A STUDY AND EVALUATION OF CLIENT DROPOUT AT A DRUG COUNSELLING CENTRE IN CAPE TOWN.

by

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ABSTRACT

This study is motivated by the fact that half the clients attending a drug counselling centre in Cape Town, dropped out of treatment before the fourth interview. The study examines and describes the factors which contribute towards this dropout behaviour.

Literature describing dropout behaviour and patterns of illicit drug abuse, identified multiple factors influencing dropout behaviour. The present study utilizes four such categories: a) motivation factors, which include the pressure that families or employers exert on clients to attend treatment; b) client factors, including aspects of demography, symptomology and personality; c) treatment factors, such as evaluation methods, the initial contact, client expectations of the agency and treatment effectiveness; and d) therapist factors including therapist attributes, contracting and response to dropout behaviour.

In order to explore factors contributing to dropout behaviour, an initial sample of 32 subjects was selected of which fourteen were interviewed by means of a structured questionnaire. An analysis of the results gives rise to the following important findings: Families do not influence the dropout to continue with treatment. Dropouts tend to have unrealistic treatment expectations, such as immediate medical relief from drug related symptoms. Dropouts also tend to have lower educational status and are more frequently employed in relation to the average client. The dropouts experience anxiety during the initial contact, which is often met by uncaring therapist attitudes. Finally the study demonstrates that inflexible agency hours and a lack of therapist contracting also contribute toward dropout behaviour.

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CHAPTER 1

ORIENTATION TO AND CONTEXT OF THE STUDY

1.1 INTRODUCTION

The Cape Town Drug Counselling Centre (DCC) was established during 1985 in response to two issues. Firstly, the illicit abuse of dagga in combination with Mandrax was increasing and secondly, there was a dearth of appropriate treatment facilities, a matter confirmed by Gibson in 1986. The basic principles developed at the time of the DCC's inception are unchanged. These are that the DCC will function as:

1. An outpatient, walk-in clinic, offering assessment.
2. A clinic which refers to appropriate resources.
3. A treatment centre offering psychosocial and medical therapy.
4. An after-care unit.
5. A clinical education resource unit.

During the history of the DCC, there have been high rates of treatment dropouts. Statistics from 1988/89 (Table 1. in Appendix 3), reflect that from an intake of 751 new clients, 387, more than half, dropped out of treatment. This figure (52%) is considerably higher than the 19 to 25% reported in three American University counselling centers (Epperson, 1983). However, in studies on out-patient detoxification programs for heroin addicts, Baekeland (1975) noted dropout rates varying from 26 to 68%. Dropout rates therefore appear to change according to the type of drug used, the client population and to the kind of treatment offered.

This relatively high rate of dropout has caused concern amongst management and staff as to the DCC's ability to meet the needs of the community it serves. This study aims to assess and evaluate client dropout from the DCC.

An initial examination of dropout behaviour reveals that it is precipitated by one or more variables. For example, agency policy such as fee payment or intake procedures may distress or alienate clients. Improved functioning prior to treatment completion may also lead to dropout behaviour. Another precipitator could be that clients have preferences in terms of therapist variables, such as age and sex, which are not met. Alternatively, some clients may receive enforced (statutory) treatment and lack motivation. Others may have personalities more disposed to dropout behaviour, including borderline or dependent personality disorders. Therapists themselves, may inadvertently contribute toward dropout behaviour in their use of contracting methods, by not meeting gender expectations or in failing to work within the transference relationship. As a consequence of the aim of this study and the multiple potential variables contributing toward dropout behaviour, the following research objectives were identified:

1. To describe the personal characteristics of people who drop out of treatment and dispel myths or stereotypes about them.
2. To describe factors within the DCC which contribute toward dropout behavior such as the intake procedure, evaluation methods and theoretical bases for intervention.
3. To describe therapist factors which contribute toward dropout behavior, such as age, sex and level of experience.
4. To describe motivation factors which contribute toward dropout behavior and examine the impact of external support, such as that from courts and employers.

In an attempt to provide the reader with a guide to this study, the following layout has been adopted. The current chapter provides a background to the study, a definition of terms, a description of the functioning of the DCC and finally, a discussion of the research design and its limitations. Chapter 2

describes illicit drug abuse in South Africa and the Western Cape and presents a backdrop to the DCC and it's clients. Chapter 3 is a review of foreign and local literature which examines the forces contributing towards dropout behaviour, according to motivation, client, treatment and therapist factors. Chapter 4 presents the results of the research, according to the four factors identified in the previous chapter. Finally, Chapter 5 reviews the aim and objectives of the research, in the context of the major research findings.

Several Appendices are presented, containing background information and items not suitable for inclusion in the main body of the text. A complete Bibliography of all referenced documents is also included.

1.2 DEFINITION OF TERMS

1. DCC: This is an abbreviation of Cape Town Drug Counselling Centre.
2. CLIENT: The person with the identified drug problem (the index person) who is on the DCC files.
3. THERAPIST: A clinical psychologist or social worker, offering individual, marital, family and sometimes group therapy.
4. DROPOUT: A client who attends one, two or three interviews with a therapist and who either cancels or fails to attend the following booked appointment.
5. DROPOUT SUBJECT: A client classified as a dropout and interviewed for the purposes of this study.
6. SAMPLE: Refers to the group of dropouts selected as potential subjects for the purposes of the study.
7. DAGGA: This is a colloquial term in South Africa for an illegal drug, Cannabis sativa. It is also referred to as "pot", "weed", "grass", "zol" and "marijuana".
8. MANDRAX: This is a term for Methaqualone. In South Africa this was prescribed as a sedative-hypnotic drug, but has been registered in terms of Part 1, Act 41 of 1971 as a prohibited dependence producing drug. It is no longer used for medicinal purposes, but continues to be illegally abused. It is usually smoked in conjunction with dagga, and this mixture is referred to in the drug sub-culture as a "white pipe".
9. DRUG: This is a chemical substance which can produce psychological dependence with or without physical dependence in the user, abuser or drug dependent person.
10. PSYCHOACTIVE SUBSTANCE (DRUG) USE: This refers to the "use of certain substances to modify mood or behaviour under certain circumstances generally regarded as normal and appropriate."

(DSM111R, 1987, 165). These are culturally accepted substances such as alcohol and caffeine, which may be used as a stimulants.

11. PSYCHOACTIVE (DRUG) ABUSE: Defined as :

"A. A maladaptive pattern of psychoactive substance abuse indicated by at least one of the following:
   1. continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by use of the psychoactive substance.
   2. recurrent use in situations in which use is physically hazardous (eg. driving while intoxicated).

B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.

C. Never met the criteria for Psychoactive Substance Dependance for this substance." (DSM111R, 1987, 169)

12. PSYCHOACTIVE SUBSTANCE DEPENDENCE: Defined as:

"A. At least three of the following occur:

1. substance often taken in larger amounts or over a longer period than the person intended
2. persistent desire or one or more unsuccessful efforts to cut down or control substance use
3. a great deal of time spent in activities necessary to get the substance (eg. theft), taking the substance (eg. chain smoking) or recovering from its effects.
4. frequent intoxication or withdrawal symptoms when expected to fulfill major role obligations at work, school or home (eg. does not go to work because hung over, goes to school or work "high", intoxicated while taking care of his or her children) or when substance use is physically hazardous (eg. drives when intoxicated)
5. important social, occupational or recreational activities given up or reduced because of substance abuse
6. continued substance use despite knowledge of having a persistent or recurrent social, psychological or physical problem that is caused or exacerbated by the use of the substance (eg. keeps using heroin despite family arguments about it, cocaine- induced depression, or having an ulcer made worse by drinking)
7. marked tolerance: need for markedly increased amounts of the substance (ie. at least a 50% increase) in order to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount

Note: the following items may not apply to cannabis, hallucinogens, or phencyclidine (PCP):

8. characteristic withdrawal symptoms (see specific withdrawal syndromes under Psychoactive Substance- induced Organic Mental Disorders)
9. substance often taken to relieve or avoid withdrawal symptoms

B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time." (DSMIIIR, 1987, 167-168)

1.3 OUTLINE OF DCC TREATMENT

The service offered by the DCC is composed of three procedures; intake, assessment and treatment. Each of these procedures will be briefly discussed to present a framework against which factors contributing toward dropout behaviour may be examined.

1.3.1 INTAKE

In the past, DCC therapists booked appointments for prospective clients. However, appointment non-arrivals resulted in therapist frustration and time wastage. This problem was resolved by the decision to operate a morning clinic specifically for new clients on a "first come, first served" basis. The morning clinic operates between 8:30 and 10:30, while the afternoons are kept free for scheduled appointments with existing clients.

Although the initial contact is sometimes made by telephone, prospective clients usually arrive in the morning and are welcomed by the receptionist. People arriving outside morning clinic hours are asked to return the following day.

The receptionist decides - sometimes in conjunction with a therapist - whether the new arrival is suitable for treatment. Unsuitable people are those who are acutely intoxicated, present with psychotic behaviour (ie. states of unreality), have an alcohol rather than drug problem or who have non-drug related criminal charges pending.

For those arrivals deemed suitable for treatment, the receptionist, in privacy with the client, documents personal details, opens a file and negotiates therapy fees according to a sliding scale based on income (Appendix 5). All clients are assisted, even if no payment is made, but outstanding amounts are expected to be paid at the following appointment. This done, clients sit in the waiting room until a therapist is available.

1.3.2 ASSESSMENT

The duration of the assessment is dependent on the complexity of the client's problem and the therapist's style, experience and training, but usually it lasts for one session. Generally the therapist completes a drug and personal history using a revised Maudsley History Schedule (Appendix 6). This schedule relies on client self-report, a method found to be reliable in a review of literature by Gibson (1986). Although Gibson recommended the use of the Addiction Severity Index, to effectively match DCC clients to treatment settings, no client-treatment matching tools are employed.

The assessment may result in a referral to another agency, or the client may even decide to terminate at this point. Otherwise, a treatment contract is agreed upon between therapist and client. The client's next appointment and the form of treatment is then scheduled. If appropriate, the therapist may supply the client with literature on drugs and information on community support groups.

1.3.3 TREATMENT

Although it is clinically recognised that clients are exposed to "treatment" from the time that initial contact is made with the DCC, the treatment paradigm in this study includes the available services at the DCC, namely;

1. Individual, family and sometimes group therapy rendered by DCC therapists.
2. Medical examination by the DCC's General Practitioner who prescribes medication, depending on the extent of withdrawal.
3. Psychiatric assessment performed by the DCC psychiatrist.
4. Psychometric testing performed by a psychologist.
5. An Emit urine test to confirm the presence or absence of cannaboids in a client's urine.

Although the other services will be mentioned in the text where relevant, it is the first treatment form, mentioned above, viz therapy, that is the focal point of this study. The DCC treatment format requires clients to attend therapy sessions from one to three times a week, and for one to three months, depending on their needs and the therapist's style. Therapy is usually individual, but may be with family members or in a group. Therapy continues until completion or until the client drops out of treatment.

1.4 RESEARCH DESIGN

This research follows a descriptive survey method, which is employed to "process the data that come to the researcher through observation." (Leedy, 1985, 140). This method does not necessarily seek or explain cause-effect relationships, but describes the facts and characteristics of a given population or area of interest. It is chosen as the data are derived primarily from questionnaires. Although the data are presented quantitatively for purposes of discussion, no statistical analysis was performed due to the small sample size. Statistical hypotheses are therefore unsuitable and instead this research makes use of stated objectives.

The research design includes the performance of a literature review and personal interviews with informed and consenting subjects following a structured questionnaire.

1.4.1 LITERATURE REVIEW

Literature was obtained from the DCC, the South African National Council for Alcoholism and Drug Dependence, Phoenix House and other treatment settings, current journals and relevant research dissertations. A printout was obtained from the Human Sciences Research Council, listing South African drug treatment studies. A Dialogue Search was performed on the Social Sciences Citation Index database at the University of Cape Town. The terms used in the

search were "dropout, premature termination, early termination, substance or drug dependent, use, abuse and treatment".

No studies were found to discuss dropout rates at drug treatment settings in South Africa, so relevant literature from international sources was obtained for generalization to South Africa and the DCC. It should be noted that two South African studies were found to be partially relevant to this research. One focused on drug abuse (Gibson, 1986), but not dropout behaviour, while the other examined dropout behavior, but in a marriage guidance setting (Hill, 1987).

1.4.2 SAMPLING

The sample of choice is dropouts assessed by DCC therapists. The definition of therapist excluded one voluntary unregistered DCC counselor whose lack of professional training could introduce additional therapist variables. The clients of this counselor were excluded from the study.

Random subject selection ensures that a sample is representative of the population as a whole. However, haphazard sampling, although described as arbitrary and sloppy (Cozby, 1981), is the sampling method used in this research. There are three reasons for this. Firstly, clients dropping out of treatment after November 1989 were excluded on the grounds that the researcher's employment at the DCC from this time could lead to subject response bias. Bias could stem from subjects' difficultly in criticizing the therapist, if therapist and researcher were the same person. Secondly, subjects were selected from as recent a period as possible, to maximize their recall of reasons for dropout behaviour. Lastly, it was unnecessary to select subjects from each month of the year as no seasonal variations of intake numbers were evident (Figure 1 in Appendix 4).

Due to the constraints of the sample selection discussed above, a sample size of 30 interview subjects was decided upon. At the time that this decision was taken,

the 1987/88 statistics revealed that on average, 15 clients dropped out of treatment per month (Table 1 in Appendix 3). A three month period period from 1 August 1989 until 31 October 1989 was thus expected to yield about 45 dropout subjects. This was considered sufficient to accomodate for untraceable or unwilling clients and administrative errors . However, the large number of clients counselled by the unregistered voluntary counsellor was not considered in the above calculations and the resulting sample size was 32. Chapter 4, Section 4.2 describes the breakdown of this sample in more detail.

1.4.3 INTERVIEW SCHEDULE

The Interview Schedule (Appendix 2) is comprised of four sections:

Section A: Identifying Client Data: Client name, address and contact persons were recorded from client files prior to performing the Initial Contact Outline by telephone on subjects. This data was destroyed after completing the research, to maintain client anonymity.

Section B: File Data: Data relevant to the research, present in client files, was recorded to reduce interview duration.

Section C: Structured Questionnaire: Contains questions designed to explore reasons for dropout behavior. In addition, some questions were included specifically at the request of the DCC management and play no part in the research itself. The responses to these questions are excluded from this research.

Section D: Outcome Data: Contains data relating to the appointments of the research interview .

The Initial Contact Outline and Structured Questionnaire were written in English and translated into Afrikaans. The Afrikaans versions were re-translated into English by a different translator, to check the reliability of the translation. These were piloted on five people, counsellors and drug addicts, the latter of which did not form part of the research universe and therefore does not

which did not form part of the research universe and therefore does not contribute to research bias. On the basis of the piloting, certain questions were altered in order to operationalize terms and constructs.

Piloting the questionnaire presented an opportunity to gauge the interview duration, eradicate ambiguities and practice conducting the questionnaire. This also permitted verification of the face validity of the questionnaire - that it measures what it is intended to measure (Leedy, 1989).

1.4.4 DATA COLLECTION AND ANALYSIS

The data collection format followed by the researcher was composed of three steps.

Step 1: The researcher telephoned the dropout subject, identified herself, explained the purpose of the study by reading the Initial Contact Outline (Appendix 1) and with the dropout subject's permission, arranged an interview venue.

Step 2: Completed the Interview Schedule (Appendix 2).

Step 3: Collated and analyzed the data.

The interviews were conducted over a three week period during August 1989. All interviews were conducted by the researcher to create consistency in interviewer reliability (Cozby, 1981). One interview was conducted in the presence of a colleague who accompanied the researcher into a dangerous area for safety reasons. In fact, this interview was conducted at the subject's bedside as he had been recently stabbed in a gang encounter.

Data analysis was to be performed by computer using the Lotus 123 package, but constraints with the loading of data and the small sample size, resulted in manual analysis. Therefore, raw figures have been used in preference to percentages which tend to exaggerate the findings of a small sample. In some cases

percentages have been used, but only for purposes of comparison with other data.

1.5 STUDY LIMITATIONS

The research findings are descriptive of a small group of dropout subjects, which were not randomly sampled, and as such, are not generalizable to clients of the DCC, or any other drug abusing population. The researcher does however highlight the strong similarities between the sample group and the DCC client population and predicts that similar findings may be found at other drug centres. This offers a basis for further research.

Furthermore, data collection, using archival and self-report data has limitations. The reliability of archival data is limited, as client files contain data recorded by more than one therapist. These therapists record their subjective views of the client's problem using differing criteria, whilst in different moods and may even transcribe client details inaccurately.

Self-report measures also have limited reliability and validity, as behavior is frequently ego-syntonic (ie. not regarded by the person as undesirable). Validity could not be examined as verification of the subjects' responses would have impacted on the confidentiality of the research and the treatment offered at the DCC. Furthermore, the nature of illicit drug abuse is such that the person's responses are not consistently reliable: ".. chronic drug abusers are often unable to control their lying and the habit becomes compulsive. It's often a case of the drug doing the talking, not the addict." (Searll, 1989, 124).

Three methods of data collection were considered. A postal survey was rejected as some subjects had no contactable addresses. Furthermore, the researcher had unauthorized use of DCC client addresses as many of them attend the DCC in private and confidentiality principles would be breached if their mail were to be

opened by others. In addition to this, clients who fail to complete treatment, may also fail to return surveys.

Telephone interviewing was also considered, but was rejected as subjects might be uncomfortable reporting their illegal drug use to an unseen and unknown person. Therefore, personal interviews with informed and consenting subjects following a structured questionnaire posed the most effective and suitable research design.

The retrospective design of this study, means that subjects were required to recall an event which occurred seven to ten months previously. Accurate recall is hampered by the passage of time and the emotional state of the subject, both during treatment and during the interview itself. The emotional state of the dropout is depicted in Table 4.11 (Chapter 4) which shows that more than half the dropout subjects felt nervous/scared or confused during their first DCC contact.

Furthermore, the recall of an event such as dropping out of drug treatment, may be minimized or exaggerated in order to deal with the consequences of the experience. Hence, the current circumstances of the dropout influence the degree and perspective of the recall. This view is encapsulated by Hoult (1984) in Isaacs (1989, 370): "..there is the all-too-human tendency to reconstruct our autobiographies in an effort to bring them into greater congruence with our present identities, roles, situations and vocabularies" (Hoult, 1984, 143). For the above reason, the researcher facilitated recall of the experience of the DCC treatment rather than attempts to quantify the experience itself by employing probing questions within the structured questionnaire.

Although the researcher conducted all interviews in a standardized and consistent fashion, it is possible that factors such as tone of voice, gender or authority issues arising from the status of being a DCC employee may have

influenced responses to the questionnaire. These factors may have affected recall as the subject may respond according to social desirability and fake good or bad (Cozby, 1981).

Personality factors were considered during the design of the structured questionnaire, but no diagnosis or discussion of traits was included for two reasons. Firstly, the absence of standardized measures could not ensure the reliability of the results. Secondly, it was impossible to perform an accurate personality assessment in one research interview, using self-report measures.

The Interview Schedule (Appendix 2) has a limitation in its examination of improved functioning as there is no specific question about improved functioning but deduces this from the responses to a question on reasons for dropping out of treatment. Furthermore, in the Discussion of Results (Chapter 4), cross-relational tables could have demonstrated relationships between two variables more clearly than pie-charts, such as in Figure 4.7.

1.6 CONCLUSION

The high dropout rate at the DCC has caused concern about the effectiveness of treatment. The research aim to study and evaluate dropout behaviour, is explored through an examination of the forces impacting on the client seeking treatment. These forces contributing toward dropout behavior are categorised into four factors; motivation, client variables, treatment and therapist profiles. These four forces will be examined in detail within Chapter 2 and Chapter 3 which respectively discuss the literature and research results.

CHAPTER 2

DESCRIPTION OF ILLICIT DRUG ABUSE IN SOUTH AFRICA AND THE WESTERN CAPE WITH SPECIAL REFERENCE TO DAGGA

2.1 INTRODUCTION

Dagga, the drug of focus in this chapter was reported, in the United States of America, to be the most widely abused illicit drug. An American community study, cited in the DSMIIIR (1987, 177) and using its criteria for substance abuse, was conducted from 1981 to 1983. It indicated that approximately 4% of the adult population were diagnosed with Cannabis Abuse at some time in their lives. It was also been estimated from a door-to-door study of four American cities, that 17% of the large population surveyed, met the DSMIIIR criteria for drug dependence or abuse (Galanter, 1990).

In South Africa, the most abused illicit drug is reported to be dagga (Hickey, 1985; De Miranda, 1987; Searll, 1989). Although locally cultivated and available, the extent of dagga use and abuse is not fully known. There are inherent problems in gathering data on a subject which is socially condemned by some people. The legal status of the drug also generates fear in admitting to use, which impedes research of this nature.

Harsh penalties are associated with illicit drug use in the South African statutes. Presently, the fines for drug dealing and drug possession have no ceiling and are left to the discretion of the magistrate. Drug dealers may receive up to 25 years imprisonment and people convicted for possession may receive up to 15 years imprisonment (Government Gazette, 4 July 1990).

