

EVALUATION REPORT

SANCA SINETHEMBA PROGRAMME

Date: 6 May 2009

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Introduction

While substance abuse has historically been considered a Department of Social Development (DoSD) issue in South Africa, international research has highlighted the need to incorporate health and mental health issues into treatment, and the need for treatment to be evidence-based. Thus, a collaborative partnership between the departments of Social Development and Health was established, and SANCA was identified as an implementing partner (Weich, 2008). Funding from the Department of Social Development, and later from the DoH as well, led in March 2007 to the expansion of out-patient services at the SANCA Athlone/Gugulethu office into a comprehensive and structured multi-professional service, the Sinethemba Programme (Fourie, 2008).

The concept of Sinethemba hinges around a 'one-stop shop' for all aspects of substance abuse rehabilitation, that importantly also has the capacity to make dual diagnoses. The Sinethemba staff is therefore multidisciplinary, including a clinical psychologist (also the coordinator), consulting psychiatrist, a psychiatric nurse, an occupational therapist (OT), social workers and a medical officer (post still vacant). Alongside the comprehensive programme, the more specialised Matrix Model was introduced, which utilises a well-known evidence-based four month manualised (for both clients and facilitators) psycho-educational programme. Together with an initial comprehensive assessment and the group based sessions, clients are offered individual counselling sessions, family sessions, OT sessions, consultation with the clinical psychologist, psychiatric nurse and consulting psychiatrist, as well as aftercare sessions (on Saturday mornings) for both parents, current clients and those who have completed the programmes. There has also been an attempt to include a range of extra mural activities, such as sports, leisure, arts and crafts, amongst others.

Thus, the Sinethemba Programme runs alongside the other SANCA programmes, including its shorter regular programme and individual diagnostic and consultative sessions, and referrals (for example, to in-house detoxification programmes) where necessary.

Aims

The main aim of this evaluation was to assess the impact and effectiveness of the Sinethemba Treatment Programme. More specifically the objectives were to measure rates of abstention, adherence and prevention of relapse, as well as the perceptions of the effectiveness of the programme of clients, their families and programme staff.

Methods

The intention was to conduct a summative evaluation of the programme, including both qualitative and quantitative measures. The key activities included:

- Collection of qualitative data regarding perceptions of the effectiveness of the programme, and experiences of participation in the programme from key stakeholders, including clients, their families and relevant staff and managers
- Analysis of existing information and statistics that have been gathered to assess impact on the abstention, adherence and prevention of relapse. Such measures included: number of clients; demographic breakdown of clients; urine test results; attendance; conduct during the programme.

Data gathering

This process involved the following key phases, namely preliminary consultations with Sinethemba leadership; an archival analysis of relevant documents; a quantitative analysis of data available from the existing information gathering and statistical management methods; and fieldwork evaluations of participant, family, SANCA staff and provincial government staff experiences and perceptions of the impact of the programme:

- *Initial consultations* were held with relevant SANCA Sinethemba Programme staff, to clarify expectations and parameters, establish procedures, and operationalise key indicators. Ongoing consultations also occurred around each of the key evaluation stages to develop appropriate evaluation tools.
- *Archival analysis* was conducted in two stages. Firstly, documentation of the programme, including reports and proposals, as well as existing evaluation reports were analysed qualitatively, to provide background context to the current evaluation [See Appendix A for list of documents consulted]. Secondly, available computerised client records and statistical data for the period April 2008 to February 2009, were interpreted quantitatively to provide evidence of impact within the defined criteria.
- *Qualitative interviews* were conducted with staff and clients [See Appendix B for list of interviews and focus groups conducted]. These involved either individual depth interviews or focus group discussions. Interview schedules for the various qualitative evaluations were developed in consultation with the Programme Manager [See Appendix C for interview guides].

Firstly, a number of key *managers and staff*, both from within SANCA, as well as members of the programme task team, were identified, again in consultation with the Programme Manager. Individual interviews were then conducted with:

- the Director of Specialised Services, Department of Social Development
- the Deputy Director, sub-directorate: Mental Health and Substance Abuse Programme, Department of Health
- the SANCA Western Cape Director
- the Sinethemba Programme Manager
- the Psychiatrist for Substance Disorders, APH
- the Consulting Psychiatrist, Stikland Hospital

In addition, a focus group discussion was conducted with SANCA staff working in the programme, namely three social workers, an occupational therapist and a psychiatric nurse.

Secondly, *client* interviews were conducted as follows: individual depth interviews were conducted with a sample of nine clients (some who completed the programme and some who 'dropped out'); two focus groups were held with current clients; and one focus group was held with family members. The interviews and focus groups were conducted by members of the research team, in an appropriate language for participants. The interviews were audio-taped with permission of participants, transcribed verbatim and translated where necessary.

Ethical considerations

All standard ethical procedures for research with human subjects were adhered to, including signed informed consent, assurance of confidentiality and anonymity of the interviewee, and the option to leave the research at any time if they so wished.

Data analysis

Given the nature of the available computerised client data, only descriptive statistics were generated. Qualitative thematic analysis was conducted on the interview transcripts.

Results

Quantitative data analysis

Client data, captured electronically for the period April 2008 to February 2009, was used to identify some markers of programme impact. The data provided client information on: gender; age; substance/s of choice; referrals; session attendance for months 1, 2 and 3; urine test results for months 1,2 and 3; ad team evaluation for months 1, 2 and 3. However, the data provided did not distinguish between those clients admitted to the Matrix Programme and those referred to the general SANCA programme, so that it was not possible to make any comparisons between outcomes of the two programmes.

Data indicated that:

- Almost three quarters of clients were male (72%)
- One third (33%) were 22-30 years of age, while just over a quarter (27%) were 18-21 years old, 19% were 30-41 years, 15% were 7-17 years, and 6% were older than 41
- Tik/speed was the most commonly abused substance (41%), followed by alcohol (21%), dagga (18%), and heroin (16%)
- Most clients were referred to the Matrix Programme (44%), followed by the SANCA programme (37%). Nine percent received a referral for individual counselling, 4% were referred to a psychiatrist, a further 4% were referred for admission as in-patients, and 3% for detox
- Group attendance increased over the three month period, from 59% in the first month, to 66% in the second month, and 69% in the third month (see Table 1 below)
- Individual session attendance decreased monthly, from 31% in the first month, to 23% in the second, and 21% in the third
- Support group attendance increased slightly monthly, from 4% in the first month, to 5% in the second, and 7% in the third
- Family group attendance was very low, and decreased over the three month period, from 1.5% to 1%, to 0% (although this might reflect incomplete data collection)

Table 1: Attendance over 3 months

Session attendance	Month 1 total	Month 1 percentage	Month 2 total	Month 2 percentage	Month 3 total	Month 3 percentage
Groups	968	59.98%	371	66.25%	140	69.31%
Individual	501	31.04%	129	23.04%	43	21.29%
Nurse	20	1.24%	6	1.07%	1	0.5%
Psychiatrist	17	1.05%	6	1.07%	2	0.99%
Psychologist	7	0.43%	9	1.61%	0	0%
Doctor	15	0.93%	5	0.89%	2	0.99%
Support grp	63	3.9%	29	5.18%	14	6.93%
Family group	23	1.43%	5	0.89%	0	0%

- The percentage of urine not tested decreased over the three month period, from 60% in the first month, to 39% in the second, and 29% in the third. During this period, the number of positive tests decreased slightly, while the number of negative tests increased noticeably, so that in month 1, 20% tested positive and 20% tested negative; in month 2, 16% tested positive and 46% tested negative, and in month 3, 14% tested positive and 57% tested negatively (see Table 2 below).

