

**UNIVERSITY OF KWAZULU-NATAL**

**Evaluation of the Substance Abuse Programme of the  
South Coast Recovery Centre,  
Focusing on Patients' Satisfaction.**

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A mini-thesis submitted in partial fulfilment of the requirements for the Master's degree  
in Clinical Psychology in the Department of Psychology, University of the KwaZulu  
Natal

2009

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## DECLARATION

I declare that *Evaluation of the Substance Abuse Programme of the South Coast Recovery Centre, Focusing on Patient's Satisfaction* is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Welmi Booyens

February 2009

Signed: .....

## ACKNOWLEDGEMENTS

I would hereby like to thank first and foremost Jesus Christ for giving me both the strength and ability to complete this study.

A heartfelt thank-you to my family, who have guided, supported and encouraged me every step of the way.

To all my friends who supported me in different ways in order for me to finish this study.

To the management and residents of the South Coast Recovery Centre where this study was conducted, thank you for making this study possible.

To my fellow students and colleagues, as well as other staff members of UKZN, for sharing information and providing support.

And last but not least, thank you to my supervisor Prof Duncan Cartwright, for all his patience, guidance and assistance. May you have every success in your future.

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## **ABSTRACT**

Substance abuse has a severe impact on the South African population. Various organizations, governmental and non-governmental, take on the challenge to assist in the treatment of substance abuse. Several gaps have been identified in dealing with substance abuse in South Africa. One of these gaps includes regular audits of treatment services and prevention programmes. One of the major concerns is that most primary prevention programmes appear to be implemented in the absence of evidence on their effectiveness and are mostly implemented on an ad hoc basis. The respondent organizations appear to display a poor understanding of evaluation. It was evident that there is a need for a systematic review of what works in the context of substance abuse prevention among the South African population as well as the development of an effective regulatory regime regarding primary prevention activities. Evaluation can be an important tool to provide monitoring, as well as a tool to identify strengths and weaknesses in treatment programmes.

In light of the above, the South Coast Recovery Centre, a substance abuse treatment centre that operates in the private sector, was approached to evaluate the effectiveness of its treatment programme. The research focused on gaining insight into and exploring the strengths and weakness of the programme based on how patients experienced the programme and how satisfied they were with it.

The use of multimethod approach which included positivist and interpretative approaches to evaluation was viewed as an appropriate method to use for the study in facilitating an understanding of the patient's experience of the programme and how satisfied they were with the intervention they received. The study is both qualitative and quantitative in nature and used questionnaires and focus group interviews as data sources. All participants in the study were inpatients at the South Coast Recovery Centre. Frequency distributions, chi square analysis, as well as a thematic analysis were used to analyze the data of the study.

The study concluded that patients were in general satisfied with the treatment programme. The programme provided opportunity for behavior changes and introspective learning. They were satisfied with professionals' skills and behaviours,

types of interventions provided, efficacy and accessibility. Areas that patients were not satisfied with included: the facilitated involvement of relatives, the provision of information, and the large amount of residents in the programme.

Recommendations were made with regards to programme improvement. The recommendations included the following:

- a. A coherent programme with clear links between outcome objectives and programme activities should be created.
- b. The number of counsellors in the programme should be reconsidered.
- c. The number of patients that should be allowed in the programme should be reconsidered.
- d. A platform for counsellors to deal with their personal emotions and counter transference should be created.
- e. Counsellors' emotional involvement with patients should be addressed and exposed.
- f. More structured leisure activities that use interactive learning styles could be implemented in order to facilitate the learning of social skills.
- g. An awareness of possible comorbid mental disorders should be developed.
- h. Patients can be more involved with the cost aspect of the programme in order to facilitate more ownership of their treatment process.
- i. Provision should be made in the programme to allow for more involvement of relatives.

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# CHAPTER ONE

## INTRODUCTION

### 1.1 BACKGROUND

*“Our country is faced with a growing problem of substance abuse. This has implications for millions of citizens because it contributes to crime, domestic violence, family disintegration and other social problems.”* (Mr. Nelson Mandela, The National Drug Master Plan, 1999).

The growing problem of drug and alcohol abuse is a problem that cannot be ignored. According to the World Health Organization (2002), there are 185 million illicit drug users in the world and 2 billion alcohol abusers. Although statistics on drug use in South Africa are limited and vague, indications are that 32.8% of males and 32.4% of females are abusing substances in South Africa (WHO, 2002).

A recent South African study (Parry, Bhana, Myers, Pluddemann, Flisher, Peden, et. al., 2002) showed that alcohol contributed in some way to 40,3% (Durban) and 91,8% (Port Elizabeth) of patients' reasons for being admitted to trauma units. Alcohol was also implicated in 40,3% (Durban) and 67,2% (Port Elizabeth) of mortality cases. Further, Parry et. al. (2002) also found that school children tested positive for alcohol in 54,3% (Durban) and 36, 5% (Cape Town) of the cases explored. The above statistics, although based on one study, highlight the gravity of substance abuse problems in South Africa.

### 1.2 MOTIVATION FOR STUDY

In a review of the National Drug Master Plan of South Africa (Parry, 2005), it is evident that there are several gaps in dealing with substance abuse in South Africa. One of these gaps includes regular audits of treatment services and prevention programmes. According to a report to Parliament by the South African Medical Research Council (SAMRC, 2008), one of the major concerns was that most primary prevention programmes appear to be implemented in the absence of evidence on their effectiveness and are mostly implemented on an *ad hoc* basis. The respondent organizations also displayed a poor understanding of evaluation. It was evident that

there is a need for a systematic review of what works in the context of substance abuse prevention among South African populations as well as the development of an effective regulatory regime in the form of minimum norms and standards for primary prevention activities. Parry (2005) also indicated that to ensure that substance abuse prevention meets international best practice standards, publicly-funded primary prevention training courses should be developed for organizations doing prevention work. This study attempted to address some of these concerns through investigating patient satisfaction at a rehabilitation unit.

### 1.3 THE AIMS OF THIS STUDY

The aims were:

- a. To generate knowledge on the patients' satisfaction levels for different aspects of the treatment programme;
- b. To determine how satisfaction levels are related to the general characteristics of the programme and what it reveals about the programme's strengths and weaknesses.

### 1.4 CHAPTER OUTLINE

The study will be presented as follows: In chapter two relevant literature in the area of substance abuse will be reviewed as well as associated factors, treatment, and the characteristics of effective programmes. Chapter three focuses on the theoretical framework of the study. Based on the complex nature of substance abuse and factors impacting on treatment, general systems theory was used as a theoretical framework for this study. This was integrated with a person-centered approach. Chapter four describes the research methodology. The research design of a multi method approach was used. A combination of qualitative and quantitative approaches is described. The chapter further describes the sample of the South Coast Recovery Centre, the research instrument, data collection procedures, as well as ethical considerations. In chapter five the findings of the study are presented and quantitative and qualitative data are used to substantiate the findings. The discussion of the findings is found in chapter six. The findings are integrated and assessed in light of the theoretical framework and compared to findings of previous studies discussed in the literature review. The recommendations and conclusions form the final section of chapter six.

## **CHAPTER TWO**

### **REVIEW OF LITERATURE**

Substance abuse can be linked to a number of factors that need to be considered in treatment. A number of factors external to the treatment programme may impact recovery. Further, various other factors have an influence on treatment from within the treatment context. For example, individual ‘external’ factors associated with substance abuse like, culture, and gender, have an effect on treatment, while the content of the program itself also affects the outcome of treatment. Other factors like the management’s viewpoints with regard to treatment approaches and factors like drop-out rates also have an impact on substance abuse treatment. Part of the objective of this study is to explore some of these factors from the viewpoint of the patient and the service provided.

#### **2.1 SUBSTANCE ABUSE AND ASSOCIATED FACTORS**

Substance abuse can be linked to a number of psychological and social factors that needs consideration in the treatment of substance abuse problems. Psychopathology, socio-economic factors, psychological factors, cultural influences, and gender have been found to be important factors associated with substance abuse.

##### **2.1.1 Psychopathology**

The National Institute of Drug Abuse found that 6 out of 10 people a substance abuse disorder also have a mental disorder (NIDA, 2009). This is often overlooked in the treatment of substance abuse. The most important aspect to be considered in the treatment of those with dual diagnosis is the development of an integrated treatment programme. This integrated treatment programme should simultaneously provide treatment for the mental illness and the substance abuse disorder (Wormer & Davis, 2003).

##### **2.1.2 Socio-economic factors**

Often substance abuse can be linked to job loss, poverty, poor housing and living conditions, family violence and abuse, and restricted access to resources (Petersen & McBride, 2002). Several studies refer to the positive correlation between crime and

substance abuse. (French, McCollister, Alexandre, Chitwood, & McCoy, 2004; Bean & Nemits, 2004). Parry, Pluddeman, Louw and Legget (2004) found that 45% of people arrested for crime in South Africa, tested positive for at least one drug. The correlation between substance abuse and crime flow into affecting the economy. The patients involvement with crime, although not always self-evident, pose a number of challenges to treatment programmes in terms of whether such patients can be treated successfully and the overall impact this may have on the programme (Parry, Pluddeman, Louw and Legget, 2004).

Social class has a complex relationship with substance abuse. It is reported that people from lower socio-economic groups are more vulnerable to substance abuse disorders (Wallace, Kohatsu & Last, 2007). However, it has also been argued that substance abuse problems occur across all social classes. Although people from lower socio-economic groups are more vulnerable for substance abuse, it is not exclusive to people from lower socio-economic groups (Petersen & McBride 2002). According to Alterman (1985), substance abuse takes different forms in different classes. Higher socio-economic groups drink more often, while lower socio-economic groups have fewer drinkers, but a higher percentage of this smaller number drinks problematically. Substance abusers from lower socio-economic classes have less access to treatment facilities and usually surface in prisons and morgues, while substance abusers from the middle and upper socio-economic classes are treated more privately and have more access to treatment facilities (Alterman, 1985).

The above factors appear to contribute to patients moving in and out of treatment programmes and impact on treatment outcomes (Petersen & McBride, 2002).

### 2.1.3 Psychological factors

It has been found that trauma (e.g. sexual abuse, physical abuse) contributes to substance abuse (Wyatt, 2007). Substance abuse has also been associated with risky behaviour. More particularly, it has been found that substance abuse is linked to increased risky sexual behaviour among South African adolescents (Morojele, Brooks & Kachieng, 2006; Kadivar, Garvie, Heston & Flynn, 2006). This is mainly due to the effect of drugs on inhibitions, rational thinking, and safer sex negotiation skills. Increased risk to HIV infection is therefore a common factor associated with

substance abuse. Conversely, trauma and adjustment problems related to HIV/AIDS diagnosis may also lead to substance abuse problems (Wyatt, 2007).

Relapse of a recovered addict is another important psychological factor associated with substance abuse and needs consideration in the treatment programme.

According to a study done by Xie, McHugo, Fox and Drake (2005) almost one-third of patients relapsed within the first year after treatment. After three years almost half of the patients relapsed and by nine years more than two-thirds had relapsed. In outcome studies of alcoholics, approximately 65-70% of patients have been found to relapse within one year of treatment, with the majority of these patients relapsing within less than three months (Miller & Hester, 1986). In outcome studies of drug- or polysubstance-dependent patients, relapse rates following treatment are similar to, if not greater than, those found for patients solely dependent on alcohol (McKay, Alterman, Rutherford, Cacciola & McLellan, 1999). These findings confirmed the chronic fluctuating nature of substance abuse.

It is also important to be aware of the impact that substance abuse has on significant others. Studies by Hussong and Hicks (2003) and Fair (2006), indicated that drug using parents often neglect their children's emotional growth and this, in turn, leaves them vulnerable to substance abuse themselves.

#### 2.1.4 Gender factors

According to Heflinger, Chatman and Robert (2006), substance abuse disorders are more frequently found in males than females. Green (2006) found that women are less likely to enter substance abuse treatment programmes. However, once a woman gained access to treatment, their outcomes were more positive. It is important to note that gender-specific treatment was found no more effective than mixed-gender treatment (Green, 2006). According to Green (2006) gender-specific treatment refers to treatment programmes that were designed for a specific gender and would include having only that specific gender in the programme.

#### 2.1.5 Cultural factors

The study of Choi, Harachi and Catalano (2006) suggested that contributing factors linked to substance abuse in adolescents were similar regardless of race or ethnicity. However, other studies showed that predictors of vulnerability to substance abuse

differ between cultures. Examples of these differences include sensation seeking, peer influences on substance use and peer pressure (Brown, Miller & Clayton, 2004). Very little research has been done on the role of culture in the treatment of substance abuse, especially in South Africa. It is evident that all substance abusers are not the same, and racial and ethnic values are a critical part of engaging and maintaining people in the recovery process (Wormer & Davis, 2003). Treatment programmes therefore need to be sensitive to understanding cultural differences and practices.

## 2.2 TREATMENT

The Royal College of Psychiatrists defines the treatment of substance abuse as follows:

*“The prevention and reduction of harm resulting from the use of drugs, includes social, psychological or physical harm, and may involve medical, social or educational interventions, including prevention and harm reduction.”* (Royal College of Psychiatrists, 2000, p.155).

Awareness of the health problems associated with the misuse of substances emerged in the 1930s, when people began to view alcoholics as sick rather than sinful (Wormer & Davis, 2003). In the 1950s, the treatment of addiction took a progressive turn when addiction was conceptualized as a disease (Wormer & Davis, 2003). Although this led to some stigmatization, it also led to the development of programmes like Alcoholics Anonymous (A.A.), which offered a highly structured programme for recovery. A.A.-type programmes view addiction as a physical and emotional illness from which the addict can recover but cannot be cured. These programmes are guided by basic steps that have to be followed in order to recover and be able to live a healthy life (Alcoholics Anonymous, 2001). More recently, treatment strategies have moved away from dogmatic authoritarian strategies to approaches based more on motivational strategies shaped by the individual’s need. (Wormer & Davis, 2003)

According to Marsden, Ogborne, Farrell and Rush (2000a), different types of services and treatments have been developed for substance abuse disorders and can be broadly categorized as “open access” services and “structured” services. “Open access” services would include advice, education, information and early intervention

programmes. “Structured” services would include prescribed interventions (inpatient/outpatient/community settings), community-based psychosocial counselling, relapse prevention and residential rehabilitation programmes. These are however, not the only services available. Social reintegration and support services may sometimes be used to support treatment given by “open access” or “structured” services (Marsden, Ogborne, Farrell & Rush, 2000a). Social reintegration refers to any social intervention with the aim of integrating former or current drug users into the community. The three areas of social reintegration are housing, education and employment. Other measures, such as counselling and leisure activities may also be used (EMCDDA, 2005). This study will focus on the evaluation of a “structured” service domain, namely an inpatient, community-based, treatment programme.

## 2.2.1 Current issues in treatment.

### 2.2.1.1 *Accountability*

The need for greater accountability in substance abuse treatment programmes in South Africa was raised in the National Drug Master Plan of South Africa (Parry, 2005). Bordnic, Waller and King (2004) also emphasize similar issues. The need for accountability has been influenced by the implementation of managed care systems and evidence-based medicine, restriction of funds and competitive funding systems, as well as pressure from mental health consumers and family members. Consequently, substance abuse treatment programmes are being held more responsible for the quality and outcome of treatment and service delivery methods.

### 2.2.1.2 *Accessibility to adequate treatment*

It appears that South Africa is not currently able to cope with the increased demand for treatment from younger persons (Myers, Parry & Pluddeman, 2004). In addition, it has been found that many treatment programmes do not operate according to evidence-based models and use outdated practices that focus on single components (Myers, et al., 2004). Programmes that focus on single components only focus on certain aspects of substance abuse, for example on social skills. Alternatively, treatment programmes can use a multimodal approach to address multiple aspects of substance abuse (First Nations, Inuit and Aboriginal Health, 2005). Another study found that treatment services for alcohol addiction in South Africa appear adequate, but the demand for narcotic treatment services is in increasing demand (Myers, et al.,

2004). Either way, it still appears that substance abuse treatment programmes remain largely inaccessible to woman and black South Africans (Myers et al., 2004). The need for accessible and comprehensive services is highlighted by Parry (2005) and recommendations have been made to evaluate and improve access to services.

#### *2.2.1.3 Inpatient or Outpatient Treatment?*

There is ongoing debate as to whether inpatient or outpatient treatment is superior. A study (Schneider, Mittelmeier, & Gadish, 1996) that was done on cocaine dependence, showed that after 3 months the inpatient group had a statistically higher rate of total abstinence when compared with the outpatient group, but the difference at 6 months was not statistically significant. The costs of outpatient treatment was however much lower than those of inpatient treatment. However, the extra time that it took to reach the same level of treatment as the inpatient group appeared to increase the end costs. This is mainly because outpatients had to spend more time in individual therapy sessions, which contributed to the increase in the cost of treatment (Schneider, et al., 1996). A study done by Moos, Finney and Moos (2000), showed that an episode of inpatient care may provide additional resources that enhance treatment outcomes for some patients with comorbid diagnoses. From these research studies (Moos et al., 2000; Schneider et al., 1996) it is evident that both inpatient and outpatient treatment can be effective and have a role to play. It is important though to assess the patient's unique circumstances before a decision is made on the type of treatment. Duffy, Dunlap and Zarkin (2001) found that client characteristics impacted on treatment setting choice. For instance, problem severity, which was measured by frequency of use at admission, was generally positively associated with inpatient admission (higher usage increases chances of admission). Further, being homeless and referred by a treatment provider also was a positive predictor for inpatient treatment. On the other hand, being employed generally reduced the likelihood of inpatient treatment.

#### *2.2.1.4 Abstinence or controlled use?*

There are many controversies around the issue of abstinence or controlled use. Some suggest that a gradual decrease of substances should be the way to treat, while others promote total abstinence. On the one hand, once the use of substances has escalated to dependence, it is unlikely that the patient can return to the controlled use of alcohol or

drugs (Foirentine & Hillhouse, 2001). From this point of view, the inability to control use is not the result of poor motivation or the inability to learn behavioral techniques, but is seen to be the nature of addiction itself. On the other hand, others argue that treatment should be flexible, must suit the client, and the client should not be forced into a standardized treatment process (Wormer & Davies, 2003). The treatment philosophy and approach would be clearly influenced by the treatment programme's view on the issue of abstinence or controlled use.

### 2.3 CHARACTERISTICS OF EFFECTIVE PROGRAMMES

According to Springer, Sale, Hermann, Sambrano, Kasim, et al. (2004), findings on evaluation studies in substance abuse programmes are limited to the uniqueness of every setting. Each individual evaluation study captures a unique programme implemented in a unique set of circumstances. Given this, one has to be cautious in applying information from one programme to another. They did, however, find in their research that there are connections between setting, organization and programme design, which can strengthen or diminish programme effects.

Over the last decade, there has been a rapid increase in the development of substance abuse programmes. Springer et al. (2004) reported a study that includes 46 programmes. Aspects of the programmes that were effective in reducing substance abuse on a consistent and lasting basis included: 1) A focus on behavioral life skills development; 2) emphasis on team-building and interpersonal delivery methods; 3) emphasis on introspective learning approaches focusing on self-reflection; 4) clearly articulated and coherent programme theory and 5) intensive psychotherapy or counselling sessions particularly with youth.

#### 2.3.1 Behavioral life skills content

Research on the effectiveness of the "information only approach" has demonstrated that while these programmes may improve knowledge related to alcohol and drug use and might have a slight effect on attitudes toward substance use, they have little effect on actual behaviour (Botvin, 1986; Brown & Caston, 1995). Behaviour life skills programmes emphasize the development of behavioral and social skills as protection against use. This includes refusal skills, anger management, conflict resolution, decision-making skills, social skills and academic enrichment

interventions. Despite research showing that the information approach is ineffective, many programmes continue to use this approach. Research findings indicate that this approach should only be used in combination with other modalities (Botvin, 1986; Brown & Caston, 1995; Springer et al., 2004).

### 2.3.2 Teambuilding and interpersonal methods

Techniques that focus on building positive relationships with peers or supportive adults, and methods that use interactive, rather than passive learning styles, are more effective (Springer et al., 2004). Garrity, Prewitt, Joosen and Tindall (2006) confirmed the effectiveness of the interpersonal method. They found that the building of social support might help to lessen subjective stress and its consequences. Motivational interviewing seems to be a very effective interpersonal method to establishing positive, supportive relationships. It has been shown to help the patient to overcome ambivalent feelings about treatment and moving towards change. (Petersen & McBride, 2002; Wormer & Davis, 2003). Motivational interviewing is a directive, client-centered counselling style for eliciting behavior change by helping clients to explore and resolve ambivalence. The examination and resolution of ambivalence is its central purpose, and the counselor is intentionally directive in pursuing this goal (Rollnick & Miller, 1995). Although motivational interviewing has showed to have positive outcomes in short term substance abuse treatment, evidence for positive outcomes in long terms substance abuse treatment still need to be established (Carroll, Ball, Nich, Martino, Frankforter, et al., 2006)

### 2.3.3 Introspective learning approach.

The introspective learning approach focuses on self-reflection. Springer et al. (2004) found that methods that encourage the patient to think through their own positions and circumstances have positive results. Wormer and Davis (2003) emphasize the role that group therapy can play in moving patients into doing introspection and reinforcing their insights.

### 2.3.4 Articulated and coherent programme theory

Springer et al. (2004) found that programmes with coherent programme theory that is clearly articulated are more effective. Programme theory refers to interventions that are based on researched theory (Malkin, Benschoff, Beck & Toriello, 1996). This

would include making evident clear links between outcome objectives and programme activities (Springer et al., 2004). The positive outcomes of coherent programming are enhanced by consistent well-organized schedules of activity. Springer et al. (2004), confirmed by Heinrich and Fournier (2005), found in their investigations that coherent programme structure was one of the key categories that facilitated the implementation of practice improvements. Wolfer (2006) also found, in her study, that patients' positive perception of the structure of the programme had a positive impact on patients' level of recovery.

### 2.3.5 Therapy Sessions

Springer et al. (2004) view intensive counselling contact with the patient as an important indicator of success. This has been confirmed by other studies. Daley, Salloun, Zuckoff, Kirisci and Thase (1998) found that individual group sessions held promise for improving treatment adherence and completion. Passye, Flaherty and Didcott (2006) also confirmed this where patients identified counselling sessions as the most important element of their programme.

Although all of the above factors are important for effective substance abuse treatment programmes, McLellan, Woody, Metzger, McKay, Durell, et al. (1996) found in their study that no single factor contributes to the effectiveness of a programme. It is rather the integration of all the factors that appear to enhance effectiveness in treatment.

## 2.4. OTHER FACTORS THAT INFLUENCE TREATMENT

### 2.4.1 Assessment

Assessment comprises much more than information gathering. Both Bean and Nemitz (2004) and Petersen and McBride (2002), refer to the importance of the assessment process. It is often very difficult for a substance abuser to admit to his/her problem. Accurate assessment of the problem and the accurate matching of the patient to a treatment option can be crucial. McLellan et al. (1996) emphasized the importance of the first assessment session in matching the patient to treatment options. This can result in better outcomes in the programme.

#### 2.4.2 Dropout

Dropout (where the person discontinues her/his treatment) during detoxification is another common factor associated with substance abuse treatment. Wickizer, Maynard, Atherly, Frederik, Koepsel, et al., (1994) found in their study that the dropout rate for inpatients was between 19-63% while the dropout rate for outpatients was 70%. This is a re-occurring pattern in detoxification programmes. It accounts for what is commonly known as the “revolving-door” problem where inpatient detoxification clients account for a disproportionately high number of admissions.

#### 2.4.3 Treatment duration

Kumpher (1997) suggested that effective programmes are those that provide longer interventions. The study of Hiller, Knight, Saum and Simpson (2006) confirmed this. It showed that change that occurs in the patient’s social functioning, in other words, the capability to deal with social situations and stresses, develop modestly during the first 90 days of treatment. Specifically, risk taking behaviour decreases with time, while social conformity and hostility increases with time. Thus, the value of a 28-day programme is questionable due to the amount of change that can occur in 28 days. Opposed to this, Longabaugh, Beattie, Noel, Stout and Malby (1995) found that longer treatment is only effective if the treatment intensity and quality is ideal. These studies imply that effective treatment programmes should therefore implement a measure of a minimum time limit for treatment, but that this should occur in conjunction with good quality service. This should also be consistent with realistic treatment goals that are in keeping with the limited period of treatment.

#### 2.4.4 Medication

Medicines are often prescribed during the treatment of substance abuse, especially during detoxification and withdrawal. Unfortunately, medication, due to deadly overdose and the selling of these drugs on the illicit market, can be associated with negative effects. It is therefore important that the medical staff in treatment programmes have specialist knowledge of medication in the substance abuse field (Bean & Nemits, 2004).

