

**FACTORS HINDERING TREATMENT OF DRUG  
ABUSERS IN SELECTED DRUG TREATMENT AND  
REHABILITATION  
CENTERS IN NAIROBI PROVINCE, KENYA**

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## DECLARATION

This thesis is my original work and has not been presented for a degree in any other University or any other award in any other university

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## **DEDICATION**

I dedicate this thesis to my beloved late husband; Mario Nyaga, my loving son; Domenic Muriithi and my loving daughter; Ivy Muthoni.

## **ACKNOWLEDGEMENT**

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## TABLE OF CONTENTS

Declaration.....	.ii
Dedication.....	iii
Acknowledgement.....	iv
Table of contents.....	v
List of tables.....	ix
List of figures.....	x
Acronyms and abbreviations.....	xi
Abstract.....	xii

### CHAPTER ONE: INTRODUCTION

1.1	Background to the study.....	1
1.2	Statement of the problem.....	5
1.3	Purpose of the study.....	7
1.4	Objectives.....	7
1.5	Research questions.....	7
1.6	Significance of the study.....	8
1.7	Assumptions.....	9
1.8	Delimitations and limitations.....	9
1.9	Theoretical framework.....	9
	1.9.1 Social learning theory.....	10
	1.9.2 Psychometric theory.....	11
1.10	Operational definition of terms.....	13

## **CHAPTER TWO: LITERATURE REVIEW**

2.0	Introduction.....	15
2.1	Overview of treatment modalities.....	15
2.2	Previous studies on factors hindering treatment drug abusers.....	18
	2.2.1 Need for qualified personnel's.....	18
	2.2.2 Lack of medical drugs in treatment centers.....	19
	2.2.3 Patients failure to adhere to prescribed treatment.....	20
	2.2.4 Lack of after care services.....	21
	2.2.5 Availability of psychoactive drugs in the society.....	22
	2.2.6 Lack of co-operation from the wider community in treatment services.....	23
	2.2.7 Lack of training in vocational and life skills.....	24
2.3	Other factors affecting treatment of drug abusers.....	26
	2.3.1 Age of the drug abuser and type of drug abused.....	26
	2.3.2 Gender and treatment of drug abusers.....	27
2.4	Summary.....	29

## **CHAPTER THREE: METHODOLOGY**

3.0	Introduction.....	30
3.1	Research Design.....	30
3.2	Variables.....	30
3.3	Location of the study.....	31
3.4	Target population.....	31

3.5	Sampling techniques and sample size	
3.5.1	Sampling techniques.....	31
3.5.2	Sample size .....	32
3.6	Research instrument.....	32
3.7	Pilot study.....	33
3.7.1	Validity of the study instrument.....	33
3.7.2	Reliability of the study instrument.....	34
3.8	Data collection technique.....	34
3.9	Logistical and ethical considerations.....	35

#### **CHAPTER FOUR: DATA ANALYSIS, RESULTS AND DISCUSSION**

4.0	Introduction.....	36
4.1	Methods of data analysis.....	36
4.2	Background information of respondents.....	36
4.3	Specific factors hindering treatment of drug abusers in rehabilitation centers in Nairobi.....	40
4.4	Similarities and differences existing among the problems experienced in the drug rehabilitation centre.....	43
4.5	Perception on the influence of the types of the drug abused and treatment offered.....	50
4.6	Treatment modalities used in treatment of drug abusers in the rehabilitation centers .....	52
4.7	Perception of treatment offering personnel on the relationship	

between treatment of drug abusers, age and sex..... 55

**CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS**

5.0 Introduction ..... 59

5.1 Summary..... 59

5.2 Implications of the findings..... 60

5.3 Conclusion ..... 60

5.4 Recommendations ..... 61

5.5 Further Research..... 62

REFERENCES ..... 63

APPENDIX..... 66

## LIST OF TABLES

3.1	Sample size.....	32
4.1	Treatment centers and their location.....	37
4.2	Treatment offering personnel's professional qualifications.....	38
4.3	Factors hindering treatment of drug abusers.....	40
4.4	Problems experienced by rehabilitation centers .....	44
4.5	Supportive services offered to clients.....	48
4.6	Respondents perception on nature of drugs abused and treatment given to the abuser.....	50
4.7	Treatment modalities in the rehabilitation centers.....	52
4.8	Respondent's perception on sex and treatment given.....	55

## LIST OF FIGURES

4.1: Location of centers.....	37
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## **ABBREVIATIONS AND ACRONYMS**

- UN** - United Nations
- NIDA** - National Institute on Drug Abuse
- NACADA** - National Agency for the Campaign Against Drug Abuse
- PSTD** - Post Traumatic Stress Disorder

## **ABSTRACT**

The Government of Kenya and NGOs have put a lot of effort in treatment of drug abuse and dependence yet there is an increase in demand for psychoactive drugs in the country. The study was carried out to investigate factors hindering treatment of drug abusers in drug rehabilitation centers in Nairobi province. Referred literature was reviewed on factors hindering treatment of drug abusers in Kenya and other parts of the world. Quantitative research approach was used where survey research design was employed. The study targeted drug rehabilitation centers in Nairobi Province from which seven (7) rehabilitation centers were sample. Purposive and simple random sampling procedures were used to arrive at the sample size. Data was collected using a questionnaire designed for the treatment offering personnel in the centers. Data was analyzed and presented using frequency table and percentages. The data analyzed revealed that some of the factors hindering treatment of drug abusers included; lack of qualified treatment offering personnel, available of psychoactive drugs in the society, lack of community participation in the treatment services and that problems experienced were not similar in all the centers among others. The study recommended that more assistance from the relevant Government Ministry in terms of monetary services required to boost the activities of the rehabilitation centers. There is an urgent need for carrying out a research to assess the extent to which the current treatment modalities in drug rehabilitation centers are impacting on drug abusers.

## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1 Background to the Study**

Recently the problem of narcotics has assumed an increasingly serious and complex magnitude in the international context. Drug abuse has become a serious problem not only in developed countries such as United States and Europe, but in developing countries as well (UN 1987). Efforts by the countries concerned to curtail production of illicit drugs are yet to bring about any visible results. However, extensive efforts have been and continue to be made by governments at all levels to suppress the illicit production, trafficking and distribution of drugs.

The United Nations adopted guiding principles of demand reduction where a comprehensive strategy to reduce the demand for all substances of abuse was initiated. The principles were geared towards programmes which would be integrated to promote co-operation between all concerned, and should include a wide variety of appropriate interventions and to promote health and social well being among individuals, families and countries. It should reduce the adverse consequences of drug abuse for the individual and society as a whole.

In Kenya drug abuse among adolescents and young adults, which embrace secondary school and college students, has increased significantly. Little was known about hard drugs and their usage in Kenya in the 1960s and 1970s. However, there has been a consistent rise

in the usage of hard drugs by students particularly those in secondary schools. This reached a crescendo in the late 1980s.

Between 2001 and 2002, the National Agency for Campaign against Drug Abuse (NACADA) commissioned the first-ever national baseline survey on the abuse of alcohol and drugs in Kenya (NACADA 2004). Targeting the country's youth aged between 10 and 24 years, the survey brings together a great deal of information on substance abuse in the country that up till the survey was conducted had not been available. In the process, it provides benchmark information that:

- establishes the extent of substance abuse,
- Identifies types of substances abused,
- Outlines problems of substance abuse, and
- Explores available support while recommending interventions required to prevent or treat substance abuse.

Significantly, the survey observes that the use of alcohol, 'bhang' and 'miraa' has indigenous roots and that the three substances have been widely used in the indigenous society; there however exists no evidence that substance abuse has been part of indigenous heritage; indeed, the indigenous society for the most part regarded drunkenness as a disgrace

.

In light of this observation, the rapid spread of substance abuse can be traced to the breakdown of the indigenous society and to the introduction of foreign influences that have made a variety of substances available on a large scale. Ultimately, substance use by the

youth implies a breakdown of family values evident in the indigenous society. As a result, several parents have lost control over their children, and, freed from parental control, some children have succumbed to substance abuse.

The term 'drug' would mean "any substance that, when taken into a living organism, may modify one or more of its functions", while abuse' implies "a particular application of a drug more destructive than constructive to society, or the individual". One may be hooked emotionally and psychologically, and may have a physical dependence, where one has a drug addiction problem, whether to a legal or illegal drug, there is a craving for it. The individual wants to use the drug again and again, and if it is stopped, there are usually unpleasant physical reactions (Martin 1997).

While it is not everyone who uses drug that becomes addicted, many people do. Drug addiction involves compulsively seeking to use a substance, regardless of the potentially negative social, psychological and physical consequences. Certain drugs, such as narcotics and cocaine, are more likely to cause physical dependence, than other drugs are, (Amodeo, 2006).

The problem of substance abuse in the country is associated with the introduction of foreign styles of life that have been undermining cultures of the indigenous societies. On the whole, the culture restricted the use of some substances such as alcohol to senior age groups and to special occasions, often sanctioning the use of alcohol under strict conditions. The conditions spelt out that only elders could take alcohol, which could be consumed only during on occasion such as when a baby was born, after the harvest of

crops, and during funerals. This is no longer the case today: The consumption of alcohol is no longer restricted to senior age-groups or to special occasions. Instead, alcohol is readily available to adults and to youth between 10 and 24 years, that is, children, teenagers, and young adults—though the law prohibits its sale to and use by youth under the legal age. Not only does the youth consume alcohol but also uses drugs to the extent that the substances pose a danger to their health and ultimately, to the well-being of the nation.

There is therefore growing concern in the country over the growing numbers of young people—both female and male and both student and non-student using increasingly diverse types of substances that the law permits or prohibits. The substances law permits are miraa, some medicines used without curative need, alcohol, and tobacco; (the last two are the leading substances of abuse in the country). The law however prohibits the use of bhang and chang'aa that are produced in the country, as well as imported drugs such as cocaine and heroin that find their way into the country mainly on transit to Europe and North America (UN 1987).

The danger substance abuse poses to the country are apparent in behaviour that has resulted in violence and deaths in schools as well as in terms of people who have died as a result of drinking alcohol suspected to have been spiced with poisonous stuff—battery acid, jet fuel, methanol, or formaldehyde. In the event, it is necessary to urgently respond to substance abuse before it translates into a national disaster. Drug abuse has harmful effects on individual user, the family and the society. These effects include; violence, immorality, theft, accidents, and school dropouts. The economic standard of a country where drugs are

produced and consumed or in transit is affected, especially as a result of low output in terms of production at work (Githinji 1995).

