

EFFECTIVENESS OF DRUG REHABILITATION PROGRAMS ON BEHAVIOR
MODIFICATION OF DRUG ADDICTS IN NAIROBI COUNTY

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DECLARATION

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



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DECLARATION BY THE SUPERVISORS

This project has been submitted with our approval as University supervisors



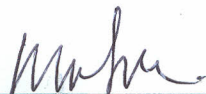
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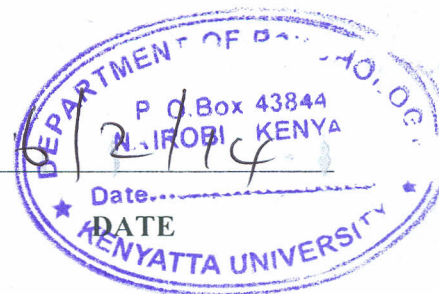
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DEDICATION

I dedicate this work to my dear brother Gregory Musia for his special support, and my entire family members.

ACKNOWLEDGEMENT

I give thanks to God for helping and enabling me to make it this far. I also thank my family members for the support they gave me during the whole period of the study.

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ABSTRACT

According to the World Drug Report (2007), approximately 200 million people, about 5% of the world's population aged between 15 and 64 years have either been forced or voluntarily sought help of rehabilitation centers for behavior modification. These rehabilitation centers over years have admitted drug addicts into their rehabilitation programs meant to bring about behavior change among the rehabilitees. However, little is known about the effectiveness of the programs offered. The purpose of the study was to investigate the effectiveness of drug rehabilitation programs on behavior modification of drug addicts in rehabilitation centers in Nairobi County and establish the existing rehabilitation programs put in place to help the drug addicts. The study design was cross sectional as methods of data collection. The study population was the staff and the rehabilitees of the purposively sampled ten (10) rehabilitation centers in Nairobi County. Questionnaires were used as tools for collecting data, one for the staff and questionnaire guided interview for clients. The study mainly found out that: Drug users' evaluation in terms of assessment emerges was the key program offered by rehabilitation centers in Nairobi County; staff members in rehabilitation centers in Nairobi County were sufficiently trained, with a good number of them holding degrees, diplomas and certificate from reputable institutions. They also possess proficiency in drug management and rehabilitation tasks; rehabilitation centers in Nairobi County carried out continuing/after care services to their clients using psychological interventions, and personal empowerment of the rehabilitees; financial impediments like lack of sufficient staff, medication and facilities as well as inconsistent follow ups are the major challenges facing rehabilitation centers in Nairobi County; these challenges can only be curbed by sufficient funding of these institutions to enable employment of adequate staff and acquisition of better infrastructure to enable enhanced individual attention to rehabilitees. The study recommended that: rehabilitation centers management should foster establishment and implementation of a comprehensive drug rehabilitation schedule that caters to the individual needs of a rehabilitee and at the same time manages rehab time to avoid boredom among the patients; rehabilitation centers staff should gain insights on various needs of the rehabilitees to avoid unnecessary strife in the rehabs. They should also learn to handle the rehabilitees with professionalism to enable a successful rehabilitation process; rehabilitees in the rehabilitation program should also learn a number of personal management tips to help them adequately plan for and make the most out of the period they are in the rehab center; The Ministry of Special Programs should look into various problems encountered by staff and clients in rehabilitation centers. The ministry should then formulate policies on the funding and staffing of these centers to facilitate a sound drug rehabilitation process

LIST OF ABBREVIATIONS

AIDS	–	Acquired Immunodeficiency Syndrome
HIV	–	Human Immunodeficiency Virus
ITP	–	Individualist Treatment Planning
NACADA	–	National Campaign Against Drug Abuse (Authority)
NGO	–	Non- Governmental Organization
NIDA	–	National Institute of Drug Abuse
WHO	–	World Health Organization

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CHAPTER ONE

1.0 INTRODUCTION

1.1 Background of the Study

The use of drugs has been around since time immemorial. People have used drugs for various purposes depending on culture and activities at hand. At most drugs have been known to bring euphoric feelings that change moods of people to pleasurable feelings especially in social celebrations and when people are operating under tension. Because of their ability to relief tension many people use drugs and with the stressful life associated with challenges in contemporary society the number has been on the increase. Hence initiating the use of drugs is always associated with the benefits that it brings to the users.

However, People who use drugs experience a wide array of physical effects other than those expected. Marijuana and alcohol for example, interfere with motor control and are factors contributing too many automobile accidents. Users of marijuana and hallucinogenic drugs may experience flashbacks, unwanted recurrences of the drug's effects weeks or months after use. Abrupt abstinence from certain drugs results in withdrawal symptoms. For example, heroin withdrawal symptoms cause vomiting, muscle cramps, convulsions, and delirium (Benjamin 2003). The excitement of a cocaine effect, for instance, is followed by a "crash": a period of anxiety, fatigue, depression, and a strong desire to use more cocaine to alleviate the feelings of the crash (Bruner et. al., 2008). This is due to its addictive nature that lures the users into over use. The after effects of drugs and the assumption that relieve can only be used in continuous use of drugs leading to increased drug abuse and dependence with many negative psychosocial effects. With the continued use of a physically addictive drug, tolerance develops; i.e., constantly increasing amounts of the drug needed to duplicate the initial effect. Because the purity and dosage of illegal drugs such as heroin are uncontrolled, drug overdose is a constant risk. Many drug users engage in criminal activity, such as

burglary and prostitution, to raise the money to buy drugs, and some drugs, especially alcohol, are associated with violent behavior (Bruner et. al., 2008).

Therefore one of the greatest concerns in nations today is the rapidly rising number of drug users worldwide. According to the World Drug Report 2007, the total number of drug users in the world is now estimated at some 200 million people, equivalent to about 5 percent of the global population (UNODC, 2009). The UNODC estimates that between 155 and 250 million people (3.5% - 5.7% of the population aged 15-64) use illicit substances at least once. Consequently it is estimated that there are between 16 and 38 million 'problem drug users' every year.

The abuse of drugs in Africa is nevertheless escalating rapidly from cannabis abuse to the more dangerous drugs and from limited groups of drug users to a wider range of people abusing drugs (Odek-Ogunde and Owiti, 2003). The most common and available drug of abuse is still cannabis, which is known to be a contributing factor to the occurrence of a schizophrenic-like psychosis (Ball and Dehne, 1998). Regionally according to Kilonzo, Mbwambo, Kaaya and Hogan (2001) a rapid situation assessment carried out in five Tanzanian towns found heroin to be a major concern. Just like other parts of the world, Kenya has experienced upsurge in number of drug and substance abuse.

In Kenya more worrisome statistics came from a NACADA Authority survey of (2009) that showed about 40% of Kenyans aged between 15 and 65 years have drunk one type of alcohol or another, and that at least 13% of people from all provinces in Kenya except North Eastern are current consumers of alcohol. Worst hit are the youth. The 2007 study found that alcohol is abused by 77% of youths out of school and 28% of youths in school. It also established alcohol, tobacco and bhang as being the most easily known abused substances by over 50% of 15-65 year-olds (NACADA, 2010). The trend is worrying to many policy makers, parents and society at large.

The intensity of drug abuse has been a major concern in recent years. Drug abuse has invaded homes, schools and work places affecting individuals of all ages and classes (UNDCP, 1992). Mouti, (2002) argues that this disturbing scenario has largely been caused by high rates of unemployment, media influence on the youth, breakdown of African traditional system that had checks and balances on individuals' behavior, poverty and ignorance of the effects of drugs. In a nutshell drugs have many negative effects to the individual, family and society at large. In this regard communities all over the world have been preoccupied with search for programs to help those affected by drugs. Different societies worldwide have sought different ways of assisting those addicted to change their behavior. It is from this understanding that rehabilitation program are crucial as intervention measures arises for behavior modification (Nathaniel & James, 2002).

According to the World Drug Report (2007), approximately 200 million people, about 5% of the world's population aged between 15 and 64 years have either been forced or voluntarily sought help of rehabilitation centers for behavior modification. According to surveys carried out in 1991 and 1996 among adolescent students in Nova Scotia in Canada, over one fifth (10.9%) of the students reported to have used alcohol, tobacco and cannabis underwent rehabilitation programs (Poulin and Elliot 1997).

The first use of the term 'behavior modification' appears to have been used by Edward Thorndike in 1911. In his article, *Provisional Laws of Acquired Behavior or Learning*, he makes frequent use of the term "modifying behavior". He argues that behavior in human beings can be modified through effective programs. Historically, rehabilitation programs in relation to behavior modification can be traced to First World War in Germany. The soldiers who were involved in the war and were able to survive, experienced traumatic experiences which resulted in drug taking and later on addiction. Harry, (2000), writes that about 5,000 soldiers who were addicted and accepted to join rehabilitation programs, showed signs of

improvement after four months. He further indicates that three quarters fully recovered after six months while a quarter went back to same habit after leaving the rehabilitation centers. European community project on alcohol and other drugs is another example where rehabilitation of drug addicts has been successful in behavior change. According to Hibbel, Anderson, Bjarnason, Morgan and Narusk (1995) 17% of community members successfully underwent rehabilitation programs. For example study conducted in Mexico by Hennis (1998) to find out the success of rehabilitation programs on drug rehabilitees found out that after care programs by the immediate family and the community around rehabilitees played a bigger role in reducing relapse cases. The implication is that effective rehabilitation programs can work for the good of the community.

Rehabilitation programs have since, come to refer, mainly to techniques for increasing adaptive behavior through reinforcement and also decreasing maladaptive behavior through extinction or punishment. Meltenberger (2008) describes rehabilitation as behavioral interventions designed to influence the behavior change of people or individuals in a way that benefits them and the society at large. Drug rehabilitation, according to Higgins (2003) is the processes of medical or psychotherapeutic treatment, for dependency on psychoactive substances such as alcohol, prescription drugs, and so-called street drugs such as cocaine, heroin or amphetamines. Dependency in this case means a situation where a rehabilitee is unable to do without a specific drug. The main intention of drug rehabilitation is to help addicted individuals stop compulsive drug seeking and use. In addition to stopping drug abuse, the goal of treatment is to return people to productive functioning in the family, workplace, and community. The ultimate goal of drug rehabilitation centers is therefore to create opportunity for behavior change through helping the drug addicts to curb psychological, physical and emotional problems brought about by the drugs.

Scientific research since 1970 shows that effective rehabilitation programs address drug addiction and health related complications of the addict person. Professionals from the National Institute on Drug Abuse (NIDA) recommend medication and behavioral therapy combined, as important elements of a therapeutic process that begins with detoxification that follows with treatment and doesn't set aside prevention of relapse, since this is essential to maintain the positive effects of therapy. Behavioral therapy requires individuals to admit their addiction, renounce their former lifestyle, and seek a supportive social network who can help them remain sober while detoxification method gets toxins out of the body that causes cravings, anxiety, and depression.

Just like other parts of the world, Kenya has experienced upsurge in number of drug addicts that has forced the government, non-governmental organizations, religious and individuals to come up with rehab centers offering rehabilitation programs meant for behavior modification. Examples of drug rehabilitation centers offering rehabilitation programs to drug addicts in Nairobi include: Nairobi Outreach Services, Asumbi Treatment and Counseling Centre, Kenyatta National Hospital Patients Support Centre and Chiromo Lane Treatment Centre (NACADA, 2010). These rehabilitation centers over years have admitted drug addicts into their rehabilitation programs meant to bring about behavior change among the rehabilitees. However, little is known about the effectiveness of the programs offered. This study therefore examines the effectiveness of rehabilitation programs on behavior modification of drug addicts in Nairobi County.

1.2 Statement of the problem

The problem underlying this study is that, although there have been different programs in different rehabilitation centers meant for behavior modification among drug addicts in Kenya, little is known about their effectiveness. Drug rehabilitation centers worldwide are mainly meant to offer programs that modify behaviors of the rehabilitees specifically to enable the

rehabilitee to stop using drugs. The programs are designed to address the needs of the drug addicts to help bring about the desired permanent change in behaviors among the rehabilitees and prevent going back to the vice. But studies for example Otieno (2011) noted that most drug addicts revert to the vice after treatment. He cites insufficient psychological care during and after treatment as the reasons that contribute to relapse. However, he does not state whether the inefficiency is a result of programs offered or other factors

Recently, over 30 drug addicts volunteered to seek rehabilitation services in Mombasa. They were received and enrolled into the program. However, after a week, the rehabilitees complained of lack of basic amenities and treatment for their condition. Three quarters of them dropped from the rehab centre and went back to drugs (KBC Reporters, 2011). However, it is unclear to what specific issues about the program led them to pull out. Studies have been done on factors contributing to one to seek rehabilitation services, programs offered in rehab centers but little has been done to establish the effectiveness of the programs on behavior modification. This study therefore sought to fill the gap by examining the effectiveness of programs offered in rehabilitation centers in relation to behavior modification of drug addicts with an aim of establishing how drug rehabilitation programs can be improved to help bring about effective treatment.

1.3 Purpose of the study

The purpose of this study was to investigate the effectiveness of rehabilitation programs in relation to behavior modification of drug addicts in rehabilitation centers in Nairobi County.

1.4 Study objectives

The following specific objectives guided the study:

1. To identify the types of programs offered in drug and substance rehabilitation centers in Nairobi County.
2. To assess the effectiveness of the programs in addressing the needs of drug addicts

3. To assess the capacity of service providers (staff) to offer rehabilitation services in rehabilitation centers.
4. Examine the type and quality of continuing/after care services available in the rehabilitation centers?
5. To find out challenges influencing the effectiveness of rehabilitation programs
6. To find out what needs to be done to improve the effectiveness of the programs in existing rehabilitation centers.

The data was collected among the staff and the practitioners offering services in the rehabilitation centers and the clients admitted.

1.5 Research questions

The study was guided by the following research questions:

1. What are the types of programs offered in drug rehabilitation centers Nairobi County?
2. In what ways do the rehabilitation programs in rehabilitation centers effectively address the needs of the addicts?
3. How adequate are the staff capacities to offer rehabilitation services in rehabilitation centers?
4. Examine the type and quality of continuing/after care services available in the rehabilitation centers?
5. What are the challenges facing effectiveness of rehabilitation programs in Nairobi County?
6. What can be done to improve the effectiveness of the existing rehabilitation programs?

1.6 The significance of the study

The study was significant in that the findings may be used to modify or to support the existing rehabilitation programs to make them more effective in addressing diverse needs of

the rehabilitees. The stakeholders may find it necessary to put in place legislations and policies that will guide establishment and management of rehabilitation centers to curb congestion and make the environment more conducive. It is anticipated that more studies will be conducted in the area of rehabilitation programs that will enhance behavior modification among drug addicts.

1.7 Justification of the study

Drug abuse and addiction are a threat to the survival of the society. Therefore the increasing rate of drug problem in the society is a concern to all people. Through rehabilitation programs, people who are addicted to drugs can be assisted to change their behavior. However, it is only effective programs that can bring about behavior change. Understanding the effectiveness of the rehabilitation programs used could be achieved through an empirical study in which the strengths and the weakness are identified and analyzed. This can be able to inform the service providers on areas that need to be improved to enhance their ability in bringing about behavior change. It is for this reason that this study on the evaluation of effectiveness of current existing rehabilitation program.

1.8 Scope and limitations

This study confined itself to effectiveness of rehabilitation programs among drug addicts in rehabilitation centers in Nairobi County only. Information was sourced from rehabilitees admitted in rehab centers within Nairobi County on effectiveness of the rehabilitation programs on behavior modification.