#### 2.4.5 Knowledge, skills and attitude of staff

Addicts often display challenging behaviours for a number of reasons. Anxiety, a sense of powerlessness, denial of the effects of their behaviour, attributing problems to others and rationalization of their behaviours, might be some of these reasons. Therefore, Petersen and McBride (2002) emphasize the importance of knowledge, appropriate skills and a positive attitude, in order to work effectively with substance abusers. Knowledge should include contextual knowledge and basic health knowledge. Except for task specific skills, interpersonal skills, as well as skills related to negotiating personal boundaries, will be crucial for the staff working in a substance abuse treatment programme (Petersen and McBride, 2002). The staff should also be able to be effective in self-management to prevent stress and burnout (Petersen and McBride, 2002). Passey et al. (2006) confirmed in their study the importance of adequately skilled workers.

#### 2.4.6 The complexity of the substance abuse problem

It is evident that treating substance abuse is complex. As has been discussed earlier, factors associated with substance abuse include: increased risk to HIV/Aids related problems, psychopathology, socio-economic factors, psychological factors, gender factors and cultural differences. All these interact in different ways depending on the specifics of the case. This kind of complexity needs to be considered during the treatment of substance abuse.

#### 2.4.7 Patient's perception of the programme

Several studies (e.g., Smiley-McDonald & Leukefeld, 2005; Garrity et al., 2006) show that patients' perception of their treatment impacts on treatment retention and the benefit they gain from treatment. In other words, patients' perception can influence the successful completion of the programme.

According to Koestner (2008), both motivation and support plays an important role in the extent to which individuals perceive health care facilitations to be supportive of them as they pursue their health goals. Support from others, including service providers can play a vital role in facilitating goal pursuits, especially when such support enhances feelings of autonomy (Koestner, 2008). The motivational role of

others can also change patient's perceptions and help facilitate treatment goals aimed at reducing or stopping substance abuse (Koestner, 2008). Goal motivation appears to allow individuals to make better use of implementation plans that specify how, when and where they will enact goal-directed behaviors. There is also evidence that successful goal progress results in enhanced well-being, particularly if the goal pursuits involve satisfaction of intrinsic psychological needs.

According to Borge and Fagermoen (2008), patient's perceptions of a programme itself can influence the recovery process. Patients' experience of professionalism, kindheartedness and aesthetic qualities of the programme; socializing with fellow patients; the daytime therapy programme; as well as leisure time contributed to the patient's positive experience of the inpatient treatment programme (Borge & Fagermoen, 2008).

According to Jha, Orav, Zheng and Epstein (2008) information about how patients experience and perceive care provided, is necessary for quality care improvement. It appears therefore that the gathering of the patient's perspective on the programme is important as part of the evaluation process of a treatment programme. The importance of the patient's perspective will be further highlighted in chapter three where the 'people-centered development approach' will be discussed as part of the theoretical approach used in this study.

## 2.5 CONCLUSION AND MOTIVATION

In order to gain knowledge on whether treatment programmes are effective and why they are effective, evidence-based research, client satisfaction and process analyses within programmes are required. The current increase in substance abuse in South Africa challenges service providers to provide effective and accountable interventions. Evaluation of services can enhance the professional health services' knowledge and the Government stands to benefit from data acquired from such projects. This evaluation analyzed only one factor operating within the programme, namely the satisfaction of the patients.

## **CHAPTER THREE**

### **THEORETICAL FRAMEWORK**

This chapter provides a conceptual outline of the theoretical approaches that are appropriate and viewed as supportive in achieving the aims and objectives of this study.

#### **3.1 GENERAL SYSTEMS THEORY**

Substance abuse and treatment modalities can not be viewed in isolation. Therefore, this study will draw on general systems theory, first proposed by Ludwig von Bertalanffy in the late 1920's (Goldberg & Goldberg, 2004). Von Bertalanffy proposed that a system is characterized by the interactions of its components and the nonlinearity of those interactions (McNeil & Freiburger, 1993). According to Kuhn (1974) one common element of all systems is that knowing one part of a system enables us to know something about another part.

In systems, information is sensed, and changes are effected in response to the information. Kuhn (1974) refers to this as the detector, selector, and effector functions of the system. The detector is concerned with the communication of information between systems. The selector is defined by the rules that the system uses to make decisions, and the effector is the means by which transactions are made between systems (Kuhn, 1974). According to Kuhn (1974), systems can either be closed or open. A closed system is one where interaction occurs only among the system components and not with the environment. An open system is one that receives input from the environment and/or release output to the environment.

To summarize, general systems theory assumes that factors are better understood as a function of the context or “system” within which they occur. When these factors are integral parts of the system, they are both caused by aspects of the system (effects) and, in turn, can cause or maintain aspects of the system (Terre Blance & Durrheim, 2002).

The study of systems can follow two general approaches. A cross-sectional approach deals with the interaction between systems, while a developmental approach deals with the changes in a system over time (Kuhn, 1974). According to Kuhn, (1974) there are three general approaches for evaluating subsystems: (1) A holistic approach examines the system as a complete functioning unit, (2) a reductionist approach examines the subsystems within the system, (3) the functionalist approach ‘looks upward’ from a particular point in the system to examine the role it plays in the larger system. All three approaches recognize the existence of subsystems operating within a larger system (Kuhn, 1974).

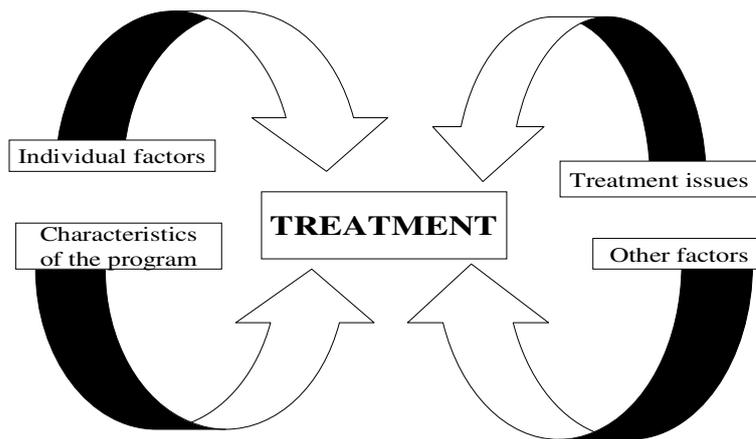
General systems theory offers a meta-analytic tool for understanding some common characteristics of all systems – an understanding and insight that help make sense of the world. This theory assists one to look at the links and impacts of systems, both large and small, on the primary system of intervention (Hearn, 1969). In this way, thinking about the interlinking of systems can help in understanding the intervention.

3.1.1 General systems theory in the context of substance abuse and treatment. According to Hearn (1969), individuals, small groups (including families and organizations) and other complex organizations, such as neighborhoods and communities, can all be regarded as systems with certain common properties. A substance abuse treatment facility can therefore also be viewed as a system.

General systems theory is often applied in the treatment of substance abuse, especially the family systems approach (Rotgers, Morgenstern & Walters, 2006, Wormer, Besthorn, & Keefe, 2007). According to Rotgers, Morgenstern and Walters (2006) the family systems approach applies the principle of general systems theory to families, with particular attention paid to the ways in which families maintain a dynamic balance between substance use and family functioning (Rotgers, Morgenstern & Walters, 2006). In the same way, general systems theory can be applied to the treatment of substance abuse in inpatient units, paying attention to ways in which the treatment programme maintains a dynamic balance between various aspects of the programme that contribute to successful completion, dropout or other possible problems in the treatment system.

Taking into consideration the literature review, it is clear that an array of factors are in operation in considering the treatment of substance abuse. Such factors may contribute to the etiology or maintenance of substance abuse behaviours. Individual factors like psychopathology, socio economic factors, psychological factors, gender and cultural factors influence whether substance abusers enter into substance abuse treatment programmes and rates of drop out (Duffy, Dunlap and Zarkin, 2001).

The specific characteristics of the substance abuse treatment programme further impact the treatment of substance abuse in a systemic way. The literature review indicated that behavioral life skills content, teambuilding and interpersonal methods, introspective learning, an articulated and coherent programme theory, the quality and quantity of therapy sessions, all play an important role in determining whether a patient successfully completes the treatment programme (Springer, et al., 2004; Botvin, 1986; Brown & Caston, 1995; Garrity, Prewitt, Joosen & Tindall, 2006; Wormer & Davis, 2003; Passye, Flaherty & Didcott, 2006). This is further complicated by current issues in substance abuse treatment which include accountability, a demand for quality services, inpatient versus outpatient treatment, and abstinence or controlled use. Other factors like proper assessment on entering into treatment, dropout from treatment, the duration of treatment, medication used in treatment, the knowledge, skill and attitude to the treatment staff, the patient's perception of the program, all impact in the treatment of substance abuse. Further complicating matters, treatment can, in turn, impact on individual factors in the patient and other characteristics of the program. In other words, to draw on general systems theory, all the above factors impact on the treatment of substance abuse. In addition, they can also precipitate and maintain substance abuse, all depending on the system in which such factors function. This systemic impact is demonstrated in figure 3.1.



*Figure 3.1 Different factors operating in the context of substance abuse, causing and maintain substance abuse and the treatment thereof.*

The factors (as outlined in chapter two) operating within the system of the treatment programme can therefore contribute to successful completion of treatment or dropout. Therefore evaluating the different factors operating within the treatment system can give an indication of the effectiveness of the programme.

### 3.2 PERSON-CENTERED APPROACH

This study is also embedded in a person-centered approach and acknowledges the fact that only the patients in the programme are able to remark on the issues that impact on their experiences as patients in the programme and on the quality of their lives.

According to Corey (2005), the person-centered approach is based on a subjective view of human experience. It places faith in and gives responsibility to the client in dealing with problems. This approach focuses mainly on reflecting and clarifying the clients' communication with the aim of gaining insight into the feelings expressed by clients. Carl Rogers, who developed this approach, assumed that the best vantage point for understanding how people behave was from their own internal reference (Corey, 2005). This approach focuses on client's perceptions and calls for the researcher to enter the client's subjective world. It further emphasizes the patient's capacity of self-awareness. According to Rogers (1987), people are trustworthy, resourceful, capable of self-understanding and self-direction, able to make constructive changes, and are able to live effective and productive lives. If the researcher communicates congruency, unconditional positive regard and accurate

emphatic understanding, participants will become less defensive and more open to themselves and their world, and they will behave in constructive ways (Rogers, 1987). According to Devkota (2000), people representing different social, cultural and ecological realities always have different perceptions of what is desirable to them. This implies that meaning of development varies across societies, cultures and ecological settings (Devkota, 2000).

Since the patients in the treatment facility are all part of the same system, they can provide valuable information with regards to the functioning of the treatment system. This approach implies that the study use subjective experience about the programme as a way of exploring the programme as a system. Therefore this study uses the patients in the programme in order to evaluate the programme.

The usefulness of the person-centered approach in evaluation was demonstrated in a study by Tucker, Bray and Howard (1989). Due to the time consuming nature of evaluation, Tucker, Bray and Howard (1989) used this approach to evaluate counsellors in a school guidance programme. Due to the expensive nature of the programme, as in this study, it was important to ensure that counsellors' performance met the needs of the treatment system. According to this study, the person-centered approach was used to generate subjective data from patients to assist in making a more valuable and reliable evaluation of performance.

## **CHAPTER FOUR**

### **METHODOLOGICAL FRAMEWORK**

This chapter provides an overview of the methods and research design used in evaluating the substance abuse treatment programme of the South Coast Recovery Centre.

#### **4.1 PROGRAMME EVALUATION**

Programme evaluation is the use of social research methods to systematically investigate the effectiveness of social intervention programs in ways that are adapted to their political and organizational environments and are designed to inform social action and improve social conditions (Rossi, Lipsey and Freeman, 2003).

##### **4.1.1 Multimethod approach.**

A multimethod approach to program evaluation uses traditional quantitative methods, subjective assessments developed from the quantitative tools, and qualitative methods, to evaluate programmes (Gliner & Sample, 1996). In a multimethod approach, the quantitative part of the evaluation is used to establish *what* aspects of the programme work or are problematic, while the qualitative part of the evaluation helps one understand details regarding *how* the programme succeeds or fails (Padgett, 1998). The addition of qualitative methods to a quantitative evaluation adds flexibility and depth (Padgett, 1998). In this study the quantitative part of the evaluation is based on the positivist approach to evaluation research, while the qualitative part of the evaluation is based on the interpretative approach to evaluation research.

##### *4.1.1.1 The positivist approach to evaluation research*

Positivist evaluation research is based on the belief that the scope of programme evaluation is limited to those aspects of social programmes that can be objectively observed and tested (Terre Blanche & Durrheim, 2002). These are usually applied within a systemic framework, which means that different forms of evaluation are conducted depending on the phase of development of a programme (Rossi & Freeman, 1985). Evaluations that are commonly used as part of positivist approach

include (1) needs assessment, which is done to determine a particular area of need requiring intervention; (2) programme planning, which examines the process of programme conceptualization and on the feasibility of the programme plans; (3) formative evaluation, which focuses on the process of programme implementation; and (4) summative evaluation, which has a retrospective focus and involves an attempt to establish the outcomes, effects or impacts of the programme by observation or measure (Terre Blanche & Durrheim, 2002). According to Terre Blanche and Durrheim (2002), summative evaluation also examines evidence relating to indicators of programme effectiveness.

Since the aim of this study is to determine knowledge on patients' satisfaction levels for different aspects of the programme (to determine how satisfaction is related to the general characteristics of the programme and what it reveals about the programme's strengths and weaknesses), this study will make use of summative evaluation.

#### *4.1.1.2 The interpretive approach to evaluation.*

The interpretive approach to evaluation will be used in the qualitative part of the study. This approach argues that understanding all stakeholders' perspectives is essential to understanding a programme (Terre Blanche & Durrheim, 2002).

Therefore gaining insight into the patients' perception of the programme fulfils part of this objective.

The interpretive method of evaluation developed due to criticism of evaluation approaches that were based on positivist based research principles. The main criticism rejected 'the outsider position' adopted by the researcher because it leads to limited findings that were not useful for the purposes of decision-making (Patton, 1980). It was felt that understanding of the values of a programme required access to the knowledge and understanding of programme insiders, as well as qualitative and subjective interpretation (Terre Blanche & Durrheim, 2002). According to Terre Blanche and Durrheim (2002), a number of alternative evaluation approaches were suggested. These include: (1) focusing on analysis of the perceptions of stakeholders involved in a programme, (2) the analysis of the transactions between different stakeholders and (3) analysis of the content of a programme.

The interpretive approach to evaluation is based on the assumption that different programme stakeholders are likely to have different perspectives of the programme and its development and that these differences may be indicative of different value positions and ideologies. According to Denzin (2001), the interpretive approach focuses on those life experiences that radically alter and shape the meaning persons give to themselves and their experiences. According to Terre Blanche and Durrheim (2002), the interpretive approach argues that both subjectivity and reflexivity are necessary for valid interpretation. Without being personally involved and drawn into the world of others, it would be impossible to develop an understanding of social life and discover how people create meaning in natural settings. By implication, without this type of understanding, it would be impossible to adequately evaluate a programme.

According to Stake (1974) the term stakeholder refers to persons with a vested interest in a particular programme. This includes those who fund the programmes, those who plan and implement programmes, programme participants and users, as well as those whose interests are affected by the work of programmes. Although the programme funders, the programme planners and implementers were not interviewed in this study because of time constraints, the programme participants and users were the stakeholders whose perspectives were investigated.

According to Denzin (2001), the interpretive approach can contribute to evaluation research in the following ways: Firstly, it can help researchers to identify different definitions of the problem in the programme being evaluated. Through the use of personal experiences and descriptions of lived experiences, researchers can compare and contrast the perspectives of patients. Secondly, researchers can locate the assumptions held by various interested parties – assumptions that often underlie the ‘facts’ of experiences. Thirdly, it can be used to identify strategic points of intervention into social situations. In this way the services can be evaluated and improved. Fourthly, it makes it possible for the researcher to suggest an alternative moral point of view from which the problem, the policy and the problem can be interpreted and assessed. Because of its emphasis on experience and its meaning, this approach suggests that the program must be judged by and from a point of view of the persons most directly affected. In this case it would be the patients, the participants of

the programme. Finally, researchers can expose the limits of statistics and statistical evaluations by using the interpretive approach to add contextual meaning to various aspects of the programme.

#### 4.2 PERSONAL STANCE OF THE RESEARCHER

Due to the use of an interpretative methodological approach, together with the theoretical framework of general systems theory, it is important for the researcher to reflect on her own personal stance with regards to substance abuse and treatment in order to understand her position within the research context.

In growing up I was never exposed to substance abuse from relatives or friends. However, growing up on a farm in the Northern Cape, I often was exposed to intoxicated laborers and soon learned from adults to avoid them when intoxicated. I did however see how alcohol could change people. During young adulthood I occasionally witnessed drunken people, but in the same way as during my childhood, I tended to avoid intoxicated people. I for the first time got formally involved in substance abuse when I started to work at a substance abuse treatment centre in 2006. I worked there for one year as a counsellor. Due to my exposure there I developed a personal viewpoint with regards to substance abuse and substance abuse treatment, which includes the following: (1) Although substance abuse can cause people to display socially unacceptable behavior, people with a substance abuse problem are not necessarily people with 'bad' characteristics. (2) Treatment can be successful and patients can overcome substance abuse problems. (3) Substance abuse is a multifaceted problem. No one factor can be singled out as the cause for substance abuse. A combination of different emotional, social and physical factors contributes to substance abuse problems. Therefore the treatment of substance abuse must also address multiple aspects, which must address physical, emotional and behavioral issues. (4) While people are in active addiction, they learn certain behaviors in order to be able to maintain their addiction. These behaviors manifest long after the substance abuse has stopped. However, this makes them vulnerable to relapse. (5) Substance abuse treatment should be a long term treatment. Short term programmes only assist the patient with detoxification, not with emotional and behavioral issues that contribute to substance abuse. (6) My personal viewpoint also includes the opinion that abstinence is a better approach than controlled use. I believe that

substances, even in moderate use, take away inhibitions and make people vulnerable to lose control and relapse. (7) I further view substance abuse as a disease that can be managed, but not cured. (8) Due to the socio-economic situation in South Africa, people from the low socio-economic groups have a poor prognosis. Firstly, because they do not have access; and secondly, because many of these people have very little hope and expectations to have a better future.

The above mentioned points reflect my own personal viewpoint of substance abuse and substance abuse treatment. It was important for me to be aware of my own personal beliefs and subjectivity due to my previous experience of substance abuse interventions, since it inevitably created a bias for certain factors of substance abuse treatment. However, having had the exposure also made me more aware of the context of the social life inside a substance abuse treatment programme. Without my personal previous exposure I might have lacked insight into certain areas of the social world in the treatment context.

#### 4.3 RESEARCH DESIGN

As mentioned earlier, this study made use of a combination of qualitative and quantitative approaches. Both qualitative and quantitative methods of data-collection have strengths and weaknesses in programme evaluation. Qualitative methods give access to meaning and context and facilitate in-depth exploration, while quantitative methods are more applicable for comparison across sites and lend themselves more to standardization. The quantitative method is also more likely to avoid observer effects such as biased interpretations and, the ‘leading’ of the respondents; both affecting data-collection situation adversely. However, through combining qualitative and quantitative methods, the strengths of both methods are used and ensure high quality data in programme evaluation (Babbie & Mouton, 2004).

##### 4.3.1 Instrumentation

###### 4.3.1.1 *The Verona Service Satisfaction Scale*

The scale that was used to measure the patients’ satisfaction qualitatively was the Verona Service Satisfaction Scale, the European Version (VSSS-EU) (Ruggeri, et al., 2000). (See Appendix A).

Satisfaction in Mental Health Services has been shown to be a multidimensional concept (Ware, Davie-Avery & Steward, 1978). Often instruments have been limited to a few broad items which only enquire about one or two mental health care dimensions. This has contributed to an inadequate detection of dissatisfaction in various programmes.

The above scale was developed in order to address this problem. It was specifically developed for the EPSILON Study of Schizophrenia (Ruggeri et al., 2000). It has been found to be a reliable instrument for use in comparative cross-national research projects as well as in routine clinical practice in mental health services (Ruggeri et al., 2000). Reliability for the instrument was done through three kinds of tests: (1) Cronbach's Alpha, to check the internal consistency of the whole questionnaire and the different dimensions, (2) the Intraclass Correlation Coefficient, to evaluate test-retest reliability of the total mean score and the dimension mean score, and (3) Cohen's weighted Kappa, to evaluate test-retest reliability of single VSSS-EU items. Reliability testing has shown that the VSSS-EU has good internal consistency. The alpha coefficient for the VSSS-EU total score in the pooled sample was 0.96 (95% CI 0.94-0.97) and ranged from 0.92 (95% CI 0.60-1.00) to 0.96 (95% CI 0.93-0.98) across the sites, which indicated good reliability. Test-retest reliability for VSSS-EU total score, pooled over sites, was 0.82 (95% CI 0.78-0.85), and ranged from 0.73 (95% CI 0.6-0.86) to 0.93 (95% CI 0.89-0.97) across the sites (Ruggeri et al., 2000), which also indicated good reliability.

This scale has been specifically designed for community-based mental health services run by multidisciplinary teams of psychiatrists, psychologists, social workers and nurses. The VSSS-EU can easily be adapted to community settings that differ from the original context in which it was developed (Ruggeri, et al., 2000). The items in VSSS-EU cover seven dimensions: Overall Satisfaction, Professionals' Skills and behaviour, Information, Access, Efficacy, Types of Intervention and Relative's Involvement. Each dimension is made up of a certain number of items that cover various aspects of satisfaction with services. Subjects are asked to express their overall feeling about their experience of the mental health service. Items 1-40 indicates satisfaction on a 5-point Likert scale (1=terrible, 2=mostly dissatisfactory, 3=mixed, 4=mostly satisfactory, 5=excellent). Items 42-63 consist of three questions:

first the subject is asked if he/she has received the specific intervention, if the answer is “yes” he/she is asked his/her satisfaction on a 5-point Likert scale (1=terrible; 5=excellent). If the answer is “no”, he/she is asked if he/she would like to receive that intervention. These questions allow measurement of the subject’s satisfaction both on interventions provided and on the professional team’s decision not to provide an intervention. The latter may be considered a measure of under-provision of care from the patient’s point of view. The VSSS-EU is designed for self-administration and can be completed without prior training. Administration takes 20-30 minutes.

#### *4.3.1.2 The focus group interview*

Kreuger (1988) defines a focus group as a “carefully planned discussion designed to obtain perceptions in a defined area of interest in a permissive, non-threatening environment” (p.18). A focus group interview taps into human tendencies where attitudes and perceptions are developed through interaction with other people. During a group discussion, individuals may shift due to the influence of other comments. Alternately, opinions may be held with certainty (Kreuger, 1988). According to Kreuger (1988), the purpose is to obtain information of a qualitative nature from a predetermined and limited number of people. According to Stewardt and Shamdasani (1990), the focus group questions should grow directly from the research questions. For this reason the dimensions of the questionnaire were used as a guideline for focus group questions (see Appendix F). This included questions that investigated overall satisfaction, professional’s skills and behavior, information, access, efficacy, types of intervention and relatives’ involvement. The questions were also used to explore the strengths and weaknesses of the programme. In addition, issues that surfaced from interpreting the questionnaire were also explored with focus group participants. The focus group session lasted two hours. The researcher, whose function it was to facilitate the discussion, ran the group.

#### *4.3.2 The South Coast Recovery Centre and the Sample*

The South Coast Recovery Centre (SCRC) is located in Ramsgate, on the lower south coast of KwaZulu-Natal. This centre is not a government institution and operates in the private sector. Fees start from R10 450 per month and a minimum stay of five months is required. From time to time, management will sponsor financially needy patients, but the decision to assist a patient financially is at the discretion of the

management of the centre. The only requirement for admission is that the patient or the patient's family show adequate motivation for treatment. Whilst being accessible, it is also a reasonable distance from major cities. One other treatment facility, about 20 kilometers away from this centre, is also available in the area. It should be noted, this treatment facility is also a private institution. No government supported treatment services are available in the area.

