INFLUENCE OF THE IMPLEMENTATION OF THE CURRICULUM ON DRUG ADDICTS IN DRUG REHABILITATION CENTRES IN MOMBASA COUNTY, KENYA

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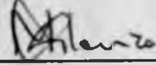
DECLARATION

This research project is my original work and has not been submitted for a degree in any other university.



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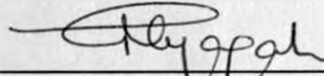

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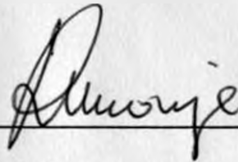

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DEDICATION

This work is dedicated to my parents, my brothers, sisters and all my relatives for being who they are to me.

ACKNOLEDGEMENT

I wish to give thanks, glory and honour to the almighty God for giving me guidance, knowledge, and wisdom through out this period of my study.

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LIST OF ABBREVIATIONS AND ACRONYMS

ACK	Anglican Church of Kenya
DO	District Officer
FBOs	Faith Based Organizations
KCA	Kenya Counsellors Association
NACADA	National Campaign Against Drug Abuse
NACADAA	National Campaign Against Drug Abuse Authority
NGOs	Non-Governmental Organizations
PCEA	Presbyterian Church of East Africa
PSC	Public Service Commission
RRI	Rapid Results Initiative
SPSS	Statistical Package for the Social Sciences
UK	United Kingdom
UN	United Nations
UNODC	United Nations Office on Drugs and Crime
US	United States

ABSTRACT

The purpose of the study was to find out the influence of the implementation of the curriculum on drug addicts in drug rehabilitation centres in Mombasa County, Kenya. The specific objectives of the study were to determine whether the treatment centres follow the set standards when attending to their clients, to establish the competence of the personnel offering counselling in the rehabilitation centres under study, to establish the follow up strategy for monitoring rehabilitated addicts from going back to abusing drugs, to identify aspects of the program that can be intensified to improve inadequacy of services where this is the case. Descriptive survey design was used. The study targeted everybody in a drug rehabilitation centre currently recovering from substance abuse. Purposive sampling was used to select 10 patients from each of the 8 centres and 2 counsellors from each of the centres. Hence the total population was 80 drug users and 16 counsellors. The main research instrument in this study was questionnaire. Two sets of questionnaires were administered. To test the reliability of the instrument test-retest technique was used. Descriptive statistics, including means, frequencies and percentages was used.

The study established that there were many services put in place to rehabilitate the drug users. The centres had many counsellors trained to handle the drug users who had several needs psychological, social and health (Physical). However these counsellors needed to undergo more training specifically geared toward chemical dependency counselling. The centres were found to have many challenges which could affect the quality of service they provided to attend to the needs of the users. The centres also needed to improve some of their facilities used. It was also established that the centres were not solely responsible for relapse in patients. Denial in clients and client attitude were also to blame. These factors combined were contributors to lack of sustainability of treatment in clients.

Based on the findings of the study the following recommendations are made. The counsellors in the centres should have more emphasis on psychological counselling. This can be done by having more sessions of individual counselling per client in the centre. There is need for on-going training for the counsellors and service providers. There should also be support and supervision for those giving support. The centres should intensify their programs by having more followed up services and using motivational methods. The following areas for further research are suggested. A study should be carried out to find out stress and burnout in counsellors in drug / alcohol rehabilitation centres. A study should be carried out to identify counselling approaches and methodology in use in alcohol / drug rehabilitation centres.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Substance abuse poses great harm to an individual's health, the social fabric and even political stability of many countries (UN 1998). Over the past two decades the use of illegal drugs among adolescents and adults and misuse of therapeutic drugs has spread at an unprecedented rate and has reached every part of the globe (Lord, 1984). In recent past, reports on drug use in Kenya have been very dramatic, with cases touching on the youth at secondary schools and halls of residence in universities. The alarming thing is that the available drugs range from alcohol, tobacco, cannabis and khat to petrol, heroin and cocaine (Okut, 2005).

In Africa, the problem of drug abuse is increasingly becoming a serious threat to the lives of the youth of the continent (Okut, 2005). The young people are the most affected in the use and abuse of drugs (Asuni and Pela, 1986, Owiti 1999). Drug and alcohol misuse is a cause of concern for health services, policymakers, prevention workers, the criminal justice system, youth workers, teachers and parents. Drug abuse is manifested in several ways, but most evident among drug abusers are those who follow deviant life styles, whose criminality derives not from drug use alone but also from the influences and attitudes that lead to drug use, (Ongwen 2003).

There is not only the drug use of the disadvantaged but also the often substantial drug use that exists among the successful and most advantaged. There are older drug users and young adults, adolescents and pre-adolescents. Beyond the users are the victims

of drug abuse; the families of the abusers, those against whom the crimes of addicts are committed, communities which are victimized by drug dealers and users, schools where drug abuse disrupts learning, and industries where drugs have crept into the workplace.

The United Nations International Drug control program world Report (2000), ranked Kenya among the top four consumers of narcotics. According to the report the port of Mombassa was noted as a major transit point for drug traffickers in Africa. According to a national study (Daily Nation October, 2003), there is rampant drug abuse in schools and universities in Kenya and more than a fifth (22–7) per cent of primary school children in Kenya have taken alcohol, a figure that rises to more than (68 per cent for university students) (NACADA, 2004). According to the report prevalence of drug use increased from primary to tertiary institutions, alcohol was the most frequently abused drug followed by miraa, tobacco and bhang "The tertiary institutions form an excellent experimenting ground for drugs and other substances that even leads to dependency" Gacicio (2005) quoting Kaguthi the National Campaign against Drug Abuse boss then. He suggested that by 2007, the war against drug abuse will have been put in place some dating back to the 18th Century. This has not been the case.

According to Nacada (2010), the problem of drug abuse in Coast Province is growing at an alarming rate especially among populations of children under 18 years. The lack of reliable statistics to reveal the scope and magnitude of drug abuse has left many institutions guessing and speculating on the seriousness of the problem. The local

media has recently been presenting gloomy pictures of escalating drug use and abuse in the region.

With mandate to coordinate efforts aimed at addressing the problem of drugs in a sustainable manner, the presence of reliable statistics to benchmark program activities and evaluate future progress is a key requirement for NACADA Authority. Fitting within the Rapid Results Initiative (RRI) framework, NACADA commissioned a baseline study to understand the current status of alcohol and drug use and abuse in five districts of the coast province as specified in the RRI framework. The districts under focus were Mombasa, Kilindini, Kwale, Lamu and Malindi. The baseline survey was conducted between the months of May and June 2009 in partnership with the Provincial Administration, the Kenya National Bureau of Statistics, law enforcing agents and the community. Stakeholders from Kenya's National Campaign Against Drug Abuse Authority (NACADAA), the United Nations Office on Drugs and Crime (UNODC), and civil society organizations promptly initiated emergency services at the Coast Provincial General Hospital and eleven surrounding primary health care facilities in order to respond to the crisis. Within no time the problem of substance abuse received substantial media coverage. Between January and June 2011, a total 5000 drug users were reported to have accessed drug treatment services from the 14 health facilities.

More effort has been put on prevention of drug / substance abuse because as the old adage which goes "prevention is better than cure" The situation on the ground however reveals that there are too many persons addicted to drug/ substance of abuse

who need treatment and rehabilitation. In the government's program of action for the next 10 years and beyond, the division of mental health recommends the establishment of drug / substance treatment centres in every district in Kenya (NACADA, 2002). Drug / substance abuse treatment programs are categorized according to whether they offer inpatient (residential) or out patient (non residential) services. Inpatient centres are also known as Detoxification centres. Detoxification is a process whereby alcoholic or drug addicted persons are withdrawn from the drug often under chemotherapy. Medication is necessary for the control of the withdrawn symptoms, which can be fatal if not closely monitored and treated. Residential treatment has treatment duration of 3-6 months. Individual and group therapy sessions are carried out in a therapeutic community set up (NACADA, 2002).

Relapse prevention training and work motivation is an essential component of the rehabilitation process, however most centres are not paying special attention to it. There is also long term treatment, which takes between 6-12 months. In the developed countries long-term treatment programs are gaining popularity in the criminal justice system where therapeutic community systems are incorporated as part of the correction system within the prison. The treatment and rehabilitation of drug dependent persons can not be complete without the application of different counselling approaches or methods which include; cultural based approaches, social integration of the addicts, establishment of support mechanisms for the individual and family to prevent relapse (Okut, 2005).

For women who are alcoholic addicts, the treatment programs should be geared to their needs yet so far there are few centres dealing with treatment. Very few people have access to treatment and rehabilitation. This is due to few the numbers of centres available in the country and the cost of treatment. There are also very few trained counsellors. Many who come for treatment end up relapsing within days or weeks after treatment. Many drug takers have great difficulty in establishing themselves in normal society. The aim of rehabilitation is to enable the drug dependent person to leave the drug subculture and develop new social contacts. Unless she can do this, any treatment is likely to fail. In Europe and America some clinics provide methadone maintenance for heroin addicts. Methadone maintenance has not gained acceptance in Kenya. According to Ryan (2004) recovery is not just about remaining drug and alcohol free. Professionals within the treatment industry need to understand and educate their clients that underlying issues have to be treated if real sustainable recovery is to be achieved.

According to NACADA (2010), the notorious drug peddling areas in Mombasa includes; Coast general hospital, godown, Tononoka, Mwembe Tayari, Sidiria, Redstart Bar Maduhaha, Bakarani and Mtopanga stage in Mombasa; Harambee street, Shella beach, Mkomani, Kashmir, Kizingitini in Lamu; Shella, Maweni and Kwa Jiwa in Malindi, and Majengo in Kwale. While areas where drugs are mostly abused include Mamburi, Kisauni, Maweni, Godown, Mwembe Tayari, Majengo, Portreitz, Bokole, Mworoto, Mikindani in Kilidini and Maweni.

There are also several rehabilitation centres (NACADA, 2010) and among the most well known rehabilitation facilities include Coast General, Mewa rehabilitation centre, Wema Centre-Bamburi, Barsheba Rehab Centre, Mewa Hospital, Onesmus Boys, Dickson Centre and Grandsons of Abraham. These institutions are known throughout the county and are said to provide a holistic range of services that include counselling, rehabilitation and equipping of life skills to drug addicts. Many centres are using people who are not trained in counselling to handle the clients. Most centres are relying a lot on the use of recovered addicts to counsel the others, which leads one to question the quality of counselling methods in use. The rate at which the clients relapse makes the researcher get curious at the approaches in use and whether they are valid.

Hence, the rationale behind this study is to establish whether there is absence of alternative sources of support to addicts; are there enough affordable rehabilitation centres, are parents fearing to report their children to law enforcers for fear of arrest hence with no safe place to turn to they end up tolerating their children behaviour other than turn them in and is there lack of a follow up strategy to monitor rehabilitated addicts and to establish whether this is the reason that has led to the high relapse rates experienced in the region. The rationale for choosing Mombasa as the area of study is that many drug addicts, distributors and suppliers live there. Hence since the addicts go through rehabilitation, the researcher wishes to find out whether there is any effect on the same when addicts pass through rehabilitation, there is usually no focused exit plan and most often than not they are welcomed back in society by their friends who are addicts and soon relapse to addiction. In as much as

rehabilitation centres are being established, are they helping or is there need for improvement?

