An evaluation of the Cape Town Drug Counselling Centre's treatment programme

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Abstract

The goal of the study is to evaluate the treatment programme of the Cape Town Drug Counselling Centre. Overall the evaluation reflects a positive picture of the services offered by the Centre. The study commenced in January 2000. Respondent acquisition commenced on the 1st April 2000 and was completed 31st December 2000. All clients that were assessed during this period formed the study population. The sample was selected from the population using convenience sampling. Three follow-up interview schedules were conducted at six weeks, three months and six months post assessment.

This study was explorative in nature and has shown the treatment programme offered by the CTDCC to be effective in terms of abstinence. Respondents favoured longer attendance in the treatment programme. The treatment option combination of individual therapy, motivational groups, and aromatherapy treatment sessions produced the highest rate of respondents who were abstinent at six months post assessment. The relationship between treatment and its effect on drug related criminal activity was briefly investigated. Also investigated were additional measures of treatment efficacy; and the relationship between treatment and shifts in the respondents employment status over the period of the study.

Conclusions and recommendations affecting the treatment programme were made. The goal of the study, that is, to evaluate the treatment programme, was achieved satisfactorily.

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CHAPTER 1 THE CAPE TOWN DRUG COUNSELLING CENTRE AND IT'S TREATMENT PROGRAMME

1.1 Introduction

This study is an evaluation of the Cape Town Drug Counselling Centre's treatment programme. Outcome based programme evaluation in the substance abuse field within a South African context is remarkably scarce. Rickel and Becker-Lausen [1994] and Rocha-Silva [1998] note that the dearth of information relating to drugs other than alcohol, complicates risk identification. As such, the more research done in the field of South African substance abuse treatment Centres, the better the opportunity for effective treatment.

The Cape Town Drug Counselling Centre [CTDCC] is the largest and longest serving out-patient drug treatment Centre in the Western Cape and has been operational since 1985. Over the last 16 years, it has grown from a small organisation with a limited service focusing only on treatment, to its current state. At present the CTDCC offers a three-tiered approach which is comprised of treatment, training and prevention services. This study will focus on one specific aspect of the CTDCC's service delivery programme, namely that of the treatment or intervention component. For the purpose of this study, the researcher has chosen to use the term 'treatment', rather than vacillating between the terms 'treatment' and 'intervention'.

1.2 Overview of the Cape Town Drug Counselling Centre

The Centre was founded in 1985 by psychiatrist Dr David Rabinowitz, and a concerned parent Adele Searle. From its inception, the CTDCC functioned on an out-patient basis. It began with a small clinical team that provided counselling only.

Currently there are four different options for the treatment of drug abuse in the Western Cape. The first is that of out-patient treatment where the client attends daily, or a few times per week. Secondly there is short-term in-patient treatment, the client remaining in treatment for a period of less than six weeks. The third option is long-term in-patient treatment, where a client stays in therapy for a period of longer than six weeks. The final treatment option is called a therapeutic community or a secondary care facility where a client spends an undetermined period of time making the transition from recovery back into the community. The therapeutic community or secondary care option is usually used as an intermediary phase between a short-term in-patient treatment episode, and the community. The CTDCC falls within the parameters of the first option. It offers out-patient treatment where the client attends on a daily basis, or a few times per week.

The CTDCC provides a service to all Capetonians experiencing drug abuse related problems. In 2000, the CTDCC treated 40% of all people seeking help for the abuse of illegal drugs in the greater Cape Town area. Not only do the CTDCC treatment services give the client a chance of a normal life, but they

also impact on many areas of society, for example leading to a reduction in crime, and HIV/AIDS infection.

1.3 The Cape Town Drug Counselling Centre's Organisational Structure

An executive committee comprising of ten voluntary members oversees the management of the CTDCC. They meet monthly with the management team. The chairperson is elected internally by the fellow executive committee members. The executive committee steers the overall direction of the Centre's strategy and planning. The daily functioning is the responsibility of the unit managers, who have regular meetings with the staff in their departments. [Refer to appendix 10 for the organogram]

Below the executive committee is the Acting Director. The CTDCC does not currently have a full time director and therefore the Acting Director assumes responsibility for the daily functioning of the Centre. The Acting Director reports to the executive committee, and is supported by the heads of the different departments. These are divided into finance, marketing, administration, prevention, strategic planning, training and clinical. Feedback to the staff within each department is the function of the head of that specific department.

The CTDCC employs 13 full time staff and six sessional staff. The clinical team is comprised of 4 clinical social workers and a clinical psychologist. The administration department includes a receptionist, an administrative assistant

and the financial director. The fundraising department employs a fundraiser and a fund raising assistant. One person staffs the prevention department, and another the training department.

The fundraising department generates the income required to keep the CTDCC operational. The Centre receives a subsidy from the Provincial Administration of the Western Cape's Department of Social Services, but this covers only 12% of the annual running costs. The subsidy has not been increased during the last five years. The remaining 88% of the required funding is self generated, and like most not-for-profit organisations, the CTDCC faces financial difficulties.

The head of the clinical department is a clinical psychologist who has been with the CTDCC since its inception in 1985, and is also the acting director of the CTDCC. The financial director heads the administration department, while the training co-ordinator and the head of the prevention department report to the strategy and planning manager. The unit managers collectively form the management team which meets on a weekly basis.

1.4 Various Departments

The CTDCC has various departments that make up the organisation. The Youth Outreach Department conducts prevention work in schools. The Training Department trains employers and employees in drug issues and policy development. The Fund Raising Department sources funding to keep the Centre running. The Clinical Department offers treatment to clients

experiencing drug-related difficulties. The administration department offers administrative support to all departments.

1.4.1 Youth Outreach Department

The primary objective of the Youth Outreach Department is to enable schools to rise to the challenge of substance abuse themselves, rather than rely on outside agencies for once off sessions that are often ineffective and expensive. The department offers both primary prevention work with students and teachers in schools, as well as secondary and tertiary prevention with adolescents at the Centre. The programme focuses on preventing substance abuse amongst adolescents by educating teachers about prevention work, thus enabling them to run programmes independently on an ongoing basis. Information is also provided to parents.

The Youth Outreach Department is active in schools in diverse communities throughout Cape Town and further afield. During 2000, more than 60 schools were reached. This department has worked in areas outside Cape Town, including Suurbraak and Hermanus. A major outcome of the CTDCC work in Hermanus was the launch of the Overberg Drug and Alcohol Action Committee.

The programme focuses primarily on the 10 to 14 year old age group. Although the emphasis is on primary and secondary schools, the CTDCC also works with tertiary institutions and teaching colleges. The student workshops are interaction based and provide a space for adolescents to choose the

issues they wish to explore. The CTDCC has developed - and is constantly updating - a variety of resources including a web page, posters, video material, pamphlets, teacher's manuals and lesson plans. The Centre is well established in the Western Cape and provides ongoing support to schools.

1.4.2 Training Department

In 1993, the CTDCC began offering creative training solutions in order to equip people with the knowledge and skills needed to effectively address problematic substance use in the work environment. During 2000 the focus has been on developing and piloting new training programmes and projects for workplaces, communities, campuses and professionals. The workplace programme is the latest training initiative and during 2000 the Training Department worked with approximately 40 companies.

The Training Department postulates that for every person with a drug or alcohol problem, between 7 and 17 people are negatively affected, including family, work colleagues, friends and others in the community. Through the CTDCC training programmes, this negative cycle can be reversed. During 2000, more than 30 training events took place with a total of over 1000 participants.

Courses and workshops are facilitated by staff members who are directly involved in prevention and/or treatment services. Various experts from a variety of resource organisations contribute to enrich the process. The courses are adapted to suit the unique needs of the participants, and topics

typically covered include attitudes to addiction, understanding problematic substance use, identifying the latest drugs of abuse, and signs of problematic substance use.

1.4.3 Fund Raising Department

This crucial department's challenge is to generate adequate funding in order to maintain and develop the CTDCC. Funds are collected through a variety of means. The Centre holds fundraising events e.g. a telethon. They also have a direct mail appeal and a corporate mail appeal. New ideas for raising money need to be generated on a daily basis as many Capetonians suffer from increasing levels of donor fatigue. The aim of this department is to maintain CTDCC services as affordable and accessible to the greater community of the Western Cape.

1.4.4 Clinical Department

The clinical department is the largest department including four therapists and a clinical manager. The services offered by this department include individual, group & family counselling, family workshops, acupuncture, aromatherapy, reiki, reflexology, medical & psychiatric services and art therapy. The primary client base is adolescents and their families.

The field of substance abuse is highly specialised and therefore the Clinical Department is staffed by qualified social workers and psychologists, making it cost intensive. In line with the CTDCC mission statement, the services need to

be affordable and many clients pay a minimum fee. The Clinical Department is therefore the most costly service run by the CTDCC.

The clinical team comprises of four social workers and a clinical psychologist. All therapists are trained extensively in the treatment approach followed by the CTDCC. The treatment approach is client Centred and the primary therapy utilised is Motivational Interviewing. All therapists operate with a practice framework that includes motivational interviewing as the primary treatment therapy. Most of the training is done internally. New therapists undergo an average of three months training during which they learn about the various aspects of the Centre's treatment programme, the different treatment options, motivational interviewing and group work. The clinical team is offered external courses from time to time.

Therapists are encouraged to educate themselves continually, and journal articles are made available on a regular basis via an external journal source. Weekly clinical team meetings are held to discuss the progress of groups, and for therapists to discuss clinical issues. Case discussion forms part of the clinical meetings, and during these sessions, therapists present cases that are particularly difficult for them, or cases that may be of interest to the whole team.

Weekly consultation is provided internally, with less experienced therapists consulting with more experienced therapists in an attempt to work through difficulties that they might have encountered during the week. The CTDCC

promotes staff development and holds conflict resolution and personal growth groups on a fortnightly basis. These are attended by all staff members, and are facilitated by an external clinical psychologist.

The CTDCC employs a large sessional staff compliment. Sessional staff include a psychiatrist, a general practitioner, an art therapist, an aromatherapist, who also performs the reflexology and reiki treatments, and an acupuncturist. The sessional staff members compliment the clinical team in the client's recovery process. Added to the sessional staff compliment, are the students that are trained by the CTDCC on a yearly basis. The Centre has a long-standing arrangement with the University of Cape Town, to accept and train final year social development [social work] students, as well as psychiatric registrars.

1.5 The Cape Town Drug Counselling Centre's Treatment Programme

The CTDCC is client Centred in its approach to substance abuse, addiction and the resulting problems and is equipped to treat clients abusing either legal drugs e.g. over the counter medications such as benzodiazepines, pain killers etc, or illegal drugs such as dagga, crack cocaine, mandrax, etc. The Centre's treatment programme works on three levels namely, psychotherapy, group work and alternative therapies. All three levels combine to make up the client's treatment programme. Clients are motivated to take an active role in the selection of treatments that will best suit their specific needs and wants.

The treatment programme is expected to last a minimum of six weeks with no maximum ceiling set.

1.5.1 Assessment

Assessment clinics are held every Monday and Thursday morning. All presenting clients watch an introductory video that outlines the treatment services offered by the CTDCC. After the introductory video, the client is assessed by one of the social workers who has completed specific addiction training. During the assessment interview the therapist guides and supports the client while focusing on specific areas. These focus areas include motivation for attending rehabilitation, current and past drug usage, social and psychological background, behavioural problems, criminal behaviour, mental status evaluation, brief medical background and treatment options. On completion of assessment, a treatment plan is formulated in conjunction with the client and therapist. An assessment session usually lasts for 45 to 60 minutes.

With the exception of clients who present with current or pending court cases, the CTDCC will treat all clients with substance abuse or dependence related problems, that approach the Centre. The reason for the exclusion is that over time the CTDCC has found that the time spent by therapists in court appearances was not justified. It was also felt that most of the clients that presented at the CTDCC with drug related criminal action pending, were motivated to enter treatment because they felt that the courts might be more lenient when sentencing. The net result was that clients whose motivation was

more internal, were lost due to the therapists' time being consumed by court appearances.

The assessment process forms the foundation of the working relationship between the client and therapist. It is essential to the therapeutic process. If during the assessment the therapist identifies areas of concern that the CTDCC is not able to address, an appropriate referral is made. The CTDCC acts as a referral resource, and a client may be referred to either an in-patient drug treatment Centre, or to another facility more suited to the client's needs. Referrals are only made with the client's consent.

1.6 Out-Patient Treatment

If a client is motivated to attend the CTDCC, a treatment programme is co-planned by the therapist and the client, according to the client's individual needs. The treatment programme may include any or all of the 12 treatment options available at the time of assessment. At the time of the study these included:

- Individual therapy where a client has the opportunity to explore their underlying reasons for drug use.
- Group therapy where clients experiencing problems stemming from their drug use, have an opportunity to share their experiences and also to benefit from the experience of others.
- Family therapy in which clients and families have an opportunity to resolve drug abuse related issues of importance to them.
- Medical assessment with the option of medication to reduce the effects of withdrawal.

- Psychiatric consultations for clients with a dual diagnosis. By dual diagnosis, the researcher implies substance abuse or dependence as defined by the DSM IV coupled with another DSM IV classified mental disorder such as depression or anti social personality disorder. These sessions are also utilised for the monitoring of withdrawal from benzodiazepines or other over the counter medications.
- Art therapy to help the client get in touch with and explore feelings through the medium of art, within a supportive group.
- Acupuncture to reduce withdrawal symptoms and re-energise the body.
- Reiki, a gentle non-physical form of healing that promotes relaxation.
- Reflexology, a treatment that involves foot manipulation which promotes relaxation.
- Aromatherapy massage using essential oils that help the client feel relaxed and refreshed.
- Spirituality Group is a group in which clients learn to listen to themselves and others, and regain a sense of their spiritual selves.
- Adolescent workshops are three-day workshops for adolescents who are experimenting with drugs or who have encountered problems with mood altering substances. These workshops are held on CTDCC premises during the first week of every school holiday and are life skills orientated.

At assessment the therapist and the client select a treatment programme that suits the client's needs. The options are flexible and the client can change his or her mind in terms of adding or removing treatment options at any time during the treatment process. Clients usually attend between one and three times per week during the initial six-week period, after which time the client is prompted to continue attending less frequent aftercare sessions.

1.7 Fees

Over time, the CTDCC has found that a client's commitment to treatment increases when they are required to pay for services received. Initially the services were free, but now clients are expected to pay a small fee per session, which is based on their financial circumstances. Fees are payable on the day the service is rendered. If clients are not able to pay immediately, they are not turned away; rather a small line of credit is established and the client is encouraged to settle outstanding fees later. The line of credit is five sessions if the client pays R20.00 and three sessions if the client pays more than R20.00.

Clients that are students or are unemployed, are charged R20,00 per session. All other fees are determined on a sliding scale which is based on earnings. A salary up to R2000,00 per month is charged at 2% of the gross monthly income and between R2000,00 and R4000,00 the fee is 2.5% of the gross monthly income. Between R4000,00 and R6000,00, the fee is 3% of the gross monthly income. The fee ceiling is R180,00 and if a client pays more than R80, 00 per session, all sessions over three treatment sessions per week are without further charge. One of the driving reasons behind the CTDCC is the idea that without the Centre, clients experiencing drug related difficulties would be left with two options namely that of paying for expensive treatment in private institutions, or 'battling' along without any professional assistance.

1.8 Determining Efficacy

It is important to determine the effectiveness of any treatment programme in order for practitioners to know whether their efforts are directed positively. The CTDCC is often asked the very basic question: "What is your success rate"? This question is of paramount importance, as the solution holds not only the key to treatment direction and enhancement, but it also directs the future growth of the CTDCC and could affect income generation. There is, however, an inherent problem contained within the question namely how would one test and measure efficacy. The problems that arise from the term 'efficacy' are multifaceted and will be revisited later. For now all that is important is for the reader to be aware of the direction that this research project will be taking.

To elucidate the point, it is important that the reader be aware of the fundamental difference between causal based outcome's research, and ecosystemic based programme evaluation. Basically causal based outcomes are rooted in Freud's cause and effect model which was developed in the early 1900's. This model is no longer able to provide accurate explanations for emerging social anomalies. The reasons for this are numerous and varied, but basically stem from the model's inability to reflect societal change over the last few decades. One of the models that appears more able to accurately reflect societal change is the ecosystemic model. In terms of the cause and effect model, a problem is always related to a symptom in terms of a cause, whereas the ecosystemic model identifies systems rather than causes [Compton and Galaway: 1994]. A system could be referred to as a cluster or grouping of people, environmental factors or circumstances that exert

influence over the individual. A system, therefore, manifests symptoms of underlying needs or stresses, encapsulated within said system.

CHAPTER TWO RESEARCH METHODOLOGY

2.1 Introduction

In this chapter, the researcher will explore the methodology, or the way in which the research was conducted. This study focuses on evaluating the treatment component of the CTDCC's service delivery. It does not focus on any specific treatment option, but rather takes a global look at all the treatment options. However, it does explore the treatment options used most frequently by the respondents in greater depth than those that were used less frequently.

The researcher has identified the ecosystemic model as the foundational basis for this research. The reason for this is that the ecosystemic allows for circular approaches to problem identification unlike the linear approach of a causality model.

2.2 Motivation For The Study

At the commencement of the study, there were 23 registered treatment Centres in the Western Cape. These treatment Centres provided services to individuals suffering from a variety of substance abuse or addictive behavioural problems. Of these a few were private, even less were state managed, and the remainder were not-for-profit organisations. The researcher has conducted an extensive search, both regionally and nationally, and has been unable to find any previously published studies conducted on the subject of programme evaluation at an out-patient treatment Centre. The researcher

is under the impression that the CTDCC is the only out-patient treatment Centre in South Africa that has evaluated its treatment programme. This situation points to the need for results driven empirical research, in order to avoid perpetuating flawed activities. It is hoped that the clients, the CTDCC and the greater drug treatment services community, will benefit from the research.

The evaluation of the CTDCC's treatment programme will provide the Centre with treatment direction. It will also enhance the client's experience of the CTDCC, by improving service delivery. The need for programme evaluation is further motivated by the CTDCC's need for accountability to the community that the Centre serves. The researcher feels that it is of the utmost importance for organisations to measure the effectiveness of their service delivery on a regular basis.

2.3 Research Goal

The goal of this research project is to evaluate the CTDCC's treatment programme.

As with any research project, goals, objectives and tasks need to be identified. The goal as stated by Johnson [1995] can be seen as the long-range outcome or the overall expectation of the research. The goal is often very complex and as such, it is deconstructed into various objectives that assist the researcher to achieve the desired outcome. These objectives are further subdivided into

numerous practical activities called tasks that enhance objectivity and therefore promote goal attainment.

Rehabilitation centres dealing with substance abuse, as well as other professional bodies that work in the addiction milieu, should frequently evaluate either formally or informally, the progress their clients are making while in treatment [Compton and Galaway: 1994]. The findings that emerge from research enable the clinical team or specific therapist, to make informed decisions with regards to the case management of the client. This can include deciding to continue the treatment as planned, to modify the treatment plan or to adjust the service delivery. Furthermore it will aid in the decision to terminate the treatment due to attainment or non-attainment of specified treatment.

2.4 Research Objective

It is the intention of the researcher to ask respondents questions in order to determine their perception of the treatment programme as offered by the CTDCC.

2.5 Research Questions

1 When comparing the findings of respondents who completed the six-week programme with those who did not complete the six-week programme, which had the highest abstinence rate six-months post assessment?

2 What are the respondent's feelings and experiences of the CTDCC and its treatment programme?

3 When comparing data collected at assessment with data collected six-months later, is criminal activity [theft] lower six months after treatment than at assessment?

4 What combination of treatment options did the respondents find the most beneficial?

5 Has there been a change in the respondent's drugging behaviour during the 6-month follow up period?

2.6 Methodology

2.6.1 Design

The researcher posed both qualitative and quantitative research questions, through a series of questionnaires and follow-up interview schedules. According to Babbie [1995], De Vos [1998] and Dooley [1995], quantitative measurements are those that are numerical, e.g. "16 male students stole to support their drug abuse prior to assessment". Qualitative measurements express a non-numerical response e.g. "the respondents felt more self-confident after individual therapy". In this study all data collected at or pre-assessment is quantitative, while most data collected post assessment is qualitative.

Le Roux [1989] notes that a research design or model is a plan for a research project through which data is collected in order to test the posed research questions. This study is based on an explorative research design. Babbie [1995] notes that explorative studies are typically implemented for three reasons. First to promote a better understanding of the subject matter; secondly to test the feasibility of more extensive studies; and thirdly to provide

a basis from which other studies can be launched. The explorative research design is coupled with non-probability convenience sampling. Dooley [1995] and Williams, Grinnell and Tutty [1995] note that one of the best sampling methods, which results in an increase in sample size without decreasing validity, is the convenience sampling method. This was therefore the method selected for the study.

Stark [1992] in Chick et al [2000] states that there is a very high rate of non-response when dealing with addiction research. Chick [2000] notes that an attrition rate of more than 50% within the first month of treatment is not uncommon. Chick further states that high rates of voluntary termination are the accepted norm within multi-centre treatment studies in the United Kingdom. If high attrition rates were deemed acceptable in a developed nation like the United Kingdom, the researcher expected the same outcome in the current study, and sought to minimise this by opting for a sampling method that would compensate for the expected outcome.

2.6.2 Respondents

The study focused on all respondents assessed by the CTDCC from 01 April 2000 to 31 December 2000. The total number of respondents assessed during this nine-month period was 409. The study has both a qualitative and a quantitative component. Of the 409 respondents assessed, 29 [7%] chose not to participate at all and 380 agreed to participate. Ninety-seven respondents chose to participate in only the quantitative component. The researcher excluded a further 53 from the qualitative component of the study. The

reasons for their exclusion will be discussed later. The researcher has attempted to identify reasons why 97 respondents decided not to participate in the qualitative aspect of the study. He is of the opinion that they felt threatened at being contacted telephonically. It is also possible that the respondents did not understand the nature of the study, and because of misperception chose not to participate. The remaining respondents, 250, agreed to take part in both the qualitative and quantitative components.

Of the 230 respondents who agreed to participate in both the quantitative and qualitative study, only those respondents who were available when telephonic contact was attempted, formed part of the sample. A maximum of three telephonic attempts were made with each respondent at each follow-up interview schedule, of which there were three. If telephonic contact was unsuccessful, a follow-up letter was mailed to the respondent's given address. If, after these attempts, the respondent was still uncontactable, then that particular respondent was marked off as not participating for that particular research schedule. These research schedules will be discussed later.

The reason for this approach in sample selection lies in the availability of resources, and according to Williams, Grinnell and Tutty [1995] this approach falls within the parameters of convenience sampling. The CTDCC is a non-profit organisation and only allocated an annual budget of R400.00 for research. The real cost of the research appears closer to R30,000.00 per annum. On average, the research telephone costs were R300.00 per month, and therefore there were simply not adequate financial resources to continue

attempting making contact with potential respondents. This, coupled with the fact that each respondent needed to be contacted three times over the six-month follow-up period, meant that the researcher did not have time to exceed three calls to any given respondent per interview schedule.

The sample was selected from the population using a non-probability accidental sampling, otherwise known as the convenience sampling method. De Vos [1998] also refers to this sampling method as the accidental sampling method. Convenience sampling as noted by De Vos [1998] allows the researcher to select a sample of the first respondents who were available from the population. The researcher felt that this was the most appropriate method for sample selection, due to the client base's naturally occurring high rate of attrition, as discussed by Chick [2000].

2.6.3 Exclusion criteria

The researcher elected to exclude certain respondents from the qualitative component of the study. The exclusions encompassed all respondents who would be difficult to contact, i.e. had neither a permanent home telephone, nor were contactable via work telephone numbers, or reported having cellular telephones as their only communicative means. All respondents who could not speak English or Afrikaans were excluded. "Returning" clients i.e. those who had previously been in the CTDCC treatment programme, during the period of study March to December 2000, were also excluded. In all, based on the listed exclusion criteria, 53 respondents were excluded from the study.

2.6.4 Materials

The researcher developed the interview schedules by modifying existing measuring tools in use by the CTDCC to suit the purposes of the study. The materials section is divided into two parts, section one being pre-assessment materials, and section two post treatment materials.