Table 2: Urine tests over 3 months

Urine tests	Month 1 total	Month 1 percentage	Month 2 total	Month 2 percentage	Month 3 total	Month 3 percentage
Urine not tested	413	59.94%	85	38.81%	26	28.57%
No of positive tests	138	20.03%	34	15.53%	13	14.29%
No of negative tests	138	20.03%	100	45.66%	52	57.14%

- Client drop outs decreased with each month of the programme, from 46% in the first month, to 23% in month 2, and 19% in month 3. Overall, 316 out of 527 clients dropped out (60%).

Table 3: Team evaluation over 3 months

Team evaluation	Month 1 total	Month 1 percentage	Month 2 total	Month 2 percentage	Month 3 total	Month 3 percentage
Good	78	13.2%	57	37.5%	28	49.12%
Fair to average	118	19.97%	33	21.71%	9	15.79%
Poor	75	12.69%	20	13.16%	3	5.26%
Referral	37	6.26%	6	3.95%	6	10.53%
Dropped-out	270	45.69%	35	23.03%	11	19.3%
Other	13	2.2%	1	0.66%	0	0%

The above figures indicate that for all SANCA clients, the majority of clients were referred to the Matrix Programme. Regarding markers of impact, group attendance increased over the three month period, while individual session attendance decreased. Family group

attendance was low and decreased. Urine testing increased over the three month period, and the number of negative tests increased markedly. Also, drop out rates decreased over the three month period.

Qualitative analysis

Staff and management

A number of key themes were explored in the interviews with staff and management, and are elaborated upon below.

Strengths

Interviewees identified a number of strengths of the Sinethemba Programme. The one-stop comprehensive and intensive multidisciplinary approach was viewed as a major strength. Key advantages cited were that a diagnosis of psychiatric co-morbidity was possible, and that clients did not need to be shifted from place to place and potentially lost in the process, given that substance abuse clients often lack motivation for treatment:

There is a need for an integrated service. A one-stop shop approach. Because clients get easily demotivated so they must not have to go from pillar to post for services.

When we look at the kind of scenario of substance abuse in the country, and especially the WC, this is the answer for treating clients effectively ... often we have people with dual diagnosis problems, people living with HIV, a vast range of other overlapping problems

The multidisciplinary team model is a strength

The multi-disciplinary team is good, and we have successes with it being on board

The Matrix model was viewed very positively. While it was acknowledged that the approach is not that different to SANCA's own approach, strengths identified related to the

standardised format and resources, as well as its location in evidence-based research. Further key areas of strength of the Matrix model raised by staff and management were that it is accessible and easy to implement and 'cool and vibey for youth'. The participatory methodology of the Matrix was also viewed positively as it facilitated greater investment of participants through the discussions, exercises and handouts for participants that are provided in the Matrix package. The manual in particular was appreciated as a valuable resource that may facilitate replicability, since it provides standard materials for both facilitators and clients:

I think it works, I am very excited about Matrix. I think it works. The patients I see give very positive feedback about it.

The Matrix is well researched and developed. It has homework, handouts and some videos that go along with it. It is a well developed integrated standardised programme with a good facilitator's manual.

The Matrix is developed with a lot of exercises, so it makes it that much easier for the facilitators

The manual is a strength, it is effective and makes it easy to replicate the programme elsewhere

The methodological model of the Matrix as a non-judgemental, positive, non-punitive, motivational approach which differs from many of the other interventions was highlighted as one of the successful components of Sinethemba, since it facilitates greater retention of clients:

The Matrix programme is respectful of clients, it builds on non-judgement, while a lot of other programmes work on 'breaking down' the client, this works in a very different way

Sinethemba is different to others [other programmes]. It is less confrontational, completely opposite to other places that 'break the addict', 'bring them to their knees'. This is more nurturant and encouraging.

The approach is very positive, non-punitive and motivational ... staff enjoy implementing it, and refer more patients to the doctor than the other SANCA staff

It was especially encouraging for staff to see the positive impact of the programme already, especially among those abusing tik, the most common drug of choice of addicts in the Western Cape:

We have seen the successes already by the first month ... definitely see good results

There have been successes, especially with respect to tik

There are more people completing, which is encouraging. More than our estimated targets for completion have been met ... we have been amazed by the successes with tik addicts in particular, in the first month they start coming clean

A further aspect of the programme that was identified as significant was the appointment of a dedicated programme manager, which was considered to have had a positive impact on the programme and its outputs:

She pulls people together. She is hands-on which has made a remarkable difference. The programme has improved, its going much better.

The role the programme manager has played as clinical psychologist and qualified nurse with multidisciplinary experience ... it will be difficult to make such a programme successful, so we need people like that, it will succeed.

She has been able to do a good job, has a very good understanding, professional experience

The aftercare component was seen as an important innovation, with clients continuing after the programme to attend this support, thus assisting in sustaining the gains made:

An important innovation is the aftercare component, clients continue after the four month programme to attend supportive, structured aftercare

To have an effective aftercare programme as part and parcel of the treatment programme

The partnership between the two provincial departments – the Department of Health and the Department of Social Development – was regarded as a further major strength of the programme. This was seen as a relatively novel collaboration in the area of substance abuse outside of the medical context and in-patient programmes, and had ‘led to improved relations, much more collaboration and communication’:

The partnership is fabulous, we have a good relationship. We are on the same wavelength. We are each clear on our roles. We understand that we need each other.

