THE EVALUATION REPORT OF ST MARTIN CSA'S ADDICTION TREATMENT APPROACH, AND INTENSIVE OUTPATIENT REHABILITATION PROGRAMME

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ABSTRACT

Substance use addiction presents a significant social and public health challenge globally, with an estimated 35 million people suffering from substance use disorders, as reported by the World Health Organization. In Kenya, substance abuse rates remain alarmingly high, with regions like Laikipia County experiencing a notable rise in alcohol and drug dependency, especially among the youth. Despite various rehabilitation efforts, persistent challenges, including social stigmatization, physical, psychological, and emotional difficulties caused by addiction, and inadequate community-based interventions, hinder recovery. St. Martin Catholic Social Apostolate (CSA) addresses this gap through its addiction treatment approach and Intensive Outpatient Rehabilitation Programme (IOP). This community-based intervention employs a mixed-method approach, integrating the biopsychosocial, 12-step Alcoholics Anonymous (AA), and disease models. Grounded in the understanding that addiction stems from the interplay of biological, psychological, and social factors, the program aims to provide a holistic, client-centered pathway to recovery. However, despite its implementation since 2010, the effectiveness of the program and factors influencing its outcomes remained underexplored, highlighting the need for this evaluation. The primary objective of this study was to evaluate the effectiveness of St. Martin CSA's addiction treatment approach and IOP in improving clients' quality of life and facilitating recovery. Specific objectives included assessing clients' functioning before and after rehabilitation, evaluating program implementation, and exploring factors influencing program outcomes. Employing a mixed-method research design, the study involved 133 program beneficiaries and key stakeholders such as family members, peer supporters, and volunteers. Quantitative data were collected through structured questionnaires, while qualitative insights were gathered from focus group discussions and interviews. Statistical analyses, including percentages and means descriptive statistics as well as one-way ANOVA inferential statistics, were used to compare clients' functioning pre- and post-treatment, while qualitative data were analyzed thematically to identify emerging trends. Key findings indicate significant improvements in clients' psychosocial health, self-esteem, and overall quality of life post-rehabilitation. The hybrid outpatient model, characterized by structured weekend inpatient engagements and community-based support, was particularly effective, enabling clients to apply recovery skills in real-world environments while benefiting from intensive weekend interventions. While relapse was reported by 55% of respondents within the first six months post-treatment, most relapses were short-lived, with 86% of clients achieving sustained sobriety at the time of data collection. The program's emphasis on community involvement, peer support, and family therapy was instrumental in fostering long-term recovery and reintegration into society. St. Martin CSA's addiction treatment approach demonstrates significant potential as a cost-effective and adaptable model for addiction rehabilitation. By addressing biological, psychological, and social dimensions of addiction, the program effectively bridges gaps in traditional rehabilitation methods. The study's findings will give insights into addiction recovery, offering evidence to support the refinement of community-based rehabilitation programs. Beyond immediate program improvements, the evaluation underscores the important role of integrated, community-supported interventions in addressing substance use disorders, benefiting individuals, families, and society as a whole.

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LIST OF INITIALS AND ACRONYMS

AA: Alcoholics Anonymous
ANOVA: Analysis of Variance
ASAM: American Society of Addiction Medicine
CDC: Center for Disease Control and Prevention
FDG/s: Focused Discussion Group/ Focused Discussion Groups
IOP: Intensive Outpatient Program
KNBS: Kenya National Bureau of Statistics
MSA: Medically Assisted Treatment
NA: Narcotic Anonymous
NACADA: National Campaign against Drugs Abuse
NIDA: National Institute on Drug Abuse
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UNODC: United Nation Office of Drugs and Crime
WHO: World Health Organization

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CHAPTER ONE: INTRODUCTION

1.1 Background Information

St. Martin Catholic Social Apostolate (St Martin CSA) is a grassroots organization registered as a trust with the main aim of strengthening community capacities to care for and empower vulnerable people and marginalized groups by unlocking community capabilities and shifting perspectives about the poor and vulnerable people. They envision a just society in which communities uphold dignity and respect the voices of vulnerable and marginalized people. Its work focuses on children's rights, mental health, gender equality, peace building, youth development and livelihood support. St Martin CSA has its headquarters in Nyahururu town and serve a population of approximately 500,000 people in Laikipia, Nyandarua and Baringo Counties. It also has outreach in Nakuru and Nairobi Counties. The organization has a direct contact with over 600 community volunteers who are trained and formed to serve over 10,000 underserved groups of people.

The Community Programme for Mental Health under St. Martin CSA was established in 2010, and since then it has taken an active role in addressing the increasing challenge of alcohol and drug addiction in its target area. This programme provides a range of interventions, including outreach, prevention, rehabilitation, and aftercare support services for individuals recovering from alcohol and drug addiction. The programme is particularly known for its Intensive Outpatient Rehabilitation intervention, which aims at providing comprehensive treatment for individuals battling addiction while allowing them to remain integrated within their communities. The programme blends different approaches in rehabilitation of people in substance use addiction. The objective of developing this intervention was to create a multipronged and cost-effective approach in addiction rehabilitation at individual, family and community level. Rehabilitation under intensive outpatient program involves structured therapy sessions, addiction education, relapse prevention, creating and linking individuals to peer support systems, as well as a wide range family and community-based interventions depending on the needs at hand.

Despite the implementation of addiction rehabilitation interventions since inception of the program, the organization has limited understanding of the effectiveness of its approach and the intensive rehabilitation program, as well as the factors influencing its achievements. This underlines the need for this evaluation to measure effectiveness of the organization's mixed approach to alcohol and drug addiction treatment and the contribution of intensive outpatient rehabilitation program to the organization's achievements, plus the factors influencing outcomes of the approach and the intensive rehabilitation program. This study will therefore assess the effectiveness of the mixed approach and intensive outpatient program in rehabilitation and factors contributing to their outcomes. Areas of focus will be implementation of the approach and the program and the outcome to answer the questions whether the resources were used appropriately and whether the program was worthwhile. Findings of this evaluation would be used to enrich the intervention and contribute to the body of knowledge on recovery of people in substance use addiction.

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1.2 Objectives of the Evaluation

1.2.1 Broad Objective

The broad objective of this evaluation is to explore the effectiveness St Martin CSA Addiction Treatment Approach, and Intensive Outpatient Rehabilitation Programme.

1.2.2 Specific Objectives

1. To assess clients' level of functioning before joining St Martin CSA's Intensive Outpatient Rehabilitation Programme
2. To explore implementation of St. Martin treatment approach and Intensive Outpatient Rehabilitation Program in rehabilitating clients.
3. To assess clients' level of functioning after St Martin CSA's Intensive Outpatient Rehabilitation Programme
4. To evaluate the effectiveness of St. Martin treatment approach and Intensive Outpatient Rehabilitation Program in facilitating clients' recovery.

1.2.3 Evaluation questions

1. How functional in quality of life were clients before joining St Martin CSA's Addiction Treatment Program?
2. How was St Martin CSA's Addiction Treatment approach and program implemented in rehabilitating clients?
3. What changes in quality of life functional did clients experience after St Martin CSA's Intensive Outpatient Rehabilitation Programme?
4. How effective was St. Martin treatment approach and Intensive Outpatient Rehabilitation Program in facilitating clients' recovery?

1.3 Scope and Limitation of the Study

This evaluation was limited to exploring the effectiveness of St Matin CSA's Addiction Treatment Approach, its intensive outpatient rehabilitation program and factors influencing their outcomes. The study population was therefore limited to individuals who had ever received St Martin CSA's substance use treatment services and/or were involved in offering rehabilitation and integration services, or support to people undergoing treatment in the organization. Based on the above, the 133 people recovering from addiction after undergoing treatment in St Martin CSA since 2018 were the primary respondents to the study. Registered family members, peer supporters, and community volunteers, were also included to the study. Additional data on technical and expert perspectives on the approach and the intensive outpatient rehabilitation program was sought from the project staff.

This study targeted to reach 100 people in recovery who had received rehabilitation services St Martin CSA, though Intensive Outpatient Rehabilitation program. However, the total response rate

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was at 50%. This was attributed to challenges in clients tracing where some were reported to have moved out of the project's target area while others were not willing to participate in the study. The research team worked with the data collected from the 50 respondents and leveraged on desktop review and qualitative data collected from key project stakeholders to validate data collected from primary respondents.

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CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

In this chapter related literature is reviewed. The review will focus on the quality of life of people in addiction prior to addiction, treatment approaches and programs during rehabilitation process, Changes in quality of life among people undergoing recovery from addiction and effectiveness of treatment approaches and programs. The aim of the review is to lay the ground for effective evaluation by understanding the related concepts and procedures in evaluation of rehabilitation approaches and programs.

2.2 Quality of Life of People in Drugs and Substance Addiction Prior to Rehabilitation.

Globally, alcohol and drug addiction have become significant public health challenges, affecting individuals, families, and communities. According to the World Health Organization (WHO), over 35 million people worldwide suffer from substance use disorders, with alcohol and opioid dependence being the most prevalent forms of addiction (WHO, 2021). The consequences of addiction are far-reaching, including physical and mental health problems, social marginalization, and an increased risk of crime and poverty.

In Africa, substance abuse has been on the rise, fueled by factors such as socio-economic instability, unemployment, and inadequate access to mental health services (Atwoli et al., 2011). The African Union has recognized substance abuse as a key health and development issue, urging member states to adopt comprehensive policies and programs to address addiction (AU, 2019). Kenya, in particular, has faced a growing epidemic of alcohol and drug abuse. National Campaign against Drugs Abuse (NACADA) reports on the status of drug and substance abuse in Kenya (2012, 2017 and 2022) have indicated a sustained high prevalence rate in alcohol and drug abuse in the country. Notably, Laikipia County, (target area of St Martin CSA's Mental Health Interventions), has witnessed a sharp rise in alcohol and drug addiction, particularly among the youth. According to NACADA (2017) approximately 6% of Laikipia's population struggles with alcohol and drug abuse, hence the relevance of St Martin CSA Mental Health Intervention.

This increase in drugs and substance use has been associated with physical and mental health challenges, increased criminality, and myriads of socioeconomic challenges such as poverty, family and marital disintegration, illiteracy, high mortality rates at the individual, family, community and societal level (Khan et al, 2023; Kuria, 2013; Nyaga, 2021). In a study by Khan et al, (2023) on adolescent in substance and drugs abuse in India, 72.7% reported Very Poor (40.9%) and Poor (31.8%) Quality of life indicative of the degrading effect of drugs and substance abuse. Going by the 2019 population and demographic census in Kenya separation rates were 5.2% and 4.0% in females and males respectively and divorce rates at 2.2% and 1.4% compared to among the people in addiction 21.6% separated and 14.6% divorced (KNBS, 2022; Nyaga, 2021). On family status rate of above 78.7% in females and 74.3% in males were married as from age group 30 years and above going by age groups compared to 40.1% single and 59% married among people

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in addiction (KNBS, 2022; Kuria, 2013). The same trends have been registered in illiteracy and economic levels where respondents were found to be earning very low income (Kuria, 2013: Nyaga, 2021) indicating a high poverty level and limited capacity to meet their needs. These socioeconomic factors result in people in addiction being disrespected, ignored, and rejected (Anjum, et al 2020) reducing their quality of life.

People in addiction are more likely to experience comorbid physical and mental disorders such as physical conditions such as hypertension, liver complications, lung cancer among others, depression, bipolar, Schizophrenia, phobia, Anxiety, and PTSD. Roughly two-thirds would seek medical attention in health facilities only to be mismanaged due to staff attitude or misinformation on addiction (Anjum, et al 2020). The rate of 63% depression comorbid among alcohol abusers and other mental disorders was reported by Kuria, (2013). Among addicts of heroin and other hard drugs, McHugh, et al (2020) found a prevalence of comorbid mental disorders among a variety of drugs to range between 8.7% for bipolar disorder to 36.1% for depression. A diagnosis of mental disorder alongside drugs addiction complicates recovery (Fein, 2015; McHugh, et al 2020; Santo et al 2022).

Among the domains of quality of life, the psychological domain is the worst affected by addiction to drugs and substances. Khan et al, (2023) observed the lowest mean in psychological domain (M=9.8) in quality of life compared to physical health domain (M=10.5), social relationships (M=10.6) and environmental (M=11.5). This is indicative that by the time the family, community and society aspects of quality of life are being affected the individual aspect of quality of life (self-awareness and acceptance, self-identity, self-respect and care, self-worth and efficacy, emotional and behavioural control and eventually physical health) are highly compromised. These results are in agreement with results from a study from Ethiopia where majority of respondents perceived their health to the negative with 34.41% highly dissatisfied (7.8%) and dissatisfied (26.34%) and 39.52% being unsure (Tarekegn, et al 2022). The situation would worsen as users of substances and drugs slip to abuse considering the population was adolescents using substances.

2.2 Addiction Treatment Approaches and Program implementation

Alcohol and drug use and abuse are highly influenced by the social and cultural context in which it happens as well as innate factors influencing the user or the person in addiction (Ndirangu, 2021). This presents challenges among scholars and practitioners in developing an all-inclusive "quick fix" in addiction treatment. As a result, a litany of addiction treatment models has emerged as the literature and understanding of addiction continue to grow, with the majority of practitioners preferring mixed approach to addiction treatment out of its complexity and dynamism and the fact that different models have their strengths and weaknesses, and are best applied in deferent contexts. This section explores some of the most practiced addiction treatment models that informs different approaches taken by practitioners with emphasis on their general success rate.

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2.2.1 The 12-Step Alcoholics Anonymous and Narcotics Anonymous model

According to Humphreys (2004), Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are worldwide, nonprofessional, peer-to-peer support organization that intends to support individuals in addiction to recover from alcohol and drug addiction. AA and NA use the 12-step model and encourage members to share personal narratives of their alcohol and drug addiction and recovery experiences to help one another overcome addiction. The program seeks to improve psychological well-being, and interpersonal skills, cope with stress, and adapt to abstinence and sober lifestyle (Kelly, 2009). Humphreys (1999) observed that the AA and NA 12-step approach can be combined with other interventions such as psychological counseling, family therapy, and brief interventions during and after treatment to sustain remission over time. Further, peer support and role modeling provide a sense of belonging that works positively in addressing feelings of shame, loneliness, and guilt (Yalom, 2008) and instill hope for recovery through sharing personal success stories.

The 12-step model of addiction treatment is a structured program designed to help individuals struggling with substance abuse achieve and maintain long-term recovery. The approach emphasizes on spiritual growth, peer support, and personal responsibility, with participants encouraged to work through a series of structured steps to overcome addiction (Donovan et al., 2013). According to Alcoholics Anonymous World Services (2016), the 12-Step model is based on the following core assumptions: a) Addiction is a chronic disease: Both AA and NA treat addiction as a progressive, incurable disease that can be arrested but not cured. b) Powerlessness: Addicts are powerless over their addiction and require help from a higher power (spiritual, not necessarily religious) and peers to achieve recovery. c) Abstinence is necessary: Complete abstinence from drugs and alcohol is a requirement for recovery. e) Self-examination: ongoing personal reflection and self-inventory are essential for identifying and addressing underlying issues. f) Peer support: Group meetings offer shared experiences, mutual support, and accountability, which are critical to maintaining sobriety. g) Spirituality and humility: Adherents are encouraged to adopt a spiritual (though non-denominational) approach to recovery, recognizing a higher power that can help them navigate their journey.