For along time, victims of drug abuse have been considered as criminals and have been shunned by the society. This situation has not been helping the victim or the society. The problem of drug abuse has to be tackled in totality with an aim of helping the victims of drug abuse especially drug abusers who have a social and psychological problem. The researcher observed that the studies done by NACADA between 2001 and 2002 among other information established was on available support required to prevent or treat substance abuse but did not address factors hindering treatment of drug abusers in Kenya.

## **1.2 Statement of the problem**

According to UN (2000) treatment of drug abuse is seen as a comprehensive approach to identification, assistance, health care and social integration of persons presenting problems caused by any psychoactive substance used. Treatment should be aimed at reducing dependence on psychoactive substance to reduce the morbidity and mortality caused by, or associated with the use of psychoactive substances, and to ensure that users are able to maximize their physical, mental and social abilities and their access to services and opportunities and to achieve fully social integration.

Treatment is generally recognized as an essential component of a comprehensive demand reduction strategy. This is because in addition to helping individuals to reduce drug consumption, improve health status, reduce criminality and increase social functioning; treatment reduces drug abuse in an important segment of the population which in most

countries is responsible for the bulky of the consumption of the drugs. Therefore, if treatment is readily available and a high percentage of drug abusers receive it, it can have measurable effects on the overall demand for illicit drugs. With fewer drug abusers involved in the recruitment of new abusers prevalence of drug abuse is likely to decline.

For treatment to be an effective strategy, which has an overall impact on drug demand, it has to be effective in reducing drug consumption and a large number of drug dependant persons must have access to treatment so that the effectiveness is translated into an overall reduction with a measurable impact on the drug market.

There is sufficient evidence today that drug abuse and dependence are treatable conditions if treatment is available, accessible and attractive to drug abusers (UN 2000). Despite the prevention and treatment efforts by the government and NGOs there is a growing drug abuse problem in Kenya. Mwenesi (1985) noted that, there are very few drug abusers, who avail themselves for treatment. He also noted that there is a steady upward trend in abuse of cannabis and heroin in the country. Reports on drug seizures by Anti-narcotic unit today indicate that drug market is growing despite treatment efforts.

This is a clear indication that treatment of drug abusers is not yielding the expected results and thus could suggest there are factors hindering treatment of drug abusers in the country. It was in view of the above that this study aimed at investigating factors that could be hindering treatment of drug abusers in Nairobi Province.

### **1.3 Purpose of the Study**

The purpose of this study was to identify the specific factors hindering the treatment of drug abusers in drug rehabilitation Centers in Nairobi Province. The aim was to explore the opinions of the staff offering treatment regarding their perspectives on the factors that hinder treatment, rather than promote treatment of drug abusers in the selected drug rehabilitation Centers in Nairobi Province. Efforts were made to explore the extent to which these factors vary across the study Centers.

### **1.4 Objectives of the study**

This study aimed to fulfill the following objectives:

1. Identify specific factors hindering the treatment of drug abusers in rehabilitation centers in Nairobi.
2. Examine the similarities or differences of these problems across the rehabilitation centers in Nairobi.
3. Explore the perception of the treatment offering personnel on influence of the types of abused drugs and treatment offered in the rehabilitation centers in Nairobi.
4. Explore the treatment modalities employed in the drug rehabilitation centers.
5. Explore the perception of the treatment offering personnel on the extent of the factors such as age and sex of drug abuser influence to treatment given.

### **1.5 Research Questions**

Specifically, the study attempted to answer the following research questions:

- i) What are the specific factors hindering treatment of drug abusers in Nairobi Rehabilitation Centers?

- ii) What are the similarities and differences of the problems experienced by the centers under study?
- iii) What is the perception of the treatment offering personnel on the relationship between the nature of drug abused and treatment offered to drug abusers in the selected drug rehabilitation centers?
- iv) What kind of treatment modalities are used in treatment of drug abusers in the drug rehabilitation centers?
- v) What is the perception of the treatment offering personnel on the relationship between treatment of drug abusers and;
  - i. Sex
  - ii. Age

## **1.6 Significance of the Study**

This study was deemed significant in that it would help to highlight the factors that hinder treatment of drug abusers in drug rehabilitation centers in Nairobi, Kenya. The findings of the study will be beneficial to the following: - The treatment personnel in the rehabilitation centers such that, the findings would enlighten on the problems associated with treatment of drug abusers hence alert them on the appropriate treatment modalities depending on individual drug abuser.

Also the government policy makers may draw a lot of guidance from the findings since the results of the study would help them to identify where to direct their limited resources to improve the centers effectiveness, since drug abuse problems affects society as a whole.

## **1.7 Assumptions of the Study**

The study was based on the following assumptions;

- a) There were problems encountered by the sampled drug rehabilitation Centers in treatment of drug abusers.
- b) The administrators of the drug treatment centers and other treatment offering personnel would be willing to give honest and accurate information about their experience and knowledge of treatment of drug abusers.
- c) The researcher would find the targeted respondents in the centers and would be willing to provide the required information.

## **1.8 Delimitations and Limitations**

Due to time and financial constraints, the study was based on drug rehabilitation centers in Nairobi Province, Kenya and the factors hindering treatment of drug abusers. The study was not concerned with the administering of treatment but with exploring the reasons why treatment modalities were not yielding the expected results.

## **1.9 Theoretical framework**

Two theories were adopted for the study, namely, Social Learning Theory with Social Cognitive model and Psychoanalytic theory with the structural model. These theories help to explain that, treating psychological problems and interventions used are based on behavioral principles and psychodynamic principles reflecting different assumptions about nature of substance abuse and the recovery process. Behavioral treatment postulates that substance abuse is the result of maladaptive learning and the recovery involves unlearning patterns of behaviour that contribute to persistent substance abuse. In contrast,

psychodynamic treatments are based on the assumption that substance abuse is a symptom of childhood conflicts to be resolved by moulding or changing the behaviour that has been labeled socially deviant.

### **1.9.1 Social Learning Theory**

This theory was developed by Albert Bandura to show how people learn or unlearn certain behaviours. Negative reinforcement, which can extinguish maladaptive behaviour, places limits on self destruction behaviour (Bandura, 1977). He also noted that motivation is primarily concerned with how behaviour is activated and maintained. Some instigators arise from the stimulation of environmental events and bodily conditions. People are moved to actions by various types of aversive external stimuli. A great deal of human behaviour, however, is initiated and sustained over a long period in the absence of compelling immediate external stimulation. In this instance, the inducement to action is rooted in cognitive activities. The capacity to represent future consequences in thought provides a cognitive best source of motivation. Cognitive representations of future outcomes functions as current motivators of behaviours. Many of the things we do are designed to gain anticipated benefits and future difficulties. Reinforcement operations affect behaviour largely by creating expectations that conditional behaviour will produce desired outcome.

Cognitively based sources of motivation operate through the intervening influences of goal setting and self regulated reinforcement. When individuals commit themselves to explicit goals, perceived negative discrepancies between what they do and what they seek to achieve create dissatisfaction that serve as motivational inducements for change.

In this view of social learning theory, psychological change can be recognized as mediated through cognitive processes, but the cognitive events are induced and altered most readily by experiences arising from successive performance. Psychological procedures whatever their form, alter expectations of personal efficiency.

This social cognitive model can apply to this study because it deals with factors hindering treatment of drug abusers whereby they have psychological problems that need a change of behaviour, which would be brought about by collective learning experiences. Cognitive based source of motivation would help the drug abusers have a goal, which would stop drug abuse and this would require regulated reinforcement towards behaviour change or drug abuse, that is unlearning the undesirable behaviour.

### **1.9.2 Psychoanalytic Theory**

This theory was developed by Sigmund Freud (1856 – 1939) for the purpose of treating neuroses-using hypnosis. It states that behaviours and attitude of a person may depend upon emotional factors which he/she is unaware and that these must be traced back to their unconscious motivation (Smith and Velter, 1982). There are forces within the personality which fight change and champion the status quo. The individual offers ID resistance by refusing to give up primitive and infertile satisfaction. These forces defend the personality against the recognition of painful targets, perceptions and memories. The theory suggests that behaviour problems develop over a long period of time and is rooted in the unconscious. The person may be having good intentions to modify his behaviours, but the unconscious forces mitigate against the progress (Herbert, 1975).

Success or enhanced psychosocial functioning might be impeded by irrational guilt, other people cannot modify their behaviour because certain infertile wishes seek constant gratification and other people may not accept assertiveness and spontaneity that are necessary for mature functioning. This theory applied to this study shows that the treatment should allow the patient to become consciously aware of his or her motives, thereby strengthening the ego, modifying the structure of personality and changing the disturbing behaviour patterns.

Drug abusers have psychosocial problem, which develops over a long time and is rooted in the unconscious. Those people who present themselves for treatment have the intention to modify maladaptive behaviours but the unconscious forces inhibit the progress of treatment. This shows that treatment of drug abusers encounters problems because it not only involves treating the maladaptive behaviours (drug abuse) but also improving social functioning and productivity of drug abusers. This theory helps the drug abusers to understand and eventually give his/her resistance (Herbert 1975).

The indulging assumption for both theories discussed above is that learning processes plays an important role in the development and continuation of abuse and dependence. Therefore, treatment is aimed at altering the outcome and expectancies of drug related behaviours through the development of coping strategies which will then allow positive reinforcement to arrive from non-drug related activities.

Theories adopted for the study are important because they attempt to explain why, perhaps, treatment of drug abusers does not yield the expected results despite efforts put in by the treatment centers. They help to explore factors that hinder treatment of drug abusers which is a major concern of the study. To help addicts attain drug free life depends much on the reasons for taking drugs and the motivation to stop.

### **1.10 Operational Definition of Terms**

In this study the following terms were used as defined below:

**Drug Abuser:** This refers to a person who uses unacceptable drug and excessively or inappropriately uses acceptable drugs so that physical or psychological harm results.

**Drug:** A substance that directly affects the brain or nervous system. It is any chemical substance which affects bodily function, mood, consciousness and which has a potential for misuse and may be harmful to the individual or society.

**Drug Rehabilitation Centers:** These are centers that try to make drug abusers able to live a healthy, useful or active life again by giving medical treatment and imparting necessary life skills that enable them to function normally.

**Life Skills:** Refers to abilities for positive behaviour that enables the Individual to deal effectively with the demand and challenges of everyday life. Such skills include self-awareness, self-esteem and assertiveness.