The South Coast Recovery Centre was started in 2001. The objective in developing the Centre was to provide effective treatment protocols for substance abuse. The Centre specializes in the treatment of crack, cocaine, heroin, marijuana, mandrax, ecstasy, alcohol, eating disorders and other addictions. The approach to the treatment of substance abuse is a multimodal approach that follows the philosophy that abstinence, long term treatment, inpatient treatment and the limited use of medication are important factors in treatment. From an initial staff of three (in 2001), SCRC now employs a staff of 31. The professional team currently includes three social workers, three addiction counselors, one spiritual counselor (pastor), one psychiatric nurse, one registered nurse and a contracted part-time doctor who is available daily for consultations and emergencies. A part-time psychologist is also available on an ad hoc basis for psychological assessments. The Centre currently reports a sustained recovery rate of 80% of residents that successfully complete the programme. However, it is not clear on what basis this success rate was evaluated, the time period of this evaluation and how recovery was defined. At the time of the research, there were 61 primary care residents and 11 halfway house residents. Primary care residents attend the programme on an inpatient basis whilst halfway house residents enter a process of reintegrating into society and are either working, studying or doing both during treatment. At the time of the study there were 18 females and 43 males. The majority of these residents were from Gauteng Province, which is about 450kms from the Centre. Sixteen of the residents were from the United Kingdom. These resident referrals were based on reports of good outcomes. 93% were White, 5% were Colored and 2% were Indian. The statistics of the centre confirm the findings of Parry (2005) that women and blacks in South Africa have less access to treatment services. According to Green (2006), the reasons for this disparity are mainly related to socio economic reasons.

**Table 1a. Demographic Characteristics of the patients**

Characteristics	N	%
	(N=61)	
Men	43	70
Women	18	70
Ethnicity		
White	57	93
Coloured	3	5
Indian	1	2
Black	0	0
Nationality		
RSA	45	74
UK	16	26
Age		
Under 21	6	10
21-30	41	67
31-40	11	18
41-50	3	5
Over 50	0	0

#### *4.3.2.1 The programme content and format.*

The South Coast Recovery Centre (SCRC) incorporates several program formats within the structuring of a personalized program. The programme operates from the viewpoint that it is imperative that individuals entering treatment are given as much training as possible, in order to equip them to meet the challenges of society and for them to effectively sustain management of themselves. It further operates from the viewpoint that short term recovery methods are unsuccessful and that it is only by structuring individual programs, over using tried and tested methodology that sustainable recovery can be achieved. It is believed that each drug has its own idiosyncrasies, craving cycles and effect, the drug of choice is factored into the individualized program. The programme is based on the International Narcotics Anonymous (NA) and Alcohol Anonymous (AA) Programme. The scope of this program is much broader than just changing drinking behavior. This process encourages the transformation of the alcoholic' character, producing a "personality change sufficient to recover from alcoholism" while abstaining from alcohol, one day at a time. The personality change is believed to be brought about by means of a

spiritual awakening achieved from following the twelve steps, helping with duties and service work. This programme shares the view that acceptance of one's inherent limitations is critical to finding one's proper place among other humans and God. The twelve-step program is a set of guiding principles outlining a course of action for recovery from addiction, compulsion, or other behavioral problems. The twelve-steps include the following:

1. The patient admits he/she was powerless over alcohol/drugs—that his/her lives has become unmanageable.
2. The patient comes to believe that a Power greater than him/herself could restore him/her to sanity.
3. The patient makes a decision to turn his/her will and lives over to the care of God as we understand Him.
4. The patient makes a searching and fearless moral inventory of him/herself.
5. The patient admits to God, to him/herself, and to another human being the exact nature of his/her wrongs.
6. The patient is entirely ready to have God remove all these defects of character.
7. The patient humbly asks Him to remove his/her shortcomings.
8. The patient makes a list of all persons he/she has harmed, and become willing to make amends to them all.
9. The patient makes direct amends to such people wherever possible, except when to do so would injure them or others.
10. The patient continues to take personal inventory and when he/she is wrong promptly admits it.
11. The patient seeks through prayer and meditation to improve his/her conscious contact with God as we understand Him, praying only for knowledge of His Will for us and the power to carry that out.
12. The patient who has had a spiritual awakening as the result of these steps, tries to carry this message to alcoholics, and to practice these principles in all his/her affairs.

Each step is worked through in great depth and detail, with each resident completing up to Step 7 before leaving the program. The viewpoint is that unless the character

defects are removed through the completion of Step 7, any program has little lasting value. All work is marked and processed in detail with each patient.

Upon entering the programme a patient is usually allowed a few days to go through the process of detoxification and withdrawal symptoms before having to start with the formal programme. The programme is started by having to write his/her life story and presenting it to the rest of the patients. While busy doing the 12 step programme, patients are compelled to attend group therapy, individual therapy sessions are available on an informal basis, compulsory lectures are presented in order to psycho-educate patients, patients have compulsory duties lists and leisure activities are also done on an ad hoc basis.

The programme does have an informal outreach programme. This part of the programme involves patients going out to local schools to give talks about substance abuse. There are also annual projects which involve the Centre going into the rural areas and handing out food, clothes and blankets to the poor. Donations for this project are mostly generated by patients themselves. The philosophy behind this project is that during their time of abusing substances, they have taken a lot from society and that it is time for them to start giving something back to society and communities. In sum, although the programme has an outreach programme into the local community and patients are sponsored from time to time, the programme does not strive to meet the needs of its immediate surroundings, or of the average South African citizen. It rather focuses on the needs of a middle and upper class substance abuser.

#### 4.3.3 Sample

Systematic sampling (Terre Blanche & Durrheim, 1999) was used to determine the sample for the focus group. In systematic sampling every  $n^{\text{th}}$  case from the sample frame gets selected. Every resident in the centre thus had a known chance of being selected. In this case, the Centre consisted of 61 primary care residents. To select 10 people to participate in the focus group every 6<sup>th</sup> resident on the resident list was selected. Residents were on this list in order of dates of entry into the Centre. In selecting the sample systematically, it was ensured that both longer staying and new residents were included in the sample. This selection process prevented staff members

from selecting patients who they might have thought to give certain responses. This sample might have been problematic if records of residents were outdated, but since the South Coast Recovery Centre updated these records daily, it was not problematic. In generating sample questionnaire respondents, an attempt was made to ask all the residents to complete the Service Satisfaction Scale.

#### 4.3.4 Data analysis procedure

In collecting the data written consent was firstly granted by the management of the centre to do the evaluation. Thereafter all the patients were invited to attend a brief meeting to be informed of the intended research. The researcher introduced herself and described the purpose of the study. Ethical issues related to the research and their participation was also discussed. This included confidentiality, freedom to choose to participate and freedom to withdraw at any given time during the study. Those patients who chose not to participate were also free to leave the meeting. Those who did participate signed an informed consent form (see appendix C) and were then asked to complete the questionnaire which was handed out by the researcher.

A total of 43 residents completed the questionnaires. Several other residents signed consent but terminated halfway through the questionnaire. Generally, there was a positive attitude towards the research and participating. After the questionnaires were scored and interpreted, a focus group was set up. This was done through the above discussed sampling method. The management of the Centre allocated a venue where the interview took place without the disruption of other patients or staff members. Again, the purpose of the study and related ethical issues were explained at this point. The patients were observed as being positive towards the researcher and the study. The focus group interview were recorded and transcribed.

##### 4.3.4.1 *The Verona Service Satisfaction Scale*

As suggested by the manual (see appendix B) of the Verona Service Satisfaction Scale, the scale were analyzed by determining mean scores form the Likert scores. Mean scores are arithmetic averages of all the values of that particular aspect of the questionnaire (Terre Blanche & Durrheim, 2002). Firstly the mean score was calculated of the total scores of each questionnaire. Thereafter the mean score was calculated on each dimension (see appendix D). Secondly, a descriptive analysis was

done by drawing frequency distributions in order to investigate the distribution score on each variable. According to Terre Blanche and Durrheim (1999), descriptive analysis aims to describe the data by investigating the distribution of scores on each variable and by determining whether the scores of different variables are related to each other. As part of the descriptive statistics used, a frequency distribution was generated in order to get a better understanding of the data. Descriptive analysis is done first to help the researcher gain an initial impression of the data that were collected. (Terre Blanche & Durrheim, 2002). A frequency distribution was used for this purpose and comprises a graphical representation of the number of subjects who obtained a particular score on the variable. (Terre Blanche & Durrheim, 2002).

After the inferential data analysis was done in order to determine if score differences were statistically significant. Inferential statistics are used to draw conclusions about populations on the basis of data obtained from samples. Such methods are used to determine the significance of differences in responses that occur across respondents. In terms of this present study, inferential methods were used to test hypotheses related to levels satisfaction with the programme (Terre Blanche & Durrheim, 2002). Since the chi square test is often used to test the association between two nominal variables, it was used in this study to explore differences in satisfaction and dissatisfaction (two nominal variables) with the programme (Terre Blanche & Durrheim, 2002).

#### *4.3.4.2 The focus group interview*

All ten people selected through systematic sampling attended the group interview. The taped focus group interview was transcribed and analyzed (see appendix G). The transcription provided a permanent written record of the interview. This could be shared at a later stage with other relevant parties in order to facilitate further analysis (Stewart & Shamdasani, 1990), should it be needed.

In order to maintain the true character and flow of the group discussion, editing of the transcriptions was kept to a minimum. A thematic analysis technique was used to analyze the data of this study. Thematic analysis is a process whereby themes and patterns emerging from the study are identified and used to build a valid argument (Aronson, 1994). The validity and reliability of the findings gained through the

process of thematic analysis are improved by combining it with relevant literature (Aronson, 1994). A qualitative cut-and-paste technique described by Steward and Shamdasani (1990) was used in this process. This is a common analytic technique used by focus group researchers and is seen as a quick and cost-effective method for analyzing a transcript of a focus group discussion in the absence of computer programmes. This process was considered beneficial in analyzing the transcripts for this study. According to Steward & Shamdasani (1990) this process consists of five major steps. These steps were followed in this study. Firstly, sections of the transcript that were seen as important and relevant to the objectives of the study were identified. Secondly, major topics and issues were categorized in a system that was developed shortly after the initial reading of the transcripts. Thirdly, the coded copy of the transcript was cut apart and sorted according to particular topics. Fourthly, the various pieces of transcribed material were used as supporting material and incorporated within an interpretative analysis. Finally, themes and sample statements within major themes were identified (i.e., concepts were grouped into broader categories in which properties and dimensions were identified to inform understanding).

Non verbal communication, gestures, and behaviour observed by the facilitator were not recorded. Reliability of the data was found in repetition of the themes and issues that emerged from both the questionnaire and the focus group interview.

#### 4.3.5 Ethical considerations

Relevant ethical issues were considered in conducting this evaluation. The first relevant issue was the principle of autonomy (Terre Blanche & Durrheim, 2002). This principle involves voluntary participation, informed consent, freedom to withdraw from the research at any time and the participant's right to anonymity in any publications that might arise out of the research. The process was explained to every resident who was willing to partake in the evaluation. This was done through an information letter that accompanied the consent form. They were also informed about their rights to withdraw and anonymity during an introductory meeting as outlined previously. They were asked to sign a consent form (see appendix C). Counsellor's anonymity was also protected by not using their real names when patients referred to them during the study. Another important issue that was addressed was the principle

concerning harm. This involved declaring that the research would do no harm to research participants or to any other person or group of persons. In keeping with this, it was made clear that refusal or withdrawal from participation in the project would have no adverse effects regarding their treatment in the programme (Terre Blanche, & Durrheim, 2002). In protecting counsellor's anonymity, they are also protected from being harmed or negatively affected as employees.

# CHAPTER FIVE

## RESULTS

This chapter describes the findings of the collected data. The results of the quantitative data are first presented. Following this, the results of the qualitative analysis are presented in order to gain a better understanding of the reasons behind some of the quantitative results.

### 5.1 QUANTITATIVE ANALYSIS

This data depicts the findings from the VSSS questionnaire. It is firstly presented and analyzed by determining mean scores from the Likert scores. As mentioned in the previous chapter, mean scores give an arithmetic average of all values in the data set. Then a descriptive analysis was done by drawing a frequency distribution and investigating the distribution of scores on each variable. Thereafter an inferential data analysis was done in order to determine if the scores were statistically significant. As mentioned previously, inferential statistics look at the level of chance that inference will be correct. As mentioned before, the chi-square test is an inferential method used to test the association between two nominal variables and therefore was an appropriate inferential method to use in this study.

#### 5.1.1 VSSS Mean Total Score

According to the manual of the VSSS (Ruggeri et al., 2000), the data of the questionnaires should be analyzed firstly by determining the mean total score on all items of all patients that participated. The mean value is then rounded off, as the manual suggests, and compared with a 5 point Likert scale. According to the manual the mean scores are rated on the following 5-point Likert scale:

1 = Terrible

2 = Mostly Dissatisfied

3 = Mixed

4 = Mostly satisfied

5 = Excellent

$$\begin{aligned} \text{FORMULA} &= \frac{\text{Sum of all items on all questions on all questionnaires of patients}}{\text{The number of items assessed.}} \\ &= 7861/2149 \\ &= 3,66 \end{aligned}$$

The total mean score of 3.66 was rounded to a score of 4 (as the manual suggests). This indicates that patients were ‘mostly satisfy’ with the programme overall.

### 5.1.2 VSSS Mean Dimension Scores:

The mean scores for each dimension were obtained by summing up all item values on each dimension and then dividing it by the number of items in each dimension (see appendix D). The following scores were obtained and rounded off to the closest whole number (as indicated by the manual). It was then compared with the same 5 point Likert scale ratings.

DIMENSION	MEAN SCORE	ROUNDED MEAN SCORE	LICKERT SCALE RATINGS
Overall Satisfaction	3.76	4	Mostly Satisfied
Professional's skills and behaviour	3.67	4	Mostly Satisfied
Information	3.47	3	Mixed
Access	3.54	4	Mostly Satisfied
Efficacy	3.79	4	Mostly Satisfied
Types of Interventions	3.76	4	Mostly Satisfied
Relatives' involvement	3.39	3	Mixed

Table 2a: Mean scores on each dimension

This indicates that patients were mostly satisfied on all dimensions. Notably, the “information” and “relatives’ involvement” dimensions displayed mixed levels of satisfaction.

### 5.1.3 Frequency Distribution

According to Terre Blanche and Durrheim (1999), descriptive analysis aims to describe the data by investigating the distribution of scores on each variable, and by determining whether the scores of different variables are related to each other. Descriptive analysis is done first to help the researcher gain an initial impression of

the data that were collected (Terre Blanche and Durrheim, 1999). A frequency distribution was used for this purpose and comprises a graphical representation of the number (frequency) of subjects who obtained a particular score on the variable. The VSSS manual (Ruggeri et. al., 2000) (See Appendix B) suggests that the frequency distribution may be analyzed for the original scores or by using a collapsed scoring system. If scores are collapsed they are re-coded on the basis of a strict criterion or broad criteria of dissatisfaction. According to the manual, if a strict criterion for collapsed scores is used, scores 1 and 2 should be recoded into 1 (dissatisfied); score 3 should be recoded into 2 (mixed); and score 4 and 5 should be recoded into 3 (satisfied). If a broad criterion is used, score 1, 2, and 3 should be recoded in 1 (dissatisfied); and score 4 and 5 should be recoded in 2 (satisfied). According to Ruggeri & Lasalvia (2000), the use of the broad criteria helps minimize bias due to the possibility that patients might find it difficult to express dissatisfaction overtly. In order to minimize bias, the collapsed scores were used and the total scores were re-coded on the basis of a broad criterion of dissatisfaction as specified by the manual. The original scores of 1, 2 and 3 were collapsed into a score of 1 (dissatisfied), while the original score 4 and 5 were collapsed into a score of 2 (satisfied).

The data from the collapsed scores (see appendix E) was used to draw a frequency distribution graph of every dimension in order to give a rough idea about what the distributions of scores were.

### 5.1.3.1 Overall Satisfaction

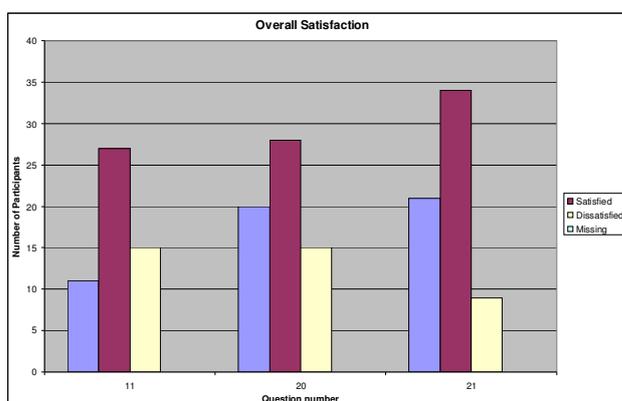


Figure 5.1 Frequency distribution for the dimension “overall satisfaction”

Overall, patients were satisfied with the programme. Question 11, 20 and 21 represent overall satisfaction. Question 21, which asked the question “in an overall,

general sense, the service you have received” received a relatively higher score than the other questions on this dimension. Question 11, which queried the amount of help received; as well as question 20, which queried the kinds of services offered also obtained higher satisfaction scores than dissatisfaction scores.

### 5.1.3.2 Professionals’ Skills and Behavior

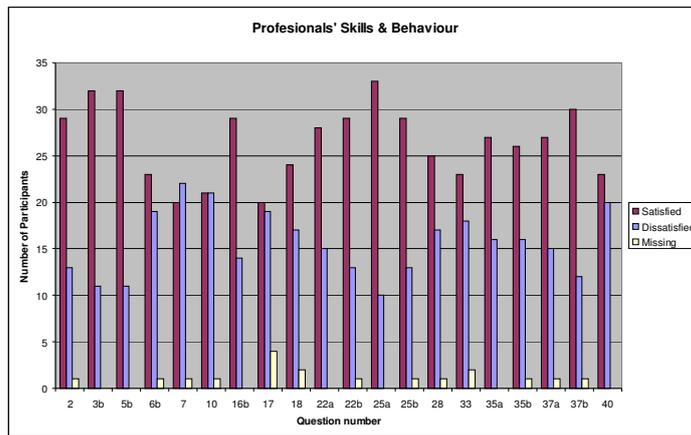


Figure 5.2 Frequency Distribution of the dimension of “Professionals’ Skills and Behavior”

Overall, patients were satisfied with the professionals’ skills and behavior. Patients had satisfied responses on all the questions, except on question 7, which questioned the punctuality of professionals when patients go for appointments. Dissatisfaction was equal to satisfaction on question 10, which questioned confidentiality and respect for patient’s rights. The equal amount of satisfied and dissatisfied responses may indicate ambivalence and was thus flagged for further exploration in the focus group interview. High levels of satisfaction with low dissatisfaction were obtained on question 3b, 5b and 25a. Question 3b referred to professional knowledge and the competence of counsellors. Question 5b referred to the ability of counsellors to listen and to understand patients’ problems. Question 25a referred to professional and personal manners or the nurse when dealing with patients. Patients were mostly satisfied with professionals’ skills and behaviors.

### 5.1.3.3 Information

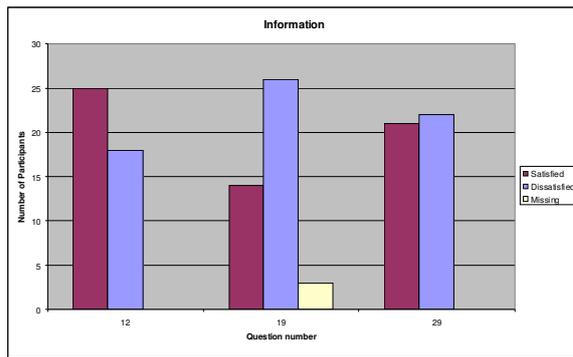


Figure 5.3 Frequency Distribution of the dimension “Information”

Overall patients were dissatisfied with the information dimension of the programme. Patients had dissatisfied responses to question 19 and 29. Question 19 referred to publicity or information about available mental health services. Question 29 referred to how information was given to the patient about his/her problem (diagnosis) and what to expect (prognosis). Due to equality in the amount of dissatisfied and satisfied responses, patients might have ambivalent feelings about this issue and it therefore was flagged for exploration in the focus group interview. Patients had satisfied responses to question 12 which referred to the explanation of specific procedures and approaches.

### 5.1.3.4 Access

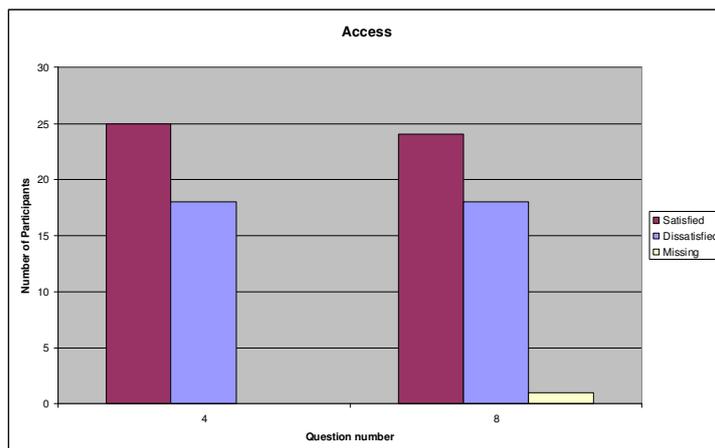


Figure 5.4 Frequency Distribution of the dimension “ Access”

Overall, patients were satisfied with access in this programme. Question 4 referred to the appearance, comfort level and physical layout of the facilities, while question 8 referred to the cost of the service to the patient. Although the majority of patients

were satisfied with this dimension, there were a lot of dissatisfaction and therefore both the issues around the physical layout and costs were noted for discussion in the focus group interview.

### 5.1.3.5 Efficacy

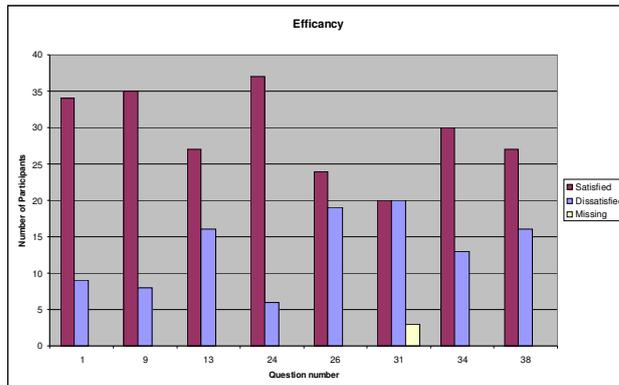


Figure 5.5 Frequency Distribution of the dimension “Efficacy”

Overall patients were satisfied with the efficacy of the service. Question 31 had equal satisfaction and dissatisfaction scores. Question 31 referred to the effectiveness of the service in helping the patient to establish good relationships with people outside the patient’s family (e.g. friends, colleagues, neighbours). Question 24 had high satisfaction responses with low dissatisfaction responses. Question 24 referred to the effectiveness of the service in helping patients to improve their knowledge and understanding of their problems. This contradicts previous findings that patients were dissatisfied with the information about their prognosis and diagnosis. This contradiction was explored in the focus group interview.

### 5.1.3.6 Types of interventions

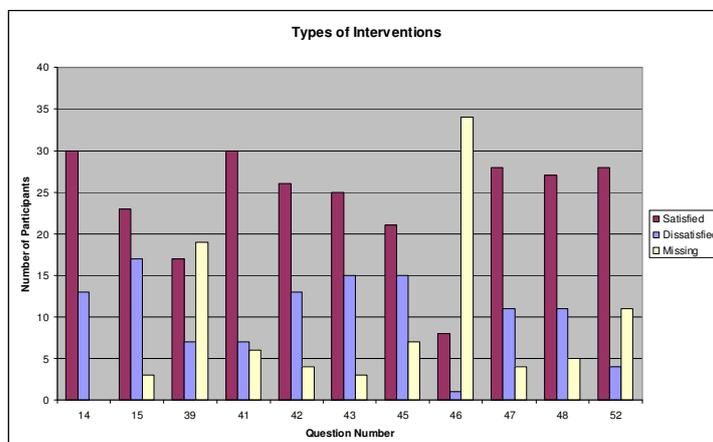


Figure 5.6 Frequency Distribution of the dimension “Types of Interventions”

Overall patients were satisfied with the types of interventions. Question 46 had a high missing score. This question was about whether the patient had been placed in sheltered accommodation in the past year and what their overall feeling was about this. It might be due to the fact that patients did not understand what was meant by sheltered accommodation. Question 39, which questioned the help received from side effects from medication, also had high missing scores. This might be due to the fact that not all patients were treated with medication. Question 41, which questioned satisfaction with regards to the management of prescribed medication, had a high satisfaction rate with a very low dissatisfaction rate. If looking at the missing responses on question 39 with regards to side effects of medication, it seems that patients are satisfied with the approach to not use medication as a main source of treatment. Question 47, which questioned satisfaction with leisure activities also had high satisfaction scores with low dissatisfaction scores. The same apply for question 48, which questioned the satisfaction with group therapy. Question 52, which questioned the assistance with welfare issues, also had high satisfaction scores with low dissatisfaction scores. In question 45, which questioned the management of family meetings with therapists, indicated more ambivalent feelings. Although the majority of scores indicated satisfaction, a very high number of scores also indicated dissatisfaction. This ambivalence was noted for exploration in the focus group interview. Question 15, which questioned around arrangements made for after hour emergencies, also indicated ambivalence with most scores indicating satisfaction, but also a high number indicating dissatisfaction. This ambivalence also had to be questioned in the focus group interview.