Despite these constraints, methods for describing the patterns of illicit drug abuse can be identified and separated into five groups. A sociological premise

may view some aspects of drug abuse as acceptable behaviour, even though the drug is deemed illegal by statutes. Police records reflect trends in drug-related arrests and confiscations. Self-report findings describe trends in the onset and prevalence of illicit drug abuse. Illicit drug abuse can also be described as a symptom of underlying problems or issues, such as adolescent drug experimentation. Lastly drug use patterns may be understood by utilizing a literature survey. These five groups will now be examined in some detail.

2.2 SOCIOLOGICAL

For centuries dagga stems were used as fibres for weaving fabric. Du Toit (1980) described how cloth, made of dagga stems, was found among the 6000 year old remains in a cave in Europe. Dagga was also used in religious contexts for its hallucinogenic properties, by Shamans in India and continues to be used in a this context within the Rustafarian culture.

Dagga was used for its medicinal properties by Indian healers and in Western medicine until relatively recently. Du Toit (1980), noted how dagga was listed in the 'Pharmacopoeia of the United States' between 1850 and 1942. It prescribed dagga for the treatment of chronic cough, stomach pain, gonorrhea, nervous disorders, melancholia, pain relief etc. This was discontinued as more effective drugs were discovered. As dagga and it's derivatives were viewed by some as harmful to the individual and a potential threat to the order and well-being of society (Theron, 1974), anti-dagga legislation became increasingly prevalent.

In South Africa today, the following Acts of Parliament empower the courts to sentence drug users and drug dealers. Act 41 of 1971 and its Amendment, Act 101 of 1986, provides regulation for statutory treatment whilst Act 51 of 1977 and its recent Amendment, Act 78 of 1990, prohibits the possession of and dealing in certain substances, including dagga and Mandrax. (Drugs and the Law Fact Sheet, undated; Government Gazette, 4 July, 1990).

The illegal status of dagga should be examined within the philosophy of South African society. Theron (1974, 146-150) described a person's value position on the dagga issue as either that of a pragmatist or an absolutist. On the one hand, the pragmatist rejected faith in traditional authority. The absolutist however, had a moral sense of duty derived from a faith in traditional values, rooted in respect for and obedience to, authority. This view was reflected in the philosophical base of the South African Statutes, which are often said to be Calvinist in ethic, by virtue of statutory sanctions against gambling, undesirable films and public entertainment on the Sabbath. The consequence of an absolutist view in the statutes, is that drug users are viewed as disreputable and associated with criminals in general.

Dagga use was viewed in three contexts: everyday use, the ritual of first use and traditional use (Du Toit, 1977, 83-84). Everyday use in traditional and modern settings involved a particular method of preparing and using dagga, such as smoking it or mixing it with tobacco. Daily use led to ritual: for example, the crushing and cleaning of the dagga, breaking a bottle to make a pipe, a second party to light the pipe and usually communal smoking of the dagga.

The ritual of first use was usually associated with entering a sub-culture as " the performance of the act changes their status ... from non-drug users to users, from persons immune from arrest under drug law to potential convicts, from observers to participants. Du Toit, 1977, 83).

The traditional use of dagga (for medicinal, religious or social purposes), daily and sometimes as a ritual of first use, can be culturally viewed as acceptable behaviour. The Zulu people for example, restrict the use of dagga to the mature, older men who use it as a ritualized way of relaxing at the end of the day, or reminiscing about the past. These people are using and not abusing dagga. In fact, groups having a traditional purpose for dagga, are less prone to abuse it,

whereas those groups whose cultural values have always rejected dagga use and therefore perceive users as abusers, are more likely to abuse dagga. A quote from Du Toit (1977, 78) illustrates the point:

> .. Whites had a cultural tradition which could readily accommodate and explain the use of alcohol and possibly some other drugs, but they lacked the historical acceptance and frame of reference for cannabis. The African today explains that the cannabis leaf is the "ugwayi abadala" (the smoke of the ancestors), while the Indian has centuries of family and cultural traditions which account its' use..

The sociological approach to the description of drug abuse examines dagga from a cultural perspective. It describes how dagga was and still is used for medicinal and religious purposes in some cultures. However, the absolutist view portrayed in the South African statutes, considers all dagga use, even that which is culturally sanctioned, as dangerous abuse and therefore illegal.

2.3 SOUTH AFRICAN POLICE RECORDS

South African Police records offer a measure of the police's success in curbing the South African drug problem. However, these records also indirectly hint at trends in drug abuse. Some authors contend that it is possible to estimate the number of drug users from the number of drug-related arrests and the amount of drugs confiscated or destroyed. Neethling (1983) for example, proposed that the number of drug related arrests in South Africa (approximately 25,000) constituted 10% of the total drug population. He estimated that the number of people involved in the drug sub-culture amounted to 250,000.

The volume of confiscated or destroyed drugs can also be used as a yardstick of drug use. Appendix 9 indicates that from 1987 to 1989, the annual average quantity of dagga destroyed by the South African Police, has increased two-fold annually, but the number of arrests and kilograms confiscated has remained fairly constant. The police may be curbing the drug problem by arresting more drug dealers and destroying more dagga. However, it is likely that as the SAP

have been involved in maintaining the State of Emergency, that they have not been able to focus their efforts on curbing the drug problem.

2.4 SELF REPORT

Another method of describing illegal drug abuse in South Africa, involves examining drug users' reports of their behaviour. As this behaviour may be labelled deviant by some groups of society and is illegal, careful research design is required to enhance the validity and reliability of the results.

One researcher, Levin (1983) completed a longitudinal study of Witwatersrand medical students during 1981 and later in 1983. Although the populations of the two years varied, a close correlation between the two studies indicated that the results of the two studies could be compared. His results suggested that as academic studies progress, increasing numbers (27% to 32%) of medical students try and continue to smoke dagga (Levin, 1983).

Furthermore, Levin's rates for both experimentation and current use of drugs amongst medical students were higher than those found by other South African researchers in university settings (Herr, 1972; Simon, 1982). Levin found that usage increased significantly between first and second years of study and proposed that "after the pressures of the first year examinations was a period when many students tried dagga for the first time .... many students were first introduced while at holiday resorts away from their parents and without the stresses of academic life." (Levin, 1983, 5).

Drug use, initiated during adolescence and early adulthood is supported by other authors: During 1973, Van der Burgh established that 15,4% of a South African sample of white men aged 16 to 18 years old, had used dagga at least once, mostly experimentally as scholars. Du Toit (1977) found that of 1152 Durban high school students, 14% of White, 19% of Indian, 12% of "coloured" and 17%

of Black students had used dagga at least once in the past. Le Roux (in Van der Burgh, 1983) found that one quarter of shebeen subjects were twelve years or younger at the onset of their dagga use and that three quarters had started smoking regularly by the age of seventeen. More recently, Van der Burgh (1983) reported that of 2653 White post-school young men, approximately one out of every ten had used dagga within the past six months and most initial experiences with dagga had occurred before entering high school. In fact, the age of first use of dagga is decreasing (Gibson, 1986).

It therefore appears that in South Africa, the onset of dagga use occurs during adolescence and early adulthood, a matter for further discussion in the following sub-section on symptomatology.

2.5 SYMPTOMATOLOGY

The above discussions outline how dagga use is illegal, is prevalent throughout South Africa and is primarily an adolescent occurrence.

Ziervogel (1986) described substance abuse in adolescents as a symptom of adolescent experimentation, an adolescent task, a conduct disorder, an underlying psychiatric illness or an established addiction. Therefore, within industrialized South African societies, adolescent substance abuse is not an intentional crime of the few but rather a common result of a peer orientated behaviour. The meaning of the drug abuse is found in the function that the drug use serves - a ritual of first use, daily use and traditional use - described above.

The adolescent who uses dagga regularly may be responding to various underlying symptoms, mentioned above by Ziervogel (1986). The ritual of first use is the adolescent's normal desire to experiment and is therefore part of one of the tasks of adolescence. It symbolizes the transition from the status of a child to an

adult, a task which can be prolonged by drug use and which is described by Kaplan and Sadock (1988, 42) as follows:

> .. In many cultures, the onset of adolescence is clearly signalled by puberty rites ... In technologically advanced societies however, the end of childhood and the requirements for adulthood are not clearly defined. In such circumstances the adolescent undergoes a prolonged and, at times, confused struggle to attain adult status..

Therefore, the legal restrictions placed on dagga and the rituals required in actual use, serve to assist some adolescents in the task of shifting social interactions from family to peer group and to enhance peer group trust and friendship (Kaplan and Sadock, 1988). This adolescent function of initial and ongoing drug use is supported by the fact that drug abuse peaks in the 18-22 year age group and declines to low levels by the late twenties (Van der Burgh, 1983).

2.6 LITERATURE SURVEY

Another method of describing patterns of drug abuse is to survey literature. Gibson (1986) referred specifically to Cape Town, where the DCC is situated and therefore has special relevance to this dissertation. A summary of Gibson's conclusions with updates, will be presented.

Gibson concluded that no group racially segregated by South African law was exempt from drug use and that there was an increased demand for treatment at Groote Schuur Hospital in "coloured" and White race groups as a result of the clinical study conducted by Ben Arie (1984).

Data on which to base discussion of Black drug abuse is scarce partly because "Black" people rarely attend drug clinics (Gibson, 1986; Karassellos, 1989). This may be due to ".. the low prevalence of drug abuse (as opposed to drug use) or to non-alignment between such treatment facilities and Black culture - that is, Blacks may perceive such a treatment environment inappropriate to drug abuse problems" (Gibson, 1986, 168).

Gibson found minimal literature on the Muslim and Asian community. However, since 1986, Capetonians reacted to what they perceived as a serious drug problem and on 31/5/1990 thousands of Moslems protested about the escalating drug peddling occurring in their neighbourhoods. The Salt River Co-ordinating Council was created to maintain community commitment to this cause (Newsletter Vol. 1, No. 1, June 1990). The consequence of this protest was the plan to open a drug counselling and community centre in Salt River.

There have been many other responses to the Cape Town drug problem. Lentegeur Hospital opened an in-patient drug unit. Drug Counselling Centres were opened in Bellville and Somerset West, whilst those in Langa and Salt River are nearing completion. Tough Love groups for families of drug addicts and Narcotics Anonymous developed, as self-help organizations. Finally, the DCC itself expanded to employ more therapists.

2.7 CONCLUSION

Illicit drug abuse in South Africa cannot be accurately quantified, but it can be examined from various angles. Trends of drug abuse are reflected in both South African Police records and in literature describing the development of drug treatment facilities and increasing numbers of drug dependent people. A sociological method of examination outlines how the drug statutes impact on cultures which sanction the medicinal, social and religious use - not abuse - of drugs, particularly dagga. Furthermore, this drug's abuse has developed from a culturally sanctioned, traditional activity amongst some to that of an adolescent activity amongst more industrialized groups. These adolescents are practicing rituals which are part of the transition from childhood to adulthood.

This description of the South African and Western Cape drug abuse and use patterns, offers a background to the literature - local and international - surrounding dropout behaviour.

CHAPTER 3

LITERATURE REVIEW OF FORCES CONTRIBUTING TO DROPOUT BEHAVIOUR ACCORDING TO MOTIVATION, CLIENT, TREATMENT AND THERAPIST FACTORS

3.1 INTRODUCTION

Literature describing the phenomena of dropout behaviour in respect of drug abuse is scarce. Baekeland and Lundwall (1975) reviewed 20 years of dropout studies and found only seven to examine drug abuse populations. A possible explanation for this dearth, is that drug abusers are expected to drop out of treatment, as they are stereotyped as having poor impulse control and low frustration tolerance (1975, 765).

Studies of psychiatric, general mental health, alcoholic and drug treatment settings will be selected for critical discussion according to their relevance to dropout behaviour. Although this literature is not necessarily generalizable to the illicit drug abuse population in South Africa, it provides a comparative background and some support for the conclusions of the drug abuse studies.

The literature will be reviewed under four headings which divide the material according to broad reasons for dropout behaviour:

1. Motivation factors which influence dropout behaviour externally, such as legal and family pressures, or internally such as subjective feelings of distress or exhaustion.
2. Client factors which include discomfort from symptoms and the clients' personality.
3. Treatment factors such as the agency's treatment model or administration procedures.
4. Therapist factors which examine therapist attributes and the therapeutic techniques employed in treatment.

3.2 MOTIVATION FACTORS

Motivation factors include the overt and covert reasons for people seeking treatment for a given problem. They may be divided into two groups: the external pressures such as family and legal coercion, and the internal pressures such as subjective fears of addiction. Looney (1974, 528-668) described the relationship between internal and external sources of motivation. He noted how drug addiction produces physical and mental exhaustion which catapults people into treatment. He termed this the "fatigue factor", which leads to a hunger for treatment and poignant expressions of internal motivation. However, the fatigue is short lived, as people soon find themselves feeling physically and mentally stronger and drop out of treatment. This view is supported by Crisis Theory (Aguilera, 1982) as the normal defences of people seeking treatment are lowered and coping methods are impaired. When familiar patterns of coping arise, they feel better and drop out of treatment.

Looney's view is further substantiated by four authors who examined the impact of external sources of motivation on dropout behaviour. Ben Arie (1986) and Allan (1987) examined legal sources of motivation, and Stanton and Todd (1982) and Hill (1987) examined familial sources of motivation.

Ben Arie completed his follow-up study (1986) seven years after alcoholics had completed compulsory treatment. He found that 44% of the subjects with external, legal pressure showed improvements in their patterns of use. Although one quarter of the subjects were untraceable, producing unknown bias from non-response, his research indicates that almost 50% of coercive legal referrals, benefit from treatment.

Another issue in the examination of external pressures, is that internal motivation is rarely sufficient to ensure success in treatment, unless supplemented by external pressure. Allan (1987) concluded this after analyzing

archival data from a sample of 121 consecutive alcoholic attenders at a community-based agency and found that coercive (externally motivated) referrals attended twice as long and twice as many appointments as self-referrals. There were controls for treatment barriers such as inflexible agency hours, stigma with woman therapists treating women clients and gender-aware treatment, as women were found to be more comfortable individually than in groups.

Stanton and Todd (1982) added a familial dimension to the discussion on external pressure. This linked with the therapist factor that families may collude in the drug problem by adopting survival roles such as a hero, lost child or mascot (Ketcham, 1989; Steiner, 1984). Stanton and Todd (1982, 109) emphasized family therapy in the treatment of drug abusers, supporting the view that drug abuse is not only an individual, but also a family illness (Ketcham, 1989). Therefore, drug abuse can be treated within a System's Theory paradigm, with external pressures from family or courts playing a significant role in dropout behaviour.

The importance of external pressure is further indicated by Hill (1987) who compared a randomly selected group of marriage guidance dropouts with continuers. Hill found that dropout behaviour is associated with minimal family pressure, thereby directly linking dropout behaviour to a lack of external pressure.

Society views substance abuse by men and women differently. Intoxicated men's behaviour is condoned, but intoxicated women's behaviour is viewed as deviant and threatening to family functioning (Ihsan, 1980). Women are subject to significantly more stigma if they abuse substances, as they deviate from their prescribed societal roles as feminine and nurturant. This stigma results in their

difficulty in acknowledging the problem and thereby responding to internal pressure by seeking treatment.

Less external pressure on women to seek treatment than men is evident in the finding that there was a resistance among health professionals to detect alcohol problems in women (Duckett, 1985) and because employers and traffic officers were less likely to confront or arrest intoxicated women than men (Straussner, 1985). Consequently, women are subject to fewer external and internal pressures than men and therefore tend to drop out of treatment more easily than do men.

It can be seen that a combination of both internal and external pressure for treatment will sustain treatment motivation. However, one of these in isolation, will probably result in dropout behaviour. Drug abuse - and the crisis of physical and emotional exhaustion - leads to internal pressure for treatment. Unless this crisis is sustained by family or legal pressures, this internal pressure fades and the person drops out of treatment. The factors which contribute towards this internal pressure originate from the client factors such as personality and withdrawal symptoms.

3.3 CLIENT FACTORS

These factors include some of the personal attributes of people seeking treatment, which influence their dropout behaviour. The literature on these factors will be divided into demographic, symptom and personality groupings.

3.3.1 DEMOGRAPHIC

The literature on the demography of treatment dropouts and that of drug abusers has been thoroughly investigated by three authors: Hill (1987), Baekeland and Lundwall (1975) and Gibson (1986). All three concluded that demographic factors in isolation, did not contribute towards dropout behaviour.

They did however find that sex, socioeconomic status and age influenced dropout behaviour.

Sex differences in treatment dropouts were examined in two settings. In marriage guidance settings, dropouts were found to be indistinguishable from continuers with regard to sex (Noonan in Hill, 1987) but in drug settings, more women than men dropped out of treatment (Baekeland and Lundwall, op cit). An explanation for these contradictory findings on sex differences, follows from the previous section (4.2), where stigma was noted to impact on women seeking and accepting drug treatment. Drug abusing women are more socially stigmatized for receiving drug treatment than women receiving marriage guidance. In fact, the few women who seek drug treatment in comparison to men - although it is estimated that half the alcoholic population are women (Steele, 1985). - are subject to minimal external pressure from employers, families etc. In drug settings therefore, women will be more likely than men to dropout of treatment.

Lower socioeconomic status, indicated by education level, occupation, race and income, was also found to be associated with dropout behaviour by Baekeland and Lundwall (1975) in 16 of 18 dropout studies. Other researchers (Curtis in Hill, 1987) confirmed these findings. However, socioeconomic status should be noted only cautiously as a predictor of dropout behaviour for two reasons: Drug abuse is prevalent amongst all groups of society, but tended in the literature findings to be most associated with lower socioeconomic status groups (Gibson, 1986) who are more accessible research subjects than higher socioeconomic groups who are treated in private clinics. Furthermore, it is these lower socioeconomic groups who were found most likely to be pushed out of treatment by a negative attitude on the part of their therapists (Baekeland and Lundwall, 1975).

People of increasingly younger ages abused drugs (Ahers, 1972; World Health Organization, 1973; O Connor in Gibson,1986) and it is younger people who tended to drop out of treatment (Baekeland and Lundwall, 1975). Drug treatment is therefore focusing increasingly on adolescent drug abuse and the turmoil associated with this age group, may influence dropout behaviour.

The literature indicates a trend of clients of lower socioeconomic status, women rather than men and younger rather than older groups of people tending to drop out of treatment. However, this behaviour is interrelated with the therapist's attitude and even the agency treatment models, and will be discussed later.

3.3.2 SYMPTOM LEVEL AND DURATION

The results of three major studies concerned with these symptom aspects will be examined in relation to dropout behaviour. Powell (1974) surveyed a small sample of alcoholics at an American Alcoholic Day Hospital and found that attenders with early onset of drinking, were more likely to report symptoms than those with a later onset. Robinson (1982) examined the relationship between onset and dropout behaviour. He matched single session dropouts from correctional drug treatment by race and date of entry, with a group who stayed in treatment for 16 weeks. He found that dropouts had used drugs longer than those who remained in treatment.

Baekeland and Lundwall's extensive literature study of dropout drug abusers (1975) found that drug addiction was associated with high symptom levels in 22 out of 35 studies. Drug addicts were also found to be less tolerant of delay in relief of symptoms, were easily frustrated and therefore tended to drop out of treatment more frequently than other groups. This finding provides support for Robinson (1982) who stated that dropouts had longer drug abuse patterns. It also supports Powell (1974) who found that they also have higher symptom levels than in other illnesses.

The literature surveyed indicates that dropouts from drug treatment have longer use patterns and higher symptom levels than continuers. Symptoms of high usage initially may precipitate people seeking treatment, but the corresponding high withdrawal symptom levels cause discomfort and frustration, in turn leading to dropout behaviour.

3.3.3 SYMPTOMS

Three groups of symptoms will be discussed : withdrawal symptoms resulting from abrupt stoppage of drug use, unpleasant effects, and concomitant psychiatric disorders arising from continued drug use. These symptoms cause discomfort and result in people seeking treatment but conversely lead to frustration and dropping out of treatment. They will be outlined in relation to the primary drugs of abuse at the DCC, namely dagga and Mandrax.

DAGGA

The DSMIIIR (1987) does not cite withdrawal symptoms for dagga. However, it was shown experimentally (Jones, in Tunving 1987) that if dagga was used daily for at least 10 days and was abruptly stopped, that withdrawal symptoms developed (Tunving, 1987). DCC therapists and doctors reported that the most common complaints were insomnia, restlessness and mild depressive symptoms. Other authors supported this finding and add irritability, anxiety, nausea, and appetite disturbance to the listing of withdrawal symptoms (Medical Letter, 1985).

An extreme reaction to dagga was a psychotic episode or Cannabis Delusional Disorder (DSMIIIR, 1987), during which the client experienced feelings of persecution and believed that strangers intend to hurt him/her. Other features were; marked anxiety, emotional lability, depersonalization, and subsequent amnesia from the episode.

Unpleasant effects associated with the use of various illicit substances, including dagga were examined by Patterson (1974). He confidentially surveyed 19 000 new military inductees on their previous illicit drug use. Adverse effects for dagga were reported by 2,1% of subjects and included headaches, paranoia and the experience of a "bad trip" whilst Smart (1982) reported confusion and anxiety in his huge sample of 491 901 Canadian high school students. Smart reported that 60% of daily users had unpleasant dagga reactions but that only 4% sought medical help. Smart suggested that most dagga users, rather than seeking medical help, treat their unpleasant effects alone or with the assistance of friends.