**Psychoactive Drugs:** These are chemical substances that alter mood, perception, or Consciousness. For example alcohol, marijuana, stimulants, sedatives, Opiates, hallucinogens and inhalants

**Relapse:** Refers to the drug abuser returning to drug abuse after years of abstinence.

**Treatment:** Any process that focuses on helping individuals with drug related problems.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.0 Introduction**

The purpose of the chapter was to review some literature related to treatment of drug abusers. The chapter looked at the treatment modalities employed by drug rehabilitation centers and studies previously done on factors hindering treatment of drug abusers.

#### **2.1 Overview of treatment modalities**

Treatment for drug abusers varies according to the activities and strategies used to relieve symptoms and induce change (UN, 2000). Types of treatment offered are distinguished by their underlying philosophies, goals intended, target groups and by setting in which they are provided, that is outreach, outpatient or residential. Many agencies that provide treatment for drug abusers offer two or more modalities of treatment. They include detoxification, pharmacological, psychological/counseling interventions, and therapeutic communities and also provide rehabilitation, relapse prevention, after care services, and twelve steps (Ashrey, 1985 and Barber 1995). However, studies have shown that treatment is influenced by type of drug abused, type of the program undertaken and time span between initiation of drug use and treatment. A national treatment study in the UK conducted in the late 1990's among 1,075 patients (UN 2000) showed that people in residential treatment showed better results for curbing heroine abuse than those in outpatient programs. Amodeo (2006) observed that drug addiction is typically a chronic disorder characterized by occasional relapses and one time treatment often is not sufficient

and no single treatment approach is appropriate for all individuals and therefore, it is necessary to apply a variety of interventions since the type of treatment needed is based on the severity of the problem.

A study developed by Drug Abuse Reporting Program (DARP) UN (1989) studied 44,000 Clients admitted to 139 programs in USA in 1990's and the results indicated improvements notably in regard to heroine. The study further revealed that the longer the clients stayed in treatment the better the results. Clients staying less than three months in treatment generally did worse than those who remained longer in treatment. Drop outs faired worse than people who remained on treatment. Early engagement in treatment was associated with high levels of poor treatment abstinence. Therefore long term residential treatment programs seemed to achieve the best results.

A survey by Drug Strategies (2001) revealed that early interventions provide immediate assistance and substantially reduce use of drugs. It is also less costly than making treatment available only after individuals develop addiction. It was also noted that types of drug abused tend to vary with age e.g. bhang and alcohol are most prevalent among clients under 18 while cocaine is associated with elder clients. although treatment is required as essential component of comprehensive demand reduction strategy on drugs, most developing countries the number of drug addicts being given access to treatment services are very small indicating the need to strengthen and expand the treatment infrastructure. It was also noted that not all drug abusers seek treatment, and those that do, tend to do so rather late in their drug abuse practice and most countries lack an appropriate treatment infrastructure which reduces chances of success (UN 2000).

Oakley and Ksir (1999) observed that treatment systems need to be planned and developed in many parts of the world. This would take account of assessed local needs, the appropriate social context and current scientific knowledge. Treatment services need to be broader in scope and available for all groups in need. Treatment options should be diversified and coordinated with other services in order to respond to the different needs and characteristics of drug abusers. Client's own perspectives and experiences of treatment need to be better understood and taken into account in the design of treatment systems. From the above studies, the researcher realized there was need to find out if the same factors discussed above influence treatment modalities in rehabilitation centers in Nairobi and to what extent. It was important for this research to establish treatment modalities applied in the residential treatment offering drug rehabilitation centers in Nairobi. This aimed at finding what similarities and differences in the treatment modalities offered in the study centers.

## **2.2 Previous studies on factors hindering treatment of drug abusers**

Previous studies have revealed that the following factors influence treatment of drug abusers:

### **2.2.1 Need for qualified personnel**

Miller (1976) noted that the improvements in diagnostic measures and sophistication of analytical techniques mark a major advance in the drug abuse field. Through the testing, standardization, and utilization of diagnostic tools, investigators and clinicians are able to identify patients suffering severe depression because they require special treatment

instruments such as the addiction severity index (ASI) enables programmes to obtain better description of patients subtypes .An instrument such as this can easily be administered and secured by a technician. This shows that there is great need for trained personnel in the treatment centers of drug abusers.

In addition, current client/treatment matching is necessary to ensure that the treatment administered is appropriate to clients' needs. The matching of client to treatment is an important step forward in reducing treatment failures and budgetary waste. This indicates that qualified personnel to handle drug abusers are necessary. More over, studies have shown that the patients receiving professional psychotherapy did better than those receiving counseling from non-professionals. Fox (1977) noted that treatment should follow standard patterns in therapy that includes exploration, confrontation, explanation and termination of behaviour this calls for adapted treatment modalities that are comprehensive which encompass; detoxification, pharmacological, psychological/counseling, therapeutic communities, rehabilitation, relapse prevention and after care services. Although Resource Links (2003) noted that no single treatment works for all addicted persons, he adds that treatment for addiction to any substance must include a variety of options. Ronald (1999) noted that addiction treatment providers have resisted attempts to standardize treatment and thus standardize ways in which results of treatment can be measured. He said further that those who seek addiction treatment in the country need to know it is consisted throughout the country that is in both public and private institutions.

Miller (1976) and Ashery (1985) observed that drug abuse treatment could be improved by the addition of competent professional psychotherapists. In Kenya, studies by UN (2000)

acknowledged that the treatment of drug abusers is offered by people who are trained in other fields including medical doctors, nurses, psychiatrists, social workers and not professionals specially trained to handle drug abusers or those who have pursued training in addiction and substance abuse. These non-specialists find the treatment of drug abusers to be very difficult and it was also noted that drug abusers were admitted together with other mentally ill patients in the same wards. This clearly shown that appropriate services were not given to drug abusers and this could hinder treatment of drug abusers. Amedeo (2006) noted that professionals, particularly those who specialize in substance use disorders, were an important asset during treatment and especially during time of relapse. They help the individual learn techniques for containing feelings, focusing on present and making use of support from others.

### **2.2.2 Lack of medicinal drugs in treatment centers**

Miller (1976) noted that medical drugs were required to treat those on opiates, alcohol, barbiturates and cocaine as those often need to be hospitalized because of side effects from detoxification and painful withdrawal symptoms. He acknowledged that ant abuse, anti depressants, habituates or sedatives and tranquillizers are used for withdrawal, support and maintenance of those patients willing to abstain from drug abuse. Although it has been evidenced that successful outcome is enhanced when a series of ancillary services are offered to patients such as counseling, Mwenesi (1995) noted that treatment provided to patients in Kenya depended on drug abused, the state of the patients and what is available in the clinic, hospital or institution. In his study he also indicated that heroin, alcohol, cocaine, LSD and valium (tranquillizers) were mostly abused in Nairobi. Again resource

links (2003) acknowledged that medication in conjunction with other treatments could be prescribed for mood stabilization, depression, anxiety, post-traumatic stress and psychosis. An addicted person, who carries a dual diagnosis such as post-traumatic stress disorders (PTSD), is likely to experience more anxiety and emotional disturbance as they withdraw and become sober. It was also noted that women due to a greater occurrence of particular traumas in their histories often suffer from PTSD and find becoming sober distressing. Thus addressing all regions of the person's life, such as gender and history of abuse, is necessary in treatment in order to identify the right medical drugs. Amedeo (2006) observed that treatment addresses the individual's physical, psychological, emotional and social conditions and that a variety of scientifically based approaches are used which include behavior therapy and medication.

### **2.2.3 Patient's failure to adhere to prescribed treatment**

This is also a factor that hinders treatment. Miller (1976) found out that the inpatient psychiatric and hospital facilities tend to be more expensive to maintain drug clients in treatment for long periods of time. Consequently, most of these inpatient programmes had established referral networks in which after problems and need of patients had been diagnosed, clients were referred to outpatient facilities. This led the client not to be regularly engaged in therapy. In Kenya low-income earners, who are exposed to treatment services, sometimes do not cope with the charges, hence drop out rate is high (Mwenesi 1995). Others feel stigmatized to go to treatment centers offering therapy and this increases drop out rates (poley, 1979). Hart (1998) noted that treatment for addiction should be sustained to retain patient in continuing care for better results.

In addition, drug strategies (2001) noted that awareness of drug treatment options was fairly low and many were unsure of the accessibility of treatment and many thought treatment programs were either fairly difficult to find or not readily available. It was also noted that due to scarcity of treatment centers, the healthcare among both public and privately funded treatment providers had created a new emphasis on short term interventions, rather than sustained treatment for chronic addiction and thus affected the outcome of treatment. Amedeo (2006) found that although individual treatment outcome depend on the extent and nature of the patient presenting problems, their appropriateness of the treatment component and the related services used to address those problems, the degree of engagement of the patient in the treatment process is paramount. This is because the patient should be willing to accept help from treatment offering personnel and invest energy in working on recovery.

#### **2.2.4 Lack of aftercare services**

These services when available are critical phase for ultimate success for treatment. Former drug abusers often face severe problems of adoption when moving from the protected and well-structured environment of therapeutic community, back to normal life. There is considerable risk of facing a number of frustrations in process. Howard (1979) noted that drug abusers engaged in a treatment process usually need help, not only to acquire social vocational skills to be better prepared for the life outside, but also to establish or re-establish links with the community and to find accommodation and employment. Some programmes have alumni associates that assist discharged clients to establish themselves in the community, and these would draw on family members and friends to help in the process where possible. Also Aftercare service has the objective of preventing relapses and

to enhance social and psychological functioning. The services range from the occasional telephone contact with a therapist or case manager to regular individual or group meetings. Many refer clients to mutual aid groups for aftercare. UN (2001) noted that a number of early studies had shown positive relationship between involvement in continuing care and improved post-treatment functioning of people treated for drugs problems. There was need to find out if this was being done in drug rehabilitation centers in Nairobi or not. Fox (1977) observed that some programmers such as conventional or hospital based had no time for follow-up services. In Kenya institutions that consider aftercare follow-up as important, were handicapped by lack of funds .Some lack motor vehicles, funds to fuel vehicles available and most of their patients were inaccessible due to impassable roads. This made it difficult to prevent relapse and to enhance social and psychological functioning (Mwenesi, 1995).