... greater multi-disciplinary collaboration and integrated treatment, which results in better retention of patients

The partnership relationship between DoH and DoSD is good

In principle it [the partnership] has worked, over the last two years we have regular task team meetings ... we basically monitor the implementation and progress of service

There was also a sentiment that the specific model of intervention was less important than that the two departments were collaborating on providing holistic services:

We don't mind which model is used, as long as it occurs within a partnership

Challenges

Participants identified various problems that the programme still had to address. Geographical location and the physical environment of the current Sinethemba Programme were viewed as major obstacles to the success of the programme by all interviewed:

We don't feel we are creating a really good therapeutic environment for the team and clients. There is huge frustration on all sides

Our environment is not very conducive or welcoming to running a programme like ours

... the very inhospitable building which houses the programme

It is important to have our own venue and a nice welcoming space ... It is not a welcoming building, we need a better environment

The physical environment is a major obstacle, leading to fragmentation, and undermines cohesion

Interviewees highlighted the Matrix model's weaknesses in treating heroin addiction. Such clients needed a medical substitution programme as well as a longer psychosocial programme. Currently, the team are looking at a pilot evidence-based project for heroin treatment:

We [the task team] have identified the increase of heroin users, who have a different kind of problem ... to look at research that has been done and think about a maintenance programme for those on heroin who have been in the programme

Heroin is much more tricky, we need to think about devising a longer psycho-social programme with medication as well, right now we are failing our clients, as they are graduating from the programme but are still using heroin

Matrix is designed for stimulant abuse, it works with tik addicts, but we maybe need to adapt the programme for the heroin addicts

Client retention and keeping clients motivated were viewed as major challenges. The open group system in which clients can join the groups at any stage was seen by programme implementers as contributing to early drop out, together with other material factors like lack of transport. Some felt that the contingency approach of client rewards, already being utilised, should be expanded, and highlighted the need for donations with respect to rewards like vouchers:

One challenge is that in the past we had closed groups of clients, and now it is open. Clients can now come in at any point and join the group. This is one of the challenges, as now some clients fall through the cracks and we lose them ... they go home and use, and don't want to come back – relapse, it's a pity as we need to follow them up

We lose them [clients] especially in the first couple of weeks of attending the open group when we haven't yet established relationships

We have a difficult client base, from disadvantaged communities, so still have a high drop out of clients, there are transport problems, a general lack of skills

And then to really look again at the motivational behavioural approach, we need more rewards and acknowledgements, and more continuous networking with resources

Although we are optimistic about it, we don't have enough incentives in place as it is based on rewards. We need to get gift vouches, because of low level of motivation, we need to do something more drastically to lesson dropouts. We need to get sponsorship from companies. ... Graduation is very important but we need other incentives in between.

At the level of the collaboration between the DoH and the DoSD, while as highlighted above, this was thought to be one of the great strengths and successes of Sinethemba, there were also concerns that the partnership needed to be strengthened at the highest level, so that there was a shared vision of substance abuse management at that level.

There were also thought to be some challenges with respect to the functioning of the task team at the management level. One concern related to low attendance at meetings of the task team, while all three stakeholders' attendance at such meetings was viewed as important for the programme to be effective:

A challenge is that the task team is not well attended by all members ... would prefer if we have meetings well attended as well

SANCA needs the full support and buy-in of both departments, we need both the medical and sociological approach, we cannot do it from one angle only

Facilitating the gelling of the multi-disciplinary team was viewed as a further challenge. Clarity about roles and ways of working together was seen as a hurdle that had to be overcome. Considerable resistance from some staff to the multidisciplinary approach, and with this, reluctance to do mental health assessments and refer clients to the psychiatric staff was observed. Some interviewees felt the social work staff in particular were threatened by the multidisciplinary approach. There was also a sense that there was a lack of expertise and experience among the social workers to conduct more mental health diagnoses and interventions. Thus some staff felt that they required more training:

From the SANCA side this was our first attempt [at a multidisciplinary team]

Resistance to new ways of doing things, especially from those with social work backgrounds, in relation to diagnosis, more therapeutic interventions, and working in an interdisciplinary team, there's a sense of 'we've been doing it fine our own way'

At first there were undercurrents of suspicion, but mostly at the level of those providing the services, not at management level, there was apathy around learning, a lack of curiosity in the field

Hence the need for more in-service training to provide specialist and enhanced skills regarding substance abuse

There's a need for more psychotherapeutic skills for the individual counselling, there is a lack of confidence about diagnostic skills in particular.

There was however a sense that the multidisciplinary team was beginning to work better together in the field:

It is improving and relationships are more harmonious and there is more acceptance of the programme ... There is increasing realisation that SANCA's reputation is at stake so we need to get it together

It [the multi-disciplinary programme] is starting to look like it will achieve what it should, but it took a while to work our problems of starting

The team was a good idea, but it took time for all role players to be recruited, now it is working better

Some staff also indicated that they felt that there was a lack of consultation with all staff in the programme, and that at times organisational climate issues were not effectively dealt with:

I feel change should be consultative, there is a lack of consultation with staff and a lack of reassurance around certain initiatives ... [the organisation] target based, less focus on process and the person doing the work

Traditional hierarchy plays a role, the question of being open minded and I'm not sure if people are all of the time, tolerating different disciplines is not always evident

We recommend that we have more meetings to discuss issues and raise concerns. A whole range of things get done and not discussed.

There was in addition a sentiment that, as many staff were young and inexperienced in the field of substance abuse, there needed to be more qualified and experienced staff appointed, and that this was hampered by the low salary scales within the public sector.

For example there was no medical officer yet, even though this is a key component of the one-stop approach:

We want the most qualified people, but public sector salaries are a problem

We need to recruit specialised people, and then also provide intensive orientation/training

Finding the right people for the team, we started the programme with inexperienced staff ... a lot of training has to take place, there's a lot of room for development of the team

With respect to the Matrix package, language was seen as a challenge, since the Matrix manual is only in English and sessions are presented largely in English, which means that Xhosa and Afrikaans speakers are disadvantaged and may not benefit as much. Similarly the materials are euro-centric and middle class and not always easy for clients to relate to:

The only need is the language, it is all in English and there is a need to have it translated into the other two languages – not the programme, but the handouts. The videos have very middle class American examples ... it becomes the challenge of the facilitator to bring it to clients' own context

Services need to be culturally appropriate, contextual, counselling is relational, so it must be contextual

Lack of resources to assist clients in reintegration was identified by most interviewees as a key concern. Staff mentioned the importance of more inputs on life-skills, job opportunities facilitation, career development assistance, as well as more leisure activities for participants, to keep them stimulated outside of the groups and therefore decreasing the chances of relapse:

Most of our clients are anyway under-skilled, so we need to get them into places where they can get more training, more career guidance, and so on. We are fine on life-skills, but we need much more than that. It's a lack, but clearly an objective ... and we have been working on networking in this respect, there is progress, but we would like to see much more of that.

We are intending an extension of the programme ... more activities and stuff are needed ... linking with resources in the community

Involvement of families was cited as a challenge. In particular how to make families more intimately involved in the overall programme was viewed as an important issue, but not achieved well enough in the current implementation of the programme. While families were offered a support group, this was perhaps not enough and they needed more inputs on how to best support participants of the programme:

We must never underestimate the role of the family. There is a huge need to get them to be part of the programme, to get them to understand the problem and how to handle it in the family ... less than 40% are coming to family sessions. At the moment when family members are also involved, there is probably a more effective outcome. Family is part of the treatment plan.