2.6.4.1 Pre-assessment materials

2.6.4.1.1 Pre-assessment questionnaire

The researcher adapted the intake or pre-assessment questionnaire from an existing intake questionnaire that was in use prior to the commencement of the study. The CTDCC's intake workers completed the pre-assessment questionnaire. [Refer to Appendix one in the attached resource list.]

2.6.4.1.2 Assessment Form

Once again, the existing assessment questionnaire that was in use by the CTDCC before March 2000, was adapted by the researcher for the purpose of the study. The new assessment form is loosely allied to the American Addiction Severity Index, which is the primary addictive behaviours assessment tool in the United States. CTDCC therapists completed the assessment form after receiving training on the correct use of the assessment tool by the researcher. The researcher would like to bring to the readers' attention that not all the questions contained in appendix two were used by him for the purposes of this study. Only the questions that are underlined were used [Refer to Appendix two in the attached resource list.]

2.6.4.2 Post-assessment materials

2.6.4.2.1 Data collation form

The researcher developed a data collation form that was used for the quantitative data collection and was completed by the researcher himself. Information for the data collation form was extracted from research specific questions, contained in the pre-assessment materials. [Refer to Appendix three in the attached resource list].

2.6.4.2.2 Six-week interview schedule

The six-week interview schedule was a telephonic interview schedule that was completed by the researcher 6 weeks after the respondents' assessment date. Its primary focus was to extract respondent experiences of the treatment programme. [Refer to Appendix four in the attached resource list].

2.6.4.2.3 Three-month interview schedule

The three-month interview schedule was a telephonic interview schedule that was completed by the researcher three months after the respondents' assessment date. Its primary focus was to elicit the respondents' feelings on the notion of external or internal pressure which influenced their attendance at the CTDCC. [Refer to Appendix five in the attached resource list].

2.6.4.2.4 Six-month interview schedule

The six-month interview schedule was a telephonic interview schedule that was completed by the researcher six months after the respondents' assessment date. Its primary focus was to explore shifts in the respondents'

drugging behaviour over the six months since their assessment at the CTDCC. [Refer to Appendix six in the attached resource list].

2.6.4.2.5 Additional materials

The following additional materials were used during the course of the study:

Information Letters: A set of English and Afrikaans information letters informed all clients that were assessed by the CTDCC about the research programme before they were asked to participate in the research. [Refer to Appendix seven and eight respectively in the attached resource list].

A follow-up letter was also used, but only if telephonic contact with the respondent was unsuccessful. The follow-up letter option was terminated in December 2000, as the response to the letters was very poor and was not worth the postage costs involved. [Refer to Appendix nine in the attached resource list].

2.6.5 Research Process

All the respondents who were assessed at the Centre were asked to participate in the research programme, but were informed that they had the right to choose whether they wanted to participate or not. All respondents were requested to sign the data release form, allowing the researcher access to their data. The respondents chose to allow the researcher access to their quantitative data or to both the quantitative and qualitative data. The quantitative element of the study focused on details such as number of respondents, how many weeks abstinent, types of drugs used, average age

etc. The qualitative aspect of the study looked at the subjective feelings, experiences and ideas of the respondent. Some of the questions posed were; "Do you have any suggestions for the CTDCC"?; "Are there things that you feel could have been done differently"? The researcher completed the quantitative component of the study based on the respondent's answers to the research specific questions during the initial assessment.

2.6.6 Follow-up

The researcher attempted telephonic contact with all respondents who had consented to participate in the qualitative section of the research programme. Follow-up was conducted over a period of 64 weeks and was categorised into three different time stages captured in the different interview schedules. For purposes of the study the researcher partitioned the time frames into groups.

2.6.6.1 Six-week interview schedule

Telephonic contact was made at six weeks from the assessment date. For the six-week interview schedule purposes, follow-up began at week six on the 17th May 2000, and the follow-up period was terminated for this phase at the end of week 43, the 31st January 2001. Sixty-nine [30%] out of 230 respondents, who agreed to participate, were successfully contacted. All data collected relating to this interview schedule is hereafter referred to as group three [G3].

2.6.6.2 Three-month interview schedule

Telephonic contact was made at three months from the assessment date. In order to achieve the three-month interview schedule, follow-up began at week

14, the 12th July 2000 and was completed on week 51, the 28th March 2001. Sixty-one [27%] out of 230 respondents who agreed to participate, were successfully contacted. All data collected relating to this interview schedule is hereafter referred to as group four [G4].

2.6.6.3 Six-month interview schedule

Telephonic contact was made at six months from the assessment date. In order to complete the six-month interview schedule, follow-up began at week 27, the 11th October 2000 and was terminated on week 64, the 27th June 2001. Fifty-eight [25%] out of 230 respondents who agreed to participate, were successfully contacted. All data collected relating to this interview schedule is hereafter referred to as group five [G5].

At each telephonic contact, respondents were asked various questions relating to their subjective feelings and experiences while at the CTDCC, and about their current drug use. A maximum of three telephonic attempts was made to contact each research participant. If the respondent was not reached telephonically, a research follow-up letter was mailed to the respondent's given address. If after three telephonic attempts and a follow-up letter the respondent was still uncontacted, that particular respondent was recorded as a non-participating respondent. This approach falls well within the parameters of convenience sampling.

2.7 Ethical Considerations

Babbie [1995] notes that social research projects are often created and shaped by a combination of the administrative, ethical and political persuasions of the organisation doing the funding, and of the researcher. Various ethical considerations were identified and considered during the planning stages of this research project. In consultation with staff members at the CTDCC, one of the ethical principles that emerged was that the research needed to be voluntary. This principle was achieved by the implementation of three steps. Firstly, every Monday and Thursday morning the CTDCC held an assessment clinic. Before assessment, all presenting clients were provided with an English or Afrikaans letter, depending on their language preference, explaining the research programme in terms of its aims and expectations. Secondly, at the assessment clinics the research project was discussed with all respondents who presented for treatment that morning.

This discussion took place in a group format after the introductory video, but before the assessment interview. Emphasis was placed on the fact that the respondent had the right to say 'no', and that they should not feel in any way intimidated into participating if this was against their wishes. Thirdly, on completion of the assessment interview, CTDCC therapists asked respondents if they would like to participate in the research programme or not, again stating that they were under no obligation to do so. It is at this point that the respondents decided to participate or not. They agreed by signing consent. The respondent then entered into a written contract by signing the research acknowledgement of participation. In so doing, the respondent

provided informed consent. Confidentiality was paramount and consequently only file numbers were used during sample compilation and data analysis.

Ethics are typically associated with societal morality. As is noted by Dooley [1995] the discovery of the horrors of medical research performed during the Second World War, led to the introduction of the Nuremberg code. The Nuremberg code regulates social research and offers researchers parameters within which they can operate. Despite this, there have been gross human rights abuses committed in the name of social research. Examples of this are The Tuskegee Syphilis study conducted by the U.S. Public Health Service, as mentioned in Dooley [1995], the Tea-room Trade as researched by Laud Humphreys, and the Observing Human Obedience test conducted by Stanley Milgram, as noted in Babbie [1995].

2.8 Time frame

Globally the research was ongoing for two years. This time period was sub-divided into various stages.

January to March	2000	Planning
April to December	2000	Respondent acquisition
April to December	2000	Qualitative data acquisition phase
May 2000 to January	2001	Six-week interview schedule follow up
July 2000 to March	2001	Three-month Interview schedule follow up
October 2000 to June	2001	Six-month Interview schedule follow up
July 2001 to September	2001	Data Analysis
September	2001	Submission

The implementation date of the study was 01 April 2000. Data was captured on a weekly basis. All participating respondents were contacted telephonically on a date six weeks, three months, and six months from their assessment date. The respondent acquisition period ended on 31 December 2000. Thereafter the follow-up period continued for six months from the last respondent assessed in December 2000. After the six-month follow-up period, all data collected was analysed and interpreted. This process ran from 01 July 2001 until 31 August 2001.

2.9 Definitions of terms

A definition is nothing more than an instrument of explanation. To this end the researcher has compiled a list of definitions that appear self-explanatory. The need for elucidating these definitions is that jargon often leads to confusion. This is especially true where terminology is often multidisciplinary in nature as it is in the case of addiction. The researcher feels that it is important to establish what a term or concept means, pertaining to the current research.

2.9.1 Resistance

Masson & O'Byrne [1984] note that resistance is seen as any aspect of the family, client or therapeutic system that interferes with the process of the therapy or treatment programme.

2.9.2 Drugging

The term drugging is jargon used at street level. The term refers to drug usage. If a person has been using drugs for 5 years, the respondent will often say that he or she had been drugging for 5 years.

2.9.3 Relapse

In terms of the Dictionary of Psychology [Reber: 1985] relapse is defined as "the falling back into a previous state or into an earlier behavioural pattern", while Miller and Rollnick [1991] note that "life is a chronic relapsing condition". From both it is possible to conclude that relapse is both a regressive as well as a chronic condition.

2.9.4 Addiction and substance dependence

In this study, the term addiction meets the criteria for substance dependence as defined in the DSM IV. There are many definitions of the term addiction. For research purposes, Daley and Raskin's definition [1991:15] of addiction will be used. They define addiction as "an uncontrollable physical and or psychological need or dependence on any substance".

2.9.5 Voluntary termination

For the purposes of this study, the term 'voluntary termination' will be used, as opposed to an existing but more disparaging concept, namely 'drop-out'. For the purposes of this study voluntary termination is applied only to respondents who did not complete the six-week treatment programme. Voluntary

terminated was not applied to respondents who terminated after the six-week period. Respondents who voluntarily terminated stopped treatment by their own choice, without consulting their therapist.

2.10 Possible Limitations of The Study

Despite the use of convenience sampling, the research project has yielded a smaller number of respondents than the researcher had expected. One of the limitations of convenience sampling itself is that it limits the degree to which one can generalise findings to other parts of the population. This is primarily due to a lack of representativeness in the sample.

The study might not be wholly applicable to other addiction centres. This in no way detracts from the value that it has for the clientele of the CTDCC. One of the goals of the research is to provide information that will enhance the service delivery to CTDCC respondents. The CTDCC provides an out-patient treatment programme, and as such respondents' attendance is determined by their motivation to rehabilitate themselves. Respondents are not forced to attend by any means other than voluntarily, or by the perceptions of pressure placed upon them by significant others.

The lack of South African research in the area of programme evaluation of treatment models in rehabilitation centres, has affected the study. If treatment does not meet the needs of the respondent, then the treatment programme might be ineffective. Forcing a respondent to partake in a treatment mode in

which he or she does not want to participate, often engenders resistance within the respondent.

The researcher was also concerned with the extrapolation of findings of foreign research to the South African addiction milieu. He is aware of the inherent problem within this scenario and has made efforts to ensure that the cultural and socio-economic conditions of South Africa are considered when analysing the data. According to Gomm [2001] it is a mistake for agencies to directly apply findings of research conducted at other centres to their centre.

A further disadvantage that might influence the research is researcher bias. The researcher is a full-time employee at the CTDCC. As a social worker, working within the clinical team, the researcher is in a good position to understand the intricacies of the treatment programme. The negative aspect of this involvement is that the researcher might not be as objective as an outsider. This is especially true considering the fact that he will be in contact with some of his own respondent base during the research programme. Some respondents will be talking to their own therapist when the researcher conducts the follow-up interview schedules, and the respondents might feel the need to embellish on their feelings and experiences in an effort not to disappoint the researcher. This might negatively influence the validity of the findings.

There is also the problem of self-reporting which might affect the study. The respondents might also not be honest about their current drugging behaviour

despite measures taken to assure the respondents that their answers would be confidential. Over and under reporting might still occur because, as Terblanche and Venter [1999] note, the activity that the respondent is requested information on, is perceived as being illegal or socially deviant. Terblanche and Venter refer to Levinthal [1996] and Del Boca and Nol [2000] state that all interview schedules and questionnaires are inherently imperfect, because there is no foolproof way of determining the validity of what the respondents are saying about themselves. In essence, what the respondent offers you as an answer to a question, is not necessarily the truth. Verbal reports might be variable but they are still functional in nature and sensible in terms of the context of the question posed. Additional mechanisms should be introduced in future studies in order to improve reliability of responses from the respondents. These measures could include an interview with the respondents' or significant other. This will ensure two perspectives on a particular answer, and thus highlight discrepancies. The suggestion is that both interviews take place consecutively, so as to reduce informant bias.

2.11 Possible Benefits of the Study

Several aspects promote the research on a concrete and abstract level. For the researcher, these advantages include evaluating a treatment programme that has grown eclectically over the past 16 years. Another factor is that, to the best of the researchers' knowledge, this will be the first time that a South African substance abuse treatment centre has had its treatment programme empirically evaluated, making it a worthwhile if not long overdue activity.

CHAPTER 3 LITERATURE REVIEW

3 Introduction

In this chapter, the researcher looked at the variables that influence the rehabilitation process and identified two broad focus areas. The first would be that of the treatment programme itself. In this section, existing literature relating to treatment programmes is evaluated. The second focus area would be that of voluntary termination, in which literature relating to this subject is elucidated. Voluntary termination is a major problem in addiction rehabilitation centres and more so, in out-patient treatment centres.

3.1 Treatment Programme Evaluation

3.1.1 Introduction

The researcher investigated the available literature and contemplated what has been reported about the current study. Evaluation is a word that has considerable variations in meaning, depending upon the context in which it is applied. Johnson [1995] states that in its most general use, evaluation encompasses gathering and analysing information concerning an individual, a treatment programme, a group of treatment programmes, or other entities. There is usually a standard, whether explicit or implicit, against which the evaluation data is compared and judgements are made [Weiss, 1972 and De Vos 1998].

3.1.2 Relevance of Programme Evaluation

Treatment programme evaluation is important and essential to the overall relevance and wellbeing of the research target, be that an individual, group or community, as well as for the organisation implementing the evaluation. De Vos [1998], Dooley [1995], Rutherford and Banta-Green [1998] have identified a variety of reasons for this. Some of these are:

- ➔ Determining whether treatment programme objectives or individual treatment goals have been reached;
- ➔ Planning and making decisions about clients or treatment programme elements, based on appraisals of achievements compared to goals and objectives;
- ➔ Monitoring standards of performance;
- ➔ Generalising the effectiveness of a treatment programme or treatment programme component, to other populations;
- ➔ Developing and fostering both personal as well as treatment programme accountability;
- ➔ Promoting a positive and general awareness of treatment effectiveness.

Substance abuse professionals frequently evaluate, either formally or informally, the progress their clients are making during the treatment process. Based on these evaluations, therapists are able to decide on continuing, modifying, or terminating the treatment. Strydom [1998] studied research amongst social workers in South Africa and noted that social workers have been loath to embrace research. Strydom also notes that many social workers prefer to operate on experience and intuition rather than research. In the field of addictive behavioural programme evaluation, Strydom might be correct. The very low level of programme evaluation of substance abuse treatment centres in

South Africa has complicated the current research, as most available research was internationally based and as such internationally focused.

Treatment programme evaluation is a specialised field. As mentioned, there is no uniform agreement about the precise definition of programme evaluation. Patton [1977] notes that most people involved in evaluation agree that there are two broad purposes for treatment programme evaluation and thus two "types" of treatment programme evaluation. Formative evaluation, the study of the treatment programme process; and summative evaluation, the study of treatment programme efficacy or non-efficacy. In practice, most evaluations contain both aspects and there are no clear dividing lines between them. However, the terms are conceptually useful in understanding what one wishes to achieve from the evaluation.

3.1.3 Formative Evaluation

Compton and Galaway [1994] state that formative evaluation is the study of the treatment programme process. Formative evaluation provides information that helps the evaluator shape, build, form and transform a treatment programme. Thus, formative evaluation allows for constant accurate checking of an implemented treatment programme. Formative evaluation is an important aspect of programme evaluation. Without it, there is no evidence that the intervention programme has been effectively implemented. A more thorough formative evaluation of the situation will provide reasons why a treatment programme has not been implemented correctly. Reasons for this often include inadequate training in the particular therapy, unclear boundaries within which

the organisational staff should work, inappropriate staffing, or unexpected structural barriers such as space deficiency or organisational bureaucracy.

Formative evaluation typically involves gathering information during the early stages of a research project. The focus is on finding out whether a treatment programme is being implemented as planned. In the process, formative evaluation uncovers obstacles to effective implementation. It also identifies mid-course adjustments and corrections required, to ensure the success of the treatment programme. Rutherford, M. Banta-Green, C [1998] and Bloom, Fischer and Orme [1995] have noted that programme administrators and staff in particular, but also the target of the study, benefit from formative evaluation in the following ways:

- ➔ The data can be used to make decisions about continuing or changing certain aspects of the treatment programme or services, offered by the agency;
- ➔ Programme evaluators can document whether services meet acceptable standards;
- ➔ Potential funders can be shown whether that money is being spent appropriately;
- ➔ Those referring clients to the organisation are afforded the opportunity to understand the treatment programme and its successes.

Formative evaluation is viewed as a structured manner in which to provide additional feedback to the professionals implementing the treatment programme. In so doing, the treatment programme is fine-tuned. Some information may also be reported in a summative evaluation of the treatment programme. As Bloom, Fischer and Orme [1995] note, some treatment programme evaluation projects evolve continuously, never reaching completion.

Posavac and Carey [1997] note that formative evaluation activities may be extended throughout the life of a treatment programme in order to help guide the treatment programme's evolution.

3.1.4 Summative Evaluation

Compton and Galaway [1994] state that summative evaluation is the study of treatment programme effectiveness or ineffectiveness. It is often referred to as 'outcome studies'. According to Yates [1996] summative evaluation is generally produced for policy makers, funding sources or potential adopters of the treatment programme, and is aimed at delineating clearly the benefits of the treatment programme. Posavac and Carey [1997] combine both explanations of the term by stating that summative evaluation involves the preparation of a formal report outlining the impact of the treatment programme. The report, often referred to as the programme evaluation report, will typically detail who participated in the treatment programme, what activities they participated in and what gains or improvements resulted from their participation. The evaluation report will include details regarding what prerequisites or conditions are essential or helpful to the enhancement or replication of the treatment programme.

There is no crisp dividing line between formative evaluation and summative evaluation. Much of the information gathered during formative evaluation activities may be reported in formal summative reports. Normally the summative evaluation report is a 'showcase' for outcomes associated with the treatment programme [Posavac and Carey 1997].

Rutherford and Banta-Green [1998], De Vos [1998], Strydom [1998] Compton and Galaway [1994] and Wolfe and Miller [1998] all place emphasis on the activity of planning before evaluation. Information must be gathered before treatment programme evaluation can start. This is done so that the researcher can determine what changes have occurred once the treatment programme has been initiated. For both formative and summative evaluation, measurement and data collection tools and data management systems must be part of the basic foundational planning of the project. Wolfe and Miller [1998] note that building and implementing a strong evaluation plan starts with outlining a logic model or causal map of the project.

The value of spending time at the beginning of any research project developing a strong evaluation plan cannot be too strongly emphasised. As Perkinson [1997] notes, the plans and measurement strategies are always rewarded later with useful critique or comments, thereby increasing the chances of research success. Beginning with a well-developed plan and measurement model, will also allow for thorough, convincing evidence of how treatment programme successes are achieved, and how these successes might be continued or replicated.

3.1.5 Programme Evaluation Research

Peveler [1999] and Hubbard [1996] agree that rehabilitation treatment does work. They both studied the results of the major studies completed in the United States such as Drug Abuse Reporting Programme, Drug Abuse and Treatment Outcome Study and the Treatment Outcome Prospective Study.

The aforementioned studies were commissioned by the National Institute on Drug Abuse. The National Treatment Outcomes Research Study conducted in the United Kingdom also came to the conclusion that substance abuse treatment does work for many individuals [Gossop, Marsden and Stewart: 2001].

Treatment programme evaluation is often focused on the design of the treatment programme, i.e. the way in which the research was implemented. When treatment objectives are achieved, substance abuse treatment becomes cost effective. This cost aspect is balanced against the addict's behaviour before entering a treatment programme such as labour productivity, health and welfare costs as well as costs arising from criminal activities and the resulting criminal justice responses. However, to facilitate funders or the government making decisions about policies and funding, they need to have at their disposal a recent evaluation report. This perspective is internationally recognised. There are three levels of substance abuse treatment programme evaluations that need to be considered:-

- ➜ Treatment outcome evaluations which focus on the effectiveness of different treatment models and approaches;
- ➜ Treatment programme evaluations which are concerned with accountability and the promotion of informed choices;
- ➜ Patient evaluations that are aimed at tracking a patient's progress throughout the treatment programme.

[Gossop, Marsden and Stewart: 2001]

Wolfe and Miller [1998] mention the various levels at which programme evaluation information should be gathered. They refer to scientific terms such as effort, outcome, performance and efficacy, which they have transcribed into volume, reach, effect and value. They see these components as being important to investigate with regards to an existing treatment programme. From their perspective, volume relates to how much service activity is generated in terms of staff hours required, clients interviewed etc. Reach refers to how well the programme met the needs of the organisation or community. Effect implies the impact that the programme has on the respondents. Value refers to how much effect is generated from the cost of the programme. These components should be considered before planning the evaluation study, in an effort to generate research questions [Wolfe and Miller: 1998].

3.1.6 Treatment Outcome Evaluations

Treatment outcome evaluations are conducted in order to inform the practitioners and the policy makers about the efficacy of the various treatment models and treatment programme elements. From the National Treatment Outcomes Research Study in the United Kingdom, the Drug Abuse Treatment Outcome Study, and the Drug Abuse Reporting Treatment Programme studies, it is evident that rehabilitation treatment does work. This view is supported by Peveler [1999] who says that the findings of these studies cannot be generalised. He argues that most research was focused on narrow population groups or were limited to one drug. In addition, one has to keep in mind that not every addict treated will benefit from treatment, nor will any treatment approach work well with every addict.

Treatment outcome evaluations inform practitioners and decision-makers about the efficacy of the treatment programme. In general, findings from previous evaluations have indicated that substance abuse treatment does work for a significant number of clients. [Fiorentine, Nakashima, and Anglin 1999, Fiorentine and Hillhouse 1999]. However, it cannot be concluded that all treatment approaches work equally well for all individuals. It is also not true that every client experiencing drug dependency will derive benefit from treatment. Fiorentine and Hillhouse [1999] note that many of the treatment effectiveness studies to date have focused on narrow population groups, usually heroin dependent males. Babbie [1995] and Peveler [1999] point out that it cannot necessarily be generalised that similar programmes would be equally effective for women, adolescents, or other special population groups. Many studies have also been limited to one type of substance abuse, such as heroin or alcohol.

Hubbard [1992] and Singer [1992] have both alluded to a few key points about treatment effectiveness. The researcher has noted the comparisons and listed them below:-

- ➜ Overall, treatment is effective, and the benefits outweigh the costs;
- ➜ The more time spent in treatment, the better the treatment outcome;
- ➜ Clients who are legally coerced or legally mandated to participate in treatment, do as well or better than those who seek treatment of their own volition;
- ➜ The frequency of both drug use and criminal behaviour, has shown a decrease during treatment;
- ➜ Clients whose values and behaviour are more consistent with the majority of society, have more favourable treatment outcomes;

- ➔ Clients with severe psychopathology or with histories of extensive criminal activity, tend to have poorer treatment outcomes;
- ➔ Treatment effectiveness varies within modalities and among programmes because of differences in staff, clinical competence, and experience.

3.1.7 The Efficacy of Rehabilitation Treatment

The term 'success' in any treatment programme has always been fraught with difficulties. The reason for this is that the term is in essence arbitrary. One institution's idea of success is not another's. Each institution has a paradigm concerning success or efficacy, which is influenced by the community, culture, socio-economic and political make up of the organisation. Traditionally success was viewed as total abstinence, but during the last decade, this traditional view of success has changed. McCaffrey [1996], notes that although abstinence appears to be the ideal goal of out-patient drug-free treatment programmes, reduced drug use is commonly viewed as a more realistic goal. McCaffrey further states that reduced drugging is becoming an acceptable sign of treatment efficacy. In an out-patient treatment centre, the clinical measures of effectiveness are particularly difficult to discern. This is due to the enormous diversity within the modality, and the relative scarcity of available outcome studies. Like the other major treatment modalities, out-patient drug-free programmes also appear to focus on client's drug use when assessing treatment effectiveness.