The findings of this study may only be applicable to Nairobi County or other areas with similar characteristics. The researcher anticipated that there would be some inconsistency in provision of information and lack of co-operation by rehabilitees who may have still been having psychological challenges in rehabilitation centers. However, the researcher incorporated Psychologists, Counselors and other service providers in the centers in offering

any necessary assistance to the rehabilitees. This way, the level of inconsistency was minimized.

1.9 Operational definitions of terms

Addiction : having a physical and or psychological dependency on a substance.

Adequacy : degree to which an aspect of the rehabilitation centre conforms to the laid down standards by the national overseeing body (NACADA)

Aftercare : follow up care that offers continuing ongoing support to maintain abstinence, personal growth and integration into the community for persons trying to stop drug and substance abuse.

Counseling : the explicit offer and expertise by a professional to assist an individual or group to deal with feelings and attitudes towards self and others and accept himself/herself and the world he or she lives in.

Effectiveness : reducing alcohol and drug use and improving personal and social functioning of drug addicts.

Rehabilitation

Programs : a set of professional programs used to effect behavior change

Rehabilitation : The processes of medical or psychotherapeutic treatment, for dependency on psychoactive substances such as alcohol and other drugs

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

In reference to the study on effectiveness of drug rehabilitation centers in Nairobi County, this chapter presents an up to date review of related literature. The literature was sourced from relevant professional education journals, and published papers. The chapter is divided into the following sections: Introduction, theoretical framework, review of related literature, and conceptual framework.

2.1 Theoretical frame work

The study was based on Cognitive behavioral theory which has profound implication for person with drug and substance abuse disorders.

2.1.1 Cognitive behavioral theory

Cognitive behavioral theory by Aaron Becks approach emphasize teaching clients self management skills and how to restructure their thoughts, the clients learn to use these techniques to control their lives to deal effectively with present and future problems and function well without ongoing therapy (Corey, 2008). According to Liese, Beck and Seaton, (2002) cognitive process cover numerous mental activities such as beliefs, ideas, schemas, values, opinions assumptions among others that are likely to lead addictive behaviors including anticipatory beliefs, relief oriented beliefs, automatic thoughts facilitative beliefs and instrumental beliefs. This cognitive process interacts with the emotional, environmental, physiological and developmental process to determine if a person will manifest addictive behaviors. For example, as highlighted earlier in the background, most people initiate taking of drugs in anticipation of feeling good, relieving of stress and forgetting about the challenges they may be facing in life. Lesie et al (2002) argue that most addictive behaviors can be traced to various activating stimuli also known as triggers which could be both internal and

external. Internal triggers are mostly experienced as emotions e.g. anxiety, depression anger or boredom) or physiologic sensation (fatigue, pain, tension). People use addictive behavior as compensatory strategies to regulate and cope with feelings. For example, many people get into drugs when they join groups to relieve boredom, to relieve anxiety and depression. External cues include exposure to addictive substances, people and places. Many addicted youth feel helpless about urges and cravings they associate with external cues.

Cognitive behavioral addiction treatments focus on modifying thoughts and behavior and developing coping skills. Some of the goals of cognitive theory are teaching clients about relapse prevention strategies, coping with anxiety disorders and managing stress disorders. These are vital treatment programs for persons with drug and substance abuse disorders which include depression, social behaviors and other maladaptive behaviors that lead to drinking and taking drugs. Therefore according to this theory an effective program should help clients to understand the consequences of defective thinking and be assisted through restructuring their self concept to evade incongruence which undermines their psychological wellbeing (Corey, 2008). Psycho education and skill building mood control, motivation and readiness to change, crisis management and finding meaning in life are some of the areas to be emphasized in skill training (Lesie et al, (2002) to assist drug addicts in maintaining healthy behaviors. In addition Jone (2004) states *Most drug addicts feel wounded, neglected and need love, empathy and conducive or less threatening environment respond positive to therapeutic processes*. The programs should also cater for emotional needs if they have to facilitate healing among drug addicts. Essentially, most patients can benefit from treatment delivered in either in- or outpatient settings, although specific subgroups seem to respond optimally to particular environments (Landry, 1996).

The cognitive behavioral theory found its entry into the current study due to its basic assumption that most problematic behaviors, cognitions and emotions have been learned and

can be modified by new learning. Ben (2003) came up with a view that people need to cast aside their self defeating or negative thoughts and replace them with the positive ones. This process results to liberation of the mind from dependence on drugs and substances, leading to positive behavioral modification. Cognitive theory techniques enhance self control which is vital for rehabilitees to remain sober.

2.2 Drug and substance abuse

A base line survey NACADA 2004 on drugs and substance abuse targeting 10 – 24 years old youth indicate that the trend for drug and substance abuse is on the increase. Drug and substances of abuse have direct consequences on the users some use them to overcome problems and or cope up with some challenging issues in their lives. Drug abuse refers to the use of illegal drugs or the inappropriate use of legal drugs. According to NACADA (2010) the commonly abused drugs and substance by Kenyan youth include: - alcohol, tobacco, miraa, bhang, host of inhalants and prescription drugs. Personality factors, genetic factors and environmental influences are important determinants of drug and substance abuse in Kenya.

The United Nations office on drug and crime (UNODC) has supported several studies on drug abuse in Kenya. One of the studies, 'A rapid assessment study (Mwenes, 1995) points out that the drug abuse problem has permeated all levels of society with the youth and young adults being most affected (NACADA 2010).

2.3 Factors contributing to taking drugs

The major factor among the youth is peer pressure, instigated by need for acceptance and approval from their peers. Peer pressure accounts for 21 – 42 % influences in all types of drugs and substance consumed. Curiosity for reason of experiencing the Euphoria associated with certain drugs a person may be tempted to use drugs and substance accessible. In the process of satisfying curiosity an individual ends up being hooked. Curiosity accounts for the highest influence which ranges from 23 – 48 % NACADA (2010) Stress is another factor

influencing the use of drug and substances as away of running away from problems or harsh realities of life (United Nations Office on Drugs and Crime, 2008). Stress could be precipitated by poor job design, financial problem, family problem, poor academic performance, poverty and other depressive issues. Family negligence or instability may drive some members to taking drugs and substances as a way of escaping the realities of life. Lack of parental love and guidance lack of basic necessities may make children join the street families ending up inhaling solvents, glue and using drugs to cope up with frustration. Social occasion accounts for 35.4% of the reason for taking alcohol this is due to the esteem that most societies associate with taking alcohol at party times.

2.4 Effects of drugs

Drug abuse, also called substance abuse or chemical abuse, is defined by McCance-Katz (2004) as a disorder that is characterized by a destructive pattern of using a substance that leads to significant problems or distress. On the other hand, drug addiction, also called substance dependence or chemical dependency, is a disease that is characterized by a destructive pattern of drug abuse that leads to significant problems involving tolerance to or withdrawal from the substance, as well as other problems that use of the substance can cause for the sufferer, either socially or in terms of their work or school performance (Etheridge, and Hubbard, 2001).

The abuse of drugs in Africa is nevertheless escalating rapidly from cannabis abuse to the more dangerous drugs and from limited groups of drug users to a wider range of people abusing drugs. The most common and available drug of abuse is still cannabis, which is known to be a contributing factor to the occurrence of a schizophrenic-like psychosis (Ball and Dehne, 1998).

Drugs and substance abuse has both short and long term effects on the users. A meeting held in August, 1991 in Mombasa by preventive health education against drug abuse outlined the

effects of drugs in three categories; health, social and economic on the individual, family, community and the nation. Drugs damage body organs causing loss of self-control, emotional instabilities leading to maladaptive behavior; financial problems become evident as health care cost rises because of treating and rehabilitating the users. Due to effects on the health, loss of job due to constant absenteeism leads to low productivity hence loss of income which contributes to poverty.

2.5 Rehabilitation programs

According to Roberts (2001) rehabilitation programs is a term for the processes of medical and/or psychotherapeutic treatment, for dependency on psychoactive substances such as alcohol, prescription drugs, and so-called street drugs such as cocaine, heroin or amphetamines. The general intent is to enable the patient to cease substance abuse, in order to avoid the psychological, legal, financial, social, and physical consequences that can be caused, especially by extreme abuse of drugs.

There are many rehabilitation programs for drug and alcohol addiction. These programs include: Assessment of drug users which entails brief history of the substance in use, any past treatment and mental status examination. This should be done before any treatment program is drawn for the client (drug addict), self management programs and self directed behavior which includes teaching the rehabilitees how to live a self directed life and not to be dependants, counseling which will help people identify their problems and how to cope with them, individualized treatment plan, pharmacotherapy and medical care which deals with physiological effects of drugs which need medication such as detoxification, and relapse prevention techniques is to help the rehabilitees remain sober after being discharged from the rehabilitation centers NACADA (2010).

One objective of the study was to find out whether the human and infrastructural resources are enough and adequately trained to offer appropriate services to the rehabilitees. The

rehabilitees and rehabilitators should cooperate to ensure that the rehabilitation process is effective. Regular physical and social activities in the post-rehabilitation period are necessary for relapse prevention (Elton, 2003), and that is why infrastructural resources is important for recreation activities.

2.5.1 Assessment of drug users

In behavioral therapy the function and role of therapist is to conduct thorough functional assessment to identify the maintaining conditions by systematically gathering information about the situational antecedent, the dimension of the problem behavior and the consequences of the problem (Corey 2008). This guide to formulate initial treatment goals, design and implement a treatment plan to accomplish these goals. According to National Standards for treatment and rehabilitation of persons with substance use disorders NACADA (2010), client assessment should be done immediately a client is accepted or admitted in a rehabilitation treatment centre. The assessment comprises of assessing the physical and psychological functioning of the client which include Mental Status Examination (MSE) so that relevant therapeutic plan is arranged for the specific rehabilitee.

The services of the counselor are also of significance here. According to Drake and Mueser (2003), before assessment, the counselor should engage with the rehabilitee. One on one encounter between the rehabilitee and the counselor assists the rehabilitee to accept his or her problem, and his/her need for help. According to NACADA no treatment- in this case meaning drug rehabilitation therapy- should be administered to any client before assessment which entail brief history of client the substance in use any past treatment, risk potential for instance suicidal attempts and mental status examination (MSE). This forms the baseline of coming up with appropriate treatment plan to address the actual problems of the rehabilitee. The objective of assessment is mainly to understand the impact substance abuse has had on the individual, identify problems to be addressed in treatment programs and match the

participant to appropriate levels and types of substances abuse services to enhance recovery process. The rehabilitees should be put in program that helps them change their maladaptive behaviors and be able to practice them even after leaving the centers to avoid relapse. (Schuckit, 1994; American Psychiatric Association, 1995): established specialized substance abuse treatment programs had three similar generalized goals namely:

- Reducing substance abuse or achieving a substance-free life
- Maximizing multiple aspects of life functioning
- Preventing or reducing the frequency and severity of relapse

Murithi (2006) conducting a study to establish appropriate intervention measures for curbing drug addiction in Meru County observed that majority of studies focused on the effects of drug abuse but not assessing the causes of drug abuse so that the victims could be helped to lead normal life. NACADA (2008) highlighted in their study of drug addicts in Nyanza province that one of the causes of relapse cases was as a result of poor assessment of addicts prior to their admission in the rehabilitation centers. This observation was vital for this study for it helped the researcher find the appropriate procedures carried out in rehabilitation centers in Nairobi County. Assessment was the most carried out procedures in rehabilitation centers which the service providers used to base the treatment plan for their clients.

2.5.2 Self management programs and self directed behavior

In rehabilitation centers involvement and commitment of the clients in their treatment plan is crucial in behavior change. The client (rehabilitee) should own the treatment plan for change comes from within. This involves psychologists being willing to share their knowledge so that the consumers in this case the drug and substance addicts can increasingly lead self-directed lives and not be dependent on the experts to deal with their problems (Corey, 2005).

The rehabilitees should be helped to understand that their life is in their hands despite the kind of support they may get from the treatment centers. The centers have programs and

forums where clients participate in decision making in reference to the programs they are involved in, to help them become aware of what they are doing and get them out of the victim role (May (1981). Rehabilitees should be trained self management skills for instance being assertive, change their self-sabotaging beliefs and work out on their own given assignment to help change their self defeating behaviors. One of the factors in existential therapy states and I quote *"Learning that I must take ultimate responsibility for the way I live my life no matter how much guidance and support I get from others"* Yalom (1977, pg 56). Rehabilitation centers should have standardized programs to enable rehabilitees to remain sober even after leaving the centers. This can be done through effective after care services. Rehabilitees in treatment should fully participate in all activities designed to achieve the set goals in the treatment plan for them to achieve the desired changes within the given time. Decision making is an important self management skills the rehabilitees should be trained on making sound decision to effect positive behavior change. They should make decisions concerning behavior they want to change. There are five basic steps of self management program provided by Watson and Tharp (2002) these steps of self management program provided include: selection of goals which specifies behavior to be changed translating the goal into target behavior. Self monitoring among clients helps them observe their own behavior. This helps them (the rehabilitees) in devising a plan to bring out actual change. Further, this enables them to finally evaluate an action plan which should be flexible for easy adjustment bearing in mind that evaluation is a continuous process. This thus calls for full participation and commitment of the client (rehabilitee) on therapeutic programs offered in the rehabilitation centers.

Khantzian, et al (1997) observed that there can be defects that affects tolerance, distress, tension rage, shame and loneliness that clients may be unable to deal with. These may be caused by irrationally thinking/reasoning. Cognitive theory techniques which emphasize on

processing information rationally are very crucial for survival of any organization being inclusive in training self management skills to drug addicts. The researcher found that more is required to train the rehabilitees to own the programs and manage their self defeating behaviors.

2.5.3 Counseling in rehabilitation centers

Counseling is a therapeutic intervention which offers support and guidance and is undertaken by relevantly trained accredited and professional staff members NACADA (2010). In rehabilitation services are offered by interdisciplinary team with a primary counselor assigned to each client at the treatment centre. The counselor who is professional is responsible for the assessment and ongoing treatment of the client while at the centre. Counselors' help individuals identify behavior problems related to the use of drug and substance and come up with a recovery treatment plan. Higgins (2003) cites that the therapist functions as teacher and coach, fostering a positive, encouraging relationship with the patient and using that to reinforce positive change. The counselor should apply techniques which alter the irrational thinking beliefs and emotional and behavioral disturbance exhibited by person with drug and substance abuse disorders.

According to David et al (2010) Psychotherapy approach had developed a process of counseling people with drug and alcoholic problem the process involves exploring the patients problem, assisting the client set goals, motivating the client and helping them to maintain the changes they gain in the recovery process. It is believed that counseling process changes the individual behavior and counselors need to look at the broader framework of the patient lives before starting any therapy session. The Counselor is to apply techniques appropriate to individual clients in reference with the initial assessment reports by the interdisciplinary team in the rehabilitation centers. The counselor in rehabilitation to

understand the drug and substance abused their effect physically, socially and economically and how they affect the normal function of the clients.

Counselors (therapists) are trained to conduct treatment session in a way that promotes the client self-esteem dignity and self worth. National standards for treatment and rehabilitation of persons with substance use disorders advocate for professional mental health practitioner to offer service in drug and substance rehabilitation treatment centers.

2.5.4 Individualized treatment plan

Individualized treatment (ITP) is one of the programs recommended for treatment of persons with drug and substance disorder. Baker (2002) observes that individualized treatment focuses directly on reducing or stopping the addict's illicit drug use through regular monitoring and multiple interventions like behavioural therapy, group counselling, cognitive therapy and medication. It also addresses patient's recovery program by seeking the intervention of family members and the rehabilitee's immediate community on addressing certain external factors that influence the rehabilitee to take up drug abuse and other illicit activities. Individual treatment selection depends on the nature of the substance addiction and psychological condition of the personal preferences, strengths and characteristics and the social needs. The individual plan includes the clients' responsibility and commitment to the rehabilitation process and the type of therapeutic activities the client will be involved. The client should be involved in the plan, to own it and work towards the set goals to eradicate the self defeating behavior (Corey, 2008).

