, economic and cultural welfare. Treatment of persons with Drug and substance abuse is a big challenge both to the individual, their families and the society at large. This is because of the chronic and relapsing nature of Drug and substance abuse (DSA). In Kenya structured treatment of Drug and substance is a new phenomenon, Treatment and rehabilitation of persons with Drug and substance abuse problem is mostly in the hands of private individuals.

Purpose of the study

This study sought to establish and document the various treatment models applied on clients admitted in rehabilitation centers in Nairobi as well as establish the qualification of staff working in the rehabilitation centers.

Design of the study

This was a descriptive qualitative study of all the drug rehabilitation centres in and around Nairobi.

Study Sample

Included all residential drug rehabilitation centers in and around Nairobi as per NACADAA records and the counselors directly dealing with the treatment of clients in these centers.

Data collection procedure

A 2 level researcher designed questionnaires was used to establish the treatment models used in the various in patient drug rehabilitation centres from the respondents, using a qualitative key informant interview. The questionnaire and interview schedule were researcher administered.

Data analysis

Data of the study was analysed and presented using descriptive and inferential statistics. The En vivo statistical package was used to group the obtained data into predetermined thematic areas, and then the grouped data was used in the final descriptive analysis.

Results of the study

The study found out that various models of treatment were used in treatment of clients admitted in drug rehabilitation centres in Nairobi. The commonly used models included the 12 step program of the Minnesota model, Therapeutic community model, Medical model and in most places a mixture of the various models. The most qualification of addiction treatment staff was Diploma level at 53.3%.

CHAPTER 1: INTRODUCTION AND BACKGROUND

Drugs and substance abuse is a problem that has raised concern all over the world.

An estimated 205 million people in the world use illicit drugs, including 25 million who suffer from illicit drug dependence. (WHO, 2008). Drug abuse affect people at all levels of development, and especially children when they are introduced at very early age of between l0-l4 years. (NACADA, 2004; NACADA and KIPPRA, 2005; NACADA, 2008; Ngesu et al, 2008).The abuse of alcohol and other substances, including narcotic drugs, has permeated every sphere of the Kenyan society leaving behind untold suffering, decay and underdevelopment.

The abuse of drugs is a noted danger to public health and the quality of life that consequently affects the political, economic and social stability for both industrialized and developing countries alike. The important role of drug dependence prevention and treatment as part of demand reduction and public health has been repeatedly emphasized in international agreements (WHO, 2008)

Previously viewed as a social and criminal problem, drug abuse and illicit trafficking has in the recent years become a major threat to the health and security of all persons as it is responsible for the destruction of many, majority in their prime age, (NACADA, 2007).

According to a National Survey on Alcohol and Drug Use undertaken by NACADA in the year 2007, at least 13% of Kenyans aged 15 and 65 years are current consumers of alcohol. The report further indicated that alcohol poses the greatest harm to Kenyans as evidenced by the numerous calamities associated with excessive consumption and adulteration of alcohol. In September 2011, thirty two (32) deaths were reported following consumption of adulterated drinks. Others that survived the ordeal are reported to have lost their sight.

For some persons, substance abuse progresses from experimental or social use to dependency and addiction. Major consequences ensue for these individuals, their families, and society (NACADA, 2007). Addicted persons usually experience increasingly debilitating or dysfunctional physical, social, financial, and emotional effects. Treatment is essential for those who become chemically dependent and are unable to control their use of alcohol or other drugs. Various types of programs offer help in drug rehabilitation, including: residential treatment (in-patient), community based rehabilitation and outpatient rehabilitation services.

According to Hayes et.al. 1993, there are numerous models and approaches used to treat chemical dependency. Drug rehabilitation (often drug rehab or just rehab) is a term for the processes of medical and/or psychotherapeutic treatment, for dependency on psychoactive substances such as alcohol, prescription drugs, and so-called street drugs such as cocaine, heroin

or amphetamines, the writer further notes that, the general intent of treatment is to enable the patient to cease substance abuse, in order to avoid the psychological, legal, financial, social, and physical consequences that can be caused, especially by extreme abuse. Psychological dependency is addressed in many drug rehabilitation programs by attempting to teach the patient new methods of interacting in a drug-free environment. Scientific research since 1970 shows that effective treatment attends to multiple needs of the addicted person and not just his or her drug abuse. In addition, medically assisted detoxification is only the first stage of treatment and it does not help much to change long-term drug abuse (Hayes et.al., 1993).

Historical background of rehabilitation services in Kenya

Dr. Njagi a leading psychiatrist in Kenya had this to say about the history of rehabilitation services in Kenya, *"Here in Kenya, the first rehab was in 1986. This is at a place called Asumbi, in Gusii land. It's actually a half-way house; let's say it was the first Rehab. It has recovered addicts who are helping others by the experience they have gone through, but you can call it the first rehabilitation center. The second one, came all the way in 1998, some 12 years later and this is Brightside DART center, and this one now was the first formal rehab center, where you are bringing in professionals, psychiatrics, psychologist, psychological counselors, chemical dependency counselors, and even medical staff. We may need nurses because when we treat this depression and all that, we need some medical personnel. That is why we are calling it a dual diagnosis. This one was the first formal center, but second to Asumbi. By 2001, the Red hill started. 2003 we had the Mathare addiction center, actually am the one who started it when I was there. Because of that training in the US, I didn't have an opportunity, so we organized group counseling sessions, getting some counseling psychologists from USIU, this USIU they used to assist us quit a lot, so before I left and identified two wards which I was renovating, note I left in 2001, those who came continued, by 2003 they started admitting. Of course now they have mushroomed, you go to Mombasa you get several. Even Nairobi they are so many. Am just giving a short history"* (Key informant interview on 23 august 2012)

Theoretical framework of addiction

A variety of theoretical models have arisen to try and explain the complexity of drug abuse. These models fall within a framework of five different paradigms:

1. The disease model
2. The learning theory models
3. The psychoanalytic model
4. The family theory models
5. Bio-psychosocial model

The disease model theory

The disease model view drug abuse as a disease influenced by genetic vulnerability which is reflected in the abnormality in brain chemistry, (Jang *et al.*, 2000). The abnormalities create an

altered response to drug abuse. The in ability to control amounts, cravings and withdrawals are all pointers of a biological component of drug abuse.

The learning model theory

Learning theories encompass different schools of thought regarding learnt or conditioned behaviors. They include; classical conditioning, modeling theories as well as cognitive behavioral or social learning theories. They subscribe to the notion that substance abuse represents a learnt or modeled bad habit that is subject to change and thus can be analysed and modeled by applying learning theory principles, (Akers 1977).

The psychoanalytic model theory

The psychoanalytic theories view drug abuse as an adaptive mechanism by which an individual attempts to cope with self-regulatory deficits arising from infantile deprivation and maladaptive child-parent relationship.

It views adolescent drug abuse as an attempt to escape the overwhelming anxiety of preparation for adult roles. Drug abuse is also viewed by this theory as a pharmacological attempt to reduce stress by the abuser. Individuals are seen to select different drugs on the basis of personality organization and ego impairments.

The choice of a specific drug is based on the premise that it relieves the feeling they find particularly problematic or painful. Early childhood developments issues and trauma are primary in this theory.

The family models theory

There are three family models used to explain the causation of drug abuse. They include family systems models, family behavioral models and family disease models. These models view drug abuse as a symptom of a dysfunctional family. In particular, the concepts of homeostasis, the rules that and goals that govern the interactions between family members and ways in which the rules are applied, may all contribute to drug abuse. This theory emphasizes the need to include family members in treatment and address family dynamics so that the drug abuser has a heathier, stable flexible and open family environment after treatment.

Bio-psychosocial model theory

The Bio-psychosocial model is based on the premise that biochemical factors, disorders of self, learned or conditioned behaviors, family and social factors contribute to the initiation and

maintenance of drug abuse. The theory stress that there are multiple pathways to abuse and that the differential effect of these factors varies from individual to individual. Once the individual progresses to the point of dependence, however, the problem becomes primary and has its own symptoms, (Ashton and Stepney, 1982).

This study seeks to provide information on the various treatment models in use in Kenyan drug rehabilitation centres.

1.1 Statement of Research Problem

Some persons who use drugs do not need drug treatment. Many people can use alcohol and some illicit drugs without encountering adverse consequences. Some grow weary of a lifestyle in which the pursuit of drugs and managing the varied consequences of substance use predominates.

Most people who have not progressed to the point of dependency or addiction are able to decide to stop using drugs and maintain this resolve. For those who are dependent or addicted, treatment for substance abuse is crucial in controlling their substance abuse and improving their health and social functioning. A social climate that is intolerant toward substance abuse and the risk of social, legal, or employer sanctions may be needed for them to make and maintain their decision to stop or limit their drug use (ONDCP, 1990).

Without treatment, substance abuse may ultimately be fatal because of the risk of overdose, related suicides and homicides, and infectious diseases and other assaults to one's health. Yet few voluntarily seek treatment. Cessation of drug use is very difficult and treatment programs can be demanding and intense (ONDCP, 1990).

There was the need to investigate and document the various treatment models in use in drug rehabilitation centres in order to form a baseline data to harmonise treatment modalities and guidelines in Kenya.

1.2 Study Justification

In Kenya today there are 61 registered rehabilitation centres (NACADA 2008), the operation of these rehabilitation centers is not well coordinated, yet they play an integral role in the treatment and rehabilitation of persons with drug and substance abuse disorders.

It was necessary to assess and document the various treatment modalities in use, this was a situational analysis of the practice on the ground, it documented the current practice in the rehabilitation field in Kenya, and this was to help in identification of gaps in the treatment field

and inform areas of intervention. This study documented the current situation on the ground in the field of addiction treatment and would go a long way to inform policy on the process of treatment modalities in the country.

This was also to help come up with an assessment of the treatment modalities used in the field of addiction management in the country.

1.3 Research question

1. What treatment models are used in rehabilitation centers in and around Nairobi?
2. What are the qualifications of the counselors who deal with alcohol and drug dependent clients?

1.4 Study Objectives

1.4.1 Broad Objective

To find out what treatment models were used in rehabilitation centers in and around Nairobi, and the qualifications of the staff counseling the clients.

1.4.2 Specific Objectives

1. To identify the treatment models in use in the selected rehabilitation centers.
2. To determine the qualifications of personnel handling alcohol and drug abuse cases in rehabilitation centers in Kenya.

CHAPTER 2.0 LITERATURE REVIEW

Introduction

This chapter looks at the various studies which have done on the treatment and management of alcohol and substance abuse disorders. Most of the studies cited here are from the high and middle income countries as no studies have been documented in lower social economic areas.