#### **2.2.5 Availability of psychoactive drugs in the society**

Illicit drugs are worldwide problem and so are readily available in Kenya. A study conducted by Mwenesi (1995) with the help of United Nations International Drug Control Program (UNDCP) cited Western Kenya, South Nyanza and along Athi-River as areas where bhang was grown. In addition, every community had a type of beer that was locally brewed and abused. Gum and glue were easily obtained from the shops. Kenya has also been used as a transit country whereby drugs from the East pass through our major parts of entry such as Mombasa and Nairobi. Also night-clubs and discotheques are major points of drug distribution in Nairobi. This could pose problem to treatment because patients having completed their treatment program join others in the society where drugs are abundant, hence are tempted to go back to the old practice without feeling stigmatized. Presence of

drugs in the society contributes to relapse in treated drug abusers. It would be interesting to find out whether this presence of drugs in the society is a factor that affects treatment among centers to be studied.

#### **2.2.6 Lack of co-operation from the wider community in treatment services**

Githinji (1995) noted that drug abuse evokes feelings of threat to the society. People fear that drug abusers may cause damage. This is usually in reference to past damage that has been done by such abusers. This presumed damage might be to the family, social institution, places of work or to the people they may come across. This is reflected in the way many education institution expels treated drug abusers from school, others sacked by employers and others still perceived as criminals. This suggests that the community is not involved in the treatment and reintegration of the drug abuser. The society should help to enhance treated of drug abusers self-concept and self- efficacy. This will help them build a positive perception of themselves making it easy for them to adjust quickly to the society after treatment. The government should also be willing to subsidize the treatment of drug abusers so that many would afford to complete their treatment due to less cost.

Githinji (1995) also noted that the drug abusers require proper medical rehabilitation, education and vocational training. These are lacking because of funds to maintain these facilities and to run them. He further noted that counseling services were also necessary as well as social services for both the drug abuser and his/her family. When the community is not involved in the treatment of drug abusers, relapse was likely to occur. The community does not perceive the drug abusers positively even after treatment and this makes them have a negative self-concept about themselves and perceive themselves as they cannot

function normally in the society. Preventive Health Education (1991) noted that community has a role to play in preventing drug abuse. All the different groups that constitute a community can provide support by modifying attitudes, values, behaviors and skills of the former drug dependant persons in order to encourage transition to and maintain a drug free way of life. Providing the social support needed to establish drug dependant persons in the community is also very necessary.

### **2.2.7 Lack of training in vocational and life skills**

Treatment of drug abusers also encompasses vocational training to help acquire skills, which make them self-reliant. Addictive behavior (1997) views supportive services such as vocational training as vital for successful treatments of addicts. However, the availability of these services across programs varies.

Einstein (1990) suggested that the stronger emphasis on vocational services in residential treatment may help clients surmount obstacles to employment. An absence of adequate problem-solving skills exacerbates the stress and may result in failure for the ex-addicts. The loss of a job is clearly associated with relapse. It was noted that the onset of any drug use by a recovering addict was followed by the loss of a job and the start of dealing in illicit drugs.

Vocational rehabilitation is generally viewed as the most effective means of refocusing drug abusers towards the world of work and, subsequently, main stream society Einstein (1990). Rehabilitation typically includes assessment of individual's vocational needs, counseling, skills training, and job placement. A number of vocational rehabilitation

programs for addicted populations have been attempted. For example, supported employment, job placement, training in job-seeking skills, and employment readiness training but have been met with varying success.

According to Drug Strategies (2001) drug treatment programs needs to make a serious effort to provide vocational employment services, particularly in the light of the importance of employment in the social readjustment of addicts. It was noted that such services tend to be relatively non-existence in drug abuse clinics. Furthermore, staff members engaged in providing such services should have specific training in “what works” and should ideally provide services in accord with predetermined protocol that allows for identification of personal barriers to employment and provide for their remediation.

Einstein (1990) observes that entry into treatment and retention in treatment may have varying effects on employment. However, it should be realized that vocational or employment services, or both, do not generally appear to be readily available to clients of addiction treatment programs. Vocational and employment needs, in contrast to other services needs, are typically given low priority by the program.

In Kenya most treatment centers embark only on counseling and forego vocational training. Many also overlook the training in life skills such as training them to be assertive to be able to be firm and principled so as to say no to drugs as noted by Mwenesi (1985). This made relapse to be very prevalence with patients from these institutions.

## **2.3 Other factors affecting treatment of drug abusers**

### **2.3.1 Age of the drug abuser and type of drug abused**

Studies have established that age of the drug abuser influences the treatment administered to the patient. According to Storie (2005) treatment for various groups require a comprehensive approach that addresses their social, medical and psychological needs. He observed that treatment for adolescent psychoactive chemical dependents involved a highly structured and supportive environment that is equipped to address delinquent and anti-social behaviours. The chemical dependency in adolescents is most likely the consequence of the patient's fear and inadequacies. They would require empathy and compassion in conjunction with family therapy to achieve holistic treatment. It is also necessary to give social skills training to avoid destructive peer groups and behaviour in future.

He further noted that aging made the human body more vulnerable to the effects of psychoactive chemicals. The typical health risk associated with dependency is exacerbated in the elderly, leading to greater complications and/or more rapid dependence. The treatment would be addressing reasons for abusing drugs, the physical, psychological, and social consequences resulting from the dependence. This would allow the patient to receive appropriate medical attention while in treatment and increase his/her ability to cope with life. It was also important to note that treatment for the youth differed from that provided for adult populations. This was attributed to the fact that different drugs were popular with different populations. The youth would abuse alcohol, bhang and cigarettes as opposed to adults who would abuse mostly hard drugs such as cocaine heroin among others. This was because adult abusers could afford hard drugs unlike young people. The different drugs will have different effects in the individuals hence necessitating variations

in the treatment given (NIDA 2000). It was necessary for this study to find out if treatment given in the rehabilitation centers in Nairobi was dictated by the age of the abuser.

Psychoactive drug use for a long period would have serious effects on individual's life. NIDA (2000) argued that young adults who start using psychoactive drugs at an early age might lead to delayed normal development. Therefore the treatment given should be relevant to individual concerns, interests, and social activities and should be flexible enough to adapt to the clients developmental deficits. The longer the period one had abused psychoactive substances the more the abuser was affected and therefore, it would require treatment which was tailored to individual needs. The longer the period of abuse the severe the effects of the drugs abused and this then explains why the period of abuse would influence treatment.

A study by NIDA (2000) demonstrated that relapse rates for heroin addicts increased with time and that the probability of long run abstinence depended on the age of the first drug abuse and period of abuse. Those who started daily heroin use at a younger age were more likely to relapse than those who started later. It was therefore, necessary for this study to find out if period of abuse was a factor considered when treating drug abusers in the rehabilitation centers under study.

### **2.3.2 Gender and treatment of drug abusers**

Studies by NIDA (2000) found out that gender differences play a role from the very earliest opportunity to use drugs. Women and men tend to abuse different drugs, that the effects of

drugs were different for women and men, and that some approaches to treatment were more successful for women than for men.

The study further observed that women and men were equally likely to become addicted to nicotine, yet women typically smoke cigarettes with lower nicotine content than those smoked by men, smoke fewer cigarettes per day and inhale less deeply than men. However, women were less successful than men in quitting smoking and had higher relapse rates after they did quite. This study also established that treatment involving nicotine replacement therapy works better for men than for women.

Inaba and Cohen (2004) in their studies discovered that women with substance addiction compared to men had more mental disorders i.e. depression, anxiety, eating disorders and post traumatic stress disorder and lower self-esteem. They had more difficulty with emotional problems and treatment should be tailored to addressing specific needs of a group. They also noted that the stigma attached to females who abused psychoactive drugs acts as a barrier to treatment.

Ehorre (1997) found out that overdrinking women were seen as inferior in contrast to their male counterparts and often in comparison to other women i.e. those who did not over drink and stereotypes also apply in official treatment settings, hence for some women treatment caused further damage. A study also done in the similar area by Storie (2005) suggested that the onset of psychoactive chemical dependence was very rapid for women than in men, even with comparable usage. He noted that women success during treatment

comes when they had support from their families and friends. However, women felt more comfortable participating in the same gender support groups as opposed to group therapy with men and women. He also observed that traumatizing situations in a women's life such as sexual and physical abuse could cause low self esteem and feelings of powerlessness leading to psychoactive use. He recommends that the person treating should approach them with sensitivity, being careful to progress at a comfortable pace. All of the above shows that various treatment modalities were also dictated by the period of abuse, nature of drug abused, age and sex of the abuser. It is important for this study to find out whether these factors were considered while treating drug abusers in drug rehabilitation centers in Nairobi Province.

#### **2.4 Summary**

Most of the above studies revealed that treatment of drug addicts was not yielding the expected results despite efforts made in the treatment. Most studies show some treatment programs were inadequate in the services they give to their clients hence not getting the expected results and attributed their weakness to the personnel offering treatment, nature of the disease being treatment and the institution offering the treatment. Other studies indicated type of drug abused, period of abuse, sex and age of the abuser influenced treatment given.

It would be of interest to find out how the current study could confirm or refute these findings besides establishing the major problems hindering treatment of drug abusers in Nairobi Centers.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.0 Introduction**

The chapter described the kind of the research design used and location of the study. It also described target population, sampling technique and sample size, research instrument, piloting of the research instrument, data collection techniques and logistical and ethical considerations.

#### **3.1 Research Design**

The study design selected was descriptive survey method. It was chosen because it involved collecting data in order to answer research questions concerning the current status of the subject of the study. It was also used to assess attitudes and opinions about events, individuals or procedures (Gay, 1992; Kerlinger, 1973; Goodwin, 1995 and Coolican, 1994). In that regard, it enabled the researcher to obtain treatment offering personnel's opinion about the factors hindering treatment of drug abusers in drug rehabilitation centers in Kenya. In addition, descriptive survey method was used to obtain quantitative data regarding rehabilitation environment which drug abusers were treated in. The independent variables of this study were age, sex, time spent in abusing drugs, type of drugs abused, type of treatment given and category of the drug rehabilitation centre.

#### **3.2 Variables**

The independent variables of the study were sex, age category of the rehabilitation centre and type of drug abused. The dependent variable was treatment given to drug abusers.

### **3.3 Location of the study**

The study was conducted in drug rehabilitation centers in Nairobi province. Nairobi province is within the urban setting and its population had a higher chance of interacting with the outside world hence influence in drug abuse was prevalent.

### **3.4 Target population**

The researcher targeted both inpatient and treatment offering personnel in all the drug rehabilitation centers in Nairobi Province. However, at the piloting stage the researcher realized the rehabilitation centers did not allow their patients to be interviewed. Therefore the target population resulted to be treatment offering personnel alone.