MANDRAX

The effects of orally taken Mandrax are well documented. The withdrawal symptoms include restlessness, irritability, sleep impairment, anxiety, headaches, appetite loss, nausea, vomiting, abdominal pain, muscle twitches and mild tremors (Cox, 1983; Straughn 1989; Inaba, 1973). The adverse reactions include dizziness, vomiting, skin eruptions and burning sensations (Mandrax Fact Sheet, SANCA, undated).

In South Africa, Mandrax, in its' abused form, is smoked in combination with dagga. This unique method of use lacks documentation in the literature. Wilson (1990) stated that this form of use has withdrawal symptoms which correspond to orally taken Mandrax, described above. He stated that a combination of dagga and Mandrax may have a synergistic effect, as the combustion of Mandrax may increase the absorption of dagga.

As Mandrax is illicit in South Africa, its' authenticity, quality and content are unknown factors, hence the severe adverse reactions reported when Mandrax contained a combination of Methaqualine and Benzodiazapene (Cape Times, 1989):

> "The clinical syndrome comprised of an initial rush (euphoria, hallucinations or suicidal thoughts), asyncopal attack with a feeling of lower limb paralysis; regaining motor activity, disorientation with purposeless wandering; a final stage of physical and verbal aggression. The duration is from 1 to 4 days and the patient is amnesic for all or part of the period." (Wilson, 1989).

Mandrax is a Sedative-Hypnotic drug which may produce a Withdrawal Delirium (DSMIIIR, 1987) when a person abruptly stops using it. This has features including autonomic hyperactivity (for example, sweating), reduced ability to maintain or appropriately shift attention to external stimuli and disorganized thinking.

3.3.4 SIMULTANEOUS SUBSTANCE USE AND PSYCHIATRIC DISORDERS

Substance Use Disorders can exist simultaneously with most psychiatric disorders. This relationship was described by Meyer (in Bukstein, 1989) who noted that psychiatric disorders can develop as a consequence of substance use and that psychiatric disorders can also alter the course of substance use. He also noted that substance use can alter the course of psychiatric disorders.

Substance use is commonly found alongside Affective (Mood) Disorders, Antisocial Personality Disorders, Anxiety Disorders and Eating Disorders (Bukstein, 1989). This section will concern itself with three groups of psychiatric disorders commonly found to be concurrent with Substance Use Disorders at the DCC. These are Mood, Anxiety and Personality Disorders of which the first two will be discussed simultaneously due to their degree of overlap.

MOOD AND ANXIETY DISORDERS

Mood Disorders include depression and manic episodes while Anxiety Disorders relate to panic reactions, phobias et cetera. Often people undergoing withdrawal present with features of Mood or Anxiety Disorders. However, a diagnosis

should only be made after detoxification, to avoid confusing withdrawal with Mood and Anxiety Disorders. The findings of two researchers who examined the concurrence of psychiatric diagnosis with Substance Use Disorders will follow.

Schuckit (1988) examined concurrent Substance Use and Mood or Anxiety Disorders in alcoholics. He reviewed literature and found no link between Anxiety Disorders and Alcoholism, but found some evidence for concurrent Mood Disorders and Alcoholism. He also interviewed 577 alcoholics and found that one-quarter had experienced a secondary Mood Disorder.

Another researcher, Oppenheimer (1988) tried to demonstrate that opiate users were more depressed than the normal population, using Beck's Depression Score. In this he was unsuccessful. However, the design was marred by the fact that he did not wait until the detoxification period was complete, before administering the Score.

The scarce literature suggests that Mood Disorders, unlike Anxiety Disorders, may occur simultaneously with Substance Use Disorders. No research examined the relationship between Mood or Anxiety Disorders and dropout behaviour.

PERSONALITY DISORDERS

Personality disorders are present in people who from adolescence, have related to the world in a particular manner. This manner must be inflexible, maladaptive and cause either significant functional impairment or subjective distress (DSMIIIR, 1987).

Simultaneous Personality Disorder and Substance Use Disorder, will be discussed in respect of adolescent and adult populations. There will be an emphasis on Conduct Disorder in adolescents and its adult equivalent, the Anti-social Personality Disorder. Literature on dropout behaviour will also be reviewed.

Caton (1989) examined a group of adolescents consecutively admitted to a New York Psychiatric Hospital. Although this population is not generalizable - being a specific population requiring admission for chronic psychiatric problems - Caton's findings are important as he examined Personality Disorders concurrently with Substance Use Disorders. He found diagnoses of Dependent, Schizoid and Conduct Personality Disorders associated with Substance Use Disorders.

Bukstein (1989) also examined adolescent populations. He reviewed literature on the simultaneous occurrence of Substance Use with other psychiatric disorders. He supported the findings of Caton (1989), as he too found Conduct and Anti-social Personality Disorders associated with adolescent populations of substance users.

Studies of adult populations tend to indicate that Anti-Social Personalities are linked to dropout behaviour. Baekeland and Lundwall (1975) found Sociopathic Character Disorders (Anti-Social Personality Disorders) to be associated with dropout behaviour. Similarly, Robinson (1982) found that one-day dropouts from drug treatment were more impulsive, antisocial and pathological than the continuers with whom they were matched.

In a later study, Robinson (1987) found that one-day dropouts also had significantly more drug related crimes like possession or dealing, while the continuers had significantly more crimes against property. Criminal behaviour of drug treatment dropouts may indicate antisocial personality traits but it is more likely that their drug problems are so severe that criminal activity is required to finance drug habits.

Craig (1984) refuted Robinson's (1982 and 1987) and Baekeland and Lundwall's (1975) findings above. Craig reviewed all personality tests attempting to predict treatment dropouts and found no conclusive evidence that personality was a

predictor of dropout behaviour. He performed the Millon Clinical Multiaxial Inventory Personality Test and found no personality differences between drug treatment dropouts and continuers.

Simultaneous diagnosis of Personality Disorder and Substance Use Disorder is prevalent amongst adolescents and adults. It is impossible to identify consistently a single Personality Disorder occurring concurrently with Substance Use Disorder or with dropout behaviour, although Antisocial Personality is frequently cited. This inconsistency is explained by the fact that antisocial acts are most likely to be performed as a result of drug craving, rather than as a result of an Antisocial Personality Disorder.

3.4 TREATMENT FACTORS

Treatment factors associated with dropout behaviour will be examined according to the philosophy and treatment model of the agency. Agency functioning will be examined from three angles: the impact that the first contact person makes on the new client; followed by the client's response to the services; and finally, treatment effectiveness will be examined according to symptom improvement.

3.4.1 EVALUATION METHODS

Tracy (1977) reviewed evaluation methods in an American community mental health center. He found that a behavioural analysis led to more treatment contacts than the traditional psychiatric evaluation method such as that used by the DCC (Appendix 6). He explained that amongst other reasons, traditional evaluation methods are often not understood by clients and contribute toward dropout rates. These clients may expect more action on the part of the therapist. More active or different treatment styles like those of Crisis Intervention theorists (Golan, 1978; Aguilera, 1974) are perhaps more effective than traditional psychiatric evaluation methods.

Other authors indicated that the orientation of the treatment setting influences dropout behaviour. Reed (1985) noted that substance abuse treatment centers and models were male oriented and not geared to the special needs of women. She noted numerous treatment barriers which included the labelling of these women as sicker, less motivated, more sexually deviant and harder to treat than men. Notions such as these were derived from Freud, who described women as passive, narcissistic and masochistic (Michell, 1974). It is therefore not surprising that Feldstein (1979) found male subjects significantly more satisfied with therapists than female subjects.

Reed (1985) examined studies of human service delivery and found that the type of people served, greatly influenced agency practices and services. Agencies develop routine procedures and expertise appropriate for the bulk of their clientele at the cost of minority groups. Research into client demography at the DCC (Karassellos 1988), showed women and "Blacks" to be minority treatment groups. Minority group exclusion can be reduced by the use of a cross cultural approach which can examine male orientated or racially biased treatment norms and procedures (Reed, 1985).

The literature indicates two important issues whereby treatment philosophy influences dropout behaviour. On the one hand, treatment models develop to meet the needs of the majority of people served, thereby neglecting minority group needs and leading to a higher incidence of dropout behaviour. On the other hand, traditional evaluation methods may not promote the client's sense of being understood by the therapist, hence facilitating dropout behaviour.

3.4.2 INITIAL CONTACT

The client who telephones the DCC or arrives for the morning clinic may speak to one of a number of employees. These could be the receptionist, the secretary, a therapist, a General Practitioner or the psychiatrist. Usually, the initial contact person at the DCC, is the receptionist.

The literature on initial treatment contact was thoroughly researched by Hill (1987) who found that long waiting times for marriage guidance and family therapy are linked to dropout behaviour (Gaines, Curtis in Hill, 1987). The demand for immediate appointments at the DCC indicates that people in crisis will tend to pressurize the initial contact person for urgent assistance. This may be problematic, particularly when agency policy dictates the use of waiting lists for first appointments. It is therefore not surprising that Hill (1987) found a reassuring manner on the part of the receptionist, to positively affect client engagement in treatment.

Dropout studies in family therapy settings indicated that inflexible agency working-hours promote dropout behaviour (Berg in Hill, 1987; Stanton and Todd, 1982). Other authors supported these findings, especially in relation to treating women with child-related responsibilities (Reed, 1985). Hill (1987) did not find that agency hours affected dropout rates, but her results of married couples are not generalizable to whole families meeting at possibly inconvenient times.

The therapists' experience and training, as an initial contact person, is noted by two authors: Gaines (in Hill, 1987) found that dropout rates of clients rose (by 10% to 25%) when a new and inexperienced intake worker was employed. The variable of training was excluded by Gaines (in Hill, 1987) but included by Hill (1987) who did not find it to affect dropout behaviour significantly .

Literature findings demonstrate that the initial contact person, usually a receptionist or therapist, plays an important role in projecting a positive agency image. The receptionist's experience and ability to negotiate appointments reassuringly and sensitively affects dropout behaviour. Furthermore, the therapist's experience, not training influences clients to drop out of treatment. An intake system with flexible agency hours and no waiting lists will reduce dropout behaviour.

3.4.3 AGENCY EXPECTATIONS

Literature from studies on treatment expectations will be presented in order to highlight the relevant features of agency expectation. These studies of children, disabled people, marriage guidance seekers and alcoholics may be applied to drug treatment settings for the following reasons: all subjects' expectations were measured on treatment entry, they all sought behaviour change and subsequently presented with dropout behaviour.

Plunkett (1984) sequentially selected families at a Child Psychiatric service in Michigan. He sent self-report questionnaires to parents and 70% of them returned the questionnaire. He found that congruence between expected and actual treatment was associated with accepting treatment form and duration. These results were supported by a study in a physically and mentally disabled people's rehabilitation center (Burhmaster, 1982). This study found that dropouts, unlike treatment completers, had unrealistic expectations of treatment.

Zweben (1981) measured discrepancies in treatment expectations amongst a small, mainly alcoholic, substance abuse population, using a discrepancy scale. Therapists subsequently performed a role induction interview which educated clients about treatment to overcome affective barriers of ambivalence, anxiety and mistrust. Zweben concluded that role induction was helpful to subjects with less discrepant expectations, but that subjects with highly discrepant expectations

still dropped out. He hypothesized that social problems such as job insecurity, pending court cases and financial anxieties precipitate dropout behaviour. Zweben recommended that assistance with social problems be made available to clients with highly discrepant treatment expectations, before engaging them in role induction or treatment for alcoholism.

Although the reliability of Zweben's research (1987) can be queried for using an untested scale, sequential subject selection and the small sample size, it is significant in that it proposes a model for the resolution of discrepant treatment expectations. It also identifies other factors, such as concrete problems, that may intervene in resolving discrepant expectations about treatment.

Powell (1974) examined the relationship between medication and attendance in an alcoholic day hospital. He collected data from 127 admissions and found that subjects who received medication, regardless of type or dosage, had higher attendance rates than those who received no medication. This research identifies that the administration of medication is positively linked to continuance of treatment. This may be due to the relief of withdrawal effects wherein the medication became a tangible way of demonstrating caring. Psychodynamically, the satisfaction of the need to be loved occurs through the ingestion of a substance and is gratifying. Furthermore, ingestion of medication replaces the loss of the drug of abuse.

Another study (McLellan, George, Luborsky, O'Brian, Druley, 1983) examined treatment expectations of a large sample of drug users who were undergoing detoxification, prior to drug therapy. The researcher graded the subjects according to problem severity. Half the subjects were placed in one of six treatment centers reputed to be best equipped for treating each subject's problems. The other half were sent to the treatment centers that they most expected to help them. The staff at the treatment centers were blind as to whom

the matched or unmatched subjects were. Results indicated that subjects treated in expected settings did significantly better than those treated in unexpected settings.

The literature demonstrates that subjects tend to drop out of treatment when they have highly discrepant expectations of the treatment form or duration. Treatment expectation is suggested as being more significant to dropout behaviour, than the ability of the agency to offer successful treatment.

3.4.4 TREATMENT EFFECTIVENESS AND SYMPTOM IMPROVEMENT

One method of measuring dropout behaviour is via outcome studies of a group of treatment entries. However, outcome studies establish treatment effectiveness by following-up subjects after treatment completion to establish whether they have sustained changes achieved during their treatment. In a situation where the dropout rates are high, treatment will be incomplete, implying no behaviour change and ineffectual treatment. To follow-up dropouts will therefore have greater meaning than an outcome study. In fact, outcome studies are noted by Goldstein and Surber (1984) to lack adequate design, including adequate control groups, prospective design, adequate outcome measures and sufficient follow-up. Furthermore, it is difficult to establish whether the change in the subjects is a response to treatment, or some other factor.

Eysenck (1965) proposed the Spontaneous Remission Hypothesis which states that there is a tendency to recover from non-psychotic disturbances with time irrespective of the intervention of professional psychotherapists. Hill (1987), in examining reasons for dropout behaviour, found some support for spontaneous remission (3%) as did Baekeland and Lundwall's literature review (1975). The latter found that in general psychiatric out-patient studies, symptom

improvement occurred in 4 to 5% of drop-outs, between one to five years after treatment. Baekeland and Lundwall also found that alcoholics and narcotic addicts spontaneously improved without any specific treatment.

Gibson (1986) critically reviewed the literature in approximately ten outcome studies of psychotherapy with drug abusers. She found, amongst other things, that psychotherapy resulted in improved functioning when accompanied by medical treatment. Medication was also noted earlier to significantly affect dropout rates (Powell, 1974). The importance of medication is reflected in the DCC's medical component to treatment and it is likely that its availability at the client's first contact, will assist in reducing dropout behaviour.

In settings of high dropout rates a more effective method of examining treatment effectiveness is via follow-up of dropouts. Spontaneous remission has been identified in outcome studies to affect a small proportion of the population, leaving the rest to deteriorate or sustain the changes achieved during treatment.

3.5 THERAPIST FACTORS

> "How much the patient's propensity to drop out is simply the result of attitudes he brings with him and how much it is a reaction to boredom, incomprehension and dislike on the part of the person who is treating him, is a matter for further investigation." (Baekeland and Lundwall, 1975, 769).

It is difficult to examine therapist behaviour toward the treatment population. Sound research design prescribes the blindness of subjects, in this case therapists, to the research hypothesis. However, some researchers have made valiant attempts to delineate many demographic and other therapist attributes which contribute toward dropout behaviour.

3.5.1 THERAPIST ATTRIBUTES

Baekeland and Lundwall (1975) examined 35 dropout studies and found that therapist attitudes and behaviour were implicated in all of them. They conclude

that therapists who drive subjects out of treatment are male, permissive, introverted, detached, ethnocentric and are unsympathetic towards subjects of lower socioeconomic status.

Hill (1987) found that marriage counselors' language and age did not significantly affect dropout behaviour. Greater experience and more advanced professional qualifications tended to limit dropout behaviour. Baekeland and Lundwall (1975) concluded in their literature review on dropout studies, that therapist experience is negatively related to dropout behaviour. This is supported by Gaunt (in Hill, 1987) and Epperson, Bushway and Warman (1983). Gaunt noted that experienced therapists "weed out" and terminate early with likely dropout candidates whilst Epperson et al (1983) noted that inexperienced therapists tend to retain clients and facilitate dropout behaviour. Other researchers however, found that counselor experience levels did not significantly affect dropout rates (Krauskopf, 1981; Betz, 1979).

The above findings should be briefly discussed. Terminating early with likely dropouts implies that the therapist has clearly differentiated this group. As this literature review has not easily identified predictors of dropout clients, these therapists are clearly acting on supposition, probably some prejudice and clearly some counter-transference responses. Furthermore, they neglect to explore the meaning of their responses to the client and seem to reject the client, before the client has a chance to reject them. Such behaviours omit the process of contracting, give the client no choices, serve to imply a low dropout rate and actually indicate a high rate of therapist rejection.

Therapist credibility is affected by factors such as qualification, experience, training and gender, but in the final analysis, is a function of the interaction between the client and the therapist. Haase (1980) found that therapist credibility was influenced by reputation, training and non-verbal behaviour.

Credibility was also influenced by the subjects's view of the suitability of therapist's gender to certain concerns. Women therapists were suitable for concerns such as child-rearing, whilst male therapists were suitable for concerns such as vocational counseling. Another researcher (Feldstein, 1979) examined the femininity and masculinity of the therapist, rather than the gender and found that men were more satisfied with feminine therapists than masculine ones. Women, on the other hand preferred masculine counselors.

It is the interaction between the therapist and client which influences dropout behaviour. The attitude that the therapist conveys, rather than age, sex, experience et cetera will influence dropout behaviour. Dropout behaviour is influenced by ethnocentricity, class discrepancies and the personality of the therapist.

3.5.2 CONTRACTING

Therapeutic contracting is a democratic process whereby the therapist and the client, agree upon treatment goals. This serves to empower the client, to shift the power and responsibility which the client invests in the therapist to "cure", back to the client. It is a crucial process particularly for drug abusers who control their withdrawal symptoms, their life-styles, et cetera by drug abuse. Losing this control can be fearful and precipitate dropout behaviour. Therefore, contracting increases the likelihood of the person in treatment being committed to completing the treatment plan.

Three researchers found that therapist-client disagreement on problem definition significantly influences dropout behaviour. Krauskopf (1981) found that clients at university counselling centers who agreed with their therapists on their presenting problems returned to treatment more often than those who did not. Epperson (1983) measured client and therapist problem definition and found that clients drop out of treatment if their problem definitions were not

recognized by the therapist. Similarly, Hill (1987) found that client and therapist disagreement on the presenting problem precipitated dropout behaviour. She also found continuers to be more aware of treatment goals and treatment duration than dropouts.

Therapist-client disagreements on the presenting problems can result from the therapist's perception of the clients' chronological, rather than functional age (Birmingham, 1986) or from proposing treatment goals which are incompatible with the clients' beliefs (Sjoberg, 1987).

Therapists neglecting to contract with clients about the duration and goals of the therapeutic relationship, contribute towards dropout behaviour.

3.5.3 THERAPIST RESPONSE TO DROPOUT BEHAVIOUR

Dropout behaviour can be symbolic of a desire to continue treatment and testing therapist caring. Oppenheimer (1988) found that it represents avoidance of failure in treatment or becoming controlled or dependent on the therapist.

Bernal (1976) did not examine the symbolism in dropout behaviour but perceived it as an excuse to not engage in treatment. He defined an excuse as not receiving a telephone call, not making appointments, not accepting therapy or not agreeing to the times and dates of an appointment. Bernal found that the more excuses given, the higher the likelihood of dropout behaviour. He demonstrated that therapists are given clues (ie. excuses) for dropout behaviour and can therefore engage the client in a discussion of the meaning of treatment and the excuses so as to contract accordingly.

Another method of attempting to predict dropout behaviour was attempted by Craig (1982). He found that therapist availability did not distinguish dropout from continuer groups. He compared 75 addicts who dropped out prematurely from an opiate detoxification program with 75 who completed the program. He

found that subjects were more likely to drop out of detoxification when the number of staff absences and primary therapist absences increased. Two explanations can be posed: Firstly, therapist absences probably facilitated engagement with the treatment centre and the process of detoxification. Secondly, therapy produces additional discomfort to withdrawal discomfort, precipitating dropout behaviour.

Therapist response to dropout behaviour is a symbol of the therapist's availability to continue assisting the dropout client. The importance of responding to clients who drop out of treatment, is reported in the literature. Baekeland and Lundwall (1975) indicated that reaching out in an alcohol and Tuberculosis treatment clinic resulted in reduced drop-out rates. Sutherland (1985) found that dropouts completing research interviews returned for second appointments significantly more often than those who did not.

The therapist's response to dropout confirms or refutes the client's experience of the therapist. Reaching out can reinforce a positive experience, or change a negative one, as it is a demonstration of therapist caring and acceptance.

3.6 CONCLUSION

This literature review examines four factors contributing toward dropout behaviour. External pressure such as family and legal pressures, are identified as being crucial to the client's motivation for treatment. Dropout behaviour is associated with self-motivated clients who are unpressurized externally to seek and complete treatment.