2.1 Studies on 12-Step Model

Studies have shown that Alcoholic Anonymous (AA) and Narcotic Anonymous (NA) provide long-term benefits to youth, even if the adolescents stop attending after a time. Published in the journal *Alcoholism: Clinical & Experimental Research*, one study followed 160 adolescents, with an average age of 16, through four- and six-week treatment programs based on a 12-Step model. After treatment ended, participants were re-assessed on a number of clinical variables at six months, and one, two, four, six, and eight years. (http://www.drugrehabprogram/are-12-step-programs-beneficial-for-teens.php)

John F. Kelly, associate director of the MGH-Harvard Center for Addiction Medicine at Massachusetts General Hospital said, "We found that patients who attended more AA and/or NA meetings in the first six months post-treatment had better longer term outcomes, but this early participation effect did not last forever – it weakened over time, the best outcomes achieved into young adulthood were for those patients who continued to go to AA and/or NA. In terms of a real-world recovery metric, we found that for each AA/NA meeting that a youth attended they gained a subsequent two days of abstinence, independent of all other factors that were also associated with a better outcome." (http://www.drug-rehab-program.org)

Researchers found that even small amounts of AA/NA participation (once per week) was associated with improved outcomes, and three meetings per week was associated with complete abstinence. Not surprisingly, severely addicted teens attended a greater number of meetings and benefited most from the AA/NA focus on complete abstinence.

In a survey by Massachusetts General Hospital Center for Addiction Medicine, teens reported that the group dynamic, support, and sense of hope they gained at AA/NA meetings were the most appealing aspects of the 12-Step program. Addiction experts point to the following additional benefits of a 12-Step program for adolescents:

• The 12-Step program is focused specifically on abstinence and addiction recovery.
• Twelve Step meetings are widely available in most communities, and can be accessed any day, evening, or weekend.
• Services are free.
• The 12-Step program provides easy admission into a large social support network with fellow adolescents in recovery, meeting teens' particular need for social affiliation and peer-group acceptance.
• Teens can attend regularly or on an as needed basis.
• Twelve Step meetings offer social activities and sober fun as an alternative to drinking, doing drugs, and partying.

2.2 Evidence on Cognitive-Behavioural Approaches

Deficits in skills for coping with the antecedents and consequences of drinking/drug use are considered to be a major contributor to the development and maintenance of addictive behavior (Miller & Hester, 1989). As a result, considerable effort has been devoted to studying coping skills training, to determine whether it has practical utility as a means of reducing risk and curtailing addictive behavior. A large body of clinical research has been produced on this topic, and three meta-analyses have ranked coping skills training as either first (Holder et al., 1991) or second (Miller et al. 1995; Finney & Monahan, 1996) based on evidence of effectiveness, as compared to a variety of other treatments for alcoholism. Nevertheless, despite the high rankings in the meta-analyses, Longabaugh and Morgenstern (1999) have questioned whether the research studies provide adequate grounds for concluding that coping skills training is superior to other forms of treatment. They outline steps that should be taken to resolve the matter, and it seems certain that the question will remain open for a number of years while further studies are conducted, before it is finally settled. In the meantime, coping skills training does receive strong support from the evidence currently available and it is widely employed in addictions treatment programs.

Similar questions have been raised regarding Relapse Prevention (RP) treatment studies (Carroll, 1996). Interventions that focus on relapse prevention have been found beneficial for maintaining the effects of treatment during follow-up periods and for reducing the severity of relapse episodes that do occur, but there are diminishing returns inasmuch as these benefits have been

found to decrease with increasing time since treatment completion (Carroll, 1996; Allsop et al., 1997).

A meta-analysis focused specifically on relapse prevention treatment outcome studies found that RP treatment was beneficial, but its impact on psychosocial functioning was greater than on substance use itself (Irvin et al., 1999).

Another finding of clinical relevance from RP treatment outcome studies is that among the various categories of risk for relapse specified by Marlatt and Gordon (1985), negative emotions have been consistently identified as a major relapse precipitant (Longabaugh et al., 1996). Based on that, coupled with findings that coping ability is related to treatment outcome (Miller et al., 1996; Connors, Maisto, & Zywiak, 1996), it has been recommended that skills training to foster improved coping with negative emotions be provided as a means of reducing relapse risk (Connors, Longabaugh, & Miller, 1996).

2.3 Evidence on the Biopsychosocial model

Outpatient Long-term Intensive Therapy for Alcoholics (OLITA) is a four-step biopsychosocial outpatient therapy program for severely affected alcohol-dependent patients, aiming at immediate social reintegration within the sheltered setting of psychotherapeutic treatment and medical care. Therefore, basic elements of psychiatric patient care, client-centered and cognitive-behavioral psychotherapy, as well as classical addiction therapy, are integrated into a comprehensive, intensive and long-term treatment approach. In order to take into account both the impaired stress tolerance of the patients during early abstinence and the chronicity of the disease, the OLITA concept combines high intensity (i.e., high frequency of therapy contacts) and long duration of therapy. Following inpatient detoxification, the treatment extends over 2 years.

The OLITA pilot study started in 1993 and was terminated successfully in 2003 after 10 years and the completion of 180 patients assigned to recruitment cohorts 1-6. The main therapeutic elements of OLITA are: (1) frequent contacts, Initially daily, with a slow reduction of contact frequency up to the end of the second year; (ii) therapist rotation; (iii) support of social reintegration and aggressive aftercare; (iv) induction of alcohol intolerance through application

of alcohol deterrents (inhibitors of acetaldehyde dehydrogenase); (v) explicit control: supervised intake of alcohol deterrents and regular urine analysis for alcohol and other drugs of abuse.

The therapeutic phases of OLITA consist of the inpatient period (detoxification; 2 to 3 weeks; daily individual sessions, 15 minutes), the outpatient period i (intensive phase; 3 months; daily individual sessions, 15 minutes), the outpatient period II (stabilizing phase; 3 to 4 months according to individual need; three times a week individual sessions, 15 minutes), the outpatient period III (weaning off phase; 6 months; twice a week individual sessions, 30 minutes), and outpatient period iV (aftercare phase; 12 months; once weekly group session; initially once weekly individual session, 30 minutes, which is gradually tapered off). After completion of the 2 years of therapy, patients participate in weekly to quarterly follow-up contacts and are offered to make use of both the emergency service and the crisis interventions of the therapeutic team.

Inclusion criteria for OLITA are alcohol dependence according to DSM-IV, residence nearby, and health insurance-covered treatment costs. Exclusion criteria are presence of moderate to severe dementia and acute concurrent abuse or dependence on substances other than alcohol (with the exception of caffeine and nicotine). Thus far, 180 alcoholics (144 men, 36 women) have been treated with a 7-year follow-up success rate of over 50% abstinent patients despite a "negative selection," with regard to severity of alcohol dependence, co morbidity, and social detachment, upon entering the program. Patients were on average 44±8 years old, had a duration of alcohol dependence of 18±7 years, approximately 7±9 prior inpatient detoxification treatments, and 1±1 failed inpatient long-term therapy. Almost 60% of the patients were unemployed. Psychiatric co morbidity amounted to 80%. About 60% of the patients suffered from severe sequelae of alcoholism, such as polyneuropathy, chronic pancreatitis, or liver cirrhosis. To illustrate addiction severity in our population, representative scores of the European Addiction Severity Index were 0.58 (±0.38) for medical status, 0.56 (±0.47) for economic status, 0.51 (±0.37) for job satisfaction, 0.83 (±0.11) for alcohol use, 0.59 (±0.30) for family relationships, and 0.46 (±0.21) for psychiatric status.

2.4 Studies on Harm reduction

In order to reduce alcohol-related harm and the disease burden associated with excessive alcohol use, researchers and clinicians need to develop a much greater understanding of why and how people change with and without treatment. Most alcohol treatment researchers and clinicians

agree that treatment is effective (Miller, Walters, &Bennett, 2001).Yet, very little is known about the mechanisms by which treatment is effective (Morgenstern & Longabaugh, 2000), and even less is known about how individuals change without treatment (Matzger, Kaskutas, & Weisner, 2005; Sobell, Ellingstad, & Sobell, 2000). Matzger et al. (2005) addressed the question of *why people change* through conducting a quantitative analysis of 'reasons for drinking less' (p. 1637) in a sample of 659 problem drinkers, including 239 adults who did not receive treatment
In the past 12 months and 420 adults who received some form of public or private alcohol treatment. Problem drinking was defined as affirmative responses to two of the following: one binge episode at least once a month, alcohol-related social consequences, and one or more alcohol dependence symptoms. At 1, 3, and 5 years following a baseline interview, the respondents who indicated they were drinking 'a lot less' were provided with a list of potential of being non-problem drinkers at follow-up. In the treatment sample, individuals who reported receiving a warning from their doctor and weighing the pros and cons of drinking had lower odds of being in remittance. The results from Matzger et al. (2005) suggest that 'quantum changes' (Miller & C'de Baca, 2001) greatly increase the odds of an individual remitting from problem drinking, and interventions performed by family members or medical doctors are negatively related to positive outcomes. A prospective analysis using objective measures of drinking and reasons for not drinking will be needed to replicate the findings.

Witkiewitz (2005) and Witkiewitz and Masyn (2004) conducted a thorough analysis of *how people change* following treatment using latent growth mixture modeling, an analytic strategy that estimates common patterns in individual trajectories. Three hundred and ninety-five individuals were assessed monthly on measures of drinking frequency and quantity for 12 months following treatment. The results supported a model with four common drinking trajectories following an initial lapse. The most common outcome trajectory (64% of the sample) was characterized by an initial lapse followed by a return to abstinence or moderate drinking.
Only 12% of the sample reported a stable heavy drinking pattern following the initial lapse. Individuals with the heaviest drinking trajectories were unique from all other drinkers in that they had significantly lower scores on measures of coping and self-efficacy and significantly higher scores on measures of negative affect and distal risks. Interestingly, many individuals in the Witkiewitz (2005) analysis, particularly those with higher scores on measures of negative affect and distal risk, had very turbulent drinking trajectories characterized by nearly 100%

abstinence in one month, followed by nearly 0% abstinence in the next month. This pattern of results and the analyses described by Matzger et al. (2005) point to a relationship between risks Factors and drinking behaviour that is highly nonlinear.