### **3.5 Sampling techniques & sample size**

#### **3.5.1 Sampling techniques**

Purposive sampling technique was used to select the seven drug rehabilitation centers in Nairobi Province since they were the only centers offering residential drug treatment in the province.

The same sampling technique was used to categories the centers into those within the hospitals and those without hospitals. These were as follows:

- (a) centers within hospitals; Mathari drug rehabilitation centre, Avenue Hospital & Chiromo Medical lane.
- (b) Those without hospitals; Asumbi Karen, Nairobi Place, Bright Side & Bestain Lavington.

### 3.5.2 Sample Size

Nairobi Province has 12 drug rehabilitation centers from which seven (7) centers that offered residential treatment to drug abusers were sampled for the study. Simple random sampling technique was used to select seven (7) respondents from each of the sampled rehabilitation centers leading to total of forty nine (49) respondents. The sample size was as shown in table 3.1 below.

**Table: 3.1 Sample Size**

Centre	Number of Personnel	Sample Size	Percentage
a] Within Hospital			
- Mathari Rehabilitation	18	7	14.3
- Avenue Hospital	15	7	14.3
- Chiromo Medical Lane	9	7	14.3
b] Without Hospital			
- Asumbi Karen	12	7	14.3
- Nairobi Place	10	7	14.3
- Bright Side	8	7	14.3
- Bustani Lavington	9	7	14.3
Total	81	49	100

### 3.6 Research Instrument

The Researcher intended to use a questionnaire and an interview schedule as tools for data collection for this study but the interview schedule which was meant for the inpatients was not used because the researcher never had access to the patients in all the centers. The researcher was able to use only the questionnaire with the treatment offering personnel. The Questionnaire was used to seek views from the treatment offering personnel. Items in the questionnaire sought information on major factors hindering treatment of drug abusers,

the extent to which these factors were related to the nature of drug abused, sex and age of the abuser. It tried also to explore ways and means by which these difficulties could be minimized. They also sought for recommendations of a more satisfactory strategy for subsequent treatment process, in working with drug abusers in the rehabilitation centers of the study. The researcher used direct method to distribute the Questionnaire to treatment offering personnel which was structured. This method enabled the researcher to clarify any question which was not understood and also gave the researcher a chance to explain what was required.

### **3.7 Pilot study**

The pre-testing of the questionnaire was done in two centers which were not involved in actual study. This helped reveal any flaws in the instrument that were then refined before the actual study. Pre-testing give an opportunity to improve the quality of the questionnaire items, reliability and validity of measures which was verified by the supervisors.

#### **3.7.1 Validity of the study instrument**

According to Orodho (2005) validity is the degree to which a test measures what it purports to be measuring. In order to identify and correct questionnaire problems, piloting was done in Sapta drug rehabilitation centre in Nairobi. Treatment offering personnel in the centre were requested to respond to all the items on the questionnaire, perhaps noting any items where the meaning was unclear or where information was not easily available. The respondents were also asked to suggest additional information that should be incorporated in the tool. The questionnaire was refined with assistance of the University supervisors.

### **3.7.2 Reliability of the study instrument**

The reliability of the instrument for the study was measured using test-retest method. That involved giving a questionnaire to a group of selected treatment offering personnel. Once the questionnaire was filled, the researcher scored manually. After a period of two weeks the same procedure was repeated. Comparison was made between the two scores obtained from administering the questionnaire first and second time. That was to ascertain the reliability of the questionnaire items since reliability was the consistency of a set of measurements or measuring instruments, (Gall O.; Gall P; & Borg 2003). Spearman rank order correlation was employed to compute the correlation coefficient which was established at 0.8 which was high hence judging the instrument to have high reliability.

### **3.8 Data Collection Technique**

The researcher visited the sampled rehabilitation centers and briefed the authorities on the purpose of the study. She thereafter distributed questionnaires directly to the respondents with the help of the administrators in the centers. The researcher gave detailed instructions to respondents before filling the questionnaires. However, some respondents suspected the research was being done by the government officials disguising themselves and despite reassurance of confidentiality of the information; the possibility of under reporting or over-reporting could not be completely overruled.

### **3.9 Logistical and ethical considerations**

The first step was to obtain a research permit from the Ministry of Education Science and Technology. This enabled the researcher to visit all the rehabilitation centers that were sampled for the study.

Before data collection exercise began, the researcher obtained a research permit from the Ministry of Education Science and Technology. The researcher then visited the sampled drug rehabilitation centers and informed the administrators of the nature of the research to be carried out. She also obtained consent from the respondents and guaranteed them anonymity and confidentiality. She also respected and informed the intended respondents that participation was voluntary and were free to withdraw if they felt uncomfortable with the study. The researcher then proceeded on and discussed appropriate time to meet with the respondents for data collection.

## **CHAPTER FOUR**

### **DATA ANALYSIS, RESULTS AND DISCUSSION**

#### **4.0 Introduction**

In this chapter, presentation and data analysis was done based on the research questions. The findings were discussed based on the major areas of the study. Those included drug abuse treatment modalities and factors hindering treatment of drug abusers. Findings were generated from quantitative data derived from questionnaires. The data was presented using frequency tables and charts where necessary.

#### **4.1 Methods of data analysis**

Data was analyzed using descriptive statistics that involved tabulating and describing data collected. Data analysis was done by computer using statistical software Statistical Package for Social Sciences (SPSS) which was useful for the quantitative data collected.

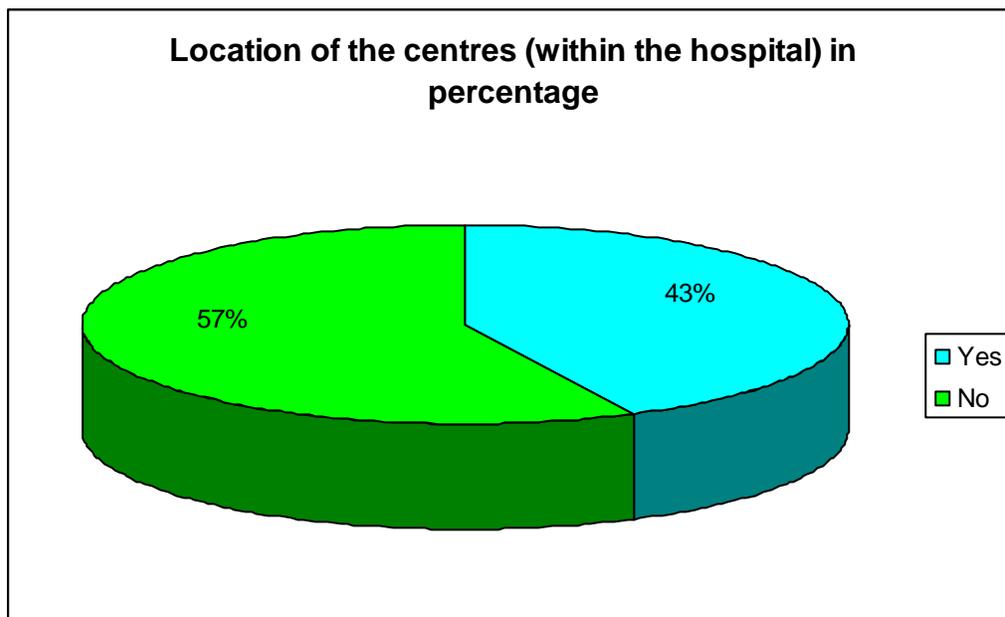
#### **4.2 Background Information of the Respondents**

The drug rehabilitation centers visited Asumbi Karen, Nairobi Place, Bright Side, Chiromo Medical Lane, Mathari drug rehabilitation, Bustani, and Avenue Hospital. The centers were all residential facilities but some located within hospitals and others without hospitals. Those within the hospitals were; Mathari Rehabilitation centre, Avenue Hospital and Chiromo Medical Lane. Those without hospitals were Asumbi Karen, Nairobi Place, Bustani and Brightside as represented in the table and figure below.

**Table 4.1: Treatment centers and their location**

Response	Within the hospital	Without the hospital	Percent per centre	Percent per location
Asumbi Treatment Center (Karen)		1	14.3	57
Nairobi Place		1	14.3	
Brightside Center		1	14.3	
Bustani Medical Center		1	14.3	
Chiromo Lane Medical Center	1		14.3	43
Mathari Rehab Center	1		14.3	
Avenue Hospital	1		14.3	
Total	3	4	100.0	100.0

**Figure 4.1 Location of centers**



The above figure shows that 57% of the centers (4 centers) were without the hospitals and 43% of the centers (3 Centers) were within the hospitals.

#### 4.2.1 Professional qualifications of the respondents

**Table 4.2 Treatment offering personnel's' professional qualifications**

Professional qualifications	Asumbi Treatment Center (Karen)		Nairobi Place		Brightside Center		Chiromo Lane Medical Center		Mathari Rehab Center		Bustani Medical Center		Avenue Hospital		TOTAL	
	freq	%	Freq	%	freq	%	freq	%	freq	%	freq	%	freq	%	freq	%
Higher diploma in counseling	1	2.04	1	2.04	1	2.04	0	0	0	0	0	0	0	0	3	6.12
EEG technician/ technician	4	8.16	4	8.16	3	6.12	4	8.16	1	2.04	3	6.12	3	6.12	22	44.9
Minor in chemical dependency	0	0	1	2.04	0	0	0	0	0	0	0	0	0	0	1	2.04
Clinical Officer	1	2.04	0	0	0	0	0	0	1	2.04	0	0	1	2.04	3	6.12
Marriage and family therapist, addiction counselor	0	0	1	2.04	0	0	0	0	0	0	0	0	0	0	1	2.04
Lab technician	0	0	0	0	1	2.04	0	0	0	0	1	2.04	0	0	2	4.08
Nurse	0	0	0	0	0	0	1	2.04	4	8.16	3	6.12	2	4.08	10	20.4
Pharmacy technician	0	0	0	0	0	0	1	2.04	0	0	0	0	0	0	1	2.04
Psychiatrist	0	0	0	0	0	0	0	0	1	2.04	0	0	1	2.04	2	4.08
No response	1	2.04	0	0	2	4.08	1	2.04	0	0	0	0	0	0	4	8.16
TOTAL	7	14.285	7	14.285	7	14.285	7	14.285	7	14.285	7	14.285	7	14.285	49	100

The respondents were asked to indicate their professional qualifications and (44.9%) of them reported being EEG technicians/ technicians, nurse 10 (20%), clinical officer and higher diploma in counseling reported by 3 (6.1%) each. Laboratory technicians and psychiatrists 2 (4.1%) each. Minor chemical dependency, pharmacy technicians and marriage and family therapists 1 (2%) each, and 4 (8.2%) of the respondents never responded to the question.