The record keeping and monitoring and evaluation system emerged as a major weakness of the current programme. Record keeping was cumbersome and did not allow easy access for all the members of the multidisciplinary team. Linked to this, the methods of data capturing did not allow for adequate monitoring and evaluation of client progress through the programme. In this respect it was imperative to ensure that clear measures and methods for consistent and effective evaluation of client progress and the impact of the programme are put in place:

Especially problematic is the M & E system, the data base system is inaccessible and difficult to understand, and there are multiple forms of record keeping that do not speak to each other ... I'm not sure if our system of M & E is working well enough

I would value the development of clear measures of success, in order to evaluate the programme more comprehensively.

Administratively we need to look at something we can really streamline. We need to work out a way that we can have more valid evaluation tools to do this. We need to have something more appropriate for the programme and that could be implemented, streamlined and made more easy to apply.

We need to find a unified way of capturing data, so that each staff member adds their information on to a composite data base on clients

An established model of evaluation is missing, we need to identify measures of success

There is a problem with the current report structure, as it does not reflect what the staff are actually doing, we need to devise a different kind of stats keeping ... there is not enough qualitative data

There was a sentiment that it was perhaps too early to quantitatively measure the success of the programmes:

At this stage we are in pilot process. We have been over optimistic to think we could do it in a two year period. My recommendation is that we continue the pilot for at least another two years and focus on all the gaps identified and then look again and see where we stand ... before we see what the results can be.

What was striking to the evaluators was the confusion that seemed to prevail about the different components of SANCA services, so that staff struggled to articulate clearly how Sinethemba, and the Matrix Programme in particular, related to the rest of SANCA services:

It's very confusing

There is a lot of confusion about the relationship [between Sinethemba and the rest of SANCA] ... there is some competition between Sinethemba and other clients

I'm not clear what the rest of SANCA does with its clients

Indicators of success

Related to the above issue of monitoring and evaluation, staff and management were asked what they considered to be important indicators of success in treating substance abuse. They identified a number of components which they considered central to evaluating the success of the programme. Retention of clients was seen as a key indicator in this regard:

Retention of clients in the programme ... and getting clients clean, keeping them clean

Success is measured by whom ends up in aftercare, that is, who stay clean and how long they attend

For some, urine testing was seen as a key strength of the programme and a valuable measure of success. A debate about the value of urine testing as a measure of success was however raised. While some saw it as an important motivator or deterrent, others raised the expense of the testing and were not convinced it made much difference:

Success is measured by drug testing

Traditionally criteria like abstinence, urine analysis and drop out rates are viewed as measures of success. But this is viewed with some caution by some

But that does not really work for our population. We need to look at whether there is improved quality of life which ... would be measured by self-report.

Some stakeholders underlined the assumption that longer and more inputs leads to better retention and results. This should be tested and assessed as to the link between quantity of input and success:

Data should tell us whether a greater amount of services leads to greater retention of clients, the longer a client stays in the programme, the more likely they are to improve

At this stage of the programme most felt that qualitative feedback from clients was an important measure of the success of the programme. In particular their perception that they had improved quality of life, not only abstention from substances, was seen as important. There was a strong argument for emphasising lifestyle change, rather than abstinence alone as an indicator of success:

Emphasis is 20% on substance abuse and the rest is on life style change ... to help people to emerge into the world, to leave their old lifestyles.

[We need to establish] has there been a mind-shift regarding the understanding of substance abuse, the numbers are less important

We want to know is the application of the programme OK, do clients feel happy, are there better outcomes, especially for public service clients

Do clients and families feel good about the programme, compare client experiences of this and other programmes, what do clients say they want?

Qualitative feedback form clients that they value the service, that they are more productive, with better quality of life

Some interviewees felt that the retention of staff was an important indicator of success:

It is important that we keep staff consistency. An important indicator is consistency of staff and keeping experienced staff here so that they can bring their expertise to bear on the programme.

Replication of the model

A key concern was whether Sinethemba was a model for replication elsewhere. One of the issues regarding replicability was the strong sentiment that the model of partnership between the departments of Health and Social Development in managing substance abuse needed to be replicated and was replicable, although not necessarily in the Matrix format. From the side of the departments, the following was articulated:

Roll-out would not necessarily involve replicating this exact model. Not a set model. But rather looking at how partnerships can best happen.

[I] am more concerned to get an interdisciplinary approach to substance abuse in the province accepted and to work more holistically on this growing and crucial problem in the province.

We hope to expand the partnership to include more DoH staff at NPOs, and more substance abuse support in hospitals ... we need dual-diagnosis clinics

On the other hand, programme staff felt that Sinethemba was a model that should be replicated. However, although in theory the model appeared to be one that could well be successfully replicated, there were many concerns that still needed addressing. Funding and capacity, given the resource intensive nature of the programme, were both identified as constraints in this respect. A need for policies and procedures to be developed and implemented consistently was also highlighted:

The whole of SANCA should adopt the Matrix model, although it would need cultural adaptation

This is a model that can be replicated, it has a lot of value

It must be taken elsewhere, the need is so great

The costs are greater than for other SANCA programmes

The bottom line is funding is a huge barrier to replicate or roll out the programme

What we have learned for replication is that a lot of training needs to be done at such new sites; we need to help people look at minimum norms and standards; the appointment and training of staff; a close supervision/management of new sites to help the service get underway. We have learned through a lot of mistakes and can avoid them in the future.

Staff and management recommendations

Staff raised a number of ways of improving the programme, but there was a general feeling that the programme needed more time before proper evaluation of the impact could be measured, as articulated by one of the managers:

At this stage we are in pilot process. We have been over optimistic to think we could do it in a two year period given it is still less than one year. My recommendation is that we continue the pilot for at least another two years and focus on all the gaps identified and then look again and see where we stand, what is real impact and sustainability thereof and then look at processes, and then think about how to roll it out. What policies, procedures and training need to be in place so that people do not waste time and money making same mistakes again. We still need another two years at least to iron out these things before we will see what the results can be.

Key recommendations made related to extending the range of the programme and providing more structured daily activities beyond what is currently offered, as well as the provision of a range of extra-mural activities, including leisure activities, arts and crafts, career development and so forth. Staff also suggested the delivery of an after hours programme for those working, since some clients get jobs during the course of the programme and this may lead to them dropping out before completion. Generally participants recommended the need to focus more on the retention of clients. Some felt that there should be more training for staff, especially individual counselling and diagnostic skills and/or that more experienced staff should be recruited. A call for a better developed,

accessible and appropriate monitoring and evaluation system was articulated by many interviewees.

Clients

The individual interviews and focus groups with clients and their families produced a number of common themes, outlined below.

Entry into the programme

Clients entered into the programme through a number of different channels of referral, highlighting the accessibility of the Sinethemba Programme and its visibility in professional and community contexts. Some clients were referred by hospitals, others by NGOs and community/civil society organisations (like FAMSA), some through family members, and quite a few through having broken the law and been referred through the courts system or through an employer. One client's family had found the programme on the internet.