1.2 Statement of the problem

The effort being made by counsellors and medical doctors to bring recovery of the drug / substance users in Kenya is commendable. Some people get help and that is admirable. Even so, the problem of people going through programs which takes between 12 weeks to one year, only to relapse after one week or so, is questionable. Many people come to the centres, spending a lot of money going through the set program but on going back to their former environment, united with their families and friends they immediately go back to their substance abuse and continue with their anti social and destructive life styles. Many of the studies carried out locally in the field of drugs and substance abuse focus on the use of alcohol and substance abuse but not on the treatment and rehabilitation of those already 'hooked'.

According to NACADA (2001) treatment and rehabilitation centres in Kenya have grown exponentially in the recent past, particularly beginning in the year 2000. This was due to the fact that Alcohol and Drug abuse is a problem that is escalating in leaps and bounds (Masinde Muliro University, 2009). The increase in demand for treatment and rehabilitation services has attracted many players including individuals, non-governmental organizations (NGOs), faith based organizations (FBOs), civil society, Private and Public institutions. Huge variations exist within these centres in terms of facilities, personnel competences, treatment options and costs. It's in view of this that NACADAA developed "standards for residential and non-residential

treatment and rehabilitation facilities and programs for persons with substance use disorders". This was meant to help bridge the gap.

These guidelines attempted to define minimum standards to be met within treatment and rehabilitation centres in Kenya. These include: rights and responsibilities of clients, levels of treatment, treatment centre management, and procedures for treatment centres management; thus, the standards will specifically, advise on the best practices and discipline of licenced rehabilitation operators, ensure professionalism in the treatment and rehabilitation of persons with substance use disorders, provide guidelines and minimum requirements for service providers to ensure that the rights of persons with substance use disorders and their families are protected, define the basic services and procedures that every treatment and rehabilitation facility should provide to clients, provide clear guidelines on intake, screening, assessment, placement, documentation, case management, treatment planning, discharge planning, and other core areas of treatment and rehabilitation, ensure clients seeking treatment and rehabilitation services get value for their money and are protected from exploitation, provide a basis for administrative and clinical supervision, monitoring and evaluation of treatment and rehabilitation procedures, services and facilities, establish a basis for resource mobilization and medical insurance coverage (NACADA, 2001).

Mombasa is said to be the hub of drug supply to the other parts of the country. The major drug barons dwell in the posh estates of Mombasa (Nyali), and coordinate the importation and supply of their illegal merchandise within and elsewhere in the East

Africa (NACADA, 2011). Cannabis is mainly reported to come from upcountry and is transported to Mombasa either using public transport as normal luggage or in private vehicles; drugs are also smuggled into Mombasa from Tanzania, through the largely un- manned fishing sea ports. They are also smuggled into the country from overseas (from as far as Afghanistan) through JKIA or Moi international airport then driven in VIP vehicles to Mombasa town. Drugs are smuggled into Lamu-mostly Cannabis from Mombasa, Kilifi and Malindi by road and into Lamu through the Mokowe jet or by sea, and into Lamu through the many entry fish landing points along the open Lamu coastline. This has also promoted to the emerging of many rehabilitation centres within Mombasa. Hence the researcher felt the need to carry out a study on the influence of the implementation of the curriculum on drug addicts in drug rehabilitation centres and follow the set standards by NACADA that is rights and responsibilities of clients, levels of treatment, treatment centre management, and procedures for treatment centres management (NACADA, 2011).

1.3 Purpose of the study

The purpose of the study is to influence of the implementation of the curriculum on drug addicts in drug rehabilitation centres in Mombasa County, Kenya.

1.4 Objectives of the study

The specific objectives of the study were:

i) To examine the treatment centres follow the set standards when attending to their clients in Mombasa county.

ii) To establish the competence of the personnel offering counselling in the rehabilitation centres under study.

iii) To establish the follow up strategy for monitoring rehabilitated addicts from going back to abusing drugs

iv) To identify aspects of the program that can be intensified to improve inadequacy of services where this is the case.

1.5 Research Questions

The following research questions guided the study:

i) What standards have been put in place in rehabilitation /treatment centre when attending to drug and substance abuse clients in Mombasa County?

ii) How competent are the personnel offering counselling in the rehabilitation centres under the study?

iii) What strategies have been put in place to monitor rehabilitated addicts from going back to abusing drugs?

iv) What aspects of the program can be intensified to improve inadequacy where this is the case?

1.6 Significance of the study

The rehabilitation programs set by hospitals, organizations, psychiatrists and groups which aimed at abstinence and sobriety and moulding of character seem to yield limited success. The study was to unearth possible reasons for the shortfalls. The study findings shall thus be intended to act as a procession as well as a spring board from which other researchers could conduct investigations into the rehabilitation of

alcohol/drug addicts. Based on these findings, the chemical dependency counsellors would be in a position to discover where they are weak and need to adopt appropriate approaches or strategy in dealing with the alcohol/drug addicts in recovery and their counselling needs. The findings may also be useful to the government, hospitals, policy makers, professional counsellors, religious organizations like P.C.E.A, A.C.K and bodies that participate in the current fight against drug and substance abuse especially NACADA.

The study would be of benefit to a number of stakeholders directly or indirectly. Among those who may find the findings of this study of relevance includes the ministry of health officials. The ministry officers may find the findings of this research of great importance in a number of ways. As the findings would be a good feedback as it assisted in strategic planning. Another beneficiary of this research were the rehabilitation centres. This is because these institutions are the key players and hence the findings were an eye opener to the heads of the institutions, and counsellors. The Public Service Commission (PSC) also stands to benefit from this study. This is because it served as a source of information from the centres about the use of rehabilitation in addressing the issue of drug and substance abuse. This may put the PSC at a better place to reorganize its resources in terms of personnel.

1.7 Delimitations of the study

The study considered all the rehabilitation centres in the county which include Coast General, Mewa rehabilitation centre, Wema Centre-Bamburi, Barsheba Rehab Centre, Mewa Hospital, Onesmus Boys, Dickson Centre and Grandsons of Abraham sample

of treatment centres in Mombasa. It was limited to the answers given to the questions by the respondents. It only targets those present at the time of administering the questionnaires. Caution was therefore taken in generalizations, to ensure that the sample of the study covered both private and government rehabilitation centres in Mombasa County. Since counselling requires quiet areas, most of the centres are situated in the suburbs of Mombasa except for Coast general and Mewa rehabilitation centre. There is scanty local research done on drug rehabilitation centres in Mombasa County especially on areas of assessing the rehabilitation centres and set standards by NACADA.

1.8 Limitations of the study

There is a possibility of the respondents sharing in the process of answering the questionnaires. Therefore the researcher assured the respondents of confidentiality before filling in the questionnaires. It was difficult for the researcher to control the attitude of the respondents as they responded to the questionnaires.

1.9 Assumptions of the study

The research is based on the following assumptions;

1) Professional counselling is lacking and lack of trained counsellors may be the cause of addiction beliefs in influencing the treatment in the rehabilitation centres.
2) Clients' attitude and readiness for treatment will contribute to lower relapse rate
3) Fewer individual counselling sessions will lead to higher relapse rate.

1.10 Definition of significant terms.

Abuse refers to misuse of substance that would affect your body.

Addictive behaviour refers to the behaviour based on the pathological need for a substance or activity. It may involve the abuse of substance such as alcohol or cocaine or the excessive ingestion of high caloric food resulting in extreme obesity.

Alcoholic refers to an individual with a serious drinking problem whose, drinking impairs his or her life adjustment in terms of health, personal relationships and occupational functioning.

Craving refers to having a very strong desire for something.

Dependence refers to a psychiatric disorder made up of psychological, behavioural and physiological symptoms such as continued use of drugs and problems with withdrawal.

Drug refers to any chemical substance which when taken into the body can affect one or more body functions

Drug abuse refers to the use of drugs for purposes other than medical reasons. It refers to misuse of any psychotropic substances resulting in changes in bodily functions, thus affecting the individual in a negative way socially, cognitively or physically. Social effects may be reflected in an individual's enhanced tendency to engage in conflicts with friends, teachers, and school authorities. Cognitive effects relate to the individual's lack of concentration on academic work and memory loss such as "blackouts".

Dopamine refers to a substance which when released in the brain causes pleasure.

Psychoactive drug refers to chemicals that induce changes in moods, thinking perception and behaviour by affecting neuronal activity.

Recovery refers to the state of getting treatment to help them recover from drug and substance abuse.

Relapse refers to failure to maintain behaviour change over time, the event of resumption of a pattern of substance abuse or dependence.

1.11 Organization of the study

The study is organized into five chapters. The first chapter has the introduction that covers the background of the study, statement of the problem, purpose of the study, objectives of the study, research questions, significance of the study, delimitations of the study, limitations of the study, assumptions of the study, definition of significant terms, and organization of the study. The second chapter is literature review that covers introduction, counselling needs of the recovering drug addicts, services offered to the recovering addicts, the qualification of the counselling staff in the rehabilitation/educational centres under study, addicts and counsellors rating of the services offered to the addicts, the challenges facing counsellors in the rehabilitation programs in Mombasa and aspect of the program that can be intensified to improve inadequacy of services where this is the case, summary of literature review, theoretical framework, and conceptual framework. The third chapter deals with research methodology, which includes introduction, research design, target population, sample size and sampling procedure, research instruments, instrument validity, instrument reliability, data collection procedures, and data analysis techniques. Chapter four deals with analysis of data, the findings of the study and a summary of research presented. Chapter five consists of the summary of the research, conclusions, recommendations, and suggestions for further research.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature on presence of follow up of standards sets by NACADA in rehabilitation centres. the qualifications and effectiveness of the counselling staff in the rehabilitation centres, the follow up strategy to monitor rehabilitated addicts from going back to abusing drugs, aspects of the program that can be intensified to improve inadequacy of services where this is the case, theoretical framework and a conceptual framework will also be included.

2.2 Set Standards by NACADA in rehabilitation centres in Mombasa County

A study by NACADA (2010) indicated that the need for rehabilitation and counselling services for drug users is very evident in Coast province. With substantial research pointing to a biological basis for alcohol and drug dependency, treatment strategies focus on arresting the progression of this chronic illness by fostering abstinence from alcohol and addictive drugs (Okut, 2005). Most treatment centres rely on 12 step facilitation methods. Common too many countries are the continued abuse, overuse and dependence on drugs and alcohol even after treatment completion (Wikipedia, 2010). A lot of time, money and effort have been expended in studying patient characteristics as predictors of relapse in the U.S and U.K. There is little evidence to link patient characteristics such as age, gender intelligence, mental health complications or educational status to treatment outcome (Tomlinson, 2001).

The effectiveness of all has been studied and residential rehabilitation seems to be effective. depending on the problems and motivations of the person being treated and the quality of intervention. Many patients entering treatment have high levels of psychological health problems. 50% have committed some form of crime in the three months prior to intake. There is high drop out rate. 28% of those being treated leave in two weeks 40% by three months. Counsellor beliefs and values influence the success of the therapeutic enterprise. Beliefs and attitudes shape the interactions between therapists and clients (Alessandro, 2004).

In Mombasa County there are several rehabilitation centre that offer trauma resolution. Interventions that do not accommodate trauma may prove largely ineffective. By ignoring trauma resolution they are not addressing the factors. Shultz (2004) feels that Trauma Resolution in the treatment of addiction is still in its infancy. Most will have come across it as part of cognitive behavioural therapies, or talk therapies. However many of these methodologies are proving ineffective or are delivered by inexperienced or even unqualified counsellors.