Examination of client factors indicates that both drug abusers and dropout subjects are young people with high symptom levels and long patterns of drug use. Antisocial Personality Disorders are inconclusively associated with dropout behaviour and drug abuse. Furthermore, depressed mood appears to be

associated with drug abuse, but no literature indicates whether mood or anxiety disorders are associated with dropout behaviour.

An examination of both client and treatment factors in dropout behaviour indicates that women tend to drop out of treatment more frequently than men. They are more stigmatized, less likely to be referred to treatment and less likely to be externally pressurized to seek and complete treatment than men. They are a minority group in treatment settings which are geared to the majority's needs. Male orientated treatment models therefore preside in most treatment settings, do not meet the needs of women and promote dropout behaviour.

The treatment and therapist factors are also associated with dropout behaviour. Agency policy on fees, appointment times, waiting time before appointments and assessment methods such as behavioural versus psychiatric, influences dropout behaviour. As dropout subjects have few treatment contacts, the initial contact person's ability to reassure clients pressurizing for appointments, influences dropout behaviour. Therapist attitude, irrespective of training, experience, sex, age et cetera, may portray racist or negative attitudes and influence dropout behaviour. The encounter with the agency influences the client's sense of being accepted and understood.

Discrepancies in treatment expectations are associated with dropout behaviour. In fact, treatment expectations are found to be more important than the agency's ability to offer successful treatment. It is therefore essential that clients verbalize their expectations and that therapists negotiate to meet these needs. Inadequate therapeutic contracting on the goals of treatment entrench these discrepancies further.

The client who responds to treatment dissatisfaction or satisfaction by dropping out, has difficulty with assertion. The client's problem may have improved spontaneously without treatment, or as a consequence of treatment may have

deteriorated. On another level, dropout behaviour can be a test of therapist caring, or can be an expression of fear of transferring dependence from drugs to therapists. Therapists who reach out to dropouts can therefore explore the meaning of the behaviour and offer further assistance.

The literature has been reviewed according to the four fources impacting on the client who drops out of treatment. The following chapter will present the findings within the framework of these four forces, linking relevant literature where suitable.

CHAPTER 4

DISCUSSION OF RESULTS

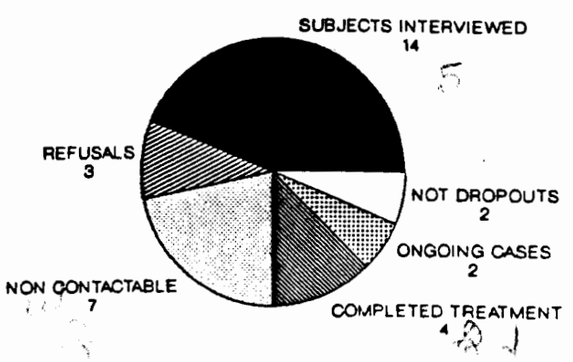
4.1 INTRODUCTION

The results arise from the dropout subjects' responses to the Interview Schedule (Appendix 2) and are discussed within the four factor framework used in Chapter 3 where the literature review was presented. Hence, the relevant literature is noted alongside the results according to motivation, client, treatment and therapist factors. Before examining each of these factors, the origins of the dropout sample of fourteen subjects are described.

4.2 DESCRIPTION OF THE UNIVERSE

The sample was comprised of all new clients registering at the DCC between 1 August 1989 until 31 October 1989. Of the sample of 32 subjects who were initially defined as dropouts, 14 were interviewed and form the universe for this study (termed "dropout subjects"). Of the remaining 18 subjects, ten were excluded as they were not contactable, refused to assist, or did not respond to outreach letters (Appendix 7) and the remainder had completed treatment, were still in therapy or were not dropouts. The below figure demonstrates the breakdown of the original sample into the sample universe of 14 dropout subjects.

Figure 4.1 FIGURE DEPICTING BREAKDOWN OF SAMPLE OF 32 SUBJECTS (N=32)



4.3 MOTIVATION FACTORS

Motivation factors consist of the internal and external pressures causing people to seek treatment. External pressure originates from courts of law, employers, schools and families while internal pressures relate to subjective experiences, such as social withdrawal, physical illness and emotional exhaustion. The following table depicts the reports of therapists (in client files) with the reports of dropout subjects (during the research interview) according to whether internal or external pressures motivated them to seek treatment.

Table 4.1 TABLE COMPARING SOURCES OF MOTIVATION FOR SEEKING TREATMENT, AS REPORTED BY THERAPISTS AND DROPOUT SUBJECTS (N=14)

SOURCE OF MOTIVATION	THERAPIST REPORTS	SUBJECT REPORTS
EXTERNAL PRESSURE	6	8
INTERNAL PRESSURE	8	6

Table 4.1 above, depicts how both internal and external pressures are present when dropout subjects sought treatment Therapists may have responded to the subject's initial "fatigue", a drug-related physical and emotional exhaustion, which presents as internal pressure (Looney, 1974). This is probably short lived as the subject soon recovers (drug remission) and drops out of treatment. The presence of the initial fatigue or internal pressure, means that external pressure, such as family involvement in treatment, may be overlooked by the therapist. It is clear that a combination of internal and external pressures, influences dropout behaviour.

Table 4.2 TABLE DEPICTING THE PLACE OF RESIDENCE OF DROPOUT SUBJECTS (N=14)

PLACE OF RESIDENCE	NUMBER OF DROPOUT SUBJECTS
FAMILY	10
ALONE	2
OTHER	2

The above table indicates that almost three-quarters of dropout subjects live with their families. It is surprising therefore, that only three dropout subjects report family pressure as a motivation for seeking treatment. This may be due to non-disclosure to the family, on the part of the subject - either in terms of the problem or the treatment. Furthermore, the family may be unaware of treatment availability or they may be minimizing the problem. In fact, "Everyone who lives with a Dependent also lives with denial: denial that the disease exists, denial that it is getting worse, denial that it is bad enough to get worked up about." (Ketcham, 1989 ,132).

Stigma is an external pressure as it forms stereotypes of drug abusers, often making help-seeking difficult and predisposing to dropout behaviour. Another external pressure is peer pressure, which serves to encourage dropout behaviour, especially when the only common link is drug abuse. This is discussed further in Client Factors.

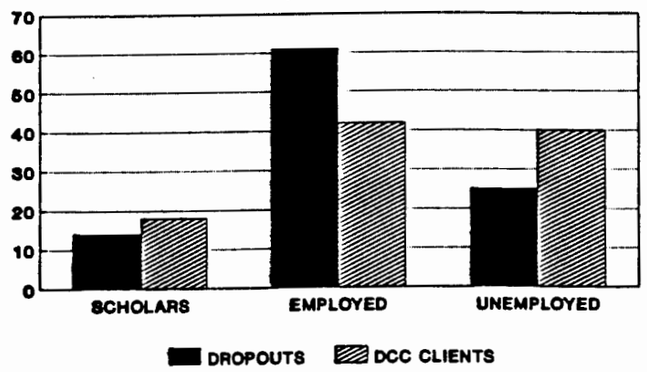
4.4 CLIENT FACTORS

Client Factors contributing towards dropout behaviour are the demographic aspects such as age, sex and education levels; the problem-related aspects which include withdrawal symptoms and mood; and the issue of whether client personality contributes towards dropout behaviour.

4.4.1 DEMOGRAPHIC

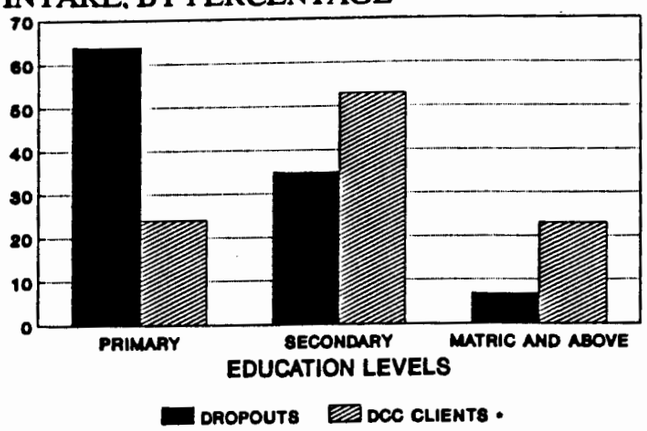
The characteristics of the 14 dropout subjects are similar to those of the 568 DCC clients assessed during 1988 (Figures 2 - 7 in Appendix 4). Both groups have an average age of 23 years, are 90% male, and are predominantly unmarried and classified as "coloured". The primarily drug of abuse is dagga used in conjunction with Mandrax. Approximately half of both groups earn up to R1000 monthly, with the remainder being unemployed. In both groups, the home language is divided between English and Afrikaans, and religion, where indicated, is fairly evenly divided between Agnostic and Christian groups. However, differences are evident in employment status and education levels of both groups, as depicted in the following two figures:

Figure 4.2 FIGURE COMPARING THE EMPLOYMENT PROFILE OF 14 DROPOUT SUBJECTS AND 568 NEW DCC CLIENTS FROM 1988 INTAKE, BY PERCENTAGE



The above figure demonstrates that almost twenty percent more dropout subjects are employed than DCC clients. An explanation is that employed people experience difficulties attending appointments during working hours (Berg, in Hill 1987; Stanton and Todd, 1982). This issue is discussed further in section 4.5.1. where agency hours are reported by some dropout subjects to be treatment barriers.

Figure 4.3 FIGURE COMPARING EDUCATION LEVELS OF 14 DROPOUT SUBJECTS AND 568 DCC CLIENTS FROM 1988 INTAKE, BY PERCENTAGE



The above figure indicates that dropout subjects tend to have lower education levels compared to DCC clients. More than half the dropout subjects have only primary school education.

This finding is related to leaving school for financial, drug-related or other reasons. The education crisis has disrupted the schooling of thousands of South African youth, many of whom do not complete their schooling (Nasson in Burman, 1986). Furthermore, "Chronic or prolonged drug abuse can result in poor scholastic performance which sometimes deteriorates to the point where the pupil cannot cope at all and fails his year or has to 'drop out'." (Searll, 1989, 123).

Poor performance either at school, home or at work is often the consequence of centering most activities around obtaining drugs. These activities often include resolving drug-related problems such as withdrawal discomfort.

4.4.2 DRUG RELATED PROBLEMS

This sub-section discusses illicit drug abuse duration, frequency, withdrawal symptoms and psychiatric aspects such as personality disorders. These drug related problems contribute towards dropout behaviour. Withdrawal discomfort and even the personality of the client may precipitate or predispose dropout

behaviour. Furthermore, the expectations that clients have of treatment such as comfort and solution of problems, is in sharp contrast to the high symptom levels and discomfort experienced during withdrawal.

4.4.2.1 DURATION AND FREQUENCY

As mentioned earlier, dagga abused in conjunction with Mandrax is the primary drug of abuse for both DCC clients and dropout subjects. The average frequency of abuse for dropout subjects is 6,5 times each day. Unfortunately, there are no comparative DCC client drug frequency statistics, to indicate whether this is the norm. The present street value of one Mandrax pill is approximately R15.00 to R20.00. Considering that half the dropout subjects earn less than R1000 monthly and the other half are unemployed, it is obvious that the habit is difficult to support. Drug abuse may therefore lead from financial predicament to criminal activity, jail and sometimes to death (Berelowitz, 1990).

Table 4.3 TABLE DEPICTING DROPOUT SUBJECTS' AGE, ONSET AND DURATION OF DRUG USE (N=14)

	AGE (years)	ONSET (years)	DURATION of use
	25	17	12
	22	15	7
	18	14	4
	19	15	4
	23	12	11
	25	16	9
	45	13	32
	33	12	21
	29	16	13
	19	13	16
	14	14	0
	21	14	7
	16	15	1
	20	14	6
AVERAGE	23	14.2	9.5

Table 4.3 above demonstrates that on average, the onset of drug use occurs at 14,2 years and drug use duration is 9,5 years. No comparative statistics are

available to determine whether these figures are high or low for the general DCC client population. Literature however, supports the above finding than onset occurs during adolescence (Van der Burgh, 1983; Levin, 1983; Du Toit, 1980) and indicates that dropouts continue to use drugs longer than those who continue treatment (Robinson, 1982). In fact, drug usage of long duration results in high symptom levels (Powell, 1974; Baekeland and Lundwall, 1975) and it is this discomfort which is relieved by continued drug use and therefore, dropout behaviour. The administration of medication, a treatment factor, therefore reduces dropout behaviour (Powell, 1974).

4.4.2.2 WITHDRAWAL

Withdrawal refers to drawing or taking something back or away (Chambers Twentieth Century Dictionary, 1979). A person may feel discomfort, fear the consequences, feel depressed about the loss and will hesitate to change. The reasons for hesitating to stop drug use and therefore under-go withdrawal follow:

Table 4.4 TABLE DEPICTING DROPOUT SUBJECTS' REASONS FOR HESITANCY TO STOP DRUG USE (N=14)

REASONS	never	sometimes	often always
PEER PRESSURE	12	2	0
WITHDRAWAL	6	4	4
NO SELF-CONFIDENCE	10	1	2
RE-STARTING DRUG USE	8	2	1

The above table demonstrates that few dropout subjects hesitate to stop using drugs because of peer group pressure, no self-confidence or fears of resuming drug use. Approximately half the dropout subjects claim that fears of withdrawal contribute to ongoing drug use.

It is important to note that 5 dropout subjects were ignorant about withdrawal symptoms. In these instances the researcher equated the word "withdrawal" with

"problems from stopping using drugs". Ignorance about withdrawal may indicate that dropout subjects are unprepared for discomfort. They may also be unable to articulate the meaning of the symptom to the researcher, highlighting the adage that the reality of the client seldom corresponds with the reality of the therapist.

> ... The ways in which individuals organize their perceptions of the world do not constitute a uniform process.... For the individual the world is not objectively known, but is filtered through a cultural lens, the most important feature of which is language... (Whorf, in Green, 1982, 69)

It is with the above limitation in mind that the withdrawal experiences of dropout subjects are presented.

Table 4.5 TABLE DEPICTING DROPOUT SUBJECTS' EXPERIENCES OF WITHDRAWAL SYMPTOM (N=14)

NO WITHDRAWAL		4
PHYSICAL	sleeping problem	2
	appetite loss	3
	stomach, chest or muscle pain	1
MOOD	irritability	7
	fear or anxiety	4
	depression	1

The above table cites withdrawal symptoms experienced by dropout subjects. The literature confirms that these are all symptoms of dagga and Mandrax withdrawal (Wilson, 1990; Tunving, 1987; Smart, 1982). The most frequent withdrawal symptoms reported by dropout subjects are mood changes, particularly irritability. It is these symptoms, particularly when at high levels, that cause discomfort, followed by dropout behaviour (Baekeland and Lundwall, 1975). This links with the earlier notion that dropout behaviour can be reduced by the prescription of medication.

Table 4.6 TABLE DEPICTING DROPOUT SUBJECTS' REPORTS ON THE FREQUENCY OF PROBLEM RELIEF THROUGH DRUG USE (N=14)

DRUG USE RESOLVES THE FOLLOWING PROBLEMS :		ALWAYS	SOMETIMES OFTEN	NEVER	N
PHYSICAL	sleeplessness	4	4	6	14
	need to relax	4	4	6	14
MOOD OR AFFECT	avoid arguments	0	6	8	14
	fear or anxiety	2	8	4	14
	depression	1	8	5	14
SELF-IMAGE	grp acceptance	2	7	5	14

Table 4.6 demonstrates the problem-solving effects of drugs, as reported by the dropout subjects. It supports literature associating affective states (Bukstein, 1989) and physical side-effects (Patterson, 1974) with ongoing drug abuse for tension reduction or self-medication.

The above table also supports the literature finding (Du Toit, 1980) that group acceptance is associated with drug abuse. This finding is further supported as 10 of the dropout subjects report that the occurrence of both their first drug experience and on-going drug abuse was in the company of friends. However, the positive relationship between group acceptance and ongoing drug abuse is not confirmed in a finding reported earlier, which found hesitating to stop drug abuse not to be associated with peer group pressure (Table 4.4).

This conflict is explained by the nature of the peer group, whose only reason for existence is drug abuse. The dropout subject may therefore have difficulty in admitting that stopping drug use would result in being rejected by the peer group. This is succinctly described by Du Toit who says: "Groups which have cannabis as their only tie will guard that link closely. Groups which have a diversification of ties between members are able to take a more relaxed attitude towards cannabis use or non-use." (1980, 120).

Comparison of tables 4.5 and 4.6 leads to the observation that drug use relieves symptoms but causes the same withdrawal symptoms - sleeplessness, fear/anxiety and depression. These are reported by few dropout subjects in the above table, but by over half the dropout subjects in Table 4.5. It is therefore possible that dropout subjects are unknowingly tied to a cycle of drug use followed by discomfort, with additional drug use necessary to alleviate the discomfort. Dropout subjects may be unaware that permanent abstinence, although leading initially to withdrawal, will eventually terminate the very side effects which are given as reasons for continuing drug use.

The aforementioned cycle will produce distress, so it is not surprising that dropout subjects report feeling mood states which are more intense than that which they perceive to be normal.

Table 4.7 TABLE DEPICTING DROPOUT SUBJECTS' PERCEPTION OF THEIR MOOD STATES COMPARED TO NORMAL MOOD STATES (N=14)

MOOD	ALWAYS	OFTEN	SELDOM	NEVER	N
AGGRESSIVE BEHAVIOUR	-	-	6	8	14
EXTREME DEPRESSION	-	-	8	6	14
HIGH ANXIETY	1	2	5	6	14
SUSPICIOUS OR PARANOID IDEAS	1	5	3	5	14

The above table indicates that high anxiety and suspicious or paranoid moods are experienced by approximately half the dropout subjects. This enhances normal treatment resistance such as fears of disclosure and discomfort (Segal, 1990) or fears of failure and control (Oppenheimer, 1988). It can be hypothesized that these high levels of anxiety, suspicion or paranoia may predispose dropout subjects to feel mistrustful and drop out of treatment.

The therapist's response to this anxiety may enhance or reduce it. Contracting empowers the client and reduces anxieties of treatment failure or being

controlled by the therapist. Similarly, minimal waiting time for appointments, a treatment factor, will demonstrate the therapists' ability to respond to the urgency of the crisis and reduce associated anxieties. Immediate intervention in a crisis allows a pro-active response with new learning, rather than a reactive response with the usual defense mechanisms in play. In other words, the person is assisted in finding more adaptive ways of functioning, and indirectly some personality change may occur.

4.4.3 PERSONALITY

Personality disorders are often present in drug abusers, but no standardized personality measures are used in the present research to accurately conclude on personality clusters or traits (DSM111R, 1987). However, dropout subjects' self-descriptions are examined to establish trends present.

Table 4.8 TABLE DEPICTING DROPOUT SUBJECTS' SELF-DESCRIPTIONS (N=14)

SELF-DESCRIPTION	ALWAYS	OFTEN	SELDOM	NEVER
LIKABLE	3	4	6	1
SHY OR WITHDRAWN	2	2	7	3
EMOTIONAL OR DRAMATIC	1	3	4	6
FEARFUL OR ANXIOUS	-	4	3	6
SOCIABLE OR FRIENDLY	3	5	4	2
MOODY	3	4	2	5
DIFFERENT OR ECCENTRIC	1	-	6	7

The above table demonstrates that most dropout subjects describe themselves as likable, sociable and friendly. Few believe that they are eccentric, emotional and dramatic, but half are often or always moody. Moodiness can be a personality feature, can be associated with underlying psychiatric illness and can also be noted as a withdrawal symptom (DSMIIIR, 1987). The latter is supported by earlier reports that the most common withdrawal symptom is irritability and the most common mood is fear or paranoid feelings (which are also withdrawal symptoms).

Table 4.9 TABLE DEPICTING DROPOUT SUBJECTS' REPORTS ON PERSONALITY FACTORS : CRIMINAL ACTIVITY AND PREVIOUS TREATMENT ATTEMPTS (N=14)

FACTORS	YES	NO
PREVIOUS TREATMENT ATTEMPTS	2	12
CRIMINAL CHARGES	7	7
DRUG RELATED CRIMES	5	9
LIES, THEFTS, CRIMES FOR DRUG MONEY	8	6

Table 4.9 establishes that most dropout subjects received no previous treatment for drug use, that half of them were found to be in possession or dealing with drugs, and that fewer were convicted for non-drug related criminal offences. Approximately half the dropout subjects had lied, or broken the law to access money to buy drugs. This supports the results of Baekeland and Lundwall's (1975) literature review which finds that dropout drug addicts have prior arrest records but contradicts their finding that most have previous treatment attempts.

If the lack of previous treatment attempts is representative of the greater DCC population, it has an important implication. This is that most drug abusers seek treatment only once. Therefore if DCC treatment is unsuccessful, they drop out never to return. This is confirmed amongst dropout subjects as none sought treatment after dropping out from the DCC.

From the aforementioned discussion of client factors it is evident that although a larger proportion of dropout subjects are employed than in the greater DCC population, they earn less than R1000 monthly which cannot support a drug habit of an average of 6,5 Mandrax tablets and dagga daily. This implies that dropout subjects are financially stressed and may find it difficult to afford absenteeism from work to attend DCC appointments. Furthermore, they experience both moodiness and higher levels of anxiety than others, which reduce toleration of withdrawal and increase the fears associated with treatment. These factors contribute toward dropout behaviour from treatment.