Generally there was consensus among clients interviewed both individually and in groups that they understood the goals of the programme and were well briefed at the onset of the programme. Clients foregrounded the substance abuse focus of the programme as the major goal, articulated as to get 'clients clean and to keep them clean at all times'. They did however also highlight the more social skills component of the programme as helping them cope with stress and manage day to day activities, and generally assist them in 'getting their life back in order', for example:

To give me the tools to stay clean, to prevent risky situations where I did not fall into the same trap – preventative measures

To help you control yourself. To make you think about what you did and to think what is right and wrong.

To learn how to socialise again with people. Getting back to how you were before you were using drugs.

To help me change, to try to help me help myself change.

To live a life without drugs.

Most clients felt that they were clearly informed and understood the programme from the beginning:

We were told all about Matrix; that it came from another country, they were trying it out here.

Yes, definitely, it was all explained in the introduction interview.

On the other hand, some spoke of how their lack of personal motivation and commitment to the programme undermined their ability to internalise the goals of the programme, which shifted when they had personally chosen to be there, as in this client's experience:

I had only come because my mother told me to come. My mind was not 100% here, I did not come for myself. But the second time was different. I came the second time because I got into trouble with the law. It was my only way out. I am here with a clear mind, and I am very clear now what it has to offer.

Attendance in and completion of the programme

While all respondents attended group sessions, most did not do individual sessions and some spoke of struggling to get their families to attend the family programme. Overall, it appears that the group sessions were experienced as most useful for participants, with the strongest motivation for this preference being that they benefited from the common understanding, identification and sharing that takes place in a group situation. Clients spoke of feeling understood by those who shared their struggles, and the value of hearing how others dealt with similar challenges. They experienced the group as facilitating the greatest sense of belonging and being a part of something bigger than themselves. On the other hand, the few who attended individual sessions found them very useful to deal with

individual issues and challenges that they felt they could not deal with in the group. And those who attended both group and individual sessions were positive about the benefits of combining these, and especially mentioned how having access to the psychiatrist and counsellor were complementary to the group work:

I like everything about the programme, especially because you get to be open with yourself... you get to know what this experience is about and you realise that others are going through the same things as you.

... it was very good because I could really talk about how I feel [with the psychiatrist] and in groups sometimes I participated and sometimes I withdrew

While about half of the individual interviewees attended the full four month programme, others did not, dropping out at various stages. This was usually related to getting work or relapses. Some felt they dropped out due to lack of family support and trust. Those who completed the programme generally attended all the sessions; amongst the individual interviewees all who completed had attended every session. Some mentioned that transport was a problem with respect to attending due to taxi strikes and the cost of transport.

Of those who had left the programme, about half reported that they were still clean. Others were taking other substances but had not returned to their substance of choice and therefore do not see this as a problem. Amongst those who did not complete the programme a number of relapses had occurred.

Experiences of the programme: benefits and advantages

Most participants in the focus groups and individual interviews felt that the programme had definitely met their needs and that they would recommend the programme to others. Also the majority of participants felt strongly that they would definitely return to the programme if they needed help again. This positive assessment also seemed to link with an experience of finding the programme welcoming and they felt accepted:

I felt it was the only place that would help me. I thought I'd be chased away but they were glad to see me. They uplifted me and put me back in the sessions.

They would welcome you with open arms.

I know somebody will be here for me. It's my only guide really

Clients reported having gained much from their participation in Sinethemba, beyond becoming clean and staying clean. Key areas of benefit highlighted by participants related to gaining self-awareness, self-confidence, interpersonal skills, life skills and generally a sense of greater physical and emotional well-being:

It taught me a lot of things about life and how to go about it.

It helped me know who I am, to become a better person.

It taught me there is a better life without the drugs and I am a much more independent person now.

Talking is really the best policy.... It helped me see a lot of potential in myself.

I got skills on how to prevent relapse. How to deal with emotional issues that make me want to use again.

My skin is getting better, I've started wearing nice clothes again, not so dull and I've started buying things for myself instead of buying the drugs

I became a better person; I was also able to help friends. Because of me my best friend is also off drugs now. I learnt how bad drugs are for you; its not healthy, they make you mad and crazy.

Similarly, parents and family appreciated the impact of the programme on their children and valued it for themselves as well:

There is a difference in what my son does. There is a change in his behaviour since he has been in the programme.

You can come and vent things here. You are not forced to talk, even if you just come and sit, because everyone has the same experiences.

The people speak to you in terms that you can understand.

They provide me with the tools to identify and understand the problems and to help them help themselves.

One of the positive aspects identified by many clients was the participatory, interactive nature of the methodology of the Matrix. This facilitated an experience of being respected, appreciated and listened to. The non-judgemental and nurturant approach was especially appreciated. Some felt that the discussion based approach also allowed them to gain confidence in talking about themselves, as well as self understanding:

I liked the attention we all got!

It is an interactive programme, not like the other programmes. It makes you think about other things.

There is no judging, you are free.

...parents don't understand, whereas class mates do. I can speak here without being judged

In this respect, participants compared the Sinethemba Programme to others that they had attended or participated in, highlighting the strengths of the former. In particular there was much agreement that Sinethemba was more supportive of them than other programmes they had attended:

I know of people who had gone to other places and this one was totally different. It was the best one they had encountered.

A major strength of the programme that was raised by both participants and their families was the value of camaraderie and group experience. As mentioned above the group experience allowed for participants to be with others with whom they could identify, who shared and therefore understood their experiences. As has been illustrated in other support group forums, such as work with abused women, the experience of being with and sharing with those who have a common experience, serves an important therapeutic role in breaking the silence and marginalisation of the client. A perception of the programme as a family also emerged in this respect, and for some clients the group extended into the setting up of social gatherings. For example, in one of the focus groups, clients reported that they meet up at each others' houses for social events, which helps them to keep clean and stay away from previous friends and other potential triggers for relapse:

Communication was so good. It was a fantastic experience with the people in my class. The way we communicated with each other. The bond we had.

... we made friends

Participants also spoke of educational gains from the programme. Some described the materials as exciting and stimulating. They felt they not only gained self understanding but also greater understanding of a wide range of issues. Their use of the term 'class' and 'lecturer' in describing the group situation and the social worker with whom they worked, gives some indication of their perception of the programme as an educational space, not only a support group, which clearly contributed to giving participants 'a sense of purpose' while in the programme.

Participants too showed appreciation for the incentive component of the programme, which is a key part of the Sinethemba Programme, highlighting the value of the rewards and

graduation in their process of staying clean, which also linked in with their metaphor of the programme as course of study: 'It is like a university'.

Participants further showed positive appreciation for the outpatient format of the programme, feeling that they gained more through being in their own context rather than being removed from it, as is the case in many other substance abuse programmes. One participant described how she had attended a wonderful inpatient programme in a small village in the Western Cape, but how the minute she returned to her own context it was difficult to avoid triggers:

The other things [other inpatient programmes] don't prepare you for the outside world. It is not in the real world where it happens.