In the Matzger analysis, the participants identified 'hitting rock bottom', traumatic events, and quantum changes (Miller & C'de Baca, 2001) as the reasons for remittance from problem drinking. Gaining a better understanding of how and why people change their drinking will likely require idiographic and/or nonlinear dynamical analyses of individual drinking habits (Hufford, Witkiewitz, Shields, Kodya, &Caruso, 2003; Witkiewitz & Marlatt, in press). Reasons for why they would be drinking less. In both samples (treatment and no treatment), logistic regression analyses predicting sustained remission from problem drinking showed that the odds of remitting were highest in individuals who identified 'hitting rock bottom', traumatic events, and spiritual/ religious experiences as reasons for cutting down. In the no-treatment sample, individuals who reported 'receiving a spouse's warning about their drinking' and those who reported weighing pros and cons of drinking had *lower* odds.

2.5 Studies about Therapeutic Communities

For three decades, National Institute on Drug Abuse (NIDA) has conducted several large studies to advance scientific knowledge of the outcomes of drug abuse treatment as typically delivered in the United States. These studies collected baseline data from over 65,000 individuals admitted to publicly funded treatment agencies. They included a sample of TC programs and other types of programs (i.e., methadone maintenance, out-patient drug-free, short-term inpatient, and detoxification programs). Data were collected at admission, during treatment, and in a series of follow ups that focused on outcomes that occurred 12 months and longer after treatment.

These studies found that participation in a TC was associated with several positive outcomes. For example, the Drug Abuse Treatment Outcome Study (DATOS), the most recent long-term study of drug treatment outcomes, showed that those who successfully completed treatment in a TC had lower levels of cocaine, heroin, and alcohol use; criminal behavior; unemployment; and indicators of depression than they had before treatment.

CHAPTER 3.0 METHODOLOGY

3.1 Study Design

A descriptive qualitative study of rehabilitation centres in Nairobi and all the counsellors working there was employed.

3.2 Study Area

20 rehabilitation centres in and around Nairobi were included in the in the study.

3.3 Study Population

The study restricted itself to examine;

i. Treatment models applied in rehabilitation of clients in the selected rehabs
ii. The staff and their qualifications.

3.4 Inclusion and Exclusion Criteria

3.4.1 Inclusion Criteria

i. Rehabilitation centres which deal with alcohol and drug abuse patients
ii. Rehabs which consented to participate
iii. The staff who consented to participate

3.4.2 Exclusion Criteria

i. Rehabilitation centres which did not consent to participate.
ii. Rehab centres which are not located in the study area

3.5 Sampling Procedures

3.5.1 Sampling Technique

All 20 rehabilitation centres in and around Nairobi area, as per NACADA website were conveniently included to participate in the study and all the counsellors in these rehabilitation centres who gave consent were interviewed.

3.6 Data Collection instrument and Procedure

- A researcher designed questionnaire was used and an interview schedule was administered to the in charge of clinical services staff in the rehabilitation centres that consented to participate. The interview was recorded with permission of the interviewee, using a voice recorder and transcribed later for analysis.

3.6.1 Data Collection Process

- The researcher contacted the selected rehabilitation facility and explained the nature of the study and then booked an appointment with the person in charge of clinical services at the consenting facility. On the appointed day, the researcher explained again the nature of the study to the person in charge of clinical services and requested for their consent in order to record their conversation. Afterwards the researcher requested for consent to meet with the counsellors in order to fill a researcher designed social demographic questionnaire. All who gave consent filled the questionnaires. Confidentiality was observed at all levels.

3.7 Limitations of the study

i. This was a qualitative research the information given could not be verified

ii. Since this was a one-off, cross sectional study qualitative research and since the researcher did not participate in the treatment sessions the data obtained could not be verified as truly representative of the practice.

iii. Study was limited to situation analysis or description only and did not analyze the described models for efficacy and relevance in our Kenyan context.

3.8 Ethical Considerations

i. Departmental approval proposal presented to lecturers and students at the departmental level and permission sought

ii. Ethics committee approval proposal was sent to the University of Nairobi and Kenyatta National Hospital Ethical committee and their approval sought to conduct the research

iii. Permission from ministry of science an d technology was also sought to conduct the research

iv. A letter of introduction from the University of Nairobi department of psychiatry

v. Permission from directors in the rehabilitation centres was sought and the nature of the study explained to them

vi. Informed consent from all the participants

vii. Confidentiality was maintained at all levels

3.9 Data Management, Analysis and Presentation

Data was recorded using a voice recording device, it was later transcribed from voice to word format, En Vivo computer software was used, to group the transcribed data into pre-determined themes, the data was then thematically analysed. The results were then presented in prose format, tables, bar charts and pie charts.

Social demographic data was analyzed using spss computer software and presented in tables, bar charts and pie charts format.

CHAPTER 4.0 DATA ANALYSIS AND INTERPRETATION

4.1 Introduction

This chapter presents the data analysis and interpretation of results. The analysis was done as per grouped data from interview schedules that were used to the collect data. The results are presented in narratives, figures and tables to highlight the major findings. Out of the target population of 25 rehabilitation centres, 20 were reached, this was because, some declined to participate, while others did not meet the inclusion criteria, as while they were listed as drug rehabs, were actually not residential centres, while others had closed down operations or moved to other areas, this gives a response rate of 80% which is sufficient for the study. The rehabilitation centres visited were in Nairobi County, Limuru, and Ngong counties, these counties serve a population of about 4million people as per last censors of 2011. The rehabilitation centres capacity accommodate between 30 and 15 clients each. The rate of male to female clients was 4:1 in 3 of the rehabs, while the others admitted purely male clients. The average clinical staff in all the rehabilitation centres visited was 3. The results are also presented sequentially according to the research questions of the study. The raw data was transcribed from voice to word format, it was then coded in predetermined thematic areas, evaluated and tabulated to depict clearly the results of analysis of the treatment models used in registered inpatient alcohol and drugs rehabilitation centers in and around Nairobi.

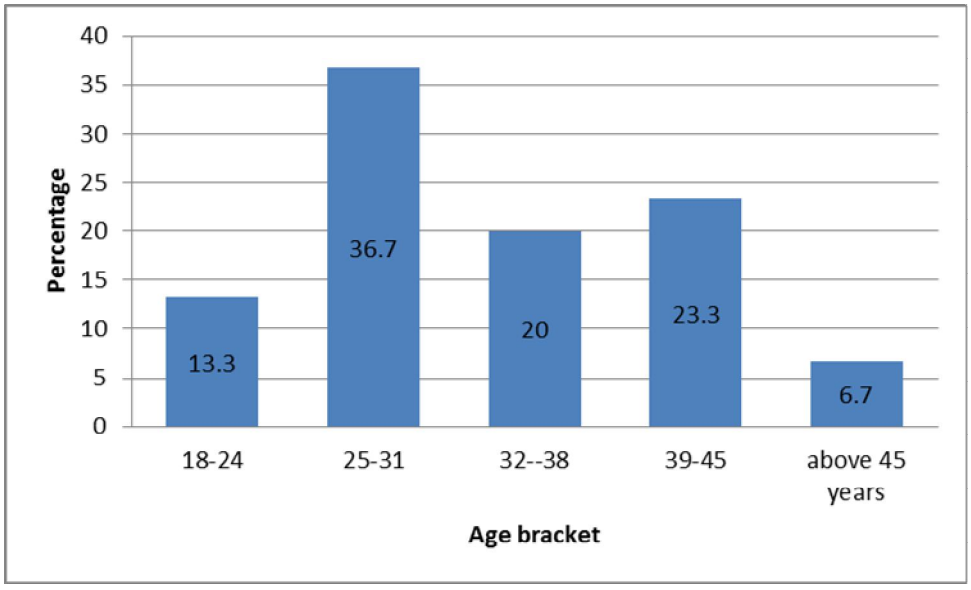
4.2 Demographic information

This section provides the demographic information of the respondents. This includes the age, gender, marital status, and level of education. The section also includes information about their drug addiction and current status of addiction.

4.2.1 Age bracket

The study attempted to establish the ages of the counselling staffs in the rehabilitation centers. The results are shown in the figure below.

Figure 4.1: Age bracket

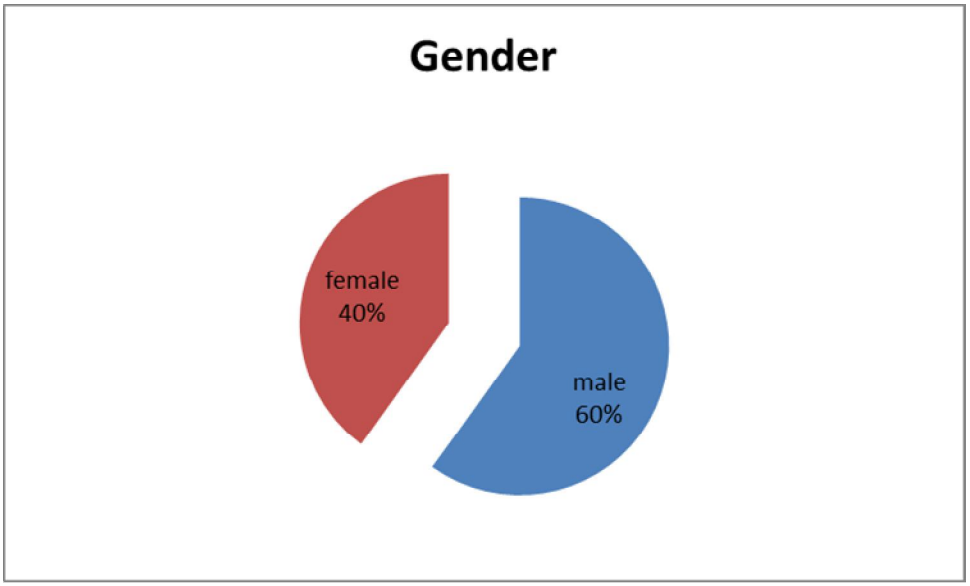


The results show that most of the respondents in the study were of the age bracket 25-31 years old. This was followed by those who were aged between 39-45 years 20% indicated they were aged 32-38 years, 13.3% indicated they were aged 18-24 years while 6.7% were aged above 45 years.

4.2.2 Gender

The respondents were requested to show their gender, this was expected to guide the researcher on the conclusions regarding the degree of congruence of responses with the gender characteristics. The study findings are shown in figure 4.2 below.