### 5.1.3.7 Relative's Involvement

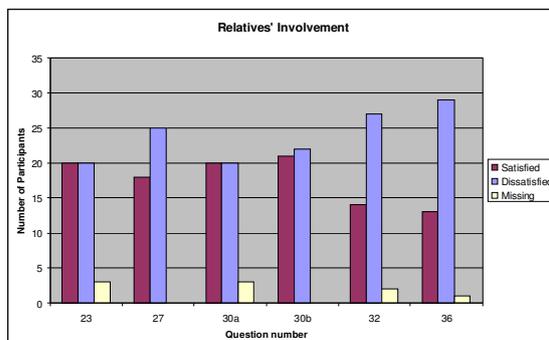


Figure 5.7 Frequency Distribution of the dimension "Relatives Involvement"

Overall, patients were dissatisfied with relatives' involvement. Question 32, 36 and 27 had high dissatisfaction scores. Question 32 was about how information was given to the main carer about the patient's problem (diagnosis) and what to expect (prognosis). Question 36 was about the effectiveness of the service in helping the main carer deal better with the patient's problem. Question 27 was about the effectiveness of the service in helping main carers improve their understanding of the patients' problem. More ambivalence was indicated on question 23, 30a, and 30b, since there was an equal amount of satisfaction and dissatisfaction score. Question 23 was about recommendations made to the patient's closest relative about how they could help the patient. Question 30a referred to the ability of counsellors to listen and understand the worries of the patients' main carer. Question 30b referred to social workers ability to listen and understand the worries of the patients' main carer. On this dimension, high levels of ambivalence with regards to the relatives' involvement are present. This might be due to the fact that most residents were from outside the local community and therefore the family might also be far away and not available for these interventions. This was a further point that needed exploring in the focus group interview.

#### 5.1.4 Chi Square analysis

Chi-square analysis was used as a test of significance when the available data are expressed in frequencies. As mentioned previously, the chi-square test is appropriate to use when an inference wants to be drawn about the relationship between two nominal variables. In this study the two nominal variables are satisfaction and dissatisfaction. Chi-square test (or  $\chi^2$ -test) is a statistical test to test the hypothesis that the unequal distribution of frequencies observed in a table is within accepted limits of random sampling variation (Terre Blanch and Durrheim, 1999). Since the missing responses in the questionnaire do not give an indication of whether patients are satisfied or unsatisfied, these responses were not used in the calculation of chi-square.

##### 5.1.4.1 Overall satisfaction

On the dimension 'overall satisfaction', 69% of the patients were satisfied with the programme. Since this is more than 50% of the patients, the null hypothesis on this

dimension is set that there would be significantly more “2” (satisfied) responses than “1” (dissatisfied) responses across items:

Ho:  $U_2 > U_1$

The alternative hypothesis would then be that the amount of “2” (satisfied) responses would be less than the amount of “1” (dissatisfied) responses:

H1:  $U_2 < U_1$

The hypothesis is tested by using the general formula for the chi-square:  $\chi^2 = (O - E)^2/E$

Question No.	Observed Frequencies (O)	Expected Frequencies (E)	(O-E) <sup>2</sup> /E
11 S	27	29.203	0.244
11 U	15	13.102	0.305
20 S	28	29.898	0.093
20 U	15	13.102	0.305
21 S	34	29.898	0.628
21 U	9	13.102	1.221
			$\chi^2 = 2.790$

$\chi^2 = 2.790$
p = 0,050
Df = 2

Table 3a: Chi Square analysis of Overall Satisfaction Dimension

Since the calculated value of 2.796 on this dimension is smaller than the table value of  $\chi^2 = 5.991$ , the null hypothesis is accepted with a 95% level of confidence that the patients are satisfied with ‘overall’ aspects of the program.

#### 5.1.4.2 Professionals’ skills and Behaviour

On the dimension ‘professionals’ skills and behaviour’, 61.6% of the patients were satisfied with the programme. Since this is more than 50% of the patients, the null hypothesis on this dimension is set that there would be more “2” (satisfied) responses than “1” (dissatisfied) responses:

Ho:  $U_2 > U_1$

The alternative hypothesis would be that the amount of “2” (satisfied) responses would be less than the amount of “1” (dissatisfied) responses:

H1:  $U_2 < U_1$

Question nr	Observed Frequencies (O)	Expected Frequencies (E)	(O-E)2/E
2 S	29	26.437	0.236
2 U	13	15.563	0.402
3b S	32	27.067	1.118
3b U	11	15.933	1.271
5b S	32	27.067	1.118
5b U	11	15.933	1.271
6b S	23	26.437	0.463
6b U	19	15.563	0.787
7 S	20	26.437	1.598
7 U	22	15.563	2.715
10 S	21	26.437	1.144
10 U	21	15.563	0.209
16 S	29	27.067	0.231
16 U	14	15.933	0.141
17 S	20	24.549	1.721
17 U	19	14.451	0.848
18 S	24	25.808	0.242
18 U	17	15.192	0.148
22a S	28	27.067	0.083
22a U	15	15.933	0.016
22b S	29	26.437	0.236
22b U	13	15.563	0.402
25a S	33	27.067	1.561
25a U	10	15.933	1.899
25b S	29	26.437	0.236
25b U	13	15.563	0.402
28 S	25	26.437	0.085
28 U	17	15.563	0.145
33 S	23	25.808	0.475
33 U	18	15.192	0.411
35a S	27	27.067	0.009
35a U	16	15.933	0.016
35b S	26	26.437	0.009
35b U	16	15.563	0.016
37a S	27	26.437	0.009
37a U	15	15.563	0.016
37b S	30	26.437	0.463
37b U	12	15.563	0.787
40 S	23	27.067	0.453
40 U	20	15.933	1.271
			$\chi^2 = 24.663$

$\chi^2 = 24.663$ $p = 0.050$ $Df = 19$
-----------------------------------------------

Table 3b: Chi Square analysis of Professionals’ Skills and Behaviour Dimension

Since the calculated value of 24.663 on this dimension is smaller than the table value of  $\chi=30.144$ , the null hypothesis is accepted with a 95% level of confidence that the patients are satisfied with the professionals' skills and behaviour aspect of the program.

#### 5.1.4.3 Information

On the information dimension, 46,5% of the patients were satisfied with the programme. Since this is less than 50% of the patients, the null hypothesis on this dimension is set that there would be more "1" (dissatisfied) responses than "2" (satisfied) responses:

Ho:  $U_1 > U_2$

The alternative hypothesis would then be that the amount of "1" (dissatisfied) responses would be less than the amount of "2" (satisfied) responses:

H1:  $U_1 < U_2$

Question nr	Observed Frequencies (O)	Expected Frequencies (E)	(O-E)/E
12S	25	20.476	1.221
12U	18	22.524	0.710
19S	14	19.048	1.890
19U	26	20.952	0.764
29S	21	20.476	0.049
29U	22	22.524	0.000
			$\chi^2 = 4.634$

$\chi^2 = 4.634$   
 $p = 0,050$   
 $df = 2$

Table 3c: Chi Square analysis of the Information Dimension

The calculated value of 4.634 on this dimension is smaller than the table value of  $\chi=5.991$ , therefore the null hypothesis that patients are dissatisfied with the information aspect of the program is accepted ( $p=0,050$ ).

#### 5.1.4.4 Access

On the dimension access, 55.1% of the patients were satisfied with the programme. Since this is more than 50% of the patients, the null hypothesis on this dimension is set that there would be more "2" (satisfied) responses than "1" (dissatisfied) responses:

Ho:  $U_2 > U_1$

The alternative hypothesis would then be that the amount of “2” (satisfied) responses would be less than the amount of “1” (dissatisfied) responses:

H1:  $U_2 < U_1$

Question nr	Observed Frequencies (O)	Expected Frequencies (E)	(O-E) <sup>2</sup> /E
4 S	25	24.788	0.010
4 U	18	18.212	0.000
8 S	24	24.212	0.010
8 U	18	17.788	0.000
			$\chi^2 = 0.020$

$\chi^2 = 0.020$   
 $p = 0,050$   
 $df = 1$

Table 3d: Chi Square analysis of the Access Dimension

The calculated value of 0.020 on this dimension is less than the table value of  $\chi = 3.84$ , therefore then null hypothesis is accepted with a 95% level of confidence that patients are satisfied with the access aspect of the program.

#### 5.1.4.5 Efficacy

On the dimension efficacy 68% of the patients were satisfied with the programme. Since this is more than 50% of the patients, the null hypothesis on this dimension is set that there would be more “2” (satisfied) responses than “1” (dissatisfied) responses:

Ho:  $U_2 > U_1$

The alternative hypothesis would then be that the amount of “2” (satisfied) responses would be less than the amount of “1” (dissatisfied) responses:

H1:  $U_2 < U_1$

Question nr	Observed Frequencies (O)	Expected Frequencies (E)	(O-E) <sup>2</sup> /E
1 S	34	29.507	0.684
1 U	9	13.493	1.496
9 S	35	29.507	1.023
9 U	8	13.493	2.236
13 S	27	29.507	0.213
13 U	16	13.493	0.466

$\chi^2 = 22.605$   
 $p = 0,050$   
 $df = 7$

24 S	37	29.507	1.903
24 U	6	13.493	4.161
26 S	24	29.507	1.028
26 U	19	13.493	2.248
31 S	20	27.449	2.021
31 U	20	12.551	4.421
34 S	30	29.507	0.008
34 U	13	13.493	0.018
38 S	27	29.507	0.213
38 U	16	13.493	0.466
			$\chi^2 = 22.605$

Table 3e: Chi Square analysis of the Efficacy Dimension

The calculated value of 22.605 on this dimension is more than the table value of  $\chi=14.067$ , therefore the null hypothesis that patients are satisfied with this dimension is rejected and the alternative hypothesis that patients are dissatisfied with the efficacy aspect of the program is accepted with a 95% level of confidence.

#### 5.1.4.6 Types of Interventions

On the ‘types of interventions’ dimension 55.6% of the patients were satisfied with the programme. Since this is more than 50% of the patients, the null hypothesis on this dimension is set that there would be more “2” (satisfied) responses than “1” (dissatisfied) responses:

Ho:  $U_2 > U_1$

The alternative hypothesis would then be that the amount of “2” (satisfied) responses would be less than the amount of “1” (dissatisfied) responses:

H1:  $U_2 < U_1$

Question nr	Observed Frequencies (O)	Expected Frequencies (E)	(O-E)/E
14 S	30	29.997	0.000
14 U	13	13.003	0.000
15 S	23	27.905	0.862
15 U	17	12.095	1.989
39 S	17	16.743	0.004
39 U	7	7.257	0.009
41 S	30	25.812	0.680
41 U	7	11.188	1.568
42 S	26	27.207	0.054

$\chi^2 = 14.957$
$p = 0,050$
Df = 10

42 U	13	11.793	0.124
43 S	25	27.905	0.302
43 U	15	12.095	0.698
45 S	21	25.114	0.674
45 U	15	10.886	1.555
46 S	8	6.279	0.472
46 U	1	2.721	1.089
47 S	28	27.207	0.023
47 U	11	11.793	0.053
48 S	27	26.509	0.009
48 U	11	11.491	0.021
52 S	28	22.324	1.443
52 U	4	9.676	3.330
			$\chi^2 = 14.957$

Table 3f: Chi Square analysis of the Types of Intervention Dimension

The calculated value of 14.957 on this dimension is less than the table value of  $\chi^2 = 18,307$ , therefore then null hypothesis that patients are satisfied with this dimension is accepted with a 95% level of confidence that patients are satisfied with ‘types of interventions’.

#### 5.1.4.7 Relatives’ Involvement

On the dimension ‘relatives’ involvement’ 41% of the patients were satisfied with the programme. Since this is less than 50% of the responses the null hypothesis on this dimension is set that there would be more “1” (dissatisfied) responses than “2” (satisfied) responses:

Ho:  $U_1 > U_2$

The alternative hypothesis would then be that the amount of “1” (dissatisfied) responses would be less than the amount of “2” (satisfied) responses:

H1:  $U_1 < U_2$

Question nr	Observed Frequencies (O)	Expected Frequencies (E)	(O-E) <sup>2</sup> /E
23 S	20	17.028	0.519
23 U	20	22.972	0.385
27 S	18	18.305	0.005
27 U	25	24.695	0.004
30a S	20	17.028	0.519
30a U	20	22.972	0.385

$\chi^2 = 6.545$
p = 0,050
df = 5

30b S	21	17.028	0.927
30b U	22	24.695	0.294
32 S	14	17.454	0.684
32 U	27	23.546	0.507
36 S	13	17.88	1.332
36 U	29	24.12	0.987
			$\chi^2 = 6.545$

Table 3g: Chi Square analysis of the Relatives' Involvement Dimension

The calculated value of 6.545 on this dimension is less than the table value of  $\chi^2 = 11.0705$ , therefore the null hypothesis that patients are dissatisfied with this dimension is accepted with a 95% level of confidence.

## 5.2 QUALITATIVE ANALYSIS

This section discusses the findings of the focus group interview. As mentioned previously, thematic analysis was used to analyze the group interview. In keeping with the qualitative paradigm, 'thick descriptive' data was used to authenticate the findings (Potter, 1996). The structure of the questionnaire was used as a guideline for questions in the focus group. In order to gain a better understanding of the dynamics of the programme, the results of the quantitative analysis were kept in mind and used to probe during the qualitative part of the study. The data is presented in terms of the main themes that emerged from the perceptions of the patients.

Initially patients were reserved in their participation, but after the ethical issues and confidentiality were discussed again, patients were more open to participation. Most patients were then eager to give their opinion and contributions. There were however two patients in the group who did not participate spontaneously and had to be drawn into the interview by asking them direct questions.

The findings of this study suggest that the patients had different satisfaction levels on the SCRC's treatment program. While some were very satisfied, others were more skeptical. Based on the information that emerged from the focus group interview, the following information with regards to the factors operating within the SCRC's treatment is discussed.

### 5.2.1 Overall Satisfaction

The theme of *overall satisfaction* covers general aspects of satisfaction with mental health services. Overall patients were satisfied with the programme. Since the questionnaire's questions around this were very vague, this aspect was explored to create a better understanding of how patients felt overall about the programme. On this dimension, the following themes emerged:

#### 5.2.1.1 Uniformity and diversity

Patients felt that the programme was both uniform and diverse and that it allowed every patient the space to be treated individually. For example patient 10 had this to say:

*“Because even though we follow the same general steps and we all do the same steps there will be different people who have problems and issues to deal with so there will be certain areas some people will work on more than others.....”*

Patient 2 confirmed this with the following:

*“...I think for every single person the programme is different one way or another...”*

Patients felt that by having counsellors from a multi disciplinary background allowed for diversity in input into treatment. For example patient 2 had the following to say:

*“Because ‘counselor 1’s approach is a bit more medical....where ‘counselor 2’ approaches things from the angle of a pastor. This is a good thing, very diverse. It gives you different perspectives on things”*

Patient 3 added the following:

*“They are all uniform in enforcing rules and enforcing regulations in up keeping the standards of tender loving care and not taking any attitude or anything. So they have commonness and a similarity, but they have diversity*

*when it comes to giving you advice, giving you perspective, giving you feedback and guiding you.”*

It appears that uniformity is related to rules and regulations, whilst diversity is mostly related to individual treatments and the different approaches from the staff.

#### *5.2.1.2 Flexibility and adaptability*

The general feeling was that the programme was flexible and adaptable, that a broad range of techniques were used in order to treat the patients' addictive behaviours.

Patient 9 and patient 4 had the following to say:

*“...the programme is very spontaneous ...and they use a very flexible way to play it...and they are able to adapt. For example when an issue or crisis appears, they will quickly and easily change the programme for the day. ‘Counsellor 3’ will easily call a group together and allow for the problem to be dealt with. Also, if a patient tries to abscond and staff is occupied with handling that patient, the rest of the programme does not come to a stand still.”*

*“...it is a very broad technique that they use. Any tool they have learned to work with they will use to keep that addictive behavior out...If it mean for them to punish you unfairly, they will do that. Or they would put emotional pressure on you in order to force you to let your true feelings and behavior surface, so they can deal with it. They do not use one technique on everybody and for everything. They do different things that would work for different people”*

It seems ‘flexibility’ and ‘adaptability’ is related to the ability of the programme format to easily adjust to crises that might emerge during the day. The broad techniques seem related to using different methods in order to facilitate individual results.

### 5.2.1.3 *The programme structure*

Interestingly participants felt that the structure of the programme allowed very little space for manipulation, a characteristic that most patients felt was crucial in the treatment of their addiction. For example patient 2 responded as follows:

*“..I do not always understand what is going to happen next, but that prevents me from manipulating the programme...”*

This response also indicates that the patient does not know what is coming next and therefore there might be a need for more information about the programme. This is confirmed by the statement of patient 9, who said:

*“I feel there could be some better planning and I think just from that a person can gain a lot more momentum.”*

These statements indicate a tension between getting enough information about the programme and the lack of information about the programme and programme structure. On the one hand patients felt that if they did not have all the information it prevented them from manipulating the programme and therefore not benefitting from it. On the other hand they felt that the lack of information and structure prevented them from fully benefitting from the programme, since they could not always see the objectives and what was supposed to be achieved. The need for more structure also seemed to contradict the need for uniformity as mentioned earlier.

## 5.2.2 Professional's Skills and Behavior

The theme of *professional's skills and behavior* covers various aspects of satisfaction with the professionals' behavior such as technical skills, co-operation between service providers and so forth. The following themes emerged on this dimension from the focus group.

### 5.2.2.1 *Favoritism, therapeutic tool, or too many patients?*

From the questionnaire an issue that surfaced was the punctuality of professionals when patients went for appointments. In exploring this issue patients mentioned that they often had to wait a long time before they could talk to a counsellor and often had

to ask several times to have one counselling session. Patient 3 made the following comment around this issue:

*“Like if I want to see a counsellor and ten minutes later I’ll have to go back and then I usually get scheduled to go back a third time.”*

It became clear that there was a feeling that this might be due to favoritism. It was felt that some patients got easier access to individual therapy, and that more time was spent with them. Patient 2 made the following comments:

*“I definitely think there is some favoritism ... More time goes into some people’s programmes...”*

Patient 3 added the following comment.

*“...there are counsellors who take on individual sponsors and they will treat you completely uniquely...”*

Patients were not quite sure why some patients got priority but there was a vague feeling that due to their level of addiction and emotional problems, these patients needed more time with counsellors. Patient 2 made the following remark:

*I try and look at it and say well maybe I do not need as much one on one sessions and as much time as that person since my addiction and problems were not that bad.”*

Others felt that counsellors paid attention to patients according to what patients were willing to put into their recovery. Patient 3 made the following comment:

*“If you do not grab hold of what they are offering you, you are not going to have any time put into you. They only pay to you as much attention as you want them to pay to you.”*

However there was no consensus in the group around this. Other patients felt that this was a ‘therapeutic tool’ that was used in order to bring out addictive behaviors in the controlled environment by frustrating the person. Patient 2 said the following:

*“I have come to the conclusion that we play out our addictive behavior in this controlled environment and they stimulate us by not seeing us and frustrate you by not seeing you.”*

Some felt that it was an approach to teach them assertiveness and ‘pro-activeness’. For example patient 3 said the following:

*“They want you to be proactive and assertive in your approach”*

It was also argued that it is about taking ownership of your own recovery. For example patient 3 made the following comment:

*“They do not force you or spoon feed you or run up behind you and tries and pulls up your nappy.”*

The other perspective on this was that due to patient numbers, individual therapy was difficult to access anyway. For example patient 2 said the following:

*“...they could do with doubling the number of staff here...I do not think it will actually be possible for each of the counsellors to give each resident half an hour in the week. It is not possible; there is just not enough time.”*

Patient 4 added the following:

*“That is definitely the case (too many residents), the counsellors I think, are juggling us from each week. You know ... who to see this week and what is it all about, but they do pay they do give attention to each of us, but this depends on how much we are willing to help ourselves by asking for help.*

It seemed that the issue around punctuality was related to different possibilities which included 1) more time was spent with certain patients due to favoritism, 2) a therapeutic tool which was used in order to allow for disruptive behavior to surface, and to learn skills like assertiveness and pro activeness; and 3) insufficient amount of counsellors for the number of patients that needs individual counselling.

#### *5.2.2.2 The counsellors' experience with addiction.*

Patients felt that the fact that some of the counsellors were previous addicts themselves helped them in their recovery. They felt that due to the fact that these counsellors came from the same background, they were more aware of behaviors associated with addiction, like the use of manipulation. This made some participants feel that they could not get away with using manipulative behaviours on the programme. For example patient 10 made the following comment:

*“Because some of them were addicts as well, they come from where we come from and it is like, ya, it is like you cannot manipulate them so they give you good advice and you cannot bullshit them. They know all the tricks in the book, cause they have done it themselves”*

#### *5.2.2.3 Diversity in approaches*

They also felt that the fact that some members of staff came from other backgrounds (not associated with addiction) added to the different approaches in the treatment programme. They felt that some counsellors worked from a spiritual perspective, others from a social worker's perspective, others from a medical perspective and others from the substance abuser's perspective. For example patient 3 said the following:

*“So their diversity is very important like the social worker starts some things, while the addiction counsellor comes from a clean cut ‘addict way’, and the psychiatric nurse brings in a medical input.”*

Based on this diversity, patients generally seemed to use these different perspectives to their advantage by choosing to ask for advice from counsellors based on the nature of the relevant issue. Patient 9 said the following:

*“... if I have issues in terms of access of my children then I go to a specific counsellor because I know she has a lot of experience in that area but I would not go to her with other issues I wanted to discuss. I would go to someone who I thought was more relevant. So I tend to pick and look at who I think, rightly or wrongly, help me with advice or advise me on a particular issue that I am having.”*

It seemed these choices of a counsellor were usually made on the basis of the professional identity of the counsellor in the programme. Issues that had legal and social implications were usually taken to social workers, while spiritual issues were taken to the spiritual counsellor. However, the personality of the counsellor did not play an insignificant role when making these choices. Patient 9 added the following:

*“It is a personal thing the way I relate to them. I suppose it depends on the respect or whatever you have for that person that is giving the message”*

Patients viewed the different approaches that were used by different counsellors as a positive attribute of the programme, since it allowed for diversity in inputs in their treatment. They felt that this allowed for experts on different aspects of life to give an input. The different approaches also taught them to form a personal viewpoint on issues. Patient 3 commented on this as follows:

*“...diversity when giving you advise, giving you perspective, giving you feedback and guiding you or pushing or pulling you, helping you to be able to live a successful balanced life and to form your own opinion about things”*

#### *5.2.2.4 Skills and knowledge of counsellors*

There was general consensus that counsellors had adequate skills and knowledge. Patient 2 made the following comment with regards to this issue:

*“.....to be dealing with someone who knows exactly what all my tricks are or who knows exactly what my behaviors are when I do not even know myself.”*

This indicates that patients felt that staff was skilled because of their knowledge of tactics, and because they bring insight and understanding to behaviours not understood from the patient's perspective.

#### *5.2.2.5 Respectability and life experience of counsellors.*

There was a sense that there were different levels of respect towards different counsellors. It appears that the patient felt that some counsellors had more life experience and therefore had more skills and thus commanded more respect. Life experience also appeared to be more valued more than academic experience. For example, patient 9 made the following remarks:

*“I suppose it depends on the respect or whatever you have for the person what is giving the message. Ya, so it is the areas of expertise that I perceive them to have...”*

*“I suppose I am judging some of the counsellor's life experience ... and when I talk about experience I am not talking about people with letters after their names.”*

#### *5.2.2.6 Honest, straight-forward and unorthodox approaches of counsellors.*

Patients appreciated the fact that counsellors were honest and straight forward and experienced this as speeding up the recovery process. Patient 4 had the following to say about this:

*“It is a very efficient thing. Instead of humming and having counselling sessions for seventy odd hours to get one thing out they go straight for it.”*

Patients felt that patients who were not motivated to change did not like this honest, straight-forward approach and would respond negatively towards counsellors. For patients, this appeared to be linked to patients who were in the early stages of treatment. For example patient 3 said the following:

*“... it is a very frustrating thing for a person who is still relatively new out of active addiction to be dealing with someone who knows exactly what all your tricks are...”*

*“So if someone wants to be here and generally wants recovery, they are generally going to be a lot more positive towards counsellors even though some of the feedback from them may be seemingly negative. Whereas people who do not want to be here are going to look at the whole process and just think “it is a load of junk.”*

It was reported that counsellors often has an unorthodox way of working and addressing behavior. This was perceived by patients as counsellors putting pressure on them in order to let true behaviors and feelings surface. Although seen as unpleasant, most patients were satisfied with this approach because they felt that this allowed them to confront themselves and their addiction. For example patient 3 said the following:

*“They might do unorthodox thing, like taking away a privilege or punishing you unfairly, which they think is beneficial for you but which might not particularly pleasant for the resident at that point in time.”*

Patient 10 added the following:

*“Then specifically I saw the results of what they have achieved with certain people by putting them on that sort of regime and I think in a normal therapeutic environment the counsellors would not use that approach...they put you under a lot of pressure which I think brings to the surface the underlying flaw of behavior that we suffer from.”*

Patients were satisfied with this straight-forward, unorthodox approach. This approach seemed to be experienced as specific to the programme. It also seemed that observations regarding the positive influences of the programme on other patients had a beneficial effect.