The 12-step program combines individual self-work and community involvement. Members regularly attend meetings (mainly closed) where they share their experiences, provide mutual support, and offer encouragement to others. The concept of a "sponsor" (a mentor figure with more sobriety time) is a critical element, as sponsors provide guidance and accountability through the recovery process. Participants work through the steps at their own pace, often revisiting them as needed to maintain recovery (Kelly & Humphreys, 2017).

AA and NA approaches to addiction treatment have been criticized for their insistence on spirituality and acknowledgment of powerlessness. Its critics postulate that this may not resonate

with everyone. Some individuals may prefer approaches that emphasize personal empowerment, and secular alternatives as opposed to spirituality and submitting to addiction.

2.2.2 Disease Model of addiction

The disease model of addiction views addiction as a chronic brain disease, characterized by relapse and compulsive substance use (Heilig, 2021), rather than an individual's choice or lack of morals. According to The American Society of Addiction Medicine, addiction is a brain disease characterized by an inability to consistently abstain from a substance and impairment in behavioral control. This suggests that addiction is rooted in neurobiological changes within the brain, particularly in areas that govern reward, impulse control, and decision-making (ASAM, 2020).

This theory is based on the following key tenets: 1) Addiction results from long-term changes in brain structure and function, particularly in the dopaminergic reward pathways and the prefrontal cortex which persist even after the individual stops using the substance, making relapse a common feature (Volkow et al., 2019). Addiction is therefore viewed as a chronic and relapsing disease. 2) The brain changes make individuals with addiction to lose the ability to regulate their use of substances, leading to compulsive drug-seeking behavior despite harmful consequences (Heilig, 2021), creating a distinction between substance use disorders from casual or non-problematic use. 3) Biological factors; particularly genetic predispositions play a significant role in addiction risk, increasing individuals' vulnerability to developing addiction (NIDA, 2020) hence, it is not simply a matter of choice or willpower.

The disease theory of addiction has been criticized for being overly reductive. Some scholars argue that the model places too much emphasis on biological factors and neglects the social, environmental, and psychological dimensions of addiction. Critics also contend that framing addiction solely as a disease may reduce personal agency and responsibility (Hall et al., 2020). In response to these critiques, there has been a shift towards a more integrated biopsychosocial model, which recognizes that addiction is influenced by a combination of biological, psychological, and social factors. This model allows for a more holistic approach to treatment that incorporates medical, behavioral, and social interventions. The disease theory has shaped the development of both pharmacological and behavioral treatments for addiction. The model advocates for a comprehensive approach that includes medication-assisted treatment (MAT), cognitive-behavioral therapies, and peer support.

2.2.3 Biopsychosocial Model

The biopsychosocial model of addiction appreciates that addiction arises from the dynamic and complex interplay between biological, psychological, and social factors (Griffiths, 2005). According to the theory, biological factors account for the genetics, neurochemistry, and brain physiology that predispose an individual to addiction. Psychological factors on the other hand account for the differences in personality traits, cognitive processes, emotional regulation, and coping mechanisms that lead to addiction. Use and addiction to alcohol and drugs occur in a social

context and therefore factors such as social environment, interpersonal relationships, cultural norms, socioeconomic status, and life experiences influence addictive behaviors Skewes & Gonzalez, (2013). The theory therefore attributes addiction to a multiplicity of factors and advocates for mixed interventions to attain a lasting remittance. Volkow et al., (2020) observed that genetics, neurobiology, and physical health significantly contribute to the development of addiction, and hence make some individuals more vulnerable to addiction than others. Repeated use of the drug of choice on the other hand leads to changes in brain structures, leading to compulsive use of the drug of choice and therefore reinforcing the cycle of addiction. This underlines the need for the use of biological interventions in treatment to correct neurochemical imbalances.

Psychological factors such as individual mental health status, past traumatic experiences, emotional stability, deficiency self-identity, esteem, behavioral control and cognitions in terms of belief system play central roles in addiction. This explains high rates of comorbidity of substance use disorder and other mental illness such as depression, bipolar, schizophrenia, Dissociations, anxiety disorder, and post-traumatic stress disorder (Buchman et al., 2020; Fein, 2015; McHugh, et al 2020; Santo et al 2022) making treatment of addiction complicated.

Social factors such as family dynamics, child rearing, peer pressure, cultural practices, and gender among others, influence individual behavior towards alcohol and drug use and addiction. Further, the availability of drugs, law, social norms, and exposure to stress are also potential contributors to substance use disorders. Owing to the complexity and dynamism of factors contributing to addiction, the biopsychosocial model advocates for the use of a wide range of interventions that include among others, family therapy, community-based interventions, psychological counseling and a wide range of behavioral and empowerment approaches to attain long term positive outcomes in addiction treatment (Kelly et al., 2021). This model's comprehensive nature therefore enables practitioners in addiction treatment to consider a wider range of factors when developing treatment plans, promoting a more individualized approach to addiction recovery.

2.2.4 Community-based treatment model

Community-Based Addiction Treatment model provides a continuum of care for people suffering from addiction to alcohol and drug addiction. This includes interventions such as outreach services, professional help and aftercare follow ups. It involves the provision of several specialized health, psychological and social treatment, and other non-specialist services needed to meet the needs of the people in recovery and the community (UNODC, 2014). This model puts more emphasis on engaging different constituents of the community to treat addiction. It leverages on community resources to facilitate recovery through case management. The community-based approach is based on the assumption that addiction is not an individual problem but a social problem that requires collective efforts to address it. Community-based addiction treatment models offer a continuum of care that supports long-term recovery using different approaches. These models also seek to address the social influence of addiction and expose individuals to the risk of relapse.

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The community-based approach to treatment is based on the following core tenets; 1) The community is a key resource for individuals in recovery including social support systems such as families, peers, and local organizations in providing emotional, psychological, and material support during recovery (Kelly et al., 2021). 2) Substance use disorder treatment should address a wide range of needs of individuals recovering from addiction including among others legal issues, mental health care, and basic human needs among others (Brocato & Wagner, 2020). 3) At the center of the community-based approach is the involvement of peer support groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), which provide support and guidance from personal experience with addiction and recovery. Such interventions help reduce stigma, offer shared experiences, and foster a sense of community among individuals in recovery (Bassuk et al., 2019). The outstanding strength of community-based addiction treatment among other models is its success in mitigating social factors in addiction and relapse.

2.2.5 St Martin CSA addiction treatment approach and program

St. Martin CSA employs a mixed-method approach in the treatment of drug and substance addiction. The organization's addiction intervention is an integrative community-based approach that combines biopsychosocial, AA 12-steps and disease models in conceptualizing clients' experiences with addiction.

The mixed method allows for a holistic and personalized treatment plan and hence increases the likelihood of long-term recovery. Each component of the integrated approach used by the organization complements the other in addiction treatment. At the center is the biopsychosocial model. It supports recognition of biological, psychological, and social factors in addiction, and it addresses each domain through a comprehensive treatment approach. In St Martin CSA, medical care for clients suffering from drug-induced mental and physical illnesses balances the biochemical reactions improving the clients' physiological functioning as well as deliberateness in making choices by reducing compulsivity. Improved physiological functioning gives room for psychotherapy, psychological counseling, and social support services that empower the individual in meeting their needs appropriately through conscious decision making, as well as emotional and behavioral control by changing maladaptive emotions, thoughts and behaviors that contribute to substance abuse (Carroll, 2020). Psychotherapy on the other hand addresses underlying mental health issues, such as depression or trauma that often co-occur with addiction (McHugh, 2021). Under St Martin CSA's mixed approach, psychological counseling is expected to provide individual clients with tools to address cravings and manage stress. Social support services provided in community-based systems such as caregivers, community volunteers, peer supporters, spiritual services and livelihood support assist in addressing different facets of addiction, and helps to tailor treatment plans to meet individual needs based on their biological, psychological, and social conditions. Smith (2022) noted that treatments following the biopsychosocial model improved quality of life and reduced relapse by addressing the comprehensive needs of individuals.

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The biopsychosocial aspect integrates with AA 12-step in preparing individuals mentally for community-based recovery support. The 12-step facilitation program fosters peer support and accountability, offering individuals a structured spiritual approach to recovery (Kelly, 2021). By emphasizing acceptance, surrender to a higher power, personal responsibility, and group support, this the AA 12-steps help individuals to stay connected to recovery communities long after formal treatment ends. As an extension, engaging in AA and NA groups complement counseling by providing emotional support from peers, reinforcing the individual behavioral changes initiated during therapy, and providing ongoing support through post-treatment phases, critical for relapse prevention. Kelly (2021) highlights that AA and NA participation boosts the likelihood of long-term sobriety, especially when combined with formal therapy. A study by Humphreys (2020) showed that individuals who regularly attended AA meetings had greater abstinence rates compared to those in therapy alone.

The disease aspect of the biopsychosocial framework and the disease theory of addiction are particularly important in St Martin CSA alcohol and drug abuse prevention interventions as well as in creating awareness whether for the general knowledge or soliciting for social support for people in and recovering in addiction. Conceptualizing substance use disorder as a disease creates urgency and zeal among the local community to prevent it as well as support those in and recovering from addiction. In addition, it dispels the perception that addiction results from poor child upbringing, lack of morals, deviance, or being bewitched.

St Martin CSA is a grassroots community-based organization with its motto being, “only through community”. The organization holds that the community has adequate resources to address the needs of its vulnerable members. The organization therefore focuses on creating capacity within its target population to enhance their ability and efficacy in addressing their needs. It also rallies the community to meet the financial, social, and emotional needs of its vulnerable members. Under St Martin CSA Approach, the basic unit of support is the family/household. The approach assumes that individuals close to the person in or recovering from addiction have a pivotal role to play in promoting recovery. More so, both the family and the person in recovery should heal together for healthy coexistence and reintegration. The family is therefore targeted with some interventions according to the underlying needs. The most common services given to the family include family therapy, psychoeducation, relapse prevention, and their role in recovery. This is mainly facilitated by community volunteers who are trained and empowered to undertake this role in their localities. People in recovery are introduced to peer groups as well as AA or NA support groups for further support. Both the family/household and the person under recovery are given regular follow-ups by the volunteers and occasionally by rehabilitation workers to identify emerging issues and address them. Marshall (2021) observed that community-based treatment should emphasize on social reintegration, social support, and local recovery groups. According to a study by Marshall (2021), community support reinforces the skills learned in therapy and provides a stable environment that

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reduces risk factors for relapse, such as social isolation or homelessness. It also encourages real-life application of coping mechanisms and emotional management learned in counseling.

The mixed methods approach to addiction treatment used by St. Martin CSA offers several advantages: 1) It ensures holistic care for people in and recovering from alcohol and drug addiction. The approach addresses the biological, psychological, and social components of addiction, this approach seeks to ensure that no aspect of the disorder is left untreated. Each method complements the others, creating a comprehensive individual treatment plan that is more effective than any single approach alone. The plans are also adjusted to meet the developing, reoccurring, and emerging needs of individual clients and their significant others. 2) Treatment under this approach is customized to meet the unique needs of each patient. For example, those with co-occurring mental health disorders may benefit from additional psychological counseling, while those with stronger social support networks may thrive in AA and NA programs. 3) Research has consistently shown that combining different treatment methods reduces the likelihood of relapse and improves long-term recovery outcomes and therefore higher chances of long-term remittance. 4) The inclusion of community-based care ensures that patients have access to support networks beyond the clinical environment, which is vital for relapse prevention and reintegration to their local communities.

The St. Martin addiction rehabilitation approach is operationalized into a program that integrates screening and assessment, medical attention, social support, psychological interventions, psychoeducation on addiction and recovery and peer support. This approach is designed to address the multi-faceted nature of addiction by combining interventions that cater to the different treatment needs of its clients. The program is designed to operate in three phases each assisting clients at different stages of behavior change (Recovery at the Crossroads, 2020) being: 1) Outreach phase, 2) Treatment Phase and 3) Aftercare Phase. The outreach phase focusses of people who are active in drugs and substance abuse, their caregivers and their hosting community. Through community health volunteers, St. Martin CSA staff and peer supporters home visits and reaching out to meeting those active in abusing drugs in their natural environments as well as engaging the community through established institution where factual information is passed to create awareness, facilitate contemplation to change addiction behaviours and combat stigma through change of attitude. Screening is done to people in active addiction to determine their needs and referral point.

At the treatment phase the program is an outpatient program with an aspect of inpatient engagement for 13 weekends which makes it unique. Since the outpatient mode is dominant it is referred to as St. Martin Intensive Outpatient Program. As an outpatient rehabilitation clients largely live at home while attending scheduled treatment sessions, usually during weekends, to manage addiction. This program admits individuals with less severe addictions or those who cannot commit to residential care due to personal, financial, or professional obligations (Carroll,

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2020). According to Kelly (2021). During the planned weekend sessions clients get engaged in a combination of individual therapy, group therapy, psychoeducation, relapse prevention and AA 12-steps. During the weekdays clients go back to their normal life where they are expected to apply recovery skills in their daily lives. Clients prefer outpatient because of its flexibility, accessibility, affordability and allows clients to attend their daily routines in the family and workplace (Githinji, 2021; Mugo, 2022, Owino & Odeny, 2020).

The inpatient aspect of the St Martin Intensive Rehabilitation Program entails clients' engagement in 13 consecutive weekends which is mandatory. During the weekends where they report on Friday evening and leave on Sunday, they are engaged in a variety of activities one of them being the AA 12-steps, psychological interventions in groups, individually therapy, relapse prevention, leisure activities and experiential sharing. Any substance or drug of addiction is not allowed into the camp. The incorporation of the inpatient component introduces some structure where clients are shielded from weekend temptations, intensive treatment and peer support hence reducing stigma all of which were identified as weaknesses in outpatient rehabilitation (Githinji, 2021; McHugh, 2021; Mugo, 2022; White et al. 2020). Consequently, it is allowing them to be at home in weekdays to face triggers and apply skills and strategies they learned, experiences they share during the weekend. At the end of the 13 weeks a formal graduation ceremony is held to mark the end of active rehabilitation and the beginning of aftercare phase. Aftercare keeps the client on track and empowers the client to keep practicing what he learned while in active rehabilitation. From experience point of view as a treatment center Recovery at the Cross Roads (2020) recommended clients should be in some form of aftercare for at least one or two years after completing a course of rehabilitation program.

Intensive Outpatient programs of rehabilitation seek to bridge the gap between inpatient and outpatient. Most intensive outpatient programs engage clients for more hours during the day where they are engaged in intensive treatment activities such as therapy and psychoeducation. St Martin Intensive Outpatient Rehabilitations hybrid nature seeks to bridge the gap between outpatient, inpatient and other intensive modes of treatment. Clients are provided with free rehabilitation services and therefore the services are accessible. The 13 weekends camp model which is comparable to the standard 90 days duration in an inpatient rehabilitation facility helps to create a structure where they are not allowed to use drugs and substances and are engaged through the day in intensive activities. Weekends pose the greatest risk due to weekend parties from Friday to Sunday hence they are shielded from high risks and yet they spend in their natural environments through the week offering them opportunities to test learned skills with weekends opportunity for socials support where they faced difficulties and ended up consuming the drugs. This treatment program is recommended for persons with substance use dependence ranging from level I to level II, according to the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. Clients are screened to ensure only suitable clients are admitted to the program. Others are supported by the organization to undergo impatient program.