Individualized treatment assists in addressing the actual individual problem without generalizing for individuals react differently though using same drugs. Individualized treatment can be a motivator to enhance participation for the clients feels accepted and well understood. Freedom of expression is guaranteed for some individual clients may be shy to share their experiences (Baker, 2002).

Individualized drug counseling helps the counselor interact with the patient effectively. During general counseling sessions, patients might find it hard to discuss or disclose some personal information in relation to circumstances that led to use of the drugs. Through its emphasis on short-term behavioral goals, individualized drug counseling helps the patient develop coping strategies and tools for abstaining from drug use and then maintaining abstinence. However, extensive individualized counseling is important as a form of follow up process that aims at ensuring that the rehabilitees don't go back to their old habits (Peirce, 2006). Though individualized treatment is important according to the study findings most rehabilitation centers prefer group counseling due to lack of adequate staff. This hinder many rehabilitees individual needs not be addressed leading to slow recovery process.

2.5.5 Group counselling

Besides involving counselors in the recovery process, it is equally important to use this method in preventing cases of addiction. Qualified counselors are involved in group counseling where collective counseling is offered to the group (Solhkhah, 1998). In ensuring that the counselors drive in their points clearly, they may decide to incorporate previous drug and alcoholism recovering addicts in advising the group of the importance of abstaining from drugs.

In drug and substance rehabilitation centers the clients share some similar problems. Group counseling will enable the practitioner work with more clients and especially where there is inadequate staff. Group members also benefit from the feedback and insight of other recovering addicts. Persons with drugs and substance disorders experience poor interpersonal relationship so in participating in group therapy the interactions may assist them learn how to establish meaningful and intimate relationships (Corey, 2008).

Anxiety and depression are common problems associated with drug addicts. This leads to low self esteem, suicidal attempts and severe psychosis. As the members share their experiences,

in group session the recovering drug addicts' acts as a role model to others who may be in denial or lost hope in life. One major goal of group therapy is to increase self acceptance, self confidence, and self respect and achieve a new view of oneself and others (Corey 2008). As the addicts interact they gain insight and practice new skills like communication, commitment to the ongoing treatment programs as they hear and observe their fellow group members. Group members through the guidance of therapists, can form support group which can benefit the members after being discharged from the centre. According Corey (2005) group therapy could be applicable to addicts experiencing resistance by learning to shed off the facade and face the reality of life. Some addicts may be in denial and may be blaming others for their current state.

In conclusion, counseling should focus on growth and development, enhancement of prevention, self-awareness and releasing block to growth (Corey 2005) The role of counselors is to ensure that the patient get the required attention especially offering non judgmental and yet assertive counseling. During withdrawal process, behavioral symptoms may be experienced and counseling sessions could be of help at this point. It is suggested that more refined counseling need to be offered beside the renowned self help group counseling (Solhkhah, 1998). The counselors in such situations are expected to enhance motivation while offering cognitive therapies. Although the decision to withdraw from drugs and alcoholism comes from the victim, some may fail to accept their conditions and this may lead to self denial that eventually leads to suicide.

The counselors have to be very careful in ensuring that they pay attention the patient's clinical history involving alcohol and drug withdrawal complications. This would help them evaluate on which best approach to use in helping the patient recover effectively (Davidson, et al, 2010). Medical treatment of patients with withdrawal symptoms should go hand in hand with the psychological therapy that is intended to help the patient in coping with problems

like depression. For the patient to completely withdraw from addiction, counseling programs should be extended to the family members and friends of the victim. Since the counselors cannot be able to stay with the patient throughout, the immediate people need to be highlighted on how to carefully take care of the patient.

It is very important that the counselor ensure that the patient is discouraged to intermingle with people that may end up influencing them to go back to drugs and alcoholism. In some instances, it's the parents who are affected and this affects the children as well. Therefore, the counseling services should be extended to other family members who may be affected by the withdrawal symptoms by the patient/drug addict in the family, which the researcher found fairly applied by most rehabilitation centers.

2.5.6 Pharmacological intervention

Pharmacological intervention is an individualized treatment and therapy using prescribed drugs. Addiction is abnormal psychological status created by misuse of drugs and substances, pharmacotherapy can provide relief for abnormal psychological disorders which include depression, anxiety and accompanied withdrawal symptoms. Medication is applied to reduce the effects of the drugs which may be pathological. Detoxification is a collective of intervention directed at controlling acute drug intoxication and drug withdrawal NACADA (2010). Detoxification is used on drug addicts while anti abuse is commonly used on alcoholism to revert the effects. Ibogaine is an experimental medication proposal to interrupt both physical dependence and psychological craving to a broad range of drug including narcotics, stimulants and alcohol Spate Dagoto and Kalata (2006).

According to the National Institute on Drug Abuse (NIDA) patient stabilized on adequate sustained dose of methadone can keep their jobs avoid crime and violence and reducing injection drug and drug related high risk sexual abuse. Anti abuse produces a very unpleasant

reaction when taking alcohol which includes flushing, nausea, and palpitation. These disturbing feelings force an alcoholic client to stop taking alcohol.

According to NACADA 2010, only a trained medical clinician should administer medication after an intense assessment of the client. Medicine can have adverse, severe effects on the client if poorly administered. Close monitoring should be put in place to address any negative reaction.

2.5.7 Relapse prevention

Relapse prevention and management techniques should be emphasized to help clients (rehabilitees) avoid and deal with relapse situations after learning skills at the treatment centers (Khan, 1998). The relapse prevention approach to the treatment of cocaine addiction consists of a collection of strategies intended to enhance self-control. Specific techniques include exploring the positive and negative consequences of continued use, self-monitoring to recognize drug cravings early on and to identify high-risk situations for use, and developing strategies for coping with and avoiding high-risk situations and the desire to use. A central element of this treatment is anticipating the problems patients are likely to meet and helping them develop effective coping strategies (Spate, Pagoto, and Kalata 2006). Research indicates that the skills individuals learn for instance stress management, coping with and avoiding high risk situations which may trigger craving may remain after the completion of treatment.

In one study, most people receiving this cognitive-behavioral approach maintained the gains they made in treatment throughout the year following treatment (Alan, 1985). Alan describes four psychosocial processes relevant to the addiction and relapse processes: self-efficacy, outcome expectancies, attributions of causality, and decision making processes. Self-efficacy refers to one's ability to deal with high risk relapse provoking situations competently and effectively. Outcome expectancies refer to an individual's expectations about the psychoactive effects of an addicted substance. Attributions of causality refer to an

individual's pattern of beliefs that relapse to drug use is a result of internal or rather external, transient causes (e.g. allowing oneself to make exceptions when faced with what are judged to be unusual circumstances) finally; decision making processes are implicated in the relapse process as well. Substance use is the result of multiple decisions whose collective effects result in consumption of the intoxicant. Furthermore, Alas (1985) stresses some decisions may seem inconsequential to relapse but may actually have downstream implications that place the user in a high risk situation. According to the research findings relapse cases reported in most rehabilitation centers were attributed to lack of sufficient individualized treatment, lack of adequate staff and infrastructural constraints in some centers.

2.5.8 Aftercare programs

Aftercare refers to the continuing treatment a person receives immediately after being discharged from residential rehabilitation center. Aftercare helps addicts put their newfound skills to practical use with the support of the rehabilitation centers. It is one of the most important actions any recovering addict can take to increase their odds of successful sobriety (Elton, 2003). Recovery from drug addiction doesn't end once rehabilitees leave the doors of rehabilitation center. Completing a rehabilitation treatment program is just the beginning of a long journey to maintaining sobriety. Drug rehabilitation teaches the skills needed to remain sober, but the real test comes once rehabilitees leave the program and enter the real world.

The period of time directly following rehabilitation treatment is the most fragile time for recovering addicts. According to Morton (1999), this is stage in which the rehabilitee faces the society in a different state of mind. How he/she adapts to the perception of those around him/her might determine long term abstinence from drugs or a roll back to more severe addiction state. Treatment provides a safe and structured environment that supports a sober lifestyle, but the real world is full of temptations and triggers that threaten sobriety at every turn. Aftercare helps patients transition to 'the outside' and apply the lessons they learned in

rehabilitation centre with the support of professionals and other addicts in recovery. Other than the mandatory medical and psychological therapies in the rehab, the professionals are mandated with equipping the rehabilitees with crucial life skills. Case managers and counselors help the rehabilitees with life management issues such as living arrangements, employment, relationships, emotional healing, and continued skill building in maintaining sobriety. Peer support groups allow you to connect with other individuals just like you who can help keep you on track toward your goal of sobriety (Shorter and Onyonka, 1999). The implication is that successful rehabilitation facility must factor an after care service program in there approach to behavior change

Otieno (2011) argues that most drug addicts revert to the vice after treatment because of insufficient psychological care during and after treatment. NACADA said more emphasis should be put on psychological intervention to compliment medicine in the treatment and rehabilitation of addicts. This should recur both during regular therapy and during aftercare services. NACADA observes that treatment and rehabilitation of addicts needs a two-pronged approach with concerted efforts from the authority, the society and the addicts. "In the treatment of addicts, the pharmacological intervention and psychological care are all important. But the psychological aspect is more important because it deals with the aftermath of treatment," said NACADA treatment and rehabilitation program boss, George Murimi. Murimi said dealing with addicts needs a lot of sacrifice if they are to be helped to completely quit. So, it is important both the rehabilitators and rehabilitees to collaborate if a rehabilitation process are to be any effective. The study established that quite a number of rehakilitees were not aware of the aftercare programs or support groups.

2.5.9 The matrix model

This treatment approaches includes drug education and self help participation. It is a detailed treatment manual, contain worksheet for individual sessions, family educational groups, early

recovery skills, relapse preventions conjoint sessions, urine test, 12 step programs, relapse analysis and social support groups (Nutbearn 2000). Matrix model comprises of the treatment programs advocated in rehabilitation centers which involve interdisciplinary team to achieve set goals. In rehabilitation centers there should be individual counseling to address individual diversities, family involvement for enhancement of recovery process, urine test for monitoring and evaluating healing process and more so relapse prevention.

The Matrix model is a drug and substances treatment plan that gives a framework for engaging a stimulant, which abusers who are involved in treatment can use to help them achieve abstinence from such drugs (Sullivan and McKendrick, 2007). Since most substance and drug abusers develop dependency on the drugs and the stimulants can assist them fight the urge. Robert (2001) asserts that a number of projects have demonstrated that participants treated with the matrix model demonstrate statistically significant reduction in drug and alcohol use and curbing many effects of drug and substance disorders thus improvement in psychological indicators and reduced risky sexual behaviors associated with HIV transmission. Persons with drug and substance disorder are associated with multiple problems need comprehensive intensive programs to address the problem.

Matrix model provides a frame work for engaging stimulant abusers in treatment and helping them achieving abstinence. Rehabilitees exposed to this model learn about issues critical to addiction and relapse receives direction and support from trained personnel to become familiar with self-help programs. The program includes education for family members affected by the addiction Robert (2001) family education and counseling is very essential it helps parents and significant others to accept and understand the conditions of drug addict within the family and offer appropriate support towards recovery and minimize relapse. Family support and involvement is required in rehabilitation centers as part of the treatment programs for the family members need to be trained also on how to cope with co-dependency

NACADA (2010). In conclusion matrix model is a multi tasking program which comprises the major programs in the rehabilitation centers.

2.6 Summary of literature review

The study was based on the effectiveness of rehabilitation programs in modifying behavioral disorders exhibited by drug addicts. Rehabilitation programs entail medical and psychotherapeutic treatment. The programs include Assessment which is very crucial on determining the kind appropriate programs for specific client. It entails brief history of the client, the substance in use, any past treatment and Mental Status Examination (MSE).

Counseling ascertain the client willingness to undergo the therapy and identifying which part of assessment to be designed for effective treatment program for the client. Pharmacotherapy is part of medical treatment which entails detoxification as the initial stage of drug treatment. Drug addicts are likely to experience complicated withdrawal symptoms which need to be addressed detoxification alleviates some of the life threatening symptoms. Lastly matrix model is multi component framework treatment for stimulant abusers which addresses their needs systematically. It entails psycho education; relapse prevention, individual contact with therapist which enhances behavior change.

Review on Cognitive behavioral theory (CBT) reveal that processing of information is crucial for the survival of any organism, thus helping clients to correct their irrational ways of processing information in the environment. The theory is designed by Psychologists and Psychiatrists to help disturbed people to function normally as expected in the society through developing rational thinking and avoiding faulty mental process which causes them to manifest the characteristics of emotional disturbances (Ellis, 2008).

The conceptual framework of this study, Illustrated the rehabilitation programs which enhance effectiveness in assisting drug addicts in rehabilitation centre. If the programs/services are adequate, well structured and based on the client's specific needs are

identified through comprehensive assessment may lead to high achievement in modifying personality disorders exhibited by drug addicts.

2.7 Conceptual framework

The conceptual framework of this study emanates from the correlation between competent rehabilitation practices and ideal resources with respect to effective drug rehabilitation. This is shown in figure 2.1

Figure 2.1: Conceptual Framework

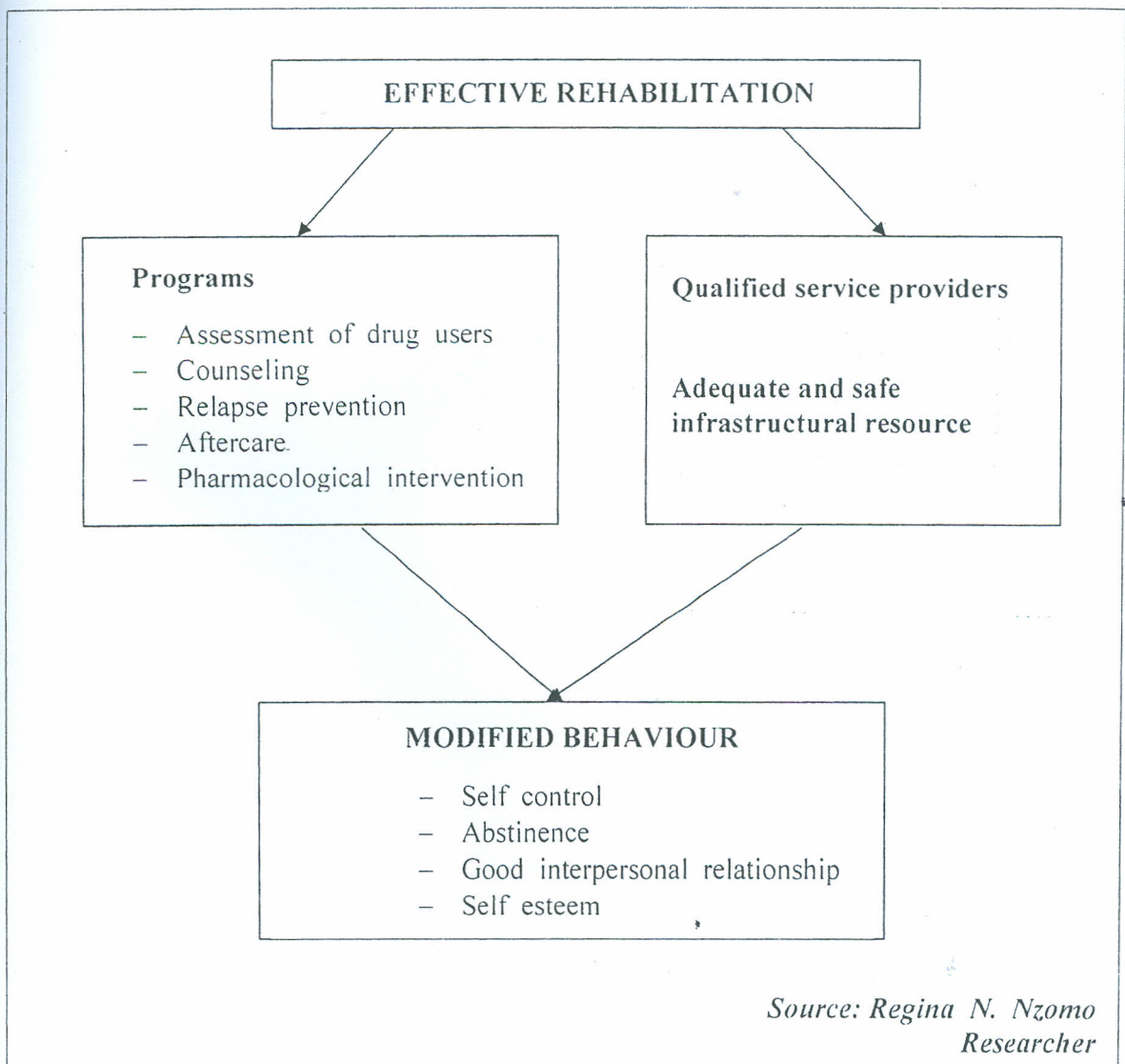


Figure 2.1 shows that successful drug rehabilitation is determined by the relationship between certain competent rehabilitation practices and ideal resources. Effective rehabilitation practices include adequate treatment programs, qualified service providers, efficient assessment procedures, adequate and safe infrastructural resources. An ideal interplay of these ideal resources in the rehabilitation centers ultimately results to an effective drug rehabilitation process hence modified behavior.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

The purpose of the study was to establish the effectiveness of rehabilitation programs in relation to behavior modification of drug addicts in rehabilitation centers in Nairobi County. This chapter dealt with description of the methodology that was used in conducting the research on the effectiveness of drug rehabilitation centers in Nairobi. The section is divided into the following subsections: research design, study location, target population, sampling technique, research instruments, pilot study, data collection procedures and data analysis technique.