#### 5.2.2.7 *Coherent, effective group functioning of the counsellors*

It was felt that the counsellors functioned well as group. There was a sense that each had his or her own unique experience. The patient also felt that the counsellors shared knowledge amongst each other and that they command leadership. This is seen as a strength that prevent patient's manipulating the programme. For example patient 10 and 3 said the following:

*“They function incredibly together. Each has their own unique experience leading towards the position they are in now....they share knowledge between each other and they do it daily.”*

*“They have a very good uniformity as a counsellor group and they have a strong leadership so you cannot get one way with one counsellor and another way with another counsellor. ...there is no fighting amongst them. They are all sort of on the same page that they all know exactly where you are on the programme in the same sense that they do not let you see any weakness in their leadership.”*

It seems this coherent group functioning adds to preventing patients from manipulating counsellors, as well as to ensure that counsellors are informed about patients' progress in the programme.

#### 5.2.2.8 *Counsellors were passionate about their work and were informed about patients' progress.*

Patients felt generally that they were appreciated and accepted by counsellors. For example, patient 10 said the following.

*“...it is amazing to sit in group and at any point in time any of the counsellors can speak to any resident and it is nice to know that they give so much attention to you and they really care about you. It is not like a 28 day programme or like other rehabs where they just get you in, get you clean and get you going. It is nice to know that you are here and that they are willing to help you ... like really willing to get you through your recovery...”*

There was a sense that counsellors always knew where a patient was in the programme. They felt that the counsellors were passionate about what they were doing. Counsellor care was also linked to the extended length of the programme. This seems to have a positive impact on treatment.

#### *5.2.2.9 Emotional involvement of counsellors*

Although counsellors were viewed as passionate and appreciated and accepted patients, participants were however concerned that counsellors get emotionally involved. For example patient 2 said the following:

*“...they got their heart into what they do as well as perhaps even sometimes more so as they should. I think sometimes they get very emotionally involved...I do not think it is overly a good thing, but actually maybe from time to time it can be but they only human.”*

*“Getting emotionally involved, their objectivity gets clouded; they might start feeling sorry for you and then treat you differently than they should have.”*

Although patients had understanding and appreciation for the emotional involvement of counsellors, they did not always perceive it as a good thing, since it was felt that counsellors might lose their objectivity and they might treat patients differently to the programme format.

#### **5.2.3 Information**

The theme of *information* covers aspects related to satisfaction with information on services, disorders and therapies. The following themes emerged during the interview on this dimension:

##### *5.2.3.1 Information about procedures and approaches.*

The issue about information about procedures and approaches again surfaced on this dimension. On the questionnaires patients were satisfied with the explanation of specific procedures and approaches, but when this was explored in the focus group interview, patients reported that they often felt uninformed about the strategies for their own treatment and about the treatment programme in general. Interestingly

however, this was not necessarily viewed as negative, since they felt that this limited their ability to manipulate the treatment programme and finish the programme before they are ready to maintain a sober life. For example patient 2 made the following comment:

*“Sometimes I do not really understand the methods and I never really know what is going to happen next. But at the same time I can see why they keep it like that... because if I can see what is going to happen next or predict the outcome on something, then I can manipulate the outcome much more easily...”*

It was also felt that this uncertainty about the service and the treatment programme is a reflection on the uncertainties of real life and that it would assist them in dealing with real life once they leave the programme. For example patient 2 said the following:

*“... and things do not always go according to plan but then I think that reflects life”*

It seemed that the lack of information about procedures and approaches was used as a therapeutic tool to prevent patients from manipulation, but also as a tool to teach them life skills.

#### *5.2.3.2 Available Mental Health Service*

This theme had to be explored since the questionnaire indicated dissatisfaction with information provided about available Mental Health Services. On exploring this issue it became evident that patients felt that due to most of them living far away, this information might not be available to the staff. Patient 4 made the following comment:

*“We might benefit from joining a support group or something after we leave the centre, but I do not think they know the places in Johannesburg, so they can not give us the information.”*

### 5.2.3.3 Information about diagnosis and prognosis

Again this theme had to be explored since the questionnaire indicated ambivalent feeling with regards to information provided about diagnosis and prognosis.

Although the majority of patients were dissatisfied, a large number were satisfied. On exploring this issue, it became evident that patients often felt that they wanted more information on whether staff members thought they would be able to successfully complete the programme and be able to maintain a sober life. Patient 6 commented as follows:

*“I at least wanted to know whether I stood a chance to make it. If I would be able to live a normal drug-free life.”*

Others felt it was impossible for staff to tell whether they were going to complete the programme successfully or not. Patient 3 replied as follows:

*“They can predict whether you would be able to make it or to live a sober life, but they can never tell for sure. I have heard of a lot of people who relapsed a year or even two years after treatment. It would be unfair to expect them to tell you whether you’re going to make it or not. And if they do tell you, you might fall into a comfort zone and stop to work hard for your recovery”*

This statement also indicated that if staff makes a positive prognosis, patients might not work as hard for their recovery as they should.

It seemed that some patients felt they wanted to know what their prognosis was, while others felt it was better to not know since it might hinder their treatment programme from being successful.

### 5.2.4 Access

The theme of *access* covers aspects related to satisfaction with service location, physical layout, and costs. The following themes emerged on this dimension from the interview:

#### 5.2.4.1 *Uninvolvement in costs*

Patients were very much uninvolved with the cost aspects of the programme. It was clear that most of them were sponsored by relatives or other people. Most only had a vague idea that the programme must cost their sponsors a lot of money. For example patient 5 said the following:

*“I’m not sure what the cost of this is, but it must be a lot of money. If my father did not sponsor me, I would not have been able to come.”*

#### 5.2.4.2 *Facilities and layout*

Patients were also generally satisfied with the facilities’ location and layout. For example patient 7 and 3 said the following:

*“We’ve got a beautiful view from upstairs”*

*“The rooms and cupboards are small, but it’s great in comparison to what I had when I was in active addiction”*

The satisfaction with the physical appearance of the facilities, comfort level and physical layout can be linked to the privileged nature of the programme.

#### 5.2.5 Efficacy

The theme of *efficacy* covers aspects related to satisfaction with overall efficacy of the services, and service efficacy on specific aspects such as symptoms, skill, and relationships. Patients were generally satisfied with the efficacy of the programme. Themes that emerged on this dimension during the interview were the following:

##### 5.2.5.1 *Helping patients to improve their knowledge and understanding of their problem.*

On the questionnaire there was a contradiction with regards to this statement. On this dimension patients were satisfied with this issue, while on the dimension of information, patients indicated that they were dissatisfied with diagnosis and prognosis. In order to create a better understanding of this issue this was explored further. It became evident that this was two separate issues. Although patients did

not know whether they would be able to recovery from substance abuse (prognosis), the programme gave them good knowledge and understanding of problems related to substance abuse. Patient 9 commented as follows:

*“Understanding the problem of substance abuse is different from understanding what is going to happen to me during the programme and during the rest of my life. They know exactly what substance abuse is and how it works. Counsellor 3 does a very good lecture on helping us to understand substance abuse, but that does not mean they can predict what is going to happen to me after I leave the programme.”*

#### 5.2.5.2 Self-reflection

Patients felt the programme forced them to reflect on themselves. For example patient 7 said the following:

*“The programme forces me to confront myself and my addiction.”*

It was viewed that self-reflection was especially linked to group therapy situations, as well as to situations where they were punished for unacceptable behaviors. Patient 9 commented on this as follows:

*“...but if 20 people in group start getting on my case about something, I am going to start thinking, maybe there is a point. So you take things said to you in group a lot more seriously, and you go and think about what they said.”*

Patient 2 commented on the punishment as follows:

*“While I had to wash all those dishes, I had a lot of time on my own, and a lot of time to think about what I did and why I did it. Without this I would have never thought about what I was doing and would have never changed my behavior.”*

It seemed that patients were satisfied that the programme allowed for self-reflection.

It seemed self-reflection was activated by situations that put patients under pressure, and the reflection was mostly related to such behaviors.

#### *5.2.5.3 Dealing with emotions and beliefs*

There was also a general feeling that they learned to deal with emotions and that their belief systems had been changed considerably. For example patients 3 said the following:

*“I have learnt... emotions ... how to deal with them, recognize them, put a name to them and to know what is what.....and also belief systems, how they have changed. This I managed to learn through step work that was given back to me to redo, through feedback of other residents, feedback of counsellors and been confronted in group.”*

It seemed the management of emotions was learned through a combination of interventions which included ‘step work’ (which referred to the 12 step AA part of the programme), group interventions, individual therapy, as well as through patient interaction.

#### *5.2.5.4 Changes in confidence, attitude and motivation*

Others felt that the programme gave them confidence and changed their attitude and motivation. Patients 1 and 6 said the following:

*“It gave me a little bit of confidence to talk in front of people. You are forced to do this in the group”*

*“It was a very gradual process, but my motivation and attitude has definitely improved.”*

*“A combination of things, group, individual sessions, talking to others, seeing what happens to others and what can be achieved.”*

It seems patients were satisfied with the efficacy of the programme due to new skills learned and changes in motivation and attitude towards a sober life. This was again

achieved through a combination of interventions, which included group therapy, individual therapy, patient support, as well as experiencing others' experiences.

#### 5.2.6 Types of Interventions

The theme of *types of interventions* covers various aspects of satisfaction with mental health care such as drug prescription, response to emergency, rehabilitation, admissions, housing, recreational activities, work, benefits and so forth. There was a generally positive feeling towards the combination of interventions used. The following subthemes emerged on this dimension during the interview:

##### 5.2.6.1 Medication used in treating substance abuse.

From the questionnaire the assumption was made that not all patients' substance abuse was treated with medication and that patients were satisfied with that approach. Since it was an assumption, this had to be explored in the focus group interview. Exploring this issue did confirm that the centre does not treat substance abuse with medication. A patient would be treated with medication during the initial phase while going through withdrawals, but this is only for a short period and only when needed. Thereafter the policy is to get the patient drug free, which includes unnecessary medication. Necessary medication is strictly managed by the nurse on site. Patients were satisfied with this approach, since they believed it prevented them from using their medication as a drug. They also felt more "normal" and healthy for they no longer needed lots of medication to have a normal life. Patient 2 commented as follows on this:

*"During my using days I often took a lot of sleeping and headache tablets, especially when I ran out of drugs. Medication can easily become a different form of drug to me."*

Patient 6 added the following comment to this issue:

*"I feel like a normal person now. I do not have to take hands full of pills just to get through the day. When I came into the centre I had bags full of psychiatric medication. I now only take one tablet per day and I never felt as healthy and normal as I feel now."*

#### *5.2.6.2 Arrangements for after hour emergencies*

The questionnaire indicated ambivalence with regards to satisfaction on arrangements for after hour emergencies. Exploring this issue indicated that the main issue was that there were no counsellors available on site after hours. Patients felt if they had emotional issues, they had to talk to senior residents, or to the two persons doing night duty. These persons were usually patients that have completed the programme and in the process of reintegrating into society. They were employed as night duty staff at the centre. Patients felt that these people were not equipped to deal with emotional issues. Patient 5 commented as follows:

*“When you really struggle with your issues at night, there is no one to talk to, except the night duty staff and they can not deal with our emotional stuff. And some things I do not want to discuss with them.”*

It seemed the dissatisfaction with after hour emergencies was not about physical or medical emergencies, but related to emotional issues and the unavailability of counsellors after hours.

#### *5.2.6.3 The size of the groups during group interventions.*

It was felt that the once weekly large group intervention had become too large and had lost its effectiveness since a lot of patients felt uncomfortable participating. On the other hand, the general consensus was that the smaller groups that were implemented were very positive. For example patient 9, 5 and 7 said the following:

*“...now there is a group of almost eighty people. I think it has lost some of its effectiveness.”*

*“Not everyone finds it easy to speak in the big group.”*

*“... having smaller groups with your counsellor which I think is very effective. I think it is a good idea and that there should be more of that where a staff member is present to guide and to get the issues out there”*

#### 5.2.6.4 *The effectiveness of group interventions in building confidence.*

On the other hand, there was also a feeling that the big group sessions contribute to building self confidence. For example patient 2 said the following:

*“...building your confidence as well because I would not even be able to speak before, but now I can speak to those people and I have people telling me ‘no you are saying the right thing and you are not stupid’. It worked both ways and I think it is important...”*

#### 5.2.6.5 *The effectiveness of the group interventions in accountability and changing behavior.*

Generally most patients still felt that the groups were very effective in that interventions had a bigger impact when patients were confronted in the group context. Patients were forced to be accountable for their acts. They felt that a stronger message was sent when confronted by a group of people rather than by an individual. For example patient 9 made the following comments:

*“The problem is that it has zero impact. (individual confrontation) ...but if twenty people in a group start getting on my case about it I am going to go ‘maybe there is a point here’. So the point is...in a group situation I am going to take it maybe a lot more seriously and that is the effect of the group.”*

*“I think we are missing one vital thing here and that is the effect that the group has after group. It is accountability because once something is raised in a group it is not over when you go out into our population here and it stays with you so that is the whole effect of the group. It is the accountability of what is said in that forum that carries forward.”*

It seems the not only did group confrontations forced patients to take accountability, but it also had a long term effect on taking accountability.

#### 5.2.6.6 *Availability of individual therapy sessions.*

Patients were generally quite dissatisfied with individual therapy. The dissatisfaction was not with the quality of the individual sessions, but rather with the availability of

these sessions. The feeling was that there was not enough staff available for individual therapy sessions. They felt it was very difficult to access a counsellor for these sessions and when they were able to access an individual session, there was always a time issue. Patients felt that they very much had to depend on themselves to access these services. Patients 9, 2, 6 and 7 made the following comments:

*“I also believe that there is not enough one-on-one counselling due to the big increase in numbers in the last year.”*

*“...because they are all so busy and they work so hard, they need more staff...”*

*“I also feel that I am not going to bug a counsellor three or four times when I want to speak about something...”*

*“...they do not have enough time to give the counselling that is needed and yes, they were prepared to.”*

#### 5.2.6.7 Life skills

Although patients were generally dissatisfied with the unavailability of individual therapy, there was also a positive side to it. Patients felt that it taught them new skills in that the programme forced them to take accountability, to become assertive, proactive and committed. Patients 7 and 9 made the following comments:

*“... I had to learn to be assertive and proactive in my approach.....and a test for your commitment”*

*“...it is so effective because suddenly you are accountable to the people around you.”*

However this viewpoint was generally held by patients who were in the programme for a longer time and who were more motivated to recover. Patients 4, 3, 7, and 9 made the following comments:

*“It is up to me to go and seek counseling, you understand, it is not for them to go to me to ask for counselling.”*

*“They want you to be proactive in your approach”*

*“They want to see how badly you want help so you have to go back and back and ask for help”*

*“...a lot of it depends on our input...”*

#### *5.2.6.8 Behavior Modification*

The intervention with regards to behavior modification was also generally perceived as positive. Patients felt that punishment due to unacceptable behavior caused consequences, something most of the patients felt they never had to deal with or face before. It also led to them having to reflect on themselves, which led to positive changes in themselves. Patients 3, 7, 4, 2 and 10 made the following comments about this:

*“...they’re breaking patterns of behavior, instituting new patterns of behavior, which is a good thing.”*

*“I am able to think things through instead of just reacting.”*

*“It (punishment) is effective, extremely effective.”*

*“... I was vindictive and was naughty but there were never consequences, so the fact that I have consequences in here is the best thing.”*

*“...it (punishment) forced me to think about myself and my behavior and it forced me to change my behavior.”*

#### *5.2.6.9 Limitations in the 12 step programme format.*

The 12 step programme, which also formed part of the programme, was also perceived positively. However there was a feeling that a more individual approach

should be worked into it. They felt that the section they do on the drug of their choice is too limited in that it only worked with certain groups of drugs. Patient 2 said the following about this:

*“At the moment there are not enough different programmes. I think they are in the process of adding a programme for alcoholics.”*

*“Individual programmes can be tailor-made to that person, especially the section on your drug of choice.”*

It seems the main criticism against the 12 step programme format was the lack of individuality.

#### *5.2.6.10 The lack of leisure activities.*

Although the questionnaires indicated that the patients were satisfied with leisure activities, it was also felt that more leisure activities which incorporate team-building should be implemented. Although time is allowed for sport activities, patients felt that was not enough. It was also felt that leisure activities could be used as a technique to learn. There was a feeling that they should be able to learn a new lifestyle through leisure activities and in order to do so, more structured time should be allowed for this. For example patient 3 said the following:

*“I think exercise can be used a lot more effectively to bring across points...it actually forces people to break a certain lifestyle.”*

#### *5.2.7 Relative's Involvement*

The theme of *relative's involvement* covers various aspects of patients' satisfaction with help given to their closest relatives, such as listening, understanding, advice, information, and helping the relatives to cope with the patient's problem. The general feeling was that relatives were not sufficiently involved in the treatment programme. The following remarks were made by patient 2, 1, 10 and 7:

*“I do not think there is enough family involvement”*

*“I am going home for a week’s visit next week and we have had one twenty minute meeting with counsellors. I do not think that is enough”*

*“The visitations are not enough for your family to actually get involved.”*

*“I also feel the parents and the family need to be more involved in my recovery because two visits are not enough...”*

The fact that so many of the patients are from far away might have contributed to their relatives not being involved. In exploring this issue, it became evident that a patient was limited to two visits from relatives during their first 5-month treatment period. Phone call contact was also limited since there were only certain times that calls could be received. Patient 9 made the following remark:

*“We are only allowed 2 visits in the 5 months, one on site and one off-site.”*

#### *5.2.7.1 Limitations of visits*

There was also criticism against the little amount of visits allowed. It was felt that the limitations on visits prevent the involvement of relatives in the recovery of patients.

Patient 10 said the following:

*“I think the visitations as well are not enough for your family to get involved. The more that they could be involved would be actually better for us ... if they are not involved in what is done there is no cross-communication”*

It was also argued that patients often ‘act out’ after visits and that visits from relatives can therefore allow for issues to surface which can then be addressed during treatment. Patient 9 said the following about this:

*“...people always have problems after they have had a visit and there is a lot of acting out and that sort of thing. So from a therapeutic basis I think they should give people more visits because it is pushing buttons and stuff comes out.”*

The limitation on visits was not only viewed negatively, since some patients felt that visits from relatives could distract them from their programme and let them lose focus. For example patient 10 said the following about this:

*“...you take your eye off the ball and you do not concentrate on the programme...”*

It was generally felt that the reason for limiting relatives' visits was due to a lack of staff to deal with relatives. For example, patient 2 said the following:

*“... I do not think there is enough staff to deal with the number of visits and that is why they cut them down.”*

#### *5.2.7.2 Lack of family preparation for patients' homecoming.*

Although they felt that the relatives were extensively informed before patients enter the treatment programme, it was the general consensus that families were not adequately prepared by the Centre to accommodate the patient when they return home. Patients felt that relatives should be better educated and provided with more support for receiving the patient back into their lives. Patients felt that if relatives were not prepared for receiving them back into their lives, the relatives might over compensate and might contribute to a relapse. For example patient 10, 8 and 5 said the following:

*“...they get the counselling session beforehand quite extensively....but they are not aware of all the ins and outs. They also need to prepare them for when we leave here to make sure that they do not over compensate...”*

*“...they need more support in what is going to happen once we leave....some education.”*

*“I feel the centre is encouraging my habits by placing my parents in a position of false trust”*

#### 5.2.7.3 *Difficulty of relatives to contact counsellors.*

Patients also reported that relatives complained that it was very difficult for them to get hold of counsellors on the phone in order to get feedback on the progress of the patient. For example patient 2 said:

*“...my dad started phoning the counsellors once a week, but I know he struggles to get through to them.”*

Again this was perceived to be due to a lack of staff to deal with these calls. For example patient 3 said:

*“...there is not enough staff to deal with these calls.”*

#### 5.2.7.4 *Patients should take responsibility in getting relatives involved in their recovery.*

There was a feeling that patients should take responsibility in getting their relatives involved. For example patient 5 said the following:

*“...there is an element of ‘I have to be responsible for their involvement’ by taking information to them...”*

Patients felt that involvement depended on the relatives themselves and that some relatives would never get involved, while others would get over-involved. For example patient 2 said the following:

*“...it comes down once again to depending on how much my family wants to get involved.”*

#### 5.2.7.5 *Utilization of community sources*

It was felt that relatives should utilize community resources to prepare themselves for a patient’s home coming in dealing with the recovering addict. For example patient 2 said the following:

*“...they can join these groups where they can get advice from people who had people in rehab. I think that is probably the best way for them to get advice and support...”*

However, it was also suggested that there was a lack of resources of this nature in communities. Patient 8 made the following comment:

*“This group is only in Johannesburg. None in Durban or Cape Town”*

### 5.3 SUMMARY OF THE KEY FINDINGS OF THE STUDY

In the quantitative analysis the VSSS mean dimension score, the frequency distribution, as well as the chi-square analysis, indicated that patients were mostly satisfied with the treatment programme. The chi square analysis, indicated satisfaction on the dimensions ‘overall satisfaction’, ‘professionals’ skills and behaviour’, ‘access’ and ‘types of interventions’, while dissatisfaction was indicated on the dimensions ‘information’, ‘efficacy’, and ‘relatives involvement’.

The qualitative analysis was used to explore reasons for satisfaction and dissatisfaction in the programme. As mentioned earlier, the person-centered approach emphasises the important of the patient subjective experience of the programme. This approach further postulates that patients are trustworthy, and therefore the information gained from them is also viewed as trustworthy and relevant (Rogers, 1987). Patients were requested to reflect and clarify key issues in the programme that emerged in the VSSS. In the process of exploring the programme, strengths, weaknesses and discrepancies were identified.

Overall, the study found that patients were satisfied with the programme. They perceived the programme as uniform and diverse. Uniformity seemed to be related to rules and regulations, while diversity was related to attention to individual treatment. The programme was further perceived as flexible and adaptable. However, it was felt that there was lack of structure. Some felt this had negative implications since it caused them to not know the programme objectives, whilst others felt it prevented them from manipulating the programme. This finding will be considered and explained later in this chapter.

On 'professionals' skills and behaviour' it was found that patients were satisfied with professionals' skills and behaviour. Patients felt that counsellors were experienced and had diversity in their approaches. They were also perceived as skilled, knowledgeable and respectable. This appears to be related to the counsellors' life experience related to drug usage. Further, patients appreciated counsellors' honest, straight-forward, unorthodox approach. Patients felt counsellors functioned effectively as a group and were passionate about their work.

Patients were however dissatisfied with the fact that counsellors at times seemed to get emotionally involved with patients. An issue related to the availability of individual therapy was raised. There were different perspectives for the reasons behind this problem. This will be discussed later.

On the 'information' aspect it was found that patients were dissatisfied. Dissatisfaction was related to providing information about diagnosis and prognosis. The lack of information concerning procedures, approaches and information on available services was also raised as an issue.

On the 'access' dimension it was found that patients were satisfied. This was mainly related to the appearance, comfort level and physical layout of the facility.

On the 'efficacy' aspect the quantitative analysis indicated dissatisfaction, whilst the qualitative part of the analysis indicated satisfaction. Dissatisfaction was related to effectiveness of the service to establish good relationships with other people. On the other hand, patients were satisfied with how their knowledge and understanding of there problems improved. They were also satisfied with the programme's approach to allow them to self-reflect, learn life skills, deal with emotions and beliefs, and change their confidence, attitude and motivation. These issues will be considered later in this chapter.

On the 'types of interventions' aspect it was found that patients were generally satisfied. Satisfaction was related to the approach to medication use, aspects of group therapy, the learning of skills and behaviour modification. Satisfaction with group therapy was related to building confidence, forcing accountability and changing

behaviours. Dissatisfaction on this dimension was related to availability of counsellors after hours, the size of the group, unavailability of individual therapy sessions, limitations in the 12 step programme format and a lack of leisure activities.

On 'relatives' involvement' it was found that patients were dissatisfied about relatives' involvement in the programme. Dissatisfaction was related to limitations of visits, the centre's failure to prepare families for patients' home coming, and difficulties relatives had contacting counsellors

## **CHAPTER SIX**

### **DISCUSSION**

This chapter presents a discussion of the key findings, strengths and weaknesses of the programme. An attempt is also made to understand these findings in the context of the theoretical framework outlined earlier. Recommendations and limitations of the study will also be discussed. In exploring the patients' experience of the SCRC programme, an insight was gained into the programme and challenges faced.