Participants were especially positive about the family component of the programme, feeling that the involvement of the parents and family had advantages for them:

The Saturday family group is a good idea as the family now also learn what we are going through and we have something to speak about.

I love that about the programme, the Saturday family group.

Finally, a further positive point made about the programme was that it is a free service, which made it accessible for those who were financially challenged.

With respect to the staff on the programme, respondents felt that the programme was being run very well, and felt very positive about the staff, whom they described as welcoming, understanding, respectful and helpful:

They were always there to guide you.

They made a very caring, supportive environment.

Excellent – no problem

Their attitude is good, they are friendly, nice people

They influence you to help others. They make you want to be a better person.

The staff is good.

Challenges and gaps in the programme

While some respondents felt there were no negative aspects to the programme, a concern about the efficacy of the programme for heroin users was articulated. Those whose drug of choice was heroin, were aware that the programme did not help them adequately to stay clean.

But for most clients, the key gaps identified in the programme related to their need for an extended programme. This concern related both to the ‘free time’ between sessions while in the programme, as well as to the gap between leaving the programme and finding work. They felt they needed a more full time programme, as well as more activities, and access to resources to help them reintegrate. A key concern related to support for career development, as well as more frequent and longer sessions to occupy them during the day, as many feared being exposed to trigger situations.

Although participants felt they had gained a lot, there were concerns about relapse and that they still needed assistance in sustaining the rehabilitation. Participants were aware that the process of rehabilitation was a long term struggle and that it did not end once the programme ended. They felt this should be emphasised more at the beginning of the programme.

Another area of challenge raised by some participants was a sentiment about the importance of continuity with the staff facilitating the groups. Those who were exposed to different facilitators during their time on the programme felt that they would have preferred

'one stable person all the time so that they could get to know you'. This was reinforced by the comments of those who had had one person predominantly that this was an advantage:

It is good to see the same person consistently

Moreover, some felt that the staff were critical at times, especially if they relapsed, and did not really understand what clients had been through, since they had not been through addiction and rehabilitation themselves. In this respect, they felt that having drug rehabilitated members of staff, who would have different understandings, would benefit the programme.

Although appreciation for the family sessions was expressed, clearly there are limitations to the current services in this respect. Clients spoke of families being unsupportive, blaming and suspicious, and generally lack of communication and sharing with the family was seen as a challenge:

You are always the one, whatever goes wrong, it is always your fault.

If I am just five minutes late, then my mother starts accusing me of using.

Lack of trust makes it difficult.

You can't speak to your mother or your family, they can't communicate on your level.

Some participants appeared to imply that their families drove them back to using through their lack of trust. While this may serve as a rationalisation for relapse, there are clearly valuable inputs that may better prepare families for how to reinforce the progress made in the programme rather than undermine it, even inadvertently.

Summary of findings

In this section, a summary of the main findings from both the quantitative and qualitative data analyses are presented.

Quantitative results

Findings for the period April 2008 to February 2009 provided some evidence for the effectiveness of services. Figures indicate that for all SANCA clients, the majority of clients were referred to the Matrix Programme. Regarding markers of impact, group attendance increased over the three month period, while individual session attendance decreased. Family group attendance was low and decreased. Urine testing increased over the three month period, and the number of negative tests increased markedly. Also, drop out rates decreased over the three month period. However, the overall drop out rate was over half (60%).

Qualitative findings

As staff/management and client interviews focused on somewhat different aspects of the substance abuse programme, the issues raised also differed to some extent, although there were some common threads, as discussed below..

Strengths

For both groups of participants, the Sinethemba Programme had a number of notable strengths. For staff/management there were two main strengths of the programme. Firstly, it was the multi-disciplinary nature of the programme that was particularly appreciated. Allied to this was the value of the model of intervention, with its participatory, motivational, non-judgemental, standardised and manualised format. They also highlighted the visible success of the programme with especially tik users, the positive impact of having a dedicated programme manager, and the emphasis placed on after-care services. Secondly, staff and management considered the partnership between the departments of Health and Social Development to be very successful, and a core feature of the programme. They

strongly recommended that this model of partnership be replicated in other substance abuse work in the province. The Sinethemba Programme was also seen by some to be worthy of replication, although there was a sentiment that this would be premature, as the programme had not been running long enough for a thorough evaluation of its effectiveness, or for the establishment of appropriate procedures. It was also seen as being resource and personnel intensive.

Clients, for their part, experienced a variety of positive aspects of the programme. They understood what the goals and nature of the programme were. Moreover, they felt that the programme met their needs, compared favourably to other types of intervention they had experienced, and agreed that they would refer others to the programme, as also found in the process evaluation conducted recently by Kansky (2008). They especially appreciated the support provided by the group sessions and other group members, confirming the earlier findings of Titi (2007) and Arendse (2007), as well as the structured nature of the sessions. They highlighted the fact that it was not just the attention to their substance abuse which was valuable, but also the focus on quality of life issues. Other positive features included the educational aspects of the programme, the involvement of family, the out-patient and affordable nature of services, and the use of incentives. They generally appreciated the role of staff, in line with the findings of Kansky (2008) and Arendse (2007), although some indicated that they would feel better understood by staff members who had also experienced substance-related problems.

Challenges

Regarding implementation of the programme, both staff and management identified the geographical location and physical space of the programme as less than satisfactory, as also found by Kansky (2008). They were also concerned that heroin addicts were not responding well to the programme, so that alternative interventions needed to be planned and implemented for the growing number of these clients (Stacey, October 2008). Furthermore they were concerned about retention of clients, improving the involvement of families, the lack of resources to expand the range of activities offered, and the fact that

they were only able to offer the programme in English. Regarding the multi-disciplinary model of intervention, there were sentiments that the departmental partnerships needed to be strengthened, and that there was still some resistance among staff to the integrated model of treatment, although this was thought to be improving. Concerns were also raised about lack of consultation of staff, and the need for more attention to be paid to issues of organisational climate. In addition, the difficulty of attracting experienced staff, given poor public service remuneration scales, was raised. A further concern related to the lack of clarity regarding the distinction and relationship between Sinethemba, the Matrix and other SANCA programmes. Finally, staff and management pointed to the absence of a comprehensive, streamlined and user-friendly system of data capturing, as well as the need to establish policies, procedures and tools for ongoing monitoring and evaluation of the programme. This issue was also highlighted by Kansky (2008) as the major challenge of the programme.

As is common in programme evaluations, clients found it more difficult to identify problems and challenges than staff (Kansky, 2008; Titi, 2007). However, they too felt that heroin addicts were not adequately treated in the programme, and called for the extension of the programme and range of activities offered, a sentiment which was echoed by staff. They also found the non-continuity of staff in the sessions problematic, and felt that their families were not always supportive of their rehabilitation efforts, as also found in the study of client perceptions of Arendse (2007).