3.1 Research design

The study was carried out using the descriptive, cross-sectional survey design. Descriptive study is concerned with conditions or relationships that exist, opinions that are held, processes that are going on, effects that are evident or trends that are developing. It is concerned with the present although it often considers past events and the influences as they relate to current conditions Best and Kahn (2009). Owens (2002:3) describes cross-sectional survey design as data collected at one point in time from a sample selected to represent a larger population. The design involved collecting data on a sample or cross-section of the respondents who were selected to represent rehabilitees (drug addicts) and service providers at the rehabilitation centers in Nairobi County.

3.2 Study location

The study was conducted in Nairobi County in gathering comprehensive information to meet its objective. Nairobi County has a wide range of rehabilitation centers manned by the government, non-governmental organizations, religious organizations as well as individuals. Furthermore drug use in urban centers is rampant due to easy accessibility.

3.3 Target population

According to Borg and Gall (1989) target population is defined as all members of a real or hypothetical set of people, events or objects to which an investigator wishes to generalize the results of the study. The population of the study was the 100 purposively sampled service providers and 30 of the rehabilitees in the rehabilitation centers who were able to provide information on availability of programs in their centers. According to NACADA (2010) there are a total of 61 rehabilitation and treatment centers for substance and drug addicts in Kenya. 18 of these are in Nairobi County. The researcher purposively sampled a total of ten (10) out of a total of eighteen (18) rehabilitation centers and 30% of the rehabilitees in the centers in Nairobi County.

3.4 Sampling procedure and sample size

The researcher used random Sampling in selecting rehabilitation centers and purposive sampling was used to select the respondents for the study. Purposive sampling allowed the researcher to select those participants who provided the richest information and those who manifested the characteristics of most interest to the researcher Best and Khan (2009). The researcher selected drug addicts undergoing rehabilitation for behavior change and also selected rehabilitation centers dealing with drug addicts in Nairobi County.

The study used stratified random sampling to sample the rehabilitation centers staff members. In stratified random sampling the population is first subdivided into strata, which are joined to form the complete stratified samples (Orodho, 2009). The researcher used this sampling procedure because the targets respondents were divided into two strata's; rehabilitees and the practitioners (service providers) at the centers. This method was supported by the assertion that if the population from which the sample is drawn does not constitute a homogenous group, then stratified sampling technique was applied to obtain a representative sample Orodho (2005). Table 3.1 shows the distribution.

Table 3.1: Distribution

CQUNTY	CENTERS	SAMPLE CENTERS	SAMPLE SERVICE PROVIDERS	REHABILITEES
Nairobi	18	10	100	30

3.4.2 Sample of the Rehabilitation Respondents

According to a study by Gay (1996), 10% of the total population is held to be representative, therefore the researcher picked 10% of the total number of service providers (staff members) and 30% of the total number of rehabilitees in the selected rehabilitation centers as the respondents in the study.

3.5 Instrumentation and data collection techniques

In this study, questionnaire and interview Guide were used. The questionnaires were selected because a large number of respondents are reached within a short time, Kothari (2004). Use of questionnaire in this study made it possible to reach all the rehabilitation centers staff members participating in the study since they were only required to fill in at their own time. The questionnaire consisted of both closed and open-ended items that were meant to capture the responses of the participants regarding the issues under investigation.

On the other hand, interview method was used since it generally yields highest cooperation and lowest refusal rates, offers high response quality, takes advantage of interviewer presence and it is a multi-method data collection (Owens, 2002). An in-depth interview with the rehabilitees solicited a lot of information that was useful in determining how rehabilitation programs are effective in behavior modification of drug addicts. Observation was also employed the researcher was interested also in the environments hosting the rehabilitees.

3.6 Validity and reliability

Validity is the degree to which a test measures what it purports to measure and consequently permits appropriate interpretation of the scores (Nachmias and Nachmias, 1996). In regard to construct validity the concept of treatment of persons with substance and drug disorder was

captured as outlined in the National standards of treatment and rehabilitation of persons with substance use disorders NACADA (2011). The content validity was ensured by the ten sampled rehabilitation centers where information was sourced from the staff members and the rehabilitees in the centers through questionnaires, interviews and observations.

Reliability is the consistency of measurement, or the degree to which an instrument measures the same subjects. Different groups which included the clients and staff from different centers were used.

3.7 Piloting

Piloting is pretesting of the instruments to be used to collect data. The purpose of piloting was to cross check the suitability of the questionnaire as per the study objective, adequacy of the space provided and for clarification. Fifteen (15) staff members and 3 rehabilitees drawn from the three rehabilitation centres were requested to complete the questionnaires and respond to interview guides respectively. The staff members were randomly sampled. The participants were encouraged to make comments and suggestions concerning the instructions in the questionnaires and interview guides, clarity of the questions and relevance of the questions to ensure that the instrument measures what it was expected to measure. The pre-tested and revised questionnaire and interview were adopted for the study. Data used for piloting was not utilized in the main study.

3.8 Data analysis procedure

The collected data was organized and prepared for analysis by coding and entry in the Statistical Package for Social Sciences (SPSS, Ver.10). The researcher used descriptive statistics such as frequencies and percentages. The outcomes of the quantitative data from the coded closed-ended items were analyzed using descriptive statistics. Further, the data was interpreted and discussed in relation to the research questions. On the other hand, the qualitative data generated from open-ended questions in the interview guide was analyzed

and categorized in themes in accordance with research questions and was reported in a narrative form.

3.9 Data management and ethical consideration

Sommer and Sommer (1997) argue that ethical considerations such as confidentiality, anonymity and avoidance of deception are very important issues in social research. Mugenda & Mugenda (2003) asserts that a researcher has to be careful to avoid causing physical or psychological harm to respondents by asking embarrassing and irrelevant questions, threatening language or making respondents nervous. In this study data collections and analysis was approved by the Supervisors, Department of Psychology Kenyatta University and Post-graduate School. The researcher sought permission to carry out the research from the Ministry of Higher Education, Nairobi County Commissioner and Nairobi County Director of Education. The researcher also sought permission from Managers/Administrators in the rehabilitation centers to carry out the research in there premises. The researcher assured the participants in this study to keep all information secure and confidential. Relevant authorization and clearance was sought binding the researcher to fulfill all aspects of ethics as required by Kenya Law in research.

CHAPTER FOUR

4.0 ANALYSIS AND PRESENTATION OF THE FINDINGS

4.1 Introduction

This chapter presents the analysis and presentation of the findings of the study on the effectiveness of drug rehabilitation programs on behavior modification of drug addicts in Nairobi County. The purpose of the study was to establish the effectiveness of rehabilitation programs in relation to behavior modification of drug addicts in rehabilitation centers in Nairobi County. The specific objectives of the study were as follows;

- i. Types of programs offered in drug and substance rehabilitation centers in Nairobi County.
- ii. Assessing the effectiveness of the programs in addressing the needs of drug addicts
- iii. Capacity of service providers (staff) to offer rehabilitation services in rehabilitation centers.
- iv. Type and quality of continuing/after care services available in the rehabilitation centers.
- v. Challenges influencing the effectiveness of rehabilitation programs.
- vi. What needs to be done to improve the effectiveness of the programs in existing rehabilitation centers in Nairobi County.

The data was collected among the staff and the practitioners offering services in the rehabilitation centers and the clients admitted.

4.2 Staff members and rehabilitees' response rate

A total of 100 structured questionnaires were administered to the Staff and additional 30 to the rehabilitees. Out of this only 86 for the staffs and 24 for the rehabilitees were returned back which translates to 86% and 80% response rate for staff and rehabilitees respectively.

According to Braun (2006), a response rate of 75% and above is deemed representative.

4.3 Background characteristics of staff members and rehabilitees

Background characteristics determined from the rehabilitation centers' staff members and rehabilitees included: gender, age, and number of years spent by staff members and the months taken by the Rehabilitees in the rehabilitation center as shown in the table 4.1 and 4.2 below respectively:

Table 4.1: Background characteristics of staff members

Background characteristics of staff members	Frequency	Percent
Gender		
Male	49	56.9
Female	37	43.1
Age		
20-30 Years	45	52.4
41-50 Years	26	30.2
31-40 Years	11	12.8
Above 50 Years	4	4.6
Years in the Rehabilitation Center		
1-5 Years	50	58.1
11-15 years	20	23.2
6-10 years	9	10.5
Above 15 years	7	8.2

From table 4.1, a majority of the rehabilitation centers' staff were male, 49 (56.9%), whereas, 37 (43.1%) were female. From the observation made in the study this may have been attributed to the aggressiveness of most rehabilitees thus hiring more male staff members than women, this may be supported by the stereotype that women are weaker than men.

With regards to age, a majority of the staff members, 45 (52.4%) were aged between 20 to 30 years; 26 (30.2%) were between 41 and 50 years old, 11 (12.8%) were between 31 and 40 years old whereas 4 (4.6%) were above 50 years. Pertaining number of years as a member of

staff in the rehabilitation center, a majority of the respondents, 50 (58.1%) had served in their respective rehab centers for 1 to 5 years, 20 (23.2%) had served for 11 to 15 years, 9 (10.5%) for 6 to 10 years, whereas the rest, 7 (8.2%) had served for over 15 years. This indicates that a good number of staff members had adequate experience in offering services in the drug rehabilitation centers.

Perhaps due to the age of the rehabilitees, may be the rehabilitation managers sought to employ young professional to motivate the rehabilitee to open up more without fear. As stated earlier therapists engaging with clients may promote participation of the rehabilitees in the treatment programs. Though age compatibilities may enhance recovery in the other hand it may also hinder effectiveness of the program. In the study findings, though there were a few number of the rehabilitees aged 41 – 50 years, opening up to the young professional could be difficult as they may view the professionals as their children. In some centers there were no staff members of the age bracket of 41 – 50 years. According to Richard Nelson Jones (2004) client benefit from therapists who can provide safe emotional climate and help them move forward in disclosing, exploring, experiencing and understanding themselves.

This age disparities may affect the achievement of the programs put in place, reason being that important information may be left out then treatment plan designed may fail to curb the rehabilitee's problem.

Table 4.2

Background characteristics of rehabilitees	Frequency	Percent
Gender		
Male	17	70.8
Female	7	29.2
Age		
31-40 Years	12	50.0
20-30 Years	9	37.5
41- 50 Years	3	12.5
Above 50	-	-
Period in the rehabilitation center		
1-3 Months	10	41.7
4-6 Months	8	33.3
7-9 Months	6	25.0
10 Months and above	-	-

From **table 4.2**, a majority of the rehabilitees were male, 17 (70.8%), whereas, 7 (29.2%) were female. The study revealed that there were more male rehabilitees than female counterparts; this could be attributed by the fact that more men than women were exposed to drugs and substance abuse. In Kenya the National Campaign Against Drug Abuse Authority (2009) gives a snapshot of the alcohol problem in Kenya showing regional distribution of prevalence of drug and alcohol abuse. In the report the Central/ Mount Kenya region is among the regions leading in alcohol use/abuse prevalence at 33.2% for male and 4.7% for female coming second to Coast which has 34.6% for male and 7.4% for female. The Rift Valley has 23.4% for male and 5.3% for female. The finding resonates well with existing literature that suggests more men than women engage in drinking alcohol.

Regarding to age, a majority of the rehabilitees, 12 (50 %) were aged between 31 and 40 years; 9 (37.5%) were between 20 to 30 years, while 3 (12.5%) were between 41 and 50 years

old. This shows that majority of the rehabilitees were in a period of midlife crisis characterized by daily life depressions leading them to drug and substance abuse.

With respect to period in the rehabilitation centers, a majority of the respondents, 10 (41.7%) had been in their respective centers for 1 to 3 months, 8 (33.3%) had been in the centers for 6 to 10 months, whereas the rest, 6 (25%) had been in the relevant centers for 10 months and above. This indicates that a good number of rehabilitees had been in the rehabilitation centers for the recommended three (3) months and few stay longer due to relapse as confirmed by some staff members. From the study findings 58% of the rehabilitees had exceeded the recommended three (3) months period in a rehabilitation centre. This may be an indication that the program treatment offered may not have met the individual needs or poor assessment prior to admission was done leading to inappropriate program designed to the client. The study therefore sought to respond to the specific objectives of the study.

4.4 Objective 1: Types of programs offered in drug and substance rehabilitation centers

The study was interested in finding out the types of programs offered in drug and substance rehabilitation centers in Nairobi County. To achieve this objective, the staff members who took part in the study were first asked to state if their centers offered rehabilitation programs. To which, all the staff members 86 (100%) agreed that they were in existence. The participating staff members were then provided with a list of drug rehabilitation programs, and asked how prevalent they were in their respective centers;

The responses are shown in table 4.3

Table 4.3: Types of programs offered in drug and substance rehabilitation centers

No.	Programs	Prevalence							
		Often		Sometimes		Rarely		Never	
		F	%	F	%	F	%	F	%
a)	Assessment of drug users	81	94.2	5	5.8	-	-	-	-
		Yes		Not sure		No			
		F	%	F	%	F	%	F	%
b)	Self management and self directed behavioral program	62	72.1	17	19.7	7		8.2	
		To a greater extent		To some extent		Not at all			
		F	%	F	%	F	%	F	%
c)	Counseling	79	91.9	7	8.1	-		-	
		Agree		Undecided		Disagree			
		F	%	F	%	F	%	F	%
d)	Individualized treatment plan	65	75.6	16	18.6	5		5.8	
		Often		Sometimes		Rarely		Never	
		F	%	F	%	F	%	F	%
e)	Pharmacotherapy and medical care	71	82.6	15	17.4	-	-	-	-
		Yes		Not sure		No			
		F	%	F	%	F	%	F	%
f)	After care and follow up programs	56	65.1	13	15.1	7		19.8	

From the table 4.3 above it was observed that an overwhelming majority of the staff members, 81 (94.2%) indicated that assessment of drug users was often offered in their center, 7 (8.1%) observed that the program was offered sometimes. Assessment is the baseline of formulating appropriate treatment plan to address the individual needs of the clients. According to Corey (2008) functional assessment carried out systematically by gathering information about the situational antecedent the dimension of the problem behavior and the consequence of the problem.