#### **6.1 UNDERSTANDING THE RESULTS ACCORDING TO GENERAL SYSTEMS PERSPECTIVES**

Although the study indicated that patients were satisfied with certain aspects of the programme, it was obvious that the same issue was often problematic on other aspects of the programme. As the general systems theory postulates, the factors in a system are better understood as a function of the context within which they occur. When these factors are an integral part of the system, they are both caused by aspects of the system (effects) and, in turn, can cause or maintain aspects of the system (Terre Blanche & Durrheim, 1999). Therefore the results of the study can not be viewed in isolation, but should be viewed within the context in which they occurred.

##### **6.1.1 Contradictory and recurrent issues in the programme**

This study explored the strengths, weaknesses and discrepancies in the treatment system or programme from the patients' perspective. Taking into consideration the general systems theory, in which this study is also embedded, many of these points could not be viewed as strengths or weaknesses alone. In certain aspects of the programme, certain issues were a weakness while on other aspects the same issues were a strength. Therefore contradictory and recurrent issues will be discussed in order to attempt to gain a better understanding of the programme as a system. These issues include 1) the programme structure, 2) problems with individual therapy, 3) the involvement of relatives and 4) tension between individual attention and uniform structure. These issues will now be discussed in the light of the general systems theory.

#### *6.1.1.1 The programme structure*

It was evident that patients experienced a constant tension between wanting more information about the programme structure and being content about the programme structure. In the focus group interview it became evident that programme structure was related to 1) the rules and regulations of the programme and 2) the programme format and objectives. It was felt that there was uniformity about rules and regulations, which patients were satisfied with. The tension seemed related to the programme format and objectives. On the one hand patients felt that not knowing the programme's objectives prevented them from seeing what they are working towards and what they should achieve. On the other hand patients felt that not knowing the programme format and objectives prevented them from manipulating the programme and just 'going through the motions' to complete the programme. According to the literature, programmes with coherent programme structure would allow for making clear links between outcome objectives and programme activities (Springer et al., 2004; Heinrich & Fournier, 2005).

This lack of structure might be a contributing factor to the lack of individual counselling sessions. Due to the lack of structure patients might not be sure when to approach counsellors for individual sessions. So while the lack of a structured format can be viewed as a strength when related to rules and regulations, it might be a weakness when related to format and objectives, like time tables and goals that should be achieved.

Not knowing the objectives and goals for treatment, might also contribute to patient dropout. Previous studies (Wickizer, Maynard, Atherly & Steward, 1994), suggested that patient dropout is a common phenomenon in substance abuse treatment programmes. It does however seem that other aspects of the programme are used to overcome the risk of dropout. According to Garrity, et al., (2006), interpersonal methods are important in building support and to lessen subjective stress and its consequences. From this perspective, patients were satisfied with counsellor care, which included a passionate and informed approach to working with patients. This seems to be linked to the extended length of the programme through allowing more time for such relationships to form which seems to have had a positive impact on the treatment system. In support of this, the literature review suggests that effective

programmes are those that provide longer interventions (Kumpher, 1997; Hiller et al., 2006).

In summary, the lack of structure affects several aspects of the treatment system. While the lack of programme structure negatively impacts on one area of the programme, it simultaneously has a positive impact on other areas of the programme. The lack of information on the programme structure is a strength in the way it prevents patients from manipulating the programme. However, the strength in this part of the programme causes a weakness in other parts of the programme. Not knowing the objectives prevent patients from being goal-orientated in their approach to recovery. It is well established in the literature that goal-directed behaviour on treatment programmes is an important part of successful treatment. Wolfer (2006) found that patients' positive perception of the structure of the programme had a positive impact on patients' level of recovery. Heinrich and Fournier (2005) found that coherent programme structure was one of the key categories that facilitated the implementation of practice improvements.

It is possible that problems with programme structure may also contribute to patient drop out rates. It is also possible that this had a negative impact on individual counselling since it might result in patients being inadequately informed about appointment times. Further, it is probable that the lack of programme structure also impacted on counsellor behaviour regarding availability regarding individual counselling. The lack of structure might also left counsellors uninformed and inadequate to manage individual counselling sessions. It seems that the lack of programme structure leads to high drop out rates, inadequate individual counselling sessions, as well as counsellors' failure to manage of individual sessions.

#### *6.1.1.2 Problems with individual therapy.*

Springer et al., (2004) and Daley et al., (1998), suggested that individual counselling is an important factor that contributes to treatment adherence and completion, as well as an important indicator of success. It has already been considered how the lack of programme structure may have systemic effects on individual counselling.

Following further investigations regarding the problems experienced with individual therapy, three different perspectives on the reasons for this were revealed. Some patients saw this as being due to favouritism on the counsellors' part where they were perceived as spending more time with certain patients. Others felt that it was a tool that counsellors used in order to teach assertiveness, pro-activeness and to force patients to take ownership of their own recovery. The conclusion here is that there were too many patients in the programme and therefore counsellors were not all able to attend individual counselling.

In exploring this issue, it seemed to reveal further information about 'professional's skills and behaviour' aspects of the programme. The issue of favouritism could possibly be linked to the issue of emotional involvement that was also mentioned. If counsellors get emotionally involved with patients, they will tend to treat such patients as more privileged. This might be the reason why others perceive it as favouritism. This in turn could also be related to the patients' experience of counsellors' care. Those patients who the counsellors were emotionally more involved with might receive more care and individual therapy since counsellors might be more eager to see these patients recover. This in turn would lead to a lower dropout rate and higher success rate amongst these specific patients due to receiving more individual care. On the other hand, the privileged nature of their treatment might cause the patient to have fewer consequences for addictive behaviours which the literature indicates as also an important factor in developing protection against use (Botvin, 1986; Brown & Caston, 1995). Therefore, such patients may also be disadvantaged by possible favouritism on the programme.

The other finding was that punctuality could be used as a therapeutic tool in order to teach patients assertiveness, pro-activeness and to take ownership for their recovery. As mentioned earlier the literature review emphasises behavioural skills content as an important aspect of an effective treatment programme. Although it is not clear whether the counsellors' lack of punctuality is a known, purposeful technique, or whether the other factors of favouritism or lack of staff, contribute to this, it is possible that it forces patients to learn skills of assertiveness and to take ownership of their own recovery by insisting and asking for individual counselling. However, according to the literature review (Petersen & McBride, 2002, Wormer & Davis,

2003), the motivational aspect of a programme is important in the treatment of substance abuse and this is usually mostly gained from interpersonal methods. So a patient who lacks motivation and does not have some level of skill will probably not be able to access individual counselling and thus be disadvantaged. This may, in turn, impact on drop out rates. Therefore it seems that the behaviour of the professionals, whether intended or unintended, may cause poorly motivated patients to be even more at risk for dropping out of treatment.

The third finding was that the problem with individual therapy was due to a lack of counsellors to attend to all the patients. This might explain why patients feel counselling is not easily available as well as the issue that relatives found it difficult to get hold of counsellors. This might also explain why visits from relatives are limited. At the time of the study there were 3 social workers, 3 addiction counsellors and a spiritual counsellor involved in daily counselling. The other staff was not involved in counselling activities. This gives a total of 7 counsellors to attend to 61 primary care residents and 11 halfway house residents, a total of 72 at a time. This yields a patient-counsellor ratio of 10,3 patients per 1 counsellor. It is not clear what other duties counsellors have, but it seems as though there might be an underlying inability amongst counsellors to effectively do time and self management. This seems to be left unattended. Petersen & McBride, (2002) and Passey et al., (2006) have suggested that substance abusers often display challenging behaviors. This suggests that there is a need for knowledge, skills and a positive attitude when working in this context. The literature therefore emphasises the importance of effective self-management of staff in order to prevent stress and burnout (Petersen & McBride, 2002; Passey et al., 2006). In sum, whether due to a lack of numbers in staff or due to a lack of effective self-management of the staff, it seems there was a weakness in counsellor self-care and management in the programme, which impacted negatively on individual counselling.

Another reason for this problem might be related to negotiating personal boundaries (Petersen & McBride, 2002). According to Petersen & McBride (2002), working in the context of substance abuse, requires not only contextual knowledge and task specific skills necessary, but also requires interpersonal skills and skills to negotiate personal boundaries. The knowledge, skills and attitude of the multi disciplinary team

equipped counsellors to effectively work with substance abusers. They had skills to identify tactics used by patients and brought insight and understanding to behaviors not understood from patients' perspectives. So the issue of punctuality might be related to counsellors' way of negotiating personal boundaries. If this is the case, counsellors should be aware of the impact this has on other aspects of the programme, like patient care and dropout, in order to maintain a balance in the way this is applied.

It is possible that counsellors themselves might need some care since it appears they to sometimes struggle with the high number of inpatients. It is not clear if this is due to the lack of counsellors, ineffective self-management, or burn out. These issues seemed to explain why the quantitative part of the study revealed dissatisfaction with the dimension of 'efficacy'. This dissatisfaction seems to be related to the underlying causes of the behaviour of counsellors regarding managing themselves in the context of the programme. Even if the perceived problem related to individual counselling is a technique that is used in order to facilitate certain behavioural skills, this technique gives raise to certain actions by counsellors which can (1) negatively impact on counsellor care regarding certain patients, or (2) due to the lack of enforcing the technique on privileged patients, not allow them to learn skills.

As postulated by the general systems theory, several factors cause problems in individual therapy. These include the lack of programme structure, emotional involvement of counsellors, lack of staff and staff self-management. On the other hand, the problems related to individual counselling cause other systemic effects like the development of life skills that impact on the length of stay and dropout rates. The negative impact that the lack of availability has on treatment adherence and completion, drop out rates due to low patient care, seems more significant than the impact it has when used as a 'technique' to learn skills

#### *6.1.1.3 The involvement of relatives*

It seems the uninvolvement of relatives can be linked to several factors. It might be linked to 1) the structure of the programme, 2) limitation of visits, 3) patients relatives living far away, 4) lack of staff to deal with relatives.

It seems that the programme structure does not allow enough official time for relatives. This might be the reason why meetings with relatives are not well organised and managed. Involvement is further hindered by the limitations of visits of relatives. Although, as patients see it, visits can distract patients from focusing on their programme, 2 visits in a 5 month period appears not sufficient to rebuild family relationships and social support. As also mentioned by patients, emotional issues related to relatives can surface during or after visits. When these visits are limited, opportunities to deal with these emotional issues are lost and it leaves the patient vulnerable to relapse when going back to the same family environment with these unaddressed issues. It is not clear what the policy behind limited visits was. But looking at the results of the study, there might be 2 underlying reasons for this: 1) a lack of staff to deal with these visits, or 2) a lack of structure to organise and manage these visits.

Another reason for the uninvolvement of relatives is the fact that most residents were from far away. It would be costly for the relatives, who were already paying a lot of money for the programme, to travel long distances. This would make it difficult for relatives to stay more involved in the patients' recovery process. This might also be the reason behind the policy of limiting the visits, since some residents families might be financially able to drive down every weekend, while others might not be able to do this. It seemed that relatives were trying to overcome this issue by trying to stay involved through phone contact. This, however, seemed unsuccessful, since it was difficult to get hold of counsellors. As stated previously, this appears linked to the unstructured nature of the programme, which does not allow for a set time for counsellors to handle calls from relatives.

Since the over involvement of relatives can distract patients from focusing on their treatment programme, involvement was limited. However, the lack of relatives' involvement was perceived as a weakness in the programme leading to poor social support. It is possible that this may adversely affect reintegration into the family environment.

The issue related to relatives' involvement revealed that the structure of the programme contributed to poor management of relatives' involvement. As mentioned

earlier the literature emphasises the importance of building positive relationships, since building social support might help patients to lessen the subjective stress and its consequences (Springer et al., 2004; Garrity et al., 2006). The lack of involvement leads to the lack of opportunities to build positive social relationships with relatives.

#### *6.1.1.4 Tension between individual attention and uniform structure*

It seemed there was also tension between attention to individuals and uniform structure. As mentioned earlier, uniformity was related to the way the programme's rules and regulations were enforced, as well as to the format and objectives of the programme. It appeared that patients appreciated that patients had to adhere to the same set of rules and regulations and that no individuality related to this was necessary. However, there was a need for individuality on other areas of the programme. It seemed that this need for individuality was related to specific areas of the 12 step programme format. It was felt that the section related to 'the drug of choice' was too limited and there were a group of people who felt they were not addressed through that part of the programme. On the other hand, there was also the feeling that patients were treated individually in the way counsellors dealt with their problems. They felt patients were treated with individuality when it came to giving advice, perspective, feedback and guidance in individual counselling. It was also mentioned that, on a more negative note, that patients may have been treated individually through various forms of favouritism. By not understanding the programme and treatment structure, patients might attempt to rationalize their differences in care towards assumptions of favouritism. This might lead to mistrust and speculation, which is a very negative entity for a substance abuse programme.

In sum, uniformity that was related to programme format that compromised the patients' individual needs caused dissatisfaction, while uniformity related to programme rules and regulations did not cause dissatisfaction. The absence in uniformity in interpersonal methods, lead to individual treatment and lead to satisfaction amongst patients. Again, this confirms the importance of a coherent programme structure (Springer et al., 2004; Malkin et al., 1996; Heinrich and Fournier, 2005), as well as interpersonal methods (Springer et al., 2004; Garrity et al., 2006), as suggested in the literature review. So it seemed a strength was the uniformity related to rules and regulations enforced in the programme, while a

weakness was evident with regards to uniformity in the 'step work', since it took away individuality by not allowing for individual issues to be dealt with.

#### *6.1.1.5 The lack of information*

The lack of information was also an issue that often reoccurred during this study. Patients were uninformed about their diagnosis and prognosis, about the programme structure, about other services available, and about the costs of their programme. It seemed patients were however well informed about substance abuse and understanding the problem of substance abuse.

Returning to systems theories, the lack of information can again be linked to the lack of a structured programme. This problem in the program could be understood as self fulfilling: If no structure for the programme is laid out, no information would be available. Conversely, if no information is given about the structure it will be perceived as unstructured. It also seemed that this lack of information (and structure) was used as a tool to prevent patients from manipulating the programme. In other words to prevent addiction related behaviors. The reasoning behind this might also be that if patients had too much information they might fall into a 'comfort zone' and it therefore might prevent them from working hard to achieve recovery. The high relapse rate related to substance abuse, as evident from the literature review (Wickizer et al., 1994), might contribute to the fact that counsellors are hesitant to discuss prognosis with patients. The literature further suggests that substance abusers often display denial of the effects of their behaviour (Petersen & McBride, 2002). Giving no prognosis or diagnosis might contribute to their state of denial and cause patients to become complacent in their recovery and therefore become a relapse risk.

According to Petersen & McBride (2002), socio-economic factors often contribute to patients moving in and out of treatment programmes and impact on treatment outcomes. Therefore information about the costs of the programme could be used as a tool. It has been mentioned that the programme attempts to get patients to take ownership of their recovery. More information and involvement in the cost aspect of the programme could allow for patients to take more ownership of their own recovery.

The lack of information about other available services is probably also related to patients living far away. The counsellors probably do not have the information available about services available in the patients' home environment. Since patients can benefit from additional support systems, especially after discharge and going back in an environment far from the supportive environment of the centre, patients can benefit from this information.

As stated above the perceived lack of information has both positive and negative effects. For instance, the withholding of information with regards to a positive prognosis may also be viewed as a strength since it might prevent denial from being reinforced. Withholding information with regards to the programme structure is, as mentioned earlier, could also be viewed as a strength since it was viewed as preventing patients from manipulating the programme.

The lack of information impacts on how the programme structure is perceived. It impacts on behaviors, impact on patients' commitment and taking ownership of their recovery and on patients' support systems. This lack of information as evident in patients' perceptions is contrary to the evidence in the literature that emphasis that all areas of the programme should be made as explicit as possible (Springer et al., 2004; Heinrich & Fournier, 2005).

#### 6.1.2 Other issues in the programme that influence treatment.

##### *6.1.2.1. The approach towards the use of medication.*

The approach to treat patients with limited medication can be viewed as strength in the programme. According Bean and Nemits (2004), medication is often important during detoxification and withdrawal, but might be used for overdosing and illicit drug use. There is however a concern in the literature that this kind of policy can cause comorbidity with other mental disorders to be overlooked (Kessler, Nelson & Mcgonagle, 1996). Patients mentioned being taken off several psychiatric medications, but there was no evidence that this had been managed by a psychiatrist with experience in the field of substance abuse.

#### *6.1.2.2 The lack of counselling staff after hours*

Patients were dissatisfied with the lack of counsellors after hours. This is probably related to encouraging patients to become independent. Although patients were dissatisfied with this aspect of the programme, this philosophy is not necessarily a weakness in the programme. The literature review indicated that building peer and social support is effective in helping to lessen subjective stress and its consequences (Springer et al, 2004). The absence of counsellors might encourage patients to make use of peer support. The effect of the absence of counsellors, can positively impact on the 'efficacy' of the programme, in that it allows for peer support to grow. Peer support in turn can lessen subjective stress and its consequences (Garrity et al., 2006).

#### *6.1.2.3 The use of leisure activities*

Although patients were satisfied with leisure activities, they thought this could be developed more to become a strength for the programme. Leisure activities offer the opportunity to facilitate teambuilding, interpersonal methods, as well as interactive learning styles. According to the literature review, techniques that focus on building positive relationships with peers and methods that use interactive, rather than passive learning styles, are much more effective and contribute to a positive experience of inpatient treatment programmes (Borge & Fagermoen, 2008; Springer et al, 2004). This type of intervention can therefore impact on peer support, on learning and on the experience of the inpatient programme. This in turn can contribute to the learning of skills, lessening subjective stress and programme adherence.

## 6.2 CONCLUSION AND RECOMMENDATION

From the findings it is clear that perceived weaknesses and strengths have systemic effects on the programme.

Based on patients' perceptions, this study indicated the following strengths:

(1)The programme offers an introspective learning approach which focuses on self-reflection and contributes to change in behaviour and motivation. Group therapy, individual therapy and behavior consequences play an important role in achieving these goals. This is in keeping with literature that emphasises the importance of introspective learning in programmes through the use of self-reflection (Springer et al, 2004).

(2) The programme offers an effective way of changing addiction-related behaviour, like manipulation. It also focuses on teaching patients to develop behaviour that is pro-active, assertive and enabling. Botvin (1986) and Brown and Caston (1995) emphasize the importance of behaviour life skills as protection against substance abuse.

(3) The multi disciplinary team's levels of commitment contribute to developing interpersonal methods that provide patients with social support which contribute to motivation and treatment completion. According to the literature (Springer et al, 2004; Garrity et al., 2006; Petersen & McBride, 2002; Wormer & Davis, 2003) this is important in the treatment of substance abuse. Counsellor care is also related to the extended length of the programme, which according to Kumphier (1997) and Hiller (2006) is a characteristic of effective programmes since it allows the development of capabilities to deal with social situations and stresses.

(4) The diversity of the multi-disciplinary team offered diverse input from different approaches in the treatment programme. First Nations Inuit and Aboriginal Health (2005) suggested that it is a useful approach to use multimodal approaches to address multiple aspects of substance abuse.

(5) The knowledge, skills and attitude of the multi-disciplinary team equipped them to effectively work with substance abusers and positively contribute to the treatment programme. Counsellors were perceived as being skilled to identify tactics used by patients and brought insight and understanding to behaviors not understood from the patients' perspectives. Due to the importance of challenging behaviours associated with substance abuse, research (Petersen & McBride, 2002; Passey, 2006) indicated the importance of staff's knowledge, skills and attitude.

(6) Group therapy was viewed as a very important type of intervention to contribute to introspective learning, behaviour changes and developing life skills. All, according to the literature are important objectives during substance abuse treatment (Springer et al, 2004; Wormer & Davies, 2003; Botvin, 1986; Brown, 1995).

(7) The programme was perceived to have a good approach towards the use of medication, which according to the literature (Bean & Nemits, 2004) can contribute to the prevention of the use of illicit medication.

(8) The programme was successful in helping patients improve their knowledge and understanding of their substance abuse problem.

(9) The programme had uniformity with regards to rules and regulations.

(10) The centre had good facilities, was comfortable and had a good layout.

The study identified the following weakness in this programme:

(1) The lack of structure negatively impacted several aspects of the programme, which included individual therapy, lack of clear goals and objectives that can contribute to possible dropout rates and relatives' involvement.

(2) The rapid growth in numbers appeared to contribute to the reduced effectiveness of certain types of interventions. This was especially the case with group therapy and individual therapy, which might, in turn, have impacted on several other aspects of the programme (self-reflection, behavioral and motivational changes, as well as programme adherence and completion). Research indicates that these aspects are important characteristics of an effective programme (Springer et al., 2004; Wormer & Davis, 2003; Petersen & McBride, 2002).

(3) There was a lack in the development of social support systems. This was indicated by the lack of enough structured leisure activities, the lack of relatives' involvement, the lack of information about other available services in their areas. Social supportive relationships can contribute to the lowering of subjective stress and its consequences, as indicated by the literature review (Springer et al., 2004; Garrity et al., 2006).

(4) Relatives were not sufficiently involved in the treatment of substance abuse patients. This may lead to the under development of social relationships and social support with relatives. Relatives were not sufficiently educated and not prepared for patients' home-coming which put patients at greater risk for relapse. Again, as indicated by the literature (Springer et al., 2004; Garrity et al, 2006) poor social relationships can impact on the patients' ability to cope with stress and might cause a patient to be vulnerable for relapse.

(5) Although counsellors were perceived as being passionate about their work, their emotional involvement negatively impacted on their objectivity. This might cause certain patients to receive privileged treatment and might cause these patients to not fully benefit from the programme in learning skills of assertiveness. This may indicate that some counsellors have poor self management skills. According to the literature this is an important aspect of a substance abuse treatment programme due to the challenging nature of behaviour that substance abusers display (Petersen & McBride, 2002; Passey et al., 2006).

(6) The medical approach seemed to overlook comorbid pathologies. According to Wormer & Davis (2003), it is important for substance abuse treatment centres to consider this important aspect to consider in treatment.

Based on these strengths and weaknesses the following recommendations are made to improve the programme:

(1) Since the perceived lack of coherence and programme structure has several impacts on the treatment system (individual counselling, treatment adherence, relatives' involvement and behaviours), this will be an important aspect to address. In order to create a more coherent programme, clear links between outcome objectives and programme activities should be made more explicit to patients.

(2) The number of counsellors in the programme should be reconsidered since the lack of counsellors had an impact on more than one aspect of the efficiency of the programme (this included individual therapy, involving relatives, and providing information).

(3) The number of patients that should be allowed in the programme should be reconsidered, since that also contributed to a perceived lack of efficiency, especially during group therapy, individual sessions and relatives' involvement. In this programme large numbers, especially in group therapy, could prevent patients from benefiting fully from treatment.

(4) The counsellors' self management was outlined as a concern. In order to deal with the counsellors' emotions and countertransference in counselling substance abusers, a platform should be created for counsellors to address these issues. This could be done either in the form of a support group for counsellors or in the form of individual sessions with an objective outsider. Counsellors should also be aware of the impact of their behaviors on the efficacy of the programme.

(5) The issue with counsellors' emotional over involvement with patients should be addressed by ensuring that counsellors are professionally trained. In service delivery of this nature, it is important to expose these kinds of counsellor/patient interactions and address these issues on management level.

(6) More structured leisure activities that use interactive learning styles could be implemented. This would contribute to the learning of social skills and development skills in social relationships.

(7) An awareness of possible comorbid mental disorders should be developed. Although not sufficiently explored in this study, the psychiatric nurse and contracted psychologist can play an important role identifying comorbid disorders in the patients. Including the services of a psychiatrist would also be beneficial.

(8) Patients can be more involved with the cost aspect of the programme, since that will contribute to them taking more ownership of their treatment process.

(9) Provision should be made in the programme to allow for more involvement of relatives. These opportunities should involve the education of relatives, preparing relatives for patient's home-coming, as well as focusing on building relationships and dealing with unresolved issues between patients and relatives. Unresolved issues and insufficient education of relatives can create opportunities for relapse.

### 6.3 LIMITATIONS OF THE STUDY

This study was based on the perceptions of the inpatients of the South Coast Recovery Centre. Perceptions are inherently subjective and influenced by many different factors that this study could not control for. In this study levels of motivation might have played an important role in how patients perceived the intervention they received and whether they were satisfied with the intervention or not. Although it seemed that patients who were closer to completing the programme had higher levels of motivation and perceived the programme more satisfying, this might not be the case with all long staying patients. Patients who were not ready for change and for treatment might even view positive aspects of the programme as negative. Therefore it might be beneficial to this centre to conduct a study that included the viewpoints of counsellors, management, patients' relatives and other involved parties. Without obtaining the viewpoints of others in the programme it has been difficult to ascertain the motivations behind some aspects of the programme implemented by counsellors. However, the focus of this study was on the subjective experiences of the patients as a valid point of enquiry that is known to affect treatment success.