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During and after treatment, participants are given a wide range of services according to their needs by the community volunteers and rehabilitation workers. The family and the community, are also critical elements in relapse prevention, integration and socioeconomic empowerment. Individuals recovering from addiction are also linked to their peer as well as AA and NA for further support. Their families and close contacts receive family therapy and other interventions to ensure that they heal together with the client to enhance chances of seamless reintegration and adjustment to the new behavior.

2.3 Clients Functioning after Rehabilitation in terms of Quality of Life

Sinking into addiction is a progressive reduction of quality of life in all its dimensions being physical, social, psychological and environmental. Treatment and rehabilitation should aim at improving these domains of quality of life affected by alcohol addiction. WHO, (2000) guides that outcome measures may be selected from five broad domains: 1) Maintenance of abstinence/reduction in substance use. 2) Improvement in personal and social functioning. 3) Improvement in mental and physical health. 4) Reduction in health risk behaviors, and 5) Overall improvement in level (amount) of recovery capital. The 2nd, 3rd and 4th criteria focus on changes in clients' quality of life. In line with WHO guidance MOH, (2017) emphasized that rehabilitation programs are meant to reduce the risk of relapse by supporting change in ones' social functioning, personal wellbeing as well as that of their place, community and the wider society.

Gachara, (2020) in a study in Kirinyaga County Kenya observed that 75.2% and 71.7% of respondents reported satisfaction in their quality of health (42.6% at very much and 32.6% at extremely satisfied) and Quality of life (44% at very much and 27.7% at extremely satisfied) respectively after treatment in a 6-score scale. In specific domains psychological domain assessed in a five-score scale ranging from very high to very low social domain was rated very high with 74% in very high (M=11.52 maximum score 15, SD=2.24), psychological domain at high level with 70.2% in very high (M=22.8 maximum score 30, SD=4.22). Physical health and environmental domains were rated at moderate levels with 41.1% at very high (M=23.18, maximum score 35, SD=3.75) and 46.1% at very high (M=27.45 maximum score 40, SD=5.13) respectively. The results suggested that domains of quality of life do not develop at the same rate. Respondents were drawn from outpatient and inpatient programs from Mathari Hospital hence could be different with results from other institutions and mode of treatment.

In the process of recovery clients grow to become more self-conscious and reflective, a product of awareness and self-identity on addiction and recovery (Searidge Foundation, 2022). Self-consciousness and positive self-identity promoted self-control in the face of relapse risk factors. Improving self-control and self–identity implies need to focus on clients' psychological domain 'as a key factor in maintaining sobriety and making conscious decisions on all other domains of life.

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The process of recovery is a progressive holistic improvement freeing client from factors that predisposed them to drugs and substance abuse and addiction. The rate of reduction of the factors depends on the complexity of underlying functioning dynamics. Kuria (2013) registered decrease in comorbidity among those who stopped (55.9% compared to those who relapsed 44.1%) indicating improvement in physical and mental health. In addition, craving among those who stopped reduced to not every day 76.9% compared to those who relapsed 23% signifying regaining control as biochemical reaction normalized and psychosocial triggers reduced.

Kuyeya (2013) in the study on effectiveness of treatment and rehabilitation programs for drug and substance dependence in Mombasa County, Kenya, observed that after treatment clients improved in education (33%), improved in legal status (42.6%), stopped or reduced drugs use (66.1%), were accepted by family (57.4%) and started enjoying good health (59.8%). These results corroborated Gachara (2020) findings that social and psychological domains evolved at a high rate than physical and environmental domains. The results indicated that clients improve in social status reducing disrespect and rejection from family and community in addition good health hence reduction in stresses.

2.4 Effectiveness of rehabilitation programs in improving clients' quality of life

WHO 2000 provides guidance in assessing effectiveness of rehabilitation programs. In the guidance four assessment criteria are provided. 1) Are the treatment activities implemented as were initially intended? 2) Is the treatment program getting the intended results? 3) Were the resources such as money, community and staff, appropriately used? and 4) Was the treatment program worthwhile? This question provides a framework for assessing whether rehabilitation program was effective.

Many studies have been done on effectiveness of different rehabilitation approaches and programs across the globe. Many studies support the idea that individuals who actively participate in 12-step programs are more likely to maintain long-term abstinence. A longitudinal study conducted by Kelly et al., (2020) found out that individuals who attend AA regularly were more likely to achieve sustained sobriety compared to those who did not. The combination of peer support and the structured framework was cited as central to the success of long-term recovery. Further studies indicate that group participation helps reduce the sense of isolation that is often associated with addiction. White et al. (2020) postulated that NA participation leads to reduced drug use and increased rates of abstinence. This observation agrees with Shiraly and Taghva (2018) who noted that sustained remission among opioid users they were studying was associated with participation in NA. AA and NA therefore improve members' self-efficacy and their ability to manage cravings and relapses, with the sense of community playing a crucial role, and hence higher chances of long-term recovery. Additionally, Kelly et al. (2020) established that the 12 steps, combined with community support, contribute significantly to improving the overall mental health status of people in recovery. The study found that individuals in recovery who regularly participate in AA meetings

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experience significant improvements in emotional well-being, self-esteem, and coping mechanisms.

Findings from recent studies on the effectiveness of the Disease Theory of Addiction has supported the use of the pharmacological, brain-stimulating, and behavioral approaches to achieve long-term remission. Studies have supported medication assisted treatment in reducing risk of overdose and reducing drugs intake (Kranzler et al. 2021; Sordo et al. 2021). In addition, a study by Dunlop et al. (2022) found that brain stimulation was effective in reducing cravings for individuals with alcohol and cocaine addiction by modulating activity in the prefrontal cortex. Success in pharmacological treatments demonstrate duality in biological and psychological attributions in the problem of addiction.

Biopsychosocial model has been found to be effective in treating addiction by offering a comprehensive approach that addresses the full spectrum of factors contributing to substance use. A study by Kranzler et al. (2020) found that combining pharmacotherapy, psychotherapy, and social support was more effective in reducing heavy drinking days and promoting long-term abstinence than either intervention alone. Similarly, a study by Kelly et al (2021) found that the use of multiple methods in addiction treatment such as combining the AA 12-step program with other psychosocial interventions significantly improved long-term sobriety rates and quality of life for individuals with alcohol and opioid use disorders. Likewise, Polcin et al. (2022) research on recovery housing programs demonstrated that providing stable, supportive living environments for individuals with substance use disorders resulted in lower relapse rates, hence the importance of addressing social factors in addiction treatment.

Recent studies consistently show that community-based addiction treatment models are effective. They are particularly successful in increasing engagement in recovery and reducing relapse rates and provide an important buffer against social determinants that might otherwise lead to relapse (Bassuk et al. 2020; Krawczyk et al. 2020; Wakeman et al. 2020).

Outpatient rehabilitation has been evaluated to have low levels of success. Some registered success rates in a period of one year ranged from 53% in United Kingdom, 48% in United States, 45% in Brazil and 39% in Kenya (McHugh, 2021; Oliveira & De Souza 2022; White et al. 2020). The rates are lower than in inpatients programs. Some of the established reasons for low success rates are exposure to triggers, lack of structured environment, social stigma and lack of access to comprehensive care (Githinji, 2021; McHugh, 2021; Mugo, 2022; White et al. 2020). To overcome the challenges of low success rates, White (2020) suggested strengthening social support, such as encouraging attendance in peer-led groups like AA and NA in outpatient programs. In addition, Carroll, (2020) proposed more intensive outpatient options, such as day programs that require individuals to stay for several hours.

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Inpatient mode of treatment is associated with higher success rates than the outpatient rehabilitation. Success rates of inpatient rehabilitation measured by different studies in different countries range from 68% in United States, 65% in United Kingdom, 56% in India, 52% in South Africa and 53% in Kenya (Githinji et al. 2021; Jones, 2020; Kelly & Humphreys 2021; Singh and Sharma, 2021; Volkow et al 2022). Higher success rates than in outpatient programs have been attributed to controlled environment, reducing exposure to triggers and providing patients with a focused atmosphere for recovery and provision of medical care (Githinji, 2021; Owino & Odeny, 2020). Despite the success, inpatient programs are expensive hence limiting accessibility (Githinji et al. 2021; Jones, 2020) and isolating clients from natural environment hence need for reintegration after rehabilitation (Mugo, 2022; Smith, 2021). Volkow, (2022) recommended structured aftercare, including outpatient counseling and peer support groups to improve inpatient mode of treatment while Singh & Sharma, (2021) proposed policy intervention by introduction of sliding scale fees by government to improve on accessibility.

Intensive outpatient rehabilitation has been found to lie between outpatient and inpatient success rates. Studies from different contexts have documented intensive outpatient success rates as ranging from 60% in United States, 62% in United Kingdom, 50% in Mexico and 47% in Nigeria and Kenya (Carroll et al., 2020; Kelly & Humphreys, 2021; Morales & Cruz, 2022; Mwangi & Wanjiku, 2021; Ogundipe, 2021), The success was attributed to moderate success rate to the balance between structured therapy and the freedom to manage real-life responsibilities. However, they still require significant time commitment, hence a challenge to many with full day commitments, they remain exposed to triggering environments since they go back home every day (Smith, 2022; Volkow, 2023). St. Martin Intensive Outpatient Rehabilitation Program's is unique in nature by incorporating the inpatient 13 weekends camp model which makes it difficult to predict its outcome based on existing literature, necessitating evaluation of the effectiveness of the program.

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CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter covers the procedures and methods that will be used to conduct this evaluation. It covers research design, target population, sampling procedure, data collection tools, data analysis, and ethical considerations.

3.2 Research Design

This evaluation adopted a mixed-method research design. This design allowed the evaluation team to collect, analyze, and mix both quantitative and qualitative data in the study; and hence leveraged on the strengths of each method.

3.3 Research Population and sampling procedure

The research population was diverse and included several key stakeholder groups associated with the project. The primary respondents were the 133 project beneficiaries; however, additional qualitative data was gathered from 13 community volunteers, 9 peer supporters, 12 family members, 11 people in recovery, and 4 project staff. This multi-level approach will ensure a comprehensive understanding of the project's impact from multiple perspectives.

Beneficiaries of the project were individuals who had directly benefited from the project's addiction treatment services. They represented the core group whose outcomes and experiences were central to this evaluation. Volunteers supported the project by offering their time and skills and helping deliver services, they also served as the link between the community, beneficiaries, and the project. Community volunteers were also involved in the project implementation for a longer period. Their insights helped to deduce the effectiveness of the St Martin Addiction Treatment Approach and Intensive Outpatient Program. Peer supporters and family members were important respondents to this evaluation since they had direct contact with people in recovery. Therefore, they had first-hand information on the changes experienced by beneficiaries. Their views shed light on the effectiveness of the approach and outpatient program. Views of volunteers, project staff, peer supporters, and family members were used to enrich data collected from primary respondents.

This evaluation utilized census and purposive sampling techniques to ensure a comprehensive and representative sample. All 133 beneficiaries who had completed Intensive Outpatient Rehabilitation program were included in the study. However, the study reached 50 respondents. The low response rate was mainly attributed to challenges in tracing beneficiaries especially those who relocated to other areas after undergoing rehabilitation. 11 people in recovery were selected purposively, where every cohort of IOP with 17 participants and above, was represented by two people, and cohorts with below 17 participants were represented by one person. Census ensured that views of all research populations were collected and hence eliminated selection bias. Volunteers were selected using purposive sampling, where participants were chosen based on specific criteria relevant to the evaluation. The 13 volunteers selected had frequent interactions

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with beneficiaries for a period of not less than three years. This ensured that the experienced and knowledgeable individuals contributed to this evaluation. Same as volunteers, peer supporters were chosen using a purposive sampling procedure. The selection focused on individuals who had direct and ongoing interactions with beneficiaries; ensuring their experiences and contributions were adequately captured. Nine (9) peer supporters were selected. Twelve (12) family members were also selected using a purposive sampling procedure, targeting those who had already registered with the program and presumably were mostly involved in the lives and recovery of the beneficiaries. All project staff were included in the study, to give technical and expert views of the project intervention and outpatient rehabilitation program.

3.4 Data Collection Methods

To ensure a comprehensive evaluation, a combination of quantitative and qualitative data collection methods was used. These methods were designed to capture both measurable outcomes and the nuanced experiences of stakeholders.

Primary beneficiaries were exposed to a self-administered questionnaire, however, those who were not able to respond to the questionnaire were assisted by people of their choice. The questionnaire collected quantitative data on the beneficiaries' experiences before and after treatment in St Martin CSA, and the treatment interventions they went through. The questionnaire included closed-ended questions to ensure that the data collected was standardized, measurable, and could be statistically analyzed. This allowed the 50 respondents to independently report on their experiences with the project. A group of 11 beneficiaries selected using the procedure described above, were exposed to a focus group discussion. This helped the evaluation team to gather qualitative data that provided a deeper understanding of the beneficiaries' perspectives and experiences. This method helped to explore insights that could not be fully captured through a questionnaire. The focus group discussion allowed open-ended discussions where beneficiaries shared detailed experiences, providing context to the quantitative data collected earlier.

Data from volunteers, registered family members, peer supporters, and project staff was collected using focus group discussions. Different categories of stakeholders held separate focus group discussions to ensure homogeneity. These discussions explored participants' experiences with the project, their understanding of its successes, and their perceptions of the impact on beneficiaries. The qualitative data collected from the focus group discussions with beneficiaries, volunteers, peer supporters, and project staff was used to enrich the quantitative findings from the self-administered questionnaires. This integration allowed the evaluation to go beyond numerical data, to offer deeper insights into the reasons behind outcomes realized.

3.5 Data Analysis

This evaluation collected both qualitative and quantitative data. The collected qualitative data was analysed using the content analysis method. This involved three main stages, including data reduction, data presentation, and conclusion drawing. Collected data was summarized, typeset, and

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later coded. Coded data was organized into different emerging themes and related themes were clustered in broader thematic areas after which frequencies and relationships between sequences and variables were identified and recorded in prose format. Observable trends and relationships were tallied, coded, and keyed in the computer for analysis.

The Statistical Package for Social Scientists (SPSS) was used to process the quantitative data collected. The data was analysed using percentages, totals, means, and standard deviation descriptive statistics. To determine the effectiveness of the St Martin Intensive Outpatient Rehabilitation approach and program, One Way ANOVA was used to test the null hypothesis on the significance in means difference between clients functioning in quality of life before and after the treatment. The null hypothesis was rejected and hence confirmed the effectiveness of the treatment. Quantitative data was presented in tables, figures, and text for ease of comparison. Descriptions of common trends and relationships between variables were presented in text form.
Data collected from staff, registered family members, volunteers, and peer supporters was recorded in the form of notes and typeset. These notes were reviewed to identify the information collected. The information generated will be used to corroborate information collected from respondents and give a deeper understanding of trends observed. Secondary data collected helped the evaluation team to focus on the topics of interest to this evaluation, clear grey areas, and validate some of the information given by respondents.