Studies by Miller (1976), Fox (1977) and Ashery (1985) observed that treatment for drug abusers depended much on trained professionals. Treatment should follow standard patterns in therapy that includes exploration, confrontation, explanation and termination of behavior. This could be achieved by competent professional treatment offering personnel in the centers.

UN (2000) in their studies noted that non-specialists in treatment of drug abusers find treatment of drug abusers to be very difficult. They also observed that right professional qualification in treatment of drug abusers ensures appropriate services to them. This study established that most treatment offering personnel were not trained in substance use disorder but in different fields related to medical treatment. Therefore majority did not have training focused on treatment of substance abuse. This could explain why the centers were experiencing difficulties while treating drug abusers. Amedeo (2006) noted that professionals, particularly those who specialize in substance use disorder were an important asset during treatment.

### 4.3 Specific factors hindering treatment of drug abusers in rehabilitation centers in Nairobi.

**Table 4.3 Factors hindering treatment of drug abusers**

<b>Responses</b>	<b>Frequency</b>	<b>Percentage</b>
Lack of community support	13	26.5
Few drug rehabilitation centers	11	22.4
Availability of psychoactive drugs in the society	10	20.4
Lack of medicinal drugs in the rehabilitation centers	8	16.3
Use of personnel drawn from other fields	7	14.4
<b>Total</b>	<b>49</b>	<b>100</b>

Medicinal drugs for treating multidimensional problems facing drug abusers are very essential, however, the study findings indicated that they were not available in all the centers.

Miller (1976) acknowledged that anti-abuse, anti-depressants, habitants sedatives and tranquillizers were used for withdrawal, support and maintenance of those partners willing to abstain from drug abuse. An addicted person has multiple problems and treatment should address the individual's physical, psychological, emotional and social conditions. A variety of scientifically based approaches are used which include behaviour therapy and medication (Amedeo 2006). Lack of medicinal drugs in drug rehabilitation centers as revealed by the above findings could be attributed to the fact that some drug treatment centers were located away from hospital and others within the hospital. Hence those centers in the hospitals could have reported availability of medicinal drugs in drug rehabilitation centers.

It is worth noting that majority of treatment offering personnel were aware of the importance of using experts from other related fields since drug abusers were treated for multi-dimensional problems as evidenced in table 4.2 on professional qualifications of the respondents. However, UN (2000) noted as much as other experts complement one another in the treatment of drug abusers, there was a dire need to have professionals specially trained to handle drug abusers/addiction. This was in line with Amodeo (2006) observation that professionals who specialized in the substance use disorders were an important asset during treatment. In view of the above the researcher was of the opinion that all the experts drawn from the related field should still be trained in substance use disorders or chemical dependency to be able to tackle the drug abuse problem in totality.

The study revealed availability of psychoactive drugs in the society was a problem. Mwenesi(1995) in his study established that psychoactive drugs were readily available in Kenya especially bhang which was grown in many parts of the country, and the fact that Kenya had been used as a transit country for drugs from the west through the major ports and towns. This posed a problem since the drug abusers treated might be tempted to go back to old practice of abusing drugs.

Howard (1979) noted that aftercare services have the objectives of preventing relapses and to enhance social and psychological functioning. However, Fox (1977) observed that some programmes such as conventional or hospital based have no time for follow up services. In addition, Mwenesi (1995) in his studies found that institutions in Kenya that considered aftercare follow up as vital were handicapped by lack of funds to effect the services and other centers had not yet started giving the services. This lack of continuity support for

most addicts to maintain a life without drugs lack in Nairobi drug rehabilitation centers and this become a problem as patients/addicts go back to their old habits after release from the centers back to the community. Although the findings indicated availability of the psychoactive drugs in the society caused relapses failure to offer aftercare services could not be ruled out as a possible cause.

Few drug rehabilitation centers in Kenya was a problem as was established by the study. Drug strategies (2001) noted that awareness of drug treatment options is fairly low and many were unaware of the accessibility of treatment and think treatment programs were either fairly difficult to find or not readily available. However, Amedeo (2006) noted that treatment centers were scarce and both public and privately funded treatment providers had created a new emphasis on short term inventions. Mwenesi (1995) in his study observed that due to scarcity of drug treatment rehabilitation centers in the country drug abusers were admitted in the psychiatric wards hence not attended as expected. Moreover, drug rehabilitation centers were very important in the fight for reduction of demand for psychoactive drugs in the society. The findings of the study were worrying because it was a clear indication that the centers available were few and did not have the capacity to accommodate all those who required treatment for drug abuse. This could explain why drug abuse is in the increase in the country.

The findings also indicated that the community was not fully participating in treatment and re-integration of drug abusers in the society as was supported by 26.5% of the respondents. Various reasons why the community was not fully participating varied with respondents reporting stigmatization was rampant, lack of supportive programs within the community,

much had not been done to make treated client productive, and community did not adapt supportive social approaches. Similar observation was made by Githinji (1995) that the community shunned drug abusers and perceived them as criminals. He also observed that the government as part of the community had not subsidized the treatment of drug abusers so that many could afford. Preventive Health Education (1991) noted that community had a role to play in preventing drug abuse and all different groups constituting a community should provide support by modifying the attitudes, values, behaviours and skills of the former drug dependants persons in order to encourage the transition to and maintain a drug free way of life. It was also important to provide the social support needed to establish dependant person in the community. However, despite the community being a central force in achieving the above, it was quite unfortunate because that was not the situation in Nairobi drug rehabilitation centers and as was revealed by the findings of the study. Community support plays an important role in the fight against psychoactive drugs. The psychoactive drug problem does not affect only the abusers but the effect are felt by the entire society.

#### **4.4 Similarities and differences existing among the problems experienced in the centers for treating drug abusers**

This study sought to establish the problems that had generally hindered the treatment of drug abuse across the centers offering rehabilitation to drug abusers in Nairobi and also tried to establish similarities and differences

**Table 4.4 Problems experienced by rehabilitation centers**

Responses	Asumbi Treatment Center (Karen)		Nairobi Place		Brightside Center		Chiromo Lane Medical Center		Mathari Rehab Center		Bustani Medical Center		Avenue Hospital		Percentage for total response	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Financial	4	3.4	4	3.4	4	3.4	2	1.7	6	5.1	7	5.9	7	5.9	34	28.8
Few trained personnel	1	0.8	0	0	0	0	0	0	1	0.8	0	0	0	0	2	1.7
Failure to adhere to prescribed treatment	7	5.9	7	5.9	6	5.1	7	5.9	7	5.9	7	5.9	7	5.9	48	40.7
Lack of training on vocational life skills	1	0.8	2	1.7	1	0.8	0	0	1	0.8	1	0.8	0	0	6	5.1
Relapse	0	0	1	0.8	1	0.8	2	1.7	0	0	0	0	0	0	4	3.4
Not accepting addiction as a disease	0	0	3	2.5	1	0.8	2	1.7	0	0	2	1.7	0	0	7	5.9
Lack of aftercare services	7	5.9	0	0	2	1.7	0	0	0	0	0	0	7	5.9	16	13.6
Self denial	0	0	0	0	0	0	1	0.8	0	0	0	0	0	0	1	0.8
Total	20	16.9	17	14.4	15	12.7	14	11.9	15	12.7	16	13.6	21	17.8	118	100

The respondents were asked to indicate problems that hindered treatment of drug abusers in their centers. The table 4.4 above indicates that only failure to adhere to prescribed treatment and financial problems were similar in all the centers and was reported by 48(40.7%) and 34(28.8%) of the respondents respectively. Other problems were different in all the centers and varied from not accepting addiction as a disease reported by 7(5.9%), lack of training on vocational life skills 6(5.1%), lack of aftercare services 16(13.6%), relapse 4(3.4%), few trained personnel 2(1.7%), and self denial 1(0.8%).

The differences in problems experienced across the centers could be due to activities and strategies used across the centers to offer treatment as was observed by (UN 2000). The differences could also be as a result of centers' different locations and lack of standardized treatment modalities. All centers did not employ similar treatment modalities. The treatment centers are set and governed by different philosophies and goals. This explains why some centers would perceive lack of after care services as a problem and others would not. It depended on the understanding and the principles or goals on which the centers were based on.

Clients' failure to adhere to treatment hampered rehabilitation process and posed a problem to treatment centers. Miller (1976) observed that drug abusers may fail to remain in treatment for a long period of time due to cost implications. He observed that treatment was very expensive. This was also noted by Mwenesi (1995) who reported that low income earners might fail to continue with the programmes due to inability to cope with the

charges for the services. Hart (1998) explained that treatment for addiction should be sustained to retain patient in continuing care for better results. Poley (1979) observed that drug abusers opt to drop out of treatment due to stigma attached to drug rehabilitation centers. UN (2000) noted that those clients who dropped out of the treatment programmes showed poor treatment results and they experienced relapse. This had a significant effect because the treatment was not completed and for that reason the researcher agreed with the findings of this study that failure to adhere to prescribed treatment or failure to complete treatment gave poor results. The clients were most likely to experience relapses. The study established failure to adhere to prescribed treatment affected treatment outcome which was a common phenomenon in all the centers under study. The respondents cited the following reasons as to why drug abusers did not adhere to prescribed treatment:

- Lack of funds
- Lack of family support and peer pressure.
- Most admissions are involuntary and thus little commitment.
- Fear of stigmatization.

The respondents felt the above reason made drug abusers under going treatment not to complete their treatment.

The study also established that not all rehabilitation centers offered aftercare services to their patients. These were follow-up services that help the patients to go through their treatment once they left the centers. The findings indicated that some centers never offered aftercare services. The services offered included counseling after discharge, follow-up and

review, and family counseling as was registered by the respondents. Those who reported not giving aftercare services gave various reasons and attributing it to lack of funds and others stated the services were yet to begin. Howard (1979) noted that the aftercare services were critical phase for ultimate success for treatment. He noted that drug abusers undergoing treatment also needed to be prepared better for the life outside and there was need to assist discharged clients. UN (2001) in their studies reported positive relationship between involvement in continuing care and improved post-treatment functioning of people treated for drug problems. However, although the results of this study indicated that majority of the respondents offered after care services, it was quite unfortunate to note that not all centers were offering the services. This implied clients from those centers that never offered aftercare services had problems with relapses or readjusting into the community after completing the treatment programme. In addition to that Howard (1979) stated that treatment of drug abusers was not complete without aftercare services. The respondents who reported not offering aftercare services gave the following reasons; lack of resources to support the services required and others reported the aftercare services were not offered at all in their centers.