New paradigms that are emerging from the United States, Australia and the United Kingdom adopt a client-centred approach to the term success. Success is no longer judged in terms of client abstinence, but rather in terms of client

participation in the treatment programme [Zickler: 1997, Del Rio and Mino: 1997]. There is strong evidence to support the growing idea that the longer the client remains in treatment, the greater the abstinence rate [Hubbard: 1996, Rutherford and Banta-Green: 1998, Fiorentine and Hillhouse: 1999]. In addition, this paradigm allows the client to take responsibility for his or her own rehabilitation. Abstinence is the goal, but duration of treatment participation is the measure by which goal attainment can be judged.

Fiorentine and Hillhouse [1999], Hubbard [1996], Rutherford and Banta-Green [1998], Farabee, Prendergast and Anglin [1998] note that an empirical disjuncture remains in research about the effectiveness of drug treatment. Based on the findings of several large American studies such as the Drug Abuse Reporting Programme, the Drug Abuse and Treatment Outcome Study and the Treatment Outcome Prospective Study as well as the National Treatment Outcomes Research Study conducted in the United Kingdom, it is evident that substance abuse treatment does work for many individuals. Simpson [1984] agrees with the results of these studies. He states furthermore that they have shown that drug rehabilitation treatment is effective when measured in terms of the following: firstly, a reduction in substance misuse; secondly, by an improvement in personal health and social functioning; and lastly by a reduction in public health and safety risks.

As Anglin and Hser [1992], Gerstein and Harwood [1990], Fiorentine and Hillhouse [1999], note, there are however specific components associated with effective treatment that are not well understood. It appears that treatment

seems to be effective for many individuals, but it is not clearly understood why one treatment programme works for one client and not for another. Hubbard [1996], Vito and Tewksbury [1998] note that the more successful treatment programmes are characterised by the following:

- ➜ Adequate funding;
- ➜ Flexible policies;
- ➜ Personalised care;
- ➜ Long-term versus short-term duration.

Rutherford and Banta-Green [1998] note that the effectiveness of treatment programmes can be assessed by measuring changes in variables which are critical in the development and maintenance of substance misuse problems, specifically in adolescents. The most important are that of school performance and emotional distress. It is also noted by Hubbard [1996], as well as Vito and Tewksbury [1998] that by increasing the opportunity for group and individual counselling, the frequency of counselling incidence is increased. This in turn leads to improved treatment outcomes.

The Office of the American National Drug Control Policy [1990] note that treatment is deemed effective when, three to five years after treatment, the addict is still not using drugs. The researcher feels that outcome evaluation should not be seen as an either / or situation - treatment programme outcomes should not be seen as either a complete success or a complete failure. Strydom [1998] notes that most treatment programmes have degrees of success, and that it is unlikely that a treatment programme will be able to accomplish all the

treatment goals of every client. One should rather examine treatment programmes on a sliding scale from low to high success rates.

3.1.8 The Evaluation Process

De Vos [1998] discusses the evaluation process and refers to McKendrick's [1989] model. McKendrick offers a variety of objectives that need not all be followed when evaluating a given programme:

- ➜ Stakeholders need to be consulted;
- ➜ Clarity is required about who the users of the findings will be;
- ➜ Support should be obtained from all concerned;
- ➜ All stakeholders should have the opportunity to participate in the defining of objectives;
- ➜ The management information system chosen need to be both practical and affordable. This system should allow the researcher to capture and analyse data and findings.

It is very important to identify the outcome of the intervention as well as the cost of that intervention. The outcomes must be measurable, non-ambiguous, and practical.

3.1.9 Out-Patient Treatment

Hubbard [1996] looked at the large American studies i.e. Drug Abuse Reporting Programme and Drug Abuse and Treatment Outcome Study, and found that out-patient treatment programmes had the poorest retention rates. 41% of clients dropped out within the first four weeks, and only 18% eventually completed treatment. The exact percentage of respondents abstinent on

completion of the study per treatment mode, was not mentioned in the study. Rutherford and Banta-Green [1998] note that out-patient treatment is one of the least restrictive forms of treatment, and is utilised extensively in treating adolescents with substance use problems. Fisher and Harrison [2000] note that out-patient treatment services allow adolescents to remain in their communities, thus providing them with immediate opportunities to practice the skills or behavioural changes acquired during treatment. Rutherford and Banta-Green [1998] Fisher and Harrison [2000] therefore appear to disagree with the outcomes presented by Hubbard [1996] in that they view out-patient treatment as a very viable component of the substance dependency treatment arena.

In some cases, an in-patient or detoxification treatment programme may precede out-patient treatment. The decision as to whether a client receives out-patient versus in-patient treatment, is largely dependent on two factors. The first of these is the client. In order for a client to effectively rehabilitate to a level acceptable to themself, they need to take responsibility for their personal recovery. Therefore, it is very important to consider the client's motivation when deciding on whether in-patient or out-patient care would be most appropriate. The second factor to keep in mind is how the type or types of drugs used by the client will play a role in the rehabilitation. Certain drugs are physically addictive, and require a medical withdrawal process [McNeece and DiNitto 1994].

Rutherford and Banta-Green [1998] point out that there is considerable variation within out-patient programmes, but that they share some common elements, namely:

- ➜ Out-patient treatment can be one of many modalities, e.g. AA based, cognitive-behavioural, supportive, insight oriented, family therapy or a combination of therapies;
- ➜ Out-patient treatment currently has no standard recommended length. This is possibly because the length of treatment depends on the level of problem severity, referral and funding source;
- ➜ The intensity of out-patient treatment varies. Some out-patient treatment, e.g. day hospitals, may meet five days a week, while other treatment centres may only meet once a week;
- ➜ Relapse prevention is stressed;
- ➜ Involvement in community self-help groups, during and after treatment, is typically encouraged.

3.3.9.1 Content of Out-patient Treatment Programmes

From studies completed by Mueller and Wyman [1997], McCaffrey [1996], Barbara [1996], Rutherford and Banta-Green [1998] and the National Institute for Drug Abuse [1994] it was found that out-patient drug-free treatment includes a range of treatment options, from psychotherapy to informal peer discussions. The counselling services offered varied considerably, but they generally included individual, group and family counselling. Most had peer group support; offered vocational, marital and cognitive therapy; and ran didactic groups offering the client insight regarding his or her drugging behaviour. Often support structures included sporadic vocational counselling, recovery training and relapse prevention strategies. Aftercare services were considered necessary in order to prevent relapse and typically consisted of 12-step meetings held on site, or at satellite venues.

According to a 1996 study commissioned by Substance Abuse and Mental Health Services Administration [SAMHSA] as referred to by Marsden [1998] about 87% of clients in in-patient speciality facilities received care in out-patient programmes before admission to an in-patient facility. Currently in the Western Cape, there is only one out-patient treatment centre, namely the CTDCC. There are a few out-patient-counselling centres, but the remainder are in-patient treatment centres that might have an out-patient component attached to the programme.

3.1.9.2 Funding

According to a study conducted by Marsden [1998] poor funding led to poor treatment. Marsden based his findings on a study done by D'Aunno and Price [1985] in which the researchers examined the development of out-patient drug abuse treatment services within the community mental health system. D'Aunno and Price in Marsden [1998] looked at changes in staffing patterns and argued that changes in funding affected the type of staff hired. Increased funding thus led to the employment of more professionals, whereas professional retrenchments resulted from decreased funding. They also noted a positive causal link between reductions in professional staff with a resultant change in treatment goal setting, and decreased treatment outcomes.

3.1.9.3 Treatment Efficacy Determination

Evaluating drug abuse treatment effectiveness begins with an understanding of a number of other factors related to the drug treatment modality or programme itself. These include knowing the array of social, medical, and other services

needed and available to the drug user; understanding the extent of drug use in a community; as well as the nature and progression of drug addiction [McCaffrey: 1996].

The American National Institute for Drug Abuse [1994] commissioned a study to determine drug abuse treatment efficacy. The study noted that in addition to drug use cessation, the goal of treatment was to return the client to productive functioning within the family, workplace, and community. Measures of effectiveness typically included levels of criminal behaviour, family functioning, employability, and medical condition. According to a study by Leshner [1999], drug treatment reduces drug use by 40% to 60% and significantly decreases criminal activity during and after treatment. Individual treatment outcomes depended on: the extent and nature of the client's presenting problems; the appropriateness of the treatment components; related services used to address the problems; and the degree of active engagement of the client in the treatment process.

Various studies including Del Rio and Mino [1997], Hubbard [1997], Fiorentine and Hillhouse [1999], Mueller and Wyman [1997] and Campbell, Gabrielli, Laster and Liskow [1997] have put forward certain outcome variables that point to treatment efficacy. These include:

→ The duration of treatment was the most powerful and consistent predictor of treatment outcomes. The longer the participation in treatment, the greater the opportunity for improved outcomes. Engagement in treatment was measured as the product of the average number of weekly group and

individual counselling sessions in which the client participated. Campbell, Gabrielli, Laster and Liskow [1997] noted that the average client attended treatment three times per week, and that treatment duration of approximately three months had the best effect;

- → Reduced drugging was the secondary outcome variable. Substance dependency treatment was effective when measured by a reduction in substance misuse;
- → Improvement in personal health and social functioning and a reduction in public health and safety risks. By addressing these variables, the incidence of substance abuse was reduced;
- → The reduction of drug related criminal behaviour, including drug dealing, shoplifting, theft and breaking and entering. These crimes were chosen based on their overall frequency of occurrence.

In an unpublished World Wide Web report titled 'Addiction Treatment Successes' which was posted by the National Association of Alcoholism and Drug Abuse Counsellors [NAADAC] and delivered at the house of Government Reform and Oversight Committee's subcommittee on national Security, held on June 5, 1998, the following statistics were mentioned:

- → Fewer than 50% of sufferers from insulin dependent diabetes are compliant with their medication regime;
- → Fewer than 30% are compliant with diets and food care regimes;
- → Fewer than 30% of people suffering from hypertension and adult asthma are compliant with medication regimes.

Schildhaus [1994] notes that, like people with diabetes or heart disease, clients in treatment for drug addiction learn behavioural changes and often take medications as part of their treatment regimen. When comparing the average of 40% to 60% efficacy rate in terms of abstinence as mentioned by Leshner

[1999] with the figures mentioned by NAADAC [1998] it appears that drug abuse treatment is as effective as the treatment for other major illnesses.

According to Fiorentine and Hillhouse [1999] the more successful treatment programmes are characterised by adequate funding, flexible policies and personal care. Through treatment that is tailored to the needs of the individual, clients can learn to control their condition and live normal, productive lives. In 1998, the National Institute for Drug Abuse implemented the National Drug Abuse Treatment System Survey. This study focused on the differences between out-patient methadone treatment facilities, and out-patient non-methadone treatment facilities. Findings indicated that out-patient drug-free programmes had an average of nine staff members, compared with 13 in methadone maintenance programmes. Out-patient treatment programmes were also noted as having more staff members with advanced academic degrees and with drug abuse treatment certification or training, than methadone maintenance programmes. The study also showed that out-patient drug-free programmes employed less recovering addicts, and were more likely to employ psychologists and social workers.

3.1.9.4 Treatment Duration

Gerstein and Harwood [1990] and Tims et al. [1991] in Farabee, Leukefeld and Hays [1998] note that the longer a client stays in treatment the better the prognosis for recovery. Gossop, Marsden and Stewart [2001] completed a five-year study in the United Kingdom based on the National Treatment Outcome Research Study, and concur with the findings of the American national studies.

Drug-abuse treatment outcomes have been examined in large treatment follow-up studies which include the Drug Abuse Reporting Programme, the Treatment Outcome Prospective Study, and the Drug Abuse Treatment Outcome Study. These studies found that outcomes are consistently better for those clients that remain in a treatment programme longer

In a study assessing drug abuse treatment Ball et al [1988] in Farabee, Leukefeld and Hays [1998] reported that more than 80% of clients who voluntarily terminated methadone treatment, relapsed within 12 months. In an unpublished World Wide Web article on treatment efficacy commissioned by National Institute for Drug Abuse [1998] findings showed that clients progressed through drug addiction treatment at various speeds, therefore there was no predetermined length of treatment. However, research has shown unequivocally that good outcomes are contingent on longer periods of treatment. The National Institute for Drug Abuse [1998] found that in general, participation for less than 90 days in either in-patient or out-patient treatment, was of limited or no effectiveness, and that many clients who entered treatment dropped out before receiving all the benefits that the treatment could provide. The National Institute for Drug Abuse [1998] also noted that successful outcomes may require more than one treatment experience. Many addicted individuals were reported as having multiple episodes of treatment, with an average of three, often with a cumulative impact.

3.1.10 Summary

Current literature notes that regular programme evaluations are preferred and that all service providers should evaluate their treatment programmes for the reasons that have been mentioned thus far. All available research indicates that treatment is effective and that success is measured either in abstinence, harm reduction or, in line with new thought, duration of patient participation in a given treatment programme. Formative and summative evaluations are often combined into an evaluation report. From research it appears that most clients in in-patient treatment, had moved there from an out-patient treatment programme.

Literature on programme evaluation at drug rehabilitation centres in South Africa is virtually non-existent. Most treatment centres throughout South Africa will keep demographic details for their internal needs. Other centres complete state required performance related statistics, thus enabling the state to determine funding levels. Very few centres conduct any form of follow-up procedure and even fewer evaluate their treatment programme. This is problematic as a treatment centre can then never be sure of whether their treatment has any beneficial impact on the client, even when the centre might have a high rate of client turn over.

3.2 Voluntary Termination from Treatment

3.2.1 Introduction

The reason why many clients do not continue with treatment could be related to the programme not addressing the client's needs adequately. This section of

the literature review will elucidate reasons why clients voluntarily terminate from treatment.

If a client's needs are not being met, the solution could lie in a more extensive needs analysis. This procedure could possibly form part of the assessment interview. This area of assessment will be looked at later. In South Africa there is virtually no research on the reasons for clients not completing a treatment programme. The only study of which the researcher is aware, was conducted by Rogers in 1990. It investigated the drop out rates at the CTDCC. It is ironic that 10 years later, the CTDCC is once again the treatment centre at the forefront of programme evaluation in the Western Cape.

3.2.2 Voluntary Termination

Internationally research abounds in the field of programme evaluation. The reason for this is two fold. Firstly, as mentioned by De Vos [1998] and Strydom [1998] there is a paradigm shift amongst practitioners towards research. This shift appears to be attributable to the emergence of accountability, which in return appears to stem from a need to promote cost effective service delivery. The notion of the practitioner-researcher has been on the increase in recent years and is particularly noticeable in the field of social work [Strydom: 1998]. Posavac and Carey [1997] note that programme evaluation has only become formalised over the last 30 years.

De Vos [1998] notes that since 1981 there has been a growing trend in most authoritative textbooks towards the inclusion of a chapter dedicated to research

as a mechanism of evaluation. Drug abuse has historically been seen as a side issue. Most adults, as noted by Levinthal [1996], hold the view that drug abuse is something that is confined to other people's children, or to people from poor socio-economic backgrounds. Included in this mindset is the idea that people who are addicted to drugs are bad people, and that they are somehow responsible for their own situation. According to Leshner [1998], three decades of scientific research and clinical practice, has yielded a variety of effective approaches to drug addiction treatment. Addiction treatment is as effective as are treatments for most other similarly chronic medical conditions. In spite of scientific evidence that establishes the effectiveness of drug abuse treatment, many people still believe that treatment is ineffective. In part this is because of unrealistic expectations. Many people equate addiction with simply using drugs and therefore expect that addiction should be cured quickly. If it is not, treatment is perceived as having failed. In reality, because addiction is a chronic disorder, the ultimate goal of long-term abstinence often requires sustained and repeated treatment episodes. Following from Leshner, it is evident that one's poor character has nothing to do with addiction or treatment efficacy.

Searle [1989] notes that there has been a great deal of research in the last decade aimed at dispelling these misconceptions of the 'user', 'abuser' or 'addict'. Recent research on the genetic component to addiction, done by the National Institute for Drugs and Alcohol [1998] shows that 60% of addicts have a genetic predisposition to addiction, based on family history. McLennan [1998] looked at societal impressions of addicts, and equated the addict with people who had a chronic illness. He showed that addicts actually performed better

with regards to compliance with a medication regime and professional management of their recovery. This view is supported by the National Association of Alcoholism and drug abuse counsellors [1998] and Schildhaus [1994].

The issue of voluntary termination is very complex. To some extent, the drug of choice influences voluntary termination as observed by Del Rio and Mino [1997] in a study of treatment outcomes. They stated that the risk of voluntary termination was significantly higher for clients who had been using opioids specifically heroin. In a study by Mueller and Wyman [1997] it was found that the risk of voluntary termination was more than doubled for clients who had been using Opiates regularly for less than 7 years. Mueller and Wyman also noted that programmes with low retention rates tended to have the clients with the most problems, particularly antisocial personality disorder, cocaine addiction, or alcohol dependence. Therefore, drug of choice cannot be solely identified as the key to voluntary termination.

Del Rio and Mino [1997] also noted that in their study, clients with a long history of drug usage but with a stable income, were more likely to remain in treatment than clients that had a long history of abuse with no stable income. Clients who lacked regular income at assessment, were three times more likely to voluntarily terminate than clients who had a stable income. The study also showed that the availability of stable income increased client retention in the programme. Therefore, employment is a factor in enhancing treatment success. In the Del

Rio and Mino study, the overall incidence of voluntary termination was 15.2 per 100 persons.

There are many variables which influence voluntary termination. The researcher has grouped these variables into two categories, namely internal and external motivation.

3.2.3 Client Motivation

Drug use is fraught with difficulties. The negative effects could include illnesses, withdrawal effects, financial burdens, threat of legal problems, and possible death. At the same time, use of drugs may produce pleasurable effects and relief from anxiety, stress, depression, or boredom. Discontinuing the use of some substances can result in painful physical and psychological withdrawal symptoms. Farabee, Prendergast and Anglin [1998] note that many substance abusers have developed networks of friends among other chemically dependent persons. They may have replaced persons from their support system who would encourage them to recover, with persons who motivate or support continued use. Therefore, there is often ambivalence on the part of chemically dependent persons, about discontinuing their substance abuse.

3.2.4 Objective Reasons For Voluntary Termination

Hartjen, Mitchell, and Washburne [1981], Platt, Buhringer, Kaplan, Brown, and Taube [1988] and Rosenthal [1988] in Farabee, Prendergast and Anglin [1998] have argued that little benefit can be derived when a drug user is forced into treatment by the criminal justice system. Some of the researchers oppose

coerced treatment on philosophical or constitutional grounds, while others argue against coerced treatment on clinical grounds. Those that argued from the clinical platform maintain that treatment can only be effective if the client is truly motivated to change. According to coerced treatment antagonists, it is a poor investment to devote resources to clients who are unlikely to change because they have little or no motivation to change. In a study by Schottenfeld [1989] in Farabee, Prendergast and Anglin[1998] involuntary clients displayed a higher tendency to claim that their substance use was purely recreational, and that it posed no problem in their lives.

Other researchers including Anglin and Maugh [1992] and Salmon and Salmon [1983] in Farabee, Prendergast and Anglin [1998] argue that very few chronic addicts will voluntarily enter and remain in treatment. They point out that without some external motivation - and legal coercion was as justified as any other form of coercion - many clients will not seek treatment. The terminology used when discussing "coerced treatment" is far from consistent: "coerced," "compulsory," "mandated," "involuntary," "legal pressure," and "criminal justice referral" are all used in the literature. Coercion is not a single well-defined entity and it appears as if consensus about external motivation leading to a clients admission, is not clear.

Farabee, Prendergast and Anglin [1998] reviewed 11 published studies involving the relationship between various levels of legal pressure and substance abuse treatment. Of these, five found a positive relationship between criminal justice referral and treatment outcomes, four reported no difference,

and two studies reported a negative relationship. In addition, the study found that legally referred clients entered treatment earlier in their addiction career than would otherwise have been the case, and that they stayed in treatment longer.

3.2.5 Subjective Reasons For Voluntary Termination

In order to understand the reasons why clients voluntarily terminate from treatment, it is important to understand why the client presents for treatment. The researcher has identified the two primary motivators for presentation, namely external and internal motivational factors. Looney and Metcalf [1974] in a study by Rogers [1990] note the relationship between the two motivational categories. They note that drug addiction depletes the social, physical and mental reserves of the client, thereby pushing them into treatment. They refer to this depleted state as the "fatigue factor" and note that it promotes treatment and enables the client to verbalise any internal motivations for seeking treatment.

The 'fatigue factor' stage is however relatively short-lived, and as soon as the clients have restored their strength, they tend to voluntarily terminate from whatever treatment programme they are attending. Aguilera and Messick [1982] in Rogers [1990] support the 'fatigue factor' view by pointing out that people in crisis have lowered defence mechanisms as their coping methods are impaired. Once the client re-experiences familiar patterns of coping, they begin to feel healthier and then tend to voluntarily terminate from treatment.

Some clients will present for treatment as a means of managing a legal proceeding resulting from their drugging. Rogers [1990] notes that legal motivators form part of the external motivating factors. This view is substantiated by Benarie [1986] and Allen [1987]. In a seven-year study conducted by Benarie [1986], it was noted that clients with external legal pressure showed positive signs of rehabilitation or abstinence. Benarie's research indicated that approximately 50% [n=?] of coerced legal referrals benefited from treatment. Problems with the study included not knowing the sample size or exactly what treatment model was applied, and the fact that one quarter of all subjects were untraceable. These problems did not however detract from the fact that clients presenting with external legal factors as motivators, benefited from rehabilitation.

In a study conducted by Allen [1987] findings show that internal motivational pressures are not sufficient to ensure completion of a treatment programme. Allen analysed archival data from a community-based rehabilitation agency. He took a sample of 121 attendees and found that coerced or externally motivated referrals attended the treatment programme 50% longer than self-referrals or internally motivated clients.

External motivation in the form of family pressure is also important in determining the client's reason for presentation. Family support structures are often flexible when dealing with addiction. Mellody [1989] notes that boundaries or symbolic fences are constructs of socialisation and generally derive from the family. A family unit's boundary system will determine how much or how little

external pressure will be applied before the client presents for treatment. Families may collude with the client in a subconscious sabotage process that undermines the treatment programme, as well as increases the client's risk of recidivism.

Ketcham and Gustafson [1989] point to specific and identifiable survival roles adopted by the family unit in order to prevent full participation in a treatment programme. The survival roles are listed as hero, lost child and mascot. A similar model has emerged over the past decade indicating the roles of rescuer, persecutor and victim. In this triad model which Steiner [1984] refers to as the Karpman Triangle, the family is unaware of the negative effects of their enabling behaviour. Through the elucidation of the behaviour the mechanics of the model are deconstructed, thereby enhancing effective treatment.

In an effort to show that family pressure effected voluntary termination, Hill [1987] in Rogers [1990] compared a randomly sampled group of clients who presented for marriage guidance, some of which had withdrawn voluntarily and some who had not. His findings were that minimal family pressure increased the rate of non-attendance. Stanton and Todd [1982], Perkinson [1997] and Ketcham [1989] place emphasis on the inclusion of a family therapy component to the treatment programme.

The prevailing belief is that a combination of internal and external pressure factors should be applied to any client in order to maintain attendance in a treatment programme. Drug abuse or dependence promotes the crisis of

physical and emotional exhaustion, which in turn leads to internal pressure for treatment. Perkinson [1997] feels that external family or judicial pressures should sustain the internal crisis. The absence of either factor increases recidivism or voluntary termination.

According to Miller and Rollnick [1991], a client entering treatment before recognising that substance abuse is problematic for him or her, is unlikely to be open to therapeutic intervention. In the early stages of awareness a client is most likely to benefit from non-directive feedback and information, to help raise awareness of the problem. Direct challenges to the client will be perceived as aversive, and will typically disrupt the therapeutic progress. Over time, resistant clients tend to shift between acknowledging and denying that they have a substance dependency problem. Direct challenges by a counsellor may only serve to shift the client's perception back to denial.

3.2.6 Summary

According to Rollnick and Miller [1991] both objective and subjective motivation play important roles in the treatment process and relapse. Failure to address both types of motivation as complimentary, results in inferior treatment participation and less favourable outcomes.