This study focused only on seven dimensions of the programme. Other important aspects, like the role of different counsellors (like the role of the psychiatric nurse and the contracted psychologist, initial assessment and the programme's approach in

dealing with patient drop outs) have not been explored in depth in this study. Future studies can therefore focus on this aspect.

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## **APPENDICES**

Appendix A: The Verona Service Satisfaction Scale

Appendix B: Manual of the Verona Service Satisfaction Scale

Appendix C: Informed consent letter and form

Appendix D: Calculations of the mean score on each dimension

Appendix E: Collapsed Lickert Scale ratings

Appendix F: Guideline for Interview questions for the focus group

Appendix G: Section of transcribed focus group interview.

# APPENDIX A

## THE VERONA SERVICE SATISFACTION SCALE (VSSS\_EU)



DEPARTMENT OF MEDICINE AND PUBLIC HEALTH  
SECTION OF PSYCHIATRY AND CLINICAL PSYCHOLOGY  
UNIVERSITY OF VERONA



WORLD HEALTH ORGANIZATION  
COLLABORATING CENTRE FOR RESEARCH  
AND TRAINING IN MENTAL HEALTH

### VERONA SERVICE SATISFACTION SCALE (VSSS-EU)<sup>1 2</sup>

#### PATIENTS

THE QUESTIONNAIRE ASKS ABOUT YOUR EXPERIENCE OF THE  
COMMUNITY MENTAL HEALTH SERVICES  
OFFERED LOCALLY, DURING THE LAST YEAR

It is very important that you answer **truthfully**; please express your opinion **whatever it is**. We are especially interested to know about your **criticisms** and about **problems** you have had with the services.

All your answers will be treated **confidentially**.  
Your answers will not be discussed with the professionals working in the service or your relatives.

*Please feel free to ask the researcher for help if a question is not clear or if you encounter any problem in filling in the questionnaire.  
Please read the questions very carefully and take your time before answering.  
It is very important that every answer expresses your true opinion.*

Rights reserved. This scale can only be reproduced and used with the express permission of the authors<sup>3</sup>.

- <sup>1</sup> M. Ruggeri & R. Dall'Agnola (1993). The development and use of the Verona Expectations for Care Scale (VECS) and the Verona Service Satisfaction Scale (VSSS) for measuring expectations and satisfaction with community-based psychiatric services in patients, relatives and professionals. *Psychological Medicine*, 23, 511-523. Items from a. 1 to n. 21 and a. 23, 29, 39, as well as the two open questions, have been translated, or modified, with the permission of the authors, from the Service Satisfaction Scale-30 or derived instruments [Greenfield T.K. & Atkinson C.C., (1989). Steps toward a multifactorial satisfaction scale for primary care and mental health services. *Evaluation and Program Planning*, 12, 271-278].
- <sup>2</sup> Ruggeri M., Lasilva A., Dall'Agnola R. et al. (2000). Development, internal consistency and reliability of the Verona Service Satisfaction Scale - European Version. In *Reliable outcome measure for mental health service research in five European countries: the EPSILON Study* (ed. G. Thornicroft, T. Becker, M. Knapp, H.C. Kaudsen, A. Schene, M. Tansella & J.L. Viquez-Barquero). *British Journal of Psychiatry* 177 (suppl. 39), 41-48.
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IN THE FOLLOWING PAGES WE ASK YOU ABOUT YOUR EXPERIENCES IN USING THE LOCAL MENTAL HEALTH SERVICES DURING THE LAST YEAR.

Please mark the answer which best describes your overall impression in using the local mental health services during the last year.

You can use one of these options:

- 1. Terrible**
- 2. Mostly dissatisfied**
- 3. Mixed**
- 4. Mostly satisfied**
- 5. Excellent**

Please choose the answer which is the best description of your experience in using the local mental health services over the last year:

**WHAT IS YOUR OVERALL FEELING ABOUT THE ...**

**1. effect of services in helping you deal with your problems**

1. Terrible    2. Mostly dissatisfied    3. Mixed    4. Mostly satisfied    5. Excellent

**2. behaviour and manners of reception or secretarial staff on the telephone or when you meet them**

5. Excellent    4. Mostly satisfied    3. Mixed    2. Mostly dissatisfied    1. Terrible

**3a. professional knowledge and competence of psychiatrists**

1. Terrible    2. Mostly dissatisfied    3. Mixed    4. Mostly satisfied    5. Excellent

**3b. professional knowledge and competence of psychologists**

5. Excellent    4. Mostly satisfied    3. Mixed    2. Mostly dissatisfied    1. Terrible

**4. the appearance, comfort level and physical layout of the facilities (e.g. the waiting rooms and the offices)**

1. Terrible    2. Mostly dissatisfied    3. Mixed    4. Mostly satisfied    5. Excellent

**5a. ability of psychiatrists to listen to and understand your problems**

5. Excellent    4. Mostly satisfied    3. Mixed    2. Mostly dissatisfied    1. Terrible

**5b. ability of psychologists to listen to and understand your problems**

1. Terrible    2. Mostly dissatisfied    3. Mixed    4. Mostly satisfied    5. Excellent

*Please read the questions very carefully and take your time before answering.  
It is very important that every answer expresses your true opinion*

Please choose the answer which is the best description of your experience in using the local mental health services over the last year:

**WHAT IS YOUR OVERALL FEELING ABOUT THE ...**

**6a. personal manner of psychiatrists**

5.Excellent    4.Mostly satisfied    3.Mixed    2.Mostly dissatisfied    1.Terrible

**6b. personal manner of psychologists**

1.Terrible    2.Mostly dissatisfied    3.Mixed    4.Mostly satisfied    5.Excellent

**7.punctuality of the professionals when you come for an appointment**

5.Excellent    4.Mostly satisfied    3.Mixed    2.Mostly dissatisfied    1.Terrible

**8. cost of the service to you (e.g. prescription charges)**

1.Terrible    2.Mostly dissatisfied    3.Mixed    4.Mostly satisfied    5.Excellent

**9.effectiveness of services in helping you to attain wellbeing and preventing relapse**

5.Excellent    4.Mostly satisfied    3.Mixed    2.Mostly dissatisfied    1.Terrible

**10.confidentiality and respect for your rights**

1.Terrible    2.Mostly dissatisfied    3.Mixed    4.Mostly satisfied    5.Excellent

**11.amount of help you have received**

5.Excellent    4.Mostly satisfied    3.Mixed    2.Mostly dissatisfied    1.Terrible

**12.explanations of specific procedures or approaches used**

1.Terrible    2.Mostly dissatisfied    3.Mixed    4.Mostly satisfied    5.Excellent

*Please read the questions very carefully and take your time before answering.  
It is very important that every answer expresses your true opinion*

Please choose the answer which is the best description of your experience in using the local mental health services over the last year:

**WHAT IS YOUR OVERALL FEELING ABOUT THE ...**

**13. effect of services in helping to relieve symptoms**

5. Excellent    4. Mostly satisfied    3. Mixed    2. Mostly dissatisfied    1. Terrible

**14. response of the service to crises or urgent needs during office hours**

1. Terrible    2. Mostly dissatisfied    3. Mixed    4. Mostly satisfied    5. Excellent

**15. arrangements made for after hours emergencies**

5. Excellent    4. Mostly satisfied    3. Mixed    2. Mostly dissatisfied    1. Terrible

**16a. thoroughness of psychiatrists**

1. Terrible    2. Mostly dissatisfied    3. Mixed    4. Mostly satisfied    5. Excellent

**16b. thoroughness of psychologists**

5. Excellent    4. Mostly satisfied    3. Mixed    2. Mostly dissatisfied    1. Terrible

**17. appropriateness of referrals to your GP or other specialist if needed**

1. Terrible    2. Mostly dissatisfied    3. Mixed    4. Mostly satisfied    5. Excellent

**18. cooperation between service providers (if you are treated by more than one professional)**

5. Excellent    4. Mostly satisfied    3. Mixed    2. Mostly dissatisfied    1. Terrible

**19. publicity or information about available mental health services**

1. Terrible    2. Mostly dissatisfied    3. Mixed    4. Mostly satisfied    5. Excellent

*Please read the questions very carefully and take your time before answering.  
It is very important that every answer expresses your true opinion*

Please choose the answer which is the best description of your experience in using the local mental health services over the last year:

WHAT IS YOUR OVERALL FEELING ABOUT THE ...

**20. kinds of service offered**

5. Excellent    4. Mostly satisfied    3. Mixed    2. Mostly dissatisfied    1. Terrible

**21. in an overall, general sense, the service you have received**

1. Terrible    2. Mostly dissatisfied    3. Mixed    4. Mostly satisfied    5. Excellent

**22a. professional knowledge and competence of nurses**

5. Excellent    4. Mostly satisfied    3. Mixed    2. Mostly dissatisfied    1. Terrible

**22b. professional knowledge and competence of social workers**

1. Terrible    2. Mostly dissatisfied    3. Mixed    4. Mostly satisfied    5. Excellent

**23. recommendations made to your closest relative about how they could help you**

5. Excellent    4. Mostly satisfied    3. Mixed    2. Mostly dissatisfied    1. Terrible

**24. effectiveness of the service in helping you to improve your knowledge and understanding of your problems**

1. Terrible    2. Mostly dissatisfied    3. Mixed    4. Mostly satisfied    5. Excellent

**25a. personal manners of nurses**

5. Excellent    4. Mostly satisfied    3. Mixed    2. Mostly dissatisfied    1. Terrible

**25b. personal manners of social workers**

1. Terrible    2. Mostly dissatisfied    3. Mixed    4. Mostly satisfied    5. Excellent

*Please read the questions very carefully and take your time before answering.  
It is very important that every answer expresses your true opinion*

Please choose the answer which is the best description of your experience in using the local mental health services over the last year:

WHAT IS YOUR OVERALL FEELING ABOUT THE ...

**26. effectiveness of the service in improving the relationship between you and your closest relative**

5.Excellent    4.Mostly satisfied    3.Mixed    2.Mostly dissatisfied    1.Terrible

**27. effectiveness of the service in helping your main carer (relative or friend) improve their understanding of your problems**

1.Terrible    2.Mostly dissatisfied    3.Mixed    4.Mostly satisfied    5.Excellent

**28. nurses' knowledge about you and your medical history**

5.Excellent    4.Mostly satisfied    3.Mixed    2.Mostly dissatisfied    1.Terrible

**29. how information was given to you about your problem (diagnosis) and what to expect (prognosis)**

1.Terrible    2.Mostly dissatisfied    3.Mixed    4.Mostly satisfied    5.Excellent

**30a.ability of psychiatrists to listen to and understand the worries your main carer (relative or friend) may have about you**

5.Excellent    4.Mostly satisfied    3.Mixed    2.Mostly dissatisfied    1.Terrible

**30b.ability of psychologists to listen to and understand the worries your main carer (relative or friend) may have about you**

1.Terrible    2.Mostly dissatisfied    3.Mixed    4.Mostly satisfied    5.Excellent

**31. effectiveness of the service in helping you establish good relationships with people outside your family (e.g. friends, neighbours, colleagues at work, etc.)**

5.Excellent    4.Mostly satisfied    3.Mixed    2.Mostly dissatisfied    1.Terrible

*Please read the questions very carefully and take your time before answering.  
It is very important that every answer expresses your true opinion*

Please choose the answer which is the best description of your experience in using the local mental health services over the last year:

**WHAT IS YOUR OVERALL FEELING ABOUT THE ...**

**32. how information was given to your main carer (relative or friend) about your problem (diagnosis) and what to expect (prognosis)**

1. Terrible    2. Mostly dissatisfied    3. Mixed    4. Mostly satisfied    5. Excellent

**33. instructions about what to do on your own between appointments; the clarity, practicality etc. of recommendations**

5. Excellent    4. Mostly satisfied    3. Mixed    2. Mostly dissatisfied    1. Terrible

**34. effectiveness of the service in helping you to improve your self-care (e.g. take care of your personal hygiene, your diet, your room)**

1. Terrible    2. Mostly dissatisfied    3. Mixed    4. Mostly satisfied    5. Excellent

**35a. thoroughness of nurses**

5. Excellent    4. Mostly satisfied    3. Mixed    2. Mostly dissatisfied    1. Terrible

**35b. thoroughness of social workers**

1. Terrible    2. Mostly dissatisfied    3. Mixed    4. Mostly satisfied    5. Excellent

**36. effectiveness of the service in helping your main carer (relative or friend) deal better with your problems**

5. Excellent    4. Mostly satisfied    3. Mixed    2. Mostly dissatisfied    1. Terrible

*Please read the questions very carefully and take your time before answering.  
It is very important that every answer expresses your true opinion*

Please choose the answer which is the best description of your experience in using the local mental health services over the last year:

WHAT IS YOUR OVERALL FEELING ABOUT THE ...

**37a. ability of nurses to listen to and understand your problems**

1.Terrible    2.Mostly dissatisfied    3.Mixed    4.Mostly satisfied    5.Excellent

**37b. ability of social workers to listen to and understand your problems**

5.Excellent    4.Mostly satisfied    3.Mixed    2.Mostly dissatisfied    1.Terrible

**38.effectiveness of the service in helping you to improve your ability to work**

1.Terrible    2.Mostly dissatisfied    3.Mixed    4.Mostly satisfied    5.Excellent

**39. help you have received for side effects from medications (if occurred)**

5.Excellent    4.Mostly satisfied    3.Mixed    2.Mostly dissatisfied    1.Terrible

**40.continuity of care (seeing the same staff) you have received**

1.Terrible    2.Mostly dissatisfied    3.Mixed    4.Mostly satisfied    5.Excellent

*Please read the questions very carefully and take your time before answering.  
It is very important that every answer expresses your true opinion*

Please choose the answer which is the best description of your experience in using the local mental health services over the last year:

**WHAT IS YOUR OVERALL FEELING ABOUT THE ...**

**41. in the last year, have you been prescribed medication?**

**YES** (if you answered **YES**, please answer the following question):

- What is your overall feeling about this/them?

1. Terrible
2. Mostly unsatisfactory
3. Mixed
4. Mostly satisfactory
5. Excellent

**NO** (if you answered **NO**, answer the following question):

- Do you think you would have liked to receive this/them?

6. NO 7.DON'T KNOW 8. YES

**42. in the last year, did you receive help from staff to improve your capacity to cope with your social and working life (e.g. going to public offices, doing housework, getting on with your family and others)?**

**YES** (if you answered **YES**, please answer the following question):

- What is your overall feeling about this/them?

5. Excellent
4. Mostly satisfactory
3. Mixed
2. Mostly unsatisfactory
1. Terrible

**NO** (if you answered **NO**, answer the following question):

- Do you think you would have liked to receive this/them?

6. NO 7.DON'T KNOW 8. YES

*Please read the questions very carefully and take your time before answering.  
It is very important that every answer expresses your true opinion*

Please choose the answer which is the best description of your experience in using the local mental health services over the last year:

43. in the last year, did you have the opportunity to meet alone, on a regular basis, with your therapist (e.g. in order to help you understand your problems and/or change your behaviour in some way)?

YES (if you answered YES, please answer the following question):

- What is your overall feeling about this/them?

1. Terrible
2. Mostly unssatisfactory
3. Mixed
4. Mostly satisfactory
5. Excellent

NO (if you answered NO, answer the following question):

- Do you think you would have liked to receive this/them?

6. NO 7. DON'T KNOW 8. YES

44. in the last year, did you have compulsory treatment in a psychiatric hospital?

YES (if you answered YES, please answer the following question):

- What is your overall feeling about this/them?

5. Excellent
4. Mostly satisfactory
3. Mixed
2. Mostly unssatisfactory
1. Terrible

NO (if you answered NO, answer the following question):

- Do you think you would have liked to receive this/them?

6. NO 7. DON'T KNOW 8. YES

*Please read the questions very carefully and take your time before answering.  
It is very important that every answer expresses your true opinion*

Please choose the answer which is the best description of your experience in using the local mental health services over the **last year**:

**45. in the last year, did you have meetings with your family and therapist (with the aim of improving/changing the relationships between family members)?**

**YES (if you answered YES, please answer the following question):**

- What is your overall feeling about this/them?

1. Terrible
2. Mostly unssatisfactory
3. Mixed
4. Mostly satisfactory
5. Excellent

**NO (if you answered NO, answer the following question):**

- Do you think you would have liked to receive this/them?

6. NO 7.DON'T KNOW 8. YES

**46. in the last year, did you have a place in sheltered accomodation (e.g. foster home/family placement scheme, group home, hostel with staff available for help)?**

**YES (if you answered YES, please answer the following question):**

- What is your overall feeling about this/them?

5. Excellent
4. Mostly satisfactory
3. Mixed
2. Mostly unssatisfactory
1. Terrible

**NO (if you answered NO, answer the following question):**

- Do you think you would have liked to receive this/them?

6. NO 7.DON'T KNOW 8. YES

*Please read the questions very carefully and take your time before answering.  
It is very important that every answer expresses your true opinion*

Please choose the answer which is the best description of your experience in using the local mental health services over the **last year**:

**47. in the last year, did you have the opportunity to take part in leisure activities organized by the mental health services?**

**YES** (if you answered **YES**, please answer the following question):

- What is your overall feeling about this/them?

1. Terrible
2. Mostly unsatisfactory
3. Mixed
4. Mostly satisfactory
5. Excellent

**NO** (if you answered **NO**, answer the following question):

- Do you think you would have liked to receive this/them?

6. NO    7. DON'T KNOW    8. YES

**48. in the last year, did you have group psychotherapy** (e.g. meetings of a group of patients with one or more therapists with the aim of improving the patients understanding of their problems and/or changing their behaviour)?

**YES** (if you answered **YES**, please answer the following question):

- What is your overall feeling about this/them?

5. Excellent
4. Mostly satisfactory
3. Mixed
2. Mostly unsatisfactory
1. Terrible

**NO** (if you answered **NO**, answer the following question):

- Do you think you would have liked to receive this/them?

6. NO    7. DON'T KNOW    8. YES

*Please read the questions very carefully and take your time before answering.  
It is very important that every answer expresses your true opinion*

Please choose the answer which is the best description of your experience in using the local mental health services over the **last year**:

**49. in the last year, did you have any sheltered work?**

**YES** (if you answered **YES**, please answer the following question):

- What is your overall feeling about this/them?

1. Terrible
2. Mostly unssatisfactory
3. Mixed
4. Mostly satisfactory
5. Excellent

**NO** (if you answered **NO**, answer the following question):

- Do you think you would have liked to receive this/them?

6. NO 7. DON'T KNOW 8. YES

**50. in the last year, did you have any voluntary admission to a psychiatric hospital?**

**YES** (if you answered **YES**, please answer the following question):

- What is your overall feeling about this/them?

5. Excellent
4. Mostly satisfactory
3. Mixed
2. Mostly unssatisfactory
1. Terrible

**NO** (if you answered **NO**, answer the following question):

- Do you think you would have liked to receive this/them?

6. NO 7. DON'T KNOW 8. YES

*Please read the questions very carefully and take your time before answering.  
It is very important that every answer expresses your true opinion*

Please choose the answer which is the best description of your experience in using the local mental health services over the last year:

**51. in the last year, did you have practical help at home from the service (e.g. companionship, home help, etc.)?**

**YES (if you answered YES, please answer the following question):**

- What is your overall feeling about this/them?

1. Terrible
2. Mostly unssatisfactory
3. Mixed
4. Mostly satisfactory
5. Excellent

**NO (if you answered NO, answer the following question):**

- Do you think you would have liked to receive this/them?

6. NO 7. DON'T KNOW 8. YES

**52. in the last year, did you have help from the service obtaining welfare benefits or exemptions (e.g. Disability Allowance, Council Tax, etc.)?**

**YES (if you answered YES, please answer the following question):**

- What is your overall feeling about this/them?

5. Excellent
4. Mostly satisfactory
3. Mixed
2. Mostly unssatisfactory
1. Terrible

**NO (if you answered NO, answer the following question):**

- Do you think you would have liked to receive this/them?

6. NO 7. DON'T KNOW 8. YES

*Please read the questions very carefully and take your time before answering.  
It is very important that every answer expresses your true opinion*

Please choose the answer which is the best description of your experience in using the local mental health services over the **last year**:

53. in the last year, did you have help from the service finding open employment?

YES (if you answered YES, please answer the following question):

- What is your overall feeling about this/them?

1. Terrible
2. Mostly unssatisfactory
3. Mixed
4. Mostly satisfactory
5. Excellent

NO (if you answered NO, answer the following question):

- Do you think you would have liked to receive this/them?

6. NO 7. DON'T KNOW 8. YES

54. in the last year, did you receive help from the service to join in leisure activities separate from the mental health services (e.g. sports clubs, adult education, etc.)?

YES (if you answered YES, please answer the following question):

- What is your overall feeling about this/them?

5. Excellent
4. Mostly satisfactory
3. Mixed
2. Mostly unssatisfactory
1. Terrible

NO (if you answered NO, answer the following question):

- Do you think you would have liked to receive this/them?

6. NO 7. DON'T KNOW 8. YES

*Please read the questions very carefully and take your time before answering.  
It is very important that every answer expresses your true opinion*

**PLEASE, WRITE YOUR COMMENTS**

**The thing I have liked most about my experience of local mental health services is:**

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

**The thing I have disliked most about my experience of local mental health services is:**

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

**THANK YOU VERY MUCH FOR YOUR HELP**

## APPENDIX B

### MANUAL OF THE VERONA SERVICE SATISFACTION SCALE



DEPARTMENT OF MEDICINE AND PUBLIC HEALTH  
SECTION OF PSYCHIATRY AND CLINICAL PSYCHOLOGY  
UNIVERSITY OF VERONA



WORLD HEALTH ORGANIZATION  
COLLABORATING CENTRE FOR RESEARCH  
AND TRAINING IN MENTAL HEALTH

### VERONA SERVICE SATISFACTION SCALE EUROPEAN VERSION (VSSS-EU)

### MANUAL

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## 1. The Verona Service Satisfaction Scale (VSSS)

Patient's satisfaction is widely recognised as an important variable in the evaluation of psychiatric services and complements the measurements of other outcome variables. Unfortunately, research in the area of satisfaction with mental health services has been hampered for long time by the widespread use of many non-standardised methods, so that direct comparison between studies has been usually impossible. Moreover, most studies have used instruments with little or no data on their validity or reliability, and investigators have frequently designed their own instruments for specific studies. As a result, findings have not been easily generalizable (Ruggeri, 1994). In addition, although satisfaction has been demonstrated to be a multidimensional concept (Ware *et al.*, 1978), instruments have often been limited to a few broad items which only enquired about one or two mental health care dimensions. Thus, not only may they fail to detect any dissatisfaction, they are inherently unable to detect the reasons for dissatisfaction.

In order to fill this gap our research group (Ruggeri & Dall'Agnola, 1993; Ruggeri *et al.*, 1994; Ruggeri & Greenfield, 1995) has developed the Verona Service Satisfaction Scale (VSSS), a setting-specific, validated, multidimensional scale for measuring patients' satisfaction for mental health services.

The process of development of the VSSS took the following steps. First, an 82-item version has been developed: it was constituted by a set of 37 items cross-setting for health services and a set of 45 items specific for mental health services. The former group of items involves aspects meant *a priori* to be relevant across a broad array of both medical and psychiatric settings, and has been derived from the *Service Satisfaction Scale (SSS-30)* (Greenfield & Attkisson, 1989; Attkisson & Greenfield, 1994; Ruggeri & Greenfield, 1995). The latter group of items involve aspects relevant specifically in mental health settings, particularly in community-based services, such as social skills and types of intervention (e.g. admissions, psychotherapy, rehabilitation) and has been developed on purpose by the authors of the VSSS. VSSS-82, in its versions for patients and relatives, has then been tested for acceptability, content validity, sensitivity and test-retest reliability (Ruggeri & Dall'Agnola, 1993; Ruggeri *et al.*, 1994) in 75 patients and 75 relatives. Factor analysis has finally been performed (Ruggeri *et al.*, 1996). Combination of results obtained in the validation study and factor analysis has given origin to the *intermediate*

(VSSS-54) and the *short* version (VSSS-32), two reliable instruments that can be easily used in everyday clinical settings. Up today the VSSS has been translated into various languages (English, French, Spanish, Portuguese, German, Dutch, Danish, Greek and Japanese) and, beside use from its Authors (Ruggeri *et al.*, 1998a, b), it has been used in a growing number of studies performed in many sites in the world (Tonelli & Merini, 1995; Parkman *et al.*, 1997; Cozza *et al.*, 1997; Leese *et al.*, 1998; Boardman *et al.*, 1999; Clarkson *et al.*, 1999; Merinder *et al.*, 1999).