Finally, conclusions of the findings of the study were drawn following information generated from respondents. The conclusions guided the evaluation team in drawing recommendations for this evaluation.

3.6 Ethical Considerations

This evaluation observed the following ethical considerations to avoid harming study respondents. First, the evaluation team treated respondents to the study with respect, meaning that they sought their informed consent before participating in the study, to ensure voluntary participation. Secondly, the identity of the respondents was concealed to ensure that the information given by respondents was kept confidential. Third, the research team adhered to policies set by St Martin CSA to protect and safeguard the welfare of beneficiaries and other respondents to the study.

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CHAPTER FOUR: DATA ANALYSIS, PRESENTATION AND ANALYSIS

4.1. Demographic characteristics of respondents

4.1.1. Age and mental health status

Respondents reported their ages in categories ranging from ten years starting with below twenty to 71 years and above. As well they reported their mental health status by indicating whether they had been diagnosed of any mental disorder. Table 1 below summarizes their responses on age and mental health status.

Table 1: **Age and Mental Health of Respondents**

Age Years	Frequency (%)	Mental Health Status Diagnosed Mental disorder	Frequency (%)
21-30	14.0	Yes	20.0
31-40	24.0	No	80.0
41-50	28.0		
51-60	24.0		
61-70	8.0		
71+	2.0		

Majority of clients 28% were aged 41-50 years followed by age groups 31-40 years and 51-60 years at 24%. Only 20% had been diagnosed of Mental Disorders.

4.1.2. Social Economic Status

Respondents' socioeconomic status was assessed in terms of educational level, level of income per month, Marital status, and family status. Educational Level included categories of those who dropped at primary level and secondary levels of education. Level of income was categorized as ranging from 0-10,999, 11,000-20999, 21,000-30,999, 31, 000-40.999, 41,000-50,999, 51,000-60,999, 71,000-80,999, 90,000-100,999 and above 101,000. Family status included Two Parents, Blended Family, Single Family, Children Only, and Polygamous Family. Marital status captured Single, Married, Widowed, Separated, and Divorced. Results were summarized in Table 2 below

Table 2: **Social Economic Status**

Social Economic Status Educational Level	Frequency (%)	Level of Income per month (KSh)	Frequency (%)
Dropped from Primary	10.0	Up to 10,999	76.0
Primary Certificate	30.0	11,000-20,999	14.0
Dropped from Secondary	14.0	21,000-30,999	2.0
Secondary Certificate	28.0	41,000-50,999	4.0
Certificate Level	12.0	51,000-60,999	2.0
Diploma Level	4.0%	Missing	2.0%

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Bachelor Degree	2.0%		
Family status Family state	Frequency (%)	Marital status Marital state	Frequency (%)
Two Parents	50.0	Single	40.0
Blended Family	4.0	Married	22.0
Single Family	34.0	Widowed	4.0
Children Only	6.0	Separated	26.0
Polygamous Family	4.0	Divorced	8.0

Among the respondents' the majority (30%) had primary school certificates while 28% had secondary school certificates. On earnings 76% earned less than 10,000 Kenya Shillings per month. Regarding family status, 50 % came from two-parent families with those from single family being 34%. Despite all being of marriageable age, 40% were single having never married and 26% were separated. Only 22% were married.

4.1.3. Drugs Use Status

Drug use status was assessed in terms of the types of drugs they used. It was analyzed based on the use of each specific drug and combination of drugs. Table 3 below summarizes the results

Table 3: **Drugs Use Status**

Drug Use Status			
Drug	Frequency (%)	Drugs Combination	Frequency (%)
Alcohol	88.0	Alcohol	36.0
Cigarette	50.0	Alcohol and Cigarette	30.0
Bhang	16.0	Alcohol and Muguka	4.0
Muguka	16.0	Bhang	6.0
Chaviat	2.0	Bhang and Muguka	2.0
Vape	2.0	Alcohol, Muguka and Cigarette	2.0
Benzol	2.0	Miraa and Cigarette	4.0
Cosmos	2.0	Alcohol, Muguka, Bhang and Cigarette	2.0
Miraa	4.0	Alcohol, Cigarette and Miraa	4.0
		Bhang, Vape, Cigarette, Cosmos and Benzol	2.0
		Alcohol, Cigarette and Bhang	2.0
		Alcohol and Chaviat	2.0
		Alcohol, Muguka and Tobacco	2.0
		ALcohol, Muguka and Bhang	2.0

Alcohol was used by 88% of respondents to be the most prevalent drug followed by cigarette smoking at 50%. On drugs combination alcohol alone was consumed by 36% of respondents. Bhang was also used alone by 6% of respondents. Multiple use of drugs was highest in alcohol and cigarette combinations at 30%.

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4.2. St. Martin Program Activities

Respondents rated various program activities in a scale of 1-9 (1 meaning not helpful at all while 9 meant perfectly helpful. Two means were computed based on two assumptions. Mean (1) assumed that all respondents were to benefit from all the program considering that screening was done and all were considered vulnerable. Mean (2) Assumed that in St Martin CSA addiction treatment approach, is client based hence different programs activities would register different levels of response rate based on clients informed choice on activity that met his/her need. Table 4 below summarized the findings,

Table 4: **Impact of Different Program Activities**

	Frequency of Program Activities Rating (%) n=50												
Program Activities	Missed	1	2	3	4	5	6	7	8	9	Total	Mean (1)	Mean (2)
Home Visits	18.0	4.0	2.0	0.0	4.0	8.0	4.0	8.0	12.0	40.0	300	6.00	7.31
Talks and seminars	16.0	6.0	2.0	0.0	0.0	4.0	4.0	4.0	22.0	42.0	318	6.36	7.57
Outreach	6.0	2.0	2.0	8.0	2.0	2.0	32.0	4.0	16.0	26.0	315	6.30	6.70
Screening and Assessment	6.0	2.0	4.0	2.0	2.0	4.0	4.0	8.0	16.0	52.0	360	7.20	7.73
Medical & Psychiatric Support	38.0	16.0	2.0	0.0	0.0	2.0	0.0	6.0	4.0	32.0	196	3.92	6.09
Weekend Engagement	6.0	4.0	0.0	0.0	0.0	0.0	2.0	2.0	16.0	70.0	394	7.88	8.19
Individual Therapies	14.0	8.0	0.0	0.0	0.0	2.0	8.0	4.0	18.0	44.0	322	6.44	7.33
Group Therapies	12.0	2.0	2.0	0.0	4.0	6.0	2.0	2.0	16.0	54.0	346	6.92	7.69
Marriage and Family therapies	22.0	8.0	2.0	2.0	2.0	4.0	8.0	6.0	14.0	32.0	268	5.36	6.69
AA 12 Steps	6.0	0.0	0.0	2.0	0.0	0.0	2.0	4.0	12.0	74.0	404	8.08	8.57
Relapse Prevention	6.0	20.0	8.0	4.0	2.0	0.0	4.0	6.0	14.0	36.0	279	5.58	7.61
Peer Recovery Couch	20.0	8.0	0.0	0.0	2.0	4.0	4.0	2.0	12.0	48.0	301	6.02	7.53
Family Support System	14.0	0.0	0.0	0.0	4.0	14.0	4.0	4.0	12.0	48.0	333	6.66	7.56
Peer Support System	36.0	6.0	0.0	2.0	2.0	8.0	4.0	6.0	8.0	28.0	221	4.42	6.66
After Care Follow Ups	38.0	8.0	4.0	0.0	0.0	2.0	4.0	6.0	6.0	32.0	214	4.28	6.90
Livelihood Support	52.0	14.0	0.0	0.0	0.0	2.0	0.0	2.0	4.0	26.0	152	3.04	6.00

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AA and NA Groups	36.0	18.0	0.0	4.0	0.0	8.0	4.0	8.0	4.0	18.0	172	3.44	5.24
Community Involvement	12.0	14.0	6.0	0.0	10.0	10.0	10.0	12.0	0.0	26.0	247	4.94	5.43
Total											5,142	5.71	7.04

The highly rated program activity was the AA steps offered during the weekend program at 74% (M1=8.08, M2=8.57) and the weekend engagement at 70% (M1=7.88, M2=8.19). These were core program activities with only 6% of respondents who failed to rate them. The least rated program activities were Livelihood Support with 52% (M1=3.04, M2=6.00) failing to rate the program. Followed by AA and NA Groups with 36% non-response (M1=3.44, M2=5.24). The mean score for the program was M1=5.71, M2=7.04 out of the 9 expected scores

4.3. Functioning Before Rehabilitation

4.3.1. Different Aspects of Functioning Before Rehabilitation

Level of functioning before rehabilitation was evaluated based on levels of denial, control, perceived risk factors in terms of psychosocial problems that motivated drugs use, physical problems, self-neglect and risky behaviors, self-esteem and worth and quality of life as individual family and community. Respondents rated their functioning in a scale of five scores from strongly agree to strongly disagree based on statements that affirmed malfunctioning. Results are presented in Table 5 below.

Table 5: **Level of Functioning Before Rehabilitation**

		Rating Frequency (%)						
Aspect of Functioning	Cases	Strongly Disagree	Somehow Disagree	Not Sure	Somehow Agree	Strongly Agree	Mean	SD
Strongly Resisted rehabilitation	50	50.0	20.0	4.0	.0	26.0	2.32	1.68
Tried to stop unsuccessfully	50	78.0	12.0	2.0	6.0	2.0	1.42	.95
Had many problems that motivated drugs use	49	77.6	10.2	2.0	4.1	6.1	1.51	1.34
My problem with drugs was serious	49	71.4	12.2	0.0	6.1	10.2	1.71	1.35
My physical health was seriously at risk	49	67.3	16.3	8.2	2.0	6.1	1.63	1.13
Self-neglect and risk-taking behaviors	48	72.9	14.6	2.1	6.3	4.2	1.54	1.09

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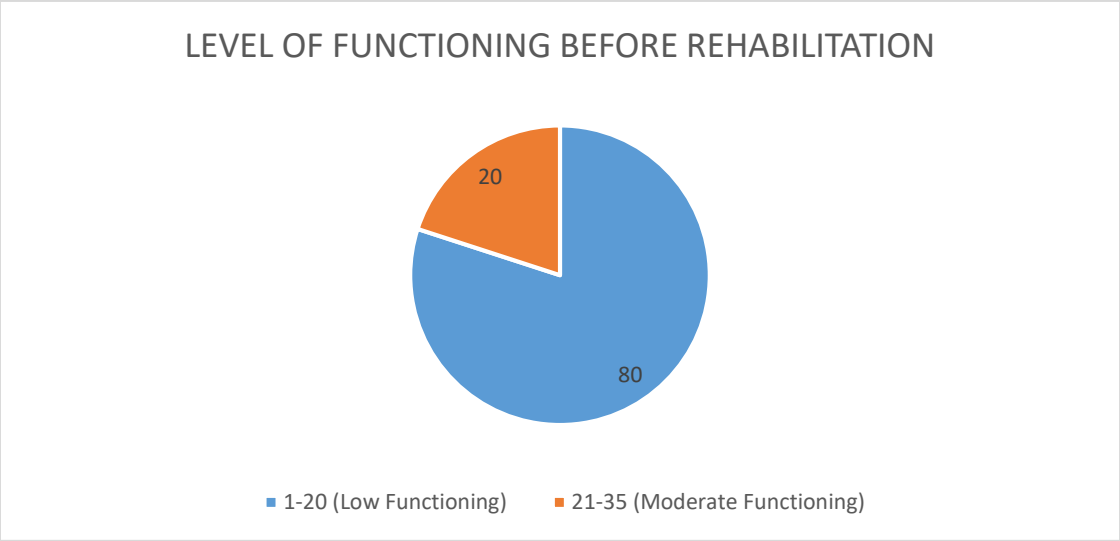
Had Extremely low Self-Esteem and worth	48	79.2%	8.3%	0.0%	4.2%	8.3%	1.54	1.23
Was disrespected and shamed by family and community	48	72.9%	14.6%	4.2%	4.2%	4.2%	1.52	1.05

Before rehabilitation respondents were low in all aspects of functioning. The most cited aspect of malfunctioning was low self-esteem and worth with 79.2% (M=1.54), then inability to stop taking the drug of choice (loss of control to drugs) at 78% (M=1.42) and having many problems that motivated drugs use at 77.6% (M=1.51). Resisting idea of rehabilitation was lowest, cited by 50% of respondents (M=2.32).

4.3.2. Overall Functioning Before Rehabilitation.

The total scores for various aspects of functioning were calculated. They were analyzed into three levels of functioning Low Level (1-20), Moderate (21-35) and High functioning (36-45). Figure1 below summarized the findings

Figure 1: ***Level of Functioning Before Rehabilitation.***



The study observed that 80% of respondents operated at low functioning before rehabilitation. Only 20% operated at moderate level.

4.4. Functioning after Rehabilitation

Level of functioning after rehabilitation was assessed through acceptance decision to change, motivation to change, commitment to recovery process, psychosocial health, relapse awareness and control, maintain sobriety, physical health, self-care, quality of live as individual, family and community, self-esteem and worth, awareness on addiction and recovery and positive view of life

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and trust in the program. Fourteen items were rated on a scale of 5 points from strongly disagree to strongly agree. The data was analyzed in terms of frequency and mean score. Results are summarized in Table5 below.

Table 6: **Functioning after Rehabilitation**

	Rating Frequency (%)							
Aspect of Functioning	Missing	Strongly Disagree	Somehow Disagree	Not Sure	Somehow Agree	Strongly Agree	Total	Mean
Acceptance And choice to be sober from drugs	2.0	4.0	4.0	0.0	20.0	70.0	221.0	4.42
Challenged and motivated to voluntarily change	4.0	4.0	2.0	0.0	4.0	86.0	227.0	4.54
Motivation and Commitment to recovery process	4.0	4.0	6.0	2.0	6.0	78.0	218.0	4.36
Psychosocial problems significantly reduced	4.0	6.0	4.0	4.0	26.0	56.0	205.0	4.10
Relapse awareness and Control	4.0	10.0	6.0	18.0	16.0	46.0	185.0	3.70
Confidence is back to sobriety after relapse	2.0	8.0	4.0	10.0	18.0	56.0	199.0	3.98
Drugs abuse is no longer a serious risk	8.0	10.0	6.0	6.0	12.0	58.0	189.0	3.78
Improved in physical health	4.0	0.0	4.0	8.0	18.0	66.0	189.0	3.78
Have regained in Self-care	4.0	6.0	6.0	2.0	14.0	68.0	210.0	4.20
Satisfying quality of life in family and community	4.0	0.0	4.0	10.0	24.0	58.0	210.0	4.20
Have improved in confidence resilience and skillfulness	4.0	6.0	2.0	4.0	18.0	66.0	212.0	4.24
Have clear Knowledge on addiction and recovery	4.0	6.0	0.0	0.0	8.0	82.0	224.0	4.48
Positive change in general view of life	4.0	0.0	0.0	0.0	14.0	78.0	225.0	4.50

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(Individual, family and community)								
Trust on the program on support to recovery	4.0	6.0	0.0	0.0	12.0	78.0	222.0	4.44

Most of the respondents acknowledged highest improvement in motivation to change at 86% (M=4.54) and knowledge on addiction and recovery at 82% (M=4.48). Other aspects of functioning that recorded majority of respondents at the highest score were commitment to recovery process (M=4.36), Change in view of life (M4.50) and trust in the recovery process (M=4.44) all with 78% and acceptance to change (M4.42) with 70%. Awareness on relapse and control (M=3.70) had the least percentage of respondents acknowledging highest score with 46%.