4.5 TREATMENT FACTORS

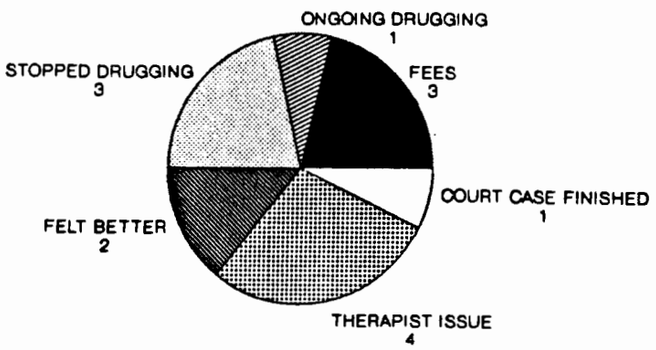
The treatment factors examined in this sub-section include: treatment barriers such as inflexible agency hours and fee payment, behaviour of the initial contact person, and client expectations of the agency professionals, treatment duration and drug change.

4.5.1 TREATMENT BARRIERS

These are examined by three approaches for two reasons: an open-ended question on dropout reasons does not examine all possibilities; and being asked by a DCC employee, albeit confidentially, about dropout behaviour, may be guilt-provoking and cause denial of treatment barriers.

The first approach establishes that most (12) dropout subjects, report requiring no further help when dropping out. Indeed, they report more satisfaction with DCC treatment than in other studies. Pekarik (1983) for example, notes that only 39% of his dropout subjects report "no need" for services when dropping out of treatment. On the other hand, denial of need is simpler, particularly if the dropout is feeling embarrassed or ashamed of dropout behaviour.

Figure 4.4 FIGURE DEPICTING DROPOUT SUBJECTS' REASONS FOR DROPOUT BEHAVIOUR (N=14)



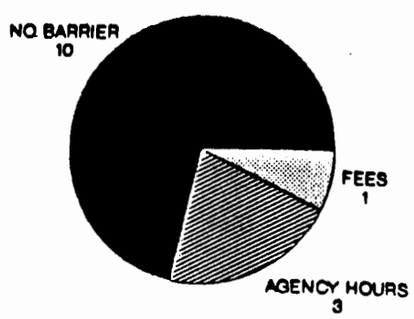
The results of the second approach are depicted in the above figure. They originate from an open-ended question on reasons for dropout behaviour. These

are separated into two groups, showing either an improvement or deterioration in functioning. The person whose reason for dropout behaviour was the culmination of legal coercion, has been excluded. Improvement in functioning is defined thus: " a decrease, however slight, in drug use, and/or an increase in adaptive functioning in other spheres." (Gibson, 1986, 77).

In the "improvement" group, there are responses such as: stopping drug use and feeling better. In fact, 5 out of 14 dropout subjects are deduced to have improved functioning, a somewhat better result than the 17% indicated in a study of marriage guidance dropouts (Hill, 1987).

In the "deterioration" group, reasons for dropout behaviour are ongoing drug use, therapist issues and problems with paying fees. These compare well with Pekarik (1983) where environmental constraints such as fee payment (39%) and dislike of the center or employees (26%) were reasons for dropout behaviour. However, a deterioration in functioning indicating the need for in-patient treatment, plus unresolved client difficulties with therapists or fee payments, implies partial failure on the part of the DCC.

Figure 4.5 FIGURE DEPICTING DROPOUT SUBJECTS' RESPONSES AS TO WHETHER APPOINTMENT ISSUES ARE TREATMENT BARRIERS (N=14)



The above figure demonstrates the third approach to treatment barrier examination, and finds most dropout subjects reporting no difficulties with attending appointments. However, 3 of them report agency hours and 1 notes fees as appointment barriers. Although Hill (1987) did not report fees and agency hours as significantly differentiating marriage guidance dropout subjects from continuers, other authors note the importance of flexible agency hours in drug treatment. (Berg in Hill, 1987 and Stanton and Todd, 1982).

Flexible agency hours have relevance to this study as all DCC intakes occur during the mornings and all appointments are held during office hours. As more dropout subjects than the general DCC population are employed - demonstrated in Client Factors - they will experience agency hours as problematic, if they are concealing the drug problem and treatment from employers.

4.5.2 INITIAL CONTACT

The initial contact is for most dropout subjects the only contact they make with treatment. Therefore the behaviour of the initial contact person, usually the receptionist, is examined, followed by an examination of the dropout subjects' feelings at this time.

Table 4.10 TABLE DEPICTING DROPOUT SUBJECTS' REPORTS OF INITIAL CONTACT PERSON'S BEHAVIOUR (N=14)

	NOT	A BIT	QUITE	EXTREMELY
RUSHED	12	1	1	-
HELPFUL	1	1	3	9

Most dropout subjects (12) first spoke to the receptionist, either on the telephone or on arrival, describing him or her as unrushed and extremely helpful. There is cause for concern about the few dropout subjects who experienced the reception staff as rushed and unhelpful, and the one subject who reported

Table 4.11 TABLE DEPICTING DROPOUT SUBJECTS' REPORTS OF FEELINGS DURING FIRST CONTACT (N=14)

	NOT	A BIT	QUITE	EXTREMELY
EMBARRASSED	3	5	2	4
HOPEFUL	2	5	-	7
NERVOUS/SCARED	5	5	1	3
RESENTFUL	12	1	-	1
CONFUSED	6	4	1	3
UNSURE ABOUT WANTING HELP	3	1	3	7

The above table indicates the broad spectrum of feelings experienced by dropout subjects during their first DCC contact. Most feel some degree of embarrassment, nervousness or confusion, supporting the above view that they are in crisis. Few feel resentment about visiting the DCC. What is most striking, is that half feel extremely hopeful, and yet extremely unsure about receiving help. These contrasting feelings are typical of the ambivalent client vacillating between positive and negative views of treatment.

All new relationships begin tentatively with both hope and uncertainty. The new client invests authority and power in the therapist, according to his or her past experiences of authority figures. Learning that the therapist does not have such power evokes doubts about the therapist's adequacy and competence. Furthermore, the new client may fear therapists' expectations that he or she should change, fear an inability to change, and fear becoming dependent on another person. Defense mechanisms such as denial, are responses to such fear or conflict which often result in flight from treatment, ie. dropout behaviour.

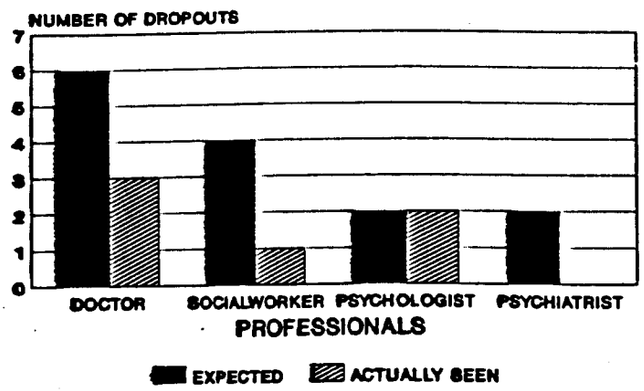
It is the task of the therapist to articulate the above feelings for the client, and to link them to both the loss, for example, of a relationship with drugs or a wife; and to fears about treatment, some of which arise from the dropout subject's expectations of the agency.

4.5.3 AGENCY EXPECTATIONS

Various expectations are invested by the dropout subject in the agency, three of which are expectations pertaining to: DCC professionals, treatment duration, and changes in drug use behaviour. Throughout the discussion of these three areas, the congruence between actual and expected treatment is examined, as it has a significant influence on whether clients accept or drop out of treatment (Plunkett, 1984; Burhmaster, 1982; McCellan, 1983).

The dropout subjects' expectations of the DCC setting yielded the result that most (9) of the dropout subjects expect the DCC to be in or like a hospital, the others expecting a house (3) or an office (1). Therefore, it can be inferred that most dropout subjects expect medical treatment. However, the following figure demonstrates that only 3 of the dropout subjects, who thought a medical or psychiatric doctor would help them , actually saw one.

Figure 4.6 FIGURE DEPICTING 14 DROPOUT SUBJECTS' EXPECTATIONS OF MEDICAL TREATMENT AND THE PROPORTION (6 DROPOUT SUBJECTS) WHO RECEIVE MEDICAL TREATMENT (N=14)



The above figure demonstrates who the 14 dropout subjects expect most to help them. The "actually seen" columns indicate that only 6 dropout subjects' expectations are realized. Therefore, less than half the dropout subjects experience congruence between the actual and expected treatment, a factor mentioned earlier as influencing whether clients accept or drop out of treatment.

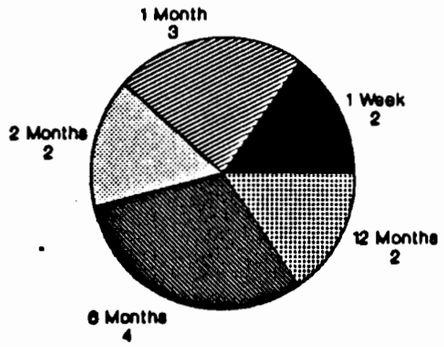
The figure indicates that half the dropouts receive their expected medical assessments, and none receive their expected psychiatric assessments. The reason for this is that 11 dropout subjects attended the initial assessment by the therapist who referred them to the medical staff. However, only two dropout subjects kept this medical appointment.

There are two explanations for failure to attend medical appointments. On the one hand dropout subjects feel an urgent need for immediate medical help, and on the other they fear medical treatment. Many authors (eg. Stanton and Todd, 1982: Parad, 1965) report that client engagement requires an immediate response to the crisis. Dropout subjects had to return for medical treatment without an immediate response and this, combined with the fact that drug addiction has high symptom levels (Baekeland (1975), probably caused them to lose motivation for treatment. Therefore, the urgent need for relief or a miracle cure, expressed by one dropout subject as "an injection", is not met.

On the other hand, dropout subjects have fears of being hospitalized or sent away from home. These fears often originate from fantasies that the past will again be re-enacted, and correspond to those fears associated with previous treatment, crisis situations or contact with authority. The therapist who neglects to examine these fantasies often provides dropout subjects with an experience which re-enacts past events (Mittenthal in Shorr, 1980) and precipitates dropout behaviour.

Fantasies surrounding the nature of therapist help are as important as fantasies of medical help. Therapists who examine fantasies of not only professionals and the meaning of being helped, but also of the treatment duration, serve to reduce incongruities between expected and actual treatment.

Figure 4.7 FIGURE DEPICTING DROPOUT SUBJECTS' REPORTS OF EXPECTED TREATMENT DURATION (N = 13)



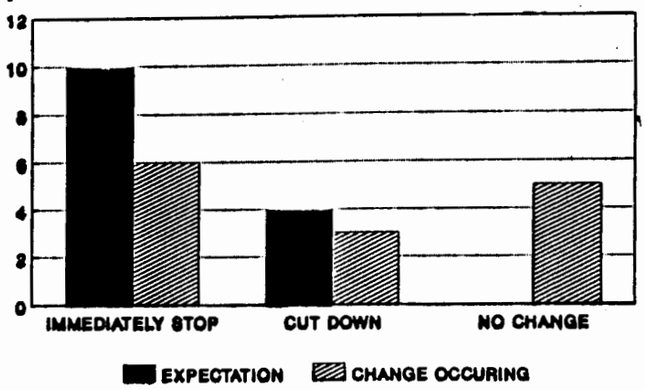
N = 13 (One subject = "dont know")

The above figure demonstrates that dropout subjects expected their treatment to last considerably longer than the time that they were in treatment. Few (4) dropout subjects report dissatisfaction with treatment duration and consider in view of their dropping out, that the treatment was too short. It is possible that the treatment is viewed as too short as DCC treatment is normally weekly, lasting from approximately one month to three months. This short-term approach used at the DCC, may leave dropout subjects thinking that their problem is not serious, or that they are not worthy of longer treatment.

The dropout subjects, by definition drop out within one to three sessions, so the table above depicts that only the two dropouts who expected a week of treatment, realized their expectations. The rest may have been disappointed but claimed to be satisfied (10) with their treatment duration of three or less appointments. This is explained as most (12) reported requiring no further help when dropping out of treatment.

4.5.4 SYMPTOM IMPROVEMENT

Figure 4.8 FIGURE DEPICTING DROPOUT SUBJECTS' EXPECTATIONS AND ACTUAL CHANGES IN DRUG USE (N=14)



Figures 4.7 and 4.8 demonstrate that there is minimal congruence between expectations and achievements of treatment. Although disappointment is anticipated, 11 subjects state feeling satisfied with not realizing their expectations. Despite this being confirmed, with no reports of help-seeking elsewhere, other factors such as ambivalence and denial associated with drug abstention, could be speculated. The strength of drug-related denial is demonstrated in the adage of how the drug user "Fiercely protects his right to use drugs, resists attempts to discuss his drug use, reacts with hostility or suspicion when confronted and generally shields his drug use from prying eyes." (Ketcham, 1989, 59). Such a person has lost motivation to stop drug abuse and probably returns to the supportive and accepting environment of the peer group.

On the other hand, a few dropout subjects report stopping drug use after dropping out of treatment, and two reasons for this can be postulated: Perhaps treatment contact returned people to a pre-crisis or improved level of functioning, or they spontaneously recovered in the manner that Eysenck (1952) found when two-thirds of neurotics, over a two year period, improved without treatment. However, many counter arguments have been reviewed in a

literature survey by Gibson (1986) who refutes the spontaneous remission hypothesis.

In conclusion, the most salient treatment factors contributing towards dropout behaviour at the DCC, will be noted. Although most dropout subjects do not report treatment barriers, fees and agency hours are problematic for some of them. Furthermore, some (5) of the dropout subjects are deduced to have improved functioning and most deny the need for, but all accept, further booked appointments. This indicates that a crisis treatment model, which immediately mobilizes adaptive coping mechanisms and does not assume further appointments, is more functional. A prevalent finding is that approximately half of the dropout subjects did not have their treatment expectations realized, which is a well-documented contributor towards dropout behaviour. The importance of exploring how these expectations relate to the past and of clarifying realistic treatment expectations in the process of therapeutic contracting, is to be discussed in the following sub-section.

4.6 THERAPIST FACTORS

These include the therapist's personal attributes such as age and sex, the use of therapeutic contracting which empowers and reduces client anxieties and the therapist's response to the dropout behaviour. These factors, amongst others, influence dropout behaviour.

4.6.1 THERAPIST ATTRIBUTES

The two therapists seen by dropout subjects are male, and aged in their late twenties and early thirties. They are older than the average dropout subject. One therapist has minimal experience, whilst the other has approximately five years experience. They are qualified as a psychologist and social worker,

respectively. How the dropout subjects value some of these attributes is explored as follows:

Table 4.12 TABLE DEPICTING DROPOUT SUBJECTS' REPORTS OF IMPORTANCE OF THERAPIST'S AGE, SEX AND QUALIFICATION (N=14)

	SEX (N=14)	AGE (N=14)	QUALIFICATION (N=14)
IMPORTANT	5	3	2
UNIMPORTANT	9	11	12

All the dropout subjects believe their therapists to be experienced, and most do not believe that therapist age, sex and qualification are important. The few dropout subjects who verbalize therapist preferences, indicate age, sex and qualification to be important therapist attributes. Previous findings were that few dropout subjects actually saw a social worker, the therapist they expected most to help them; and that dropout behaviour is facilitated by discrepancies between treatment expectations and actuality. This implies unexpressed therapist dissatisfaction. The dropout subjects' reasons for dissatisfaction with their therapist are presented as follows:

Table 4.13 TABLE DEPICTING DROPOUT SUBJECTS' REASONS FOR DISSATISFACTION WITH THERAPIST (N=6)

NUMBER OF RESPONSES	REASONS FOR THERAPIST DISSATISFACTION
1	"I was given literature for a one year old child when I needed weekend groups, films and advice."
1	"He didn't seem to want to give me any attention."
2	"I got no encouragement."
1	"I arrived for my appointment but the office was closed. Nobody phoned me at work to cancel."
1	"I wanted medicine, not someone to talk to."

Most dropout subjects are satisfied with the general treatment they received from DCC professionals. Although all dropout subjects were assessed by therapists and few were later examined by doctors by virtue of their dropping out, their dissatisfactions with DCC professionals are aimed at therapists, not at DCC doctors. The above table demonstrates that dropout subjects did not receive the sensitivity, respect or understanding which they expected from specifically therapists and generally the DCC. Here is a major discrepancy between expectation and actuality, a strong influence on dropout behaviour. The high ratio (6 of the 14) of disappointment in this area is cause for great concern because negative promotion of the DCC could occur in the community.

Furthermore, the earlier section on client demography found that dropout subjects were of lower educational standard, but more were employed than the greater DCC population. As clients of lower socioeconomic status (defined according to education, income and employment) are most likely to be pushed out of treatment by therapists (Baekeland, 1975), counter-transference reactions in therapists cannot be under-estimated and should be taken into account during assessment and treatment procedures.

From the above, it is clear that almost half the dropout subjects believe that their therapists failed them. Such failure can be prevented by the effective use of contracting.

4.6.2 CONTRACTING

Contracting is the process whereby client and therapist agree to achieve certain goals of treatment. At the DCC drug abstention is the primary treatment goal and should be openly discussed with clients, alongside the detoxification process and the nature of the therapeutic relationship. It is the therapists' verbalization of goals which helps ensure clients' awareness of contracting, agreement to work on specific issues and which reduces the likelihood of dropout behavior (Hill,

1987) This contract, "... openly reflects both stakes, provides the frame of reference for the work that follows, and for understanding when the work is in process, when it is being evaded, and when it is finished." (Schwartz in Shulman, 1984, 29)

Contracting to review treatment after a particular period of time, reduces client hesitancy about engaging in seemingly interminable treatment, and offers structure or containment.

However, most DCC therapists reportedly fail to inform clients of treatment duration. Only two subjects report being informed of the duration of treatment which they claim is six months or a year. This duration is much longer than the normal time of one to three months that clients usually spend in treatment. Both inaccurate or absent contracting on treatment duration will therefore contribute toward dropout behaviour.

Furthermore, client-therapist disagreement on the presenting problem greatly influences dropout behavior (Epperson, 1983; Krauskopf, 1981; Sjoberg, 1987; Birmingham, 1986). The presenting problem is drug abuse but some (4) dropout subjects (see Figure 4.8) intended to cut down, not stop drug abuse. Contracting may not have established this intention in dropout subjects so the postponement of treatment described by Stanton and Todd (1982) does not occur.

Another important point is that most (10) dropout subjects report no therapist-client decision to resolve non-drug problems. However, of those who did contract with their therapists, assistance with family problems is reported to help a lot for most (3) of them. The importance of family intervention is again evident and supports the earlier motivation for family therapy (Stanton and Todd, ibid).

It is therefore clear that inadequate or absent contracting on treatment goals cripples treatment effectiveness. It is likely that the absence of empowered clients (the consequence of inadequate contracting) results in their taking control by dropping out of treatment. The importance of therapist follow-up in such instances, is therefore essential to resolve the struggle for power.

4.6.3 THERAPIST RESPONSE TO DROPOUT BEHAVIOUR

Half of the dropout subjects cancelled their last appointment, two received subsequent follow-up from their therapists and most (9) report that follow-up mattered to them. This refutes therapists' rationalizations that dropout behaviour is a message of not needing further treatment. In fact, one dropout subject directly stated that follow-up demonstrates whether the therapist cares. This implies that testing therapist caring is a key dynamic for at least one and probably more dropout subjects. Minimal therapist follow-up, in conjunction with the high ratio of dropout subjects' therapist dissatisfaction (Section 4.6.1) is a possible consequence of attitudes conveyed by overworked therapists who lack time and energy to demonstrate the caring sought by clients and later the dropouts.

During the research interviews, five of the fourteen dropout subjects stated a desire for further treatment. Of those not desiring further treatment, five indicated that they had stopped drug abuse. Considering that dropout subjects may deny continued drug abuse, at least four dropout subjects still use drugs and do not want to return to the DCC. Two of these four dropout subjects report therapist dissatisfaction, thereby linking therapists directly to clients who refuse to return for treatment.

Of the five dropouts desiring further treatment, four indicate that they are still using drugs. Although none returned to the DCC, one of them notified the researcher that he had sought help at another agency closer to his home. This

could indicate that the location of the agency is a treatment barrier for some clients.

In brief, it is clear that therapist factors play a major role in dropout behaviour. Therapists are expected to be sensitive, respectful and to show caring and understanding. Failure to do so via inadequate contracting methods, counter-transference reactions and even not allowing clients' preferences on who assists them, all contribute towards failing to meet these expectations. The final demonstration of an uncaring attitude is not to follow-up clients who cancel or fail to arrive for their last appointment.

4.7 SUMMARY OF FINDINGS

The dropout subjects have similar characteristics to other DCC clients. Both groups are generally male, "coloured", unmarried, use dagga in conjunction with Mandrax and are in their early twenties. However, dropout subjects have lower education levels, but more are employed than the greater DCC population.