Recovery from drug abuse is an interactional phenomenon involving the client treatment and non-treatment components. Client factors include both external and internal pressure. Leukefeld and Tims [1988] in Farabee, Prendergast and Anglin [1998] have suggested that non-treatment components include the

client's social climate, as well as the treatment process itself. Perkinson [1997] notes that external factors including legal pressures cannot solely maintain a stable recovery. Internal factors in the form of self-motivation and commitment must be present to aid in the recovery process. The role of external pressure from this point of view is to influence a person to enter treatment. Treatment programmes that facilitate interpersonal, vocational, and economic gains and maintain pressures to remain engaged in treatment, are likely to be more effective. Nurco, Hanlon and Kinlock [1990] in Leukefeld and Schuster [1998] point out that besides the efforts of staff to motivate clients to remain in treatment, programmes can also invite family members to encourage clients.

3.2.7 Demographics

Hill [1987], Gibson [1986], Baekeland, and Lundwall [1975] in Rogers [1990] note in overwhelming unison that demographic factors in isolation do not lead to voluntary termination from treatment. The area within which the client resided was of no significant value, as voluntary termination was prevalent in all areas. Gender or population group were similarly non-conclusive when seen in isolation. Based on the findings of Hill [1987], Gibson [1986], Baekeland, and Lundwall [1975] in Rogers [1990] it appears that the notion of 'drugs do not discriminate' is correct.

3.2.7.1 Gender Variations

Gender is a specific area of focus in most studies. Mueller and Wyman [1997] looked at trends in American drug abuse treatment using data from the national studies Treatment Outcome Prospective Study and Drug Abuse Treatment

Outcomes Study. Accumulated across both studies the average gender divergence was 30% female and 70% male. In South Africa one of the largest epidemiological studies currently underway is the South African Community Epidemiology Network on Drug Use [SACENDU] project. Data from the January to June 2000 edition - with a focus on the Cape Town area - noted that 20% females and 80% males sought treatment for alcohol or other drug dependency in the first half of the year 2000.

In a study conducted by Simpson and Savage [1980] the efficacy of treatment by gender was investigated. They used existing data from the Drug Abuse Reporting Programme, and conducted a four-year follow-up study which showed little deviation between gender. However overall outcomes were more favourable for females.

In the research conducted by Baekeland and Lundwall [1975] quoted in Rogers [1990], more females voluntarily terminated from treatment than did males. According to Hill [1987] in Rogers [1990] on the other hand, voluntary termination in terms of gender differentials in a marriage guidance setting was found to be minimal. One possible explanation could be related to the stigma associated with substance abuse. Ihsan [1980] and Walker et al [1991] note that while intoxicated behaviour is condoned in males, the same behaviour in females is deemed deviant and threatening. Females that abuse drugs are more readily stigmatised than males. This statement is born out by research from the fields of mental health and medicine that has recently generated a body of research investigating alcoholism in females [Ihsan: 1980].

Forth-Finegan [1991] notes that research of this kind often creates and promotes myths about female alcoholics. She has identified male specific interview schedules and questionnaires, sexist interpretations of the findings, and male dominated research as reasons for the perpetuation of the myths. Forth-Finegan therefore also states that females are less likely to comply with the internal and external pressures that compel them to enter a treatment programme. Forth-Finegan [1991] notes that 76% of alcoholics in the U.S.A. are male while 24% are female.

3.2.7.2 Socio Economic Status

Baekeland and Lundwall [1975] in Rogers [1990] note that in 16 out of the 18 voluntary termination studies that they investigated, a low socio-economic status as reflected by education levels, income and occupation, had impacted on voluntary termination rates. Socio-economic status should however at best be an indicator when looking at voluntary termination rates. As noted by Gibson [1986] and Rounsaville [1982], drug abuse is prevalent at all levels of society.

3.2.7.3 Age

The issue of age is well documented in almost all the literature consulted. Rocha-Silva [1998] refers to a national study done in South Africa focusing on drug use and related problems in 1998 by the Human Sciences Research Council. The youth aspect of drugs was such a concern, that the body of research was divided into two main categories namely adults and youth. As far back as 1975, van der Burgh [1975] in Rocha-Silva [1998] pointed to concerns about the growth of substance misuse amongst children. Van der Burgh further

noted that statements such as "the drug problem amongst the youth has reached epidemic proportions" have been so frequently uttered, that they have become a virtual truism. The fact is, however, that van der Burgh [1984] in Rocha-Silva [1998] had to reiterate his concerns ten years after the initial call, as nothing had been done to resolve the issue. Van Der Burgh further noted that there is a tendency to misuse, misunderstand or misinterpret drug statistics. Just as the consumer of illegal drugs can be deceived, so can the unprepared consumer of drug abuse information be misled by the data with which they are confronted. Rocha-Silva [1998: 29] notes that South African based drug abuse research has been looking at the youth since the early seventies. One problem to date has been that there is no standardised research sampling procedure or measuring instruments. This has led to complications in identifying national cross-sectional patterns and trends.

Mueller and Wyman [1997], Simpson and Savage [1980], Barbara [1996] all state that the age of onset for drug use is becoming increasingly younger. Parry [2000] notes that the mean age of those first beginning to use drugs was 21.1 in 1997 and 17.7 in 1999. These figures are taken from South African Community Epidemiology Network on Drug Use focusing on Cape Town. This shows a clear 3.4-year drop in the age of onset over the three-year period. According to the United States Department of Justice [1983 in Perkinson [1997] the mean age of onset is 11.9 for boys and 12.7 for girls. According to Baekeland and Lundwall [1975] in Rogers [1990] the category of client that is most likely not to complete a treatment programme is the adolescent category. Drug treatment should therefore be increasingly focused on the youth.

In a study looking at heroin users Del Rio and Mino [1997] reported that older clients were more likely to remain in a treatment programme. This observation is supported by McLellan [1983], Norman [1994], Copeland and Hall [1992]. Del Rio and Mino [1997] who state that age was not associated with retention once the duration of heroin use had been taken into account. This suggests that only the accumulation of a client's drug related experience has any bearing on the probability of the success of drug treatment.

Coupled with the reduction in age of onset there is an increase in adolescents being treated. Karassellos [1997, 1998 and 1999] notes that in 1997 82% of the clients that presented for treatment started drugging before the age of 20 [N=611]. Of this 82%, 13 % began using drugs before age 13. In 1998 87% of the clients that presented for treatment started drugging before the age of 20 [N=719]. In 1999, 91% of the clients that presented for treatment started drugging before the age of 20. Fifty percent of these began using drugs before age 13.

3.2.8 Symptom Level and Duration

In the process of trying to identify the variables responsible for relapse or recidivism, it is important to identify how the period of usage fits into the client's addiction. The amount of time that a client uses drugs will affect different clients in different ways and the financial, biological and social ramifications will differ. Initial or 'recreational users' will not experience the same problems as those experienced by clients that have been abusing, or are addicted to drugs. Mueller and Wyman [1997] note that the majority of clients surveyed by the

Drug Abuse Treatment Outcomes Study [DATOS] reported that it took them an average of 7 years from when they first used their primary drug, to enter a treatment programme. Parry [2000] reports that 29% of users who reported for treatment, had been abusing for a period of 1 to 4 years.

By studying a sample of alcoholics in an alcoholic out-patient setting, Powel [1974] found that those clients that were at the beginning of their addiction process, were more likely to report the problems that they were experiencing as a result of their drinking, than those clients who were at an advanced stage of the 'disease'. A study by Robinson [1982] in Rogers [1990] examined the behavioural relationship between the onset of drugging and voluntary termination. He noted that clients who voluntarily terminated from treatment programmes tended to have used drugs longer than those that had remained in a treatment programme. Powel and Robinson concur that the sooner the client presents for treatment, the better the prognosis.

Rogers [1990] referred to a study conducted by Baekeland and Lundwall [1975] in which it was noted that addicts were in need of speedy symptom relief, and were less tolerant of delays in achieving this goal. Furthermore they were easily frustrated and therefore tended to voluntarily terminate from treatment programmes more frequently. The level of frustration that clients experience is not the only reason for voluntary termination. Anglin and Hser [1992] point out that it is important to note that correspondingly high levels of withdrawal indicators also influence voluntary treatment termination.

3.2.9 Withdrawal Indicators

Many withdrawal indicators result when abstinent from a mood altering substance. Perkinson [1997] notes that except for hallucinogens such as LSD [acid], Phencyclidine [PCP] and inhalants, the prolonged use of drugs will result in the development of tolerance toward the abused substance and degrees of physical dependency. The Diagnostic and Statistical Manual of Mental Disorders IV [1994], while concurring with Perkinson, points out that cannabis does not have any termination side effects.

Perkinson [1997] notes that withdrawal is the process of freeing the brain from the effects of the drug. The Diagnostic and Statistical Manual of Mental Disorders IV [1994] notes that withdrawal is more than a simple process of freeing the brain as noted by Perkinson. Rather, withdrawal is noted as a maladaptive behavioural change that occurs when blood and tissue concentrations of a substance decline. Withdrawal symptoms vary greatly across the different drug classes. Perkinson [1997] further notes that it is very important for the therapist to identify where the client is in their withdrawal process. This is done to effectively facilitate withdrawal alleviation in order to facilitate rehabilitation and to promote programme completion.

3.2.10 Client Treatment Matching

Matching a client to the treatment which would best suit the client's needs, is essential to promote goal attainment, be that abstinence or reduction in use. Leukefeld and Schuster [1998] have identified three reasons why effective client-treatment matching is essential. The first of these is to promote improved

success. When individuals receive the treatment most appropriate for their needs, they are more likely to respond positively, remain in treatment longer, and begin recovery. The second reason would be to promote programme efficiency. As no programme can meet the needs of every individual, client-treatment matching helps to channel clients with specific problems, to the most appropriate programme for them. Finally, client treatment matching promotes financial savings due to the fact that appropriate treatment leads to recovery, and thus money is saved because of lower health care, crime-related and other costs associated with substance abuse.

Client-treatment matching is not an exact science, and it might be necessary to adjust a treatment plan on assessment of scheduled evaluations of the client's progress in treatment, or when a relapse occurs.

3.2.10 Conclusion

The reasons why a client would voluntarily terminate from a treatment programme are varied but there are some common denominators such as age, duration of use, types of drugs used and gender. These, when coupled with the client's motivation and degree of loss, provide an understanding surrounding the complicated process of voluntary termination.

The CTDCC supports the view that addiction is not only an individual illness, but also that of the family. As such the treatment of addiction can be approached from a systems theory paradigm, with external pressure from families or the

judiciary playing an important role in treatment attendance and voluntary termination behaviour.

CHAPTER 4 DATA ANALYSIS

4.1 Introduction

In this chapter the researcher will be examining the data collected over the 18 months of the study, with the view to answering the stated research questions. The study was divided into two phases, with data being collected at various stages during both phases. Phase one was a quantitative phase focusing on information gathered prior to and during assessment. The second phase was primarily qualitative with a small quantitative component. Phase two dealt with the clients' post assessment experience of the treatment programme. Telephonic interview schedules were conducted at six weeks, three months, and six months post assessment by the researcher. The research questions spanned both phases.

The data analysis phase includes data collected at five different time frames. For purposes of the study the researcher had partitioned the time frames into groups.

1 Group One: [G1] relates to measurements of all respondents [380] that were assessed by the CTDCC and that agreed to participate in the study. There were 409 clients assessed, however 29 clients chose not to participate at all.

2 Group Two: [G2] relates to measurements of those respondents that agreed to participate in the qualitative section of the study, which included three telephonic follow-up interview schedules. [G2=230 respondents which amounts to 60% of G1] Groups three, four and five were followed-up from this group.

3 Group Three: [G3] relates to measurements of the respondents that were contacted at the six-week follow-up period [G3=69 respondents]. G3 indicates a 30% follow-up rate.

4 Group Four: [G4] relates to measurement of the respondents that were contacted at the three-month follow-up period [G4=61 respondents]. G4 indicates a 27% follow-up rate.

5 Group Five: [G5] relates to measurements of respondents contacted at the six-month follow-up period [G5=58 respondents]. G5 indicates a 25% follow-up rate.

4.2 Respondent Profile

Before considering the research questions a brief respondent profile will be presented. During the research period 409 clients were assessed at the CTDCC. Twenty-nine [7%] chose not to participate in the research. This left a total sample size of 380 [G1]. Respondents that chose to partake in the quantitative component numbered 150 [37%], while the remaining 230 [56%] [G2] respondents took part in both the qualitative and the quantitative sections of the study.

Unless otherwise stated all the data for the respondent profile was obtained from G1 [n=380]. The mean age of the sample was 23 with the observable range being 11 to 52. The standard deviation was 20. The researcher conducted a Pearson test based on 58 [G5] respondents, looking at the correlation between age and duration of stay in the treatment programme. The correlation was r 0.19291, which indicated no statistical correlation between age of the respondents and the duration of stay in the treatment programme. The majority of the respondents [312: 82%] [G1] were males, with females constituting 18% of the sample [68] [G1]. Gender variations did occur but did not appear to impact heavily on the study.

Generally females remained in the treatment programme 0.65 of a week longer than males. On average females remained in treatment for 4.3 weeks while males remained for 3.4 weeks. The average age of females was 19.25 with an observable range of 15 to 28. For males the average age was 26.28 and the observable range was 14 to 41. Most of the females had been using their presenting drug for between 2 to 5 years, whereas most males had been using their presenting drug for 15 to 20 years. Forty-two [62%] of the 68 female respondents had previously stopped using drugs, and the majority had stopped for between seven and 31 days. Two hundred and twenty-six [72%] of the 312 male respondents had previously stopped using drugs, and the majority had stopped for between one to seven days.

The respondent's language preference reflected the following; 232 [61%] English, 116 [31%] Afrikaans and 31 [8%] Xhosa. Three hundred and nine [81%] had never being married while 41 [11%] were legally married. Of the eight referral sources, families referred the most respondents [105: 27%] to the CTDCC, and the next highest referral source was schools [82: 21%].

When comparing the statistics kept by the CTDCC for the year end 1998 and 1999 with the current research statistics [2000], families as a referral source, was greater in 1998 and 1999 than in the current study. Schools as a referral source however showed a marked increase. In 1998 school referrals accounted for 90 [12%] of the overall client intake. In 1999 school referrals accounted for 44 [7%] of the overall client intake. The referral ratio by schools in the current study, was 82 [21%]. This indicates a rise in school referrals by

just under double when compared to the 1998 figures and two-thirds more than in 1999. There are many possible explanations for the rise in school referrals. It could be attributed to increased usage among learners The negative effects of such usage, coming to the attention of the school authorities, would result in the referral. Another reason could be an increase in and improvement of school prevention programmes. The net result is that the current study shows a big increase in school referrals. It is suggested that more research should be done in this field.

With regards to the respondents' employment status, 141 [37%] were students, 130 [35%] were unemployed, 96 [25%] were employed and 11 [3%] were self-employed. For the purposes of this study the researcher has combined the categories of employed and self employed. The reason for this is that the differences were minimal and would merely complicate the figures without having any major impact on the findings. The researcher notes that if students are combined with the unemployed category, the percentage of respondents who had no income would increase to 271 [72%] of the clients assessed by the CTDCC, during the study period. This becomes important later when the researcher looks at the amount of money the respondents spend on drugs in relation to their income.

Table 4.1 [see below] shows that in the current study, 141 [38%] respondents stated that dagga was their presenting drug, or their drug of choice [DOC]. One hundred and five [28%] stated that mandrax was their DOC and 48 [13%] said that crack cocaine was their DOC.

Table 4.1 Comparison over three years in drug of choice			
Year	1998	1999	2000
Mandrax	60%	42%	28%*
Dagga	25%	25%	38%*
Crack	15%	15%	13%*
Assessed Clients	719	583	409*

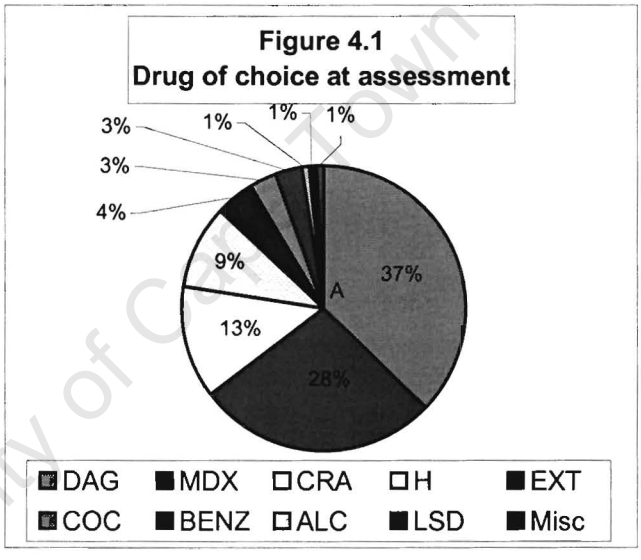
[* Denotes only 9 months of the year 2000]

The above table shows the DOC presentation over three years. It is important to be aware that only speculative comparisons can be drawn from table 4.1 because in 2000 data was collected for only nine months as opposed to 12 months in 1998 and 1999. The purpose of showing the table is to give the reader a visual presentation of what the most used DOC was in the different years and to show changes over the three years. From table 4.1 it appears that crack cocaine has remained relatively stable while dagga as the DOC has increased by 13%. The most interesting observation is in the 35% reduction in mandrax as the DOC since 1998. The researcher speculates that the increase in dagga use is probably tied to the rise in adolescent use borne out by the increase in adolescent admissions to the centre. The 35% decrease in mandrax as the DOC could have three possible explanations. Firstly, the mandrax user might have changed to another drug like crack cocaine or heroin. This is highly probable, as there has been a reduction in the street price of heroin from R300.00 per gram in 1997 to R120.00 per gram in 2000. Crack cocaine has reduced from between R40.00 and R100.00 per gram in 1997 down to between R40.00 and R80.00 per gram in 2000 [Pluddemann: 2000]. If this speculated shift in DOC has occurred, the CTDCC can expect an increase in heroin and crack cocaine abusers in the near future. Secondly, according to Pluddemann [2000] the South African Narcotics Bureau noted that from January to June 2000, 30087 mandrax tablets were seized in the

Cape Town area compared to 15093 tablets seized from July to December 1999. A reduction in the availability of mandrax on the street could have resulted in the reduction of clients presenting for treatment for abusing this drug. Finally it is possible that clients suffering from mandrax addiction could have sought help for the problem elsewhere, and as such there are less mandrax addicts presenting for treatment at the CTDCC. The researcher feels that the most accurate explanation is a combination of all three factors.

Figure 4.1 shows the DOC of respondents at assessment. All assessed clients were asked how long they had been using their DOC. One hundred and three [27%] clients stated that they had been using their DOC for between three and five years prior to assessment. Seventy-seven [20%] stated that they had been using their DOC for between one and two years prior to assessment. The remaining clients stated that they had been using their DOC for time periods that ranged from 'yesterday' or the 24-hour period prior to assessment, to 20 years and more prior to assessment. Mueller and Wyman [1997] note that the majority of clients surveyed by the Drug Abuse Treatment Outcomes Study done in the United States, entered treatment an average of seven years after they first used their primary drug. This correlates with the findings of the present study.

Figure 4.1
Drug of choice at assessment



At assessment all respondents were asked when last they had used their DOC. One hundred and five [8%] of clients stated that they had last used their DOC 'yesterday' or the 24-hour period prior to assessment. Sixty eight [18%] stated that they had last used drugs between one to four weeks prior to assessment. The remaining clients stated that they had last used their DOC for time periods that ranged from three to four days prior to assessment, to four months plus prior to assessment.

All assessed clients were also asked what drug they had first used. Two hundred and eighty [74%] of clients said that dagga was their first drug used, and this was followed by Alcohol at 53 [14%]. The combination of dagga and alcohol as the first drugs used has remained constant over a three-year period 1998, 1999 and 2000. The remaining drugs mentioned by the clients included, *inter alia*, mandrax, benzodiazepines, inhalants, ecstasy. One hundred and sixty-six [43%] clients noted that they had begun using drugs between the ages of 11 and 14, while 154 [41%] began using drugs between the ages of 15 to 18. Three hundred and sixty-five [96%] respondents were under the age of 20 when they began using drugs. Two hundred and fifty-five [67%] noted that they had stopped before. The most noted [n=79 [31%]] stoppage period was in excess of four months.

From the above it appears that a typical respondent would be an English speaking male student referred to the CTDCC by his family. He would be about 20 years of age and would be using dagga. He would have been using dagga for about three to five years having, tried to stop at least once during

this period. He would have begun using drugs around the ages of 11 to 14 and would have last used his drug of choice 24 hours prior to assessment at the CTDCC.

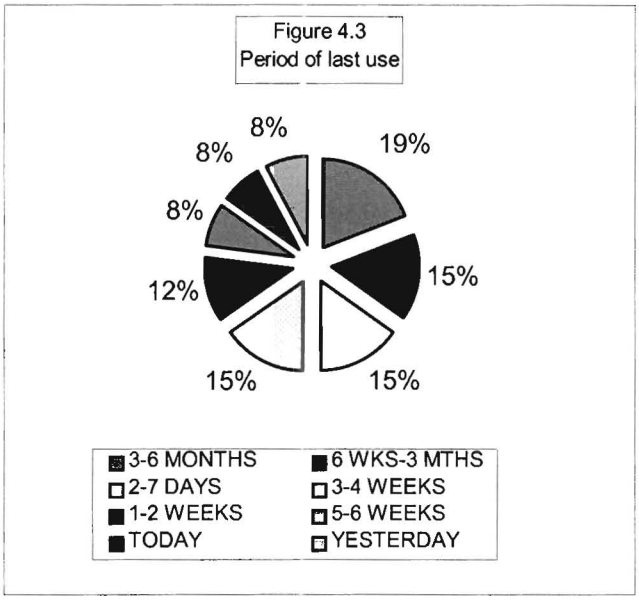
4.3 Comparative Abstinence Rates For Respondents Having Completed the Six-Week Treatment Programme and Those Who Did Not Complete the Programme.

There were 230 [G2] respondents who agreed to participate in the qualitative component of the research. The researcher was able to contact 58 [G5] of these respondents at the six months post assessment follow-up period. This provided him with a follow-up rate of 25%. Figure 4.2 shows that of the 58 [G5] respondents followed up at six months, 32 [55%] stated that they had not used drugs and 26 [45%] indicated that they had. The ratio of abstinence to usage is 55% to 45% six months post assessment. There are no statistics available in the Western Cape against which the researcher can measure the abstinence ratio. In the United States however abstinence rates are regularly published and according to a study by Leshner [1999], drug abuse treatment reduces drug use by 40% to 60% and significantly decreases criminal activity during and after treatment. This shows that the findings of this study are comparable to international standards. The researcher feels that other treatment centres in the Western Cape should evaluate their treatment programmes.

Figure 4.2
Have you used drugs in the 6 months post assessment

4.3.1 Voluntary termination of Treatment

Figure 4.3 shows an overview of the 26 [G5] respondents that had used drugs in the six months post assessment. It indicates that five [19%] had last used drugs between three and six months post assessment. Fifteen [26%] of the respondents terminated treatment six weeks post assessment or later, 13 [22%] terminated 3 weeks post assessment while 17 [17%] stated that they had stayed in the programme for less than one-week after assessment. Out of the 58 [G5] respondents that were successfully followed up on six months post assessment, 10 [17%] voluntarily terminated within one week. This voluntary termination rate is very high and needs to be investigated in more detail. A possible explanation for this occurrence could be that the respondents attended treatment in order to show a willingness to bring about a change in their drugging behaviour. This behaviour might have been a form of manipulation or crisis management, and as such the behaviour might have been curtailed once the crisis had waned.