4.5. Effectiveness of the program

Effectiveness of the program was evaluated through dynamics of relapse, respondents' level of functioning after rehabilitation and respondents' perception on effectiveness of perception. Later, one way ANOVA was be used to assess the mean difference of functioning of respondents before and after rehabilitation to determine whether the changes in client's functioning was significant or due to chance.

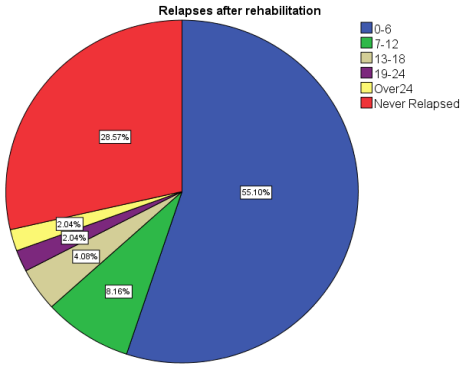
4.5.1 Relapse dynamics among respondents

In view of effectiveness of the program relapse dynamics were assessed in three dimensions. These are respondents reported their experience with relapse, duration of time taken to regain control after relapse and confidence that they were sober after relapse.

4.5.1.2. Experience with Relapse

Respondents reported whether they relapsed at different periods after graduating from the 13 weeks rehabilitation engagement. The periods ranged from 1-6 months, 7-12 months, 12-18 months, 19-24 months, after 24 months or never relapsed. Results are summarized in figure 2 below.

Figure 2: ***Relapse after Rehabilitation***



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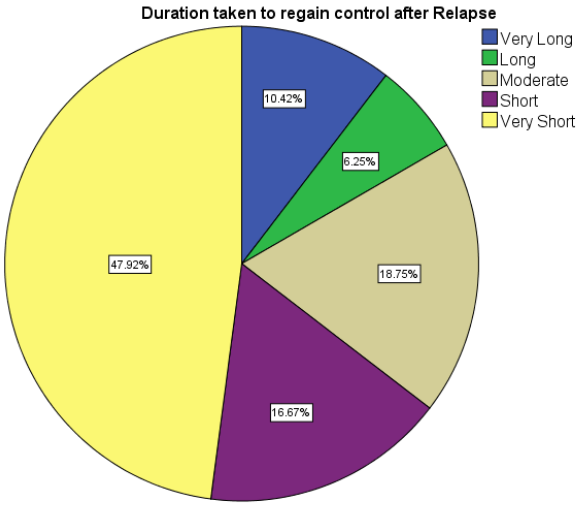
Among the respondents 55% reported that they relapsed in the first 6 months. On the other hand, 28.57% had never relapsed. Only 2.04% of respondents relapsed after remaining dry for more than 24 months.

4.5.1.2. Duration to Regaining Control after Relapse

To support the results on effectiveness of the program based on dynamics of relapses the speed at which the respondents reacted to their relapses was assessed. The duration ranged between Very Short, Short, Moderate, Long, Very Long. Very short period in relapse would reflect effectiveness of the program despite the relapse. Results are presented in the Figure 3 below;

Figure 3: ***Duration Taken to Regain Control***



After relapsing, 47.92% of respondents reported they took very short period to regain control and return to sobriety. In addition, 18.67% took a short period of time. Only 10.42% took a very long duration to regain control.

4.5.1.3. Confidence have Sobered despite Relapse

Extent to which respondents were confident of their sobriety state despite relapse in their journey to recovery after rehabilitation was assessed. The level of confidence was categorized into a five-level scale being Very Low Confidence, Low Confidence, Confident, Highly Confident and Very Highly Confident. Results were summarized in Figure 4 in the next page.

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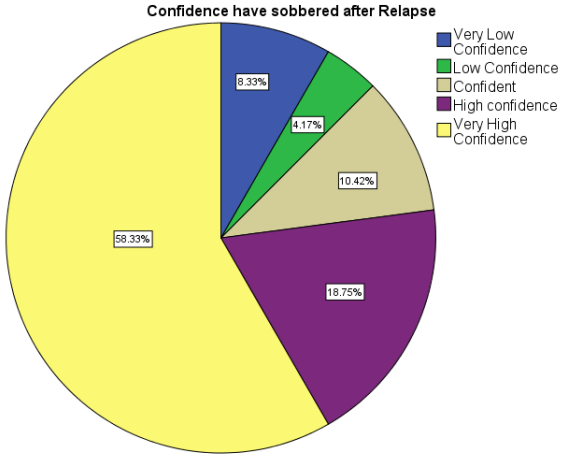
Figure 4: ***Confidence have sobered after Relapse***

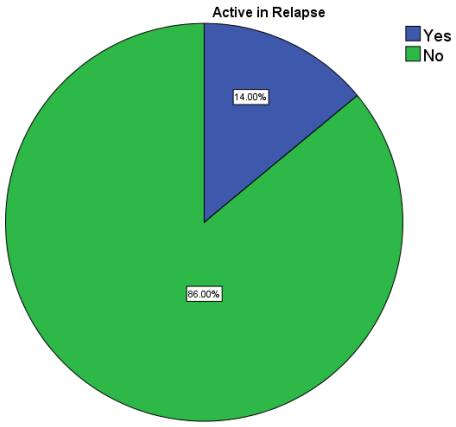


Among the respondents 58.33% reported that they had regained very high confidence in sobriety even after relapsing. In addition, 18.75% had high confidence. Only 8.33% of respondents had very low in confidence they had sobered.

4.5.1.4. Relapse Status

Participants indicated whether they were still active in relapse or not. The objective was to identify the rate of relapse as at the time of data collection. Long term reduction of relapse experiences can be a good measure of a community-based program effectiveness. Results were presented in the Figure 5 below.

Figure 5: ***Active in Relapse***



By the time of data collection 86% of respondents were abstinent from drug of choice. Only 14% were active in relapse.

4.5.2. Client Perspective on Total program effectiveness

The total score for effectiveness of all program activities was calculated and mean score generated depicting respondents' perspective of program effectiveness. Analysis was based on two

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assumptions. Assumption 1 stated that clients were to benefit from all the program activities where the mean was based on all the respondents. That I, all respondents were to engage in all the program activities. Assumption 2 stated that community-based recovery program is client centered hence the mean was based on actual number of program activities each respondent interacted with. This was based on the assumption that respondents consciously chose to engage in programs that met their needs. The mean scores were analyzed into five levels of effectiveness 1.00-1.80 (Very Low Effectiveness), 1.81-3.60 (Low Effectiveness), 3.61-5.40 (Moderate Effectiveness), 5.41-7.20 (High Effectiveness) and 7.21-9.00 (Very High Effectiveness). Results were presented in the Figure 6 and Figure 7 below.

Figure 6: ***Respondents View on Program Total Effectiveness (Assumption 1)***

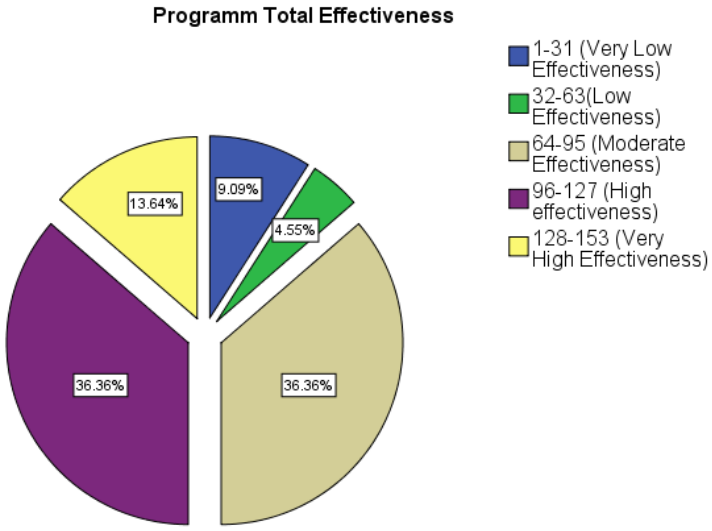
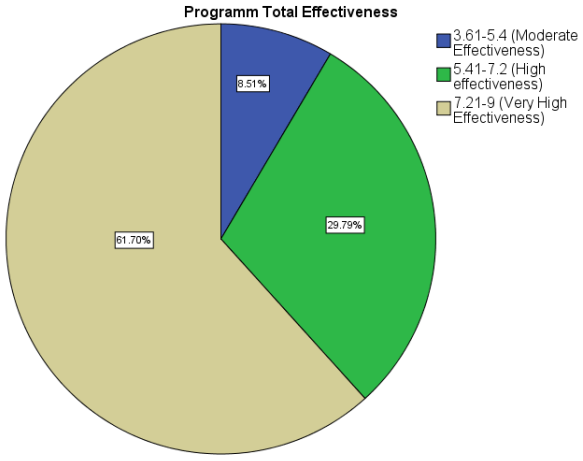


Figure 7: ***Respondents View on Program Total Effectiveness (Assumption 2)***



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Results based on assumption 1 had 36.36% of respondents at highly effective and 13.64% as very highly effective, with 9.09% at Very Low Effectiveness. On the basis of assumption 2, majority of respondents (67.70%) rated the program as very highly effective. In addition, 29.79% gave it a rating of high effectiveness with no single respondent below moderate effectiveness.

4.5.3. Improvement in Functioning

The comparison between the levels of functioning before and after rehabilitation was guided by the hypothesis:

Ho: There was no means difference between respondents' levels of functioning before and after rehabilitation.

One way Analysis of Variance was used to compare the means and therefore determine whether there was a significant mean difference in functioning before and after rehabilitation. Results were summarized in Table 7 below.

Table 7: **Mean difference between functioning before and after Treatment (ANOVA Results)**

ANOVA

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	2.421	2	1.211	10.198	.000
Within Groups	5.579	47	.119		
Total	8.000	49			

One way ANOVA analysis indicated there was a significant mean difference between Level of functioning before and after rehabilitation $F(2,47)=10.198$, $p=.000$ at $p<0,05$. The null hypothesis was rejected meaning the mean difference between levels of functioning before and after rehabilitation was not by chance. The rehabilitation process was therefore effective in improving effective functioning of respondents.

4.6 Qualitative Data Analysis

4.6.1 Findings from People in Recovery's Focus Group Discussion

4.6.1.1 Recovery Experiences in St. Martin CSA

Participants undergoing rehabilitation through St. Martin CSA's program reported significant life improvements, including financial control, self-efficacy, spiritual growth, self-awareness, relationship-building, self-respect, and physical recovery. These outcomes align with Kim et al. (2016), argument that financial control and self-efficacy are essential components of successful recovery. They also regained societal trust, restored employment opportunities, and achieved professional growth, reflecting Bandura's theory of self-efficacy, which links belief in one's capabilities to resilience and goal achievement. Spiritual growth emerged as a key factor, with

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participants attributing their recovery to newfound faith and engagement in religious activities, consistent with Galanter et al. (2007) and the AA 12-step model emphasizing spirituality in recovery.

Respondents reported improved self-awareness, self-esteem, emotional control, and better social relationships. Participants noted changes such as reconnecting with friends and family and making new, reliable connections, reinforcing findings by Waller et al. (2018) on the role of self-awareness in recovery and Moos and Moos (2006) on the importance of social support. Additionally, participants experienced mental and physical health improvements, overcoming depression and regaining physical functionality, which one participant described as "*living again*." These findings echo Witkiewitz et al. (2019), who link physical and mental health to sustained sobriety. Participants also reported regaining respect from family and community, emphasizing the holistic recovery process that aligns with the disease model's promotion of personal dignity and societal reintegration (White, 2007).

4.6.1.2 Lessons learnt on addiction and recovery

The experiences shared by individuals recovering through St. Martin CSA's Intensive Outpatient Program (IOP) highlighted the enslaving nature of addiction, characterized by the inability to self-manage due to loss of control over substance use. As a result, participants acknowledged that addiction serves as a gateway to social, psychological, and physical issues, that escalate the problem. Issues mentioned included domestic violence, unemployment, and depression, agreeing with Njeri et al. (2021) who observed that addiction negatively affects family cohesion, economic stability, and mental wellness. Further, participants observed that addiction drove them into cycles of loss and despair; including loss of family relationships, finances, employment, and life opportunities, agreeing with Kimani et al., (2020), who linked addiction to high rates of family breakdown, poverty, and unemployment. Based on responses given, people in recovery expressed a sense of shared struggle, indicating that addiction is often uniform across individuals as postulated by the biopsychosocial and disease theories of addiction.

A participant described their recovery experience under the St Martin CSA's program as being given "a second chance". This meant that addiction rehabilitation services offered provided them with opportunities to rebuild their lives as proposed by Johnson et al. (2021), who asserted that recovery is not merely the cessation of substance use but a reintegration of individuals into society with dignity and purpose. A respondent observed that "*change is possible with a positive mind*", underscoring the importance of self-efficacy and optimism in recovery. Orford et al. (2010), opined that positive psychology fosters resilience and motivation in recovery, which is associated with long-term abstinence from substances of choice. In addition, they noted that regaining respect and trust from their families and community in general through improved personal responsibility and accountability was both a motivating factor and an outcome of the rehabilitation process.

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4.6.1.3 Respondents' experience with IOP

The findings from individuals participating in the 13-week Intensive Outpatient Program (IOP) underscored its accessibility, practicality and adaptability in fostering recovery, particularly for the vulnerable, those managing work, family, and social responsibilities. All respondents concurred that the free nature of St. Martin rehabilitation accorded them a chance to "live again". They reported that during their active addiction life they depended on caregivers and 8 out of 11 earned less than 3500 Kenya Shillings per month which they used on drugs. Participants appreciated the program's flexibility, which allowed them to address personal affairs while engaging in rehabilitation, contrasting it with inpatient programs often perceived as restrictive and akin to imprisonment. They reported that the outpatient format reinforced personal agency and decision-making, enabling them to practically apply learned skills during the week and test their resilience against temptations, particularly on weekends. This aligns with findings by Witkiewitz et al. (2019), who highlighted the importance of integrating recovery strategies into real-life settings to build sustainable sobriety. The participants' accounts also suggest that IOP's structured yet flexible approach supports a gradual hardening against triggers and cravings, contrasting with the abrupt post-release challenges faced after inpatient programs, as noted by Johnson et al. (2021).

Recovery from home posed unique challenges, particularly temptations from friends and family, which required conscious effort and avoidance strategies. Participants emphasized the importance of maintaining personal boundaries and practicing proactive behaviors to mitigate risks, resonating with Njeri et al. (2021), who identified social and environmental factors as critical relapse triggers. They also highlighted the value of engaging in meaningful activities, such as revisiting farm work or constructive hobbies, to avoid idleness, which aligns with Moos and Moos (2006) on the role of structured routines in maintaining sobriety. The participants also noted the benefit of connecting with others struggling with addiction, emphasizing selective engagement with those genuinely interested in recovery, echoing the importance of peer support highlighted by White and Evans (2020). These findings reinforce the value of the intensive outpatient program in promoting practical, sustainable recovery through a balance of autonomy, structured support, and community engagement.