Trauma resolution has borne out improved rate of success and reduced relapse rate in clients especially if given by experienced therapists. Trauma is present in a high percentage of substance abuse addiction cases. Trauma work is the most sensitive part of addiction therapy which means getting it wrong can be real pain that underlies most addiction and facing it requires strength on the part of the client, and the security of knowing they are 100% supported and understood throughout the process (Lanzet, 2004). These centres include Coast General, Mewa rehabilitation centre, Wema

Centre-Bamburi. Barsheba Rehab Centre, Mewa Hospital, Onesmus Boys, Dickson Centre and Grandsons of Abraham sample of treatment centres in Mombasa.

2.3 Aspects of the program that can be intensified to improve inadequacy of services

Better treatment outcomes are generally linked to more treatment. The longer a patient stays connected with recovery-related services, the more likely she or he will maintain treatment gains. There is accumulating evidence that by extending the therapeutic benefit of treatment. clients can experience longer periods of recovery with fewer relapses and better quality of life. Patients, who not only successfully complete treatment but also continue with post-treatment services, have better treatment outcomes (Tomlinson. 2001). Fostering successful post-treatment compliance is a key factor in promoting better treatment outcomes. The greater the number of continuing care options, the greater the likelihood of patient involvement. Motivational methods which support continued change are monthly newsletters, case management services. phone interviews, annual reunions to share success stories, and educational materials mailed or e-mailed at strategic interval.

Treatment for older adults with drug related problems is effective and improves the quality of lives for older adults and their families for years to come (Menninger, 2002). Researchers have studied the prevalence of alcohol dependence, treatment needs and treatment outcomes among adult population. Older adults with alcohol and drug problems have specific medical, cognitive and emotional treatment needs. Compared to younger adults, older adults are at increased risk of cognitive and

functional impairment during withdrawal. In addition, many older adults identify depression, grief, loneliness and social pressure as common antecedent to their drinking. Adults need programs which include a slower pace, supportive rather than confrontational approaches and focus on specific issues such as grief, loneliness, boredom and retirement (Lemkke & Moos, 2002).

Research data show that those who were randomly assigned to receive age-specific programming were three times more likely to report abstinence at six months and two times more likely to report abstinence at 12 months compared to peers who received treatment as usual in a mixed age setting. Factors found to be positively related to treatment outcomes among older adults include lower pre-treatment alcohol consumption levels, having a social- group that disapproves of drinking and seeking help from mental health professionals. Treatment for alcohol problems and regular alcoholic anonymous participation are also related to alcohol abstention among adults (Mathias, 2000). Studies suggest that even minimal increase in counselling opportunities may produce impressive gains in treatment outcomes. Florentine (2001) found that patients who attended more group sessions had significantly lower levels of drug use during and after treatment than those who participated less frequently.

Adding more counselling sessions and 12 step program can boost drug abuse treatment effectiveness. The prognosis of older patients in mixed-age alcoholism treatment programs was compared to that of younger and middle-aged patients. The research sample included 432 patients in each group who provided background information. They also responded to measures of drinking quantity and frequency and

answered questions about symptoms and consequences of their substance use. The following results of the study were seen; poorer physical health and lower cognitive status at treatment entry for the older patients, reports by older patients of less consumption and fewer drinking related problems and psychological symptoms, more social support, more adaptive coping and fewer barriers to abstinence for the older patients, positive views of the programs on the part of older patients, comparable treatment for all patients, at discharge, significant change in most treatment areas for older patients, a finding that better initial status was the strongest predictor of better discharge functioning (Lemke & Moos, 2002).

2.4 Competence of personnel offering counselling services to clients

Counselling is a relationship where people agree to do things together, so the counsellor and the counselee set goals they wish to achieve at the end of the process. The client is helped to cope with personal issues or even to adjust to the environment. It is a helping relationship to help individuals to get access to a greater part of their personal resources as a means of responding to challenges of life (Gathigia, 2005). According to Mutie and Ndambuki (1999) "counselling in traditional Africa ensured the preservation of the society and continuation of a stable community". This was possible because most societies had various forms of social services that were provided to young people so that they could grow into responsible and productive members of their communities. On the other hand Lutomia and Sikotia (2002) notes that with the coming of the modern society, it is difficult to provide similar services.

Training of counsellors has to a large extent been left to individuals through in-service courses or people who are willing to invest their time and money in training as counsellors. However, for effective counselling to take place, the counsellor must have a healthy understanding of behavioural and social sciences, biological sciences and humanities. The work also requires knowledge of cultural influences, the effects of cultural change that may be facing drug addicts (Ndirangu, 2000). According to Corey (2000), counselling seeks to stimulate personality growth and development; to help people cope with problems of life, with inner conflicts, crippling emotions and to provide encouragement to those facing loses or disappointments. Counselling can also be looked at as a remedy for disruptive behaviour among the youth such as drug and substance abuse.

2.5 Monitoring rehabilitated addicts

The primary goal of alcoholism treatment as in other areas of medicine is to help the patient to achieve and maintain long-term remission of disease. For alcohol dependent persons, remission means the continuous maintenance of sobriety. There is continuing and growing concerns among clinicians about the high rate of relapse among the patients and the increasingly adverse consequences of continuing disease. For this reason, preventing relapse is perhaps the fundamental issue in alcoholism treatment today (Gordis, 2000).

There is evidence that approximately two thirds of patients will use their drugs of choice within a year following treatment 33% within the first two weeks. About 60% within 3 months and 67% lapsed within 12 months (Perkinson, 2002). Research by

Marlatt and colleagues led to classifying relapse for heroin addicts' alcoholics, smokers, and gamblers and over eaters in two broad categories, interpersonal and intrapersonal determinants (Marlatt, 1985). Intrapersonal determinants contributing to relapse include negative emotional states and negative physical states. 38 % of alcoholics, 37 % of smokers 19 % of heroin addicts relapsed in response to a negative affective state. Interpersonal precipitants of relapse include relationship conflict, social pressure to use substances and positive emotional states associated with some type of interaction with others. Social pressure to use drugs was identified by 36% of heroin addicts, 32% of smokers and 18% of alcoholics as contributing to their relapses (Shiffman, 1982).

Many treatment programs deal poorly with relapse – prone patients because they are not using specialized relapse prevention therapy methods so unsurprisingly many relapse – prone patients fail to recover (Gorski, 2001). Relapse prone patients deserve effective treatment with special methods designed to meet their needs. Relapse prone patients are not hopeless; over 50% of all relapses will achieve permanent abstinence with effective treatment and many of the remaining 50% will significantly improve the quality of their lives and lower their health care costs in spite of periodic lapses. The goal is to deal with relapse therapeutically rather than punitively when possible.

Interventions done in Kenya

Many interventions have been put in place in the war against drug abuse. Among these interventions are treaties and conventions, (the most notable being the treaty of Hagua in 1912), which was known as the international opium conventions. The

government of Kenya, in 1994 enacted the Narcotic Drugs and Psychotropic substances Act, which recommended stiffer penalties for drug offender. In March 2001 the government established the NACADA, which was mandated to coordinate the activities of individuals and organizations involved in the campaign against drug abuse. The Government has also ratified the three major United Nations Conventions on Narcotic Drugs and Psychotropic Substances, namely, Single Convention on Narcotic, (1961) Convention on psychotropic substances, (1971) and convention against illicit trafficking on narcotic Drugs and psychotropic substances (1988). Kenya has also undertaken to implement the agreements on the political Declaration by the U.N General Assembly on guiding principles of Drug Demand Reduction and measures to enhance international cooperation and to counter the world Drug problem and as a member of organization of African unity (O.A.U) now Africa's union. Kenya subscribes to the Yaonde Declaration and plan of Action on Drug abuse and illicit trafficking control in Africa adopted by heads of states and Governments in 1996.

Finally Kenya is a signatory to the East Africa region which calls on the states to work together in the elimination of drug trafficking, money laundering and illicit use and abuse of drugs through coordination among enforcement agencies and demand reduction through coordinated programs in the region (NACADA 2002). One fact is obvious we can no longer ignore the massive drug problems affecting nations and people through out the world, the greatest effect being on the studies of NACADA, Ongwen, Mwenesi, (1994) amongst others. However, despite the above mentioned physical, psychological and social effects, the treatment, rehabilitation and other interceptive measures in Kenya are either inadequate, uncoordinated or simply

lacking. In 1994, The Narcotic Drugs and psychotropic substances control Act section 52 states that "The minister may establish such number of rehabilitation centers as he thinks fit for the care treatment and rehabilitation of persons addicted to narcotic drugs or psychotropic substances" (Narcotic Drugs and Psychotropic substances control Act 1994)

A country – wide needs assessment study undertaken in 1994 by the Government of Kenya and the UNDCP revealed that drug abuse has permeated all strata of Kenyan society youth and young adults being the most affected groups. One of the main recommendations of the study is that the government of Kenya should set up specific demand reduction programs to enlighten and educate the public on the problem of drug abuse. The need for a reassessment of government policy on the treatment of addicts is stressed and it is suggested that the establishment of non stigmatizing treatment and rehabilitation centers should be considered. Intersectional collaboration between different government departments and non – governmental organizations was also proposed (Mwenesi 1996).

In Kenya rehabilitation is often undertaken in therapeutic communities. Relapse rates varies from one center to another example Asumbi has a relapse rate of 65% During the launch of crime in Nairobi; victimization survey. The director of the National Agency for campaign against drug Abuse (NACADA) noted that drug abuse is one of the crimes in Nairobi (UN–Habitat, 2002). He emphasizes the need to tackle drug abuse if crime is to be reduced and the reduction of drug abuse is therefore of significance to both governments and individuals.

Mugisha and Hagembe (2003) in their study say there is easy access to alcohol, drugs like bhang (marijuana and Cocaine and substances like glue and petrol). One of the illicit brews locally known as changa'a is very dangerous than drugs and other substances. It's locally described as "Kill me quick" reflecting its strength in 2000 at least 137 people died 500 were hospitalized and 20 were blinded in Nairobi after drinking chang'aa laced with methanol (Rowan 2000).

Mrs. Abdalla whose son is an addict is quoted to say that drug addiction is like a curse. It changes your child from what you used to know to a devil who torments you throughout your life" (Mayoyo, Nation April 2005). Her desire to rehabilitate her son had been hampered by lack of resources. She felt that the cost of rehabilitating a drug – addict was too high, and appealed to the government to open free drug rehabilitation centers in district hospitals and dispensaries to combat the vice.

2.6 Theoretical framework

Psychoanalytic /Ego–Analytic Approach.