A study by NACADA (2008) In Nyanza province highlighted one of the key causes of relapse cases was as a result of poor assessment of drug and substance abuse addicts prior to their admission in the rehabilitation centers. However, from the study, it was not clear whether the assessment carried out was effective since many rehabilitees were found to stay longer in the rehabilitation centers than the recommended treatment period.

Self management and self directed behavioral program

62 (72.1%) of staff members indicated that self management and self directed behavioral program were offered in the centers, 17 (19.7%) were not sure, whereas 7 (8.2%) it was not offered. Self management and self directed behavioral programs entails involvement and commitment of the clients in the treatment plan or programs in the rehabilitation centers. The rehabilitees owns the treatment plan, learn to be assertive change their self sabotaging belief and carry out own given assignment.

From this study observation made indicate that majority of the client were reluctant to participate in the programs, leaving question whether they voluntarily joint the rehabilitation of forced by family members. One of the factors of the existential therapy states that, and I quote: *“Learning that I must take ultimate responsibility for the way I live my life no matter how much guidance and support I get from others”* Yalom (1977, pg 56).

Clients need to participate in setting goals based on behavior to be changed. From the client (rehabilitee) views quite a big numbers felt the rehabilitation centers were boring which may have been contributed by lack of being fully engaged in programs.

Counselling

With regards to counseling, an overwhelming majority of the staff members, 81 (94.2%) were of the view that it was offered in their center to a greater extent; 5 (5.8%) indicated that that it was offered to some extent. Counselling is a therapeutic approach which offers support and guidance to the client. This involves exploring the patient problem assisting clients to set

goals on behavior to change, motivating the client and helping them to maintain the changes gained in recovery process David et al (2010).

Counselling helps the client to understand and appreciate the consequences of drug addicts and how to revert their self defeating behavior and beliefs. For this reasons, many rehabilitation centers globally offer some counseling services

Individualized treatment plan

Majority of the staff members, 65 (75.6%) agreed that individualized treatment plan was offered in their centers, 16 (18.6%) were undecided, whereas 5 (5.8%) chose to disagree.

As indicated 75% of the respondents confirmed individualized treatment plan is carried whereas individualized treatment plan assist in addressing the actual individual problem without generalizing for individuals may react differently though using same drug. According to Baker (2002) individualized treatment focuses directly on reducing or stopping the addict's drug use, through regular monitoring and multiple intervention.

Pharmacotherapy and medical care

A majority of the staff members, 71 (82.6%) indicated that pharmacotherapy and medical care was often offered in their center, 15 (17.4%) observed that the program was offered sometimes.

Pharmacotherapy intervention entails individualized treatment and therapy using prescribed drugs to relief abnormal psychological disorders, depression and anxiety, reducing the effect of drugs which may be pathological. Detoxification was commonly applied. According to NACADA (2010) detoxification is a collective intervention directed at controlling acute drug intoxication and drug withdrawal. From the staff views majority of the drug/substance addicts are brought to the centers with acute abnormal psychological disorders which require medical attention therefore making pharmacotherapy the second given therapy after assessment.

From the study findings some clients seek rehabilitation services when they are suffering from acute physiological disorders and mental disorders which require medication. Pharmacotherapy as observed help clients to be sober and most of them healed from various diseases. However some expressed fears they may get different addiction before they are discharged for some confused the drugs they were given for medication with the substances they were using before admission. This may indicate the clients were not versed why they were taking the medicine, and some confirmed they were not taking them literally they could throw them or induce vomiting due to eradicate nausea effects. According to the researcher this compromise the effectiveness of the treatment, and may be attributed to the lack of adequate staff to monitor and follow up individual client's and the prolonged stay of up to ten months which is captured in this study.

According to Matilde P. Macho (2005) programs differ in effectiveness, but entails treatment duration, matching patient characteristics and treatment, directing more services to particular areas and better patient outcome. Pharmacotherapy also entails thorough assessment of clients before any medication is administered to avoid negative effects of drugs.

Aftercare and follow up programs

A good number of the staff members, 64% observed that after care and follow up programs were offered in their centers, 36% indicated that they were never offered, though they ascertained that they were important in maintaining the clients' sobriety and reinforcing learnt skills. Aftercare programs refer to the continuing treatment a person (rehabilitee) receives after being discharged from residential rehabilitation centre.

Relapse prevention occurrences in the rehabilitation centers

The staff members outlined the following as the measures in which they take to prevent relapse occurrences in their centers:

- Frequent follow-ups to clients via parents and social media platforms

- Emphasizing the negative consequences of further drug use to the clients
- Reinforcing coping strategies to permanently kill the craving of drugs
- Advising the clients against engaging in situations that result to drug usage
- Advising the clients to join support groups after leaving the rehabilitation centers.

Relapse prevention is a major program in maintaining the sobriety of the drug addicts after discharge from the centers. From the staff members there were relapse prevention programs put in place. However family therapy and counseling was not featuring which is vital in supporting the addicts toward recovery and minimize relapse.

Robert (2011) asserts that family education and counseling is essential in helping the addicts' parents and significant others to accept and understand the conditions of the addicts to offer appropriate support, after discharge.

With all the programs offered, it was important to establish the effectiveness of the programs offered. As highlighted in chapter two, effects of drug addiction are pervasive in the society, and rehabilitation programs offer hope in helping addicts to change their behavior. But this is only possible if programs are appropriately administered to match individual problems.

4.5 Objective 2: Examine the effectiveness of the rehabilitation program in addressing the clients needs:

To examine the effectiveness of the rehabilitation program in addressing client's needs the study pegged its findings on the main procedure followed prior admission of the clients in the centers which are crucial in determining the appropriate treatment plan to match rehabilitees' needs. If clients' needs are not met then the current programs are ineffective.

Figure 4.1: Procedure of rehabilitee assessment in the rehabilitation centers

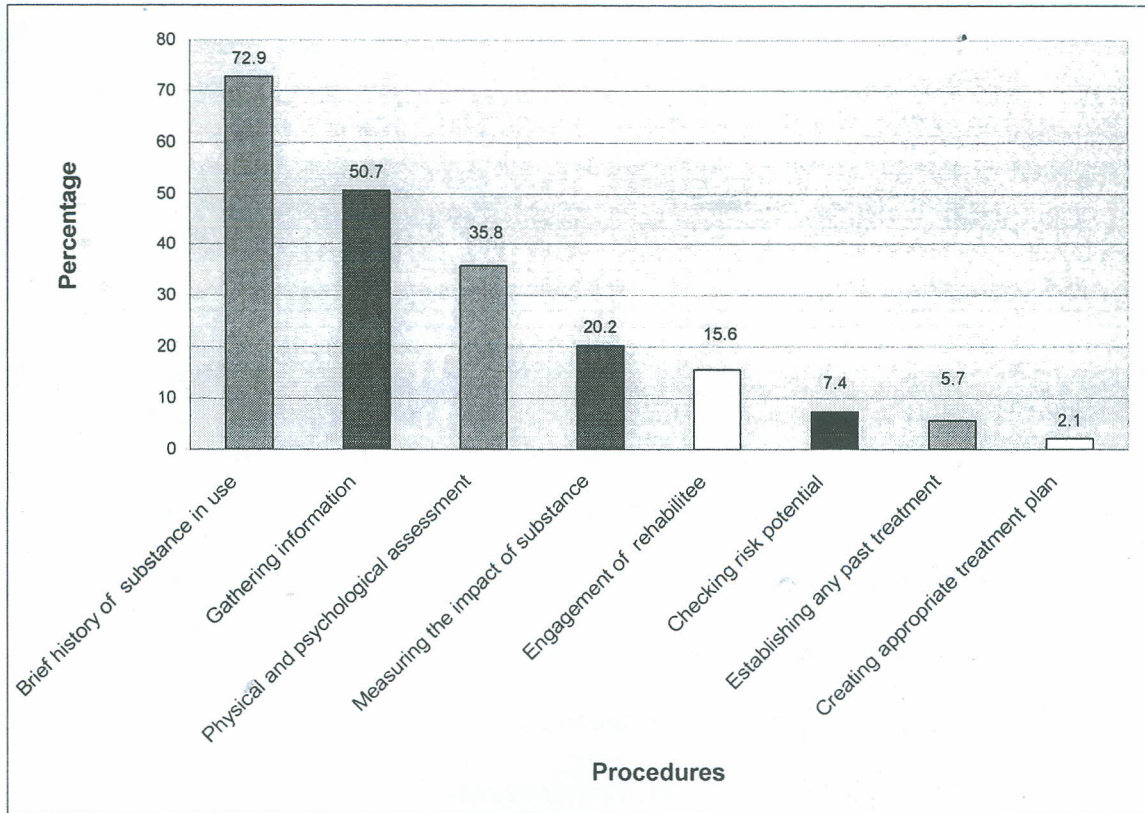


Figure 4.1 shows that a majority of the staff members (72.1%) pointed out brief history of the substance in use was given a priority in assessing the status of the client. In addition 50.7 % suggested gathering information about the rehabilitees was conducted. However, beyond assessment which partly entails gathering information other aspects that could make treatment successful thus enabling the rehabilitees to change their behavior scored very low. For example creating appropriate plan was only at 2.1 percent. This raises question on how treatment is carried out without appropriate treatment plan.

The findings also show that the engagement of the rehabilitee was just 15.5 %. Although there was an indication from a discussion with the managers that self management skills and self directed behavior programs were offered, it was not clear whether the clients were motivated to take part in given programs or whether it was poor assessment/preparation prior to admission that made it difficult to match the clients with the appropriate treatment. This

may affect the outcome of the intended behavior change, thus making the program offered not effectively addressing the actual clients needs.

From the observation made by the researcher regarding some programs such as counseling, group counseling was conducted as opposed to individual counseling which effectively could address the individual needs. A counselor is a functional teacher and coach who helps the client identify the underlying issues causing the presenting problems. However, in a group therapy (counseling) the individual problem may not be addressed because some clients shy off to disclose their problems or some may have deeper personal issue. Counselling though important in addressing client needs, it may be more effective if done individually for the therapist to ascertain whether the client is fit to join a group therapy. The researcher observed that in most of rehabilitation centers clients were put in together, that is drug addicts and alcoholics thus making it difficult to understand the client's problem/need questioning the effectiveness of the programs in addressing individual needs.. However engagement of the counselor with rehabilitee one to one was observed to be lacking in a number of the centers which is important in enhancing effectiveness of the program offered. Daker and Mueser (2003) before assessment is carried the counselor should engage with the rehabilitees one to one to help him/her accept there is a problem and need help. This is despite the understanding that for individuals to succeed in living sober life, their own effort is important. Therefore, although group therapy may be important it should not overshadow individual counseling. From the person centered theory people are thought to be constructive and through guidance they could find solutions to their problems. However, with little engagement this is unlikely to happen.

From the study observation of most rehabilitation centers have inadequate staff members to attend clients individually, from the rehabilitees view in very rare occasions when each was attended individually. The researcher observed that numerous rehabilitation centers were

offering programs which were not effectively addressing the individual client's needs; instead generalization in addressing client needs was common.

In the study the research found that alcohol and drug addicts were put together which may indicate that individualized treatment was not effectively carried out. According to Corey (2008) clients should be involved in their treatment plan, to own it and work towards set goals to eradicate the self defeating behavior.

The program should help clients to identify both personal and environmental risk factors for instance craving, triggers, peer pressure and other self management factors which they may face after discharge. The score of 7.4 may be indicative that very little is done to identify and educate rehabilitees on how to identify risk factors and protect them. This leaves them vulnerable once out they find themselves falling back in their old habits of addiction. According to Etheridge and Hubbard, (2001) drug addiction, also called substance dependence or chemical dependency, is a disease that is characterized by a destructive pattern of drug abuse that leads to significant problems involving tolerance to or withdrawal from the substance, as well as other problems that use of the substance can cause for the sufferer, either socially or in terms of their work or school performance. Past treatment may help the service providers to identify the factors pre-disposing the problem of the client's addiction or use the information to modify the treatment given previously and come up with an appropriate treatment plan which may address the client's current problem.

4.6 Objective 3: Capacity of service providers (staff) to offer services in rehabilitation centers

The study sought to find out the capacity of the service provider to offer services in the rehabilitation centers to attain the objectives, they were issued questionnaire to indicate the area of specialization, level of education and professional training, where they undertook

their training and what the courses entailed to enable them handle persons with drug and substance abuse disorders.

Table 4.4 shows area of specialization or current position of staff members in the rehabilitation centers

Position	Frequency	Percent
Psychiatrists	38	44.2
Psychologists	21	24.4
Counselors	11	12.8
Occupational Therapists	9	10.5
Clinical Managers (medical)	5	5.8
Social Workers	2	2.3

Table 4.4 shows that 38 (44.2%) members of staff who were offering services in the rehabilitation centers were psychiatrists who are doctors who treat people with mental illness through medication which include detoxification which entails reverting the effects of the drug/substance in use 21 (24.4 %) were psychologists whose service entail studying how the mind works and affects individual behavior: Mac Cance – Katz defined drug/substance abuse as a disorder that is characterized by a destructive pattern that lead distress and according to Bill and Dehne (1998) cause schizophrenic disorder.

According to the finding of the study, psychiatrist and psychologists work hand in hand to help the addicts/disturbed people mentally to function normally in the society. Ellis (2008) states that psychiatrist and psychologists develop programs to counteract irrational thinking manifested by persons with drug/substance disorders especially emotional disturbance.

12% of the staff members were counselors; Higgins (2003) cites counselors function as teacher and coach fostering a positive encouraging relationship with the patient and using that to reinforce positive change. Counselors engage with rehabilitees to explore, understand and accept they need help. Service providers in a rehabilitation centre are vital as they act as

baseline to formulate clients' treatment plan, and engage the client in setting goals towards recovery. 10% were occupational therapists. According to the findings of the study some of the rehabilitees were professional having been employed in prestigious companies while others were distressed by lack of jobs. Occupational therapist in the rehabilitation centers deal with mental disturbances or emotional disturbance caused by factors related with unemployment, dismissal from a job or retrenchment. 5.8% had specialized as clinical managers whose major task was to handle the general conditions of the rehabilitees as they undergo treatment. 2.3% were social workers who are trained to help people and offer advice to those who experience severe social problems. From the observation made and the findings of the study for the programs to be effective and achieve the set goals of individual treatment plan designed calls for involves inter disciplinary team. However, such teams were lacking in some rehabilitation centers due to inadequate staff members or a few professional were hired on part time basis. Though majority of the rehabilitation centers were doing recommendable job, services of interdisciplinary team may be essential in assisting/helping to quicken rehabilitees' recovery and maintain the three months stay in a residential rehabilitation centre than what the study found of 6 – 10 months.

Educational professional training/length of training

According to the study findings the staff members were qualified to handle persons with drug and substance disorders. However from the rehabilitees views about the services offered by the staff members, there were issues of breach of ethics especially confidentiality and hindering rehabilitees to meet with their family members. Breach of ethics can lead to mistrust and poor interpersonal relationship between the client/rehabilitee which may affect the outcome of the designed treatment program. Family therapy and counseling was rarely offered and this may have contributed to cases of relapse found in the centers.