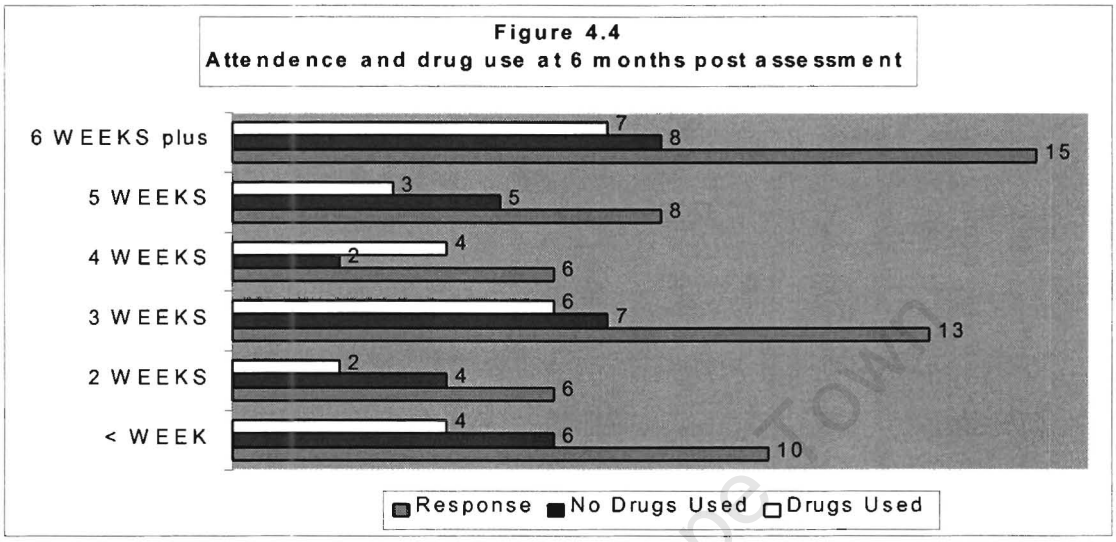
At six months after assessment 58 [G5] respondents were followed up of whom ten [17%] reported attending for less than one week [refer to figure 4.4]. Of these, six [60%] noted that they had not used drugs in the six months post assessment, while four [40%] said that they had. A possible explanation for

the abstinence of six respondents after attending the CTDCC for less than one week could be that most of them were students. Four out of the six were students and the remaining two were unemployed. Being students, they might have experimented with drugs and may not have been addicted. Therefore it is conceivable that it was easier for them to stop. This could explain the high abstinence rate on such low attendance and indicates that more student-focused research is needed. Of the four [40%] who had used drugs in the six months post assessment [G5], the time of the last usage varied, with one respondent saying that he had last used drugs between one to two weeks, and the remaining three having last used drugs between three weeks and six months prior to the six-month follow-up.

Based on the findings it appears that voluntary termination within a week or less after assessment did not necessarily negatively impact on abstinence. It must however be noted that the student component of the sample size was high. Had it been smaller the results might have been very different. The researcher also notes that data collection was done telephonically and relied on self-report. Del Boca and Noll [2000] note that self-reported research can provide useful estimates of substance use based on respondent accuracy, and as such self-report has value. Based on the above the researcher feels that the finding of abstinence in six out of 10 respondents that stayed in the treatment programme for less than one week should not be taken literally until more research can be done on short-term stays in treatment. At this stage there is no obvious explanation for the phenomenon.

4.3.2 Treatment Duration

Figure 4.4 shows the treatment duration experienced by the respondent coupled with drug use or abstinence by week. The graph was compiled from information obtained from the 58 [G5] respondents that were successfully



followed up on six months post assessment. The graph shows that 16 [26%] respondents stayed in the programme less than three weeks, 27 [46%] respondents stayed in the programme between three and six weeks while 15 [28%] respondents completed the treatment programme by staying in treatment for six weeks or longer. An overview of the attendance figures shows that the respondents favoured longer attendance.

When comparing the results of the 15 [28%] respondents that had stayed in the six-week treatment programme against those [10: 17%], who had voluntarily terminated in less than one week, abstinence was better in the group that had stayed for the full six-week programme. The abstinence rate for the group that stayed in treatment was eight [53%] at six month post assessment, compared to the four [40%] who were abstinent over the same period. The study shows, therefore, that the longer the time spent in the

treatment programme, the greater the abstinence effect. This observation is confirmed by Gerstein and Harwood [1990] and Tims et al. [1991] in Farabee, Leukefeld and Hays [1998] who stated that the longer a client stays in treatment, the better the prognosis for recovery. Treatment duration is seen as a barometer for success. Drug-abuse treatment outcomes have been examined in large treatment follow-up studies conducted in the United States which include the Drug Abuse Reporting Programme, the Treatment Outcome Prospective Study, and the Drug Abuse Treatment Outcome Study. These studies have shown that the outcomes are consistently better for those clients who remain in a treatment programme for a longer period. It would appear that attending a six-week period is more beneficial but attending for a lesser period is not without benefits. Without more detailed research, the exact relationship between attendance and abstinence cannot be fully explored.

4.4 The Clients' Subjective Feelings and Experiences Of The Cape Town Drug Counselling Centre and Its Treatment Programme.

The researcher approached this question by considering the qualitative data collected from the study. Specific questions were posed to each respondent contacted at the six-week [G3], three-month [G4] and six month [G5] post assessment follow-ups. Follow-up was conducted in order to elicit the respondents' subjective feelings and experiences of the CTDCC. Four main themes emerged from the data. Firstly, the respondents' reason's for

attending the CTDCC and secondly, the respondents expectations and needs when coming to the CTDCC. The third theme revolved around the negative or positive feelings that the respondents had about the CTDCC, and lastly any suggestions that the respondents had for the CTDCC. Each theme will be analysed and summarised separately.

4.4.1 The Reasons for the Respondents' Attendance At The Cape Town Drug Counselling Centre

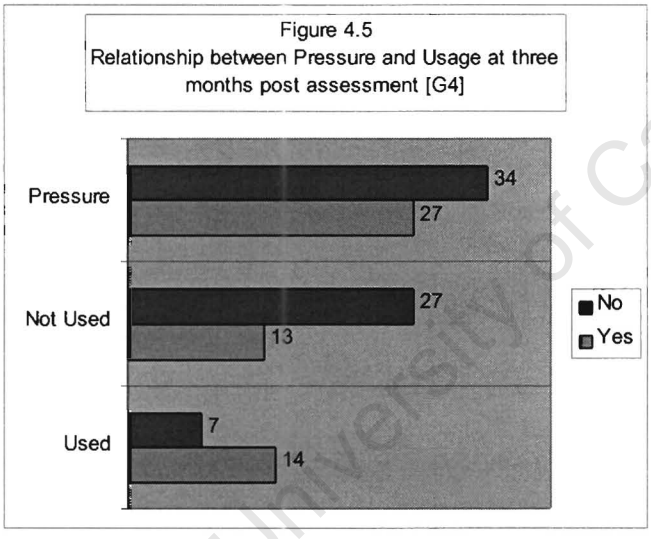
The researcher was able to contact 69 [G3] respondents from a total of 230 clients [G2]. From the 69 [G3] respondents 63 [91%] provided a reason for attending the CTDCC. Cessation of drug use was the reason named by 28 [43%] of the respondents. Twenty [32%] said that they were forced to attend the CTDCC. Eight [13%] felt that, although they had been externally motivated, they were not forced to attend. Six [10%] felt that they wanted to bring about a change within themselves and as such they felt that they had been internally motivated. Another respondent stated the reason for attending CTDCC was boredom at home.

The researcher wanted to find out from the respondents, who had been forced to attend the CTDCC, if they felt that external pressure had any beneficial effect. At three months post assessment, the researcher contacted 61 [G4] respondents and asked them if any pressure had been placed on them to attend the CTDCC. Thirty-six [56%] responded in the negative and 27 [44%] responded in the positive. The researcher enquired of the 27 [44%] who had had pressure placed on them, whether they felt that the pressure had helped

them. Of those who had pressure applied, 14 [51%] said that their mother had pressured them, whilst the school exerted pressure on five [19%] respondents, and employers on two [7%]. The remainder of the respondents were referred from sources such as father, church, wife etc. The researcher asked the respondents if they felt that the pressure had helped them. Twenty [74%] stated yes, while seven [26%] said that it had been of no value to them.

Figure 4.5 shows the data relating to respondents' usage at three months post assessment [G4] in relation to external pressure. The graph shows whether pressure was applied, followed by whether the respondents had used drugs or not. Of the 34 [56%] respondents who stated that no pressure had been placed on them to enter the CTDCC treatment programme, seven [21%] had used drugs at three months post assessment, while 27 [79%] were still clean over the same observation period. Of the 27 [44%] who stated that pressure had been placed on them to attend, 14 [52%] said that they had used drugs, and 13 [48%] indicated that they had not used drugs in the three-month post assessment period. The study therefore shows that external pressure does not reduce drugging. The figure to the left clearly shows that twice as many forced respondents had used drugs during the three-month observation period than did those who were not forced. Therefore, in this study external pressure as a tool to assist the recovery

Figure 4.5
Relationship between Pressure and Usage at three months post assessment [G4]



process is shown to be negative in the treatment milieu. This finding requires further investigation.

Farabee, Prendergast and Anglin [1998] reviewed 11 published studies involving legal pressure and substance abuse treatment. It was found that in five of the studies a positive relationship between criminal justice referral and treatment outcomes existed. Four reported no difference, and two studies reported a negative relationship. The above mentioned authors confirm the researcher's point of view, namely that more research needs to be conducted in the area of external pressure and its relationship to treatment.

The researcher then investigated the 34 [56%] respondents [G4] who had not had external pressure placed on them, to determine whether they felt it would have helped if pressure had been placed on them. Thirty [88%] of the 34 respondents said that it would not have helped, while four [12%] felt that it would have helped. The former indicated that they would have rebelled if they had been put under pressure to attend. The latter felt that external pressure would have helped as it would have shown them that people cared about them. This finding confirms the view of the researcher that external pressure has a negative impact on abstinence.

From the above it appears that the reason for presenting to the CTDCC was to stop drugging. The research shows that being forced to attend was also a reason for attending [27: 32%: G3]. The researcher notes that external pressure as a motivational factor appears futile. More than half of the

respondents who were forced to attend, were still using drugs at three months, post assessment as opposed to the respondents that voluntarily presented at the CTDCC. These findings show that for treatment to be beneficial the client has to be motivated to change. The motivation must be internal for treatment to be effective. This is a feeling long held by the researcher and will be useful when planning prevention strategies.

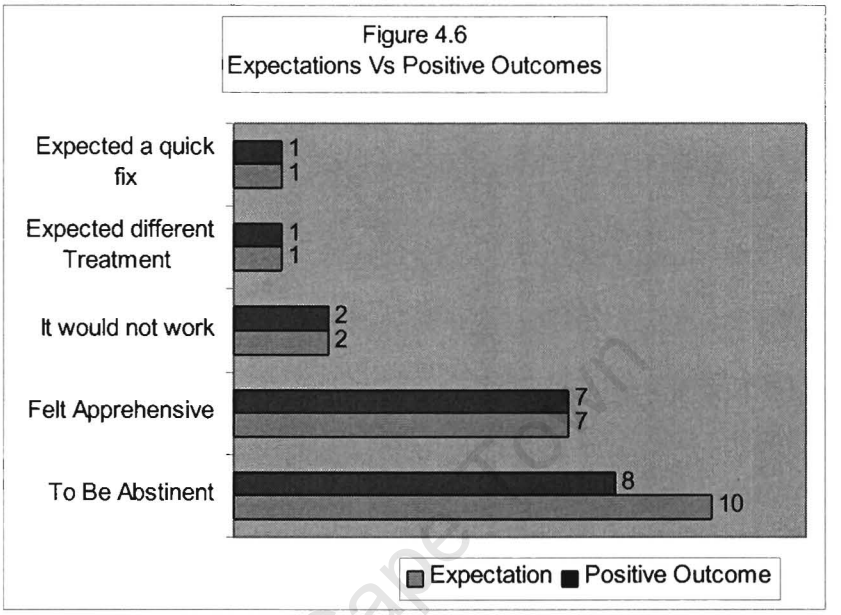
4.4.2 The Respondents' Needs and Expectations When First Coming To The Cape Town Drug Counselling Centre

At the six-week post assessment follow-up [G3] the researcher was able to contact 69 respondents. He asked the respondents if at assessment they had had any expectations of the CTDCC. From the contacted respondents 47 [68%] said that they had had no expectations at assessment, while 22 [32%] said that they had held expectations at assessment. Of these 22 respondents, the following themes emerged. Ten [47%] expected to be drug free, while seven [33%] expected treatment to be a frightening or painful experience. Two [10%] did not expect the treatment to work, and the remaining respondents expected to be treated differently or wanted a 'quick fix' to their problem. With the exception of two out of the 10 respondents that expected to be drug free, the remaining respondents all had their expectations met or altered, so that a positive result ensued. Figure 4.6 [below] shows a very high satisfaction ratio. The two respondents who had expected to be abstinent did not have their expectations met. Neither of these respondents were available

for an interview at the six-month post assessment follow-up to determine change.

At the three-month post assessment follow-up the researcher was able to contact 61 [G4] respondents at the three-month post assessment follow-up. One of the questions posed to the respondents was aimed at determining whether the respondents' needs had been met or not met by the CTDCC. Of the 61 [G4] respondents, 56 [92%] stated that their needs had been met, and five [8%] felt that the CTDCC had not met their needs. Of these five respondents, the most common reason for the reply [three: 60%] was that they were still using drugs. Another respondent indicated that he did not get along with the therapist, and still another stated that no advice had been given, and that the booking of appointments had been disorganised. The researcher notes that four of the five respondents who felt that their needs had not been met by the CTDCC at three months post assessment were no longer using drugs at six months after assessment. This shows a positive result in terms of abstinence despite not having their needs met.

Figure 4.6
Expectations Vs Positive Outcomes

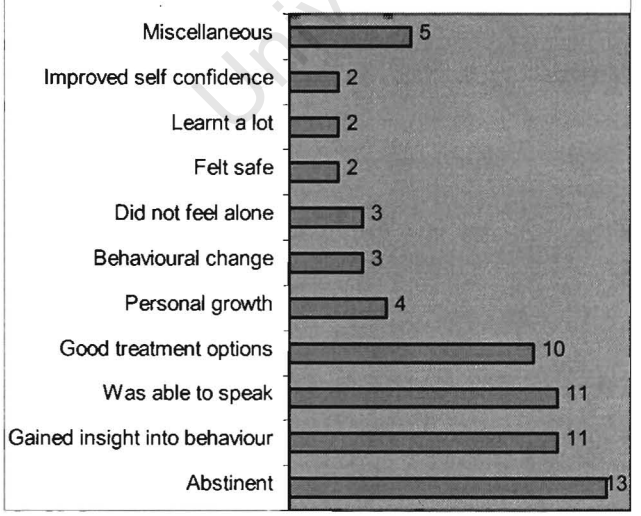


From the above it appears as though the overwhelming majority [56: 92%: G4] of the respondents contacted had had their expectations met. Those who had been apprehensive about treatment, had their expectations altered and they felt that treatment had been helpful. The CTDCC treatment programme met the vast majority of the respondents' needs.

4.4.3 The respondent's subjective feelings about the CTDCC

The researcher contacted 69 [G3] respondents at six weeks post assessment. They were asked whether or not they had benefited from their attendance at the CTDCC. The majority [66: 96%] indicated that they had benefited from their attendance at the CTDCC, while three [4%] said that they had not been helped. The respondents were prompted to elucidate as to why they felt the way they did. Figure 4.7 shows their replies. Thirteen [19%] noted that they were drug free and 11 [17%] stated that they had gained insight. Another 11 [17%] noted that they were given a chance to speak, while 10 [15%] felt that the treatment programme was good. The remaining respondents included the opportunity to speak about their drug abuse, personal growth, and improved self-confidence.

Figure 4.7
What benefit was derived from treatment



The three [4%] who felt that the CTDCC did not help them stated the following reasons. One respondent felt that he did not attend regularly enough to benefit. Another felt unable to connect with the therapist, while the last respondent felt that the CTDCC was not right for him. The fact that 96% of the respondents contacted felt that they had benefited from the treatment programme is very encouraging. It possibly shows that even though not all of the respondents contacted were abstinent during the six-week observation period, many still felt that they had benefited from the treatment programme. This finding promotes the notion of looking at alternative measures by which to determine success. The researcher is of the opinion that had the outcome of this study been measured by another measurement of success other than abstinence, the outcome would have been different to what the current study indicates. Various studies including Del Rio and Mino [1997], Hubbard [1997], Fiorentine and Hillhouse [1999], Mueller and Wyman [1997] and Campbell, Gabrielli, Laster and Liskow [1997] have put forward certain outcome variables that might replace abstinence as an indicator of treatment efficacy. Their suggestions for indicators of success include:

- ➜ Engagement in treatment;
- ➜ The duration of treatment;
- ➜ Reduced drugging;
- ➜ Improvement in personal health and social functioning;
- ➜ A reduction of drug related criminal behaviour.

From the above it is clear that the findings of the current study meet with many of the efficacy criteria as mentioned. The issue of alternate methods for determining efficacy needs more investigation. It does appear that if the

CTDCC elected to adopt additional measures for efficacy, other than abstinence, the success rates could be higher.

While completing the six-week post assessment interview schedule with the 69 [G3] respondents contacted the researcher questioned them about possible negative or positive feelings that they might have had about the CTDCC. Of the 69 [G3] respondents contacted, 48 [70%] had positive feelings. Six [9%] had disapproving feelings and 15 [22%] had no comment about the CTDCC. Of the 48 [70%] who responded with positive feelings, 20 [42%] praised the CTDCC for the good work that is being done there. Ten [21%] were grateful because they had not used drugs since their assessment. Some felt that the treatment programme was very good, and commented on the pamphlets that the CTDCC hands out, stating that they were very informative. Others felt supported and said that they were listened to, and one respondent liked the affordability of the CTDCC programme. When considering the six [9%] that had disapproving feelings, these included procedural issues such as introducing coffee for the assessment clinic, brightening up the centre, and advertising the CTDCC more efficiently. There were, however, also a few remarks about the staff such as "the therapist was not good", that "the motivational group was bad", and that "the staff needed to laugh more". The researcher feels that despite the six negative responses the overwhelming response was positive.

At six months post assessment the researcher again attempted to contact the respondents, and this time 58 [G5] respondents were contacted. In response

to the question; 'Are there things that you feel could have been done differently', the majority replied 'no' [56: 97%], while two said 'yes'. Of the two that said things could have been done differently, one respondent suggested more family sessions. The other noted that he had felt pressurised to attend acupuncture, that it was painful for him, so he stopped coming to the CTDCC out of fear of the acupuncture treatment. The researcher is aware of the three percent of the respondents' negative feelings but feels that the very low negative response has no impact on the study. The overall [56: 97%] impression left by the respondents was that they were happy with the treatment received from the CTDCC. The researcher feels that this is a positive reflection of the CTDCC treatment programme.

4.4.4 The Respondents Suggestions Regarding the Cape Town Drug Counselling Centre.

At six weeks post assessment, the researcher was able to contact 69 [G3] respondents. From this group 52 [75%] of those followed-up said that they had no suggestions for the CTDCC, while 17 [25%] had suggestions. Of the 17 who had suggestions, seven [41%] said that the CTDCC should keep up the good work. The remainder offered more practical suggestions which included working after hours, painting the building, the use of more family therapy, getting the therapist to return phone calls, and marketing the CTDCC better.

Table 4.2 [below] shows the relationship between the suggestions made by the respondents at six weeks and six months post assessment. The reader

should be aware that at six weeks post assessment 69 respondents were contacted while at six months post assessment only 58 respondents were contactable. Additionally very few of those contacted at six weeks were contacted again at six months. Out of 230 [G2] only 21 respondents were contacted at six weeks, three months, and six months. Therefore little continuity arose in the questions posed to the respondents. In table 4.2 the responses by the different respondents are possibly not the same at six weeks and at six months. The researcher could therefore not draw conclusions based on observable shifts. Nevertheless, the findings provide some indications as to what suggestions where made at six weeks and at six months. Table 4.2 shows that much of the response was praise. The researcher observed that the level of praise response had dropped from seven at six-weeks to only one at six-months.

Table 4.2
Relationship between respondents suggestions at 6 week and 6 months post assessment

Six weeks post assessment	N	N	Six months post assessment
Keep up the good work	7	1	Keep up the good work
Introduce some after hour activities	2	1	Introduce some after hour activities
Use more acupuncture	1	0	
Involve the family more	1	2	Involve the family more
Put up some murals	1	1	Paint the place
Market the place better	1	0	
Get therapist to return calls	1	0	
Use recovering addicts as counsellors	1	1	Use recovering addicts as counsellors
Talk to school	1	0	
Start an in-patient centre	1	0	
	0	1	Hand out more information
	0	1	Don't split relationships*
	0	2	Introduce adolescent groups
	0	1	Open a gym
Total	17	11	

* Refers to the separation of partners into different groups.

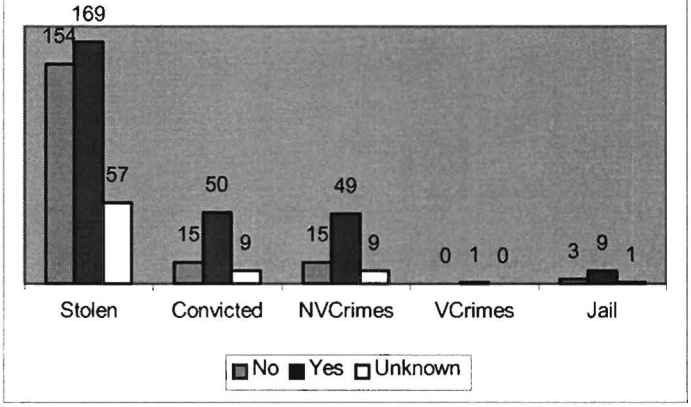
A possible explanation for this could be that at six weeks the memory of the CTDCC experience and the euphoria of not drugging anymore might be recent in the respondent's memory. Two respondents suggested getting the families more involved. Another suggested staying open after hours. At six weeks post assessment, the suggestions focused on praise and keeping the CTDCC open after hours, while at six months post assessment, the emphasis was on getting the families more involved, and introducing adolescent activity groups.

Table 4.2 [Above] also reflects certain suggestions that are repeated at both the six-week as well as the six-month follow-up interview schedules. Three respondents suggested that the CTDCC stay open after hours. Three respondents also suggested that the Centre make more use of the family as a support mechanism. The CTDCC offers a family programme once a month. However, during the study period the families of the clients in treatment poorly supported this treatment mode. The CTDCC felt that families were vital to the treatment programme and as such they made attendance of the family programme compulsory. Nevertheless it was still poorly attended. The researcher feels that families do not like to take on the responsibility of assisting the recovery process. It appears to the researcher that families feel that once the client has been admitted to a treatment programme, the families' function and responsibility is complete. This is, however, not the case. The researcher suggests that more research be conducted at the CTDCC regarding the role of the family in the treatment programme for substance abusers.

4.5 The Relationship Between Attendance Of A Treatment Programme And Drug-Related Theft.

Pluddemann [2000] intimates in his article that drug abuse is related to crime. In a speech presented by Mr Hennie Bester, the Minister of Community Safety for the Western Cape, on 28 August 2001, he stated that a large percentage of petty crime was a direct result of drug abuse. The researcher was interested in finding out whether a pattern of criminal behaviour is influenced in any way by attendance of a treatment programme. For purposes of this study criminal behaviour refers to theft, unless otherwise stated. The reason for this is that at assessment the following question was posed to the respondents! "Have you ever stolen to support your drugging?" The researcher posed a similar question to the respondents who were contacted at six months after assessment. All 380 [G1] respondents assessed during the period of the study were asked questions relating to their criminal activity. Figure 4.8 shows that 169 [44%] of the respondents had stolen to support their drugging, 154 [41%] reported that they had not stolen, while 57 [15%] respondents elected not to answer the question, therefore their response was classified as unknown. Figure 4.8 clearly indicates that more respondents stole than did not steal to support their substance dependency prior to assessment at the CTDCC. The

Figure 4.8
Criminal History of Respondents



researcher asked the respondents if they had been convicted of a drug related criminal activity. Two groups emerged namely violent and non-violent crime. For the purpose of this study non-violent crime refers to possession of an illegal substance, dealing in illegal substances, housebreaking, fraud, prostitution and theft. Figure 4.8 shows that while 154 [41%] respondents alleged not to steal to support their drugging, 15 [10%] of this group reported that they had been convicted of non-violent crimes. The researcher feels that there are two salient reasons for this disparity Firstly, the non-violent crimes were not drug related or secondly, the respondent was not being truthful when first answering the question, but later felt more comfortable with the therapist and answered truthfully.