Recommendations

In the light of the above perceptions and experiences of staff, management and clients, a number of recommendations are identified, which focus on aspects of the programme, organisational and staffing issues, monitoring and evaluation, and replicability.

The programme

Given that a minority of clients are using the individual counselling sessions, and that they were found to be useful for those who did make use of them, there is a need to strengthen this component of the programme. Two areas of recommendation in this respect include: firstly, strengthening the capacity and confidence of the relevant staff to provide this component of the programme; and secondly, finding ways of encouraging clients to make better use of this service.

As indicated by attendance figures, as well as the concerns articulated by participants regarding the role of family in supporting them and responding appropriately while they are in the programme, more attention needs to be paid to informing and engaging families in the treatment programme of their family member. This would mean finding ways to encourage those who are not attending, but also look more closely at the nature and content of those sessions, to assess to what extent the sessions are optimally covering relevant areas for families.

In view of the strong demand from clients for an expanded programme of activities and the importance of access to broader resources for their integration into society, there is a need to attempt to meet these requests. This is supported by the Matrix model's emphasis on the need for 'hourly and daily scheduling to help clients eliminate unstructured time – a key contributor to relapse' (The Matrix Model, 2009). Given that it is unrealistic to expect SANCA to provide all these additional resources, partnerships with NGOs and other community-based service providers with respect to arts, culture, leisure, sports, career development skills, and so on, is strongly recommended. One suggestion is that this be

included in the workload of one of the staff members for urgent attention. With respect to suggestions for an after-hour service, attention needs to be given to how to cater for those clients who drop out due to paid employment, or are in school.

As both qualitative and quantitative results indicated, retention of clients is a concern which needs to be addressed. Moreover most drop-outs from the programme occurred in the first month of attendance. Thus, in order to improve client retention, we suggest that more individual attention be given to clients during their first month in the group, as well as a stronger focus on motivational interviewing at the onset of the programme. Moreover, while the reported dropout rate appears high, mechanisms need to be established to follow up the reasons for such dropping out (for example, employment could be seen as a positive form of drop out), in order to better understand and address the problem. In addition, research should be conducted to compare the drop out rates for Sinethemba with those of other treatment programmes.

Since both clients and staff recognised the value of incentives in the success of the programme, we support the recommendation that this component of the programme be extended. We further recommend that programme management interrogate the role of incentives more closely, assessing which type of incentives are most appropriate and effective in enhancing client retention in the programme, as well as explore how to access such resources without excessive cost to SANCA, perhaps through partnerships with local enterprises.

Regarding the materials used in the programme, one of the strengths of the Matrix that emerged was the manualised material for both the participants and facilitators. However Sinethemba has included some components that are not a part of the Matrix, and for the purpose of sustainability it would be important to develop materials for the full package. This would be especially important for the replication of the model as discussed below. For example, there are no materials for the Occupational Therapy component and these should be developed. Apparently the current OT has just completed developing such a manual,

but this initiative should be supported by the programme so that it may be incorporated into the package.

As the Matrix model has been developed in a North American context, the materials do not always speak to local experiences and languages. One important recommendation in this respect would be the development of more local images and resources to accompany the Matrix materials, as well as assessment of the possibilities of translation into local languages – at least of the handouts for clients.

The organisation and staff

In order to provide a fully functioning one-stop dual diagnosis service, staff capacity needs to be commensurate with all these functions, regarding both expertise and a full staff complement. It may be necessary to investigate appropriate incentives for attracting suitably qualified staff. Moreover, in view of the interdisciplinary nature of the intervention model, careful attention needs to be paid to the orientation and provision of appropriate skills for staff for providing such integrated services, as the current ongoing training does not seem to be meeting needs sufficiently. In addition we suggest the inclusion of attitudinal training, for example around prejudices towards substance abuse, and the possible incorporation of rehabilitated substance abusers in the team.

Linked to the challenges of a multidisciplinary service is the need to pay particular attention to issues of organisational climate. Regular spaces for team-building, debriefing, consultation, reflection and future planning would need to be institutionalised.

Monitoring and evaluation

The need for more accessible record keeping as well as a more rigorous, comprehensive system of monitoring and evaluation emerged as a key concern among staff and managers on the programme, as it did in the Kansky evaluation (2008). Essential in this would be a more streamlined, accessible and centralised system of record keeping/data collection on clients. It is strongly recommended that such a database be electronically captured and

stored so that all staff working with particular clients have easy access to all aspects of reporting on treatment and progress.

For the purpose of monitoring and evaluation of impact it is important to return to the key goals and intended outputs of the programme, in order to operationalise a monitoring and evaluation system that sets out clear indicators of success that are measurable (The lack of consensus among interviewees, as reported above, about what the indicators of success should be supports the need for such a process). We would recommend that this be conducted through a consultative process with all key stakeholders and possibly an external agency with evaluation expertise. It would also be important to conduct a further summative evaluation after a longer time period of implementation has elapsed with clear indicators in place, since a number of participants felt that here has not been enough time to properly evaluate the programme and its impact, especially quantitatively.

Replicability

With respect to the inter-departmental partnership, given the strong and positive experience of this innovative partnership between the departments of Health and Social Development, it is clear that replication and expansion of the partnership is warranted and should be encouraged. The combination of both the medical and more social development approaches has facilitated a positive interdisciplinary and one-stop model at the intervention level, providing a more holistic and streamlined service for the client. Service delivery would be enhanced by a stronger collaboration regarding policy and implementation at higher departmental levels. Moreover, the possibility of including other government departments (for example, Sport and Recreation and Labour) in partnerships should also be explored.

However, consideration of the appropriateness of replicating the Sinethemba model raises more challenges. It is relatively demanding on resources, both material and staff, and at this point we were unable to assess and compare its effectiveness in relation to other SANCA interventions and/or other models of intervention. There needs to be some debate

among all stakeholders regarding to what extent Sinethemba may be a model for replication in the public sector.

We would strongly recommend in this respect that Sinethemba be continued and strengthened as a pilot model, and that the programme be compared more rigorously with other programmes of SANCA and other agencies offering out-patient substance abuse programmes. An evaluation model which is able to provide more statistical and qualitative evidence of the impact of the programme over the longer term would contribute to decisions about the value and future of the Sinethemba model.

Linked to this is the evidence of some confusion regarding how Sinethemba / the Matrix Programme and other SANCA programmes relate to each other. We would suggest that a stronger rationale for different/parallel interventions, which on some level diffuse energies and may be confusing for clients, is needed. Media and programme documentation should also reflect the offerings more clearly for the public at large and potential clients. The above recommended comparative research might contribute to both clarifying and informing decisions about the possibility of streamlining the SANCA services.