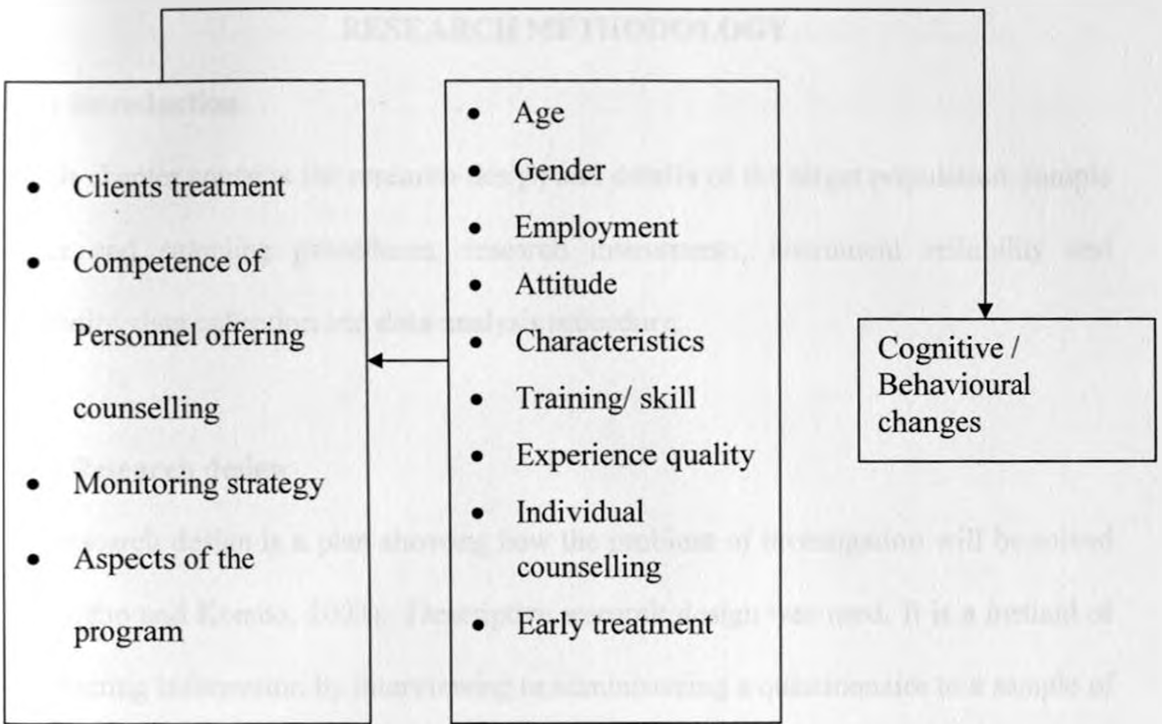
It emerges from the theoretical base of psychoanalysis that was first proposed by Freud. Freud's psychoanalytic theory of personality is at the core of this form of therapy. The therapeutic session is directed towards the patient's becoming aware of his unconsciously stored frustrations, which have their roots in childhood and are the cause of psychological maladjustment. These conflicts can only be resolved when the individual becomes conscious. Freud (1943) placed a great deal of emphasis on the release of emotional tension, a process known as catharsis; he recognized that they needed to develop insight an understanding of the unconscious roots of their

problems. Psychodynamics tend to be less confrontational and direct. It focuses on past events rather than on present realities. They tend to take longer and they tend to be geared towards a change in the whole personality structure versus a change in a single or group of behaviors or beliefs. The techniques of psychoanalytic therapy include free association, dreams, resistance and transference. In early phases of addictions therapy a non-confrontive or indirect approach would not be as helpful as a more direct confrontative approach in breaking through the client's denial regarding his addiction. In psychoanalytic therapy, there is a tendency to view the addiction only as a symptom of an underlying conflict. The therapist often attempts to first treat the conflict believing that once the conflict is resolved the symptom (addiction) will be removed as well. Typically this does not happen. The client must first stop the active addiction. If the client uses drugs to deal with his feelings uncovering more painful feelings this is not going to help the client stop using the chemical.

2.7 Conceptual Framework

Most clients come for treatment in different cognitive state. Some come when they are ready for treatment. Others come when they are in denial. This can be due to being forced to come for treatment. They also come to the centre with different behaviour patterns. The cognitive state and the behaviour patterns can influence treatment positively or negatively. Through the interaction with the counsellors and going through the program structure and process change is expected to take place. Stabilization is experienced. Some clients experience relapse after going through the program. At the end of the program what is seen is Cognitive/Behavioural changes.

Figure: 2.1 Conceptual model of treatment process



2.8 Summary of the review

From the foregoing review it is apparent drug dependency, treatment strategies focus on arresting the progression of this chronic illness by fostering abstinence from alcohol addictive drugs. The aspect of the program can be intensified to improve inadequacy of services offered by having competent personnel offering counselling services to clients. The other factor that would help would be monitoring rehabilitated addicts. This will prevent relapse of the clients back to use of drugs and substances. Hence this study sought to fill in the gap on the influence of the implementation of the curriculum on drugs rehabilitation centres. This gap is intended to change. It is for the purpose of closing this gap that the present study has been designed.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter contains the research design and details of the target population, sample size and sampling procedures, research instruments, instrument reliability and validity, data collection and data analysis procedure.

3.2 Research design

A research design is a plan showing how the problem of investigation will be solved (Orodho and Kombo, 2003). Descriptive research design was used. It is a method of collecting information by interviewing or administering a questionnaire to a sample of individuals. It can be used when collecting information about people's attitudes, opinions, habits or any of the variety of education or social issues (Orodho and Kombo, 2003). Descriptive research design was used in this study where questionnaires were administered to counsellors, addicts (patients) and administrators. The design allowed the researcher to collect views from the respondents to facilitate an assessment of rehabilitation programs in selected drug and substance treatment centres.

3.3 Target population

A population is defined as a complete set of individuals, cases or objects with some common observable characteristics (Mugenda and Mugenda, 2003). The study targeted anybody in a drug rehabilitation centre currently recovering from substance abuse. Hence all individuals in drug rehabilitation centres as well as those reporting to

health delivery points due to drug related complication was used for the study. Counsellors giving services in these centres were also used. In Mombasa there are 20 inpatient and out-patient drug treatment centres. Because of the number involved eight centres were used for the study. One public and seven private centres were selected for this study. The inpatient centres have patient capacities of between 10 to 60 patients. While the out-patients centre attends to as many as 80 patients in a day. The centres used for the pilot study were not used for the research.

3.4 The sampling procedures and sampling size

Sampling is a means of selecting a given number of subjects from a defined population as representative of that population. Orodho and Kombo (2002) define sampling as the procedure a researcher uses to gather people, places or things to study. Any statements made about the sample should also be true of the population. It was however agreed that the larger the sample the smaller the sampling error. Since the research cannot cover all the 20 drug treatment centres in Mombasa County, a sample would be selected to take part in the study. The 20 drug treatment centres attend to as many as 80 patients daily and 60 inpatient clients. The researcher used purposive sampling in selecting 8 centers and 80 respondents for the study. Purposive sampling technique is the type that allows a researcher to use cases that have the required information with respect to the objectives of his or her study. Cases are handpicked because they are informative or they possess the required characteristics Mugenda & Mugenda (1999). A sample size of 80 drug users was used from the 8 centres visited that is 10 patients per centre. These are the patients found at the time of the study. The other respondents were 16 counsellors. Two were picked per centre.

3.5 Research instruments

The main research instrument in this study was questionnaire schedule. Two sets of questionnaires were administered. They were designed to assess the rehabilitation programs in selected drug and substance treatment centres. Both structured (Closed-ended) and unstructured (open-ended) questions were used.

i) Structured or closed- ended questions

This type of questions are usually accompanied by a list of possible alternatives from which respondents select the answers that best describe their position. They allowed easier and accurate analysis of data since they are in an immediate usable form, hence precise interpretation of responses easier to administer. They are economical.

ii) Open-ended questions

This refers to questions that give the respondents complete freedom of response. They permit the respondent to use his/her own words. A small percentage of such questions were used in order to allow respondents free expression on issues that called for such freedom.

3.5.1 Validity of the instruments

According to Kombo and Tromp (2006) validity is measure of how well a test measures what it is supposed to measure. To enhance content validity, the supervisor was first appraising the instrument (Orodho, 2004). A pilot study of the instruments was conducted at the Little sister of the Poor (Tudor) clinic which is an outreach centre for one of the rehabilitation centres. The clinic has counsellors and drug users

on methadone treatment. The patients were selected as they came in for treatment. The patients have the same characteristics as the target population. There were also a pre-test for the counsellors. Expert advice from the supervisors assisted to make corrections and modifications on the items of the instrument. Items that failed to measure the variable they were intended to measure were modified and others discarded completely.

3.5.2 Reliability of the instrument

Kombo and Tromp (2006) define reliability as a measure of how consistent the results from a test are. An instrument is reliable when it can measure a variable accurately and consistently and obtain the same results under the same conditions over a period of time. To test reliability of the instrument test-retest technique was used. This test-retest method involved administering the same instrument twice to the same group of subjects. The second administration was done after a time lapse of one week after the first test. After the two tests are scored, the Pearson's product-moment correlation was computed to determine correlation co-efficient, which shows whether the scores on the two tests correlate.

The formula for determining r is given below:

$$r = \frac{n\sum xy - (\sum x)(\sum y)}{\sqrt{n\sum x^2 - (\sum x)^2}\ \sqrt{n\sum xy^2 - (\sum y)^2}}$$

Where, x is the score on test 1 while y is the score on test 2. The study reliability was 0.8 for the clients' questionnaire and 0.72 for the counsellors' questionnaire.

According to Mugenda and Mugenda (1999), a correlation coefficient r, of 0.7 is considered appropriate and hence reliable for collecting data. Hence the instruments were reliable for collecting data.

3.6 Data collection procedures

A research permit was obtained from the National Council of Sciences and Technology. The permit was shown to the District Officer (DO) in Mombasa County and the all the heads of the centres of participating rehabilitation centres. There were reconnaissance visit to the centres that were taken part in the study for introduction and establishing time for administration of instrument. The questionnaires were administered personally with accompaniment of the counsellor. Clarification was made to the patients and counsellors concerning the questionnaire.

3.7 Data analysis Techniques

Data analysis refers to the interpretation of collected raw data into useful information (Kombo & Tromp, 2006). After editing and sorting out the questionnaires for completeness, returns, and coding analysis of the data was done. The quantitative data analysis, descriptive statistics was used to analyze the data to give the percentages (%) and frequencies (f). Data was presented in form of tables and charts which helped to explain the relationship between the variables of study. Qualitative data analysis was carried on qualitative data from the open ended question. Computer software, Statistical Package for Social Sciences (SPSS) version 17 was used.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

This chapter presents a description of analysis of data, presentation, interpretation and discussions. The study was on the influence of the implementation of the curriculum on drug addicts in drug rehabilitation centres in Mombasa County, Kenya. The work is organised based on the four objectives raised for the study. Data is then presented in form of frequency tables and charts where applicable. This presentation is based on the questionnaires administered and observations made.

4.2 Questionnaire return rate

Completion rate is the proportion of the sample that participated as intended in all the research procedures. The returned questionnaires were from 67 clients and 10 counsellors who were key informants. Analysis and data interpretation was based on these returns.

Table 4.1

Questionnaire return rate

Respondents	Sample	Responded	Percent
Clients	80	67	83.8
Counsellors	16	10	62.5

From Table 4.1, 83.8 percent of the clients and 62.5 percent of the counsellors returned their questionnaires as targeted. Mulusa (1990) stated that 50 percent return

rate was adequate, 60 percent good and 70 percent very good. The return rate was hence considered good to provide required information for the purpose of data analysis.

4.3. Demographic data of respondents

The respondents were asked to indicate their gender, age and religion of the clients. The rationale behind inclusion of these attributes in the analysis is that they help to expose on clients self assessment of the rehabilitation centres programmes they are attending to.

Gender and age of the clients

The clients were asked to indicate their gender and age. The results are as shown in table 4.2.