Of the respondents who admitted to stealing, 50 [30%] had been convicted of non-violent crimes. One respondent from this group reported committing a violent crime, which in the respondents' case was aggravated assault. Three respondents who alleged not to have stolen for drugs had also spent time in jail, while 9 respondents who admitted to stealing in order to buy drugs, had spent time in jail. This indicates that either the respondents were convicted of non-drug related charges or the respondents misrepresented the facts when they answered the question. Figure 4.8 indicates a glaringly obvious disparity in the group of respondents that allege not to have stolen to support their drug abuse and the same groups' conviction of violent and non-violent crimes. The current study was unable to explore this disparity and the researcher feels that in order to promote better understanding, more in depth research is required into this disparity.

At six months post assessment, 58 [G5] respondents were contacted. At assessment 24 of these 58 [G5] respondents reported that they had stolen to support their drugging. At six months post assessment, only one out of the 24 respondents admitted to still stealing. This is coupled with the findings at six months post assessment where, of the 57 [98%] respondents who reported that they had not stolen during the six-month post assessment observation period, one respondent admitted to still stealing. This shows a positive link between treatment and the reduction of drug-related crime. It is important to note that only 58 out of 230 respondents were available to complete the six-month post assessment interview schedule. The researcher is aware that the sample size is small and therefore the identified link between drugs and crime needs to be investigated in more depth before the researcher can state that treatment for drug abuse reduces drug related criminal activity by 98%. It should also be noted that all the data in this study was obtained via self-reporting.

In order to better understand the link between substance abuse and theft the researcher turned his attention to the data collected from the 380 [G1] respondents at assessment. The data analysed related to respondents that admitted to stealing to support their drug abuse and compared the findings with respondents that had indicated that they had not stolen to support their drug abuse. Table 4.3 reflects three respondent populations namely, student, employed and unemployed. For the purposes of the study, the researcher has grouped the responses of those respondents who reported to being self-employed, under the employed population.

Table 4.3 Drugging expenditure per month in Rands

[G1] respondents who reported to **having stolen** in order to support drugging at assessment

	Students	Employed	Unemployed
Respondents	16	31	43
Mean Spent	R1980.00	R5430.64	R3508.48
Standard Deviation	R4568.97	R6869.53	R3728.12
Observed Range	R30.00 - R18.000	R300.00 - R36.000	R100.00 - R16.680

[G1] respondents who reported **not to have stolen** in order to support drugging at assessment

	Students	Employed	Unemployed
Respondents	22	20	18
Mean Spent	R1378.50	R2707.00	R2154.00
Standard Deviation	R8476.80	R4249.01	R2615.44
Observed Range	R12.00 - R12.000	R80.00 - R18.600	R10.00 - R8.000

The above table shows that respondents in all three populations who had stolen, spent more money on drugs per month than those who had not stolen. The observed ranges are recorded in Rands spent and represent the amount from the lowest amount spent to the highest amount spent. This finding confirms the suggested links between drugs and crime as mentioned by both Bester [2001] and Pluddemann [2000]. In both groups respondents who were employed spent more money per month on drugs than students or the unemployed. Students spent the least. Comparing the observable ranges of the student population with the unemployed population, table 4.3 shows that the maximum rands spent by students was larger than the maximum spent by those that were unemployed. This is possibly due to parents, caregivers or significant others indirectly funding the students' drug abuse. Students appear to have more disposable income than the unemployed, therefore they spend more money on drugs. The researcher notes that the maximum range of the employed population in both groups is almost double the maximum range of the other population groups.

The researcher also noted that the mean amount of money spent by respondents that had stolen and were employed was much higher than any other population group. A possible reason for this is that this population group might be spending a salary as well as the profits from the crime that they had committed. This explanation is supported by data contained in table 4.3. When considering the amount of money spent by the unemployed population who had stolen to support their substance dependence with the employed population who had not stolen, we see that a combination of both amounts equates to roughly the same amount of money spent by the employed population who had stolen. This finding confirms the researcher's thinking mentioned above. A large proportion of the employed population who reported having stolen to support their drug abuse were also spending their salaries. If the researcher is correct then the family structures that are supported by the employed drug abuser who steals to support his drugging must be suffering under a lack of financial resources because the provider is spending his salary on drugs. The researcher also notes that money spent on drugs is not only derived from crime. The employed drug abuser could be approaching organisations for loans or he could be pawning household items or prostituting his family members. This unlocks a room full of negative consequences, which the researcher cannot explore. It is suggested that more research be conducted on the relationship between socio-economic depravation and substance abuse in order to determine possible links between them. It should also be noted that all the data used in this study was based on self-report and as such the figures mentioned could be understated.

According to a study by Leshner [1999], drug treatment reduces drug use by 40% to 60% and significantly decreases criminal activity during and after treatment. The findings of this study reflect similar findings to Leshner's. The level of crime associated with the respondents' drug abuse appears to be fairly high thereby acknowledging the view postulated by Pluddemann [2000] that crime and drugs are related. Based on the very high expenditure of the unemployed and student populations, it seems possible that the link between crime and drugs is evident. It appears that the findings reflect a stronger link than admitted to by the respondents. More research in this area is of vital importance. The finding of the researcher is that respondents who were contacted six months after assessment, showed a marked reduction [98%] in their drug related criminal behaviour. Therefore it is possible to say, when comparing data relating to criminal activity collected at assessment, with data collected at six months post assessment, that criminal activity is much lower.

4.6 The Combination of Treatment Modes That The Respondents Found The Most Beneficial.

At assessment all respondents [G1] had access to a variety of treatment modes that included individual therapy, group work, medical sessions, psychiatric sessions, alternate therapy etc. All [G2] respondents were asked whether they felt that the treatment mode that they received had been beneficial, and reasons for their response elicited. At the time of the study, the CTDCC offered 11 optional treatment modes and one compulsory treatment, namely individual therapy, to all respondents who were assessed. Table 4.4 provides an overview of the 12 treatment modes.

Table 4.4 Treatment modes available at the time of the study			
1	Individual Therapy	2	Motivational Groups
3	Art Therapy Sessions	4	Spirituality Groups
5	Psychiatric Sessions	6	Medical Sessions
7	Reiki Sessions	8	Aromatherapy Sessions
9	Reflexology Sessions	10	Acupuncture Sessions
11	Adolescent Workshop	12	Family Therapy

With the exception of individual therapy, none of the other treatment modes were compulsory. Table 4.5 shows the treatment modes in the order of frequency used by the respondents. The researcher was unable to track each respondent throughout the period of the study, therefore table 4.5 depicts only the number of respondents who chose a particular treatment mode, and not how often a respondent actually made use of the treatment mode.

Table 4.5 Treatment modes chosen by rate of use					
Treatment Mode	N	%	Treatment Mode	N	%
Individual Sessions	69	100	Medical Doctor Sessions	7	12
Motivational Group	24	41	Adolescent Programmes	6	10
Aromatherapy Sessions	20	34	Psychiatric Sessions	4	7
Acupuncture Sessions	16	27	Reiki Sessions	2	3
Art Therapy	15	25	Family Therapy Sessions	2	3
Spirituality Groups	7	12	Reflexology Sessions	1	1

Of the 230 [G2] respondents who were willing to participate in the qualitative aspect of the study the researcher was able to contact only 69 [G3] at six weeks post assessment. These 69 [G3] respondents were asked specific questions relating to the treatment modes that they had attended. Table 4.6 shows the number of different treatment modes attended by each respondent.

The mean was 2.5 out of the 12 different treatment modes per respondent over the six-week period.

Table 4.6 Number of treatment modes utilised by all 69 [G3] respondents

Treatment Modes	Mean	Standard Deviation	Observed Range
172	2.5072	1.301845	01 - 06

The observable range for the different treatment modes was from one to six. This reflects a poor rate of use of the different treatment modes by the respondents. The researcher feels that the therapists at the CTDCC should encourage clients to attend more treatment modes. This will enhance service delivery, increase attendance at the CTDCC, as well as enhancing goal attainment.

Each of the 69 [G3] respondents contacted at six weeks post assessment, was asked if they had attended a particular treatment mode. Respondents who had attended a particular treatment mode were asked additional questions about how they had experienced the treatment mode. Each treatment mode is now considered individually. The researcher would like to bring to the readers' attention that all figures quoted in the remainder of this section, unless otherwise stated, are from the 69 [G3] respondents followed up at six weeks post assessment.

Individual Therapy

As it was compulsory, Individual Therapy was attended by all 69 respondents. Fifty-nine [85%] of the respondents felt that they had benefited from individual

therapy, six [9%] felt that they had not benefited, and four [6%] were unsure. Of the respondents who said that they had benefited from individual therapy, 24 [41%] felt that they had benefited from talking about their problems. Under the umbrella of talking, the researcher identified the themes of being able to speak openly and freely in seven [29%] of the respondents, having the chance to talk about the drug problem in a further seven [29%], being able to talk in a safe environment in five [21%] and being able to talk about their emotions and frustrations in a further five [21%] respondents.

The remaining 35 [59%] respondents who felt that they had benefited from the treatment mode sighted other reasons for experiencing individual therapy as useful. Fourteen [24%] felt that it was because they had developed insight into their drugging behaviour. Six [10%] felt it was because they were given a space in which they could express their feelings. Another six [10%] felt encouraged and motivated after individual therapy. Being able to think differently about drugs was a reason sighted by five [8%] of the respondents and the remaining respondents felt that they were understood, felt safe and always left with a positive thought in mind.

Of the six [9%] respondents who felt that they had not benefited from the individual therapy, three respondents noted that they felt uncomfortable. One felt misunderstood by his therapist, another felt that he was not listened to, and another noted that he was bored during the treatment. For the large majority of the respondents individual therapy had been a positive experience. Most of the few who felt that individual therapy had not been useful for them

noted that it was because they felt uncomfortable. The researcher is aware that therapy involves self-disclosure and many people find it a daunting experience. Therefore a certain percentage of the discomfort with therapy is to be expected. This coupled with the fact that 59 [85%] of the respondents felt that they had benefited from individual therapy leads the researcher to the conclusion that individual therapy was very beneficial to the typical respondent.

Motivational Group Sessions

Of the 69 [G3] respondents contacted, 24 [35%] indicated that they had attended motivational group sessions, and 45 [65%] had not. Of the 24 respondents who partook in this treatment mode, 20 [83%] felt that they had benefited from the experience, and four [17%] felt that they had not. When looking at the reasons why the 20 respondents felt that motivational groups had been beneficial we see that nine [47%] felt that they had learnt from the other group members. Four [21%] noted that just listening to others was helpful, three [16%] realised that they were not alone in having a substance abuse problem, and the remaining three [16%] felt that they had benefited by talking about their problems.

Of the four [17%] who felt that they had not benefited from the motivational group sessions, two said that just being in the group raised their levels of craving. One felt that the group was too critical towards parents, and another felt that he simply did not fit into the rest of the group.

Art Therapy Sessions

Sixty-nine [G3] respondents contacted at six weeks, 15 [22%] indicated that they had attended art therapy sessions, and 54 [78%] had not. The 15 who had attended were asked if they had benefited from the experience. Eleven [73%] felt that they had benefited from the experience, while three [20%] felt that they had not benefited, and one was unsure. When looking at the reasons why the 15 respondents felt that art was beneficial, we see that five respondents found art therapy useful because they enjoyed art and found it to be a "good experience". Three felt supported by the other group members. Two respondents felt that they had been given a chance to express their feelings without talking, and the other respondent said that "thinking about things" helped him.

Upon examination of the three respondents who felt that they had not benefited from the art therapy sessions, it emerged that two felt that it made no sense to them, while another respondent felt that he had never had a problem with drugs, and that he should not have been there in the first place. The researcher feels that the art process should be more clearly defined to the clients that use this treatment option, as most felt unsure of the process. Again the majority of the respondents found the treatment mode useful and benefited from attending.

Spirituality group sessions

Sixty-nine [G3] respondents were contacted. Of these seven [10%] acknowledged having attended spirituality group sessions, and 62 or 90% had

not. Of the seven who had attended, six felt that they had benefited from the experience, while one respondent felt that he had not benefited. Among the reasons for regarding these sessions as beneficial was that the treatment cleared the minds of the respondents, they learnt from the group, they learnt to cope with stress and left the group feeling positive.

One respondent did not benefit from the spirituality group sessions. The stated reason for this was that he could not focus, as there was no point to the group. Based on the above, the researcher feels that the respondent who felt that the treatment was of no benefit, was possibly unable to think in an abstract manner. The spirituality group required of the respondents to think in abstract terms as it involved meditation. A possible cause for this might be client-treatment matching that was discussed earlier. All efforts should be made to ensure that a client is receiving the appropriate treatment. Overall this group was well received even if poorly attended.

Psychiatric Sessions

Four of the 69 [G3] respondents contacted had attended psychiatric sessions. Of these four respondents, three felt that they had benefited from the experience, while one respondent felt that there had been no benefit. Reasons were obtained from the three respondents as to why these sessions had been beneficial. Two noted being able to speak freely was important. The other respondent noted being referred to an in-patient facility by the psychiatrist had had a positive outcome for him. The respondent who derived no benefit from the treatment mode stated that he had felt uncomfortable, and

unable to speak openly. As noted from the individual therapy, self-disclosure is daunting and this could have made the respondent feel uncomfortable more than the presence of the psychiatrist. This is a very valuable element of the treatment programme and the researcher feels that the four respondents contacted do not adequately represent the sample, therefore the researcher feels that a more in-depth study be conducted to determine the value of this treatment mode.

Medical Treatment Sessions

The researcher spoke to seven [10%] out of 69 [G3] respondents who had attended this treatment mode. Of these, six felt that they had benefited from the treatment, while one respondent felt that he had not benefited. Of the six who felt that they had benefited, five felt that the medication had worked well, and one respondent felt that he had developed insight from speaking to the doctor. The respondent who felt that the doctor's sessions were not beneficial stated that the medication that had been prescribed gave him too much energy. This respondent also stated that he had spoken to the doctor and the medication was changed. The researcher feels that this process of negotiation between the doctor and the respondent was positive.

Reiki Sessions

Only two of the 69 [G3] respondents contacted said that they had attended reiki sessions. Both recipients of reiki stated that they had benefited from this treatment mode. They stated that they were very relaxed at the end of the treatments. This is a positive result but once again the sample size is far too

small to make generalisations. The researcher therefore motivates for more research regarding the value of reiki as a treatment option.

Aromatherapy Sessions

Sixty-nine [G3] respondents were successfully followed up six weeks post assessment of which 20 [29%] acknowledged attending aromatherapy sessions. All the respondents who attended felt that they had benefited from the experience. Reasons given by the respondents as to how the sessions had benefited them included being very relaxed, reduced stress and the release of tension. One respondent felt that the treatment was the best, or as the respondent put it "lank kif". The researcher observed that aromatherapy was very well received as none of the respondents had experienced it in a negative light and as such it contributed to the efficacy of the treatment programme.

Reflexology Sessions

Only one respondent out of the 69 [G3] attended the reflexology sessions. This respondent felt that the treatment had not been beneficial, as it had had no effect on him. The researcher is aware that many respondents had actually attended the treatment option, but they were obviously among those that could not be contacted. This is unfortunate and mechanisms for a higher rate of follow-up need to be identified. This statement holds true for reflexology but also for all the other treatment options.

Acupuncture Sessions

The researcher spoke to 16 [23%] respondents who had attended acupuncture treatment, of the 69 [G3] respondents who had been followed-up. Of these, 12 [75%] felt that they had benefited from the experience, while four [25%] felt that the treatment experience had been negative. Reasons given by the respondents as to how the sessions had benefited them, included increased energy levels [5: 42%], relaxation [4: 33%], reduced cravings [2: 17%], and one [8%] said that it had been a new experience. Of the four respondents who felt that they had not benefited, one said that it was "too sore", one stated that it had had no effect on him, while the last respondent said that the protruding needles had frightened him. The findings reflect that although there are positive benefits from acupuncture, it does not work for all respondents.

Adolescent Workshops

A total of 69 [G3] respondents were contacted, of whom six [9%] had attended an adolescent workshop. All six noted that they had benefited. Four [66%] gave as reason for this meeting other adolescents with similar problems. Another respondent mentioned gaining self-confidence, and another mentioned that he felt respected in the group. This is a very encouraging finding. Again it must be seen in the light of a small sample size, yet it does show that the workshop was well received by the respondents who attended.

Family Therapy Sessions

Only two [3%] out of the 69 respondents contacted, had attended family therapy sessions. The reactions to this treatment mode were mixed. One respondent felt that the treatment mode was beneficial and mentioned that his parents appeared to understand him better since the sessions. The other respondent found it very difficult to talk to his parents, and as such felt the sessions had not been beneficial. This is, again, a very small sample size and no conclusions can be drawn. It does however indicate that the feelings toward the use of family therapy are mixed.

With the exception of individual therapy, motivational groups and aromatherapy, the remaining treatment modes and options were poorly attended. Once again the researcher feels that it is important to note that the follow-up sample was small and the findings might have been different if more respondents could have been followed up. The researcher also notes that from many of the treatment options there appears to be one respondent that experienced the treatment option negatively. He notes that this is not the same respondent throughout but rather different respondents expressing their feelings about the treatment options that they attended.

4.6.1 Benefit derived from attendance at the CTDCC

The researcher inquired from the 69 [G3] respondents contacted at the six week follow-up whether they felt that they had benefited from their attendance at the CTDCC. The majority, namely 66 [96%], indicated that they had been helped by their attendance, while only three [4%] said that they had not been

helped. The researcher notes most respondents benefited and this is encouraging for the CTDCC. However the researcher wanted to find out why some respondents felt that they had not benefited.

The reasons given by these three respondents who had not benefited from the CTDCC treatment programme were explored. One respondent stated that he had not attended regularly enough for the programme to have helped him. Another stated that the programme did not meet with his expectations and the third respondent noted that he did not get on with the therapist. This respondent felt that a 'culturally-specific' therapist was what he needed. The researcher notes that the clinical team of the CTDCC is culturally representative of the Western Cape. The clinical team is representative of the three dominant ethnic groups, the three dominant languages and a variety of religious denominations are represented. The researcher feels that the respondent could have been placed with a therapist more suited to his needs had he requested a change. Instead the respondent probably chose to use the cultural diversity between him and his therapist as a manipulation tool to voluntarily terminate from treatment. The fact that only two out of 69 respondents expressed dissatisfaction with the CTDCC reflects positively on the Centre's treatment programme.

The researcher is of the opinion that client treatment matching is important in order to facilitate goal attainment. It is possible that the two respondents who indicated that they had not benefited from the treatment programme, were mismatched with treatment modes as well as for the reasons mentioned. It is

clear from the findings that matching clients with specific treatment modes and therapists works well.

Leukefeld and Schuster [1998] note that client-treatment matching is not an exact science and it might be necessary to adjust a treatment plan following scheduled evaluations of the client's progress in treatment, or when a relapse occurs. Table 4.7 shows that reiki, aromatherapy and adolescent workshops scored high on the positive outcome scale. Reiki and the adolescent workshop scored low on the session attended scale, while individual, motivational, acupuncture and aromatherapy sessions appear to rate high on this scale. Table 4.7 shows that the attendance figures for certain treatment options was very low. However, as many respondents could not be followed up, it does not mean that the treatment option was not better attended.

Table 4.7 Treatment modes rated per respondent feedback							
Treatment Modes Rated per respondent feedback	Sessions attended		Positive outcome		Negative outcome		Not sure
	N	%	N	%	N	%	N
Individual Sessions	69	69	59	85	6	9	4
Motivational Group	24	35	20	83	4	17	0
Art Therapy	15	54	11	73	3	20	1
Spirituality Groups	7	10	6	86	1	14	0
Psychiatrist Sessions	4	6	3	75	1	25	0
Doctor Sessions	2	10	6	86	1	14	0
Reiki Sessions	2	3	2	100	0	0	0
Aromatherapy Sessions	20	29	20	100	0	0	0
Reflexology Sessions	1	1	0	0	1	100	0
Acupuncture Sessions	16	23	12	75	4	25	0
Adolescent Programmes	6	9	6	100	0	0	0
Family Sessions	2	3	1	50	1	50	0

The above table reflects the number of respondents that acknowledged attending a treatment option when asked at the six-week follow-up. The

researcher was only able to contact 69 [G3] respondents at six weeks post assessment out of the [230: G2] respondents who had agreed to participate in the study. Further research is required with a more intensive focus on which clients use what treatments, and for how long in order to develop a more detailed understanding of how the different treatment modes affect abstinence. Unfortunately low respondent feedback has led to reduced generalisability, thus affecting the validity of the findings. That aside, the findings provide the CTDCC with a clear understanding of what combination of treatment modes the respondents preferred, namely individual therapy, motivational group and aromatherapy.

At the six-month post assessment follow-up the researcher contacted 58 [G5] respondents and asked them which treatment modes they felt had been the most helpful and enjoyable while in the CTDCC treatment programme. Table 4.8 reflects their responses. Treatment modes that were not voted for are not displayed.

Table 4.8 Analysis of treatment modes

[n=58 [G5]]	Most Helpful		Most Enjoyable	
	N	%	N	%
Individual Sessions	30	51	23	39
Motivational Group	13	22	11	19
Aromatherapy Sessions	5	9	11	19
Art Therapy	5	9	6	10
Acupuncture Sessions	4	7	4	7
Adolescent Programmes	1	2	1	2
Spirituality Groups	0	0	1	2
Reflexology Sessions	0	0	1	2

The above table shows that individual therapy scored the highest in both categories. From this finding the researcher assumes that most of the respondents benefited from the therapeutic process. As mentioned earlier most of the reasons given by respondents for benefiting from individual therapy were related to "talking". The therapists listen to clients every day and they should feel that they are contributing to the high abstinence ratio by listening to and allowing the clients to talk.

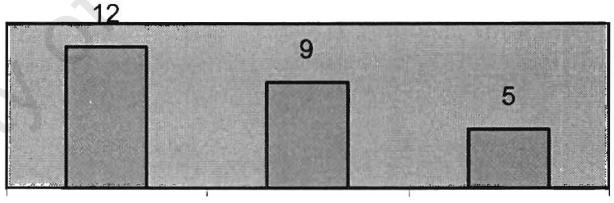
The researcher asked the respondents at six months post assessment [G5] whether there were other treatment modes that were not offered by the CTDCC that might have assisted them in their recovery. Fifty-six [96%] answered in the negative. Of the two who had suggestions, one suggested a gym and one suggested an outdoor activity such as a hike or a youth group.

The follow-up ratio was sufficient for the researcher to gather data relating to the research questions. However, it does not appear to be sufficient to promote the presentation of major recommendations. Based on the findings, if one respondent out of 69 [G3] raises a point of concern, it is questionable whether it is of importance to the collective, or whether it has intrinsic objective or subjective value. The low follow-up ratios are one of the shortfalls of this study.

4.7 The Change in The Respondents' Drugging Behaviour During The 6-Month Follow Up Period

At the six-month post assessment follow-up the researcher was able to contact 58 [G5] or 25% of the 230 [G2] respondents who had agreed to participate in the study. Of these 58 respondents, 32 [55%] indicated that they had not used drugs, and 26 [45%] admitted to having used drugs. The most salient change in drugging behaviour lies in the 32 respondents who had been abstinent for the six-month post assessment period. But what of the remaining 26 respondents? The researcher focused attention on changes that these 26 respondents might have undergone. It is important to note that just because 26 [45%] respondents had used drugs during the follow-up period, this does not follow that no change had taken place. Recidivism does not necessarily mean that there was no progress. As was discussed earlier, numerous authors put forward different options by which to determine efficacy in substance abuse treatment. The study was conducted using abstinence as the measure of success. If for example the CTDCC had adopted as its measure of success 'reduced drugging' over the six-month observation period then the findings would have reflected the following. Twelve [46%] respondents showed no change in their drug usage, nine [34%] reported to be using fewer drugs, and or milder drugs, while five [20%] admitted to their drugging having become worse. By looking at efficacy in this

Figure 4.9
Drug intake changes of the 45% of the respondents still using drugs at six months post assessment



manner it is clear that 21[80%] respondents showed no change or an improvement. It must be remembered that figure 4.9 refers only to the group of respondents who were still drugging at six months post assessment. This figure, when coupled with the 55% who were abstinent over the same period, would give the CTDCC a 91% efficacy rate in bringing about change in drug abuse patterns. From this it is evident that drug abuse treatment programme success can be interpreted in different ways, leading to different conclusions.