DCC clients who are employed are placed in a double-bind situation. Although they seek treatment, the stigma attached to drug abuse may make them less likely to approach their employer for time off work. Not only will work hours be lost, but the clients may fear victimization by the employer. The possibility of job loss, coupled with the dearth of employment in South Africa, only serves to accentuate the need to hide the drug problem. Hence clients who are employed may tend to drop out of treatment more frequently than those who are unemployed. This emphasizes the importance of DCC clinical education being extended to foster co-operation between employers and DCC clients. Furthermore, if dropout is a basis of employment, then this research omits employment as a significant external motivating factor (such as the family)

Motivation factors, particularly the absence of external pressure from family, are found to contribute towards dropout behaviour. A likely cause of dropout behavior is that most dropout subjects live in families who do not motivate them to seek treatment and are not involved in treatment. In fact, most of those whose families were involved in treatment, reported benefits. Literature shows that self-motivated people seeking treatment require additional external pressure to reduce their likelihood of dropout behaviour. To this end, family treatment is strongly indicated in the treatment regime of drug abusers.

Most dropout subjects started, and, at the time of seeking treatment, were still involved with a drug abusing group of friends. This, combined with the fact that the peer group has great value during adolescence, externally pressurizes

dropout behaviour. Stigma (Goffman, 1963) on the other hand, motivates help-seeking with the goal of becoming socially acceptable, but it also precipitates dropout behaviour, as it is embarrassing and shameful to admit to being an "addict". The opposing pressures to seek or drop out of treatment, serve to produce a range of feelings, including much anxiety and ambivalence about the DCC and treatment. Therapist contracting and attitude serve to reduce such anxieties.

Early onset of drug abuse is associated with high withdrawal symptom levels. Cyclical patterns of drug-related discomfort (mainly sleeplessness and the inability to relax) are followed by drug use to self-medicate and are then followed by ongoing abuse to avoid further discomfort. These self-medicated symptom patterns indicate an ignorance of withdrawal and a lack of preparedness for it. Tolerating withdrawal symptoms is frustrated by higher anxiety levels than most people experience, and unfulfilled expectations that treatment will alleviate the symptoms causes the already ambivalent client to drop out of treatment.

The dropout subject's expectations of the DCC, its' professionals and changes in drug use, are unfulfilled. These unfulfilled expectations are major contributors towards dropout behaviour. Therapists cannot alter clients' expectations but they can negotiate the goals of treatment, examine the origins of these expectations and the meaning of clients' fears of treatment. This process of contracting requires time and a caring attitude. Contracting is however a neglected issue, as most dropout subjects report that their therapists misinformed them on the duration of treatment and did not contract for assistance with non-drug related problems, such as family intervention.

Therapist age, sex and qualifications are important for approximately a quarter of dropout subjects. As it is not DCC policy to explore the client's therapist

preferences, some of these preferences will have been unmet, thereby contributing to dropout behaviour. The actual behaviour of therapists, left almost half the dropout subjects feeling misunderstood and frustrated.

Although about half of the dropout subjects achieve their desired treatment goals, the others list ongoing drug abuse, problems with therapists and fee payments as causes of dropout behaviour. These causes are often resolvable if therapists reach out to dropout clients, most of whom state that further therapist contact was important to them. In fact, half the dropout subjects cancelled their last appointment whilst still abusing drugs and two even state that further treatment would have benefitted them. However, few received out-reach from therapists. Whether out-reach on the part of the therapist would have led to continuance of treatment is unclear, but the contact with the researcher (6 to 9 months later) spurred one dropout subject to seek treatment.

Dropout behaviour is influenced by four main factors, namely; the level of motivation, the client variables, the treatment protocols and the therapist attributes. Both the internal and external pressures are important in maintaining treatment motivation. High symptom levels and unfulfilled expectations lead to disillusionment during treatment. Inflexible agency hours, mandatory fees and long appointment waiting times combine to present an uncaring agency image. Lastly, therapist-client misunderstanding, and a lack of contracting and out-reach are noted as sources of client dissatisfaction. These four factors all play a part in contributing towards the sensitive and delicate nature of dropout behaviour.

CHAPTER 5

CONCLUSION

In this chapter the aim and objectives of the research identified in Chapter 1 are evaluated. In addition, the most important findings will be discussed in relation to the four objectives of the study.

The general DCC client population is that of young drug abusers. According to the literature surveyed, these characteristics predispose clients to drop out of treatment, implying that the DCC client population in general, is at high risk to dropout behaviour.

The first objective of identifying client characteristics which lead to dropout behaviour, is partially met. Although the literature in this regard is inconclusive, dropouts tend towards lower education, but higher employment levels.

This finding links to the second objective of identifying factors within the DCC that contribute towards dropout behaviour. Employed people with primary education tend to hold non-professional positions and therefore fear being fired, particularly with the current unemployment crisis in South Africa. As DCC appointments are only scheduled during working hours, clients may prefer to remain at work rather than jeopardize their employment. Furthermore, mandatory fees and time spent awaiting therapists during intake, are factors identified in both the literature and by the dropout subjects, as influencing dropout behaviour. These aspects of treatment at the DCC do not convey the caring and understanding manner that the client expects from the agency.

The nature of drug addiction is such, that the discomfort caused by high symptom levels leads to help-seeking. People entering treatment are often in some form of crisis, as illustrated by the anxiety and confusion reported by

dropout subjects in Chapter 4. This discomfort is short-lived as they regain stability by either abstaining from, or returning to, drug abuse. The crisis passes and dropout behaviour occurs. One way of dealing with this problem might be as follows: Therapists, rather than taking extensive histories, could employ crisis treatment protocols, which refine the contracting, time-limited therapy, termination and follow-up protocols in a specific fashion. At least then, if drop out behaviour occurs, the client will have gained some practical benefit from the meeting.

In the literature survey it is noted that in terms of dropout behaviour, the client's expectations of the agency and it's treatment, are more important than its ability to offer effective treatment. It is therefore not surprising that most dropout subjects' expectations of the DCC were unfulfilled. They expected, but failed to receive, immediate medical assistance and to stop drug abuse. Furthermore, the dropout subjects expressed dissatisfaction with the quality of therapist interaction. Certain recommendations (Appendix 8) have been made to the DCC as a result of this research.

The third objective is to identify therapist factors contributing towards dropout behaviour. Although DCC policy does not accommodate client preferences in terms of therapist age, sex and training, these issues were found to be of minor importance to dropout subjects. Far more important is the interaction between the therapist and the client. This interaction hinges on the therapist's attitude and ability to contract for realistic treatment goals. Contracting conveys understanding, reduces anxiety and presents the client with a sense of self determination.

The fourth objective, to examine the effect of motivation on dropout behaviour, has also been fulfilled. Internal pressures may be sufficient to cause the client to seek help initially. However, external pressure, especially from families and

employers, is extremely important in maintaining treatment interest, thereby preventing dropout behaviour.

It is hoped that this dissertation has shed light on the factors influencing dropout behaviour in a drug counselling setting. It is anticipated that the findings of this work will be expanded and refined through further research.

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APPENDIX 1

INITIAL CONTACT OUTLINE

CONTENT OF TELEPHONE CONTACT :

My name is Cathy Rogers. I am a socialworker at the Cape Town Drug Councelling Centre in Observatory. Do you have a moment for me to talk to you ?

We are doing a survey about our services and how they could be improved. It would help us an enormous amount if you would be willing to allow me to ask you some questions. This will help us find out how people who come to the Drug Councelling Centre experienced our services. Your answers will be kept confidential and only identified with a number.

The interview will take no longer than 20 minutes. I am willing to visit you at home or at work ; or to pay for your transport costs to visit me at the Drug Councelling Centre. Are you willing to assist us ?

Thank you very much,

INHOUD VAN TELEFOON KONTAK

My naam is Cathy Rogers. Ek is 'n Maatskaplikewerker by die Dwelm Sentrum in Observarory. Het u 'n oomblik om met my te praat ?

Ons is besig met 'n opname oor ons dienste en hoe dit verbeter kan word. Dit sou ons geweldig help as u berreid sou wees om 'n paar vrae te beantwoord. Dit sal ons help om vas te stel hoe mense wat die Dwelm Sentrum besoek het, ons diens eervaar het. U antwoorde sal heeltemal vertroulik beskou word en u sal slegs met 'n nommer geidentifiseer word.

Die onderhoud sal nie langer as 15 min. duur nie. Ek is gewillig om u tuis of by u werk te besoek; of om u trein / bus koste te dek as u my by die Dwelm Sentrum besoek. Is u gewillig om my te help ?

Baie dankie.

APPENDIX 2

INTERVIEW SCHEDULE

SECTION A

1. DETAILS OF CLIENT

1.1. Name .....
1.2. Address .....
.....
.....
1.3. Phone Home .....
Work .....

2. DETAILS OF SIGNIFICANT OTHER:

Parent Y / N
Partner Y / N
Friend Y / N
Child Y / N

2.1. Name .....
2.2. Address .....
.....
.....
2.3. Phone Home .....
Work .....

SECTION B

Complete from client's folder

1. Client's number ¦__¦__¦ 1

2. Age

1	13	17	29
2	14	18	30
3	15	19	31
4	16	20	32
5	17	21	33
6	18	22	34
7	19	23	35
8	20	24	36
9	21	25	37
10	22	26	38
11	23	27	39
12	24	28	40
13	25	29	41
14	26	30	42
15	27	31	43
16	28	32	44
		33	other(specify)...

¦__¦__¦ 2

3. Sex

1 Male
2 Female ¦__¦__¦ 3

4. Marital status

1 Single
2 Married
3 Divorced ¦__¦__¦ 4

5. Primary motivation

1 marital problems
2 parental ultimation
3 poor work performance
4 pending/fear of court case
5 continuously smoking/amotivational
6 TB/body breaking up/weight loss
7 bad drug experience
8 social withdrawl
9 teacher ¦__¦__¦
10 other(specify)..... ¦__¦__¦ 5

6. Home language

1 English
2 Afrikaans
3 Xhosa ¦__¦__¦
4 Other(specify)..... ¦__¦__¦ 6

7. Employment Profile

a. Occupation

1 Professional
2 Skilled
3 Unskilled
4 Scholar ¦__¦__¦ 7
5 Other (specify).....

b. Employment Status

1 Employed
2 Unemployed ¦__¦__¦
3 Other (specify)..... ¦__¦__¦ 8

8. Socio-economic status

a. Education level

1 Primary
2 Secondary

	3	Matric		
	4	Technicon		
	5	University	[__]	
	6	Other (specify).....	[__]	9
b. Monthly income	1	0		
	2	0-250		
	3	251-500		
	4	501-750		
	5	751-1000		
	6	1001+	[__]	10
9. Religion	1	Christain - Anglican		
		- Catholic		
		- Protestant		
		- 7 Day Adventist		
		- Methodist		
	2	Eastern - Hindu		
		- Moslem		
	3	Jewish		
	4	Agnostic	[__]	
	5	Not known	[__]	11
	6	Other(specify).....		

10.DCC Interviews (specify number)

	1	One interview		
	2	Two interviews		
	3	Three interviews		
	4	Four interviews		
	5	No interview		
a. Therapist			[__]	12
b. Group			[__]	13
c. Doctor (G.P)			[__]	14
d. Psychiatrist			[__]	15

SECTION C

Client number ¦__¦
¦__¦

THANK YOU FOR AGREEING TO ASSIST US. I ASSURE YOU THAT THIS IS ENTIRELY CONFIDENTIAL AND THAT YOU WILL ONLY BE IDENTIFIED WITH A NUMBER.

I WILL ASK QUESTIONS FOR YOU TO ANSWER. IF YOU AREN'T SURE OF WHAT ANSWERS TO GIVE, TELL ME AND I WILL READ OUT THE POSSIBILITIES

1. ENVIRONMENTAL FACTORS

a. Who wanted / encouraged you to visit the DCC ?

1	Nobody		
2	Employer		
3	Social Worker		
4	Teacher		
5	Doctor		
6	Friend		
7	Family - husband/wife		
8	- parent		
9	- child	¦__¦	
10	- brother/sister	¦__¦	16
11	- other.....	¦__¦	
12	Court - pending court case	¦__¦	17
13	- part of sentence	¦__¦	
14	Other (specify).....	¦__¦	18

b. Who did you live with when you visited the DCC ?

1	Nobody / lived alone		
2	Family - husband / wife		
3	- parent		
4	- child		
5	- brother / sister		
6	- other.....		
7	Friend		
8	Boarding house	¦__¦	
9	Other	¦__¦	19

2. HELPSEEKING BEHAVIOURS

a Was this the first time that you came for help with drug problems ?

1	Yes		
2	No	¦__¦	20

(If Y. proceed to b.)

If N: Where ?.....

1	Lentegeur Hospital		
.....		¦__¦	
.....		¦__¦	21

How much did this previous help change your drug use ?

1	worsened the problem		
2	no change in the problem		
3	helped a little		
4	helped a lot	¦__¦	
5	other(specify).....	¦__¦	22

b. Before your visit to the DCC had you been helped with any non-drug problems by a psychologist /

1	yes		
2	no		

socialworker ? [__] 23

(If Y. proceed to c.)
If N: Where were you
helped before ?.....
.....

1 Child Guidance Clinic
2 Child Welfare
[__]
[__]
[__] 24

How much did it change your problem ?

1 worsened the problem
2 no change in the problem
3 helped a little
4 helped a lot
5 other(specify).....
.....
.....

[__]
[__]
[__] 25

c. Since visiting the DCC have you been elsewhere for help ?

1 yes
2 no

[__]
[__] 26

(If N. proceed to 3.)
If Y: Where ?.....
.....
.....

[__]
[__]
[__] 27

How much did this change the problem ?

1 worsened the problem
2 no change in the problem
3 helped a little
4 helped a lot
5 other(specify).....
.....

[__]
[__]
[__] 28

3. INITIAL CONTACT WITH DCC

a. How did you first contact the DCC ?

1 telephone
2 visit
3 other(specify).....
.....
.....

[__]
[__]
[__] 29

b. Who was the first person that you talked to?

1 therapist
2 receptionist/secretary
3 doctor
4 don't know
5 other(specify).....

[__]
[__]
[__] 30

c. How rushed/abrupt was this person towards you ?

1 not
2 a bit
3 quite
4 extremely

[__]
[__] 31

d. How helpful/friendly was this person towards you ?

1 not
2 a bit
3 quite
4 extremely

[__]
[__] 32

e. How ..... did you feel coming for help at the DCC ? (Ask all options)

1 not at all
2 a little
3 quite a lot
4 extremely

embarrassed		¦__¦	33
hopeful		¦__¦	34
nervous / scared		¦__¦	35
resentful		¦__¦	36
confused / muddled		¦__¦	37
unsure if I wanted help		¦__¦	38
other(specify).....		¦__¦	39
.....			
.....			

I AM GOING TO ASK YOU ABOUT DRUGS .

4. DESCRIPTION OF DRUG USE

4.1 Main Drug used

a. What drugs did you use most ?	1	Dagga		
	2	Dagga and Mandrax		
		Analgesics / Painkillers		
	3	- Opiates		
	4	- Non-opiates		
	5	Tranquilizers	__	
	6	Inhalents	¦__¦	
	7	Cough mixture	¦__¦	40
	8	LSD	¦__¦	
	9	Alcohol	¦__¦	41
	10	Other (specify).....	¦__¦	
		.....	¦__¦	42
			__	
b. How often did you use.. .....? (specify the drug)	1	daily	¦__¦	43
	2	weekends		
	3	weekly		
	4	monthly		
	5	yearly		
	6	other (specify).....	¦__¦	44
Frequency	1	once		
	2	twice		
	3	three times		
	4	four times		
	5	five times		
	6	six times		
	7	seven times		
	8	eight times	¦__¦	
	9	other (specify).....	¦__¦	45
			__	
c. How often did you use.. .....? (specify the drug) Pattern	1	daily	¦__¦	46
	2	weekends		
	3	weekly		
	4	monthly		
	5	yearly		
	6	other (specify).....	¦__¦	47
Frequency	1	once		
	2	twice		
	3	three times		
	4	four times		
	5	five times		
	6	six times		
	7	seven times		
	8	eight times	¦__¦	
	9	other (specify).....	¦__¦	48

d.	How often did you use... .....? (specify the drug) Pattern	1	daily	¦__¦	49
		2	weekends		
		3	weekly		
		4	monthly		
		5	yearly		
		6	other (specify).....	¦__¦	50
	Frequency	1	once		
		2	twice		
		3	three times		
		4	four times		
		5	five times		
		6	six times		
		7	seven times		
		8	eight times	¦__¦	
		9	other (specify).....	¦__¦	51
e.	At what age did you start to use drugs ?	1	0-5		
		2	6-10		
		3	11-15		
		4	16-20		
		5	21-25		
		6	26-30		
		7	31-35		
		8	36-40	¦__¦	
		9	older (specify).....	¦__¦	52
f.	Who first influenced / encouraged you to try a drug ?	1	nobody / myself		
		2	husband / wife		
		3	parent		
		4	child		
		5	sibling		
		6	group of friends		
		7	friend	¦__¦	
		8	other (specify).....	¦__¦	53
g.	With whom did you generally use drugs ?	1	nobody / myself		
		2	husband / wife		
		3	parent		
		4	child		
		5	sibling		
		6	group of friends		
		7	friend	¦__¦	
		8	other (specify).....	¦__¦	54
h.	When you tried to stop using drugs which withdrawl symptoms did you experience ?	1	none		
		2	sleeping problems		
		3	eating problems		
		4	irritability		
		5	stomach/chest/muscle pain		
		6	craving		
		7	fear/anxiety		
		8	depression	¦__¦	
		9	seeing, hearing, feeling things which others cannot.	¦__¦ ¦__¦	55
		10	never tried	¦__¦	56
		11	other (specify).....	¦__¦ ¦__¦	57

I AM GOING TO ASK YOU SOME QUESTIONS ABOUT YOUR FAMILY.

5. FAMILY HISTORY

a. Have any of your relations alcohol / drug / nervous problems / suffer from depression ?

	1	yes	
	2	no	
	3	don't know family	¦__¦ 58

(If N. proceed to 6.)

If Y: Who ?

1	parent	
2	uncle/aunt	
3	grandparent	
4	sibling	¦__¦
5	2 parents and sibling	¦__¦ 59
6	2 uncles	
7	other (specify).....	

Which ?

1	alcohol	
2	drug	
3	nervousness	
4	depression	
5	alcohol and drug	¦__¦
6	other (specify).....	¦__¦ 60

I AM NOW GOING TO ASK YOU SOME QUESTIONS ABOUT YOURSELF.

6. PERSONALITY

a. Have you ever appeared in court for possesion / selling drugs ?

1	yes	
2	no	¦__¦ 61

b. Have you ever appeared in court for any other criminal charges ?

1	yes	
2	no	¦__¦ 62

c. Have you had to lie, steal or break the law to get money to buy drugs ?

1	never	
2	sometimes	
3	often	
4	always	¦__¦ 63

d. Have you felt unusually suspicious / paranoid towards people / felt that strangers were talking or planning against you ?

1	never	
2	sometimes	
3	often	
4	always	¦__¦ 64

e. Have you been aggressive toward people and hit them or broken things ?

1	never	
2	sometimes	
3	often	
4	always	¦__¦ 65

f. Do you get more down / depressed thn other people ?

1	never	
2	sometimes	
3	often	
4	always	¦__¦ 66

g. Do you worry more than others worry ?
1 never
2 sometimes
3 often
4 always
|__| 67

h. Do drugs help you with : (Ask each alternative)
1 never
2 sometimes
3 often
4 always

depression (unhappiness) |__| 68
group acceptance |__| 69
worries (eg. financial) |__| 70
sleeping well |__| 71
avoiding arguments |__| 72
relaxing |__| 73
other (specify)..... |__| 74
.....
.....

i. Would you describe yourself as : (Ask each alternative)
1 never
2 sometimes
3 often
4 always

likable / nice |__| 75
shy and withdrawn |__| 76
emotional / dramatic |__| 77
fearful / anxious |__| 78
sociable / friendly |__| 79
moody |__| 80
different from others |__| 81
other (specify)..... |__| 82
.....
.....

j. Were you hesitant to stop using drugs because of..... (Ask each alternative)
1 never
2 sometimes
3 often
4 always

group pressure |__| 83
withdrawl symptoms |__| 84
no confidence |__| 85
starting drug use again |__| 86
other (specify)..... |__| 87
.....
.....

I AM GOING TO ASK YOU ABOUT WHAT YOU WANTED FROM THE DCC AND WHAT YOU RECEIVED.

7 DCC EXPECTATIONS

7.1 Visual expectations

a. In what kind of building did you expect the DCC to be ?
1 house
2 hospital
3 jail
4 office
5 other (specify).....
|__| 88

7.2.Treatment Duration:

a. How long did you expect the treatment to take ?

1 one week
2 two weeks
3 one month
4 two months
5 six months
6 one year
7 don't know
8 other (specify).....
.....

__ 89

b. Were you told how long the treatment would take ?

1 yes
2 no

__ 90

(If N, proceed to c.)
If Y: How long ?

1 one week
2 two weeks
3 one month
4 two months
5 six months
6 one year
7 other (specify).....
.....