4.6.1.4 Strengths and Weaknesses of the St. Martin CSA Addiction Treatment Approach

Respondents to the study identified the 13-week Intensive Outpatient Program (IOP) and weekly Alcoholics Anonymous (AA) meetings as the key activities responsible for their recovery. The IOP provided structured information, counseling, and emotional support, forming the foundation for their recovery. This program helped them to address the psychosocial complexities of addiction and offered tailored interventions to meet individual needs. The weekly AA meetings further supported recovery by creating a space for shared experiences, mutual encouragement, and relapse prevention. Kelly et al., (2011) observed that AA fosters accountability, emotional expression, and a sense of belonging, which are vital for sustained recovery. The combination of addressing underlying psychosocial drivers of addiction, and peer-led support mirrors a comprehensive care that Njeri et al. (2021) said has a positive impact on attaining long-term recovery.

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The St. Martin approach demonstrates significant strengths, particularly in addressing the needs of vulnerable populations and raising awareness about addiction. Respondents expressed gratitude for receiving care they otherwise could not afford, reflecting the program's commitment to equitable access. White (2009), postulated that community-based models are essential in addressing addiction within socioeconomically disadvantaged groups. Additionally, respondents noted that raising awareness about addiction through psychoeducation helped people in active addiction to recognize the severity of their condition and the necessity of treatment. Addiction treatment literature underlines the importance of fostering self-awareness and intrinsic motivation in promoting behavioral change, which is a core principle evident in St. Martin's addiction treatment approach. By combining accessibility with education, the program empowers individuals to take proactive steps toward recovery.

Respondents reported that St Martin CSA's program faces challenges in offering adequate aftercare services, peer support, and livelihood support. Minimal follow-up after program graduation has left clients feeling unsupported, risking relapse. Kelly et al., (2011) underscored the critical role of continued care and structured follow-ups in sustaining recovery. Similarly, the lack of a structured peer support interventions reduces effectiveness of peer support. Respondents proposed leveraging on cost effective alternatives to physical meeting like introduction of WhatsApp groups and delocalizing AA meetings to improve connectivity and peer led support. Livelihood support was perceived as inconsistent and selective, further exacerbates respondents' dissatisfaction with the program. Transparent criteria for resource allocation and vocational support could address these concerns. The disconnect between client expectations and project objectives, as noted by clients, suggests a need for deliberate realignment to enhance the program's credibility and outcomes.

4.6.1.5 Rating of St Martin CSA Addiction Treatment Interventions

The respondents' ratings of the St. Martin CSA program indicate a general consensus of moderate to high satisfaction. Scores ranged from 5 to 9, with six respondents rating the program as either a 5 or 6. This distribution suggests that while many respondents value the program's effectiveness, there is room for improvement to achieve higher ratings. The single rating of 9 reflects an outlier of extreme satisfaction, likely indicative of a respondent who experienced substantial benefits from the program. These findings align with research by McLellan et al. (2000), which emphasizes that clients' perceived value of addiction programs is often tied to program comprehensiveness and the consistency of outcomes.

The respondents' scaling of the St. Martin CSA addiction treatment approach shows a more critical evaluation. Ten (10) respondents rated the approach between 2 and 5, with only one respondent giving an 8. This distribution highlights a perception that, while the approach has merit, significant gaps exist in its implementation. Ratings clustered around 2 and 3 (5 out of 11 respondents) suggest dissatisfaction with certain aspects, potentially related to the lack of structured follow-up,

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inconsistent sponsor engagement, and limited vocational support. These findings are consistent with Kelly et al. (2011), who observed that recovery-oriented systems are most effective when they provide robust aftercare and empower individuals through structured, continuous support. The relatively low scores for the approach indicate a need to align program design more closely with client expectations, improve accessibility, and ensure more consistent support mechanisms.

Respondents suggested areas for improvement to enhance the program's effectiveness. These included expanding aftercare programs and structuring interventions around peer support. Research by White (2009) underscores the importance of scaling community-based models to improve access for marginalized groups. Enriching outreach programs and empowering beneficiaries to form support groups aligns with evidence that peer-led networks significantly enhance recovery outcomes (Njeri et al., 2021). Mechanisms for boosting follow-ups, such as regular check-ins, digital platforms, and community group facilitation, would address a major weakness identified by respondents and align with McKay et al.'s (2009) emphasis on ongoing care. Lastly, providing reading materials to support groups could foster continuous learning and engagement, reinforcing psychoeducation as a critical component of recovery.

4.6.2 Volunteers, Peer Supporters and Caregivers

4.6.2.1 Preparedness of caregivers to take up their role in addiction rehabilitation

Data collected on the preparedness of caregivers, peer supporters, and volunteers to effectively fulfill their roles in addiction rehabilitation reveals both strengths and challenges. The data highlighted variations in preparedness across these groups.

Caregivers reported moderate to high preparedness for their roles. They reported that training, assessments, and home visits that were facilitated by St. Martin CSA staff adequately prepared them to undertake their roles in supporting people in recovery. Eleven (11) out of 12 respondents confirmed receiving training, which equipped them with skills that enabled them to respectfully and effectively engage and offer care and support to people in recovery under their care. A male respondent observed "*I have two people under my care who are recovering from alcoholism; … at the beginning, I used to use violence to compel compliance despite knowing that this was not the right way to handle adults. …. After attending the training, I learned how to handle them and with time we were able to engage like adults*." A female respondent observed that the "*questions they (St Martin staff) ask during their first visit (assessment) helped me to understand addiction and kind of care I should give to my son who was deeply in addiction…and as a result, I was helpful to him. Before then I thought he was drinking to hurt my feelings."*

However, four respondents noted that the training came too late; that is after clients under their care had completed intensive outpatient rehabilitation, 13-week program. This delay limited their ability to effectively support clients during the early stages of recovery, a critical period when

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relapse risks are high (McLellan et al., 2000). Continuous learning through home visits was also appreciated, as it allowed caregivers to address challenges collaboratively with professionals, yet some found it challenging to implement advice due to the complexity of addiction dynamics. A male respondent shared that "*when they (St Martin staff) visit us at home, they check on the progress of both the recoveree and the caregiver. When we face difficulties, we seek ways of solving them and the solutions given help us to give better care and support. In most cases the advice we are given works but at times it is hard to implement or even if you try it does not work.*" Overall, these findings underscore the importance of timely and sustained caregiver support, as highlighted by Orford et al. (2010), who found that family involvement is critical for recovery but requires substantial guidance to address the emotional and practical demands of the caregiving role.

Volunteers expressed moderate preparedness for their roles, as evidenced by self-reported ratings on a scale of 1 to 5. Most rated their preparedness as moderate (scores of 3 and 4), highlighting a need for more comprehensive training, particularly in mental health. Volunteers, currently receive two to three days of training every two to three months, which equips them with knowledge and skills to recruit clients, support relapse prevention, and engage communities in tackling substance abuse challenges. Despite this, gaps remain, particularly in addressing the complex mental health needs of people in recovery, which are often intertwined with substance use disorders. This finding aligns with the work of Samhsa (2015), who stresses the need for integrated mental health and substance use training for community-based stakeholders to enhance recovery outcomes. Overall, the data indicates that while caregivers, peer supporters, and volunteers play pivotal roles in addiction rehabilitation, their preparedness is uneven and could be improved with more timely, structured, and comprehensive training. These findings align with the broader literature on addiction recovery, which emphasizes on the importance of equipping stakeholders with the skills, knowledge, and support necessary to foster sustained recovery (White & Kurtz, 2006). By addressing identified gaps in training and support.

Peer supporters exhibited varied levels of preparedness, closely tied to their duration of involvement in the program. Long-serving peer supporters (over nine years) reported feeling well-prepared due to structured training and participation in Alcoholics Anonymous (AA) meetings, which provided knowledge on addiction dynamics, relapse prevention, and communication strategies. In contrast, newer peer supporters (less than six years in the program) felt inadequately prepared, reflecting the program's recent lack of structured training. The value of mutual support and shared experiences in fostering recovery preparedness agrees with the findings of Best et al. (2016), who emphasize the role of peer support in creating a sense of belonging, enhancing self-efficacy, and promoting shared learning. A male respondent who has been in the program for the last 11 years reported that *…I was helped by my peer supporter and I learned a lot from him and the frequent training we received on peer support. Continuous learning on relapse prevention and communicating with peers is critical to ensuring meaningful peer support.*" Peer supporters also

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highlighted the instrumental role of AA participation in building skills for effective support, mirroring findings by Kelly and Yeterian (2012) on the therapeutic impact of mutual-help organizations.

4.6.2.2 Continuous support given by St Martin to the Key Stakeholders

The findings of this study revealed that caregivers benefit from a combination of training, regular follow-ups, and home visits. Training sessions equip caregivers with essential skills and knowledge for supporting people in recovery, while reminders of self-care and caregiving techniques enhance their capacity to handle the emotional and practical demands of their roles. Regular check-ins through phone follow-ups and staff and volunteer home visits provide opportunities to address emerging issues, offer encouragement, and share guidance. Further, mental health follow-ups help caregivers manage their well-being while improving their ability to support those under their care. This agreed with findings that caregiver education significantly improves rehabilitation outcomes in addiction recovery (Delaney et al., 2022). A female respondent noted that *"... the more I come for training the more I improve on how I handle and interact with my husband who is in active use of alcohol. This has reduced conflicts ... and of late we are at peace with each other and his frequency and extent of drinking has reduced significantly*." Another female respondent added that "after *receiving support, I can confidently share my experiences in supporting my son who is in active use, previously I could not because I feared people would laugh at me, it means am healed*". These practices concur with findings by Orford et al. (2010), who underscore the importance of continuous family involvement and professional support in addiction recovery. Similarly, Oteyo & Kariuki, 2019 found that caregiver training and follow-up visits can reduce stigma and improve recovery outcomes by enhancing the caregiver's understanding of addiction and fostering a supportive home environment.

Peer supporters reported that they receive continuous support through weekly Alcoholics Anonymous (AA) meetings, which foster mutual learning and accountability. However, they observed that this was inadequate in sharpening their skills and addressing their constant need for updates, knowledge, and debriefing. The provision of coffee during meetings was reported to create a welcoming and supportive atmosphere, while opportunities to share personal experiences during awareness creation sessions challenge them to maintain sobriety. St Martin further supports peer supporters by handling referrals, ensuring access to psychiatric medication for those who cannot afford it, and providing livelihood support and school fees for recoverees under their care. Continued support offered coupled with the obligation bestowed on all participants of AA meetings to be their brothers' keepers serve as motivators for peer supporters to remain committed to their roles and sobriety. Globally, studies such as those by Best et al. (2016) have highlighted the value of peer support in fostering a sense of belonging, reducing isolation, and promoting recovery.

Volunteers receive continuous training on various aspects of addiction rehabilitation, including drug education, mental health disorders, referral systems, communication, and counseling. These

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trainings prepare volunteers to identify and address mental health and substance use challenges, conduct beneficiary assessments, and mobilize communities to support recovery efforts. In addition to training, volunteers actively participate in awareness creation through church events and radio campaigns, which educate the public on mental health and addiction as treatable conditions. SAMHSA (2015), underlines the importance of community-based education and mobilization in reducing stigma and fostering collective support for recovery. Owino et al., (2020) further observed that volunteers bridge the gap between professional services and the community, particularly in rural areas where access to mental health and addiction services is limited.

4.6.2.3 Roles and benefits of involving key stakeholders in the rehabilitation process

The findings of this study demonstrate the substantial benefits of involving caregivers, peer supporters, volunteers, and the community in addiction rehabilitation. These roles, individually and collectively, create a robust support system that fosters recovery, reduces stigma, and promotes resilience.

Caregivers play an essential role in addiction recovery by creating a nurturing environment that fosters emotional and practical support. The study revealed that training and counseling provided by St. Martin CSA empower caregivers with effective communication skills and caregiving techniques, which help reduce stress and shame among individuals in recovery. A female respondent noted that as caregivers understand and support their loved ones, they create peace for both parties, reducing stress and shame, which enhances recovery outcomes for the entire family. A respondent reported that "*We become part of their recovery, and we also heal since the stress and shame they take us through make us use harsh and abusive language… This creates an environment for them to think about their lives and change their ways*." This aligns with findings by Oteyo and Kariuki (2019) that family engagement in rehabilitation programs promotes a better understanding of addiction and creates a supportive home environment that aids recovery. Similarly, McLellan et al. (2000) underscores the central role of families in sustaining long-term recovery by providing love, concern, and appreciation.

Respondents reported that peer supporters offer a unique and effective dimension to recovery by leveraging shared experiences to inspire hope, provide practical strategies, and foster accountability. The study found that peer supporters act as role models, strengthening their recovery while positively impacting others. A male respondent observed that "*The person who understands the pain, what it takes, and what an addict goes through is a fellow recovering addict*." Another respondent added, "*When you support a person towards recovery, you also gain because you learn how to avoid triggers*." This mutual exchange of knowledge and skills aligns with findings by Kelly et al. (2020), which emphasize that peer networks reduce relapse risks by fostering accountability and providing practical tools for recovery. In addition, it provides emotional reinforcement that strengthens resolve and fosters resilience. A middle-aged respondent noted, "*Alcoholics are weak against alcohol, and when they fight this battle together, they remain strong*." Similarly, a female respondent shared, "*Seeing positive change in others makes me feel*

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better. I feel I am not alone in this journey. This gives strength to avoid triggers." Therefore, social support is a critical predictor of sustained sobriety, as it alleviates feelings of isolation and reinforces motivation to stay sober. These findings agreed with Best et al. (2016) argument that the therapeutic value of peer support fosters a sense of belonging, reducing isolation, and reinforcing sobriety. Owino et al. (2020) opined that peer-led support systems are effective in promoting sustained recovery.

Volunteers contribute significantly to recovery by providing hands-on support, offering guidance on relapse prevention, and creating awareness about addiction and mental health challenges. The study highlights their role in fostering a culture of care and collaboration, ensuring individuals feel valued and respected. These findings agree with Owino et al. (2020) observation that volunteers play a crucial role in bridging gaps in addiction and mental health services, in areas with limited access to professional support. White and Kurtz (2006) argued that recovery is most successful when supported by a community that provides acceptance, encouragement, and a sense of belonging. This study identified that the local community supports volunteers in identifying individuals who need support, providing resources, referring people in addiction to volunteers, and promoting recovery. This contributes to reducing stigma and fostering a shared responsibility for recovery. According to Njeri et al., 2021, community-based programs are instrumental in addressing the stigma associated with addiction and promoting access to care.