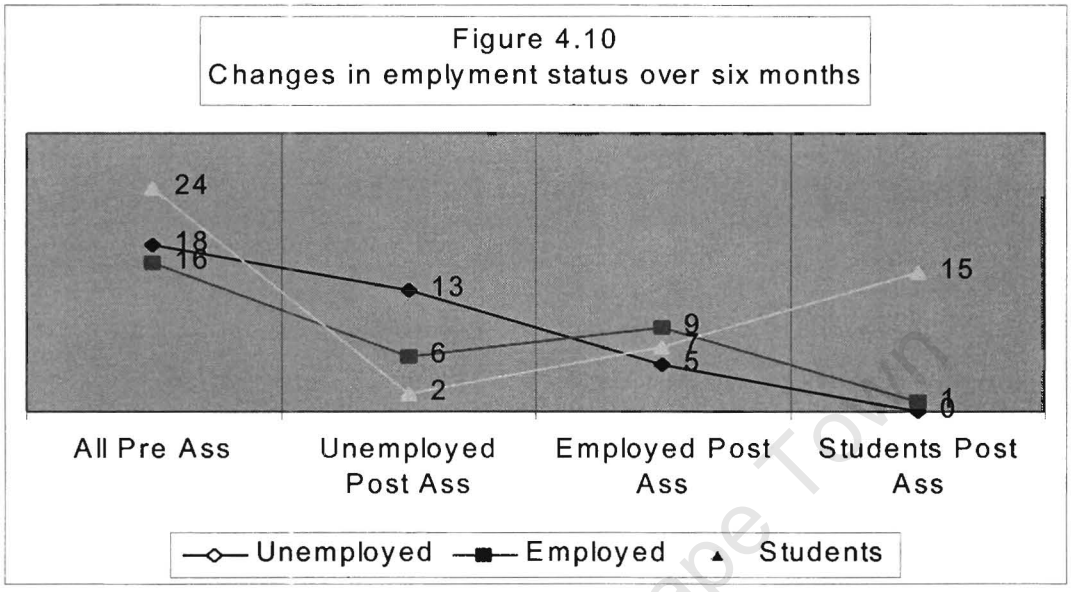
The researcher feels that, in light of this, a standardised norm should be developed for the Western Cape so as to eradicate ambiguity regarding findings and efficacy. As was mentioned earlier on as a result of consultation with CTDCC therapists', abstinence was identified as the efficacy measure for this study.

4.7.1 Employment Status and Drug Abuse

A measurement in respect of employment status was made at assessment and again six months after assessment. At the six-month post assessment follow-up the researcher was able to contact 58 [G5] of the 230 [G2] respondents who had agreed to participate in the study. The figure below shows the employment characteristics of the respondents at pre assessment and at six months post assessment.

Regarding the 18 [31%] respondents who were unemployed at assessment, 13 [72%] were still unemployed six months post assessment, and five [28%] were employed.

Regarding the 16 [28%] respondents who were employed at assessment, nine [56%] were still employed six months post assessment, six [38%] were unemployed and one had become a student.



As far as the 24 [41%] respondents who were students at assessment were concerned, 15 [63%] were still students six months post assessment, seven [29%] were employed and two were unemployed.

Figure 4.10 shows a positive shift of seven [44%] respondents from the unemployment category into fields other than unemployment. Four [22%] of the respondents moved from the employed category to the unemployed category. The exact reason for the shift is not clear as no qualitative questions were posed to the respondents at the six-month post assessment follow-up. The researcher feels that more research should be dedicated to this change.

CHAPTER 5 CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

In this chapter the researcher will summarise the findings of the research. This section will elucidate three areas. Firstly the researcher will present a list of recommendations regarding the CTDCC treatment programme. Focus will be directed at the salient findings of the research. These include *inter alia* abstinence, criminal behaviour, treatment mode combinations and changes in employment status. The positive and negative aspects of the treatment programme will also be reviewed. Recommendations are made at the end of this section in order to assist the CTDCC refine it's treatment programme. Secondly recommendations are made regarding future research opportunities at the CTDCC. Thirdly recommendations are made about collaborative partnerships to promote programme evaluation in the Western Cape.

5.2 Treatment Programme Efficacy

One of the first questions asked by many people is about the CTDCC's success rate. To obtain the answer to this question is problematic, as difficulties arise with the definition of the term success. Currently within the South African addiction field, there is no unified consensus on the term and each addiction treatment centre functions within its own perception of 'success'.

For the purposes of this study the researcher adopted the notion of abstinence in order to determine success. The study has shown that at six months after assessment 32 [55%] of the 58 respondents contacted were abstinent. In a study conducted in the United States Leshner [1999], found that drug abuse treatment reduced substance abuse by between 40% and 60%. By measuring success in terms of abstinence the researcher feels that the findings of the current study show that the CTDCC treatment programme meets with international standards.

In an unpublished report entitled 'Addiction Treatment Successes', presented by the American based National Association of Alcoholism and Drug Abuse Counsellors [NAADAC] and delivered at the House of Government Reform and Oversight Committee's subcommittee on national security on June 5, 1998, it was postulated that drug abuse treatment has a better success rate, based on treatment regime adherence, than other chronic illnesses. Therefore treatment, if effectively implemented, does have positive social and financial rewards. Effective implementation of services must be based on programme evaluation and not on guesswork of personal opinions as these are often biased toward the clinical team at the expense of the client.

In the current study respondents who completed the six-week programme showed better results when measured in terms of abstinence than respondents who did not complete the treatment programme. From the literature reviewed it is noted that the longer the client participates in a rehabilitation programme, the

higher the rate of abstinence. This finding is substantiated by the current study, which found that the longer the time spent in the treatment programme the greater the abstinence effect.

The National Institute for Drug Abuse [1998] found that in general, participation for less than 90 days in either in-patient or out-patient treatment, was of limited or no effectiveness, and that many clients who entered treatment dropped out before receiving all the benefits that the treatment could provide. The current study disproves this statement. Only one respondent was still in treatment at the six months post assessment follow up call, and the remainder had terminated at six weeks, or shortly thereafter. Nevertheless 55% [32[G5]] of the respondents contacted had been abstinent during the six months post assessment observation period. The conclusion arrived at is that the treatment programme, utilised over adequate time, delivers results, but time as a factor on its own does not.

5.3 Criminal Behaviour

At assessment 44% of the respondents admitted to having stolen to support their drug abuse. The study indicates that 98% of the respondents who had stolen to support their drug abuse had not stolen during the six-month observation period after assessment. This shows that treatment impacts on crime in a positive manner. Exactly how it impacts has not been identified in the current study. A

definite conclusion from the study is that more detailed research in this area is required.

It must be stated that the respondents contacted totalled 25% of the sample that had agreed to participate namely 230. As a result the degree to which the findings could be generalised is reduced. It has however been demonstrated that in the majority [57: 98%] of respondents contacted at the six month post assessment follow-up period [G5], drug related crime had not occurred in the follow-up period. This is a topic that has been widely studied internationally. Leshner [1999] notes that substance abuse treatment significantly decreases criminal activity during and after treatment. This shows that the findings of the current study are comparable to international findings. It is noted that the lack of South African treatment centre programme evaluation hindered the current study and the researcher feels that other treatment centres in the Western Cape should also evaluate their treatment programmes.

5.4 Treatment Combinations

The study has shown that the treatment combination that had the best results in terms of abstinence over six months included individual therapy, motivational groups and aromatherapy. Most of the therapists at the CTDCC make regular use of this combination, which is one of the possible reasons used to explain the high abstinence rate. Although the study shows that the different treatment modes are under-utilised, the respondents choose their treatment options. While

therapists make suggestions, they do not force the respondents to follow them. It is, however, possible for therapists to be more assertive in their recommendations of treatment options to the clients.

5.5 Changes in The Respondents Behaviour Relating To Drug Abuse

The most salient change was in the 32 [55%] of respondents who had been abstinent in the six month post assessment follow-up period. This figure is comparable to international standards [Leshner: 1999]. As mentioned earlier there are no comparable figures in the Western Cape. The researcher feels that this study provides the CTDCC and other treatment centres in the Western Cape or South Africa with a standard to improve on.

The researcher notes that more than half of the respondents that were still using drugs at six months post assessment stated that they were using fewer drugs than they had been using before assessment. This reflects a measure of success for the treatment programme. For a true reflection of global drug use change, variations in the type of drug used should be seen in conjunction with the changes in volume of drug usage. The researcher noted that overall the shift in drug use was toward less incidents of drug use, with the type of drug or drugs used remaining the same or shifting toward softer drugs. This is, again, interpreted as a measure of success for the treatment programme of the CTDCC. Success should not only be measured in terms of total abstinence.

5.6 Changes in Employment Status

The researcher feels that the move to employment was the most pronounced shift that occurred in the employment status of the respondents over the six-month follow-up period. It should be noted that the researcher is not stating that the shifts in employment status came about as a result of the treatment programme, but rather that there has been a change as noticed in the sample. More research needs to be dedicated to this area in future studies.

5.7 Voluntary Termination

The study shows that the respondents favoured longer attendance in the treatment programme. The study has also indicated that the longer the time spent in the treatment programme the greater the abstinence effect. The researcher concludes that the greater the support given the drug user throughout the process of treatment and long-term recovery, the greater the likelihood of treatment success.

The 16 [26%: G5] respondents that elected not to stay in treatment longer than three weeks, are a source of concern to the researcher and it is suggested that the CTDCC be more proactive in retaining these clients. Possible mechanisms that could be explored would be to place a follow-up telephone call to all clients who terminate treatment within the first three weeks. Currently the therapists post a follow-up letter to all clients who terminate before completion, but this mechanism does not appear to have the intended effect. A home visit would be a

positive step toward reducing voluntary termination, but the CTDCC does not have the resources to implement this step. The researcher therefore feels that a letter in conjunction with a telephone call would have a more positive effect on goal attainment.

Another possibility would be for the therapist, with the client's permission, to phone the referral source after assessment, and explain the treatment programmes, so as to reduce possible manipulation of the referral source by the client. If clients are voluntarily terminating as a result of crisis management, then this course of action will reduce the chances of the client leaving the programme, as the referral source will be informed about the process.

A further possible reason for voluntary termination could be inappropriate client treatment matching. This observation is possibly supported by the two [3%] respondents who mentioned that their experience of the treatment was negative. Effective drug abuse treatment requires a thorough assessment and integration of the needs of every individual entering treatment. The CTDCC has a very comprehensive assessment tool that is used to match the clients' needs with the treatments offered. Client treatment matching is not an exact science and mismatches will occur, however on a positive note, the CTDCC continually assesses the client's experience of the different treatment options selected during his or her recovery programme. The result of this is borne out in the positive abstinence rate as reflected in the study.

5.8 Recommendations for Improving the Cape Town Drug Counselling Centres' Treatment Programme

In terms of the current study, many questions were asked and investigated. It appears that many of the findings arising from the research questions need more in depth research. The researcher identified the following focus areas in which improvements can be made, thereby influencing goal attainment. The researcher notes that the recommendations mentioned below must be seen within the context of the therapeutic relationship and the ethos of the CTDCC.

5.8.1 Integration of services

The CTDCC's internal service integration is well co-ordinated, however in the arena of external service integration, the researcher recommends the following improvements. Once a client has joined the treatment programme, social integration of external support structures is lacking to a certain extent. Families form part of the puzzle, but there are also other structures such as the employer, social services, correctional services, etc. Interaction with these social systems should be utilised by the individual therapist in the client's treatment programme. This might ensure client retention, thereby improving positive outcomes. This recommendation needs to be understood within the context of the therapeutic relationship. Should a client not want external input in his or her treatment programme, then the therapist will respect the client's views.

5.8.2 Needs assessment

This is an area in which the researcher feels that the CTDCC performed particularly well. Respondents were assessed, and their needs were accurately identified. The research showed that at three months post assessment, 61 [98%] of the respondents felt that their needs had been met by the CTDCC. The Centre is aware that the clients' needs are directly related to their treatment outcomes, and based on the findings of the research, it is therefore recommended that the current needs assessment methods be continued.

5.8.3 Efforts to engage clients in treatment

In order to improve the rate of participation, the CTDCC needs to promote its services to the clients more vigorously. The research showed that the average respondent attended 2.5 out of the 12 different treatment options that were available at the time of the study. This equates to a single respondent utilising about one fifth [21%] of the overall treatment options available. By improving the rate of treatment option utilisation, the therapist would be able to increase the clients duration of stay. The combination of improved usage of the various treatment options and the expected increased duration of stay would promote goal attainment. It appears from the research that the majority of the [G5] respondents followed-up at six-month post assessment, felt that the treatment services offered were beneficial to their recovery. Those that did not feel that the treatment services offered were beneficial to their recovery [two respondents] suggested not forcing acupuncture, and conducting more family sessions. Both

suggestions are dealt with sufficiently by the CTDCC, to warrant them as superfluous.

When trying to ensure that the client stays in treatment for longer periods the researcher feels that therapists should be more assertive in their recommendations of treatment options to the clients. Therapists should also promote the treatment option that has been proven to have the greatest impact on abstinence. The study has shown that most of the respondents who at were abstinent over six months post assessment had attended a treatment combination that included individual therapy, motivational groups and aromatherapy. However, the study shows that the different treatment modes are under-utilised. It is also important to be aware that although therapists make suggestions, they do not force the clients to follow them.

5.8.4 Client retention

The study indicated that the CTDCC experienced a problem with respondent retention. Out of the 58 [G5] follow-up at six months post assessment 16 [26%] respondents stayed in the program less than three weeks. The study by Rogers [1990] puts forward the argument that clients voluntarily terminate for different reasons. Rogers does however note that the younger the client, the higher the predisposition to voluntarily terminate. In the current study the majority of the respondents 193 [51%] were adolescents, the researcher therefore expected a high rate of voluntary termination. Having said this, it therefore becomes evident

that the CTDCC should add additional treatment options to the existing range of adolescent programmes, which must be aimed specifically at retaining the younger client. During the research follow-ups, respondents suggested a number of options in respect of this type of activity, when asked for suggestions for the treatment programme. Hikes, social groups and outdoor activities like going to the beach, were suggested.

5.8.5 Cultural sensitivity

The CTDCC is representative of the Western Cape community therefore. Most of the respondents therefore had their needs met in terms of their cultural diversity. All services offered by the CTDCC are culturally sensitive, and this enables therapist client bonding, and promotes client treatment matching. This attribute of a good therapeutic programme is well entrenched into the CTDCC philosophy, and should be maintained.

5.8.6 Data collection and management services

Currently each therapist collates data gathered from his or her caseload. This data is captured onto a database that reflects the demographics of the CTDCC client base. The CTDCC uses this data, in order to identify drugging patterns, to source funding and to determine service direction. The data is however only quantitative and the researcher feels that there is room for a qualitative aspect to this database. A questionnaire looking at expectations, needs, etc, could be completed by clients at assessment. This questionnaire could be compared with

the one completed by the same client on termination of the treatment programme and another one completed by randomly selected clients at twelve months post assessment. This would be a relatively inexpensive method of ascertaining whether the clients expectations or needs have been met. Data capturing would be simple, but the information gained would be of great value. As the client would be completing the questionnaire, this option would be time efficient and affordable. The researcher suggests that CTDCC source funding for this research venture from the Medical Research Council, the National Research Foundation or other related bodies.

5.8.7 Stable sources of funding

This is undoubtedly the most problematic and vexing of the criteria for good treatment. Currently the only stable source of income that the centre has, is the 12% of its operating costs that it receives from the Western Cape Department of Social Services. The Centre sees more clients in a given year than any other treatment centre in the Western Cape, yet it receives a very small portion of the funding allocated for treatment in the Western Cape. As such the CTDCC has taken the initiative and explored many other funding options. As Capetonians experience donor fatigue however, it becomes increasingly more difficult to source funding. A possibility would be to source internationally funding, or by marketing the skills transfer programme.

5.9 Recommendations Regarding Future Research Opportunities

This study has been explorative in nature and as such it has promoted a better understanding of programme evaluation within the speciality field of addictive behaviour. It has also shown that more research is needed in this field and it has provided a basis from which other studies can be launched. As regards future research opportunities the researcher wishes to make the following recommendations:

It is recommended that:

1. the CTDCC should conduct a study of client characteristics in order to remain in touch with changing drugging trends. Funding should be sourced to enable the CTDCC to continue to expand its current demographic data collection. In this way the Centre would remain at the forefront of changing drug abuse trends in the Western Cape;
2. therapists motivate their clients to partake in the treatment combination that has delivered the best results as far as abstinence is concerned i.e. individual therapy, motivational groups and aromatherapy;
3. therapist's motivate for their clients to attend as many other treatment options as possible. The study is very clear on the fact that the longer a client stays in treatment the better the outcome;
4. the CTDCC network with existing not-for-profit organisations that are able to provide skills training. The research indicates that at assessment 132 [35%] of the respondents were unemployed. The researcher feels that by treating the addictive behaviour and not addressing the other social issues, the client is disadvantaged. It is further recommended that the CTDCC contact the state institutions such as the Department of Labour, as they offer training courses

for unemployed individuals. The networking would ideally result in a training programme that should be offered to all addicts in recovery. Depending on the organisations with which the CTDCC collaborates, basic skills training could be provided in the fields of bricklaying, tiling, electrical, motor mechanic, hairdressing, etc. As an alternative the researcher suggests that the CTDCC source funding for a skills acquisition programme. Funding for a programme of this nature could be sourced locally from the Department of Social Services or internationally from National Institute of Alcohol Addiction or National Institute Drug Abuse, as both these organisations put emphasis on sustainable treatment;

5. additional mechanisms should be introduced in future studies to improve reliability of responses from the respondents. These measures could include an interview with the respondents' parents or significant others. This will ensure two perspectives on a particular answer, and thus highlight discrepancies. The suggestion is that both interviews take place consecutively, so as to reduce informant bias;
6. the CTDCC source funding to conduct a longitudinal follow-up study, to investigate the same sample over a 12, 24, 36 month period, in order to evaluate the effect of the treatment programme over a longer time span. It is further recommended that the funding should include measures to improve the follow-up contactablity of the respondents;
7. an additional study be conducted in conjunction with the longitudinal study in an attempt to establish the long-term effects of the treatment programme and specifically the alternative therapies. The researcher is curious about the long-term benefits of the alternate therapies. The study clearly shows that they have obvious short-term benefits for the client. The researcher is of the opinion that by exploring the long term effects of the treatments better understanding of their role in the recovery process can be obtained thereby promoting their use in other treatment programmes.

5.10 Collaborative Partnerships to Promote Programme Evaluation Research in The Western Cape

In an attempt to standardise programme evaluation in the substance abuse treatment field in the Western Cape, the researcher would like to make the following recommendations.

It is recommended that:

1. the CTDCC should enter into a working relationship with all other treatment centres in the Western Cape, in an attempt to establish basic treatment programme evaluation standards;
2. a regional program evaluation body should be established in order to monitor treatment programmes effectively;
3. as part of the regional programme evaluation body effective data collecting procedures, including a data collection form, should be compiled by the participating treatment agencies. The collected data should be treatment specific. The data should be returned to the participating treatment centres in the form of quarterly feedback regarding a range of issues. The issues could cover treatment specific aspects e.g. treatment approaches and abstinence, the types of drug being used and/or changes in drug-related criminal activity;
4. local policy indicators should be developed relating to minimum standards for programme evaluation in the Western Cape. All participating treatment professionals should agree with the indicators. These minimum standards should be outcomes specific or results orientated. The researcher feels that the minimum standards selected should be realistic and reflect what is possible, as opposed to what is desirable. The latter may not be realistically obtainable;
5. the evaluation of drug abuse treatment should focus on the effects of treatment, and not on the drug problem itself;

6. treatment programme evaluation research should focus on rates of improvement as a result of drug abuse treatment, rather than on simply documenting a "cure". The researcher proposes that participating treatment professionals decide on alternative measures of success other than abstinence in order to contextualise abstinence;
7. the suggested minimum standards should include the degree of expected change in the client's behaviour. This expected change should be realistic and take into consideration the resources that are available to the treatment centre and the individual client;
8. it is recommended that all treatment centres in the Western Cape question clients on admission with regards to drug related criminal activity prior to assessment. This is in order to develop a deeper understanding of the relationship between crime and drug abuse from the treatment perspective. This should be done in a sensitive and respectful manner. Any future studies in this area should link with the current Drugs and Crime Study being conducted by the Medical Research Council and the Institute for Security Studies;
9. the suggested minimum standards should include periodic assessment of whether clients receive the treatment they need and whether [and which] other improvements are needed in treatment;
10. the suggested minimum standards should include methods of determining whether the benefits outweigh the costs of investing in the treatment system;
11. future research efforts should focus on evaluating these areas, and also on monitoring the ongoing needs of the drug-using population.

To summarise, this has been an explorative study that has shown that the treatment programme offered by the CTDCC, at the time of the study, was effective in terms of abstinence. The CTDCC programme has problems with

client retention and there is room for improvement. Overall the evaluation reflects a positive picture of the services offered by the CTDCC.

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CAPE TOWN DRUG COUNSELLING CENTER INTAKE QUESTIONNAIRE

Client details

Surname of Patient: _____

Christian names: _____

Home Address: _____ **Code:** _____

_____

_____ **Home phone:** _____

Contactable relative or friend

Name: _____ **Relation:** _____ **Ph:** _____

Employer

Employment status:

EMP	UNEMP	SELF	NEV	**STU**	OTHER

Employer: _____

Address: _____

Contact person: _____ **Phone:** _____

Medical Aid **No:** **Member:**

Salary:Self/Parent _____ **Fee:** _____ **Proof Supplied:**

YES	NO

If STUDENT which school does client attend: _____

Did you attend a drug prevention workshop at school:

YES	NO

File Details

Assessment Date: _____

File No: _____ **File Re-opened?**

YES	NO

Times Re Rx'D:

Therapists [Surname and Initial]: _____

Home Language:

ENG	AFR	XHO	OTHER

Date of Birth: _____ **Age:** _____ **Gender:**

MALE	FEMALE

Marital Status

NEVER	LEGAL	WIDOWED	LIVING TOGETHER
SEPARATED		DIVORCE	OTHER

Religion

CHRISTIAN		BUDDHIST		AGNOSTIC
HINDU	JEWISH	ATHEIST	MOSLEM	OTHER

Current occupation type

EXECUTIVE		TECHNICAL	MANAGER
CLERK	SKILLED	UNSKILLED	STUDENT
PROFESSIONAL		HOUSE WIFE	OTHER

Residential Suburb _____ **Travel Distance:** _____

Referral source

SOCIAL WORKER	FAMILY	LEGAL	SELF	SCHOOL	DOCTOR
EMPLOYER	WELFARE	HOSPITAL	FRIEND	OTHER	

DRUG COUNSELLING CENTRE ASSESSMENT FORM: 2000

SECTION 1: REASON FOR PRESENTATION NOW

I was wondering what brought you to the centre today

_____

_____

Present work and domestic situation:

_____

_____

SECTION 2: DRUGS - PRESENT DRUGGING:

2.1 MAIN DRUGS USED:

ALC	AMP	APP	BAR	BENZ	COC
COU	CRA	DAG	EXT	INH	LSD
MDX	OPI	PAIN	OTHER		

Other = specify _____

_____

2.2 Other drugs:

_____

_____

2.3 Pattern of abuse:

_____

_____

_____

_____

2.4 DURATION OF USE:

1-6 wks	6w- 3mths	3-6 mths	6-12 mths	1-2 yrs
2-5 yrs	5-10 yrs	10-15 yrs	15-20 yrs	21 yrs +

Other = specify _____

_____

2.5 DATE OF LAST USE OF PRESENTING DRUG:

TODAY	YES/DAY	1-2 days	3-4 days	5-6 days
> 1 wk	> 1 mth	> 2 mths	> 3 mths	OTHER

Other = specify _____

_____

2.6 DATE OF LAST USE OF ANY DRUG: [often the same reply as 2.5]

TODAY	YES/DAY	1-2 days	3-4 days	5-6 days
> 1 wk	> 1 mth	> 2 mths	> 3 mths	OTHER

_____

_____

2.7 Why do you use drugs?

2.8 Withdrawal symptoms present:

2.9 Why do you want to stop drugging now?

SECTION 3: PAST DRUGGING:

3.1 WHAT WAS THE FIRST DRUG YOU USED?

ALC	AMP	APP	BAR	BENZ	COC
COU	CRA	DAG	EXT	INH	LSD
MDX	NICO	OPI	PAIN	OTHER	

Other = specify ___PLEASE BE ADVISED THAT NICO = NICOTINE. ASK THE CLIENT IF THIS WAS THE FIRST DRUG USED, IF **YES** THEN PLEASE ASK **WHAT WAS THE SECOND DRUG USED** THIS IS VERY IMPORTANT.