Figure 4.2: Gender

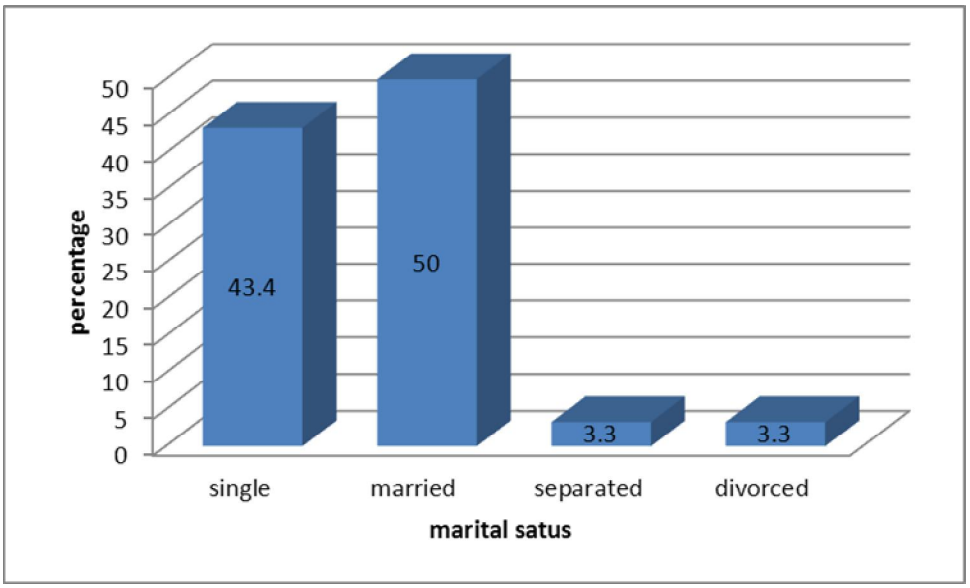


The figure above shows the findings on the gender of the respondents of this study. From the findings, majority of the respondents were Males (60%). The rest were females who accounted for 40% of the respondents. The findings implicates that majority of the of the counselling staff.

4.2.3 Marital Status

The respondents were asked about their marital status, majorit43.4 percent whilst divorced and separated formed the least number 3.3 percent each.

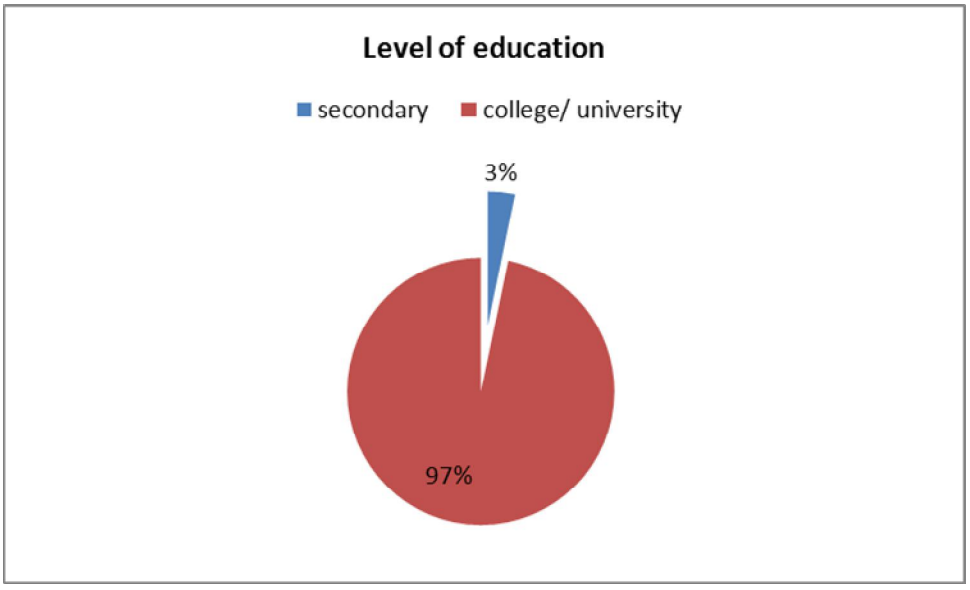
Figure 4.3: Marital Status



4.2.4 Level of education

The respondents were asked to indicate their level of education. Figure below shows the study findings.

Figure 4: Level of education

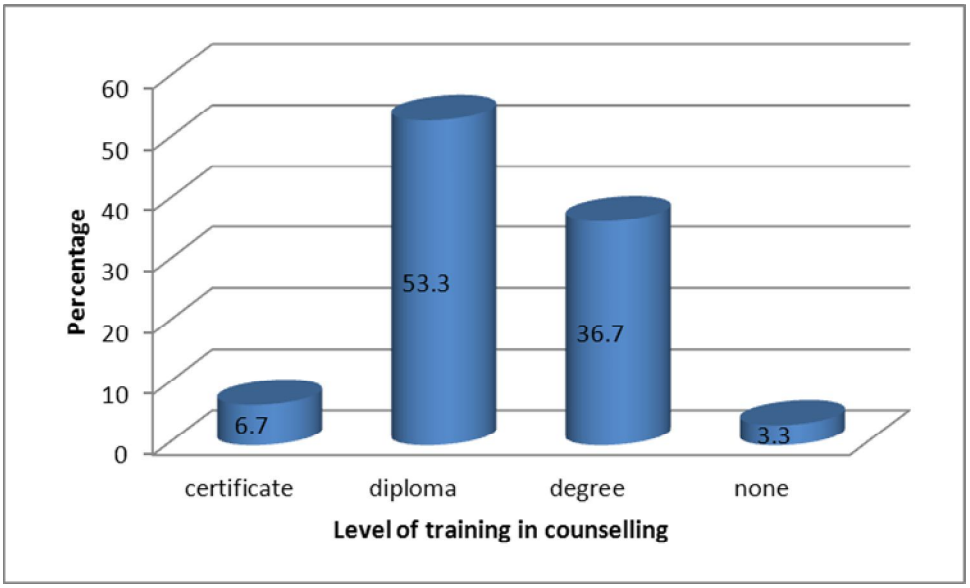


The results show that 97% of the counseling staffs in the rehabilitation centers had attained their education in the university or college level. 3% indicated they had attained their education up to the secondary school level.

4.2.5 Level of training in counseling

The respondents were asked to indicate their level of training in councelling. The results are shown in figure below.

Figure 5: Level of training in counselling

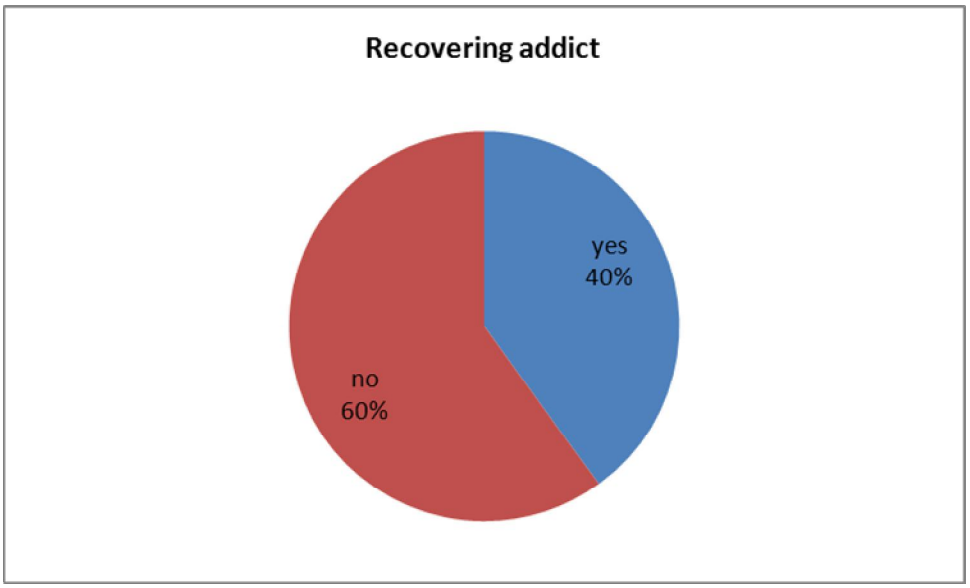


The resulst show that 53.3% of the respondents had attained councelling training upto a diploma level. This was followed by 36.7% who had attained a degree. 6.7% had attained a certificate while 3.3% had no training in counselling.

4.2.6 Recovering addict

The respondents were asked to indicate whether they were once addicts. The results are shown in figure below. The results show that majority 60% had never been addicts while 40% were once addicts.

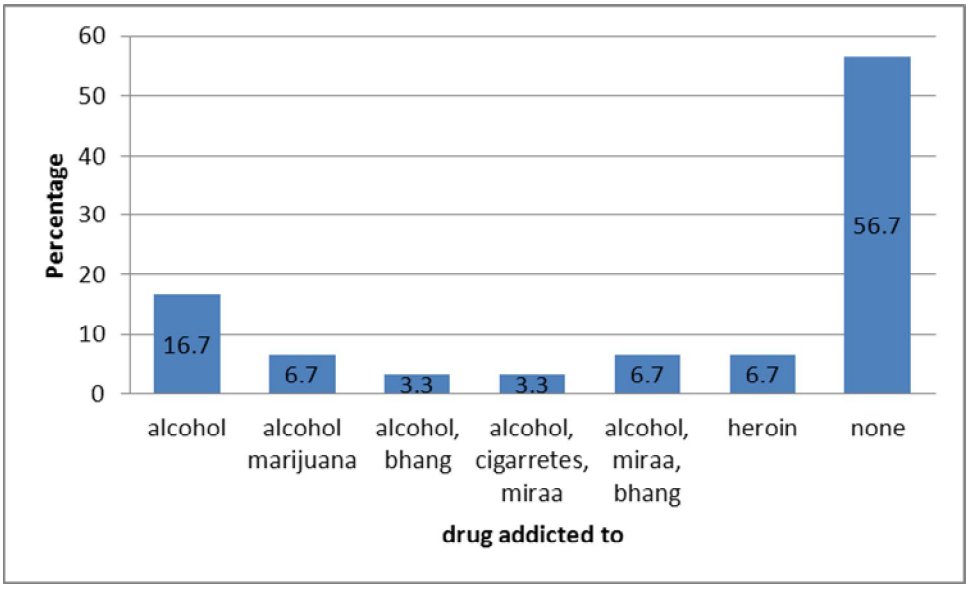
Figure 6: Recovering addict



4.2.7 What drug were you addicted to

The respondents were asked to indicate the kind of drug they were addicted to. The results are shown in figure below:

Figure 4.7: Drug addicted to

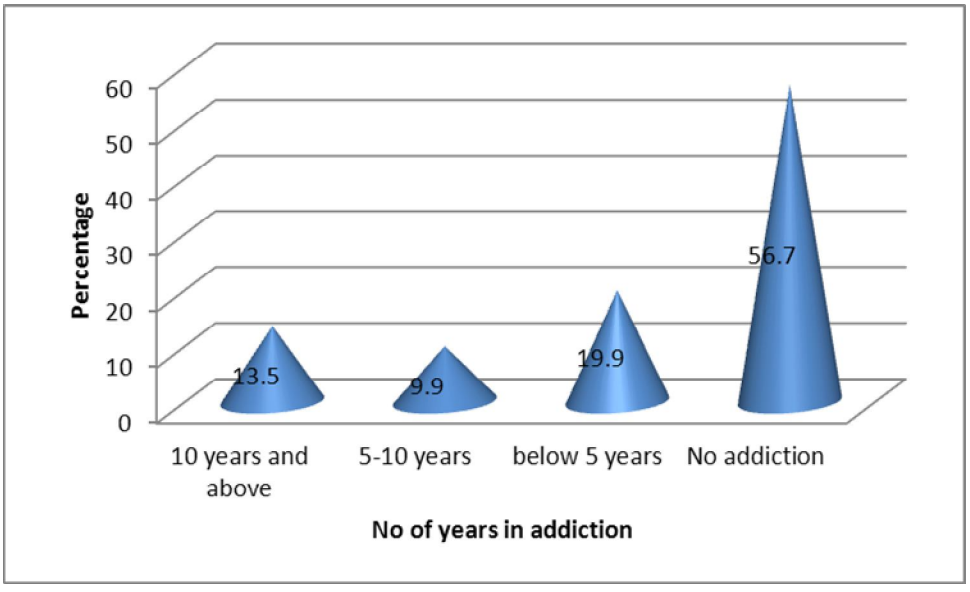


The resulst show that 56.7% had never been addicts, 16.7% were alcohol addicts, 6.7% were addicted to alcohol and marijuan and another 6.7% were addicxted to alcohol, miraa and bhang, 6.7% were also addicted to heroin. 3.3% were addicted to alcohol and bhang while another 3.3% were addicted to alcohol cigarretes and miraa.

4.2.8 No of years in addiction

The respondents were asked to indicate the number of years they had been to addiction. The results are shown in figure below,

Figure 4.8: No of years in addiction

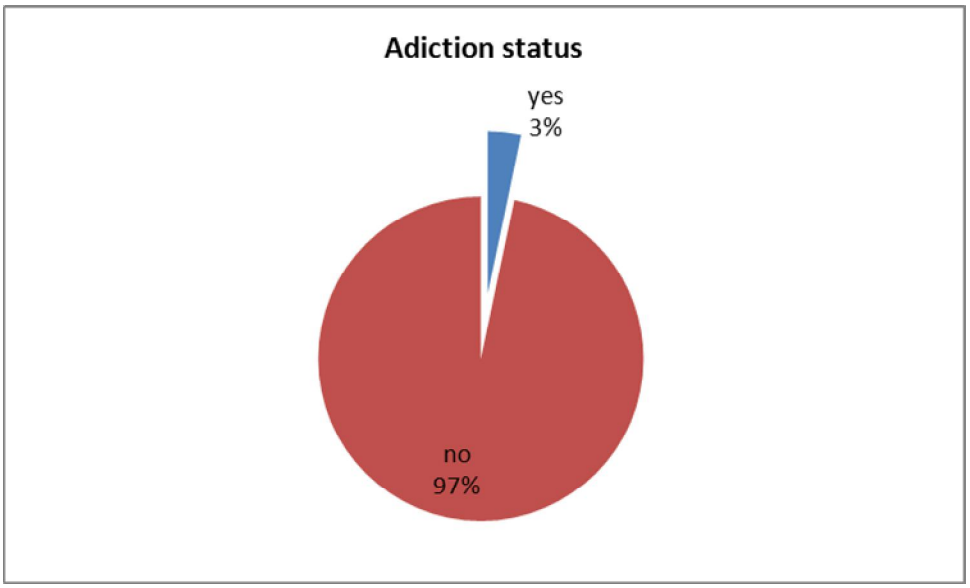


The resulst show that 56.7% had never been addicted. 19.9% were addicted for less that 5 years, 13.5% were addictred for 10 years and above while 9.9% were addicted for 5-10 years.

4.2.9 Currently living in addiction

The respondents were asked to indicate whether they were currently in addiction and the results show that majority had recovered fully as 96.7% were not in addiction while only 3.35 were currently in addiction.

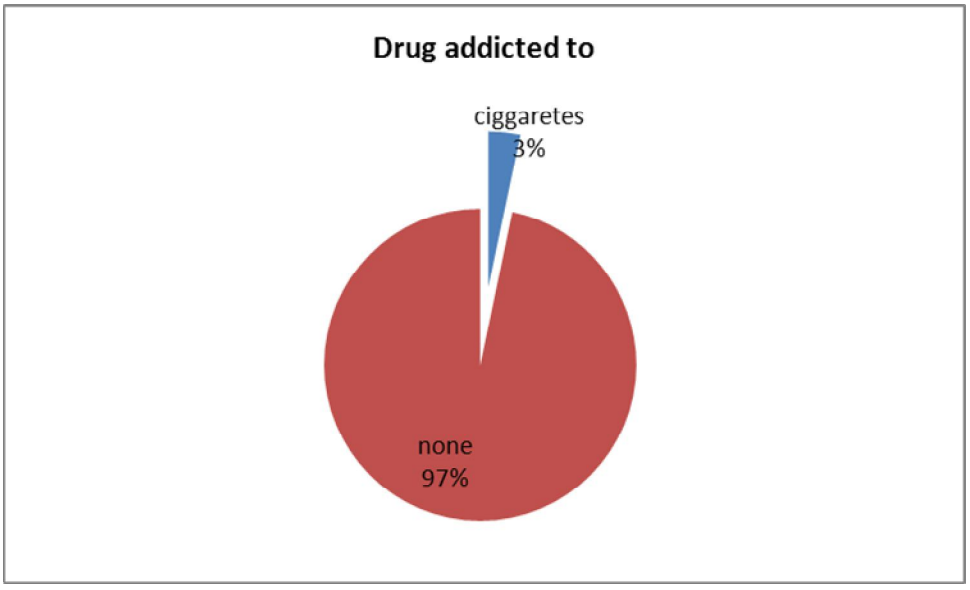
Figure 9: Currently living in addiction



4.2.10 currently drug addicted to

The respondents were asked to indicate the drug they were addicted to and the results show that they were addicted to cigarettes.

Figure 4.10: Currently drug addicted to

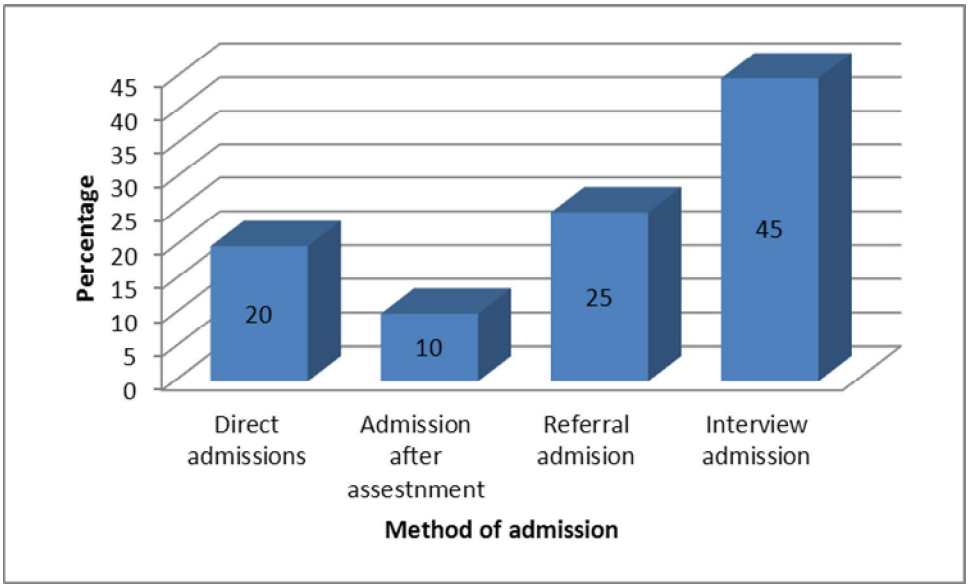


4.2 Structured processes

4.3.1 Admissions

The interviewees were asked to indicate their method of admission. This was to help the researcher understand the various methods used in admitting a client. The results show that majority 45% admissions were from outreach campaigns. 25% indicated they admitted the clients who had been referred to them, some were referred by other organizations that knew them and they knew that the clients needed such kind of treatment. 20% indicated that they did direct admissions while 10% indicated that they admitted clients who had been brought for assessment. The figure below represents the results of the findings.

Figure 4. 11: admissions



4.3.2 Assessment

4.3.3 Planning

The interviewees were asked to indicate how they plan for the care of the clients. The interviews indicated that it depends on individual patient; since some clients will come with multiple drug abuse. In case of multiple drugs the treatment needs to be intensified. Other patients may have comorbidity which makes them more disorder and their care is different. Other physical condition requires the patient be pit on detox.

Majority of the rehabilitation centres indicated that planning for detox was the first step. Detox planning includes planning for the diet given to patients. Planning needs also to be done in order to establish the psychiatrics who will offer the treatment and plan on the days they will come and treat the patient. Other clients are first referred to a detox centre so that they can go through that stabilization in the hospital setting before they are ready to come and settle down at the rehabilitation centres

Treatment planning is also done to provide individualised care to the client. They engage the client based on the assessment done earlier and the new information obtained as they continue engaging with the clients. Here they are able to identify areas where our interventions are needed. They also look at their goals and what the patient wants to achieve especially in areas of

education and vocation. Then they look at the legal issues that needs to be address, any family systemic issues that needs to be addressed and also psychosocial issues. The treatment plan is that extensive and its written down. The written treatment plan is used by the client and the counsellor enable them work with it throughout the period and this treatment plan is reviewed regularly. There is also a second and a third treatment plan which help the client continue with the assessment process to modify and build on.

Other indicated that by the end of 21 days this client is generally stable physically and a bit stable psychologically and mentally. This is when they start to implement the treatment plan. They look at individual counselling and the client receives a session once every week which is the minimum one individual session. The clients are engaged in groups and this also happens during the 21 days. At initial stages they do not engage in groups because they may be too sick and at this time they engage a lot in art therapy.