Appendix A: Documents consulted

Arendse, V: The perception of end users with regard to the effectiveness of intervention strategies at a drug rehabilitation centre, UWC B Psych project, July 2007

Fourie, D: SANCA Western Cape Proposal: Comprehensive Outpatient Treatment Programme, 11 March 2008

Fourie, D: SANCA Western Cape: Comprehensive Out-patient Treatment Progress Report, April 2007-March 2008, 12 May 2008

Kansky, R: A process evaluation of the Athlone/Gugulethu branch of SANCA, with particular reference to the Sinethemba Programme, November 2008

Titi, N: Exploring the perceptions of end-users regarding the effectiveness of interventions employed at a drug rehabilitation centre, UWC B Psych project, July 2007

Stacey, M: Sinethemba Comprehensive Out-patient Treatment Service: Athlone/Gugulethu

Stacey, M: Background to the Sinethemba Programme, interview with Dr L Weich, 29 August 2008

Stacey, M: SANCA Sinethemba Programme: Report for Western Cape Department of Social Development and Health, Quarter 2, 1 July 2008 – 30 September 2008, October 2008

SANCA Sinethemba Programme, Client Satisfaction Questionnaire

The Matrix Programme: What customers want to know

The Matrix Model Intensive Outpatient Addiction Treatment Programme, www.hazelden.org, accessed 25 March 2009.

Appendix B: Interviews and focus groups conducted

Staff/management interviews:

Debbie van Stade, Director: Specialised Support Services, Department of Social Development
Carol Dean, Deputy Director, sub-directorate: Mental Health and Substance Abuse Programme, Department of Health
Dr Lize Weich, Psychiatrist for Substance Disorders, APH
Dr Claudia de Clercq, Consulting Psychiatrist, Stikland Hospital
Dr David Fourie, Director, SANCA Western Cape
Maria Stacey, Programme Director, Clinical Psychologist, SANCA
Katherine Brown, Psychiatric Nurse, Sinethemba Programme
Anna Kurgan, Occupational Therapist, Sinethemba Programme
Emelda Isaacs, Social Worker, Sinethemba Programme
Samantha Harlock, Social Worker, Sinethemba Programme
Colleen Derby, Social Worker, Sinethemba Programme

Clients:

1 focus group with families, 5 participants
2 focus groups with current clients, 22 participants
9 individual interviews with completed or drop-out clients

Appendix C: Interview schedules

Interview schedule: Staff

- 1) Can you tell us about the background to the programme, how did it get going?
- 2) In your view what are the primary goals? To what extent has it achieved these goals?
- 3) How is success measured? Is this the most appropriate way of measuring and evaluating success? Are appropriate monitoring methods in place?
- 4) How does Sinethemba relate to the rest of the goals/programmes of SANCA?
- 5) How do Sinethemba results compare to those of other Matrix programmes?
- 6) How does Sinethemba relate to other models of intervention?
- 7) What are the strengths of the programme?
- 8) What are the challenges of the programme?
- 9) In what way have clients benefited differently to other interventions?
- 10) What is your role in the process?
- 11) How has the partnership worked?
- 12) Is this a model that should be and can be replicated?
- 13) If so what needs to be done to improve it?
- 14) Is the programme sustainable?
- 15) Is there anything you would like to add?

Focus group schedule: Clients currently in the programme

- 1) Can you tell us about how you got to be in this programme?
- 2) What have you understood the goals of the programme to be?
- 3) Were you clear at the beginning about what the programme was all about and what it had to offer?
- 4) How long have you been in the programme?
- 5) Have you attended all the sessions? If not, why have you missed?
- 6) What sorts of things have you done?
- 7) What do you like about the programme?
- 8) How would you rate the quality of the programme?
- 9) Has it met your needs? What did you get out of it? What don't you like about the programme?
- 10) Have the services you received helped you deal more effectively with your problems?
- 11) What do you think would make it a better programme?
- 12) What do you think of the people running the programme?
- 13) Would you recommend the programme to a friend who needs similar help?
- 14) If you were to seek help again, would you come back to this programme?
- 15) Have you been in any other treatment programme? If so, how does Sinethemba compare?
- 16) Is there anything else you would like to say about Sinethemba?

Interview schedule: Clients who completed

- 1) Can you tell us about how you got to be in this programme?
- 2) What did you think were the goals of the programme?
- 3) Were you clear at the beginning about what the programme was all about and what it had to offer?
- 4) What did you do in the programme?
- 5) How long were you in the programme?
- 6) Did you attend all the sessions? If not, why did you miss?
- 7) Did you complete the programme?
- 8) If so, what did you get out of it?
- 9) Did the programme meet your needs?
- 10) What did you like about the programme?
- 11) What didn't you like about the programme?
- 12) Did you attend individual sessions too? If so, did you get more benefit from the group or individual sessions?
- 13) Have you stayed clean since you left the programme?
- 14) How would you rate the quality of the service you received?
- 15) Have the services you received help you deal more effectively with your problems?
- 16) What do you think would make it a better programme?
- 17) What do you think of the people running the programme?
- 18) Would you recommend the programme to a friend with similar problems?
- 19) If you were to seek help again, would you come back to this programme?

Interview schedule: Clients who 'dropped out'

- 1) Can you tell us about how you got to be in this programme?
- 2) What did you think were the goals of the programme?
- 3) Were you clear at the beginning about what the programme was all about and what it had to offer?
- 4) What did you do in the programme?
- 5) How long were you in the programme?
- 6) Did you attend all the sessions? If not, why did you miss?
- 7) If you did not complete, at which stage did you stop coming? And why?
- 8) What did you get out of the programme while you attended? Did it meet your needs?
- 9) Did the programme help you deal more effectively with your problems?
- 10) What did you like about the programme?
- 11) What didn't you like about the programme?
- 12) Did you attend individual sessions too? If so, did you get more benefit from the group or individual sessions?
- 13) How would you rate the quality of service you received?
- 14) What do you think would make it a better programme?
- 15) What do you think of the people running the programme?

- 16) Have you stayed clean since leaving the programme?
- 17) If you were to seek help again, would you come back to this programme again?
- 18) What would make it possible for you to come back again?
- 19) If a friend needed help with similar problems, would you recommend this programme to them?

Interview schedule: Parents focus group

- How did your child come to be in the programme?
- What do you understand the programme does, ie what are its goals?
- Were you clear about what the programme entailed from the outset?
- Has it had an impact on your child? If so what?
- How is your child doing at the moment? Have they stayed clean?
- How would you rate the quality of the service your family member received?
- Did the programme meet their needs?
- Did the services they receive help them deal more effectively with their problems?
- What do you think works best about this programme?
- What part of the programme does not seem to work in your opinion?
- Do you have any ideas about how to make it better?
- Has it been a problem for your child to stay in the programme? If so why? What would make it easier for them to keep coming?
- What do you think of the staff? How have they communicated with you?
- Do you feel supported as a parent by the programme? What else could you suggest for yourselves?
- If you were to seek help for your family member again, would you bring them back to this programme
- Would you recommend the programme to other families with similar problems?
- Have you had any contact with other treatment programmes? If so, how does Sinethemba compare to any of these?