3.2 IF REPLY IS NICO HOW OLD WERE YOU WHEN YOU FIRST SMOKED?

0 to10	11-14	15-18	19-21	22 to 25	26 to 30	30 to 40	41+

3.2.1 HOW OLD WERE YOU WHEN YOU FIRST USED DRUGS? NB NOT NICO

0 to10	11-14	15-18	19-21	22 to 25	26 to 30	30 to 40	41+

3.3 HAVE YOU EVER STOP USING DRUGS BEFORE?

Yes	No

3.4 IF YES FOR HOW LONG?

1-7 days	> 1 wk	> 1 mth	> 2 mths	> 3 mths	Other

Other = specify_____

3.5 Why did you stop in the past?

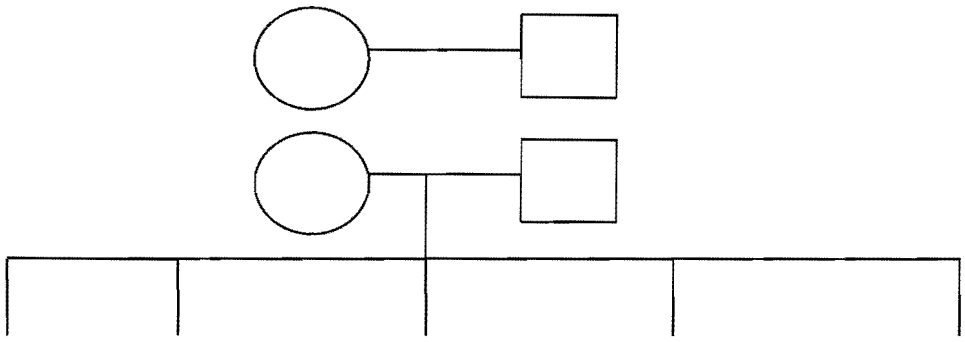
3.6 Why did you start again?

3.7 Did you seek help in the past for your drug problem?

Yes	No

3.8 If YES where?

SECTION 4: PERSONAL AND FAMILY HISTORY



4.1 DO YOU HAVE YOUR OWN CHILDREN? YES NO

4.2 IF YES DO THEY LIVE WITH YOU? YES NO

4.3 EDUCATION:

< = 5	6 to 8	9 to 10	Tech	Other

Other = specify _____

4.4 EMPLOYMENT HISTORY:

EMP	UNEMP	SELF	NEV	STU	OTHER

Other = specify _____

4.5 Relationship / Marital History:

4.6 Legal History:

4.7 Previous / Current Psychiatric Treatment:

SECTION 5: PERSONALITY:

5.1 How would you describe yourself?

5.2 Social Life/ Friends:

5.3 Use of Leisure Time:

5.4 Religious / Spiritual Life:

5.5 Premorbid Personality - how were you before you started drugging?

SECTION 6: MENTAL STATUS

6.1 Appearance, behaviour and mood in interview:

6.2 Client's description of usual and present mood:

6.3 Presence of suicide ideation - in the past and now:

6.4 Previous suicide attempts:-

6.5 Disorders of perception / thought/ physical:

Orientation		Appetite	
Memory		Weight	
Sleep		Libido	
Concentration		OTHER	

Other = specify _____

SECTION 7: INSIGHT INTO DRUGGING:

7.1 How bad do you think your drug problem is?

_____

_____

7.2 If you don't stop drugging now, where will you be in two years?

_____

_____

7.3 If you do manage to stop drugging now, how will your life change?

_____

_____

SECTION 8: CONFIDENTIALITY

8.1 Who may we speak to about client?

_____

_____

_____

_____

SECTION 9: HIGHEST LEVEL OF FUNCTIONING IN PREVIOUS YEARS AND IN THE LAST YEAR:

_____

_____

_____

SECTION 10: LEVEL OF PSYCHOSOCIAL STRESSORS:

_____

_____

_____

SECTION 11: EVALUATION / SUMMARY

_____

_____

_____

SECTION 12: PROVISIONAL DIAGNOSIS

_____

_____

_____

SECTION 13: INITIAL MANAGEMENT

_____

_____

_____

SECTION: 14 RESEARCH

14.1	Are you willing to participate in the research project?	YES	NO
14.2	Can the researcher contact you regarding the research?	YES	NO
14.3	Can the researcher contact your **family** in order to get hold of you **for research purposes only**? Yes = WHO? _____ TEL: _____	YES	NO
14.4	Can the researcher contact your **friend** in order to get hold of you **for research purposes only**? Yes = WHO? _____ TEL: _____	YES	NO
14.5	Can the researcher contact your **employer** in order to get hold of you **for research purposes only**? Yes = WHO? _____ TEL: _____	YES	NO
14.6	Can the researcher contact your **school** in order to get hold of you **for research purposes only**? Yes = WHO? _____ TEL: _____	YES	NO
14.7	Can the researcher contact **anybody else** in order to get hold of you **for research purposes only**? Yes = WHO? _____ TEL: _____	YES	NO

SECTION ONE YES NO

I hereby give permission for the researcher to use data contained in the file

SECTION TWO YES NO

I further consent to partake in the research and provide the researcher with permission to contact me with regards to my experiences of the CTDCC in order for him to obtain information from me relevant to the current research project.

Signature: _____

Date: _____

Cape Town Drug Counselling Centre Data Collection Sheet

Date on which the quantitative section was completed. _____ Y TEST 1

N.P. N

1 Respondent details

1.1 Assessment Date: _____

1.2 File No: NO DATA 0

											Total
1.3 Gender:	Male	0	Female	0	1.4 Age in years:	0					0
1.5 Suburb:											
1.6 Language:	English	0	Afrikaans	0	Xhosa	0	Other	0			0
1.7 Marital Status:	LEG	0	LIV	0	WID	0	SEP	0			
	DIV	0	NEV	0	UNK	0	OTHER	0			0
1.8 Referral Source:	DOC	0	EMP	0	FAM	0	FRIEND	0			
	HOS	0	LEG	0	SCH	0	SELF	0			
	SOC	0	WEL	0	UNK	0	OTHER	0			0

2 Employer Status:

													Total
2.1	EMP	0	UNEMP	0	SELF	0	NEV	0	STU	0	OTHER	0	0
2.2	If **STU** which school does clt attend:												
2.3	Did you attend a drug prevention program while at school									YES	0	NO 0	0
2.4	Standard	< = 5	0	6 to 8	0	9 to 10	0	Tech	0	OTHER	0		0

3 Presenting drug pattern

3.1 Presenting drugs:

ALC	0	AMP	0	APP	0	BAR	0	BENZ	0	COC	0		
COU	0	CRA	0	DAG	0	EXT	0	INH	0	LSD	0		
MDX	0	NICO	0	OPI	0	PAIN	0	OTHER	0				0

3.3 Duration of usage:

1-6 wks	0	6w- 3mths	0	3-6 mths	0	6-12 mths	0	1-2 yrs	0	
2-5 yrs	0	5-10 yrs	0	10-15 yrs	0	15+ yrs	0	OTHER	0	0

3.4 Date of last use of the presenting drug:

TODAY	0	YES/DAY	0	1-2 days	0	3-4 days	0	5-6 days	0	
> 1 wk	0	1-2 mths	0	2-3 mths	0	3-4 mths	0	4 mths +	0	0

4 History

4.1 First drug used:

ALC	0	AMP	0	APP	0	BAR	0	BENZ	0	COC	0	
COU	0	CRA	0	DAG	0	EXT	0	INH	0	LSD	0	
MDX	0	NICO	0	OPI	0	PAIN	0	OTHER	0			0

4.2 Age of first use NICO:	0 to10	0	11 to 14	0	15 to 18	0	19 to 21	0	
	22 to 25	0	26 to 30	0	30 to 40	0	41+	0	0
4.3 Age of first use OTHER:	0 to10	0	11 to 14	0	15 to 18	0	19 to 21	0	
	22 to 25	0	26 to 30	0	30 to 40	0	41+	0	0

4.4 Date of last use of any drug:

TODAY	0	YES/DAY	0	1-2 days	0	3-4 days	0	5-6 days	0	
1wk-1mth	0	1-2 mths	0	2-3 mths	0	3-4 mths	0	4 mths +	0	0

4.5 Have you ever stopped B4 attending the center:						YES	0	NO	0		0
4.6 If YES what was the longest time stopped in the past:											
1-7 days	0	1wk-1mth	0	1-2 mths	0	2-3 mths	0	3-4 mths	0	4 mths +	0	0

5 Social background

5.1 Do you have your own children:	YES	0	NO	0	0
5.1.1 If YES do they live with you:	YES	0	NO	0	0

6 WEEK INTERVIEW SCHEDULE

File No:		0	N.P.	0	TEST	1	NO DATA	0	PHONE	0

Clt contacted on: Date: _____

Date: _____

Date: _____

Letter: Sent on: _____

1 **General** Response: _____

1.1 How many weeks did you attend:

< 1 wk	0	1-2 wks	0	2-3 wks	0	3-4 wks	0
4-5 wks	0	5-6 wks	0	6-7wks	0	7 Wks +	0

1.2 Have you used any drugs in the past **6 weeks**: **YES** 0 **NO** 0

1.3 If **YES** what drugs have you used:

ALC	0	AMP	0	APP	0	BAR	0	BENZ	0	COC	0
COU	0	CRA	0	DAG	0	EXT	0	INH	0	LSD	0
MDX	0	OPI	0	PAIN	0	OTHER	0				

1.4 If **YES** when last did you use any drug:

Today	0	Yesterday	0	1-7 days	0	1-2 wks	0	3-4 wks	0
5-6 wks	0	6wk -3mth	0	3-6 mths	0	6 Mths +	0		

1.5 If **YES** can you tell me WHY you used drugs in the last 6 weeks:

1.5.1 _____

_____

1.5.2 _____

_____

1.5.3 _____

_____

1.6 If **NO** WHY do you think that you have not used drugs in the last 6 weeks:

1.6.1 _____

_____

1.6.2 _____

_____

1.6.3 _____

_____

2 **Treatment sessions**

At the D.C.C. you will have attended a number of sessions as part of the programme.
I would like to ask you about each session that made up your treatment programme.

2.1 Did you attend **individual** therapy sessions:	YES	0	NO	0	Don't no	0
2.1.1 If **YES** was it useful:	YES	0	NO	0	Don't no	0

2.1.2 If **YES** why was it useful: _____

_____

_____

2.1.3 If 2.1.1 = **NO** why not: _____

_____

_____

2.2 Did you attend **motivational** groups:	YES	0	NO	0	Don't no	0
2.2.1 If **YES** was it useful:	YES	0	NO	0	Don't no	0

2.2.2 If **YES** why was it useful: _____

_____

2.2.3 If 2.2.1 = **NO** why not: _____

_____

2.3 Did you attend **art** therapy groups:

YES	0	NO	0	Don't no	0

2.3.1 If **YES** was it useful:

YES	0	NO	0	Don't no	0

2.3.2 If **YES** why was it useful: _____

_____

_____

2.3.3 If 2.3.1 = **NO** why not: _____

_____

_____

2.4 Did you attend **spirituality** groups:

YES	0	NO	0	Don't no	0

2.4.1 If **YES** was it useful:

YES	0	NO	0	Don't no	0

2.4.2 If **YES** why was it useful: _____

_____

_____

2.4.3 If 2.4.1 = **NO** why not: _____

_____

_____

2.5 Were you seen by the **psychiatrist**:

YES	0	NO	0	Don't no	0

2.5.1 If **YES** was it useful:

YES	0	NO	0	Don't no	0

2.5.2 If **YES** why was it useful: _____

_____

_____

2.5.3 If 2.5.1 = **NO** why not: _____

_____

_____

2.6 Were you seen by the **doctor**:

YES	0	NO	0	Don't no	0

2.6.1 If **YES** was it useful:

YES	0	NO	0	Don't no	0

2.6.2 If **YES** why was it useful: _____

_____

_____

2.6.3 If 2.6.1 = **NO** why not: _____

_____

_____

2.7 Did you attend **reiki** sessions:

YES	0	NO	0	Don't no	0

2.7.1 If **YES** was it useful:

YES	0	NO	0	Don't no	0

2.7.2 If **YES** why was it useful: _____

_____

_____

2.7.3 If 2.7.1 = **NO** why not: _____

_____

_____

2.8 Did you attend **aromatherapy** sessions:

YES	0	NO	0	Don't no	0

2.8.1 If **YES** was it useful:

YES	0	NO	0	Don't no	0

2.8.2 If **YES** why was it useful: _____

_____

_____

2.8.3 If 2.8.1 = **NO** why not:

2.9	Did you attend **reflexology** sessions:	YES	0	NO	0	Don't no	0
2.9.1	If **YES** was it useful:	YES	0	NO	0	Don't no	0

2.9.2 If **YES** why was it useful:

2.9.3 If 2.9.1 = **NO** why not:

2.10	Did you attend **acupuncture** sessions:	YES	0	NO	0	Don't no	0
2.10.1	If **YES** was it useful:	YES	0	NO	0	Don't no	0

2.10.2 If **YES** why was it useful:

2.10.3 If 2.10.1 = **NO** why not:

2.11	Did you attend **adolescent** groups:	YES	0	NO	0	Don't no	0
2.11.1	If **YES** was it useful:	YES	0	NO	0	Don't no	0

2.11.2 If **YES** why was it useful:

2.11.3 If 2.11.1 = **NO** why not:

2.12	Did you attend **family** therapy sessions:	YES	0	NO	0	Don't no	0
2.12.1	If **YES** was it useful:	YES	0	NO	0	Don't no	0

2.12.2 If **YES** why was it useful:

2.12.3 If 2.12.1 = **NO** why not:

3 Client evaluation

Please answer the following questions as if you were speaking to a friend.

3.1	Do you feel that the D.C.C. helped you in any way:	YES	0	NO	0		

3.2 If **YES** how do you feel or in what way did the D.C.C. help you :

3.2.1

3.22

3.2.3

3.3 If **NO** why do you feel or in what way did it not help you:

3.3.1 _____

3.3.2 _____

3.3.3 _____

4 Support Groups

4.1 Are you attending support groups outside of the D.C.C. | YES | 0 | NO | 0 |

4.2 If **YES** which ones: | N/A | 0 | A/A | 0 | Religious | 0 | Other | 0 | _____ |

4.3 If **YES** how are you experiencing the support groups:

_____

_____

4.4 If **NO** would you tell me why you are not attending:

_____

5 Personal Comments

5.1 Do you have any suggestions for the DCC

5.1.1 _____

5.1.2 _____

5.2 What were your reasons for attending the DCC:

5.2.1 _____

5.2.2 _____

5.3 What were your expectations when you first went to the DCC:

5.3.1 _____

5.3.2 _____

5.4 Do you feel that your expectations were met:

5.4.1 _____

5.4.2 _____

5.5 Do you have any negative feelings about the DCC that they should be aware of:

5.5.1 _____

5.5.2 _____

5.5.3 _____

5.6 Do you have any positive feelings about the DCC that they should be aware of:

5.6.1 _____

5.6.2 _____

6.1 Have you told others about the D.C.C.: | YES | 0 | NO | 0 |

6.2 Are you aware that you can return to the D.C.C. at any time: | YES | 0 | NO | 0 |

3 MONTH INTERVIEW SCHEDULE

File No:		0	N.P.	0	TEST	0	NO DATA	0	PHONE	0

Clt contacted on: Date: _____

Date: _____

Date: _____

Letter: Sent on: _____

Response: _____

General

1 How many weeks did you attend:

< 6 wks	0	7 wks	0	8 wks	0	9 wks	0
10 wks	0	11 wks	0	12 wks	0	OTHER	0

2 Have you used any drugs in the past 3 **MONTHS**: YES 0 NO 0

3 If **YES** what drugs have you used:

ALC	0	AMP	0	APP	0	BAR	0	BENZ	0	COC	0
COU	0	CRA	0	DAG	0	EXT	0	INH	0	LSD	0
MDX	0	OPI	0	PAIN	0	OTHER	0				

4 If **YES** when last did you use any drug:

Today	0	Yesterday	0	1-7 days	0	1-2 wks	0	3-4 wks	0
5-6 wks	0	6wk -3mth	0	3-6 mths	0	Other	0		

5 If **YES** can you tell me WHY you used drugs in the last **3 MONTHS**:

5.1 _____

_____

5.2 _____

_____

5.3 _____

6 Do you feel that your current drugging is a problem for you? YES 0 NO 0

7 If **YES** what problems are you experiencing as a result of your drugging?

7.1 _____

_____

_____

_____

_____

_____

8 If **NO** you have not used in the last **3 MONTHS**
why do you think that you have not used? _____

_____

_____

_____

_____

9 If **NO** you have not used drugs, have you changed your life style in any way? YES 0 NO 0

10 If **YES** could you please tell me what changes you have made?

10.1 _____

10.2 _____

10.3 _____

11 Did anyone place any pressure on you to to attend the CTDCC? | YES | 0 | NO | 0 |

12 If **YES** do you feel that the pressure helped? | YES | 0 | NO | 0 |

1.2.1 Who put the most pressure on you? _____

13 Can you explain why you feel that the pressure helped? _____

13.1 _____

13.2 _____

13.3 _____

14 If **NO** pressure was placed on you do you think it would have helped if external pressure had been placed on you. | YES | 0 | NO | 0 |

14.1 Explain? _____

14.2 _____

14.3 _____

15 Do you feel that your needs were met by the DCC?

15.1 _____

15.2 _____

15.3 _____

16 Are there other ways that the DCC could have assisted you?

16.1 _____

16.2 _____

16.3 _____

6 MONTH INTERVIEW SCHEDULE

File No:		0	N.P.	0	TEST	1	PHONE	0

Clt contacted on: Date: _____

Date: _____

Date: _____

Response: _____

1 General

1.1 How many weeks did you attend:

< 1 wk	0	1-2 wks	0	2-3 wks	0	3-4 wks	0
4-5 wks	0	5-6 wks	0	6-7wks	0	7 wks +	0

1.2 Are you still attending the DCC — YES 0 NO 0

1.3 Have you used any drugs in the past **6 MONTHS**: YES 0 NO 0

1.4 If **YES** what drugs have you used in the past 6 months:

ALC	0	AMP	0	APP	0	BAR	0	BENZ	0	COC	0
COU	0	CRA	0	DAG	0	EXT	0	INH	0	LSD	0
MDX	0	OPI	0	PAIN	0	OTHER	0				

1.5 If **YES** what was your presenting or drug of choice when you first came to the DCC.

ALC	0	AMP	0	APP	0	BAR	0	BENZ	0	COC	0
COU	0	CRA	0	DAG	0	EXT	0	INH	0	LSD	0
MDX	0	OPI	0	PAIN	0	OTHER	0				

1.6 If **YES** when last did you use any drug:

Today	0	Yesterday	0	1-7 days	0	1-2 wks	0	3-4 wks	0
5-6 wks	0	6wk -3mth	0	3-6 mths	0	Other	0		

1.7 If **YES** when last did you use your presenting drug:

Today	0	Yesterday	0	1-7 days	0	1-2 wks	0	3-4 wks	0
5-6 wks	0	6wk -3mth	0	3-6 mths	0	Other	0		

1.8 If **YES** has your drug usage changed. Are you using less or more drugs now than you did when you came to the CTDCC? YES 0 NO 0

10 If **YES** can you tell what your reasons are for using drugs in the last 6 MONTHS:

a _____

b _____

c _____

1.1 If **NO** WHY do you think that you have not used drugs in the last 6 MONTHS:

a _____

b _____

c _____

2 Employment Status

EMP	0	UNEMP	0	SELF	0	NEV	0	STU	0	OTHER	0

3 History

Have you been involved in criminal activity, other than drugging, since attending the DCC

YES	0	NO	0	Don't want to answer	0

4 Treatment sessions

While at the D.C.C. you will have attended a number of sessions as part of the therapy.

4.1 Which one of the following did you find the most **HELPFUL**?

PSY	0	MOT	0	DOC	0	IND	0	ARO	0	MED	0
IND	0	ART	0	REF	0	ADO	0	ACU	0	REI	0

4.2 Which one of the following did you **ENJOY** the most?

PSY	0	MOT	0	DOC	0	IND	0	ARO	0	MED	0
IND	0	ART	0	REF	0	ADO	0	ACU	0	REI	0

4.3 Are there any treatments or activities that you feel would have helped you in your recovery that are not available in the DCC treatment program.

YES	0	NO	0

4.5 If YES what are they?

5 Client evaluation

Please answer the following questions as if you were speaking to a friend.

5.1 Do you have any suggestions for the DCC

YES	0	NO	0

5.1.1

5.1.2

5.1.3

5.2 Are there things that you feel could have been done differently?

YES	0	NO	0

5.2.1

5.2.2

5.2.3

5.4 Has you quality of life improved since coming to the DCC?

YES	0	NO	0

5.4.1

5.5.2

5.5.3

6 Costing

6.1 Regarding our fees do you feel you were charged:

2 LITTLE	0	ENOUGH	0	2 MUCH	0

7 Research

Would you be willing to participate in similar research in the future.

7.1 If **NO** could you tell me **WHY**?

YES	0	NO	0

7.1.1

ctdcc

THE CAPE TOWN DRUG COUNSELLING CENTRE

Geagte Kliënt

Die Kaapstadse Dwelm Berading Sentrum gaan binnekort met 'n navorsingsprojek begin. Die doel van hierdie projek is om ons diens aan u te verbeter.

Die projek sal 1 April 2000 begin en 31 Julie 2001 eindig. Die terugvoering van ons kliënte is vir ons baie waardevol en daarom vra ons vir u om deel te wees van hierdie projek.

Ons wil die volgende belangrike punte tot u aandag bring:

1. Alle inligting wat u aan die navorser verskaf, is hoogs vertroulik.
2. Vir die navorsings doeleindes word geen name gebruik nie.
3. U hoef niks te doen om deel te wees van hierdie projek nie.
4. Die uitslae van die projek sal teen November 2001 bekend gemaak word en u is welkom om n afskrif by die sentrum te kom besigtig.
5. Na vandag sal ons u net drie keer skakel –
   Die eerste keer: 6-weke van vandag.
   Die tweede keer: 3-maande van vandag.
   Die derde keer 6-maande van vandag.

Indien u enige vrae het, bespreek dit asseblief met die terapeut wat u later vandag sal sien. Die terapeut sal ook vir u vra of u gewillig is om aan hierdie projek deel te neem.

U kan u deelname weier maar u deelname is vir ons baie waardevol en ons hoop dat u bereid sal wees om aan hierdie projek deel te neem.

Baie dankie

Paul Coetzee
(Navorser)

1 Roman Road
Observatory
7925

P.O. Box 56
Observatory
7935

Tel: 447 8026/35/45
Fax: 447 8818
e.mail:ctdcc@iafrica.com

Fundraising no: 08 800 100 0076

ctdcc

THE CAPE TOWN DRUG COUNSELLING CENTRE

Dear Client

The Cape Town Drug Counselling Centre [CTDCC] aim's to measure its services and develop new ways of providing a better service to you the client.

For this reason the CTDCC is conducting a research program that will run from 01 April 2000 until 31 July 2001. You the client are directly linked to this research as your experiences and opinions are needed to reach our goal. We at the Centre are therefor asking you to participate in the research.

The following issues are important for you to be aware off:

1. All information requested would be treated as highly confidential by the researcher at the centre.
2. No names will be mentioned in the research.
3. You will not have to do anything to participate.
4. The research will be published by November 2001 and you will be welcome to come into the centre to read a copy of the findings.
5. You will be phoned three times after today.
   ⇒ The first time 6 weeks from today.
   ⇒ A second time three months from today.
   ⇒ A third time six months from today.

If you have any questions your therapist will give you more information when you see him or her later today. Your therapist will also ask you if you would like to participate in the research program at which time you have the right to say no.

By participating you will be benefiting the CTDCC greatly. I sincerely hope that you will be willing to participate in the research.

Thank you
Paul Coetzee
(Researcher)

1 Roman Road
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