**4.4.1 Supportive services offered to clients to enhance drug abuse rehabilitation process**

**Table 4.5 Supportive services offered to clients**

Response	Asumbi Treatment center (Karen)		Nairobi Place		Brightside Center		Chiromo Lane Medical Center		Mathari Rehab Center		Bustani Medical Center		Avenue Hospital		Percentage for total response	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Drop-in-center	7	13.5	2	3.8	0	0	2	3.8	0	0	0	0	0	0	11	21.2
Vocational training & life skills	0	0	4	7.7	2	3.8	3	5.8	7	13.5	5	9.6	1	1.9	22	42.3
Job counseling and placement	0	0	1	1.9	4	7.7	0	0	0	0	1	1.9	0	0	6	11.5
None of the above	0	0	2	3.8	0	0	3	5.8	0	0	1	1.9	7	13.5	13	25
Total	7	13.5	9	17.1	6	11.5	8	15.4	7	13.5	7	13.5	8	15.4	52	100

The respondents were asked to indicate whether they offered support services and what type of support services to the clients.

Various supportive services were offered to clients to enhance rehabilitation process where 42.3% said vocational and life skills training were offered. Another 21% reported drop-in centre services and 11.5% reported job counseling and placement. However, 25% of the respondents said there were no supportive services offered at all in their centers. Amedeo (2006) viewed supportive services such as vocational training as vital for successful treatment of drug addicts. Stronger emphasize on vocational services in residential treatment might help clients overcome obstacles to employment (Einstein, 1990). He further explained that vocational rehabilitation was the most effective means of refocusing drug abusers towards the world of work and subsequently to the society. The study findings showed that centers were offering supportive services however; effort was not put to provide vocational employment services to help in social re-adjustment of the ex-addicts as no centre reported that. Drugs strategies (2001) recommended that staff members engaged in providing these services should have specific training in “what works” and identification of personal barriers to employment and provide their remediation. From the findings it was quite evident that not all the centers embraced the idea of providing supportive services to the drug abusers undergoing treatment as many studies outlined the important of such services in the treatment of drug abuse. The findings of this study revealed that some centers lacked supportive services which were required for a comprehensive treatment for drug abusers.

#### 4.5 Perception of the treatment offering personnel on the nature of the drug abused and treatment offered to drug abusers

**Table 4.6 Respondents perception on nature of drug abused and treatment given to the abuser**

Response	Asumbi Treatment Center (karen)	Nairobi Place	Brightside Center	Chiromo Lane Medical Center	Mathari Rehab Center	Bustani Medical Center	Avenue Hospital	Percentage for total response
Influence treatment	7(100%)	5(71.4%)	4(57.1%)	7(100%)	7(100%)	7(100%)	7(100%)	44(89.8%)
Doesn't influence	0(0%)	2(28.6%)	2(28.6%)	0(0%)	0(0%)	0(0%)	0(0%)	4(8.2%)
No response	0(0%)	0(0%)	1(14.3%)	0(0%)	0(0%)	0(0%)	0(0%)	1(2%)
Total	7(100%)	7(100%)	7(100%)	7(100%)	7(100%)	7(100%)	7(100%)	49(100%)

This study sought to establish the perception of the treatment offering personnel on the type of drug abused to treatment given. The respondents were asked whether the type of drug abused influenced the treatment given. Table 4.13 above indicates that respondents overwhelmingly supported this assertion with (89.8%) saying the type of drug used did affect the treatment given only (8.2%) of the respondents indicated that the type of drug used did not influence treatment given.

For the majority who agreed that type of drug abused influenced treatment given to the abuser, gave various reasons such as not all drugs abused required detoxification, hard drugs were hard to treat due to their nature of addiction and others claimed that different drugs had different effects in the body. UN (2000) in their studies shown that the effects of the abused drugs dictated the activities and strategies to use to relieve symptoms and induce change. This agrees with respondents who stated that not all drug abusers require detoxification. This would be dictated by the severity of the withdrawal effects caused by

the drug abused. NIDA (2000) revealed that different drugs would have different effects in the individuals hence necessitating variations in the treatment given. This also concurred with the research findings that respondents perceived that type of drug abused influenced the treatment given. The researcher concurred with the research findings but felt concerned that treatment centers needed to diversify and coordinate their services in order to respond to the different needs and characteristics of drug abusers as could be dictated by the type of drug abused as supported (Oakley and Ksir 1997). As the type of drug abused influences treatment as revealed by the findings, it was worrying to note that some centers especially within hospitals employed few treatment modalities despite drug abusers using variety of drugs which had various effects in the body

#### 4.6. Treatment modalities used in the treatment of drug abusers in the rehabilitation centers

**Table 4.7 Treatment modalities in the rehabilitation centers**

Response	Asumbi Treatment Center (Karen)		Nairobi Place		Brightside Center		Chiromo Lane Medical Center		Mathari Rehab Center		Bustani Medical Center		Avenue Hospital		Percentage of type of treatment by total responses	
	Freq	%	freq	%	freq	%	freq	%	freq	%	freq	%	freq	%	freq	%
Counseling	7	5.9	7	5.9	4	3.4	6	5.1	7	5.9	6	6.1	5	4.2	42	35.4
Detoxification	6	5.1	6	5.1	4	3.4	5	4.2	7	5.9	3	2.5	7	5.9	38	31.9
Relapse prevention/ Alcoholic, narcotic anonymous method	6	5.1	6	5.1	5	4.2	0	0	0	0	0	0	0	0	17	14.3
Life skill training/ occupational therapy/	1	0.8	4	3.4	3	2.5	2	1.7	2	1.7	3	2.5	0	0	15	12.6
Family therapy	0	0	1	0.8	0	0	0	0	0	0	0	0	0	0	1	0.8
12 steps	0	0	1	0.8	0	0	0	0	0	0	0	0	0	0	1	0.8
Medication	0	0	0	0	0	0	2	1.7	2	1.7	0	0	0	0	4	3.4
No response	0	0	0	0	1	0.8	0	0	0	0	0	0	0	0	1	0.8
<b>TOTAL</b>	<b>20</b>	<b>16.8</b>	<b>25</b>	<b>21</b>	<b>17</b>	<b>14.3</b>	<b>15</b>	<b>12.6</b>	<b>18</b>	<b>15.1</b>	<b>12</b>	<b>10.1</b>	<b>12</b>	<b>10.1</b>	<b>119</b>	<b>100</b>

The table above indicates that the drug rehabilitation centers offered a range of treatment to patients as reported the respondents. These treatment included counseling 35.4%, detoxification 31.9%, relapse prevention 14.3%, life skill training and occupational therapy 12.6% and medication 3.4%. The table indicates that, the most commonly used types of treatment were counseling and detoxification, and the least used were twelve steps and family therapy. This implied that drug rehabilitation centers did not have standardized types of treatment even though all offered residential treatment. This difference could be brought about by the fact that treatment for drug abusers worked according to activities and strategies used to relieve symptoms and induce change as observed by (UN, 2000). It was worth noting that no centre was reported as using only one type of treatment which conformed to Ashrey (1985) and Barber (1995) observation that agencies providing treatment for drug abusers offered more than one treatment modalities as no single treatment approach is appropriate for all individuals and therefore, it was necessary to apply a variety of interventions. However, the researcher noted that despite the centers using variety of treatment modalities they were not uniformly applied among the centers even though they had a common intended goal and were in the same setting (residential). Fox (1977) noted that treatment should follow standard patterns in therapy that included exploration, confrontation, explanation and termination of the maladaptive behaviour (drug abuse). He explained that this called for adapted treatment modalities that were comprehensive and encompasses detoxifications, pharmacological, psychological/counseling, therapeutic communities, relapse prevention and aftercare services. He also concurred with Ashley (1985) and Barber (1995) that no single treatment worked for all addicted persons and that treatment for addiction to any substance must

include a variety of options. The researcher also noted that due to lack of uniformity in the treatment modalities there existed inconsistency in services given in centers that offered treatment to drug abusers.

It was worth noting that all centers used more than one treatment modalities. However the differences had been brought about by the centers underlying philosophies and goals intended in treatment. The difference could also be due to lack of standardized treatment as Ronald (1999) noted that treatment providers have resisted attempts to standardize treatment as standardization of treatment would lead to consistency in treatment modalities and all centers would follow standard patterns in therapy and employ modalities in treatment that were comprehensive in nature. This was because patients were treated for multidimensional problems and no single treatment worked for all addicted persons (Resource link, 2000).

The fact that the centers within hospitals had few modalities could be attributed to the fact that in patient psychiatric and hospital facilities tend to be more expensive to maintain drug abusers in treatment for long periods of time (Miller, 1976). These had established referral networks in which after problems and needs of the patients had been diagnosed, clients were referred to out patient facilities. This could explain the lack of some treatment modalities in centers within hospitals. Furthermore, this contributed to weakness in treatment. Herbert (1998) noted that treatment for drug abusers should be sustained to retain patient in continuing care for better results. This explained the importance of the aftercare services which were lacking in the centers within the hospitals. Fox (1977)

observed that hospital based programmes had no time for aftercare services. This clearly points out treatment in two given environments will yield different results.

#### **4.7 Perception of treatment offering personnel on the influence between treatment of drug abusers, age and sex.**

Respondents were required to give their opinion on whether they felt treatment was influenced by sex and age of the drug abuser and treatment given.

Majority of the respondents (65.3%) reported that treatment given to drug abusers is not influenced by the sex of the abuser and (26.5%) of the respondents agreed with the statement.

**Table 4.8 Respondents’ perception on sex influence on treatment**

<b>Variables</b>	<b>Response</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Sex influence on treatment</b>	Influences treatment	13	26.5
	Does not influence treatment	32	65.3
	No response	4	8.2
<b>Total</b>		<b>49</b>	<b>100</b>
<b>Reasons for sex differences</b>	Addiction the same	34	69.4
	women are complicated to treat	8	16.3
	No response	7	14.3
<b>Total</b>		<b>49</b>	<b>100</b>
<b>Age influence on treatment</b>	Same treatment	19	38.8
	Different treatment	27	55.1
	No response	3	6.1
<b>Total</b>		<b>49</b>	<b>100</b>

Those who did not agree with the statement gave the following reason; that addiction was the same regardless of the sex as was reported by (69.4%) of the respondent and those who felt sex influenced treatment reported that women unlike men were complicated to treat. The finding differed with NIDA (2000) observations that women and men tend to abuse

different drugs and that some approaches to treatment were more successful for women than for men. The studies also established that treatment involving nicotine replacement therapy works better for men than for women.