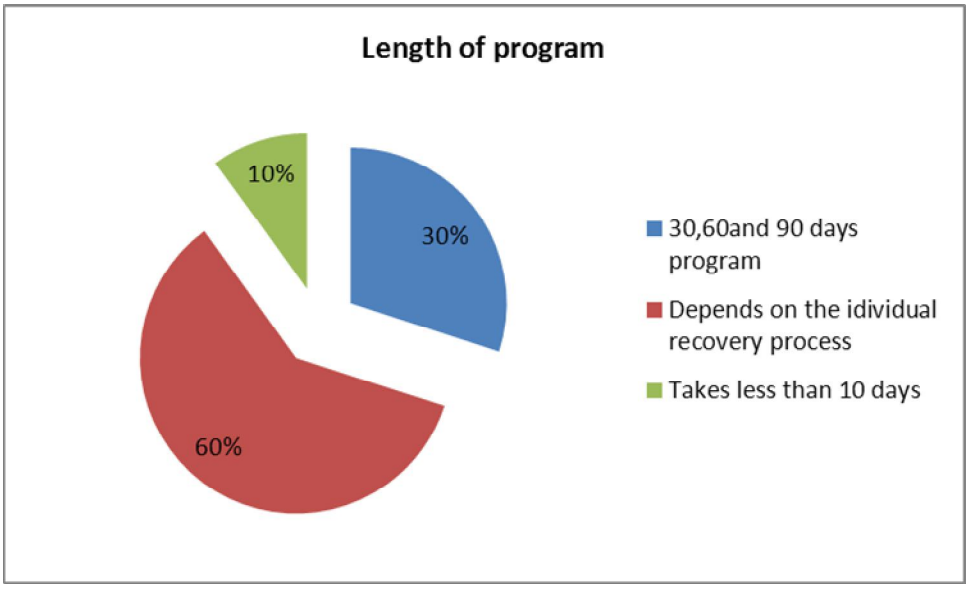
4.3.4 Client Management

The interviewee indicated that after the rehabilitation intake process, the information that is collected is used to create an orientation packet and detailed schedule for patients. This schedule generally includes a list of daily activities, counselling session times, appointments with medical practitioners, and a host of other appointments. Aside from receiving their schedules and appointments, patients will generally receive booklets that provide information about the rehabilitation centre. The history of the centre, the centre's missions and goals, the services they offer and patient testimonials are often included in these booklets. Checking into a rehabilitation centre may initially be uncomfortable for patients. The information that these centres provide to patients and their families helps them feel more confident in the facilities' ability to help the addicted person.

4.3.5 Duration

Asked how to indicate the length of the programs, the results show that 60% had programs that depended on the individual recovery process, other had a 30,60 and 90 days recovery programs while the others had a recovery program that takes less than 10 days.

Figure4. 12: Duration



Majority of the interviewees indicated that Alcohol treatment programs do not usually have a set length of time. The reason for this is that each patient is treated individually because each battle with alcohol addiction is unique. Typically, a treatment program will last no less than seven to 10 days, and it should continue for as long as the patient requires the treatment and support that is provided. The most common types of alcohol addiction treatment programs can be divided into four categories with an average length of time for each program. Often two or more treatment programs are combined to suit the patient's needs.

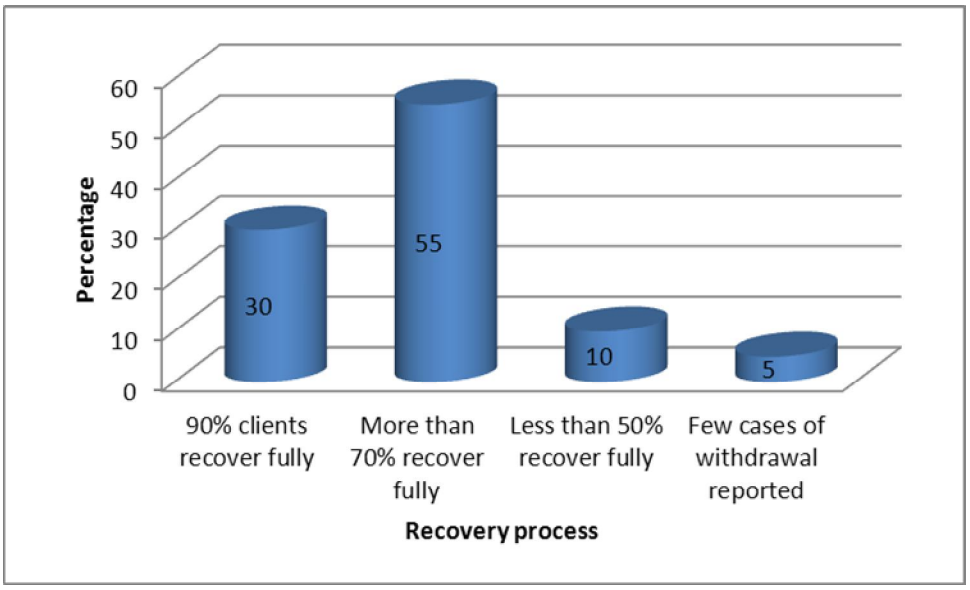
The alcoholics are also taken through Detox programs which are often an inpatient program provided in a residential alcohol addiction treatment centre, or as part of a hospital or medical facility treatment program. This treatment is typically used to help the patient cope with and overcome cravings for alcohol during the early days of the recovery process.

Others do have programmes that run up to 90 days, 60 days or 30days but this also depends on the patient recovery process they also look at how long the patient has been into alcoholism and their level of intoxications and this helps the determine which program they are going to put the patient into. There are those patients who take long to recover and other recovering quickly and once they are assed and seen that they have recovered fully, they are released.

4.3.6 Discharge

The respondents were asked to indicate whether all the clients recovered fully. 55% indicated that 70% of their clients recover fully, 30% indicated that 90% of their clients recover fully, 10% indicated that less than 50% recover fully while 5% indicated that they had few cases of withdrawal before fully recovering.

Figure 4.13: Discharge



Majority indicated that 70% of the cases are able to complete the program effectively and they leave the programs having achieved their objectives. However the rehabilitation centers agreed that they always have cases of withdrawal before completion. This is because the clients are not willing or are unable to continue with the programs due to many other circumstances. There also cases where the client threatens to leave but they do not force them to stay though they talk to them so they can realize the need of completing the program. They only allow clients to stay if they are willing.

Majority indicated that the Procedure for discharge is more or less the same. However the organizations have their own attributes of doing it. This includes ensuring the patients are free from withdrawals and the objectives are achieved. The unachieved objectives are planned for as after care. During discharge they ensure this client area supported and the support can be from their family, or identified community support system. Once the initial authorization has been completed, the Care Manager works with the treatment provider in the discharge planning process to identify: Supportive services needed, status of family/significant other support

system, type of aftercare services, Family involvement/children issues, Mental health status and Involvement with Criminal Justice.

Others indicated that they normally have an exit plan. Exit planning includes the client being able to identify in all the areas of treatment planning, the short term and long term goals. When they identify those goals they discuss them. The individual counsellor will discuss with the client and the family and at that time they clients graduate. In a bit to discharge them they normally have meeting with the whole family to discuss the issues that are likely to affect them after discharge and how they can be curbed. The client is also given advice especially on what they are likely to face after they leave the rehabilitation centre.

4.3.7 Follow up

All the organizations indicated that they always ensure they follow up their cases after discharge. This follow-ups is often at times called the after care process. It is referred to as after care since recovery process does not end when an individual completes the drug rehabilitation programs

The aftercare treatment for a recovering alcoholic is a very important step in the complete recovering process. The 1st three to six months after being diagnosed as on the road to recovery are crucial. This is the time when it is easy for an individual to slip back into negative and/ or familiar old patterns in relation to one's alcohol abuse issues. Whether it be a support group or therapy sessions, a lack of participation can lead to the downfall of one's cuter. This aftercare is a reminder and support that a recovering alcoholic needs in order to stay clean, and or focused on the positive elements in life.

Aftercare programs help an individual adapt better to life and all of the problems and/ or issues that go with it. With successful aftercare treatment programs, a long and successful maintenance can be predicted. This maintenance is a lifelong project for an individual, such as this.

The recovered patient is supposed to attend some programs to asses how they are fairing and sometimes the care mangers do surprise visits and also call for meeting with them. It helps in knowing the progression success rates.

4.4 Therapy

The interviewees were asked to indicate the kind of therapy offered in their centers. The results as shown in the table below shows that majority of the centers offered more than one kind of therapy. The most common therapy offered is the individual therapy. A population of 90% indicated that they offer the individual therapy in their rehabilitation center. This was followed by 75% indicating that they also offer the family therapy. A population of 60% represented those who offered group therapy, 20% indicated that they offered Christian therapy while 10% indicated that they offered medical therapy.

Table 4.1: Therapy category

Therapy Category	Frequency	% of Frequency
Individual	18	90
Group	12	60
Family	15	75
Christian	4	20
Medical	2	10

4.4.1 Individual

The interviewees indicated that individual therapy was a key component of all of all of the diagnosis, drug, rehab, and psychiatric treatment programs. Majority indicated that indicated that the most common form of addiction treatment therapy is the individual session. During these meetings, the recovering addict meets one-on-one in a private setting with their therapist. The goals of these sessions are: To explore the root causes behind the individual's addiction: To uncover the triggers or life stressors that lead to the individual's drug and alcohol use: To develop life-strategies that help the individual maintain sobriety: To help the individual make better decisions concerning drugs and alcohol. Individual sessions meet regularly, sometimes as often as every day, but rarely less than three times per week while the individual is in treatment.

Others indicated that they use the Cognitive behavior therapy which is based on the idea that feelings and behaviors are caused by a person's thoughts, not on outside stimuli like people, situations and events. People may not be able to change their circumstances, but they can change how they think about them and therefore change how they feel and behave, according to cognitive-behavior therapists.

In the treatment for alcohol and drug dependence, the goal of cognitive behavioral therapy is to teach the person to recognize situations in which they are most likely to drink or use drugs, avoid these circumstances if possible, and cope with other problems and behaviors which may lead to their substance abuse.

4.4.2 Group

Majority indicated that Group sessions gave the clients an opportunity for recovering since most alcohol addicts suffer alone, in isolation with their condition. during, drug rehab group therapy sessions are the first time they have ever opened up about their past issues with other people. This openness alone creates breakthroughs for many people in treatment. As a bonus, the group itself becomes a kind of support structure, offering care and love to the individual who is willing to share their own experiences. Sometimes, just hearing the stories of other recovering addicts is enough to help people realize that they are not alone in their struggles against addiction.