Table 4.2

Distribution of clients by their gender and their age

		Age bracket			Total
Gender		**15-25**	**26-35**	**36-45**	
Male	Count	10	4	40	54
	%	18.5	7.4	74.1	100.0
Female	Count	3	3	7	13
	%	23.1	23.1	53.8	100.0
Total	**Count**	**13**	**7**	**47**	**67**
	%	**19.4**	**10.4**	**70.1**	**100.0**

From the overall results it is clear there were 54(80.6%) male clients and 13 (19.4%) female clients. The male clients are distributed in different age brackets with the

highest being between 36-45years at 74.1 percent while 18.5 percent were aged between15-25 and 7.4 were aged between 26-35years. On the other hand majority of the female clients (53.8%) were aged 36-45years and 23.1 percent of them were aged between 15-25 and 26-25 years respectively. This shows that majority of those who go to the rehabilitation centres are people who are in their prime age trying to rebuild their lives.

Religion

The clients were asked to indicate their religion affiliation. The results are as shown in table 4.2.

Table 4.2

Distribution of clients with the religion affiliation

Religion	Frequency	Percent
Christian	28	41.8
Muslim	39	58.2
Total	**67**	**100.0**

The majority of the clients (58.2%) were Muslims and 41.8 percent of them were Christians. This shows that both Muslims and Christians have been affected by drug and substance abuse. This is why we had both of them going to look for solutions to the problems brought about by drug and substance abuse.

4.4 The extent to which treatment centres follow the set standards when attending to their clients

The researcher sought to identify from the clients how they first went into the rehabilitation centre. Table 4.4 shows the results.

Table 4.4

How clients first came to the centre

	Frequency	Percent
Brought myself	7	10.4
Referred by a doctor	8	11.9
Referred by a friend	14	20.9
Referred by family	38	56.7
Total	**67**	**100.0**

Majority of the clients (56.7%) were referred to the clinic by the family, while 20.9% were referred by a friend, 11.9 percent being referred by a doctor and 10.4 percent by self. This shows that there have been external factors or influence for a client to attend to a rehabilitation centre. The need for rehabilitation and counselling services for drug users is very evident in Coast province NACADA (2010). With substantial research pointing to a biological basis for alcohol and drug dependency, treatment strategies focus on arresting the progression of this chronic illness by fostering abstinence from alcohol and addictive drugs (Okut, 2005). Most treatment centres rely on 12 step facilitation methods. Common too many countries are the continued abuse, overuse and dependence on drugs and alcohol even after treatment completion

(Wikipedia, 2010). This prompted the researcher to ask the clients whether they had been in to another rehabilitation centre before. The results are as shown in Table 4.5.

Table 4.5

Had been to another rehabilitation centre before

	Frequency	Percent
Yes	22	32.8
No	45	67.2
Total	**67**	**100.0**

Majority of the clients (67.2%) had not been into another rehabilitation centre before and only 32.8 percent of them had been into a rehabilitation centre. Having not been in a rehabilitation centre one is eager to receive treatment to stop the addiction while those who have been in a rehabilitation centre may have had a relapse hence were referred back to the centre because of the relapse problem.

This made the researcher to ask the clients for how long they had been in the centre. The results are as shown in Table 4.6.

Table 4.6

Duration in the particular rehabilitation centre

	Frequency	Percent
Between 0-1 months	23	34.3
Between 2-4 months	38	56.7
Between 5-7 months	3	4.5
More than 8 months	3	4.5
Total	**67**	**100.0**

The majority of the clients (56.7%) had been in the rehabilitation centre for between 2-4 months while 34.3% of them had been there for between 0-1 month and 4.5% had been in the rehabilitation between 5-7 months and more than 8 months respectively. These results agree with Alessandro (2004) who noted that many patients entering treatment have high levels of psychological health problems. 50% have committed some form of crime in the three months prior to intake. There is high drop out rate. 28% of those being treated leave in two weeks 40% by three months. Counsellor beliefs and values influence the success of the therapeutic enterprise. Beliefs and attitudes shape the interactions between therapists and clients.

Table 4.7

Counselling needs of recovering addicts

	Agree		Not sure		Disagree	
	F	%	F	%	F	%
My alcohol/ drug dependence problem really bothers me	54	80.6	7	10.4	6	9.0
I have a problem quitting drugs and alcohol	52	77.6	0	0	15	22.4
I have difficulties relating with family members	51	76.1	6	9.0	10	14.9
I am disturbed that my family seem not to understand me	51	76.1	3	4.5	13	19.4
I have poor time management	50	74.6	0	0	17	25.4
I have low self esteem	47	70.2	13	19.4	7	10.4
I have a difficult falling asleep at night	46	68.6	6	9.0	15	22.4
I have excessive feeling of shame	46	68.7	10	14.9	11	16.4
I have a problem managing my finances	46	67.7	10	14.9	11	16.4
Feelings of anxiety usually disturb me	45	67.1	11	16.4	11	16.4
Marital conflicts in marriage usually bother me	41	61.2	8	11.9	18	26.9
I have a problem managing my anger	38	56.7	13	19.4	16	23.9
I have a problem relating with my peers	35	52.2	14	20.9	18	26.9
I have feeling of no home in life	34	50.7	10	14.9	23	34.3
I usually have no appetite	31	46.3	15	22.4	21	30.4
I often fall sick	13	19.4	19	28.4	35	52.3

N =67

From the clients ratings 80.6 percent rated first alcohol/drug dependence problem really bothered them, while 77.6 percent of them rated second the problem quitting drugs and alcohol. 76.1percent of them rated third the problem of having difficulties relating with family members and the problem that their family was disturbed and the family did not seem to understand them. And the lowest rated factor was that they were often sick at (19.4%). This shows that there is need for the clients to be offered counselling in order to deal with their different challenges they get both from the family and their own making through drug and substance abuse. These results agree with Lemkke & Moos, (2002) who noted that many older adults identify depression, grief, loneliness and social pressure as common antecedent to their drinking. Adults need programs which include a slower pace, supportive rather than confrontational approaches.

4.6 Competence of the personnel offering counselling in the rehabilitation centres under study

Counselling is a relationship where people agree to do things together, so the counsellor and the counselee set goals they wish to achieve at the end of the process. The client is helped to cope with personal issues or even to adjust to the environment. It is a helping relationship to help individuals to get access to a greater part of their personal resources as a means of responding to challenges of life (Gathigia, 2005). According to Mutie and Ndambuki (1999) "counselling in traditional Africa ensured the preservation of the society and continuation of a stable community". From the counsellors questionnaire the following responses were got on the qualifications of the counsellors as seen in the following tables. Table 4.8 shows the results.

Table 4.8

Distribution of respondents by their counsellor background

Counsellor background	Frequency	Percent
Non Recovery staff	1	10.0
Recovering from substance Abuse	1	10.0
Counsellor	3	30.0
Counsellor on Attachment	1	10.0
Nurse Care Counsellor	1	10.0
Psychologist	3	30.0
Total	**10**	**100.0**

From Table 4.7, 30.0 percent of the respondents were counsellors and psychologists respectively while 10.0 percent were non recovery staff, recovering from substance abuse, counsellor on attachment, nurse care counsellor. This was possible because most societies had various forms of social services that were provided to young people so that they could grow into responsible and productive members of their communities. On the other hand Lutomia and Sikotia (2002) notes that with the coming of the modern society, it is difficult to provide similar services. This prompted the researcher from asking the time the counsellors have been involved in rehabilitation of drug/ alcohol addicts. The results are as shown in Table 4.9.

Table 4.9

Duration the counsellors have been involved in rehabilitation of drug/alcohol addicts

Time Involved in Rehabilitation	Frequency	Percent
0-11months	3	30.0
1-2years	4	40.0
3-4years	2	20.0
5 and above	1	10.0
Total	**10**	**100.0**

Most of the counsellors (40.0%) had served between 1-2years while 30.0 percent of them had served for 0-11 months. The highest time served was 5 years and above. Counselling can also be looked at as a remedy for disruptive behaviour among the youth such as drug and substance abuse. Hence the longer the time one has worked the more they are able to assist. This prompted the researcher to ask the counsellors to indicate the selection criteria used to select them as counsellors.

Table 4.10

Counsellor selection criteria

Criteria	Frequency	Percent
Proposed by senior Colleagues	1	10.0
Self Motivated	6	60.0
Proposed by Doctor	2	20.0
Through Interviewing	1	10.0
Total	**10**	**100.0**

Majority of the counsellors were self motivated 60.0 percent that is why they joined counselling. While 20.0 percent were proposed by the doctors, and 10 percent each were proposed by senior colleagues and through interviewing.

Training of counsellors

Training of counsellors has to a large extent been left to individuals through in-service courses or people who are willing to invest their time and money in training as counsellors. The researcher then sought to identify the counselling training received by the counsellors.

Table 4.11

Counselling Training Received by Counsellors

Training Received	Frequency	Percent
Masters in counselling psychology	1	10
High Diploma Counselling Psychology/ Degree	2	20
Diploma Counselling Psychology	4	40
Certificate Drug abuse counselling	1	10
On job Training	1	10
Training for 5 years	1	10
Total	**10**	**100.0**

From Table 4.11, most of the counsellors 4 (40%) had a diploma counselling psychology, while 2(20%) had higher diploma in counselling psychology and 10 percent had a masters in counselling psychology, certificate in drug and abuse counselling, on job training and training for five years respectively. Asked to rate the counselling training they had received, the respondents gave the following responses.

Table 4.12

Rating of counselling training received by counsellors

Rating	Frequency	Percentage
Good	7	70
Adequate	3	30
Total	**10**	**100.0**

Majority of the counsellors (70.0%) rated their counselling training received as good, while 30 percent rated it as adequate. According to Ndirangu (2000) for effective counselling to take place, the counsellor must have a healthy understanding of behavioural and social sciences, biological sciences and humanities. The work also requires knowledge of cultural influences, the effects of cultural change that may be facing drug addicts. The counsellors were further asked to state reasons why they decided to train as drug abuse counsellors. Their responses are summarized in Table 4.13.

Table 4.13

Reasons of training counsellors

Reason	Frequency	Percent
Concerned about the impact of drug abuse	5	50.0
Have friends, relative affected	1	10.0
Recovered or recovering from alcohol/drug problem	2	20.0
Help others and make a positive difference in their lives	1	10.0
To have a career	1	10.0
Total	**10**	**100.0**

Half of the counsellors indicated that they trained as counsellors in drug abuse for concern about the impact of drug and substance abuse, while 20.0 percent of them trained because of the recovered or recovering from alcohol/drug problem and 10.0percent of them had friends, relatives affected, wanted to help others and make a positive difference in their lives and had a career. These results agree with Corey (2000) who noted that counselling seeks to stimulate personality growth and

development; to help people cope with problems of life, with inner conflicts, crippling emotions and to provide encouragement to those facing loses or disappointments. Counselling can also be looked at as a remedy for disruptive behaviour among the youth such as drug and substance abuse. This prompted the researcher to ask whether there was a follow up or on-going training. The results are as shown in Table 4.14.

Table 4.14

Follow-up or ongoing training

Follow-up	Frequency	Percent
Yes	5	50.0
No	4	40.0
No Response	1	10.0
Total	**10**	**100.0**

Table 4.14 shows that half of the counsellors reported that they had had follow up or ongoing training. The other four counsellors reported that they had not had any. Those who had had ongoing training said they had attended short courses or different aspect of counselling, one week workshop on impacts of drug use, short courses by KCA meeting peer counsellors and still continuing with training in college. The counsellors were asked whether they attended a counsellor support group, half of them indicated that they attend support group which helped them with the challenges they have had during counselling sections.