Also Inaba and Cohen (2004) discovered that women with substance addiction compared to men had more mental disorders i.e. depression, anxiety, eating disorders and post traumatic stress disorder and lower self-esteem. They recommended that treatment should be tailored to addressing specific needs of a group hence calling for differences in treatment modalities used. For the respondents who felt addiction was the same for all the abusers despite their sex failed to understand the fact that treatment addressed the individual's physical, psychological, emotional and social conditions (Amedeo, 2006). Women due to a greater occurrence of particular traumas in their histories often suffered from PTSD and found becoming sober distressing. This did not agree with the findings. UN (2000) found out type of treatment given to drug abuser was dictated by target group and goal intended among other reasons. Due to the above discussed reasons the researcher also did not concur with the findings since treatment of drug abuser does not only address addiction but also other conditions that impede proper functioning of the client. The perceptions of the respondents did not concur with other studies done. This could be attributed to the fact that the respondents did not have proper training in the area of addiction. This is a challenge to treatment since it would not be consistent in all the centers and affected treatment results.

#### **4.7.2 Perception on influence on treatment given.**

Majority of the respondents (55.1%) reported that age did not influence treatment while (38.8%) of the respondents felt that age influenced treatment given. Those who felt that

age did not influence treatment argued that effects of addiction were the same in all ages. Those who felt that age influenced treatment gave the following reasons; that it was difficult to treat adolescents compared to adults, teenagers had different levels of drug damage and that different age groups had different needs.

A study by Storie (2005) revealed contradicting results. It established that age of the drug abuser influenced treatment. He observed that treatment for adolescent's psychoactive chemical dependants involved a highly structured and supportive environment that is equipped to address delinquent and anti-social behaviours and gave social skill training to avoid destructive peer groups and behaviour in future. He also noted that aging makes human body more vulnerable to the effects of psychoactive chemicals. The typical health risk associated with dependency is exacerbated in the elderly leading to greater complications. Treatment addressed reasons for abusing drugs, the physical, psychological, and social consequences resulting from the dependence. He noted that treatment for the youth differed from that provided for adult population.

NIDA (2000) observed that youth abused mostly soft drugs as opposed to adults abusing hard drugs. The different drugs would have different effects in the individuals hence resulting to different interventions in the treatment given. Although this study indicted that the age of the abuser did not influence treatment given, the researcher could not ignore the responses from those who felt age of the abuser influenced treatment given. The difference in respondents' opinions on this question could have been due to lack of standardization of treatment as every centre had its own philosophy guiding treatment Amedeo, (2006). This

therefore, could have contributed to biasness in reporting since the questionnaires were administered to treatment offering personnel in those centers.

## CHAPTER FIVE

### SUMMARY, CONCLUSION AND RECOMMENDATIONS

#### 5.0 Introduction

The chapter summarizes the findings, gives the implications of the findings, conclusion, recommendations based on the research findings and suggestions for further research.

#### 5.1 Summary

The study was designed to explore factors hindering treatment of drug abusers in drug rehabilitation centers in Nairobi.

The findings were:

- There were specific factors that hindered treatment of drug abusers in Nairobi rehabilitation centers which include; lack of qualified treatment offering personnel, availability of psychoactive drug in the society were possible cause of the relapse in the treatment of drug abusers; lack of community participation in the treatment services; lack of medicinal drug in the drug rehabilitation centers; lack of aftercare services.
- Drug rehabilitation centers were not abundant in the country.
- The problems experienced were not similar in all the centers.
- Types of drug abused influenced treatment.
- Sex of the abuser did not influence the treatment given.

## **5.2 Implications of the findings**

From the findings, a number of factors were hindering treatment of drug abuses in Nairobi rehabilitation centers. This implied that the services given in these centers were not satisfactory to the clients.

The study also established that problems experienced were not similar in all the centers.

This implied that the location of the centers i.e. within or without the hospitals could be an added advantage in the treatment of drug abusers.

Types of drug abused influenced treatment. This implied that the treatment offering personnel's perception was in line with other studies done in the same. These study findings concurred with findings from other studies done in the same area.

This study established that sex and age of the abuser did not influence treatment given to drug abuser. This implied that the perceptions of the treatment offering personnel were not in line with other studies done in the same area. These perceptions could influence treatment modalities applied in these centers which did not yield the expected results.

## **5.3 Conclusion**

In view of purpose of the study and research questions, the general findings were that treatment of drug abusers in Nairobi drug rehabilitation centers was facing problems and not yielding expected results. They experienced problems such as lack of trained treatment offering personnel, psychoactive drugs in the society caused relapses, community did not fully participate in treatment of the drug abusers hence did not supplement the centers in

offering supportive services. The centers did not have standardized treatment modalities to make treatment consistent in all the centers. Those centers located within hospitals did not have any advantages over those away from hospitals although most of the problems were different. It was noted that those with hospitals utilized few treatment modalities as compared to those which were not within the hospitals.

The treatment offering personnel differed in their perceptions on the relationship between sex and age of the abuser and treatment. This explains the inconsistency in treatment modalities employed by various centers.

#### **5.4 Recommendations**

From the research findings the following recommendations were made:

- That there should be clear policy on standardization of the treatment modalities to ensure they are comprehensive in nature.
- That government through the Health Ministry should subsidize treatment cost of the drug abusers.
- Government through Health ministry should supply medicinal drugs to all drug rehabilitation centers.
- Treatment centers should expose their treatment offering personnel to training in addiction treatment.
- The Ministry of Health through the Government should establish more drug rehabilitation centers in the country.

## **5.5 Further Research**

Having looked at the factors hindering treatment of drug abusers in Nairobi drug rehabilitation centers, the researcher felt there was need for studies to be done on:

- The extent to which the current treating modalities in drug rehabilitation centers are impacting on the drug abusers.
- Measures that could be put in place to curb the prevailing conditions in the drug rehabilitation centers.

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## APPENDIX I

### QUESTIONNAIRE FOR TREATMENT OFFERING PERSONNEL

Dear Respondent,

The treatment of drug abusers has been hindered by many problems. Our country is no exception. We are trying to investigate the problems that hinder effective treatment of drug abusers in the context of Nairobi rehabilitation centers. Your clear and honest answers to the questions that follow will be of great help to achieve the desired goals and objectives of this study.

The information you give will be treated with **Strict Confidentiality** and will **only** be used for the purposes of this study. Thank you.

Please answer all questions as required.

#### INSTRUCTIONS

- A. Indicate your choices by a tick (✓) where applicable.
- B. Should you find several answers applicable, the best answer shall be taken as the most appropriate?
- C. Some questions will require detailed answers due to their open-ended nature.

Please act accordingly.

**NB:** For the purpose of this study, treatment is taken as a variety of processes that focus on helping individuals with drug related problems. The treatment begins when the drug abuser comes into contact with a health officer/provider or other community services, and may continue through a succession of specific interviews until the highest attainable level of health and well being is reached.

Drugs will include: Alcoholic beverages, Tobacco, miraa and prescription medical preparations, cocaine, heroin and marijuana (cannabis).

**BACKGROUND INFORMATION TO BE COMPLETED BY TREATMENT**

**OFFERING PERSONNEL**

1. Name of the rehabilitation centre: Please indicate this in the space provided.....  
.....  
.....

2. Indicate your professional and academic qualification below.

Professional Qualification .....

Academic qualification.....

2(b) For how many years have you been treating drug abusers since you qualified in your profession ?

.....  
.....

3. In this institution, what type of treatment are you giving to your patients? If more than one, write them in order.

.....  
.....  
.....

3(b). According to you, is the treatment you are giving satisfactory?

Yes ( )                      No ( )

(c) Reasons for your answer above,

.....  
.....  
.....

4. Although drug abusers are treated for multidimensional problems, drugs for treatment are not readily available in the treatment centers.

( ) correct    ( ) Doubtful    ( ) incorrect

5. Experts drawn from a number of treatments related fields are qualified to treat the drug abusers. Comment on this statement.

I strongly agree ( )    I agree    ( )

I am indifferent ( )    I do not agree    ( )

6(a). Availability of drugs in the society are possible causes of relapse for treatment of drug abusers.

Yes ( )    No ( )

(b) Give reasons for your answer in question 6(a).

.....  
.....  
.....

7. Rehabilitation centers offering treatments to drug abusers are abundant in Kenya, only that the society is unaware.    True ( )    False ( )

8 The community is fully participating in the treatment and reintegration of drug abusers to the society.    Yes ( )    No ( )

(b) Give reasons for your answer.

9. Which supportive services do you offer to your clients to enhance their rehabilitation process?

Vocational training and life skills training ( )

Job counseling and placement ( )

Drop-in- centre ( )

None of the above ( )

10. . Treatment is also hampered by the failure of the patients to adhere to prescribed treatment Yes ( ) No ( )

(b). Explain your answer

.....  
.....  
.....  
.....

12. Does this centre offer aftercare services to your clients?

Yes ( ) No ( )

(b). If yes, list down examples of aftercare services offered by your centre.

.....  
.....

(c). If the answer to question (12) above is NO, give reasons for your answer.

.....  
.....  
.....

13. Does the type of drug abused affect treatment of the abuser?

Yes ( )                      No ( )

(b). Why? Give reasons for your answer in question 13.

.....  
.....  
.....

14. Is treatment of drug abusers influenced by the sex of the patients?

Yes ( )                      No ( )

(b) Give reasons for your answer in question 14.

.....  
.....  
.....

15. Treatment is dictated by the age of drug abusers.

True ( )                      False ( )

(b). Give reasons for your answer in question 15.

.....  
.....  
.....

16. It is obvious that treatment of drug abusers is faced with difficulties. List at least FIVE problems and suggest solutions to the problems you have listed.

<b>Problems</b>	<b>solutions</b>
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

17. What is your view in terms of help from the Ministry of Health enhancing treatment?  
.....  
.....  
.....

18. What facilities do you expect from the ministry that you are not getting presently?  
List them.....

.....  
.....  
.....

19. What other recommendations would you make concerning the resources needed to improve treatment of drug abusers?