Others indicated that the most effective model of helping people with alcohol and drug use disorders and even other compulsive illnesses like pathological gambling, sex addiction is the group counselling and facilitations where clients are taken through group work so that they be able to recover with others since they come from a lifestyle that they used to be very isolated. Therefore the group work and facilitation is one of the effective tools of helping people with alcohol and drug problems.

Other indicated that Group therapy is also need based. They interact with them and see if they react too much, if they have issues of anger, this is taken as need to have group therapy. Though it is done minimally like once a week.

4.4.3 Family

The interviewers indicated that when an individual is suffering from alcoholism or drug addition, it impacts everyone around them. Families, in particular, bear a great deal of the brunt. Family therapy is a chance for family members to rebuild the bonds and trust that have been damaged as

a result of addiction. It is also a chance for parents, siblings and adult children to learn how to deal more effectively with the recovering addict in such a way that aids their continued sobriety. There is no finger pointing during family therapy – only help and healing.

Others indicated that family therapy is done once in a month, if a patient is admitted he is not visited until after a month, this makes them to be themselves, to really soul search and set the way forward. They encourage the family to come in for family therapy. This helps them settle down and is able to look at the issues they have to do with our relationships and what that needs to be addressed.

4.3.4 Medical

The interviewees indicated that a team of professionals is often needed to treat the alcohol dependent person. The physician usually plays a key role in medical stabilization and facilitating treatment entry, but others are routinely needed beyond the initial management for example, alcoholism counselors, social workers, psychologists, family therapists, psychologists, and pastoral counselors.

Treatment of alcoholism can be divided into three stages. Initially, the person has to be medically stabilized. Next, he or she must undergo a detoxification process, followed by long-term abstinence and rehabilitation.

Stabilization: It is the treating doctor's responsibility to treat any medical conditions related or unrelated to alcoholism. Vast arrays of medical and surgical complications are associated with alcoholism, but only stabilization of alcohol withdrawal and alcoholic ketoacidosis are discussed here.

Detoxification: This stage involves stopping alcohol consumption. This is very difficult for an alcohol-dependent person, requires extreme discipline, and usually requires extensive support. It is often performed in an inpatient setting where alcohol is not available

Rehabilitation: Short- and long-term residential programs aim to help people who are more severely dependent on alcohol develop skills not to drink, to build a recovery support system, and to work on ways to keep them from drinking again

4.3.5 Christian

Majority indicated that they always include Christian alcohol recovery programs. Christian alcohol recovery programs have become popular and effective because they embrace the best of both the religious and secular worlds. Most of these treatment methods are built upon the combination of scripture with the existing dimensions offered by the 12 Step Program of Alcoholics. The end result of this methodology is a rehab program that offers both physical and spiritual healing and is built upon a spirit of love and compassion. These treatment facilities are generally staffed with credentialed Christian men and women who are often in the long-term recovery stages of alcohol rehabilitation. Whereas many other alcoholism treatment options centre upon theories or philosophies, Christian alcohol rehab facilities are Christ-centred and treat the person based on their personal identity and their communal identity in Christ with empowerment and accountability, viewing the world through the eyes of eternity, not merely the here and now. Furthermore, there are programs available not just for alcoholics, but the people around them as well.

One of the ways the Christian alcohol recovery programs can help individuals embrace the beauty of second chances. Healing and restoration are often brought to relationships that had once been given up as lost causes. Christian treatments allow the addicts to offer and seek forgiveness for past wrongs and to work at mending the fences. Marriages and families are often resurrected out of the ashes of their previous destruction through the hope and healing of faith and forward momentum.

Alcoholics are able to acknowledge the injuries and insults that they have perpetrated in the lives of the people they love and come to terms with how connected all of us are in our lives, and how the things that affect us go on to affect others around us, whether intentionally or not. Along the way, they form new relationships with people who offer a fresh perspective and other tips, tactics and success strategies. Christian recovery programs, while not for everyone, have a lot to offer individuals committed to the message and ministry of God the Father, God the Son and God the Holy Spirit as revealed in the chapters and versus of the Holy Bible.

4.4 Model

4.5.1 12 steps model

The Twelve Steps, originated by Alcoholics Anonymous, is the spiritual foundation for personal recovery from the effects of alcoholism, not only for the alcoholic, but also for their friends and family. The interviewees indicated that they mainly use this model to train their clients. It includes the following steps steps. The index for the study of the 12 traditions icon.

Step 1: Honesty After many years of denial, recovery can begin when with one simple admission of being powerless over alcohol -- for alcoholics and their friends and family.

Step 2: Faith It seems to be a spiritual truth, that before a higher power can begin to operate, you must first believe that it can.

Step 3: Surrender A lifetime of self-will run riot can come to a screeching halt, and change forever, by making a simple decision to turn it all over to a higher power.

Step 4: Soul Searching There is a saying in the 12-step programs that recovery is a process, not an event. The same can be said for this step -- more will surely be revealed.

Step 5: Integrity probably the most difficult of all the steps to face, Step 5 is also the one that provides the greatest opportunity for growth.

Step 6: Acceptance The key to Step 6 is acceptance -- accepting character defects exactly as they are and becoming entirely willing to let them go.

Step 7: Humility The spiritual focus of Step 7 is humility, asking a higher power to do something that cannot be done by self-will or mere determination.

Step 8: Willingness king a list of those harmed before coming into recovery may sound simple. Becoming willing to actually make those amends is the difficult part.

Step 9: Forgiveness Making amends may seem like a bitter pill to swallow, but for those serious about recovery it can be great medicine for the spirit and soul.

Step 10: Maintenance Nobody likes to admit to being wrong. But it is absolutely necessary to maintain spiritual progress in recovery.

Step 11: Making Contact The purpose of Step 11 is to discover the plan God as you understand Him has for your life.

Step 12: Service For those in recovery programs, practicing Step 12 is simply "how it works."

4.5.2 Therapeutic communities

Some indicated that they also offer therapeutic community services. A therapeutic community also exists to help people overcome an addiction, but also recognizes that many of the people suffering from a dependency to drugs or alcohol lack basic socialization and life skills, and that without first learning (or re learning) these necessary skills they are at great risk for a relapse back to abuse. the intensity of therapeutic programming does differ. An alcohol rehab facility aims only to teach the needed life skills and strategies to end drug or alcohol seeking behaviors, and as such the brief period of residency is therapeutically intense. Residents will participate in differing therapies and education classes exclusively, and will not be required to do anything during the period of recovery other than focus on self healing. A therapeutic community will offer the same types of therapies, but with a lesser intensity. Firstly, because residents are expected to maintain participation for as long as two years, there is not the pressing need to teach all needed skills within a shorter duration of residency; and more importantly, the basic philosophical model of treatment has recovery and therapy occurring more out of participation and interaction in the community than through top down addictions programming.

CHAPTER 5.0 DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents summary of findings as discussed in chapter four and interpretations of the data analysis, conclusions and recommendations based on the findings. The aim of the study was to find out what treatment models are used in rehabilitation centres in and around Nairobi, and the qualifications of the staff counselling the clients.

5.2 Discussion of findings

Rehabilitation process starts on admission whereby a variety of information is collected and evaluated. The individual who collects this information must have a lot of experience in substance abuse treatment in order to evaluate the collected information properly. These questions are not designed to embarrass or judge clients. Rather, they help the treatment centre determine the severity of each individual's substance abuse problem and helps practitioners determine the treatment process that would work best for each client. The interviewer must ask clients a series of general and personal questions throughout the intake process this is in line with findings of studies done on coping ability is related to treatment outcome ***(Miller et al., 1996; Connors, Maisto, & Zywiak, 1996)***, these studies recommended that skills training to foster improved coping with negative emotions be provided as a means of reducing relapse risk.

During the intake process, patients also need to provide medical information. Because drug and alcohol detoxification is a procedure that must be closely monitored by medical practitioners, most practitioners need information about each person's medical history before starting the detoxification process. The detoxification process will be different for each client because each client will have different types and levels of toxins in their system. Physical examinations, which may include blood and alcohol testing, are often part of the intake process. This practice is in line with drug treatment protocols in the United States of America ***"****Health and medical evaluation referral information contains the results of recent medical examinations required for placement. All outstanding medical, dental, and other health issues, including infectious diseases, especially HIV and hepatitis, should be addressed early in the program through affiliation agreements with licensed medical facilities. Each client should receive a complete medical evaluation within 30 days of entry into the program" Treatment Improvement Protocols (TIPs), developed by the Center for Substance Abuse Treatment* ***(CSAT). (www.samhsa.gov)***

Rehabilitation centres indicated that planning for detox was the first step: detox planning includes planning for the diet given to patients; planning needs also to be done in order to

establish the psychiatrics who will offer the treatment and plan on the days they will come and treat the patient; this is supported by a study by ***Hayes et.al. (1993),*** there are numerous models and approaches used to treat chemical dependency; Detox is the first step in rehabilitation; Some clients are first referred to a detox centre so that they can go through that stabilization in the hospital setting before they are ready to come and settle down at the rehabilitation centres. Treatment planning is also done to provide individualised care to the client. They engage the client based on the assessment done earlier and the new information obtained as they continue engaging with the clients. Here they are able to identify areas where our interventions are needed. They also look at their goals and what the patient wants to achieve especially in areas of education and vocation. Then they look at the legal issues that need to be address, any family systemic issues that need to be addressed and also psychosocial issues.

Alcohol treatment programs do not usually have a set length of time. This is because the unique nature of each individual client needs. However, most treatment programs will last no less than seven to 10 days, and it will continue for as long as the patient requires the treatment and support that is provided; the average length of programs was 90 days. This is in line with findings of; *"studies of populations that abuse substances have shown that those who remain in treatment for at least 3 months have more favorable outcomes, a critical retention threshold of at least 90 days has been established for residential programs* ***(Condelli and Hubbard 1994; Simpson et al. 1997b, 1999)."***

"Persons admitted to residential programs likely have the most severe problems, and those remaining beyond the 90-day threshold have the most favorable outcomes ***(Simpson et al. 1999)."***

The most common types of alcohol addiction treatment programs can be divided into four categories with an average length of time for each program. Often two or more treatment programs are combined to suit the patient's needs. These include the 12 step mode, Therapeutic communities, medical model and Christian model. This is in line with several studies done in support of these models "The Therapeutic Community model has been adopted successfully in community residence programs for serious and persistent mental illness ***(Sacks et al. 1998a),*** general hospitals ***(Galanter et al. 1993),*** and substance abuse treatment programs, both nationally and internationally ***(Caroll 1990)***.