Hence the results indicates that the counsellors were competent in their work as they rated themselves and with the help of support groups where they were able to look for solution to problems encountered during counselling.

4.6 Establishing the follow up strategy for monitoring rehabilitated addicts from going back to abusing drugs

The primary goal of alcoholism treatment as in other areas of medicine is to help the patient to achieve and maintain long-term remission of disease. According to Gordis (2000) who noted that for alcohol dependent persons, remission means the continuous maintenance of sobriety. There is continuing and growing concerns among clinicians about the high rate of relapse among the patients and the increasingly adverse consequences of continuing disease. For this reason, preventing relapse is perhaps the fundamental issue in alcoholism treatment today. Hence the researcher asked the counsellors to indicate the activities they involved the clients into to discourage relapse. The results are as shown in Table 4.15.

Table 4.15

Activities the clients are involved in

Activities	Frequency	Percent
Activities they were carrying out before the problem started	2	20.0
Counsellors as recovering drug addicts	3	30.0
Carpentry	2	20.0
Recreational activities	3	30.0
Total	**10**	**100.0**

Most of the counsellors (30%) indicated that the clients were involved in counselling activities as recovering drug and substance abuse and also were involved in recreational activities respectively that would pre-occupy them to discourage a relapse. About 20 percent indicated that they encouraged the clients to continue with activities that they were carrying before they got the problem of drug and substance abuse and also they were taught different activities such as computer studies, carpentry, mechanic, welding, photography and others that would create little or no time to idle and think of a bottle of beer. These results agree with Perkinson (2002) indicated that there is evidence that approximately two thirds of patients will use their drugs of choice within a year following treatment 33% within the first two weeks. About 60% within 3 months and 67% lapsed within 12 months but can be averted if their time is pre-occupied hence discouraging drug and substance abuse.

The researcher sought to know how follow up is done. The results are as shown in table 4.16.

Table 4.16

Counsellor's Responses on follow up programmes

Programmes	**Frequency**	**Percent**
Home visits	2	20.0
Group visits	3	30.0
Use of recreational activities	3	30.0
Attending to them when they come to the clinic for their medication	2	20.0
Total	**10**	**100.0**

Most of the counsellors (30%) indicated that they had group visits with the clients and also attended recreation activities that the clients were involved in. About 20 percent of them had home visits 1and others attend to them when they came to the clinic for their medication that helps them keep away from drugs and substance abuse. Relapse prone patients deserve effective treatment with special methods designed to meet their needs. Relapse prone patients are not hopeless; over 50% of all relapses will achieve permanent abstinence with effective treatment and many of the remaining 50% will significantly improve the quality of their lives and lower their health care costs in spite of periodic lapses. Hence activities that keep the client away from drugs and substance abuse should be given to the clients.

4.7 Identifying the aspects of the programmes that can be intensified to increase inadequacy of services

Better treatment outcomes are generally linked to more treatment. The longer a patient stays connected with recovery-related services, the more likely she or he will maintain treatment gains. There is accumulating evidence that by extending the therapeutic benefit of treatment, clients can experience longer periods of recovery with fewer relapses and better quality of life. Patients, who not only successfully complete treatment but also continue with post-treatment services, have better treatment outcomes (Tomlinson, 2001). Fostering successful post-treatment compliance is a key factor in promoting better treatment outcomes. The greater the number of continuing care options, the greater the likelihood of patient involvement. The study then sought to identify the aspects of the programmes that could be intensified to increase inadequacy of services. The clients were also asked to rate the

counselling services at the centre. The responses seen as summarized in the Table 4.17.

Table 4.17

Rating of counselling services by clients

Services	Excellent		Good		Average		Inadequate		No Response		Total	
	F	%	F	%	F	%	F	%	F	%	F	%
Increasing clients acceptance of responsibility for change	20	29.9	32	47.8	10	14.9	2	3.0	3	4.5	**67**	**100**
Increasing confidence or inabilities to cope without substances	4	6.0	32	47.8	21	31.3	6	9.0	4	6.0	**67**	**100**
Help to understand that recovering is long process required	26	38.8	28	41.8	3	4.5	5	7.5	5	7.5	**67**	**100**
Families & communication	5	7.5	20	29.9	16	23.9	22	32.8	4	6.0	**67**	**100**
Developing new goals	3	4.5	27	40.3	25	37.3	6	9.0	6	9.0	**67**	**100**
Exposing to role models	8	11.9	18	26.9	34	50.7	4	6.0	3	4.5	**67**	**100**
Improve relationships	8	11.9	20	29.9	18	26.9	17	25.4	4	6.0	**67**	**100**
Chance to feedback reactions	7	10.4	12	17.9	12	17.9	32	47.8	4	6.0	**67**	**100**
Planning new ways of coping with high risk situations	8	11.9	23	34.3	24	35.8	9	13.4	3	4.5	**67**	**100**

One aspect which was rated highly by the clients was the aspect of being helped to understand that recovery was a lifelong process requiring the help of others. Rated by n= 26 (38.8%) excellent it was followed by the idea of being helped to accept

responsibility for change rate as excellent by n= 20 (29.9%). Being given a chance to feedback reactions to the treatment. intervention was rated as inadequate by the majority of respondents n=32 (47.8%), n=22 (38.8) rated as inadequate the service of helping the families to develop better communication and coping skills. N = 17 25.4 also rated as inadequate was the services of helping clients to improve relationship with others.

Duration for sufficient treatment

Both clients and counsellors were asked to state if duration for treatment was sufficient for recovery. They gave their response as seen in Table 4.18.

Table 4.18

Responses on duration for treatment sufficient for recovery

Responses	Yes		No		No Response		Total	
	F	%	F	%	F	%	F	%
Counsellors	5	50.0	5	50.0	0	0	**10**	**100**
Clients	44	65.7	18	26.9	5	7.5	**67**	**100**

Majority of the clients (65.7%) and half of the counsellors (50%) agreed that the duration was enough for treatment. The other half of the counsellors and 26.9 percent of the clients said it was not enough. The reasons given by the clients as to why the duration was not enough were because the rehabilitation services were expensive hence could only pay for few months, lack of permanent abstinence of drugs, the drugs were readily available even in some rehabilitation centres such as Coast General Hospital, some clients were forced to seek the services by family members hence the

will power was not there to stop using the drugs, lack of support from the parents and the public at large. The counsellors felt that the clients got a relapse because they were not committed, they were not positive as they underwent the treatment, the cost was high for some of them, the inter-conflicts could not be solved with the counselling offered but some need longer periods to accept their problem and be able to get solutions for their problems. The respondents were asked to give their views on relapse at the centres. Their responses are presented in the Tables 4.19.

Table 4.19

Counsellor views on relapse rate at the centre

Relapse rate	Frequency	Percentage
Extremely low	1	10.0
Low	3	30.0
Average	4	40.0
High	2	20.0
Total	**10**	**100.0**

As from Table 4.18 most of the counsellors (40%) rated relapse as average while 30 percent of them rated it as low. Hence this shows that relapse among the clients are able to follow the recreational activities and also monitoring is followed effectively. These results agree with Gorski (2001) who noted that relapse prone patients deserve effective treatment with special methods designed to meet their needs. Relapse prone patients are not hopeless; over 50% of all relapses will achieve permanent abstinence with effective treatment.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATION

5.1 Introduction

This chapter covers the summary of the study, findings, conclusions, recommendations and the suggestions for further research.

5.2 Summary of study

The purpose of the study was to find out the influence of the implementation of the curriculum on drug addicts in drug rehabilitation centres in Mombasa County, Kenya. The specific objectives of the study were to determine whether the treatment centres follow the set standards when attending to their clients, to establish the competence of the personnel offering counselling in the rehabilitation centres under study, to establish the follow up strategy for monitoring rehabilitated addicts from going back to abusing drugs, to identify aspects of the program that can be intensified to improve inadequacy of services where this is the case.

Descriptive research design was used. The study targeted anybody in a drug rehabilitation centre currently recovering from substance abuse. Purposive sampling was used to select 10 patients from each of the 8 centres and 2 counsellors from each of the centres. Hence the total population was 80 drug users and 16 counsellors. The main research instrument in this study was questionnaire schedule. Two sets of questionnaires were administered. To test the validity a pilot study was conducted. To test the reliability of the instrument test-retest technique was used. Descriptive statistics, including means, frequencies and percentages was used.

5.3 Summary of findings

The following are the findings of the study:

The extent to which treatment centres follow the set standards when attending to their clients

When asked who referred them majority of the clients (56.7%) were referred to the clinic by the family. On ever being in another rehabilitation centre, majority of the clients (67.2%) had not been into another rehabilitation centre before. The duration they had been, the majority of the clients (56.7%) had been in the rehabilitation centre for between 2-4 months. These results agree with Alessandro (2004) who noted that many patients entering treatment have high levels of psychological health problems. 50% have committed some form of crime in the three months prior to intake. There is high drop out rate. 28% of those being treated leave in two weeks 40% by three months. Counsellor beliefs and values influence the success of the therapeutic enterprise. Beliefs and attitudes shape the interactions between therapists and clients. The clients needs for counselling were as follows 80.6 percent of the clients rated first alcohol/drug dependence problem really bothered them, while 77.6 percent of them rated second the problem quitting drugs and alcohol, 76.1percent of them rated third the problem of having difficulties relating with family members and the problem that their family was disturbed the family did not seem to understand them.

The competence of the personnel offering counselling in the rehabilitation centres under study

The study established that 30.0 percent of the respondents were counsellors and psychologists respectively. On the duration the counsellors have been working with

drug and substance addicts 40.0 percent of the counsellors had served between 1-2years. On the selection criteria used, majority of the counsellors were self motivated 60.0 percent that is why they joined counselling. Training of counsellors, most of the counsellors (40%) had a diploma counselling psychology. On rating of counselling training received by counsellors, majority of the counsellors (70.0%) rated their counselling training received as good. The reason for training as counsellor in drug and substance abuse, half of the counsellors indicated that they trained as counsellors in drug abuse for concern about the impact of drug and substance abuse. These results agree with Corey (2000) who noted that counselling seeks to stimulate personality growth and development; to help people cope with problems of life, with inner conflicts, crippling emotions and to provide encouragement to those facing loses or disappointments.

Establishing the follow up strategy for monitoring rehabilitated addicts from going back to abusing drugs

Activities the clients are involved in, most of the counsellors (30%) indicated that the clients were involved in counselling activities as recovering drug and substance abuse and also were involved in recreational activities respectively that would pre-occupy them to discourage a relapse. The study established that the follow up programmes, with most of the counsellors (30%) indicated that they had group visits with the clients and also attended recreation activities that the clients were involved in.

Identifying aspects of the programmes that can be intensified to increase inadequacy of services

One aspect which was rated highly by the clients was the aspect of being helped to understand that recovery was a lifelong process requiring the help of others. Rated by n= 26 (38.8%) excellent it was followed by the idea of being helped to accept responsibility for change rate as excellent by n= 20 (29.9%). The duration for sufficient treatment with majority of the clients (65.7%) and half of the counsellors (50%) agreed that the duration was enough for treatment. From the counsellor views on relapse rate at the centre, the study established that most of the counsellors (40%) rated relapse as average. These results agree with Gorski (2001) who noted that relapse prone patients deserve effective treatment with special methods designed to meet their needs. Relapse prone patients are not hopeless; over 50% of all relapses will achieve permanent abstinence with effective treatment.