4.6.2.4 Effectiveness of communication with volunteers

The findings indicate that the communication and feedback mechanisms between St. Martin CSA and the community volunteers have generally been effective, especially through phone calls, with timely responses, efficient booking, and prompt assessments. When asked to rate the system on a scale of 1 to 5, 12 out of 14 respondents gave it a score of 3, while 2 respondents rated it a 4. However, volunteers observed a decline in effectiveness over the past few years, citing delays in feedback, particularly during beneficiary assessments and support solicited by community volunteers. They noted that previously, staff responded promptly to the outcomes of assessments and support requested by volunteers. The programme staff noted that they are understaffed and they lack adequate expertise in terms of training and experience in the field of addiction and mental health and thus delays in responding to the needs of volunteers and beneficiaries. This points a gap in implementation and monitoring of the approach and project implementation that may influence outcomes negatively. Smith et al. (2021), in his study on Volunteering and Communication in Non-Profit Organizations, emphasized on the importance of efficient communication channels in fostering community trust and volunteer engagement. Smith et al. further noted that delays in response time can undermine volunteers' morale and reduce the outreach programs' overall effectiveness, suggesting the need for St Martin to avoid such an occurrence.

4.6.2.5 Stakeholders' feedback on projects' effectiveness

The findings of this study highlighted key aspects in the current project that volunteers would like retained, changed, and addressed to improve its effectiveness in achieving expected outcomes.

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Volunteers valued retreats and training for capacity building, staff support during recovery process, home visits for motivation, and tools tokens such as badges and certificates for proper identification. They suggested forming volunteers' support groups for mutual support.

Volunteers would wish to see changes such as eliminating the responsibility of personally financing hospital visits and other beneficiaries needs that require finances. In their view, this puts undue pressure on them especially when staff, family and community members negate their responsibility in resource mobilization. They would also like their roles to be clearly defined since addiction and mental health treatment is a highly specialized field and they lack adequate technical capacity to handle some of the responsibilities they are expected to handle.

The missing links identified by volunteers that include the need for aftercare services for people recovering from addiction and mental illness to hasten healing and mitigate stigma, better preparation for caregivers to support recovery, enhancement of livelihood support as a measure towards relapse prevention, and introduction of halfway houses to manage community criticism. Additionally, volunteers face challenges such as inadequate field support from program staff, lack of effective means of transport, financial constraints, breach of confidentiality, lack of volunteer mapping, unfulfilled promises to beneficiaries, safety risks, and limited collaboration with stakeholders. Brown et al. (2022), in his study on Volunteer Engagement in Community Projects stressed on the importance of clear role definitions, resource allocation, and stakeholder collaboration as critical motivation factors for volunteers and project success. The study also emphasizes the need for structured aftercare and community sensitization to reduce stigma and enhance sustainability.

Peer supporters valued and suggest areas for improvement to enhance program effectiveness in addiction rehabilitation. They reported that treating people with love, respect, and dignity remains a cornerstone of the program and a strong motivating factor for people in addiction to seek help, and for peer supporters to offer their services. Peer supporters emphasized on retaining training and seminars for people in recovery, strengthening and decentralization of AA meetings by introducing AA meetings in areas nearer to beneficiaries and organizing periodic meetups between decentralized AA groups, as well as engaging experienced and well trained AA members or experts for trainings and seminars to make AA meetings more therapeutic, livelihood support to boost relapse prevention and hope for recovery, and introduction and strengthening of support groups for people in recovery that promote learning and personal growth. They also valued awareness creation by sharing experiences, supporting people in addiction to retain their jobs while reducing workplace stigma, and continuing to help individuals with mental illnesses access medication.

Areas of improvement suggested by people in recovery included reintroducing outpatient rehabilitation and availing professional addiction counselors for aftercare support services. They

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noted that even after being in recovery for long, they face crises that may trigger relapse and hence the need to have addiction counselors who understand their pains and risks to support them during such moments. They observed that outpatient rehabilitation should serve as the entry point for Intensive Outpatient Treatment Program, this would ensure that people in active addiction engage counselors who are recoverees for relatable guidance and strengthening. Further they suggested, offering more training to peer supporters, addressing relapse through follow-ups and readmissions of people in recovery who relapse, and training family members to prevent relapse triggers. Their observations agreed with White and Evans (2020), who underscored the importance of peer-led initiatives, structured aftercare services, and the inclusion of family education in reducing relapse rates and promoting long-term recovery. Suggested areas of improvement were mainly linked to introduction of clients to the program and offering aftercare service. These suggested weaknesses in the two areas; that is introducing people in active addiction to IOP, as well as explain the peer supporters' observation that St Martin CSA is currently serving a small number of people in addiction, since some cases that would have been handled effectively in outpatient treatment are pended awaiting to join IOP. They also noted that being introduced to recovery by a person who had undergone the same experiences sets a rich ground for long term recovery.

Caregivers highlighted aspects of the program that should remain unchanged, areas requiring modification, and suggestions for improvement to make the initiative more effective in supporting recovery. Participants emphasized retaining outpatient rehabilitation (IOP), the treatment of mental illness, and the provision of expensive but vital mental illness drugs, which ensure sustained recovery for individuals. They also supported the continuation of reaching out to others facing similar challenges. However, there were differing opinions on modifying the structure of IOP. Some felt it should run continuously for at least a month in confinement to strengthen recovery, while others appreciated the weekend model, as it allows participants to apply lessons in real-life settings and overcome triggers, fostering gradual change.

Areas of improvement proposed by caregivers included organizing regular meetings for recoverees to strengthen and support one another, offering equitable livelihood support to address financial stress and maintain engagement, and encouraging participation in AA meetings by bringing them closer to beneficiaries. Additionally, participants recommended readmitting those who relapse, providing counseling to former beneficiaries, and offering employment opportunities to successful recoverees with the required qualifications. These findings resonate Johnson et al. (2021), assertion on the value of holistic support systems, equitable resource allocation, and continuous engagement as key factors in promoting long-term recovery.

4.6.2.6 Stakeholders' Rating on the Effectiveness of St Martin Addiction Treatment Approach and IOP

The findings reveal that caregivers held St. Martin's Approach to Addiction Treatment and IOP in high regard, with six out of twelve rating its effectiveness at 8 and the other six at 9. Caregivers attribute their high ratings to several reasons. St. Martin has educated them on how to live with

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individuals in addiction, making them more informed and understanding. They also empower recoverees before reintegrating them into society, ensuring a smoother transition. Success stories of loved ones who have abstained from addiction, including two children described as "*completely healed*," highlight the program's impact. Free-of-charge services offered by St. Martin CSA make addiction treatment accessible to many families. Additionally, caregivers reported significant personal changes, such as the transformation of their loved ones from heavy substance use to sobriety, improved mental coherence, and recovery after relapses. St. Martin CSA's support has transformed individuals and improved family dynamics and social acceptance, as one respondent noted being freed from the stigma of being called "*Mama Mulevi*." These findings agree with Green et al. (2021), who argued that community-based interventions in addiction rehabilitation are more effective in achieving sustained recovery and reducing stigma if they are comprehensive, family-inclusive, and accessible to all, validating St Martin CSA's approach.

Peer supporters rated St. Martin's Approach to Addiction Treatment and the AOP highly, with ratings distributed as follows: four respondents rated it 7, four rated it 8, and one rated it 9 out of 12 respondents. Positive feedback centered on the program's ability to help individuals begin and sustain their recovery journey. Respondents highlighted the dignity and care with which everyone is treated, the good quality of services offered, the maintenance and support of AA, and the provision of free rehabilitation services accessible to all. Despite these strengths, respondents identified areas for improvement, emphasizing the need to engage professionals with a passion for addiction recovery, reintroduce relapse prevention programs for all recoverees, and expand outpatient and residential rehabilitation services. These suggestions aligned with Taylor et al. (2020), emphasis that passionate, skilled professionals and comprehensive aftercare services are important in fostering sustainable recovery outcomes.

Volunteers posted mixed reactions on the effectiveness of the St Martin CSA Approach to Addiction Treatment and IOP, with ratings ranging from 2/9 to 8/9, where 5 respondents rated the effectiveness at 4, followed by 2 who rated it at 8. Others were rating of one score in category 2, 5, 6, and 7. Positive feedback highlighted instances where the community actively supported beneficiaries introduced by volunteers, with ratings such as 8/9 reflecting the community's involvement in the recovery process and assistance with mobilization. However, challenges were also evident. Lower ratings, such as 2/9 and 4/9, highlighted issues like reluctance to support beneficiaries by the community without external pressure, labeling, and stigmatization, and a dependency mentality assuming St. Martin CSA has sufficient resources to address all beneficiaries' needs. Some community members reportedly experience burnout due to over-involvement or demand evidence, such as hospital bills, before offering assistance. The findings suggest a need for strategies to foster greater ownership, reduce stigma, and address the perceived dependency on external support. As proposed by Foster and Green (2021), who advocate for building trust, reducing stigma, and empowering communities to sustainably support recovery efforts, for better outcomes.

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4.6.3 Programme Staff

4.6.3.1 Staff Understanding of the Rehabilitation Process

St Martin CSA addiction treatment approach broad and multifaceted process involving running from client identification, assessment, treatment, aftercare services, and social reintegration. The success of such a complex treatment process often depends on the staff's understanding of its process and their ability to implement it effectively. The three staff who participated in this study agreed that the rehabilitation process begins with the identification of clients and outreach to the community to create awareness of addiction and the need for the community to address the problem. Respondents noted that they use various standard tools to evaluate levels of addiction and determine appropriate referrals. After assessment, people with active addiction are referred to the 13-week IOP for rehabilitation. Respondents agreed that the St Martin CSA IOP program focuses on psychoeducation and therapy, providing clients with the skills needed to manage their recovery journey. Sessions often involve individual and group counseling and training the client's support systems, such as family members. Literature on addiction rehabilitation underlines the importance of family, peer, and community involvement, to create a supportive environment for recovery.

4.6.3.2 Most Beneficial Aspects of St. Martin Addiction Treatment Approach

Respondents pointed out that the St. Martin CSA addiction treatment approach is an integrative model that seeks to address the diversified needs of people recovering from addiction. The most beneficial aspects of the program are family engagement, therapeutic support and the weekend program. They observed that St. Martin approach advocates for the active involvement of families in the recovery process, through home visits and family therapy sessions. According to addiction literature family engagement significantly enhances recovery outcomes, by addressing relational dynamics, encouraging accountability, reducing stressors, and creating a supportive environment for recovery and mutual healing. The program also offers individual therapy to help clients address underlying psychological issues, while family therapy works to repair relationships damaged by addiction. During IOP sessions, participants benefit from stress reduction activities such as meditation, spiritual formation, and evening walks, to enrich the program. Further, the weekend program was playing an important role in reducing risks to relapse, which often peak during weekends, and provides a learning environment where clients gain progressive knowledge about addiction and recovery and hence contribute towards relapse prevention and giving them hope to recover. Respondents identified livelihood support as an important intervention in restoring dignity and nurturing a sense of self-reliance and reducing the risk of relapse driven by feelings of hopelessness. Lastly, the graduation ceremonies and other communal celebrations are conducted to mark milestones in the recovery journey. This reinforces the motivation to maintain change and build a sense of accomplishment.

4.6.3.3 Staff Preparedness in Implementing the St. Martin Addiction Treatment Approach

Staff preparedness is an important success factor in the success of the St. Martin CSA addiction treatment program. However, one of the significant gaps observed is the limited formal education

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among staff in addiction counseling and rehabilitation. All the staff members have learned on the job through experience, online research, and consulting professionals. Other staff have formal education in counseling psychology at the certificate or bachelor's degree level, but lack specific training in addiction counseling. Programs like the NACADA Universal Curriculum have provided basic skills to the staff, but there is a notable lack of continuous professional development. This challenge limits staff's capacity to address the complexities of addiction comprehensively.

6.6.3.4 Contribution of Staff Roles to Overall Program Objectives

Staff members contribute to prevention by working with volunteers and community leaders to demystify mental health disorders, reduce stigma, and empower individuals to take preventive actions. Additionally, they disseminate knowledge about addiction as a disease, raise awareness, and foster readiness for change among community members. Rehabilitation efforts focus on helping recoverees regain normal functioning through family therapy, relationships, and collaboration with peer supporters. This aligns with the program's goal of restoring dignity and self-reliance in people in addiction recovery. Staff also act as case managers, linking clients to relevant services such as therapy, psychiatry, and spiritual programs, thus ensuring a holistic approach to recovery. Their contributions are essential to achieving the program's objective of reintegrating individuals into their communities as functional and productive members.

4.6.3.5 Advantages of the St. Martin Addiction Treatment Program

Respondents agreed that the flexibility of the St. Martin approach and IOP is one of its key advantages since it allows participants to attend their day-to-day engagements while undergoing rehabilitation. This ensures continuity in their professional lives and prevents economic disruptions that often accompany addiction recovery. Additionally, the program's location helps clients maintain privacy, protect their image, and reduce stigma. The program is also free, making it accessible to vulnerable individuals who might not afford treatment elsewhere, thus reducing barriers to care. Including home visits, follow-ups, and collaboration with stakeholders broaden the program's scope by addressing addiction as a community issue rather than solely the individual's problem, fitting in the definition of a community-based approach in addiction treatment.

4.6.3.6 Aspects of the Program Retained, Changed, and Missing Links

Respondents observed that several aspects of the program were essential and should be retained. The 13-week Intensive Outpatient Program (IOP) serves as the foundation of the initiative, offering a structured pathway for recovery. The involvement of recovery supporters is also highlighted as a critical support system, reinforcing the social environment necessary for sustained change. Additionally, robust identification, screening, and assessment ensure that appropriate clients are enrolled, avoiding mismatches in treatment.

However, certain areas require modification. The mixture of individuals with addictions to different substances has led to cross-influence, prompting some participants to experiment with

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new drugs. Introducing substance-specific groups could address this issue. Other suggested changes include conducting impromptu home visits for a more accurate understanding of clients' environments and instituting monthly reports to track progress effectively.

Missing links identified include the need for broad medical tests and psychiatric screenings to uncover undisclosed conditions, extending the 13 weeks with a preparatory phase, and introducing case conferencing to ensure coordination among staff. The addition of residential addiction counselors, a psychiatric nurse, and improved sporting facilities would significantly enhance the program's capacity.

4.6.3.7 Challenges and Scaling

Despite its many strengths, the program faces several challenges. Staffing is a major concern, with calls for more counselors dedicated to the program and better-defined roles for all staff. The lack of resident addiction counselors and psychiatric staff limits the program's ability to address complex cases. Furthermore, the abrupt post-IOP disengagement could be mitigated by implementing a phased follow-up schedule and monitoring clients over extended periods to ensure sustained recovery. Documentation practices also need improvement, with a need for personal files for clients and standardized operating procedures for staff. Scaling feedback highlights these gaps, with scores ranging from 5 to 7. Respondents praised the variety of interventions and client-centered approach, they also emphasized the need for better preparation for all groups involved and improved follow-up and outreach. Addressing these challenges would elevate the program's effectiveness, align it with evidence-based practices, and improve client outcomes.

4.6.3.8 Community Volunteer Monitoring

Monitoring community volunteers in the program involves a combination of structured and informal approaches. Volunteers provide weekly, monthly, and quarterly reports to document program progress and client experiences. However, informal individual reports, such as phone conversations, are often not recorded, limiting the potential for comprehensive data collection. This multi-layered approach enables continuous feedback loops, which are crucial for adapting programs to community needs and aligning volunteer activities with program objectives. However, the lack of formal records for informal engagements could hinder data-driven decision-making, highlighting the need for standardized reporting protocols to maximize the effectiveness of volunteer contributions.