It has spread particularly within TC agencies such as Phoenix House, Walden House, Odyssey House, Gaudenzia, and Second Genesis." ***(Guydish et al. 1994)***

5.3 Conclusions

This study concludes that alcohol rehabilitation is a vital process. Most people with alcohol problems do not decide to make a big change out of the blue or transform their drinking habits overnight. Recovery is usually a more gradual process. In the early stages of change, denial is a huge obstacle. The First stage in treatment is the Detoxification: Some residential rehab facilities have their own in-house detoxification programs, but more centres today are requiring clients to complete detox prior to entering their facilities. Most rehabilitation centres have a structured treatment program. The 12 step approach of the Minnesota model and the Therapeutic community model are the most commonly used treatment approaches, either individually, or in combination. Majority of the rehab centres used a mixture of these approaches and this depended on the needs of the clients, the competence of staffs and the ability of client to meet the costs.

NACADA the Kenyan Government's DSA regulatory agency has a non-specific policy guideline on how to manage DSA at in-patient level of care.

5.4 Recommendations

Given the pervasiveness of risky alcohol consumption and the seriousness of the health consequences of risky drinking, detection of risky alcohol consumption through routine screening should be conducted in all health care settings. This activity must be followed by a time-limited intervention aimed at reducing consumption for those with risky levels or patterns of drinking.

Rehabilitation centres catering for female and adolescent DSA clients should be set up.

NACADA should improve its policy guidelines on in-patient management of DSA specifically as concerns the following areas:-

a) What treatment models to be applied in different DSA categories
b) Provide hierarchal classification of service providers

Create a hierarchical categorization of in-patient rehab centres according to the services they offer in the same way as the Kenya Essential Packages of Health Services (KEPHS) that the Ministry of Health has implemented. This categorization will improve quality of service by encouraging specialization and will provide useful information to help clients make choices and service providers to cross-refer clients.

5.5 Recommendations for further studies

It is recommended that further studies to determine the local efficacy and cost-effectiveness of the various models in use be done so that these models can be appropriately domesticated in our Kenyan context.

This study recommends a further analysis to be done on Patient autonomy in alcohol rehabilitation. This is to identify whether the patients have a say in the kind of treatment they are given. Presenting a variety of treatments as alternatives to the alcoholic may reduce treatment dropout rate, the aversive stigma frequently associated with therapy, and ant therapeutic disruptions while improving community coordination in alcoholism rehabilitation and providing an effective approach in treating the life health of the alcoholic.

6.0 TIMELINE OF EVENTS

6.1 Organisation of the Study

6.1.1 Work plans and Budgets

The Gantt chart below (table 1) summarises the work plan and budgets for the proposed study.

Table 1:- Work plan Gantt chart.

Project Name	**A SITUATION ANALYSIS OF THE TREATMENT MODELS USED FOR REHABILITATION OF DRUG AND SUBSTANCE ABUSERS IN AND AROUND NAIROBI.**									
Owner	Researcher: Catherine Mawia Musyoka					Today's Date:	25th February 2012.			
	Project Lead:	Catherine Mawia Musyoka								
	Start Date:	25th February 2012								
Activity No	Tasks	Task Lead	Start	End	(Days)	% Complete	Working Days		Remaining	Estim Cost (Kshs)
	Task 1									
1	Preparation of proposal	Musyoka, Ndetei/Mburu	25/1/12	30/4/12	60	50%	30	0	0	2, 000
2	Approval of proposal	Ethics Committee	1/5/12	1/6/12	30	0%	60	0	30	2, 000
	Task 2									
3	Collection of	Musyoka	1/8/12	25/7/12	28	0%	45	0	45	50, 000

	data									
4	Treatment of data	Musyoka	28/9/12	28/8/12	30	0%	45	0	45	10,000
	Task 3	Musyoka								
5	Analysis of data	Musyoka	29/10/12	30/9/12	30	0%	28	0	28	10,000
6	Thesis write-up	Musyoka Ndetei/Mburu	1/11/12	30/10/12	30	0%	30	0	30	10,000
7	Thesis defence	Musyoka	20/1/13	15/11/12	15	0%	15	0	15	5,000
							TOTAL			89,000

7.0 REFERENCE

1. Annis, H.M., Herie, M.A., & Watkin-Merek, L. (1996). Structured Relapse Prevention: An Outpatient Counseling Approach. Toronto: Addiction Research Foundation.
2. Daley, D.C. & Marlatt, G.A. (1997). Managing Your Drug or Alcohol Problem. San Antonio: The Psychological Corporation.
3. Freimuth, M. (1999). "Psychotherapists' beliefs about the benefits of 12-step groups". *Alcoholism Treatment Quarterly*
4. http://www.drug-rehab-program.org/drugrehabprogram/are-12-step-programs-beneficial-for-teens.php
5. http://www.bhrm.org/guidelines/CBT-Kadden.pdf
6. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3202506/
7. http://m.drugabuse.gov/publications/research-reports/therapeutic-community/how-beneficial-are-therapeutic-communities-in-treating-drug-addiction
8. Krampe H. et al. (2007) Outpatient Long-term Intensive Therapy for Alcoholics (OLITA): a successful biopsychosocial approach to the treatment of alcoholism; 9(4): 399–412.
9. Miller, M. M. (2003). "Twelve Step Programs: An Update". *Addictive Disorders & Their Treatment* **2** (4): 157–160.
10. Roberts, L.J., Shaner, A., & Eckman, T.A. (1999). Overcoming Addictions: Skills Training for People with Schizophrenia. New York: W.W. Norton.
11. Reid Hester and William Miller, (1995) Handbook *of Alcoholism Treatment Approaches: Effective Alternatives* (Second Edition). pp. 8-11.
12. Robert D. Margolis and Joan E. Zweben (2001) *Treating Patients with Alcohol and Other Drug Problems: An Integrated Approach* pp. 42-87,
13. Witkiewitz and Marlatt Alan (2006) Overview of harm reduction treatments for alcohol problems: *Department of Psychology, University of Illinois at Chicago, 1007 W. Harrison St., M/C 285, Chicago, IL 60607, USA*, University of Washington, USA17

8.0 APPENDICES

Appendix 1: Rehabilitation Centre In-charge Consent Explanation

My name is Catherine Musyoka, a Master of Science in Clinical Psychology student at the Department of Psychiatry, University of Nairobi.

I have chosen to write my dissertation on **a situational analysis of treatment models used in alcohol and drugs rehabilitation in and around Nairobi;** I am requesting you to participate in the study by filling a Socio- demographic questionnaire that has been developed by me Catherine Mawia Musyoka.

Yours faithfully,

Catherine Mawia Musyoka
MSc. Clinical Psychology student
Department of Psychiatry
University of Nairobi
Tel: +254-721-723514

Appendix 2: Rehabilitation Centre In-charge Consent

I…… being the in charge of…….. do hereby give consent for the collection of data on the study **a situational analysis of treatment models used in alcohol and drugs rehabilitation in and around Nairobi.**

Name…….....

Signature……..... Rehabilitation center stamp

Date…….....

Witnessed by…….....

Name…….....

Signature…….....

Date…….....

Appendix 3: Participant Consent Explanation

My name is Catherine Mawia Musyoka, a Master of Science in Clinical Psychology student at the Department of Psychiatry, University of Nairobi. I am carrying out a study "**a situational analysis of treatment models used in alcohol and drugs rehabilitation in and around Nairobi".** This is in partial fulfilment for the degree award. I am being supervised by:

Prof. David Ndetei	Dr. John Mburu
Lecturer	Lecturer
Department of Psychiatry	Department of Psychiatry
University of Nairobi	University of Nairobi

I am requesting you to participate in the study by filling a Socio- demographic questionnaire that has been developed by me Catherine Mawia Musyoka. I will also ask you some questions on the treatment models used in your centre, and I will record our conversation so that I analyse it later on. There is no right or wrong responses, the information you give is purely for research purposes in order to find out what different centres are doing. You will not be rated or compared with anyone else. The information you give will be very vital in forming a baseline database on the different modalities of treatment for persons with alcohol and drug abuse problems in our country. Participation is voluntary and you can refuse to participate without any consequences to you or your facility. Your participation will however be highly appreciated.

Thank you in advance,

Catherine Mawia Musyoka
Tel: +254 721 723514
MSc. Clinical Psychology student
Department of Psychiatry, University of Nairobi

Appendix 4: Consent by Study Participants

I…….. have been explained the nature of the study by Catherine Mawia Musyoka, I therefore consent to participate in the study

Name…….....

Signature…….....

Date…….....

Witnessed by…….....

Name…….....

Signature…….....

Date…….....

Appendix 5: Socio-Demographic Questionnaire for Staff

INSTRUCTIONS:-

- Do not write your name anywhere on this questionnaire
- Answer all the questions honestly
- Respond to the questions as appropriate

PART I – SOCIO-DEMOGRAPHIC DATA

1. What is your age?

   a) 18 – 24 years ☐
   b) 25 – 31 years ☐
   c) 32 – 38 years ☐
   d) 39 – 45 years ☐
   e) Above 45 years ☐

2. What is your gender?

   f) Male ☐
   g) Female ☐

3. What is your marital status?

   a. Single ☐
   b. Married ☐
   c. Widowed ☐
   d. Separated ☐
   e. Divorced ☐

4. What is your highest level of education?

   a. None ☐
   b. Primary ☐
   c. Secondary ☐
   d. College/ University ☐

5. What is your level of training in counseling?

a. Certificate
b. Diploma
c. Degree
d. None

6. Are you a recovering addict?, If Yes

7. What drug were you addicted to?

8. How long have you been sober from your drug of addiction

9. Are you currently living in addiction? If yes, go to no. 10

10. What drug are you addicted to?

Appendix 6: Types of models used tool for counsellors offering drug rehabilitation services

INSTRUCTIONS:-

I will record our conversation so that I can refer to it later as I make my report, please do not mention your name or that of your facility. The information you give will be used with utter confidentiality for the purposes of the study only.

1. Describe your client rehabilitation process from admission to discharge
2. How do you assess the clients for admission
3. What treatment procedures do you use in this rehabilitation centre?
4. How do you plan for the care of the clients
5. Does the centre have a program model for client management?
6. What is the content of Individual therapy?
7. What is the content of group therapy?
8. What is the discharge procedure for your clients?
9. Does the centre follow up the clients' progress after discharge? If yes for how long?
10. How do you do the follow up?
11. Do you have any structured format you can share with Me.?

7.0 FLOW CHART