5.4 Conclusion

The study established that there were many services put in place to rehabilitate the drug users.

The centres had many counsellors trained to handle the drug users who had several needs psychological, social and health (Physical). However these counsellors needed to undergo more training specifically geared toward chemical dependency counselling. They also needed more support in this field.

The centres were found to have many challenges which could affect the quality of service they provided to attend to the needs of the users. The centres also needed to improve some of their facilities used.

It was also established that the centres were not solely responsible for relapse in patients. Denial in clients and client attitude were also to blame. These factors combined were contributors to lack of sustainability of treatment in clients. Marlat (1985) explains that relapse is there in two thirds of patients who have undergone treatment. Gordis (2000), states that preventing relapse is perhaps the fundamental issue in alcoholism treatment today. For this reason it is advisable for the centres to intensify their treatment programs to reduce relapse in clients.

5.5 Recommendations

Based on the findings of the study the following recommendations are made.

i. The counsellors in the centres should have more emphasis on psychological counselling. This is as a result of the clients findings on their counselling needs. This can be done by having more sessions of individual counselling per client in the centre.

ii. There is need for on-going training for the counsellors and service providers. There should also be support and supervision for those giving support. The training can include other areas such as family and couple therapy and better counselling techniques. The centres should intensify their programs by having more followed up services and using motivational methods which support continued change like monthly newsletters, case management services, phone

interviews, annual re-unions sharing success stories, educational materials mailed or e mailed at strategic intervals.

iii. The clients should be involved in recreational activities that would reduce their idleness, since this will encourage them to the possibility of abusing drugs and substances. Hence the activities should be time consuming.

iv. The government should build more rehabilitation centres which are affordable and can attend to the needs of drug users so far there is only one public rehabilitation centre.

5.6 Areas for further Research

The following areas for further research are suggested.

i. A study should be carried out to find out stress and burnout in counsellors in drug /alcohol rehabilitation centres. This is in view of high drop out rate of counsellors.

ii. A study should be carried out to identify counselling approaches and methodology in use in alcohol / drug rehabilitation centres. This is to verify what is being given to the users.

iii. It is also recommended that a study should be carried out on Relapse on those receiving age – specific programming in selected alcohol / drug centres.

REFERENCES

Asuni.T. and Pela. O.A (1986). *Drug Abuse in Africa.* 38, (1,2) Nairobi, Kenya: Bull. Narc (UN) Publication.

Alessandro. D. (January / February 2004). Research what are therapists' beliefs? *Addiction Treatment Today.* Volume .15 NO. 86. .32-33.

America, Psychiatric Association (2000). *Diagnostic and statistical Manual Of Mental Disorders.* America: Psychiatric Association.

Bandura, A. (1977). Self Efficacy: Toward A Unifying Theory Of behavioral Change *Psychological Review.* 8: 191-215.

Blow, F.C. Walton, D. (2000). Older Adult Treatment outcome following specific inpatient Alcoholism Treatment. *Journal of Substance Abuse treatment.* 19 :67-75.

Carlson, T. (2001). *Physiology of behavior.* Boston: Ally and Bacon,

Corey. G. (2000). *Theory and Practice of Counseling and Psychotherapy* Pacific Grove C.A. Brooks/ Cole

Di Chiara .(1995). Drug and Alcohol Dependency. *Psychological Review* 38: 95-137.

Doyle. A.C. (1994*). Addictions counseling of people with chemical and other addicttions.* New York: Crossroads.

Frankenstein, W.H. and Nathan. P. (1985). Effects of intoxication on Alcoholics. *Marital_Communication and Problem Solving.* 46: 1-6.

Gacicio, E. (2003). *The role of stakeholders in combating drug and substance abuse. Paper presented at HIV/AIDS Teacher training tool development retreat. Matuu. Kenya. 4th to 10th May 2003.Gordis, Enoch. (October 2000). Relapse and craving* .US Department of Health and Human Services. National Institute of Health.

Gorski, T. (June 2001). *Developing relapse prevention programs. Addiction and recovery.* Spring Hill: Gorski's Concepts Corporation.

Kaufman, E. (2003). *Family Therapy. A treatment approach with substance abuser.* New York: Guildford Press.

Keeping, score. (1998). *Drug strategies.* New York: Carnegie corporation.

Kissin. B. and Begleiter. H. (1977).*Treatment and Rehabilitation of chronic Alcoholic.* London: Plenum Press.

Kombo, D. K. and Tromp L.A. (2006). *Proposal and thesis writing.* Nairobi: Pauline Publication Africa.

Larimer, J. and Marlat, G. (1999). *Relapse prevention. An overview of Marlatt's cognitive Behavioral model.* Volume 23: No 2.

Laundergan, J. C. (1982). Easy Does It *Alcoholism Treatment outcomes. Hazelden and the Minnesota model*: Duluth: Hazelden Foundation.

Lemke, S. and Moos, R. H. (2002). Prognosis of older patients in mixed age alcoholism_treatment programs. *Journal of substance abuse treatment.* 22: 33-43.

Lutomia, G. A. and Sikotia L. W. (2002). *Guidance and Counselling in Schools and Colleges.* Nairobi: Uzima Press.

Lord, R. (1984). *Controlled Drug law and practice.* London: Butter Worts.

Ludwig, A. M. and Stark, L.H. (2000). Alcohol and Craving: Subjective and situational aspects. *Quarterly journal of studies on alcohol* 35:33. U.S. department of health and human services.

Marlat, G..A. and Gordon, J. R. (1985) *Relapse prevention: Maintenance of strategies in the treatment of Addictive behaviors.* New York: Guildford Press.

Mathias, R. (2000). National institute on drug abuse. *Journal of substance abuse treatment.* Butler center for research. Hazelden. Vol.: 14. NO. 5

Mc Kim, (1997). *Drugs and behavior.* New Jersey: Prentice Hall.

Menninger. J. A. (2002). Assessment and treatment of alcoholism and substance - related disorders in the elderly. *Bulletin of Menninger Clinic, 66.* 166–183.

Miller, W. Hester, R. (1980). Treating the problem drinker. Modern approaches in the addictive behaviors. *Treatment of alcoholism, drug abuse and obesity.* New York: Pergamon Press.

Mugenda, O. M. and Mugenda, A. G. (1999). *Research methods: quantitative and qualitative approaches.* Nairobi: Acts Press.

Mugenda, O. M. and Mugenda, A. G. (2003). *Research methods: quantitative and qualitative approaches.* Nairobi: Acts Press.

Mugisha, F. Mugisha, J. A. Hagembe, B. O. N. (2003). *Alcohol, substance and drug use among urban slum adolescents in Nairobi.* Kenya. Cities. Vol.: 20 NO 4 23 – 240 Elservier Science.

Mutie, E.K. and P. Ndambuki, (1999). *Guidance and Counselling for Schools and Colleges.* Nairobi: Oxford University Press.

Mwenesi . H. A. (1996). *Rapid assessment of drug abuse in Kenya.* Bull. Narc 48: 1-2

NACADA, (2002*). Social and legal aspects of substance abuse in Kenya. Paper presented at the Drug Advisory Service Conference*. Nairobi. Unpublished.

NACADA, (2004). Youth in peril. *Alcohol and drug abuse in Kenya*. Unpublished.

NACADA, (2010). Report of Survey on Drugs and Substance Abuse in Coast: Province Kenya. Nairobi: National Campaign Against Drug Abuse Authority.

Ndirangu, Julius M. (2003). *Youth in Danger.* Nairobi: Uzima Press.

Nowinski, J. (1990). *Substance abuse in adolescents and young adults.* New York: W.W. Norton 7 company.

Okut, E. A. (2005). Evaluation of rehabilitation programs in selected alcohol / drug treatment centers in Nairobi Province. Kenya. Nairobi: Kenyatta University. unpublished Thesis

Ongw'en. A. O. (2003). *Severity of substance abuse among persons in Nairobi. M. A Thesis*. Nairobi University.

Orodho, A.J. (2004). *Techniques of writing research proposals and reports in education and social sciences*. Nairobi: Masola Publishers.

Orodho, J. A. and Kombo, D. K. (2002). *Research methods.* Nairobi: Kenyatta University, Institute of Open Learning.

Owen, Patricia. (January 1999). Women and substance abuse. What does Research show in Psychological factors? *Research update*. Hazelden Institute.

Perkinson. R. (2002). *Chemical Dependency*. Carlifonia: Sage publication.

Polich. J. M. and Armor D. J. (1981., *Stability and change in drinking patterns. The course of alcoholism. Four years after treatment*. New York: John Willey and sons.

Rowan, D. (2000*). Alcohol deaths reflect desperate conditions in Kenya.* World scientist Website

Ryan, F. (April 2004). Minds Moods and behavior: the case of cognitive behavior *therapy. Drugs and alcohol today.* Vol. 4 Issue 1 3-5

Segal, Z. William J. M. and Teasdale, J. (2001). *Mindfulness based cognitive Therapy for Depression: A New Approach to preventing Relapse.*_London. Guildford Press.

Shiffman, S. (1982). Relapse following smoking cessation. A situational analysis. Journal of. *Consulting and Clinical psychology.* 50: 71-86

Shultz, C. (April 2004). Trauma Resolution- The key to addiction treatment. *Drugs and Alcohol Today.* Vol. 4. Issue 1. East Sussex: Pavilion Brighton.

Sue David, Sue Derald, Sue S. (1997).*Understanding Abnormal behavior.* New York Houghton Miffin.

Teasdale, J. D. Seagal, Z. Williams, J.M. (2000). Prevention of Relapse/ recurrence in_major depression by mindfulness- based cognitive therapy. *Journal of consulting and clinical Psychology* 68. 615- 623.

Tomlinson, M., (2001). A critical look at cultural diversity and infant care. *Synergy, Australian Transcultural Mental Health Network*, Winter:3–5.

UNDCP, (1992). *The united Nations and Drug Abuse control.* Vienna: UN 1993.

UNDCP, (1998) *World Drug Report.* New York: Oxford University Press Inc.

UN, (1998).*Convention Against illicit Trafficking in Narcotic Drugs and psychotropic Substances. New York UN Habitat (2000) "Crime Survey in Nairobi.* Launch of UN Habitat safer cities Publication: Keynote Address by Anna Kajumula Tibaijuka executive director. UN-HABITAT. Norfolk Hotel December. 2002.

Wanjohi, K. (Daily Nation, October 2003). *National study finds rampant drug abuse in schools and* universities.

Wikipedia, 2010. *Drug rehabilitation.* Retrieved on 15th May, 2012.

APPENDICES

APPENDIX 1

INTRODUCTORY LETTER TO RESPONDENTS

University of Nairobi

Department of Educational

Administration & Planning

P. O. Box 92

Kikuyu

The Director

……………………..

Dear Respondent,

REF: ASSESSMENT OF REHABILITATION PROGRAMS IN SELECTED DRUG AND SUBSTANCE TREATMENT CENTRES IN MOMBASA COUNTY, KENYA

I am a post graduate student in the University of Nairobi, pursuing masters of Education degree course. I am undertaking a research on the influence of assessment of rehabilitation programs in selected drug and substance treatment centres in Mombasa County, Kenya. Your institution is selected to participate in this research. I will be grateful if you may fill in the questionnaire attached. Responses will be used for the purpose of the study only. Your particulars and that of the school need not appear anywhere in the questionnaire. Confidentiality will be strictly adhered to.