4.6.1 Highest educational and professional training of staff members

Table 4.5 shows distribution of staff members in the study in regards to their educational and professional training

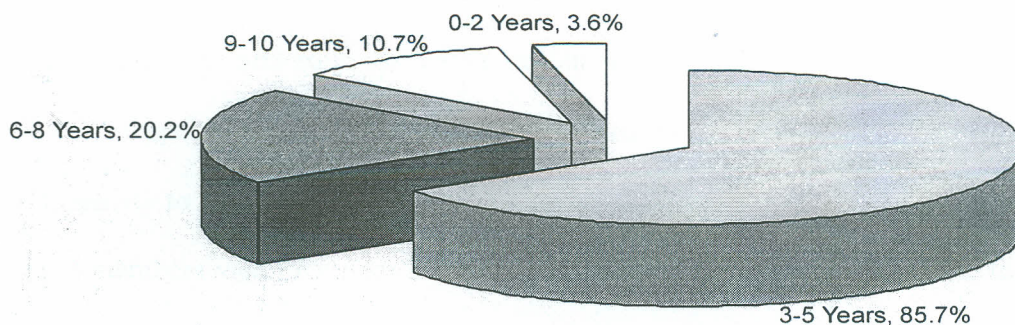
Educational and professional training	Frequency	Percent
Bachelor degree in occupational therapy	50	58.1
Masters of Arts in Counseling	19	22.1
MSc in Applied Psychology	9	10.5
Diploma in chemical dependency counseling	8	9.3

Table 4.5 shows that a majority of the staff members, 86 (61.4 %) had a bachelor degree in occupational therapy, 22 (15.7%) had a Masters of Arts in Counseling, 20 (14.3%) had a Master of Science in Applied Psychology, whereas the rest, 12 (8.6 %) had a diploma in chemical dependency counseling. According to the study it was observed that most of the staff members were qualified.

The professional qualification of the therapist or service providers is paramount in giving appropriate treatment program for they are conversant on what program matches the need of the client. NACADA (2010) states that only trained medical clinicians should administer medication to clients or rehabilitees. Medicine may have adverse severe effects if poorly administered. Richard Nelson (2004) asserts that to intervene effectively therapists require good relationship skills and good training.

4.6.2 Length the training took

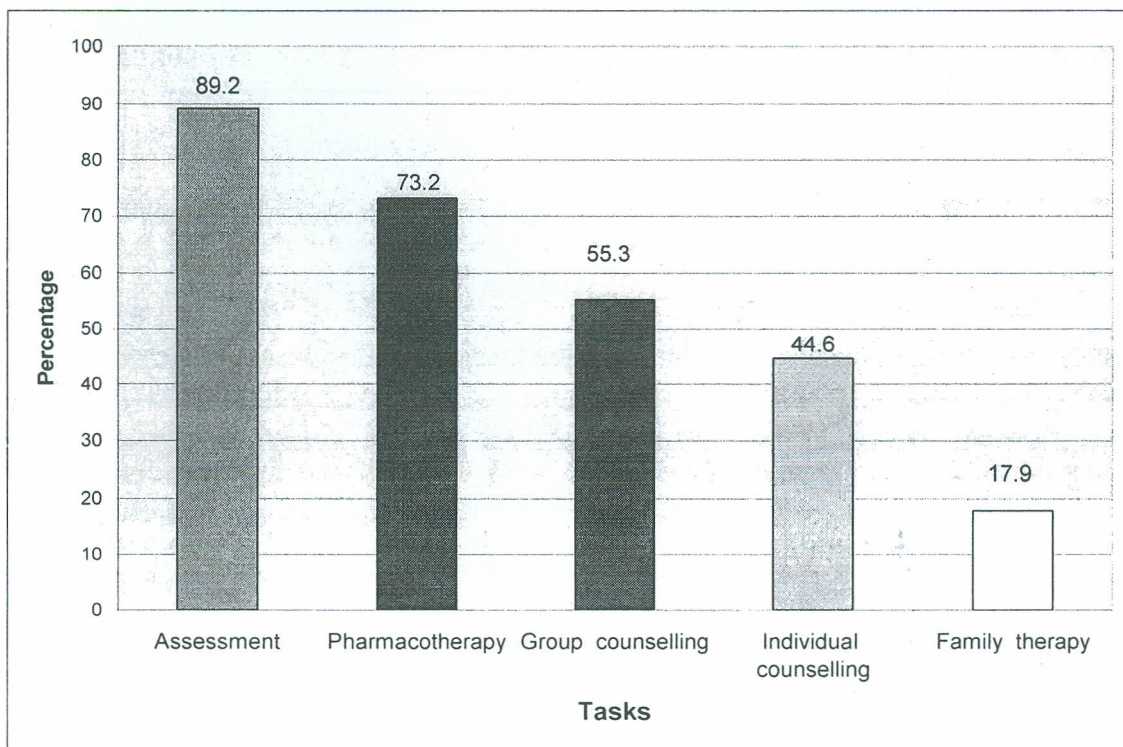
Figure 4.2 shows the period that the staff members' educational and professional training



According to Figure 4.2, a majority of the staff members (85.7%) had trained for 3 to 5 years, 20.2% had trained for 6 to 8 years. Those who had trained for 9 to 10 years and 0 to 2 years were presented by 10.7% and 3.6% respectively.

4.6.3 Tasks staff members carry out in the rehabilitation centers

Figure 4.3 shows the tasks staff members carry out in their respective rehabilitation centers



According to figure 4.3, a majority of staff members (89.2%) indicated assessment was carried out, 73.2% conducted pharmacotherapy, 55.3% group counselling, 44.6% individual counselling, and 17.9% family therapy. From the study findings the mentioned tasks were the programs offered in the rehabilitation centre. However family therapy was the least treatment programme offered in the centres, despite its credibility in helping the client remain sober after being discharged from the rehabilitation centres.

4.6.4 Capacity to handle key rehabilitation tasks

The staff members were asked to indicate their level of capacity to handle the following rehabilitation programs: Assessment; group counselling; individual counselling; family therapy; pharmacotherapy. Table 4.6 shows their response

Table 4.6: Capacity of staff members to handle key rehabilitation tasks

Capacity	Frequency	Percent
Very prepared	53	61.6
Somewhat prepared	33	38.4
Not prepared	-	-

Table 4.6 shows that a great majority of staff members in the study 132 (94.2%) were very prepared to handle the key rehabilitation tasks, 8 (5.8%) were somewhat prepared. From the study findings preparedness is crucial in offering treatment for one of the components of the courses undertaken by the staff members there is drug documentation and follow up, from some of the staff members this entail giving proper records of on going treatment and build on follow ups or amendments or valuations to make modification where necessary to address the client needs effectively. To attain this, the rehabilitees were asked whether they felt that the staff members in the rehabilitation centers were qualified enough to take them through the rehabilitation procedures. Figure 4.4 shows their response

Figure 4.4 Whether staff members were qualified enough

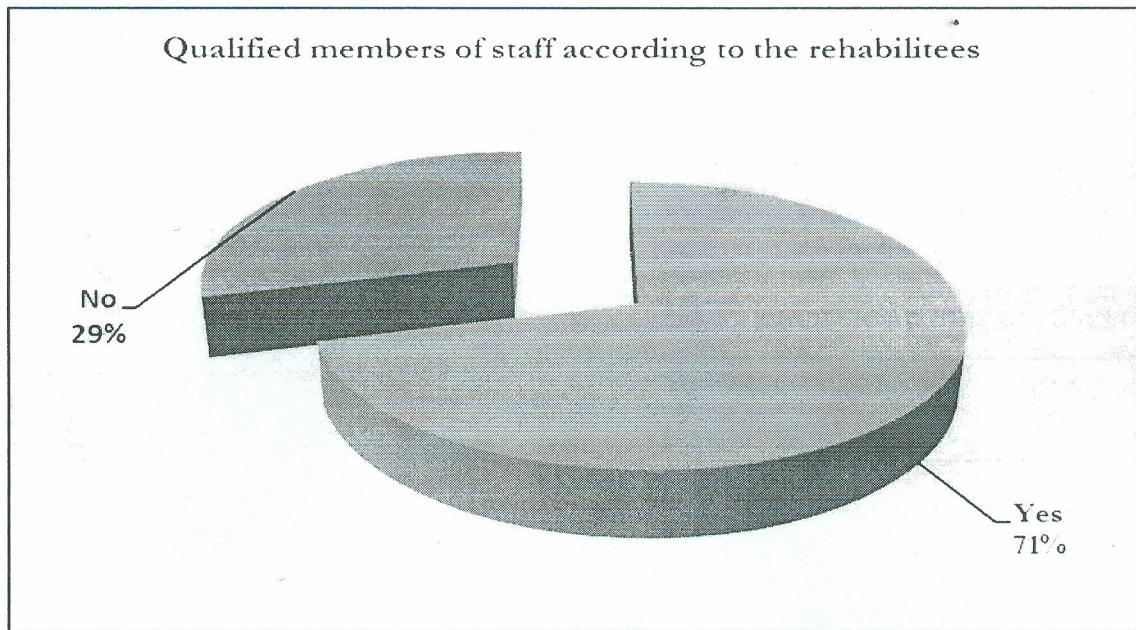


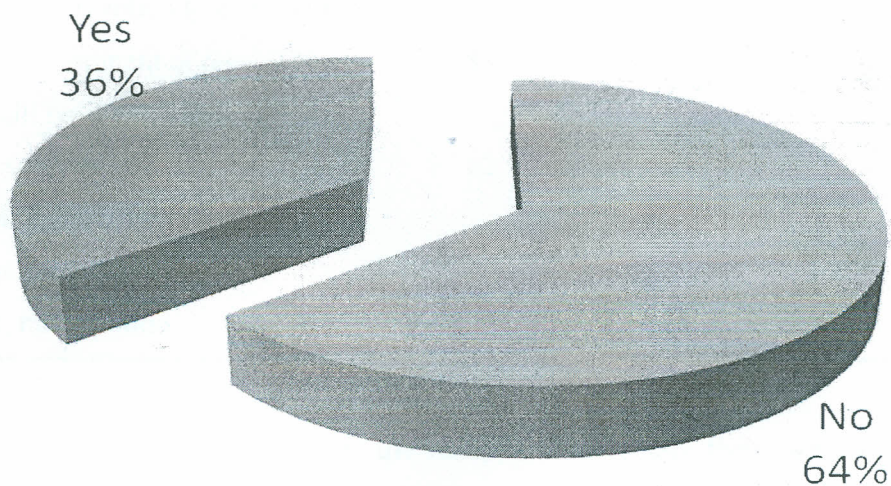
Figure 4.4 shows 71% of the rehabilitees in the study indicated that the staff members in the rehabilitation centers were qualified enough to take them through the rehab procedures, 29% observed that the staff members were not qualified. From the study findings 29% of the rehabilitees who felt that the staff members were not qualified may have had negative notion on the ongoing medication. Some tailored their irritating withdrawal symptoms to poor treatment as observed during this study. Though issue of mistrust and poor rapport among the staff and rehabilitees was highlighted in this study in previous pages, according to Robert Nelson Jones (2004) the clients need to perceive their therapists as non judgmental, open minded and as prizing them as persons despite any problem and feelings of unworthiness they exhibit.

According to the study findings though majority of the staff members were capable of handling tasks relevant with rehabilitation treatment by creating rapport with the clients, this may boost the treatment outcome. Their outcome means positive change among the clients.

4.7 Objective 4: Continuing/aftercare services in the rehabilitation centre

The study sought to find out whether there are after care/continuing services available in the rehabilitation centers and whether there were effective. The Figure 4.5 shows the response.

Figure 4.5:



According to the figure 4.5 majorities (64%) pointed out there were no continuing/after care service available in the centers while 36% indicated that there were continuing/after care services. After care or continuing services are important in assisting recovering addicts to maintain sobriety. Otieno (2011) argues that most of the addicts revert to the vice after treatment due to lack of insufficient psychological care and during (continuing) and after care services. According to study findings however, there were relapse cases in the rehabilitation centers this may be pegged to inappropriate after care services offered to rehabilitees after discharge. The researcher further in the staff questionnaires had provided a number of continuing/after care service. In rehabilitation centers and asked them to indicate to what extent they were prevalent in their centers.

Table 4.7 shows their response

Table 4.7: Continuing/after care services in the rehabilitation centers

Services	To a greater extent		To some extent		Not at all	
	F	%	F	%	F	%
	Psychological intervention to compliment medicine in the treatment of rehabilitees	81	95.3	5	5.8	-
Continued skill building of rehabilitees in maintaining sobriety	62	72.1	17	19.8	7	8.2
Helping rehabilitees with life management skills such as living arrangements, employment, relationships	40	46.5	25	29.1	21	24.4

The study found out that in most of the rehabilitation centers there were cases of re-admission. From the views some of the staff members who to a great extent confirmed there were continuing/after care services the services were after in form of appointment, but to which there were continuing services not after care. The study found out that 'alcoholics' were referred to join Anomalous Alcoholic Association (AAA) support group while others join their families.

The study further sought to find out from the staff how the continuing and after care service could effectively help the rehabilitees in terms preference.

Figure 4.6 shows the response:

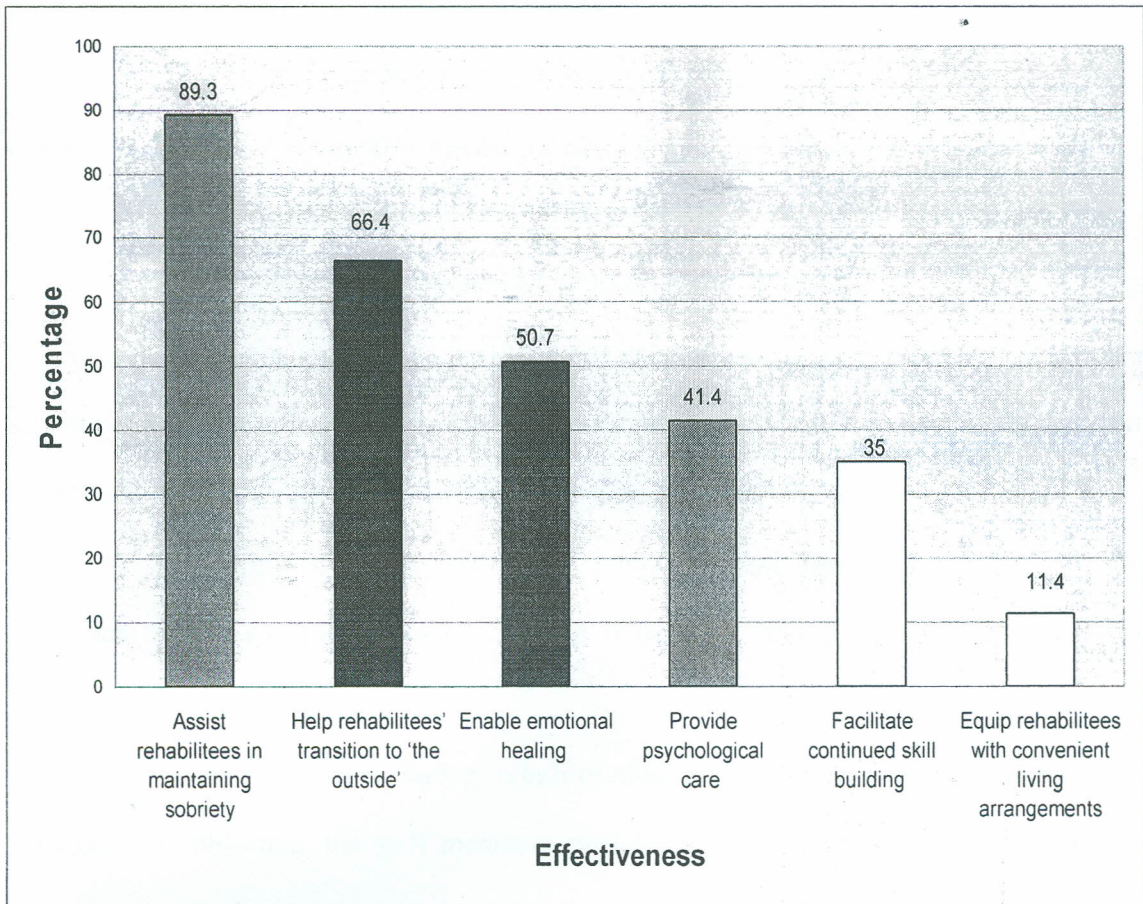


Figure 4.6 shows that a majority of the staff members (89.3%) observed that the main effectiveness of the continuing/after care services was that they assisted rehabilitees in maintaining sobriety; 66.4% pointed out that the services helped rehabilitees' transition to 'the outside world' and apply the lessons they learned in rehabilitation center; 50.7% indicated the services enabled emotional healing among rehabilitees; 41.4% observed that the services provide psychological care during and after treatment; 35%% indicated that the services facilitated continued skill building among rehabilitees; and 11.4% outlined that the services equip rehabilitees with convenient living arrangements.