__ 91

c. How satisfied were you with the length of time the treatment was going to take / seemed to take ?

1 very satisfied
2 satisfied
3 unsatisfied - too long
4 - too short
5 didn't recieve treatment
6 other (specify).....

__ 92

7.3.Staff expectations:

a. During your treatment at the DCC whom did you most expect to help you ?

1 doctor
2 nurse
3 priest / minister
4 lawyer
5 socialworker
6 psychologist
7 psychiatrist
8 therapist
9 other (specify).....

__ 93

b. What kind of help did you most expect from this person ?

1 physical examination
2 hospitalized
3 sent away for treatment
4 given medicine
5 advice
6 lectures
7 therapy
8 literature to read
9 homework
10 understanding
11 injection
12 other (specify).....
.....

__ 94

(If socialworker / psychologist / psychiatrist)
What kind of interviews

1 alone / individual
2 family
3 group
4 other (specify).....

did you expect ?		.....	¦__¦	95
7.4.DCC treatment recieved	1	doctor		
a. What kind of person	2	nurse		
did you see ?	3	priest·/ minister		
	4	lawyer		
	5	socialworker	__	
	6	psychologist	¦__¦	
	7	psychiatrist	¦__¦	96
	8	don't know	¦__¦	
	9	other(specify).....	¦__¦	97
		.....		
		.....		
b. How satisfied did you	1	unsatisfied		
feel about the	2	satisfied		
treatment they gave	3	very satisfied	__	
you ?	4	other(specify).....	¦__¦	
		.....	¦__¦	98
(If very satisfied or satisfied : proceed to 7.5)`				
If unsatisfied, explain:	1	agency factors (fees etc)		
.....	2	DCC staff - medical		
.....	3	- therapeutic		
.....	4	personal	__	
.....	5	symptom / drug related	¦__¦	
.....	6	other	¦__¦	99
7.5.Drug use:				
a. How did you expect your	1	stop using immediately		
drug use to change ?	2	cut down		
	3	no change	__	
	4	other(specify).....	¦__¦	
		.....	¦__¦	100
		.....		
b. What changes occured ?	1	stopped using immediately		
	2	cut down	__	
	3	no change	¦__¦	
	4	other(specify).....	¦__¦	101
		.....		
		.....		
c. How satisfying did	1	very satisfying		
you find these changes ?	2	satisfying		
	3	unsatisfying	__	
	4	other(specify).....	¦__¦	
		.....	¦__¦	102
		.....		

I AM NOW GOING TO ASK YOU ABOUT YOUR THERAPIST (THE PERSON WHO ASSESSED YOUR DRUG PROBLEM).

8. THERAPIST				
8.1.Personal characteristics :				
a. Was your therapist's	1	yes	__	
age important to you ?	2	no	¦__¦	103
(If N. proceed to b.)				

If Y: Did you want a therapist.....	1	the same age as you		
	2	older than you		
	3	younger than you		
	4	Other (specify).....		104
		.....		
		.....		
b. Was your therapist's sex important to you ?	1	yes		
	2	no		105
(If N. proceed to c.) If Y: Did you want a.....?	1	" same" sex therapist		
	2	"different" sex therapist		
	3	Other(specify).....		
		.....		106
c. Was your therapist experienced ?	1	yes		
	2	no		107
(If Y, proceed to d.) If N: Was this a problem for you ?	1	yes		
	2	no		108
Why ?.....				
.....				
.....				
.....				
.....				109
d. Did your therapist's professional qualification matter to you ?	1	yes		
	2	no		110
Explain :.....	1	just needed encouragement		
.....	2	How person made me feel was important		
.....	3	I wanted councelling from the DCC, who gave it wasn't important.		111
8.2.Contracting :				
a. Did you and your therapist agree to work on a non-drug problem ?	1	yes		
	2	no		112
(If N, proceed to 8.3) If Y:	1	health		
	2	money		
b. What problem ?	3	family		
	4	work		
	5	other(specify).....		113
		.....		
		.....		
c. How much did this problem change ?	1	worsened		
	2	no change		
	3	helped a little		
	4	helped a lot		
	5	other(specify).....		114
		.....		
8.3.Therapist interest:				
a. How rushed was your therapist toward you ?	1	not		
	2	quite		
	3	extremely		115

b.	How interestered was your therapist in you ?	1 2 3	not quite extremely	¦__¦	116
c.	How comfortable / easy did you feel talking to your therapist ?	1 2 3	not quite extremely	¦__¦	117
d.	Did your therapist cancel an appointment ?	1 2	yes no	¦__¦	118
e.	Did your therapist keep you waiting for an appointment ?	1 2	yes no	¦__¦	119
f.	Did you have a change of therapist ?	1 2	yes no	¦__¦	120

9 TREATMENT BARRIERS

a.	Why did you stop your treatment ?	1 2 3 4 5 6 7 8 9 10 11	agency hours transport fees self conscious walking into DCC problems with child minder couldn't stop drugging stopped drugging DCC staff - medical - therapeutic court case finished other(specify).....	¦__¦ ¦__¦	121
b.	When you stopped treatment did you believe that you needed no further help ?	1 2 3 4	no perhaps probably yes	¦__¦	122
c.	Did you experience problems keeping your appointments ?	1 2	yes no	¦__¦	123
	(If N, proceed to 11.) If Y: What problems ?	1 2 3 4 5 6	agency hours transport fees self conscious walking into DCC problems with child minders other (specify).....	¦__¦ ¦__¦	124

10 THERAPIST RESPONSE

a.	Did you cancel your last appointment ?	1 2	yes no	¦__¦	125
b.	Did your therapist	1	yes		

	contact you when you didn't arrive?	2	no	¦__¦ 126
c.	Would contact have mattered to you ?	1 2	yes no	¦__¦ 127
11	PRESENT DRUG USE			
a	Are you using a drug at the moment ?	1 2	yes no	¦__¦ 128
12.	RE-APPOINTMENT			
a.	At the moment, would you be interested in starting treatment again at the DCC ?	1 2 3 4	yes probably perhaps no	¦__¦ 129

THANK YOU FOR YOUR ASSISTANCE. THE INTERVIEW IS NOW COMPLETE.

SECTION C

BAIE DANKIE VIR JOU SAMEWERKING. EK VERSEKER JOU DAT HIERDIE VRAAGLYS VERTROULIK IS EN DAT JY SLEGS MET 'N NOMMER AANGEDUI SAL WORD.

EK SAL DIE VRAE VRA. EK WIL HE DAT JY VIR MY DIE ANTWOORDE GEE. AS JY NIE WEET HOE OM TE ANTWOORD NIE SE VIR MY EN EK SAL VERSKILLENDE MOONTLIKHEDE UITLEES.

1. OMGEWINGSFAKTORE

a. Wie het jou aangemoedig om na die DCC te kom ?

1	niemand		
2	werkgewer		
3	maatskaplike werker		
4	onderwyser		
5	dokter		
6	vriend		
7	familie - vrou / man		
8	- ouer		
9	- kind	¦__¦	
10	- broer / suster	¦__¦	16
11	- ander.....	¦__¦	
12	hof - hangende hofsaak	¦__¦	17
13	- gedeelte van vonnis	¦__¦	
14	ander	¦__¦	18

b. Met wie was jy woonagtig toe jy die DCC genader het ?

1	Niemand / alleen gebly		
2	Familie - vrou / man		
3	- ouer		
4	- kind		
5	- broer /suster		
6	- ander.....		
7	Vriend	¦__¦	
8	Koshuis	¦__¦	19
9	Ander(spesifiseer).....		

2. HULPSOEKENDEGEDRAG

a. Was dit die eerste keer wat jy hulp gesoek het vir jou dwelm probleem ?

1	ja		
2	nee	¦__¦	20

(Indien J, gaan voort na b.)

Indien N: Waar ?.....
.....
.....

1	Lentegeur Hospitaal		
		¦__¦	
		¦__¦	21

Hoeveel het hierdie vorige hulp jou dwelm probeem verander ?

1	probleem vererger		
2	geen verandering		
3	bietjie gehelp		
4	baie gehelp		
5	ander.....	¦__¦	
	.....	¦__¦	22

b. Voordat jy die DCC besoek het, het jy ooit enige hulp vir 'n "nie dwelm" probleem by 'n

1	ja		
2	nee	¦__¦	23

maatskaplikewerker / sielkundige ontvang ?

(Indien J, gaan voort na d.)
Indien N: Waar ?.....
.....

1 Child Guidance
2 Kindersorgvereeniging

24

Hoeveel het dit jou probleem verander ?

1 probleem vererger
2 geen verandering
3 bietjie gehelp
4 baie gehelp
5 ander(spesifiseer).....
.....

25

c. Vandat jy by die DCC was, het jy op 'n ander plek hulp gesoek ?

1 ja
2 nee

26

(Indien N, gaan voort na 3.)
Indien N: Waar ?
.....
.....

27

Hoeveel het dit die probeem verander ?

1 probleem vererger
2 geen verandering
3 bietjie gehelp
4 baie gehelp
5 ander(spesifiseer).....
.....

28

3. AAVANKLIKE KONTAK MET DCC

a. Hoe het jy vir die eerste keer met die DCC kontak gemaak ?

1 per telefoon
2 'n besoek
3 ander(spesifiseer).....
.....

29

b. Wie was die eerste persoon met wie jy gepraat het ?

1 terapeut
2 ontvangsdame /sekretaresse
3 dokter
4 weet nie
5 ander(spesifiseer).....

30

c. Hoe gejaagd / kortaf was hierdie persoon ?

1 glad nie
2 'n bietjie
3 redelik baie
4 vreeslik baie

31

d. Hoe vriendelik / helpvol was hierdie persoon ?

1 glad nie
2 'n bietjie
3 redelik baie
4 vreeslik baie

32

b. Hoe ..... het jy gevoel toe jy vir hulp by die DCC gekom het ? (Vra alles) verlee

1 glad nie
2 bietjie
3 redelik baie
4 vreeslik baie

33

vol hoop ¦__¦ 34
senuweeagtig / bang ¦__¦ 35
gegriefd ¦__¦ 36
verward / deurmekaar ¦__¦ 37
onseker of ek hulp wil he ¦__¦ 38
ander..... ¦__¦ 39
.....

EK GAAN JOU VRAE OOR DWELMS VRA.

4. BESKRYWING VAN DWELM GEBRUIK

4.1Hoofsaaklike Dwelm

a. Watter tipe dwelm het jy hoofsaaklik gebruik ?

1	Dagga	
2	Dagga and Mandrax	
	Analgesics / Pynstillers	
3	- Opiate	
4	- Nie opiate	
5	Kalmeermiddels	
6	Snuifmiddels	¦__¦
7	Hoesmengsels	¦__¦ 40
8	LSD	¦__¦
9	Alkohol	¦__¦ 41
10	Ander (spesifiseer).....	¦__¦
	.....	¦__¦ 42

b. Hoe dikwels het jy .....gebruik ?
Patroon:

1	daagliks	
2	weekliks	¦__¦ 43
3	maandeliks	
4	jaarliks	
5	ander (spesifiseer).....	¦__¦ 44

Gereeld:

1	een keer	
2	twee keer	
3	drie keer	
4	vier keer	
5	vyf keer	
6	ses keer	
7	sewe keer	
8	agt keer	
9	ander (specifiseer).....	¦__¦ 45
	.....	¦__¦

c. Hoe dikwels het jy .....gebruik ?
Patroon:

1	daagliks	
2	weekliks	¦__¦ 46
3	maandeliks	
4	jaarliks	
5	ander (spesifiseer).....	¦__¦ 47

Gereeld:

1	een keer	
2	twee keer	
3	drie keer	
4	vier keer	
5	vyf keer	
6	ses keer	
7	sewe keer	
8	agt keer	
9	ander (specifiseer).....	¦__¦ 48
	.....	¦__¦

d. Hoe dikwels het jy .....gebruik ?
Patroon:

1	daagliks	
2	weekliks	¦__¦ 49
3	maandeliks	
4	jaarliks	

	5	ander (spesifiseer).....	¦__¦	50
Gereeld:	1	een keer		
	2	twee keer		
	3	drie keer		
	4	vier keer		
	5	vyf keer		
	6	ses keer		
	7	sewe keer		
	8	agt keer	__	
	9	ander (specifiseer).....	¦__¦	51
		.....	¦__¦	
e. Op watter ouderdom het jou dwelm gebruik begin ?	1	0-5		
	2	6-10		
	3	11-15		
	4	16-20		
	5	21-25		
	6	26-30		
	7	31-35	__	
	8	36-40	¦__¦	
	9	meer(spesifiseer).....	¦__¦	52
f. Wie het jou aanvanklik beinvloed om 'n dwelm te gebruik ?	1	niemand / op my eie		
	2	man / vrou		
	3	ouer		
	4	kind		
	5	broer / suster	__	
	6	groep vriende	¦__¦	
	7	ander (spesifiseer).....	¦__¦	53
g. Saam met wie het jy dwelms in die algemeen gebruik ?	1	niemand / op my eie		
	2	man / vrou		
	3	ouer		
	4	kind		
	5	broer / suster		
	6	groep vriende	__	
	7	ander (spesifiseer).....	¦__¦	
		.....	¦__¦	54
h. Toe jy probeer ophou het met dwelms watter ontrekkingsimptome het jy gekry ?	1	geen		
	2	slaapprobleem		
	3	eetprobleme		
	4	geiriteerd		
	5	maag / bors / spier pyne		
	6	smagting / lus	__	
	7	vrees / angs	¦__¦	
	8	depressie	¦__¦	55
	9	dinge te sien ,hoor of voel	¦__¦	
		wat andere nie sien, hoor of voel	¦__¦	56
	10	ander (spesifiseer).....	¦__¦	57
		.....		

EK GAAN JOU 'N PAAR VRAE OOR JOU FAMILIE VRA.

5. FAMILIE

a. Het enige van jou familie lede 'n drank probleem / 'n dwelmprobleem /	1	ja		

senuweeprobleem / depressie.	2 3	nee ken nie familie nie	¦__¦ 58
(Indien N. gaan voort na 6.) Indien J: Wie ?	1 2 3 4 5 6 7	ouer oom / tannie grootouers broer / suster 2 ouers en broer 2 ooms ander(spesifiseer).....	¦__¦ ¦__¦ 59
Watter ?	1 2 3 4 5 6	alkohol dwelms senuweeprobleem teenoorgedruk / depressie alkohol en dwelms ander (spesifiseer).....	¦__¦ ¦__¦ 60

EK GAAN JOU 'N PAAR VRAE OOR JOUSELF VRA.

6. PERSOONLIKHEID

a. Het jy al ooit in die hof verskyn vir handeldryf / besit van dwelms ?	1 2	ja nee	¦__¦ 61
b. Het jy al ooit in die hof verskyn vir ander criminele aanklagte ?	1 2	ja nee	¦__¦ 62
c. Moes jy lieg / steel / wet oortree om geld in die hande te kry om dwelms te koop ?	1 2 3 4	nooit soms gereeld gedurig	¦__¦ 63
d. Was jy buitengewoon suspisieus teenoor mense / gevoel asof vreemde mense van jou praat / planne teen jou maak ?	1 2 3 4	nooit soms gereeld gedurig	¦__¦ 64
e. Het jy aggresief geraak teenoor mense en hulle geslaan / dinge gebreek ?	1 2 3 4	nooit soms gereeld gedurig	¦__¦ 65
f. Raak jy meer dikwels depressief as ander mense ?	1 2 3 4	nooit soms gereeld gedurig	¦__¦ 66
g. Raak jy meer bekommerd as ander mense ?	1 2 3	nooit soms gereeld	

	4	gedurig	¦__¦ 67
h. Help dwelms jou met : (Vra elke alerrnatief)	1	nooit	
	2	soms	
	3	gereeld	
	4	gedurig	
depressie			¦__¦ 68
groepsaanvarding			¦__¦ 69
bekeommernisse			¦__¦ 70
om goed te slaap			¦__¦ 71
om argumente te vermy			¦__¦ 72
om te ontspan			¦__¦ 73
ander (spesifiseer)....			¦__¦ 74
.....			
i. Sal jy jouself beskryf as : (vra elke alternatief)	1	nooit	
	2	soms	
	3	gereeld	
	4	gedurig	
aangenaam			¦__¦ 75
skaam / terrugetrogge			¦__¦ 76
dramaties / emosioneel			¦__¦ 77
bang / angstig			¦__¦ 78
vriendelik / sosiaal			¦__¦ 79
buierig			¦__¦ 80
anders as ander mense			¦__¦ 81
ander (spesiiseer).			¦__¦ 82
.....			
.....			
j. Was jy bang om op te hou met dwelms as gevolg van : (Vra elke alernatief)	1	nooit	
	2	'n bietjie	
	3	redelik baie	
	4	vreeslik baie	
groepsdruk			¦__¦ 83
ontrekkingssimptome			¦__¦ 84
geen selfvertrou			¦__¦ 85
dat jy weer dwelms sal begin gebruik			¦__¦ 86
ander (spesifiseer)...			¦__¦ 87
.....			
.....			

EK GAAN JY NOU VRA OOR WAT JY VAN DIE DWELM SENTRUM VERWAG HET EN WAT JY DAAR ONTVANG HET.

7. DCC VERWAGTINGS			
7.1.Visuele verwagtings a In watter soort gebou het jy verwag om die DCC te vind ?	1	huis	
	2	hospitaal	
	3	tronk	
	4	kantoor	
	5	ander(spesifiseer).....	
		.....	¦__¦ 88
7.2.Duur van behandeling			
a. Hoe lank het jy verwag sou die behandeling duur ?	1	een week	
	2	twee weke	
	3	een maand	
	4	twee maande	
	5	ses maande	

	6	een jaar		
	7	ek weet nie		
	8	ander(spesifiseer).....	¦__¦	
		.....	¦__¦	89
b. Was jy ingelig oor hoe lank die behandeling sou duur ?	1	ja		
	2	nee	¦__¦	90
(Indien N, gaan voort na c.) Indien J : Hoe lank ?	1	een week		
	2	twee weke		
	3	een maand		
	4	twee maande		
	5	ses maande		
	6	een jaar		
	7	ander(spesifiseer).....	¦__¦	91
		.....	¦__¦	
c. Hoe tevrede het jy gevoel ten opsigte van die durasie van die behandeling ?	1	baie tevrede		
	2	tevrede		
	3	ontevrede - te lank - te kort		
	4	het geen behandeling gekry		
	5	ander(spesifiseer).....	¦__¦	
		.....	¦__¦	92
7.3.Personeel verwagtings:				
a. Gedurende jou behandeling by die DCC wie het jy verwag gaan jou die meeste help ?	1	dokter		
	2	verpleegster		
	3	priester /predikant		
	4	prokureur		
	5	maatskaplikewerker		
	6	sielkundige		
	7	psigiater		
	8	terapeut		
	9	ander (spesifiseer).....	¦__¦	
		.....	¦__¦	93
b. Watter soort hulp het jy van hierdie persoon die meeste verwag ?	1	mediese ondersoek		
	2	hospitalieseer		
	3	vir behandeling wegestuur		
	4	mediesyne gegee		
	5	raad		
	6	lesing		
	7	terapie		
	8	literatuur om te lees		
	9	huiswerk		
	10	begrip		
	11	inspuiting	¦__¦	
	12	ander (spesifiseer).....	¦__¦	94
(Indien psigiater / maatskaplikewerkster / sielkundige) Watter tipe onderhoude het jy verwag?	1	alleen (individueel)		
	2	familie		
	3	groepsonderhoud		
	4	ander (spesifiseer).....	¦__¦	
		.....	¦__¦	95
7.4.DCC behandeling ontvang				
a. Watter soort persoon het jou gehelp ?	1	dokter		
	2	verpleegster		

	3	priester / predikant		
	4	prokureur		
	5	maatskaplikewerker		
	6	sielkundige		
	7	psigiater		96
	8	ander (spesifiseer).....		
		.....		97
b. Hoe tevrede het jy gevoel oor die behandeling wat hulle jou gegee het ?	1	baie tevrede		
	2	tevrede		
	3	ontevrede		
	4	ander (spesifiseer).....		
		.....		98
(Indien baie tevrede of tevrede, gaan voort na 7.5.)				
Indien ontevrede, verduidelik :.....	1	agentskap faktore (bv. fooie)		
.....	2	DCC personeel - mediese		
.....	3	- terapeut		
.....	4	persoonlike faktore		
.....	5	simptome / dwelm		
.....	6	ander(spesifiseer).....		99
7.5.Dwelm gebruik				
a In watter opsigte het jy verwag dat jou dwelmgebruik gaan verander ?	1	onmiddelike staking		
	2	afname		
	3	geen verandering		
	4	ander(spesifiseer).....		
		.....		100
b. Watter veranderings het plaasgevind ?	1	onmiddelike staking		
	2	afname		
	3	geen verandering		
	4	ander(spesifiseer).....		
		.....		101
c. Hoe tevrede het jy met die veranderings gevoel ?	1	baie tevrede		
	2	tevrede		
	3	ontevrede		
	4	ander(spesifiseer).....		
		.....		102

EK GAAN VRAE VRA OOR JOU TERAPEUT. DIS DIE PERSOONWAT EERSTE JOU PROBLEEM GE-EVALUEER HET.