Yours faithfully,

Angela M. Kilonzo

APPENDIX II

QUESTIONNAIRE FOR CLIENTS

Introduction

Dear Respondent,

You are participating in a very important study and you should feel happy to be a contributor to a body of knowledge that will be of help to many people. This questionnaire has been designed to evaluate the existing programs in the process of rehabilitation of addicts. It is not an examination and therefore there is no wrong or correct answer. All responses are valuable. The information you give will be treated with utmost confidence and will not be used in any way against you or against the centre. Once you have filled in the answers the researcher will take the questionnaire away. Your honesty and frankness in answering the questionnaire will be greatly appreciated by the researcher. Please feel free to answer the questions.

INSTRUCTIONS

1. Kindly do not write your name.
2. Read the questions and any accompanying instruction carefully before you answer.

INTRODUCTION

PART A: PERSONAL DATA FOR RESPONDENT

1) Please indicate your gender by ticking the correct one.

   Male [ ]　　　b) Female [ ]

2) What is your age bracket?

a)15-25 [ ] b) 26-35 [ ] c) 36-45 [ ]

d) 46-55 [ ] d} 56 and above [ ]

3) Religion:

Christian [ ] Muslim [ ] Hindhu [ ] Other specify-------------

4) How did you first come to the centre?

a) Brought myself. [ ]

b) Referred by doctor [ ]

c) Referred by friend [ ]

d) Referred by family [ ]

e) Other. [ ] Specify---------------------

5) Have you ever been to another rehabilitation centre before?

Yes [ ] No [ ]

6) For how long have you been in this rehabilitation centre?

a) Between 0-8 months [ ] b) Between 2-4 months [ ]

c) 5-7months [ ] d) more than 8 months [ ]

PART B :COUNSELING NEEDS OF RECOVERING ADDICTS.

Use the following classification to tick what describes your situation best.

SA – Strongly Agree A – Agree N – Not Sure D – Disagree SD–Strongly Disagree

		SA	A	N	D	SD
1.	My alcohol/drug dependence problem really bothers me					
2.	I have poor time management					
3.	I have low self esteem					
4.	I have difficulties relating with family members					
5.	***Feelings of anxiety usually disturb me***					
6.	I have feelings of no hope in life					
7.	I have excessive feelings of shame					
8.	I usually have no appetite					
9.	I often fall sick					
10.	I have difficulty falling asleep at night					
11.	I have problems relating with my peers					
12.	I am disturbed that my family seem not to understand me					
13.	I have a problem managing my anger					
14.	Marital conflicts in my marriage usually bother me					
15.	I have a problem managing my finances					
16.	I have a problem quitting drugs and alcohol					

Do you have any other problem not mentioned above. Specify---------------------------

----

Mention the needs being given more attention than the others in your center.

C) SERVICES OFFERED AT THE CENTER

1. What activities are you are you involved in at the centre during treatment?

   (You can tick more than one if it is applicable).

- Reading [ ]
- Recreation activities. E.g. games, watching T.V [ ]
- Cleaning the centre and cooking [ ]
- Praying and going to church [ ]
- Any other specify...

D) RATING OF FACILITIES AVAILABLE

What is your rating of the following facilities? Use the following classification in your rating.

1 Excellent 2 Good 3 Average 4 Inadequate

a) Physical facilities	1	2	3	4
Housing and accommodation				
Environment / surrounding				
Food				
b) Handling by staff				
c) Rules and regulations				

d) What is your rating of the counselling services received at your centre in the following areas.

Recovering techniques	1	2	3	4
a) Increasing client's acceptance of responsibility for change				

b) Increasing clients confidence in their abilities to cope with situations without using substances				
c) Helping clients to understand that recovery is a lifelong process requiring the help of others				
d) Helping clients to plan and rehearse new ways of coping with high risk situations				
E} Helping clients and their families to develop better communication and coping skill				
f) Helping clients to develop new goals and make broad lifestyle changes				
g) Exposing clients to successful role models who are overcoming their own drug problems				
h) Helping clients to improve relationship with others				
I) Giving client's the chance to feedback reactions to the treatment interventions.				

What would you say about relapse rate in those who have undergone treatment at the centre?

Extremely low ( ) Low ( ) Average ( )

High ( ) Extremely High ( )

E) ASPECTS OF THE PROGRAM THAT CAN BE IMPROVED

1. Is the centre addressing your problems? Yes [ ] No [ ]

b). Is duration of treatment sufficient for recovery? Yes [ ] No[ ]

If No. What length of time is sufficient for treatment according to you

3. Are there some aspects of the program that could be intensified?

Yes [ ] No [ ]

4. Give THREE suggestions on what can be done to improve the program

....

....

Thank you for taking your time to answer the questions.

APPENDIX III

COUNSELOR QUESTIONNAIRE

Dear respondent,

I am a student in the Educational Administration and Planning University of Nairobi, carrying out a research on the rehabilitation program of alcohol/ drug users in Mombasa as part of my educational program. I will very much appreciate if you could spare some few minutes of your busy schedule to complete this questionnaire. Your response to all questions will be kept confidential. Do not therefore write your name anywhere in this questionnaire. Your participation is voluntary.

PART ONE: Counsellors requirements and Satisfaction

Evaluation of counsellor selection training and support

1. Type of centre-(Tick as appropriate) Inpatient [ ] Outpatient [ ]

2. What is your background?

(Tick appropriately)

- Nurse [ ] Clinical officer [ ]
- Non recovery staff [ ] Social worker [ ]
- Have resolved/recovered or recovering from substance abuse [ ]
- Other Specify----------------------------

3. For how long have you been involved in rehabilitation of drug/ alcohol addicts?

....

....

Selection

4. How were you selected to be a counsellor?

- Proposed by senior colleague [ ]
- Self motivated (expand) [ ]
- Other (Specify)---------------------------

5. Do you feel that you have been pressurized into doing counselling? (explain)

....

....

Training.

6. Describe the counselling training you have received?

....

....

7. How would you rate your counselling training?

   Very good [ ] Good [ ] Adequate [ ] Inadequate [ ]

8. Give reasons why you decided to train as a counsellor

   a) Concerned about the impact of drug abuse [ ]

   b) Following personal experience [ ]

   c) Have friends, relative affected. [ ]

   d) Recovered or recovering from an alcohol/drug problem. [ ]

e) Other specify...

9. Is counselling something you feel comfortable doing or, do you have to do it as part of your job?

....

....

10. Are there any areas in which you feel you need more training

....

....

11. Have you had follow –up or ongoing training?

Yes [ ] NO [ ]

If YES, describe it

....

....

Support and Supervision

12. Do you attend a counsellor support group?

Yes [ ] No [ ]

If yes, in what way is the group helpful or not helpful?

....

....

If No, in what ways do you think you would benefit (or not benefit) from a support group?

....

....

13. Do you have access to a designated counselling supervisor to provide you with support and technical back up? Yes [ ] No[ ]

If yes who provides

a) Support --

b) Supervision --

"Burn Out"

14. Please indicate how you feel about the following statements by ticking the number which describes it best.

1=Always	2=Often	3=Occasionally	4=Never

"I feel emotionally drained by my work"	1 2 3 4
"My work is very stressful"	1 2 3 4
"Working in the addiction field is a rewarding experience"	1 2 3 4

PART TWO: SERVICES PROVIDED AT THE CENTER

Privacy

1. Do you have adequate space to ensure counselling sessions can be private?

Yes [ ] No [ ]

2. What type of space do you have?

A) Private Office [ ] B)Cubicle[ ] C) Curtained off area [ ]

Others

specify...

Confidentiality

3. Does the centre have a written policy on confidentiality?

Yes[ ] No[ ]

4. Describe the steps that have been taken to ensure confidentiality.

....

....

Services for special and vulnerable groups.

5. Do you have special services for any of the following groups?

Women. Yes-------- No---------

Young people. Yes--------No---------

Families. Yes-------No----------

Older Adults Yes--------- No---------

Group counselling

6. Is group counselling carried out at the centre?

Yes [ ] No [ ]-

If Yes, How many people on average, per group?--

How many group counselling sessions per week?--

Individual counselling

7. Is individual counselling carried out? Yes--------- No---------

If Yes, How many sessions per week per person?--

PART THREE: RATING OF FACILITIES AT THE CENTER

1. What is your rating of the services given at the centre. Use the following classification in your rating.

1. Excellent 2 Good 3 Average 4. Inadequate

	1	2	3	4
Housing and accommodation				
Environment/ surrounding				
Food				
Rules and regulations				
Follow up services at the centre				
Counsellor/client relationship at the centre?				

2. Is duration for treatment sufficient for recovery? Yes [ ] No [ ]

If No Specify the adequate time

....

....

Views on client treatment

3. Do you use the 12 step program? Yes [ ] No [ ]

4. What would you say about relapse rate at the centre?

Extremely low ( ) Low ( ) Average ( ) High ( )

Extremely high ( )

PART FOUR: CHALLENGES FACED BY COUNSELORS

From your experience what are the challenges of the rehabilitation of addicts?

....

How can the challenges be addressed?

....

Thank you very much for taking your time to respond to the questions.

APPENDIX IV: LETTER OF AUTHORIZATION

REPUBLIC OF KENYA

NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

Telephone 254-020-2213471, 2241349
254-020-310571, 2213123, 2219420
Fax 254-020-318245, 318249
When replying please quote
secretary@ncst.go.ke

P.O. Box 30623-00100
NAIROBI-KENYA
Website: www.ncst.go.ke

Our Ref: **NCST/RCD/14/012/1019**

Date: **11th June, 2012**

Angela Mapenzi Kilonzo
University of Nairobi
P.O BOX 30197-00100
NAIROBI

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on "***Influence of the implementation of the curriculum on drug addicts in drug rehabilitation centres in Mombasa County, Kenya***" I am pleased to inform you that you have been authorized to undertake research in **Coast Province** for a period ending ***30th August, 2012.***

You are advised to report to **the District Commissioner, the District Education Officer, Mombasa District before** embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

DR.M.K.RUGUTT, PhD, HSC
DEPUTY COUNCIL SECRETARY

Copy to:

The District Commissioner
The District Education Officer
Mombasa District

APPENDIX V: RESEARCH PERMIT

PAGE 2

THIS IS TO CERTIFY THAT:
Prof./Dr./Mr./Mrs./Miss/Institution
Angela Maponzi Kilonzo
Of (Address) University of Nairobi
P.O BOX 30197-00100
NAIROBI
Has been permitted to conduct research in

Location
Mombasa District
Coast Province

On the topic: Influence of the implementation of The curriculum on drug addicts in drug rehabilitation centers in Mombasa County, Kenya

For a period ending: 30th August *2012*

PAGE 3
Research Permit No. *NCST/RCD/14/012/1019*
Date of issue *11th June 2012*
Fee received *KSH.1000*

Applicant's Signature

Secretary
National Council for
Science and Technology

CONDITIONS

1. You must report to the District Commissioner and the District Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit
2. Government Officers will not be interviewed with-out prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two(2) four(4) bound copies of your final report for Kenyans and non-Kenyans respectively.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice

GPK6055t3mt10/2011

REPUBLIC OF KENYA

RESEARCH CLEARANCE PERMIT

(CONDITIONS–see back page)