From the study findings majority 89% agreed the after care/continuing service were important in assisting client maintain sobriety. However, it was observed that some rehabilitation centers had no fully structured after care services on family therapy and

counseling which are very important program as discussed in the previous chapters in the study in assisting client to acquire skills to remain sober. Before therapy ends the client may have to work with their therapists to identify people and resources for assisting them afterwards, Robert Nelson (2004), but according to the study findings was not emphasized.

In the finding of the study in some rehabilitation centre they were re-admission which may be an indication that some addicts were not well equipped to handle the craving of drugs reverting to the same vice or the family member were not able to offer the appropriate services subject due to lack of involvement in the treatment, plan of their client to assist them maintain sobriety. A study conducted in Mexico by Hennis (1998) to find out the success of rehabilitation programs on drug rehabilitees found out that after care programs by the immediate family and the community around rehabilitees played bigger role in reducing relapse case.

4.8 Objective 5: Challenges facing rehabilitation centers in service delivery

To attain this objective, the staff members participating in the study were asked whether there were challenges encountered in their various rehabilitation centers. To which all the staff members 86 (100%) indicated that there were challenges.

The staff members were then provided with a number of perceived challenges facing rehabilitation centers, and asked to indicate whether they were prevalent in their centers, not prevalent, or they were not sure if they were prevalent or not.

Figure 4.7 shows their response.

Figure 4.7: Challenges facing rehabilitation centers

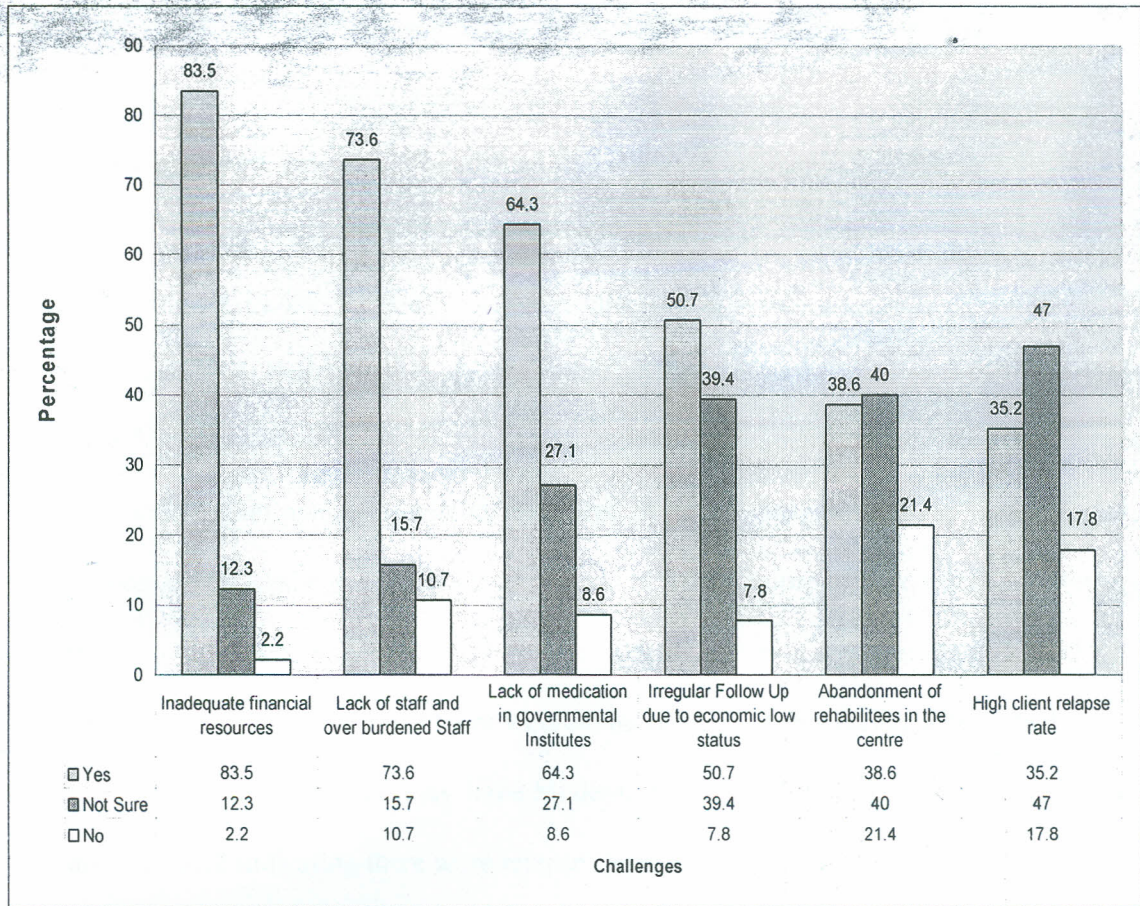


Figure 4.7 shows the response of the staff members on the challenges facing rehabilitation centers. Pertaining to inadequate financial resources to keep the rehabilitation programs running, a majority of the participating staff members (83.5%) pointed out that it was a challenge, 12.3% observed that they were not sure, 2.2% indicated that it was not a challenge in their centers. With regards to lack of staff and over burdened staff, a majority of the staff members (73.6%) indicated that it was a challenge, 15.7% observed that they were not sure, 8.6% indicated that it was not a challenge in their centers. Concerning lack of medication in governmental institutes, 64.3% of the staff members observed that it was a challenge, 27.1% observed that they were not sure, 8.6 % indicated that it was not a challenge in their centers. Regarding, irregular follow up due to economic low status, 50.7% pointed out that it was a challenge, 40% observed that they were not sure, 21.4% indicated that it was not a challenge.

With respect to abandonment of rehabilitees in the centre by relatives to get rid of them, 38.6% indicated that it was a challenge, 47% observed that they were not sure, 17.8% indicated that it was not a challenge in their centers

On high client relapse rate, 35.2% indicated that it was a challenge, 47% observed that they were not sure, 17.8% indicated that it was not a challenge in their centers.

Figure 4.7 indicate 73.6% of the staff members cited lack of staff and over burdened staff and 35.2% indicated that there were relapse cases. From the study observations there were high number of rehabilitees compared with staff members' available, compromising service delivery due to higher number of clients compared to service providers. Relapse in this study may be pegged on challenges experienced in the centers comprising the quality of service delivery.

The study found and observed that there were numerous challenges facing service delivery in the rehabilitation centre, which may have hindered to some extent the effectiveness of the program with 35.2 indicating there were relapse cases.

4.8.1 Rehabilitees' response on challenges facing rehabilitation centers

The rehabilitees observed the following as the challenges they were facing in the rehabilitation centers:

- Lack of withdrawal reinforcing drugs, this is reflected by the views made by the 64.3% of the staff members that there was lack of medication in government rehabilitation centers, although similar cases were cited in the study in private owned drug rehabilitation centers.
- Untrustworthy rehabilitation center staff members
- Ignorance of patients by management and staff members due to lack of rapport
- Lack of recreation facilities leading to boredom
- Limited or no communication of rehabilitees and their family

- Congestion of rehabilitation centers putting the rehabilitees at a risk of contacting communicable diseases
- Hostility and paranoia among the rehabilitees due to combination of patience with mild and severe cases

KBC reporters (2010) reported that thirty (30) drug addicts in Mombasa were enrolled in a rehabilitation centers, within a week the rehabilitees complained of lack of basic amenities and treatment for their condition and poor environment from the study findings most of the raised challenges were evidently observed and may contribute negatively on the out come of programs offered in the centers not acquire/achieve the set goal towards recovery of the addicts.

4.9 Objective 6: Improving the effectiveness of the existing rehabilitation centers

In rehabilitation centers the study sought to find out from the staff members and rehabilitees their views on how to improve the rehabilitation centers to effectively address the clients (rehabilitees) needs or achieve the main goals. Schukit (1994) American psychiatrist Association (1995) states there are three generalized goals:

- Reducing substance abuse or achieving a substance free life
- Maximising multiple aspects of functioning
- Preventing or reduce frequent and severity of relapse

The primary goal of the programs is the attainment and maintenance of abstinence from the drug/substance abuse or addicts.

Staff members in the study were asked to outline ways in which challenges encountered in rehabilitation centers can be countered. They pointed out the following as some of the ways of minimizing or resolving the challenges:

- Funding by the government to facilitate better services to all rehabilitation centers, private and public. One of the staff members said and I quote, “Maintaining these

addicts here is very expensive, they eat a lot, need expensive drugs and some are destructive, repairs are done almost all the time therefore there is need of sufficient funds.”

- Emphasis on individualized treatment plan instead of group therapy
- Employment of more staff members to cater to all clients
- Continuous follow ups by the rehab staff and management
- Additional recreation facilities

The rehabilitees on the other hand reported the following as the key ways to improve the effectiveness of the existing rehabilitation centers:

- Reducing rehabilitation expenses. One of the rehabilitees asserted and I quote, “Parents should listen more to the addicts in rehabilitation; not only the counselors because they most of the time lie to parents so that the clients can be added more time in the rehab hence more profit to the rehab”.
- More recreational facilities and activities
- More qualified staff to practice confidentiality
- Seeking opinions from patients. This can be done through individualized counseling, and engaging the clients fully in their treatment plan. One client commended and I quote, “Involve the clients openly in the learning process, settle disputes, and discourage gossiping and putting others down”.
- Granting a little freedom to the patients
- Focus on individual treatment which includes significant others and family members (family therapy).
- Incorporation of former addicts in offering services in the rehabilitation center to act as mentors

From the responses the study found that both the staff and rehabilitees had clues on how to better services though it was beyond their reach. The staff members felt financial constraints contributed most of the challenges.

The rehabilitees seeking freedom and feeling that they were not listened to; from observation may have been a challenge but based on their interpretation and perception of some of the set rules to retain them in the centers as they received treatment.

4.10 Summary of research findings

The researcher sought to identify the types of programs offered in drug and substance rehabilitation centers in Nairobi County, the study revealed that the main type of program offered in drug and substance rehabilitation centers in Nairobi County to be assessment of drug users, which was mainly done through determining a brief history of the substance in use, Mental Status Examination (MSE), types of abused drug, length of use and gathering information about the situation causing the drug problem. The other key programs offered were counseling; detoxification; and pharmacotherapy and medical care and relapse prevention.

As regard the service providers, the researcher sought to find out whether the service providers had the capacity to offer the rehabilitation services. Most of them were trained in various areas that were relevant for rehabilitation. The service providers in the study included psychiatrists, social workers, psychologists and counselors. Majority of them had a bachelor degree in their areas of specialisation and had trained for 3 to 5 years mainly at the University of Nairobi and Kenyatta University. Key components of drug management in their training included: Pharmacology; Medication therapy review (MTR); Personal medication record (PMR); and Medication-related action plan (MAP). The key tasks that these qualifications enabled the service providers to execute were mainly: assessment; pharmacotherapy; and group counselling - with majority of the

service providers observing that they were very prepared to handle these key rehabilitation tasks. Therefore the study established that majority of para-professional which include the counsellors, social workers and clinical officers were trained and qualified. However, half of the rehabilitees observed that the staff members were not qualified citing that the staff members were dishonest, reluctant, and rude, which created tension in rapport establishment among the service providers and the rehabilitees.

Majority of rehabilitation centers did have specified continue, after care programs (64%) indicated that there were no continued/after care services though the staff members indicated that they were crucial in helping rehabilitees maintain sobriety. Otieno (2011) argues that most drug addicts revert to the vice after treatment because of insufficient psychological care during and after treatment.

The researcher sought to find out challenges affecting the effectiveness of rehabilitation programs, the research revealed that majority of the rehabilitation centers experienced/faced inadequate financial resources (83.5%), lack of staff and over burdened staff (73.6%), lack of medication in governmental institutions (64.3%), and irregular follow up due to economic low status (50.7%) were the prime challenges facing rehabilitation centers according to the staff members. Rehabilitees observed: Lack of recreation facilities leading to boredom; lack of withdrawal reinforcing drugs; congestion of rehabilitation centers; and hostility and paranoia among the rehabilitees due to combination of patience with mild and severe cases. Most of the rehabilitation centers were faced with financial crises contributing to unemployment of adequate staff and provision of some infrastructural resources needed in the rehabilitation centers.

The researcher sought to find out what needs to be done to improve the effectiveness of the programs in existing drug rehabilitation centers, the study revealed that staff members observed that challenges can be solved mainly through: Funding by the government to

facilitate better services, individualized treatment plan instead of group therapy, employment of more staff members and well structured continuous follow ups and aftercare services. The rehabilitees outlined the following as the key resolutions: Reducing rehabilitation expenses which the study found that most rehabilitees were paying hefty amount of money to receive treatment, need for more recreational facilities, and involvement or engagement of client in treatment plan.

CHAPTER FIVE

5.0 DISCUSSIONS, CONCLUSIONS AND RECOMMENDATION

5.1 Introduction

The main focus of the study was to investigate the effectiveness of drug rehabilitation programs on behavior modification of drug addicts in Nairobi County. The findings of the study will contribute some knowledge to stakeholders, policy makers on how to come up with more effective rehabilitation centers to promote/enhance healthy recovery of the drug addicts.

This chapter presents summary of the study and research findings as per the specific objectives of the study, conclusion and recommendations on the possible ways of addressing challenges facing rehabilitation centers in offering effective treatment programs and finally areas for further research are proposed.

5.2 Discussion on the findings

The overall purpose of the study was to find out the effectiveness of drug rehabilitation programs on behavior modification on drug abuse in Nairobi County, establish challenges faced by various rehabs and come up with various proposals on how the challenges faced can be improved. The specific objectives of the study were;

- i. Types of programs offered in drug and substance rehabilitation centers in Nairobi County.
- ii. Assessing the effectiveness of the programs in addressing the needs of drug addicts
- iii. Capacity of service providers (staff) to offer rehabilitation services in rehabilitation centers.
- iv. Type and quality of continuing/after care services available in the rehabilitation centers.
- v. Challenges influencing the effectiveness of rehabilitation programs.

- vi. What needs to be done to improve the effectiveness of the programs in existing rehabilitation centers in Nairobi County.