8. TERAPEUT				
8.1 Persoonlike gegewens				
a. Was jou terapeut se ouderdom vir jou belangrik ?	1	ja		
	2	nee		103
(Indien N, gaan voort na b.)	1	dieselfde ouderdom		
	2	ouer as jy		
	3	jonger as jy		
Indien J : Wou jy 'n terapeut van..... ?	4	ander (spesifiseer).....		
		.....		104
		.....		
b. Was jou terapeut se geslag vir jou	1	ja		
	2	nee		105

belangrik ?

(Indien N, gaan voort na c.)
Indien Y: Wou jy 'n terapeut van..... ?

1 dieselfde geslag
2 teenoorgestelde geslag
3 ander(spesifiseer).....
.....

106

c. Was jou terapeut ervare ?
(Indien J,gaan voort na d.)
Indien N: Was dit 'n probleem vir jou ?

1 ja
2 nee

107

1 ja
2 nee

108

Hoekom ?.....
.....
.....
.....

109

d. Was jou terapeut se professionele kwalifikasies van enige betekenis vir jou ?
Verduidelik.....
.....
.....
.....

1 ja
2 nee

110

111

8.2. Kontrakteering :

a. Het jy en jou terapeut saamgestem om te werk op 'n nie dwelm probleem ?

1 ja
2 nee

112

(Indien N, gaan voort na 8.3)
Indien J:

b. Watter probleem ?

1 gesondheid
2 geld
3 familie
4 werk
5 ander(spesifiseer).....
.....
.....

113

c. Hoe het dit die probleem verander ?

1 vererger
2 geen verandering
3 bietjie gehelp
4 baie gehelp
5 ander(spesifiseer).....
.....

114

8.3. Belangstelling van terapeut :

a. Hoe gejaagd het jou terapeut teenoor jou opgetree ?

1 nie
2 'n bietjie
3 baie

115

b. Hoe geinteresseerd was jou terapeut in jou ?

1 nie
2 'n bietjie
3 baie

116

c. Het jy gemaklik gevoel

1 nie

met jou terapeut ?	2	'n bietjie		
	3	baie	¦__¦	117
d. Het jou terapeut een van jou afsprake gekanseleseer ?	1	ja		
	2	nee	¦__¦	118
e. Het jou terapeut jou vir 'n afspraak laat wag ?	1	ja		
	2	nee	¦__¦	119
f. Was jou terapeut vervang deur 'n ander ?	1	ja		
	2	nee	¦__¦	120

9 BEHANDELINGSBLOKKIES

a. Hoekom het jy opgehou met behandeling ?	1	agentskap ure		
	2	vervoer		
	3	fooie		
	4	selfbewus om by DCC in te stap		
	5	probleme met kinderoppasseers		
	6	kon nie ophou met dwelm gebruik nie		
	7	dwelm gebruik opgehou		
	8	DCC personeel - mediese		
	9	- terapeutiese		
	10	hofsaak klaar		
	11	ander(spesifiseer).....	¦__¦	
		.....	¦__¦	121
b. Toe jy opgehou het met behandeling het jy gevoel dat verdere behandeling nie nodig was nie ?	1	nee		
	2	waarskynlik		
	3	miskien		
	4	ja	¦__¦	122
c. Het jy probleme ervaar om jou afsprake na te kom ?	1	ja		
	2	nee	¦__¦	123
(Indien N: gaan voort na 10.)	1	agentskap ure		
	2	vervoer		
	3	fooie		
Indien J: Watter probleme ?	4	selfbewus om by die DCC in te kom		
	5	probleme met kinderoppassers		
	6	ander(spesifiseer).....	¦__¦	
		.....	¦__¦	124

10 TERAPEUT SE REAKSIE

a. Het jy jou laaste afspraak gekanseleseer ?	1	ja		
	2	nee	¦__¦	125
b. Het jou terapeut jou gekontak toe jy nie opgedaag het nie ?	1	ja		
	2	nee	¦__¦	126
c. Sou kontak vir jou 'n verskil gemaak het ?	1	ja		
	2	nee	¦__¦	127

11 HUIDIGE DWELM GEBRUIK

A Op die oomblik; gebruik jy dwelms ?

1 ja
2 nee

|__| 128

12 HERAFSPRAAK

a. Op die oomblik; sou jy belang stel om weer met behandeling te begin ?

1 ja
2 waarskynlik
3 miskien
4 nee

|__| 129

DANKIE VIR JOU HULP. DIE ONDERHOUD IS NOU VOLTOOI.

SECTION D

1. OUTCOME OF RESEARCH CONTACT

1. refused to assist
2. not tracable
3. no response to letter
   interviewed at :
   - 1st booked appointment
5 - 2nd booked appointment
6. - 3rd booked appointment
7. - 4th booked appointment
8. other (specify).....

130

2. INTERVIEW VENUE

1. DCC
2. home
3. work
4. other(specify).....

131

APPENDIX 3

TABLES NOT INCLUDED IN TEXT

APPENDIX 3 TABLES NOT INCLUDED IN THE TEXT

Table 1 TABLE DEPICTING NUMBERS OF NEW CLIENTS, NUMBERS OF DROPOUTS AND PERCENTAGES OF CLIENTS WHO ARE DROPOUTS, IN YEARLY INTERVALS FROM 1 OCTOBER UNTIL 31 SEPTEMBER THE FOLLOWING YEAR

YEARS	NUMBER NEW CLIENTS	NUMBER OF DROPOUTS		PERCENTAGE OF NEW CLIENTS WHO ARE DROPOUTS
		YEARLY	MONTHLY	
1985/86*	755	317	26	42
1986/87*	512	112	9	22
1987/88	568	176	15	31
1988/89	751	387	29	52

* The criteria for a dropout during 1985/1986 and 1986/1987 was clients who dropped out after 1-2 appointments.

APPENDIX 4

FIGURES NOT INCLUDED IN TEXT

APPENDIX 4 FIGURES NOT INCLUDED IN TEXT

Figure 1 FIGURE DEPICTING MONTHLY INTAKE OF NEW CLIENTS, IN YEARLY INTERVALS FROM 1 OCTOBER UNTIL 31 SEPTEMBER THE FOLLOWING YEAR

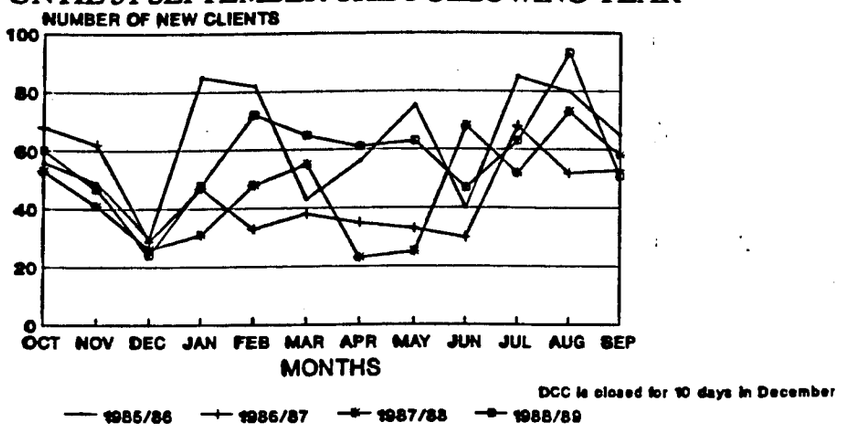


Figure 2 FIGURE COMPARING AGE OF 14 DROPOUT SUBJECTS AND 568 DCC CLIENTS FROM 1988 INTAKE, BY PERCENTAGE

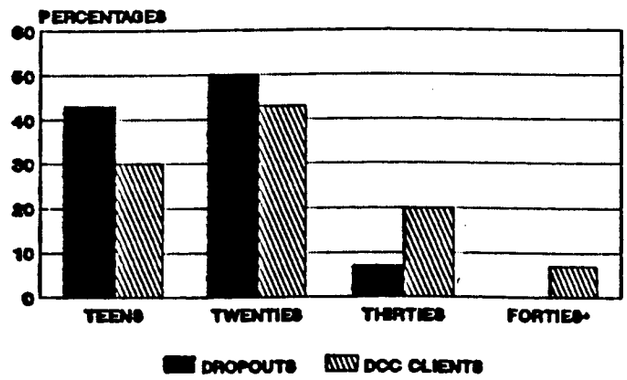


Figure 3 FIGURE COMPARING SEX OF 14 DROPOUT SUBJECTS AND 568 DCC CLIENTS FROM 1988 INTAKE, BY PERCENTAGE

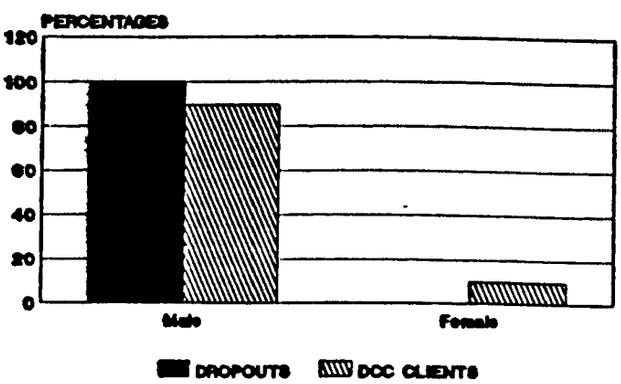


Figure 4 FIGURE COMPARING MARITAL STATUS OF 14 DROPOUT SUBJECTS AND 568 DCC CLIENTS FROM 1988 INTAKE, BY PERCENTAGE

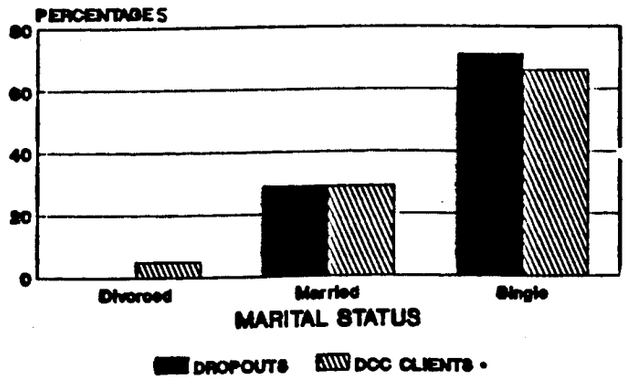
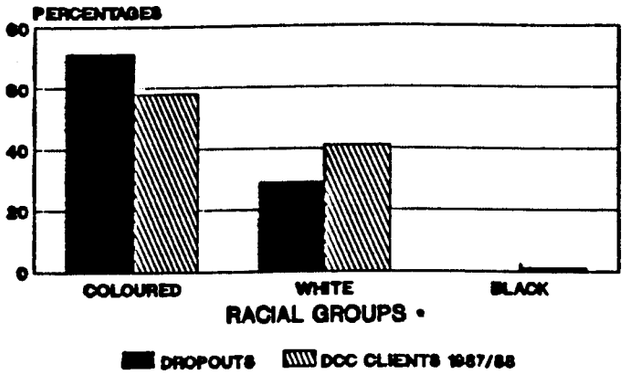


Figure 5 FIGURE COMPARING RACE OF 14 DROPOUT SUBJECTS AND 568 DCC CLIENTS FROM 1988 INTAKE, BY PERCENTAGE



No support of racism implied

Figure 6 FIGURE COMPARING INCOME AND EMPLOYMENT OF 14 DROPOUT SUBJECTS AND 568 DCC CLIENTS FROM 1988 INTAKE, BY PERCENTAGE

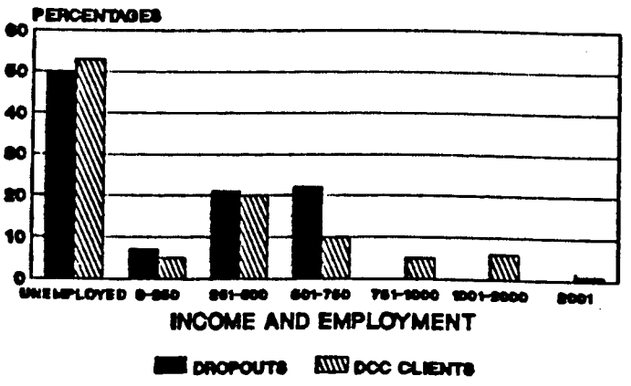
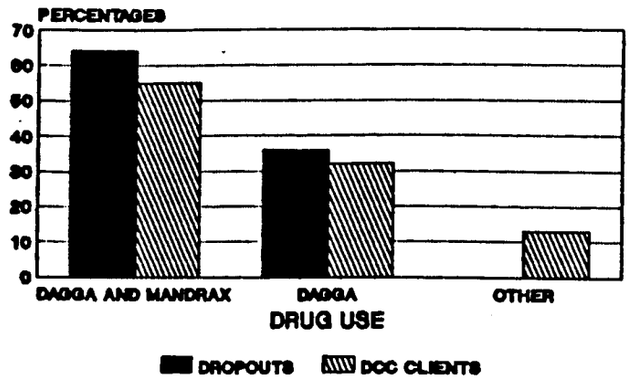


Figure 7 FIGURE COMPARING DRUG USE OF 14 DROPOUT SUBJECTS AND 568 DCC CLIENTS FROM 1988 INTAKE, BY PERCENTAGE



APPENDIX 5

TARIFF FOR CAPE TOWN DRUG COUNSELLING CENTRE CLIENTS

APPENDIX 5 TARIFF FOR DCC CLIENTS

Unemployed clients	R 1.00	
Scholars	R 2.00	
Students	R 5.00	(more if has a part-time job)
Family	R 25.00	(less if has financial limitations, more where family can afford it. Up to R 50.00)
Marital	1 %	of client's salary in initial interview. If marital sessions are agreed upon, 1 % of combined salaries.
Employed individuals	1 %	of salary
Scholars or students (sent by family)	1 %	of father's salary

APPENDIX 6

DRUG COUNSELLING CENTRE CLIENT HISTORY FORM

INITIAL ASSESSMENT INTERVIEW

Name: _____ Date opened: [ ]

Age [ ] Race [ ] Marital status [ ] Employed/Unemployed [ ]

Referred by: _____

Present domestic circumstances: _____

Reason for presentation now: _____

_____

_____

Is client involved in any court action? _____

_____

SECTION A: Drugs

Main drugs used: .....

.....

Other drugs: .....

Present pattern: .....

.....

.....

.....

Age of onset: .....

Drugging history: .....

.....

.....

.....

.....

Longest period of abstinence: .....

Previous withdrawal symptoms: .....

.....

Last period of abstinence: .....

Present withdrawal symptoms: .....

.....

Motivation for wanting to stop using drugs: .....

.....

.....

.....

Why does client use drugs? .....

.....

.....

Previous Management: .....

.....

SECTION B: Family Background

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

Marital: .....

.....

.....

.....

SECTION C: Background information

Geographical mobility: .....

.....

.....

Significant events in childhood/adolescence: .....

.....

.....

Education: .....

.....

.....

Employment History: .....

.....

.....

.....

Legal History: .....

.....

Previous psychiatric management: .....

.....

.....

SECTION D: Socio-cultural factors

Relationships and circle of friends: .....

.....

.....

.....

Hobbies: .....

Use of leisure time: .....

.....

Community Involvement: .....

.....

Religion: .....

Talents of client: .....

SECTION E: Present circumstances

Daily pattern: .....

.....

.....

Present position at work: .....

.....

Atmosphere in domestic situation: .....

.....

.....

.....

Financial position: .....

.....

Future plans: .....

.....

SECTION F: Personality

How would your friends describe you: .....

.....

.....

Feelings client has about self: .....

.....

.....

Behavioural changes/thought patterns client would like to alter: .....

.....

.....

.....

SECTION G: Mental status

Appearance and behaviour in interview: .....

.....

Usual and present mood: .....

.....

.....

Presence of any suicide ideation: .....

.....

Previous suicide attempts: .....

.....

Previous psychotic episodes: .....

.....

Disorders of thought/perception: .....

.....

.....

Orientation: .....

Memory: .....

Concentration: .....

Sleep: .....

Appetite: .....

Weight: .....

Libido: .....

Insight: .....

.....

Other: .....

.....

.....

.....

SECTION H: Evaluation/Summary

.....

.....

.....

.....

.....

.....

.....

Provisional diagnosis: .....

.....

Provisional prognosis and prognostic requirements: .....

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SECTION I: Initial management

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.....

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COLLATERAL INFORMATION

.....

.....

.....

.....

.....

.....

.....

APPENDIX 7

OUTREACH LETTERS

CAPE TOWN DRUG COUNSELLING CENTRE
(SANCA Western Cape Society)
237 Lower Main Road
Observatory
7925
P.O. Box 56
Observatory
7935

DWELMMIDDEL VOORLIGTINGSENTRUM KAAPSTAD
(SANRA Wes-Kaapland Vereniging)
Laer Hoofweg 237
Observatory
7925
Posbus 56
Observatory
7935

47-8026
47-8035
47-8045

22 May 1990

xxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxx
xxxxxxxxx
xxxx

PRIVATE & CONFIDENTIAL

Dear

I am a socialworker at the Cape Town Drug Counselling Centre in Observatory.

We are doing a survey about our services and how they could be improved. It would help us an enormous amount if you would be willing to allow me to ask you some questions. This will help us find out how people who come to the Drug Counselling Centre experienced our services. Your answers will be kept confidential and only identified with a number.

The interview will take no longer than 15 minutes. I am willing to visit you at home or at work, or pay for your transport costs to visit me at the Drug Counselling Centre. Are you willing to assist us?

Please phone me at 47 8045 (work hours) or at 461 6810 (after hours).

I will really appreciate your assistance.

Yours sincerely

CATHY ROGERS

CAPE TOWN DRUG COUNSELLING CENTRE
(SANCA Western Cape Society)
237 Lower Main Road
Observatory
7925
P.O. Box 56
Observatory
7935

DWELMMIDDEL VOORLIGTINGSENTRUM KAAPSTAD
(SANRA Wes-Kaapland Vereniging)
Laer Hoofweg 237
Observatory
7925
Posbus 56
Observatory
7935

47-8026
47-8035
47-8045

22 Mei 1990

xxxxxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxxxxxxxx
xxxxxxxxxx
xxxx

VERTROULIK

Geagte

Ek is 'n maatskaplikewerker by die Dwelm Sentrum in Observatory.

Ons is besig met 'n opname oor ons dienste en hoe dit verbeter kan word. Dit sou ons geweldig help as u bereid sou wees om 'n paar vrae te beantwoord. Dit sal ons help om vas te stel hoe mense wat die Dwelm Sentrum besoek het, ons diens ervaar het. U antwoorde sal heeltemal vertroulik beskou word en u sal slegs met 'n nommer geidentisifeer word.

Die onderhoud sal nie langer as 15 min. duur nie. Ek is gewillig om u tuis of by u werk te besoek; of om u trein en bus koste te dek as u my by die Dwelm Sentrum besoek. Is u gewillig om my te help?

Bel my asseblief by 47 8045 (werk ure) of by 461 6810 (na ure).

Ek sal u samewerking baie waardeer.

Die uwe

CATHY ROGERS

APPENDIX 8

RECOMMENDATIONS FOR THE DRUG COUNSELLING CENTRE

APPENDIX 8. RECOMMENDATIONS FOR THE DCC

1. Client Preferences for Therapists Attributes: Receptionist to establish therapist attributes of importance to the client and to allocate accordingly where possible.
2. Crisis Intervention: Therapists should establish the level of crisis experienced by the client. If the crisis level is high, a crisis intervention model should be applied.
3. Medical Treatment: Offer clients the option of immediate medical treatment during the first appointment.
4. Contracting: Therapists should identify expectations of treatment and then negotiate achievable goals.
5. Family and Employer Involvement in Treatment: The therapist should engage family members and other forms of external pressure to maintain the client's treatment interest. In addition therapists should foster co-operation between employers and clients.
6. Withdrawal Symptom Education: Ensure that clients are thoroughly educated about withdrawal symptoms during the initial interview and distribute literature for emphasis.
7. Therapist Out-reach: Introduce policy to reach out immediately to clients who drop out of treatment.

APPENDIX 9

STATISTICS FROM THE SOUTH AFRICAN POLICE

STATISTICS FROM S.A. POLICE

DETAILS	*1987	1988	1989
DAGGA			
Possession			
(arrests)		5 892	3 362
(confiscated) Kg		3 974	286
Dealing			
(arrests)		9 398	1 006
(confiscated) Kg	1 011 100	1075 285	1 023 000
Destroyed			
Kilograms	273 054	537 206	9 042 000
MANDRAX			
Possession			
(arrests)		467	196
(confiscated) Kg		3 129	41 293
Dealing			
(arrests)		987	1 305
(confiscated)			
- tablets		1 018 100	1 071 100
L.S.D.			
Possession			
(arrests)		10	4
(confiscated)			
- units		5 615	75
Dealing			
(arrests)		26	25
(confiscated)			
- units		8 767	12 358
COCAINE			
Possession			
(arrests)			5
(confiscated) gm			418
Dealing			
(arrests)			27
(confiscated) gm			1 224

*Statistics received from United Nations Report.

THESE STATISTICS WERE SUBMITTED TO THE C.T.D.C.C. FROM THE NARCOTICS BUREAU.

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