## 2. Development of the VSSS-EU

The European version of the Verona Service Satisfaction Scale (VSSS-EU) has been specifically developed for the *EPSILON Study of Schizophrenia*, a comparative, cross national, cross-sectional study of the characteristics, needs for care, quality of life, caregiver burden, patterns of care, associated costs and satisfaction levels of people with schizophrenia in five European countries (Becker *et al.*, 1999). The VSSS-EU is a reliable instrument for use in comparative cross-national research projects as well as in routine clinical practice in mental health services across Europe (Ruggeri *et al.*, 2000). The VSSS-EU has been developed from the Italian VSSS-54 patient version (Ruggeri & Dall'Agnola, 1993) and it has been produced in five European languages (Danish, Dutch, English, Italian, Spanish).

The process of conversion did not merely follow the traditional procedure (translation and back-translation), but used focus groups in order to culturally adapt the concepts underlying the instrument. The Italian VSSS-54 version was first translated into Danish, Dutch, English and Spanish by professional translators. The resulting four translations were then back-translated into Italian. The back-translations were checked by the Authors of the VSSS and compared to the original Italian version. Small discrepancies were examined and alterations made to the Italian version in order to preserve the precise meaning of each question, whilst still producing an understandable and acceptable translation into the various languages. Specific items were changed to adapt them to the context of each country's mental health system. When those changes occurred, the local researchers made a list of modifications. The next step was the focus group process, by which the content and the language of the translated instruments were discussed. In the

light of the comments and recommendations, the instrument was then revised both in its original Italian version and in each of the four translations. On the basis of the focus groups minor changes have been made to the wording of the items, and a further change has been made by deciding to keep separate the assessments regarding psychiatrists, psychologists, nurses and social workers. At this regard, items n. 3, 5, 6, 16, 22, 25, 30, 35 and 37, exploring the skills of different categories of professionals (psychiatrist/psychologist, social worker/nurse), which originally were assessed together, have been split in separate categories. For this reason, 9 items have been added to the VSSS-EU version, which overall consists of 63 items.

The process of reliability testing further ensured adequate instrument conversion. Three kinds of reliability tests have been used: Cronbach's Alpha, to check the internal consistency of the whole questionnaire and the different dimensions; Intraclass Correlation Coefficient, to evaluate test-retest reliability of the total mean score and the dimension mean scores; Cohen's weighted Kappa, to evaluate test-retest reliability of single VSSS-EU items. Reliability testing has shown that the VSSS-EU has good internal consistency and stability (Ruggeri *et al.*, 2000).

### 3. Description of the VSSS-EU

The VSSS-EU has been specifically designed for community-based mental health services run by multidisciplinary teams of by psychiatrists, psychologists, social workers and nurses. These services are assumed to have various treatment options (e.g. hospitalisation, day-care, rehabilitation, psychotherapy, home help, outpatient visits) available within the service or provided by various services which closely co-operate. VSSS-EU may be easily adapted to community settings which differ slightly from this model (e.g. less treatment options in the service or different composition of the care personnel), but caution should be used if the service organisation is radically different from the model assumed.

Conceptually, the items in VSSS-EU cover seven dimensions: *Overall Satisfaction*, *Professionals' Skills and Behaviour*, *Information*, *Access*, *Efficacy*, *Types of Intervention* and *Relative's Involvement*. While the first 5 dimensions have already been investigated by some other authors in previous studies (Ware, 1983), the last two dimensions examine domains which have not been assessed systematically previously and have been specifically developed for the VSSS.

Each dimension of the VSSS-EU is made-up of a certain number of items that cover various aspects of satisfaction with services:

1. The *Overall Satisfaction* dimension is constituted by 3 items (n. 11, 20 21) which cover general aspects of satisfaction with mental health services.
2. The *Professionals' Skills and Behaviour* dimension is constituted by 24 items (n. 2, 3a, 3b, 5a, 5b, 6a, 6b, 7, 10, 16a, 16b, 17, 18, 22a, 22b, 25a, 25b, 28, 33, 35a, 35b, 37a, 37b, 40) which cover various aspects of satisfaction with the professionals' behaviour such as technical skills, interpersonal skills, co-operation between service providers, respect of patients' rights, etc. Psychiatrists, psychologists, nurses and social workers are assessed in separate items;
3. The *Information* dimension is constituted by 3 items (n. 12, 19, 29) which cover aspects related to satisfaction with information on services, disorders and therapies.
4. The *Access* dimension is constituted by 2 items (n. 4, 8) which cover aspects related to satisfaction with service location, physical layout, and costs.
5. The *Efficacy* dimension is constituted by 8 items (n. 1, 9, 13, 24, 26, 31, 34, 38) which cover aspects related to satisfaction with overall efficacy of the service, and service efficacy on specific aspects such as symptoms, social skills and family relationships.
6. The *Types of Intervention* dimension is constituted by 17 items (n. 14, 15, 39, 41-54) which cover various aspects of satisfaction with mental health care, such as drugs prescription, response to emergency, psychotherapy, rehabilitation, domiciliary care, admissions, housing, recreational activities, work, benefits, etc.
7. The *Relative's Involvement* dimension is constituted by 6 items (n. 23, 27, 30a, 30b, 32, 36) which cover various aspects of patient's satisfaction with help given to his/her closest relative, such as listening, understanding, advice, information, help coping with the patient's problems, etc.

In the Appendix is reported the contents of the items in each VSSS-EU dimension.

In the VSSS-EU, subjects are asked to express their overall feeling about their experience of the mental health service they have been attending in the last year.

For items 1-40 satisfaction ratings are on a 5-point Likert scale (1=terrible, 2=mostly dissatisfactory, 3=mixed, 4=mostly satisfactory, 5=excellent), presented with alternate directionality to reduce stereotypic response.

Items 42-63 consist of three questions: first the subject is asked if he/she has received the specific intervention (*Question A*: “Did you receive the intervention x in the last year?”). If the answer is “yes” he/she is asked his/her satisfaction on a 5 point Likert scale (1=terrible; 5=excellent) (*Question B*). If the answer is “no”, he/she is asked *Question C*: “Do you think you would have liked to receive intervention x?” (6=no, 7=don’t know, 8=yes). These questions allow measurement of the subjects’ satisfaction both on interventions provided and on the professionals’ decision not to provide an intervention. The latter may be considered a measure of underprovision of care from the patient’s point of view.

#### **4. Administration of the VSSS-EU**

The VSSS-EU is designed for self-administration and can be completed without prior training. In cases of cognitive deficit, severe psychopathology or low level of literacy, a research worker may assist the patient and/or the relative by reading through the items with them. Special care must be taken to guarantee confidentiality and anonymity and, in case of assisted administration, to stress the independence of the research worker from the clinical team. Questionnaire administration takes 20-30 minutes.

Items from n. 1 to n. 40 are based upon the assumption that the patient has a close caring relative often in contact with the service or that the patient is cared for by a multidisciplinary team, with separate assessment for psychiatrist/psychologists and social workers/nurses performances. If some of these items are not applicable, the research worker assisting the VSSS-EU administration should write ‘N.A.’ besides those specific items.

For items from n. 41 to n. 54, the research worker assisting the VSSS-EU administration should identify the kinds of intervention which are not provided by that specific mental health service and consider the corresponding items not applicable. Therefore, before starting the data collection, the research worker should delete these not applicable items (e.g. crossing them out with a pen), in order to avoid patient’s misunderstanding. Anyway, researchers should be cautious in deleting items (also for the interventions which are not provided by the service assessed), because the VSSS-EU from this point of view can provide interesting information about the underprovision of care (e.g. about the patient’s wish to receive an intervention that actually is not available).

## 5. Item scoring

Items from n. 1 to n. 40 are rated on the following 5-point Likert scale:

- 1 = terrible
- 2 = mostly dissatisfied
- 3 = mixed
- 4 = mostly satisfied
- 5 = excellent

Items from n. 41 to n. 54 consist of three questions:

- *Question A*: “Did you receive the intervention x in the last year?” (yes/no/don't know).
- If the answer is “yes” the subject is asked his/her rating of intervention on a 5-point Likert scale (1=terrible; 5=excellent) (*Question B*).
- If the answer is “no”, he/she is asked *Question C*: “Do you think you would have liked to receive intervention x?” (6=no, 7= don't know, 8=yes).

For each item, answers to the three questions can be a) treated separately or b) collapsed into a single rating.

a) Where answers are treated separately:

- *Answers to Question A* give a profile of the type of interventions provided. The following re-coding strategy may be useful:
  - ratings from 6 to 8 = 0 (intervention not provided);
  - ratings from 1 to 5 = 1 (intervention provided).
- *Answers to Question B* (ratings 1 to 5) assess satisfaction with interventions provided.
- *Answers to Question C* (ratings 6 to 8) assess satisfaction with the professionals' choice not to provide that intervention and give information on underprovision of care according to the patients views. In this case, rating 6 will give the profile of interventions not provided but also not wanted. Rating 8 will instead give the profile of interventions not provided but wanted.

b) In order to collapse ratings obtained in questions A, B and C into a single rating, the following re-codings should be made:

rating 6 = 4

rating 8 = 2

rating 7 = missing

This rating will represent overall satisfaction with the management of the intervention, whether the intervention has been provided or not.

## 6. Data analysis

### 6.1. VSSS-EU mean total score

The VSSS-EU mean total score is obtained by summing up all items values (if all items are applicable) and dividing by 63.

If some items are not applicable, a global score is obtained summing up all the items value and dividing by the number of the items assessed.

### 6.2. VSSS-EU mean dimensions' scores

Scores for each dimensions are obtained by summing up all items values and then dividing by the number of items in each dimension as follows:

- Overall satisfaction (3 items)  
(Item 11+ 20+ 21) / 3
- Professionals' Skills and Behaviour (24 items)  
(Item 2+ 3a+3b+ 5a+5b+ 6a+6b+ 7+ 10+ 16a+ 16b+ 17+ 18+ 22a +22b+ 25a+25b+ 28+ 33+ 35a+ 35b+ 37a+37b+ 40) / 24
- Information (3 items)  
(Item 12+ 19+ 29) / 3
- Access (2 items)  
(Item 4+8)/2
- Efficacy (8 items)  
(Item 1+ 9+ 13+ 24+ 26+ 31+ 34+ 38) / 8
- Types of Intervention (17 items)  
(Item 14+ 15+ 39+ 41+ 42+ 43+ 44+ 45+ 46+ 47+ 48+ 49+ 50+ 51+ 52+ 53+ 54) / 17
- Relative's Involvement (6 items)

$$(\text{Item } 23+ 27+ 30a+ 30b+ 32+ 36) / 6$$

As for the VSSS-EU total mean score, if some items are not applicable, each dimension score is obtained summing up all the items value and dividing by the number of the items assessed.

### *6.3. Frequency distribution*

Frequency distributions may be analysed for the original ratings or for collapsed ratings. If they are collapsed, ratings may be re-coded on the basis of a strict or a broad criterion of dissatisfaction, depending on the research purpose:

#### *Strict criterion*

- ratings 1 and 2 = 1 (dissatisfied)
- rating 3 = 2 (mixed)
- rating 4 and 5 = 3 (satisfied)

#### *Broad criterion*

- ratings 1, 2 and 3 = 1 (dissatisfied)
- ratings 4 and 5 = 2 (satisfied)

Use of the broad criterion may help minimising bias due to users' difficulty in expressing dissatisfaction overtly.

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## APPENDIX C

### INFORMED CONSENT LETTER AND FORM

I am currently a Master's student in Psychology at the University of Kwa Zulu Natal. As part of my studies, I will conduct a research study at the South Coast Recovery Centre.

This study will evaluate the programme, and specifically try to identify residents' satisfaction with the programme. I will conduct a focus group interview, and a questionnaire will be handed out to be completed by residents. From this, the relevant information in order to determine satisfaction levels will be gathered. The results of this study can contribute to the programme, by developing areas that are lacking quality. No person is under any obligation to take part in this study. If you should take part, you are free to withdraw at any time. Not taking part or withdrawing from the study will in no way affect your programme at SCRC. If you should take part, your contributions will be handled anonymously. In addition, if any publication should arise from this study, your contributions will be handled anonymously. This study will also cause no harm to any person or to any group of persons.

If you decide to take part in this study, please be honest in all your contributions. This way we can ensure a valid and reliable study, which can be used to the advantage of both the centre and residents. If you have any questions, please feel free to ask.

If you are willing to participate, please sign the attached form of consent.

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Welmi Booyens

## CONSENT FORM

I, \_\_\_\_\_, hereby give consent to take part in the study and acknowledge that I was informed that the purpose of this study is to evaluate patient's satisfaction with the treatment programme of the South Coast Recovery Centre.

I declare that I am taking part out of my free will and that I am under no obligation to take part in this study. I am aware that I am free to, at anytime, withdraw from this study. Should I withdraw from the study, it will in no way affect my treatment. I am aware of my right to stay anonymous should any publications result from this study. All information will be handled as confidential.

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

## APPENDIX D

### CALCULATIONS OF THE MEAN SCORES ON EACH DIMENSION

- Overall satisfaction (128 items)  
 $= 3,76$   
 $= 4$
- Professional skills and behavior (842 items)  
Item  $(2+3b+5b+7+10+16b+17+18+22a+22b+25a+25b+28+33+35a+35b+37a+37b+40)/842$   
 $= 159+172+172+146+140+139+159+132+148+164+161+173+160+147+139+160+154+157+157+151/$   
 $= 3090/842$   
 $= 3,67$
- Information (126 items)  
(Item  $12+19+29)/126$   
 $= (149+143+145)/126$   
 $= 437/126$   
 $= 3,47$
- Access (85 items)  
(Item  $4+8)/85$   
 $= (154+147)/85$   
 $= 301/85$   
 $= 3,54$
- Efficacy (341 items)  
(Item  $1+9+13+24+26+31+34+38)/341$   
 $= (170+176+157+179+154+138+163+157)/341$   
 $= 1294/341$   
 $= 3,79$
- Types of interventions (376 items)  
(Items  $14+15+39+41+42+43+45+46+47+48+52)/376$   
 $= (163+146+87+144+142+145+122+39+148+155+122)/376$   
 $= 1413/376$

$$= 3,76$$

- Relatives Involvement (249 items)

$$(\text{Items } 23+27+30a+30b+32+36)/249$$

$$= (143+145+142+148+132+135)/249$$

$$= 845/249$$

$$= 3,39$$

## APPENDIX E

### COLLAPSED LIKERT SCALE RATINGS

Table 3a -3g represents new collapsed ratings:

Overall Satisfaction			
Item nr	Item 11	Item 20	Item 21
2	27	28	34
1	15	15	9
Missing	1	0	0
TOTAL	43	43	43

Table 3a: Collapsed total Likert ratings on Overall Satisfaction Dimension

Professional's Skills and Behaviours																				
Item nr	2	3b	5b	6b	7	10	16b	17	18	22a	22b	25a	25b	28	33	35a	35b	37a	37b	40
2	29	32	32	23	20	21	29	20	24	28	29	33	29	25	23	27	26	27	30	23
1	13	11	11	19	22	21	14	19	17	15	13	10	13	17	18	16	16	15	12	20
Missing	1	0	0	1	1	1	0	4	2	0	1	0	1	1	2	0	1	1	1	0
TOTAL	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43

Table 3b: Collapsed total Likert ratings on the Professionals' Skills and Behavior Dimension

Information			
Item nr	12	19	29
2	25	14	21
1	18	26	22
M	0	3	0
TOTAL	43	43	43

Table 3c: Collapsed total Likert ratings on the Information Dimension

Access		
Item nr	4	8
2	25	24
1	18	18
M	0	1
TOTAL	43	43

Table 3d: Collapsed total Likert ratings on the Access Dimension

Efficacy								
Item nr	1	9	13	24	26	31	34	38
2	34	35	27	37	24	20	30	27
1	9	8	16	6	19	20	13	16
M	0	0	0	0	0	3	0	0
TOTAL	43	43	43	43	43	43	43	43

Table 3e: Collapsed total Likert ratings on the Efficacy Dimension

Types of interventions											
Item nr	14	15	39	41	42	43	45	46	47	48	52
2	30	23	17	30	26	25	21	8	28	27	28
1	13	17	7	7	13	15	15	1	11	11	4
M	0	3	19	6	4	3	7	34	4	5	11
TOTAL	43	43	43	43	43	43	43	43	43	43	43

Table 3f: Collapsed total Likert ratings on the Types of Interventions

Relatives						
Item nr	23	27	30a	30b	32	36
2	20	18	20	21	14	13
1	20	25	20	22	27	29
M	3	0	3	0	2	1
TOTAL	43	43	43	43	43	43

Table 3g: Collapsed total Likert ratings on the Relatives' Involvement Dimension

## **APPENDIX F**

### **GUIDELINE FOR INTERVIEW QUESTIONS FOR THE FOCUS GROUP**

1. How satisfied are you with the programme? Explain why.
2. How satisfied are you with the ways the treatment staff work together to help you with the problem?
3. Do you view the staff as skilled enough to help you with your problem?
4. How helpful and relevant are the information provided to you and why?
5. How accessible do you feel the programme is?
6. How do you feel about efficiency of the programme?
7. Are you satisfied with the types of interventions provided?
8. Are there any parts of the programme that you like more than others?
9. How do you feel about services given to your family/relatives about your problem?
10. Have you any suggestions for ways in which the programme can be approved?

## APPENDIX G

### SECTION OF TRANSCRIBED FOCUS GROUP INTERVIEW

Interviewer: In what way?

Patient 4: Any tool they have they will learn to use to get your anxiety levels up, for example if you smoke they take away your smokes. Whatever tools there are they will use in order get that addictive behaviour out so you can deal with it.

Interviewer: So, do you think it is a good thing or not?

Patient 4: It is very efficient thing. Instead of humming and haling in counseling sessions for seventy odd hours to get one thing out they go straight at it.

Interviewer: Any one else want to comment on what he said?

Patient two: I think in a way for me the programme has been a bit like confronting myself and confronting my addiction. It can be quite irrational some times, some times I do not really understand the methods and I never really know what is going to happen next but at the same time I can see why they keep it like that.

Interviewer: You said you can see why they keep it like that what do you mean?

Patient two: If I can see what is going to happen next or I can predict an outcome on something then I can manipulate the outcome much more easily so it is quite a spontaneous program in that way and I would say the people genuinely care considering how many people are in the centre. In group when they talk to somebody they know my portfolio. They always know exactly where I am at in the program and that is quite incredible to have so many people to still be able to tell me exactly where I am. I also think it is a trial and error programme as well. I do not think they always know what outcome there will be or what they are doing.

Interviewer: Do you think that they do not know what they are doing?

Patient two: I am not exactly saying that I think that. I guess that they doing the right thing and things do not always go according to plan but then I think that reflects life.

Interviewer: You wanted to say something?

Patient ten: Yea, I just wanted to say I have been in a couple of rehabs and for me this is a total different rehab to the other rehabs. I just want to add on to what R said it is amazing to sit in group and at any point in time any of the counselors can speak to any resident and they can say you there in the program or there in the program and it is nice to know that they give so much attention to you and they really care about you it is not like a twenty eight day program or like other rehabs where they just get you in get you clean and get you going. It is nice to know that you here and that they willing to help you like really willing to help you get through your recovery not just here to get you clean and get you out.

Patient nine: I think for me, I have also been to a couple of rehabs the difference here is that I think under the normal therapeutic lines this place will cross that they will go and they might just do what it takes. They might do unorthodox things which they think is beneficial for you which may not particularly be pleasant for the resident at that point of time.

Interviewer: Can you give me an example?

Patient nine: As D said. Digging a hole getting, your cigarettes taken away, communication ban. If you look at them on their own they seem silly. When I first came in here I thought that was a bit silly and when I started looking at it I realized why they have put it in place. Then specifically I saw the results of what they have achieved with certain people by putting them on that sort of regime and I think in a normal therapeutic environment the counselors would not use that approach, so once you here they can really put you under a lot of pressure which I think brings to the surface the underlying flaw of behaviour that we suffer from.

Interviewer: Any one wants to add something on that?

Patient four: For me the program is very spontaneous. The counselors plan their day very much by ear and that is a very flexible way to play it, not necessarily the safes but very flexible and they able to adapt to problem. Like Dough said it is a very broad technique that they use.

Patient two: I think even if there are a hundred residents here, for every single person that programme is different in one way or another and I think that is unique.

Interviewer: In which way would you say it is different for every person?

Patient two: Because even though we follow the same general steps and we all do the same steps there will be different people who have different problems and different issues to deal with so there will be certain areas some people will have to work on more than others.

Interviewer: In going through the questionnaires it seemed to me there were quite ambivalent feelings towards the counselors. Some felt they were very good some felt they were awkward. Can you maybe explain that why there is such a different feeling between residents?

Patient three: I think the program is run by addicts. More or less all the counselors were active addicts at one point and it must be a very frustrating thing for a person who is still, or myself who is still relatively new out of active addiction to deal with someone who knows exactly what all my tricks are or who knows exactly what my behaviour are when I do not even know what myself. They are very sharp and they exceptionally astute and that can be very infuriating for some people who are still trying to manipulate the game and it is very comforting and scary to know that there is somebody who can read and judge me as if I am an open book it is a very unsettling feeling but also I know that I am in the right place.

Patient ten: Yes, I think they also tell us not what we want to hear but what we need to hear.

Interviewer: So would you say the people who were told things that they did not want to hear but what they needed to hear responded negatively in the questionnaire?

Patient ten: Yes, I would say most probably. I mean you go ask the counselors a question but you have already made up your mind what you want it to be, but that is not what you want to hear they are going to tell you. They tell you the answer you need to hear not just something you want to hear. I think maybe because they basically are telling you the truth

the way it should be not the sweet and buttered up version but as it is straight forward. They do not beat around the bush.

Patient six: I think it is because we addicts and our feelings and emotions are a bit warped. Well for me definitely, one moment I really do not enjoy their company. It all depends on how the day has gone there are some days in fact when you look up to the counselors and say “wow these guys are doing a great job” and then the next moment you think they do not know what they are doing. But I still feel appreciated at the end of the day.

Patient nine: But for me I do not see the counselors as a uniform group you know I respect what certain people tell me a lot more than what others tell me.

Interviewer: Why is that?

Patient nine: It is just I suppose I am judging some of the counselor’s life experience. If I have issues in terms of access of my children then I know I go to a specific counselor because I know she has a lot of experience in that area but I would not go to her with other problems or other issues I wanted to discuss I would go to someone who I though was more relevant. So I tend to pick and look at who I think, rightly or wrongly, help me with advise or advise me on a particular issue that I am having and when advise is coming back at me I look to see who it is coming from.

Interviewer: So, are there certain counselors that you do not trust or is it more a thing of you base it on who has got what experience?

Patient nine: It is a personal thing the way I relate to it. I suppose it is like anywhere if you in business or out on the street if someone tells you one thing it has a certain effect if another person tells you that same thing it has different effect. I suppose it depends on the respect or whatever you have for the person that is giving the message. Ya, so it is the areas of expertise that I perceive them to have and as I said I might be right or wrong but that is how I do it.

Patient three: I think some ambivalence also comes from where each person is in the program. Like you said the response was very poor against counselors. It depends on whether somebody wants their recovery or not. I think that is going to effect how we responded to the questionnaire because it

is going to reflect how we respond to the counselors. So if somebody wants to be here and generally wants their recovery they generally going to be more a lot more positive towards counselors even though some of the feedback from them may be very seemingly negative whereas people who do not want to be here are going to look at the whole process and just go “it is a load of junk”.

Patient nine: But you have to remember that that is on the day that questionnaire was done.

Patient three: Yes.

Patient nine: Because one day you know I might have had a hard time and I might be vindictive but the next day something might have gone my way and I might have had a break through and I think “wow, this is amazing”.

Interviewer: And do you feel the social workers are skilled to do what they do? Do you think they have enough skills and knowledge?

Patient four: Yes, absolutely.

Patient nine: As a group, yes.

Patient ten: Individually as well, I feel, I feel definitely because most of them were addicts as well, they come from where we come from and it is like a, yes, it is like you said now you cannot manipulate them. So they give you good advise and you cannot bullshit them, sorry.

Patient two: I think they have got their heart into what they do. Perhaps even sometimes more so as they should I think sometimes they get very emotionally involved. I do not mean in a bad way though because they are kind of like great but at the same time it goes back to the caring for us in general.

Interviewer: So you do not think that is necessarily a good thing to get so emotionally involved?

Patient two: No, I do not think it is overly but actually maybe from time to time it can be but they are only human.

Patient three: I think they also have a very good uniformity as a counselor group and they have got strong leadership so you cannot get one way with one counselor and another way with another counselor. There is no fighting amongst them. They all sort of on the same page that they all know exactly where you are on the program in the same sense.