5.2.1 Types of programs offered in rehabilitation centres

From the current study it was revealed that the main types of programs offered in drug and substance rehabilitation centers in Nairobi County were: Assessment of drug users (94.2%), Self management and directed behavior (72.1%), Counseling (91.9%), individualized treatment plan (75.9%) ,Pharmacotherapy and medical care (82.6%),Aftercare and follow up program(65.1%) and in addition the current study the researcher was also focused on finding out any program on relapse prevention of which the outcome was positive in which the following were mentioned. Joining support group and reinforcing coping strategies to permanently kill the craving of drugs. It was observed that assessment was done in most of rehab centers at 94.2% in Nairobi county followed by Pharmacotherapy at 82.6%.This is attributed to the fact that assessment is vital in addressing individuals needs for it entail brief history of the substance in use and mental status examination to determine the level of function on the rehabilitee. The information gathered is used to formulate appropriate treatment plan to match the individual needs. NACADA (2008) in their study of drug addiction in Nyanza province one of the major causes of relapse was as a result of poor assessment of addicts prior to their admission to the rehabilitation centers hence the need. It's worth noting that majority of the aforementioned programs are being offered in most the rehabilitation centers as per the national standards for treatment and rehabilitation of persons with substance use disorder (NACADA 2011). Therefore the current study confirmed that the recommended rehabilitation programs were applied though the manner of delivery may have reverted the intent purpose.

However, family therapy and counseling according to the study was not captured as a program offered in the rehabilitation centers. Family therapy and counseling according to

Roberts (2001) is essential in helping parents and significantly others to accept and understand the condition of drug addicts within the family and offer support towards recovery.

5.2.2 Effectiveness of programs' in addressing the individuals' needs

According to Matilde P. Macho (2005) programs differ in effectiveness, but entails treatment duration, matching patient characteristics and treatment, directing more services to particular areas and better patient outcome. In this study effectiveness means reducing alcohol and drug use and improving personal and social functioning of drug addicts. According to the findings of the study creating appropriate plan, engagement of rehabilitees in treatment plan and group counselling were carried on rehabilitation centres though they were not found to be well administered for instance creating appropriate plan scored 2.1%. As cited above for program to be effective it may be tailored to match patient's characteristics and treatment.

5.2.3 Qualification of staff in rehabilitation centre

The current study sought to find out whether the service providers had the professional qualifications to offer services in the rehabilitation centre. It established that majority of those in charge of helping the rehabilitees to recuperate from drug and substance abuses were of high qualification. From other previous researches done previously it was established that most staffs should have a minimum qualification of Diploma (NACADA 2011). From the findings majority had Bachelor's degree from various recognized learning institutions.

However, education is not all that these professionals need to have in order to bring any significant change to management of a rehabilitation centre. It is worth noting that other personal attributes and ethics are equally important to enhance/boost healing of the drug addicts especially rapport/confidentiality and trust among the staff members (therapists) and the rehabilitees.

5.2.4 Challenges faced in most rehabilitation centers

The study sought information on the challenges faced in the rehabilitation centers from both the staff (service providers) and rehabilitees. Majority of the staff members (83.5%) indicated that an inadequate financial resource was a challenge, 73% lack of adequate paraprofessional and medical clinicians.

The rehabilitees indicated congestion in rehabilitation center, lack of recreation facilities and lack of trust among the rehabilitees and therapist for the expression breach in confidentiality.

(Jones, 2004) states that, most drug addicts feel wounded, neglected and need love, empathy and conducive or less threatening environment respond positive to the therapeutic processes.

This implies that physical environment is very important in enhancing behavior change among the drug addicts. The most common challenge felt globally is the financial aspect as depicted in the researches previous done on drug and substance abuse

Readers may not be aware of the sheer scale of spending on services providing rehabilitation and recovery. A report commissioned by the Department of Health documented health and social care spending on adult mental health in 2008 (Mental Health Strategies, 2008). Of the £5.5 billion total spend, 19% is on continuing hospital care, residential and housing care and home support services that are of direct relevance to rehabilitation services thus financial aspect has posed a lot of challenges to the effectiveness of this rehabilitation centers.

5.2.5 Improvement on effectiveness of the rehabilitation centers

From the current research, it was established that there was need for subsidized cost of service charge by the government and other stakeholders, employment and deployment of more staff, renovation and expansion of the infrastructure to ease congestion in the rehab centers. Finally it was also observed that there was a call for recreation centers to curb boredom expressed by most rehabilitees and promote recovery.

Although many rehabilitation centers seemed to have embraced the issue of rehabilitation of drug users, from the finding of the study rehabilitation programs in modification of addicts' behaviors could be more effective if more paraprofessionals and medical personnel are employed to match the appropriate ratio versus the service providers and the manageable holding capacity of infrastructure inclusive to avoid congestion and make the environment more conducive. Richard Jones (2004), states that most drug addicts feel wounded, neglected and need love, empathy and conducive or less threatening environment to respond positively to the therapeutic processes.

5.3 Conclusions

The conclusions of the study were derived from the major findings and were based on the specific research objectives; most of the rehabilitation centers offered recommended programs by National Standards of Treatment (NACADA, 2011), and assessment emerged as the program offered in rehabilitation centers, which was found to be vital in identifying the client's state of functioning. Staff members in rehabilitation centers in Nairobi County are sufficiently trained, with a good number of them holding degrees, diplomas and certificate from reputable institutions. They also possess proficiency in drug management and rehabilitation tasks. Most of the rehabilitation centers do not offer well structured continuing/after care services to support their clients' psychological care, and personal empowerment after discharge. Financial impediments like insufficient staff, medication and facilities as well as inconsistent follow ups are the major challenges facing rehabilitation centers in Nairobi County. In most of the rehabilitation centers congestion is paramount and group counseling as opposed to individual counseling which may address individual needs. Most of the rehabilitation centers were costly making some clients to cut short their treatment due to expenses. Drugs and substance addiction is rife in the society and there are many drug addicts both from wealthy and poor families in need of rehabilitation services.

5.4 Recommendations

Based upon the research findings on effectiveness of rehabilitation programs on behavior modification in Nairobi County, various recommendations are proposed to enhance the effectiveness of the existing rehabilitation programs.

Rehabilitation management should recruit clients in references of the infrastructures in the rehabilitation centers to avoid congestion and the strained resources observed in rehabilitation centers during the study. The ratios among the client and service providers should also be considered to enhance individualized treatment rather than group therapy.

The study recommends the policy makers and other stakeholders to formulate ways of funding the existing rehabilitation centers whether government or private owned to reduce the current cost. Most of the rehabilitation centers are privately owned and exorbitantly expensive. Only the better off in the society can afford locking out many people who require rehabilitation services. The government to establish fully sponsored rehabilitation centers with conducive infrastructure and facilities to accommodate drug addicts who may not afford private rehabilitation services.

The policy makers need to establish ways of promoting support groups to enhance after care services once the clients are discharged from the rehabilitation centers.

Structured after care programs can help maintain sobriety of the client after discharge. The study recommends the government should establish fully sponsored rehabilitation centre, and expand and renovate the existing rehabilitation centers to accommodate the growing number of drug and substance addicts who need to be rehabilitated. The government should deploy more staff in the rehabilitation centers and fund construction of recreation facilities to avoid boredom expressed by many rehabilitees and also to improve engagement of clients in the treatment. The study recommends refresher courses or workshops for service provided to

reduce burn-out due to handling high numbers of clients as observed during the study and keep them informed of safeguarding ethics in service delivery in the rehabilitation centers.

5.5 Suggestions for further research

1. Further research can be done on how rehabilitation centres' environmental infrastructure influence the recovery of rehabilitees
2. Further research can also be conducted on contribution of support groups or after care service maintaining sobriety of rehabilitees after being discharged from rehabilitation centres.

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APPENDIX 1 : LETTER OF INTRODUCTION TO THE RESPONDENTS

KENYATTA UNIVERSITY

P. O. BOX 47515-00100

NAIROBI

RESPONDENTS

NAIROBI COUNTY

Dear Sir/Madam,

RE: REQUEST FOR INFORMATION

I am a post-graduate student in Kenyatta university. I am carrying out a study on Effects of drug rehabilitation programs in Nairobi County.

Kindly fill in the questionnaire and provide any other relevant information that may help in carrying out the research which could help in making the existing rehabilitation programs more effective in helping drug addicts function well in the society.

The information gathered will be treated with great confidentiality and will be used for study purposes.

Thank you.

Yours faithfully,

Regina N. Nzomo

APPENDIX 2 : QUESTIONNAIRE FOR STAFF

SECTION A : Background information

Please respond to each item by putting a tick (√) next to the response you prefer.

1. Gender

- a) Male
- b) Female

2. Age

- a) 20-30
- b) 31-40
- c) 41-50
- d) Above 50

3. Number of years as a member of staff in this rehabilitation center

- a) 1-5 years
- b) 6-10 years
- c) 11-15 years
- d) Above 15 years

SECTION B : Types of programs offered in drug and substance rehabilitation centers

1. Are there any specific programs that rehabilitees are taken through in your center?

- a) Yes
- b) No

2. How often do you conduct assessment of drug users in your center?

- i. Often
- ii. Sometimes

iii. Rarely

iv. Never

3. Do you offer self management programs and self directed behavioral program?

i. Yes

ii. Not sure

iii. No

4. How prevalent is counseling in your center?

i. To a greater extent

ii. To some extent

iii. Not at all

5. Do you administer individualized treatment plan?

i. Agree

ii. Undecided

iii. Disagree

6. How often does pharmacotherapy and medical care take place in your center?

i. Often

ii. Sometimes

iii. Rarely

iv. Never

7. How do you prevent relapse occurrences in your center?

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.....

8. Do you offer after care and follow up programs in your center?

- i. Yes
- ii. Not sure
- iii. No

SECTION C : Procedure of rehabilitee assessment in the rehabilitation centers

Please indicate by ticking whether the following are some of the practices undertaken during rehabilitee assessment in your rehabilitation center

- a) Assessing the physical and psychological functioning of the client
- b) Determining a brief history of the substance in use
- c) Risk potential, for instance, suicidal attempts
- d) Mental status examination
- e) Establishing any past treatment
- f) Measuring the impact substance abuse has had on the individual
- g) Engagement between the rehabilitee and the counselor
- h) Gathering information about the situation causing the problem
- i) Coming up with appropriate treatment plan to address the actual problem of rehabilitees

SECTION D : Qualifications of Service Providers (Staff)

1. What is your current position in the rehabilitation center?

.....

.....

2. What is your highest educational and professional training?

.....

.....

.....
3. How long did the training take

- a) 0-2 Years
- b) 3-5 Years
- c) 6-8 Years
- d) 9-10 Years
- e) Over 10 Years

4. Where did you partake the training?

.....

5. Which course (s) did you study?

.....

.....

6. What components of drug management did the course entail?

.....

.....

.....

7. a. Which of the following specific task do you carry out in the rehabilitation centre?

- [i] Assessment
- [ii] Group counselling
- [iii] Individual counselling
- [iv] Family therapy
- [v] Pharmacotherapy

b. Specify any other?

.....

.....

8. Indicate your level of capacity to handle the following rehabilitation tasks:

- Assessment - Group counselling - Individual counselling
- Family therapy - Pharmacotherapy

- a. Very prepared
- b. Somewhat prepared
- c. Not prepared

SECTION E : Type and quality of continuing/after care services available in the rehabilitation centers

1. Are there continuing/after care services available in the rehabilitation centers?

- a) Yes
- b) No

2. If YES, please specify to what extent the following after care services are offered in your center?

No	Services	To a greater extent	To some extent	Not at all
a)	Helping rehabilitees with life management issues such as living arrangements, employment, relationships			
b)	Continued skill building of rehabilitees in maintaining sobriety			
c)	Psychological intervention to compliment medicine in the treatment of rehabilitees			

Any other (Please specify)

.....

.....

3. In what ways are the continuing/after care services available in your center effective?

- a) Continuing/after care services help rehabilitees' transition to 'the outside' and apply the lessons they learned in rehabilitation center
- b) Continuing/after care services enable emotional healing among rehabilitees
- c) The after care services equip rehabilitees with convenient living arrangements
- d) The after care services facilitate continued skill building among rehabilitees
- e) Continuing/after care services assist rehabilitees in maintaining sobriety
- f) The after care services provide psychological care during and after treatment

SECTION F : Challenges facing rehabilitation centers

1. Are there challenges encountered in your rehabilitation centre?

- a) Yes
- b) No

2. If yes what kind of challenges do you MOSTLY encounter in your center?

a) Lack of adequate financial resources to keep the rehab running

Yes Not Sure No

b) Lack of medication in governmental Institute

Yes Not Sure No

c) Irregular follow up due to economic low status

Yes Not Sure No

d) Lack of staff and over burdened Staff

Yes Not Sure No

e) Abandonment of rehabilitees in the centre by relatives to get rid of them

Yes Not Sure No

f) High client relapse rate

Yes

Not Sure

No

Any other (please specify)

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SECTION G : Improving the effectiveness of the existing rehabilitation centers

1. Please outline ways in which challenges encountered in rehabilitation centers can be countered

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.....

APPENDIX 3 : INTERVIEW GUIDE FOR REHABILITEES

SECTION A : Background Information

Please respond to each item by putting a tick (✓) next to the response you prefer.

1. Gender

a) Male

b) Female

2. Age

a) 20-30

b) 31-40

c) 41-50

d) Above 50

3. Period in the rehabilitation center

a) 1-3 months

b) 4-6 months

c) 7-9 months

d) 10 months

**SECTION B : EFFECTIVENESS OF DRUG REHABILITATION CENTERS IN
NAIROBI**

1. What are some of the procedures that you were taken through at your time in the drug rehabilitation centre?

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.....

2. What entailed the first stage of treatment that you received from the rehabilitation service providers (practitioners)?

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3. Do you feel that the staff members in the rehabilitation centers are qualified enough to take you through the procedures?

a) Yes

b) No

4. If YES, why?

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.....

5. If NO, why?

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.....

6. What are the main problems you encountered at your time in the rehabilitation centre?

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.....
9. What do you think can be done to improve the running of the rehabilitation centre?
.....
.....
.....
.....
.....



NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

Telephone: 254-020-2213471, 2241349, 254-020-2673550
Mobile: 0713 788 787, 0735 404 245
Fax: 254-020-2213215
When replying please quote
secretary@ncst.go.ke

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

Our Ref: **NCST/RCD/14/013/1112**

Date: **24th June 2013**

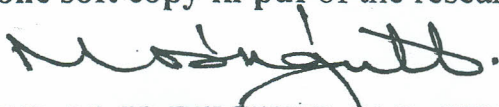
Regina Nduku Nzomo
Kenyatta University
P.O Box 43844-00100
Nairobi.

RE: RESEARCH AUTHORIZATION

Following your application dated 17th June, 2013 for authority to carry out research on "*Effectiveness of drug rehabilitation programs on behavior modification of drug addicts in Nairobi County.*" I am pleased to inform you that you have been authorized to undertake research in **Nairobi County** for a period ending 31st December, 2013.

You are advised to report to **the County Commissioner and County Director of Education, Nairobi County** before embarking on the research project.

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


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



Copy to:
The County Commissioner
The County Director of Education
Nairobi County.



Research Permit No. NCST/RCD/14/013/1112

Date of issue 24th June 2013

Fee received KSH. 1000

IS TO CERTIFY THAT
Dr. AMr./Mrs./Miss/Institution

a Nduku Nzomo
(Address) Kenyatta University

Box 43844-00100, Nairobi.
has been permitted to conduct research in

Location
District
County

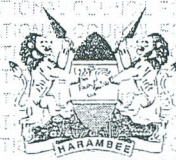


Topic: Effectiveness of drug rehabilitation
programs on behavior modification of drug
users in Nairobi County.

[Handwritten Signature]
Applicant's Signature For Secretary
National Council for
Science & Technology

validity period ending: 31st December, 2013.

CONDITIONS



REPUBLIC OF KENYA

RESEARCH CLEARANCE PERMIT

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

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(CONDITIONS—see back page)

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