4.6.3.9 Monitoring Program Interventions

Monitoring interventions within the program is largely conducted through general reports, with minimal tracking of individual client progress or the outcomes of specific therapeutic interventions. While program-wide reports provide valuable insights into overall processes, the lack of client-level monitoring limits the ability to evaluate the efficacy of specific services, such as therapy or counseling. This gap underscores the importance of implementing client-specific monitoring systems, to enhance accountability and help tailor interventions to meet unique client

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needs. Without robust monitoring of individual outcomes, the program risks overlooking critical factors contributing to long-term recovery.

4.6.3.10 Use of Monitoring Outcomes

Monitoring outcomes inform planning, refine interventions, and address challenges identified through the program. Lessons learned from monitoring reports shape future assessments, intervention frequency, and budgeting. Monitoring also helps manage volunteer expectations by aligning them with institutional capacity, thus reducing misinformation and fostering realistic program goals and is essential for maintaining consistency, ensuring continuous improvement, and achieving program objectives. However, financial constraints limit the scope of these applications, underscoring the need for resource mobilization to strengthen monitoring systems.

4.7 Discussion of Results

Findings from both qualitative and quantitative data revealed that the target population for the program was the vulnerable in the community. Respondents from all the FDGs concurred that free-of-charge services offered by St. Martin CSA make addiction treatment accessible to many vulnerable families.

The background information from clients at St. Martin rehabilitation indicated that they were relatively older than those from many other rehabilitations. The majority being between ages 41-50 years (28%) followed by those between 31-40 years and 51-60 years (24%) each were more than ages of clients under recovery as reported by other studies with high frequency at age 31-40 years range followed by those at age 21-30 years (Githae, 2016; Kuria, 2013; Kuyeya, 2021; Nyaga, J. 2021). Older clients at St. Martin rehabilitation program reflected the focus of the program on the vulnerable population. Among the respondents 20% reported that they had been diagnosed with another mental disorder. People in addiction are more likely to experience comorbid mental disorders such as depression, phobia, Anxiety and PTSD (Kuria, 2013). The rate of 20% among the respondents who mainly abused alcohol, was lower compared with 63% depression and other mental disorders reported by Kuria, (2013) among addicts of heroin and other hard drugs but closer to findings by McHugh, et al (2020) who found prevalence of comorbid mental disorders among variety of drugs to range between 8.7% for bipolar disorder to 36.1% for depression. A diagnosis of mental disorder alongside drugs addiction complicates recovery and therefore calls for support in treatment of mental disorders and consistent aftercare follow-ups (Fein, 2015; McHugh, et al 2020; Santo et at 2022)

The economic status of respondents further amplified respondents' vulnerability. Majority of the respondents (76%) earned less than 10,999 Kenya Shillings per month; hence had to wait for long to access free rehabilitation service offered in St Martin. From FGDs respondents reported

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earnings of less than 3500 per month and fully dependence on caregivers corroborating data from questionnaires. The economic status of the respondents signified limited capacity to meet their economic needs either triggering drugs abuse or caused by addiction. Respondents' economic status is concordant with findings from other studies where recovering respondents were found to be earning very low income (Kuria, 2013: Nyaga, 2021).

The social status of the respondents as analyzed through their educational status, family status and marital status depicted a social crisis among the respondents. The respondents' educational status with majority lacking secondary education was consistent with other studies. Eighty six percent (86%) of respondents were above 31years of age but their marital trend fell short of reflecting the national trend within the age bracket. Among them, only 22% of respondents were married compared to national rate of above 78.7% in females and 74.3% in males. Likewise, the separation and divorce rates of 26% and 4% were way above the national rates of adults within the age groups of utmost 5.2% separation and 2.2% divorce rates in females and 4.0% separation and 1.4% divorce rates in male KNBS (2022). The family status of the respondents equally did not reflect the national status with 50% from two parent family and 34% from single family. The social status corroborated other studies (Kuria, 2013: Nyaga, 2021). However, the age difference between respondents in this study and other studies related to drugs and substance use implied they had stagnated in social development and were more vulnerable which indicated the objective of St. Martin CSA Intensive Outpatient program of serving the vulnerable in the community was being met.

A range of nine drugs were being used by the population of St. Martin CSA Intensive Outpatient Program being Alcohol, Cigarette, Bhang, Muguka, Chaviat (Chavita), Vape (E-Cigarette for variety of drugs), Benzol, Cosmos (Chlorpromazine) and Miraa. Alcohol was the most prevalent drug at 88.0% and used alone by majority36.0%. Alcohol combined with 10 out of 14 combinations of drugs reported by respondents which would make it difficult to open the Intensive Outpatient to addicts of one drug only despite the challenges it presents (Kurui, Adeli and Barasa, 2024). Alcohol therefore remained the greatest threat in St Martins CSA area of operation unlike in other regions where heroin, cocaine and other hard drugs are available (Kuyeya, 2013; Nyaga, et al 2021). Emergence of vape as a tool of using multiple drugs such as nicotine, cannabis among others (Center for Disease Control and Prevention-US, nd) would make it easy for drugs users to engage in multiple abuse of drugs. Other emerging drugs in the area were prescription drugs benzol (benzol-2 tablets with active ingredient Trihexyphenidyl normally used to relax muscles and nerve impulses in Parkinson's disease and drugs induced disorders, Cosmos (Chlorpromazine) normally used to treat psychiatric disorders and Chaviat (chavita) with active ingredient ethanol 20% normally used as pain killer (Drugs.com (2019), Apollo Pharmacy, (nd) and Mwangi, 2024). Entrance of such new drugs into the area poses a new challenge for St. Martin CSA as a service provider.

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The program activities for St Martin CSA Intensive Outpatient Program as confirmed by respondents' engagement were 18 in number which are equivalent to services offered in other inpatient and outpatient rehabilitation centers UNODC, (2014):

1. Home Visits
2. Talks and seminars
3. Outreach
4. Screening and Assessment
5. Medical & Psychiatric Support
6. Weekend Engagement
7. Individual Therapies
8. Group Therapies
9. Marriage and Family therapies
10. AA 12 Steps
11. Relapse Prevention
12. Peer Recovery Couch
13. Family Support System
14. Peer Support System
15. After Care Follow Ups
16. Livelihood Support
17. AA and NA Groups
18. Community Involvement

Findings from qualitative and quantitative data in this study confirmed that the St. Martin CSA addiction rehabilitation program integrated psychological, social, and community-based strategies to support individuals in recovery. Its emphasis on fostering resilience, rebuilding social relationships, and promoting positive psychology reflects global best practices, proposed by Orford et al. (2010) and White and Kurtz (2006). This to some extent explains the high abstinence success rates reported by project beneficiaries.

Weekend Program with the highest mean M1=7.88, M2=8.19 impacted the respondents most in which AA Steps rated as the most impactful activity from both qualitative and quantitative data. FDG cited the program's flexibility and focus on the real-world application of recovery strategies, which enables participants to balance rehabilitation with personal and professional responsibilities to be very helpful. Respondents noted that this model allowed them to test skills learned while maintaining autonomy. Weekend Engagement challenged clients to face their resistances, their fears, unresolved psychological pains and restructure their thinking through awareness creation. Among weekend activities relapse prevention performed poorly with a lower mean 1 but for those who keenly followed they benefitted highly hence higher mean 2. Low rating for relapse prevention could be attributed to challenges such as exposure to environmental triggers and social temptations at home as cited by recoverees during FGD underscoring the need for conscious effort and structured support to mitigate relapse risks. Njeri et al. (2021) similarly noted that social and environmental triggers are significant relapse factors, requiring tailored interventions. The results corroborated white (2020) as well as Shiraly and Taghva (2018) findings that AA/NA participation resulted to abstinence from drugs and substance use. When combined with other treatments AA/NA treatment was noted to improve the global health of clients (Kelly et al, 2020).

Outreach service (M1=6.30, M2=6.70) was rated second. Outreach included Home Visits, Screening and assessment, Talks on Addiction and Recovery and Medication for physical and mental conditions, prior to seeking admission into the program mainly provided by community volunteers, peer supporters and caregivers in collaboration with St Martin staff. The broader literature on addiction rehabilitation emphasizes the need for equipping stakeholders with skills,

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knowledge, and support, since they are pivotal in attaining sustained recovery (White & Kurtz, 2006). Results implied the important role of outreach activities in the recovery process more so screening and assessment. The findings from all respondents of this study identified that the community volunteers, peer supporters and caregivers played an important role in addiction rehabilitation. However, community volunteers, peer supporters and caregivers FGDs reported their preparedness was uneven, underlining the need for more structured, timely, and comprehensive interventions, to improve the outcomes of rehabilitation efforts as proposed by Orford et al. (2010). Considering all respondents the medication activity performed poorly and therefore could leave some clients struggling with comorbid physical and mental illnesses which would make their progress difficult in terms of assessment, types of treatments required and context for recovery (European Union Drugs Agency, 2016).

The least popular service with respondents both in qualitative and quantitative data was Aftercare Follow ups. Results exposed critical gaps, with ratings clustering at lower scores due to weak follow-up systems, inconsistent peer supporters' engagement, and limited livelihood support. These weaknesses point to disconnect between program delivery and client expectations, emphasizing the need for robust aftercare and structured support, as highlighted by Kelly et al. (2011). The findings mirror general trends in literature that in the process of recovery, aftercare follow-ups have been found to be the most neglected aspect of treatment due to staffing, funding, as well as attitude and motivation issues (Kurui, Adeli and Barasa, 2024). The services failed to reach many respondents and when accessed some activities such as peer Support, livelihood support, AA/NA and community service impacted less to the respondents which could make clients feeling lonely, presenting a risk factor in the recovery process (Kuyeya, 2013). Peer support and Family support were highly impactful to respondents who accessed them. Kelly et al (2020) observed that those who participate in AA meetings experience significant improvements in emotional well-being, self-esteem, and coping mechanisms and if combined with other treatments yield to clients' overall health pointing to an area of improvement in St. Martin Intensive Outpatient Program.

Respondents' level of functioning was very low with only 20% functioning moderately before rehabilitation. They were fairly conscious of their malfunctioning (M=2.62) probably because they were already frustrated by numerous attempts to stop without success and therefore admission they had lost control. In agreement respondents in recovery FGD identified the enslaving nature of addiction, its effects on their psychological, social, and economic well-being as well as the impact of the same on family and community life. More so, they acknowledged the broader social and psychological effects of addiction, and their experiences were almost similar. These findings reinforced the consensus that addiction is a complex condition that affects multiple domains of an individual's life, as postulated by Volkow et al., (2016). To the worst their self-concept was malfunctioning leading to self-neglect, low esteem and self-worth as well as low social standing in family and community where they were shamed and disrespected. They had lost capacity to

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solve their psychosocial problems and therefore relied on drugs to nurse their pains. Apart from psychosocial problems their physical health had deteriorated. With reduced resistance, majority were ready for rehabilitation but their economic vulnerability disadvantaged them because rehabilitation services for pay were financially out of reach for them. The coming in of St. Martin free rehabilitation service was a good opportunity though at an advanced age of 41-60 years.

After rehabilitation respondents functioning remarkably improved. The improvement depicted a change process where clients first accepted the challenge to face their fears and psychosocial pains (M=4.54) creating cognitive dissonance with the way they lived in line with the fourth principle of motivational interviewing intervention (Latchford, 2010). The respondents then through self-reflective, educative and experiential sharing activities during active rehabilitation period developed a positive philosophy of life changing their general view of life (M=4.50). As they became more open to learn they gained more knowledge and awareness on addiction and recovery as well as on life and self (M=4.48), they became motivated and chose to change despite challenges of withdrawal symptoms (M=4.42), improved on self-care (M=4.20) and better quality of life in family and community (M=4.20) which reduced psychosocial problems (M=4.10). People in recovery FDG affirmed this observation viewing recovery as being given a second chance to rebuild their lives. They underscored the importance of a positive mindset and self-efficacy in their recovery process. Both quantitative and qualitative data depicted recovery in terms of abstinence from substances of abuse, financial freedom, improved self-awareness, self-esteem, emotional control, and reintegration into the family and community life. They also regained self-love, respect, trust, and supportive relationships. These findings align with Johnson et al. (2021) emphasis that recovery is a comprehensive process encompassing abstaining from substances of abuse and reintegrating individuals into family and community life.

The result revealed that the aspect of function that took time to develop is managing relapses, self-efficacy (confidence that drugs are no longer a risk in their life) and regaining physical health pointing to some weaknesses in the program mainly in relapse prevention and aftercare activities. All respondents in stakeholders, recoverees and staff FGDs were in agreement that one major challenge is the absence of structured follow-up care after program completion, leaving graduates vulnerable to relapse. The respondents noted limited peer supporters' engagement and few avenues for continued connection with AA or other recovery networks. Leveraging technology, such as WhatsApp groups or localized AA meetings, could enhance connectivity and improve peer-led support, as suggested by (Kelly et al. 2011). Delay in these three aspects could explain the high rate of relapse (55.10%) within the first 6 months which is usually high as reported in other studies at 60-80% (White 2012). Additionally, the stakeholders and rcoverees perceived inconsistency in livelihood support creating dissatisfaction and eroding trust among clients. Transparent and equitable resource allocation, along with vocational training programs, could bridge this gap. Finally, the disconnect between client expectations and program objectives points to a need for better alignment, communication, and monitoring of program outcomes to ensure that the goals of

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the intervention are being met. The fifth principle of motivational interviewing recognizes the role of clients' confidence in the process of taking action to behavior change (Latchford, 2010). Despite the weaknesses, majority of respondents reported relapse rate within the first 6 months after rehabilitation from other rehabilitations point out a higher success rate for the St. Martin Intensive Outpatient program. This systematic unfolding of functioning capacity would help the rehabilitating agents to know what to expect and needed interventions to fast track the process.

After relapse majority (47.92%) indicated they took very short time to regain control from addition to 18.67% who indicated they took a short period of time. The results indicated that majority of respondents were self-conscious and reflective; a product of awareness and self-identity on addiction and recovery (Searidge Foundation, 2022). Self-consciousness and positive self-identity promoted self-control in the face of relapse risk factors. Improving self-control and self–identity could have yielded to the very high confidence of 58.33% and 18.75% high confidence that they had regained sobriety reflected improved self-concept. A positive self-concept is imperative in self-control hence management of relapse risks factors and maintenance of sobriety. The high level of motivation, determination to change, improved self-concept and esteem as well as improved respect from family and community supported the high success rate. The 86% of sobriety depicted very high success rate for the St. Martin Intensive Outpatient Program compared to registered rates of 20%-80% relapse rate in Nairobi (Githae, 2016; Kuria, 2013; Kuyeya, 2021). The results as well depicted recovery as a process such that the initial relapses in isolation of accompanying relapse dynamics could not effectively reflect the effectiveness of a program (Martinelli, 2023), though it calls for concerted efforts to minimize the initial relapse.

The one-way ANOVA inferential statistic results ($F(2, 47) = 10.198$, $p = .000$ at $p < 0.05$) confirmed St. Martin Intensive Outpatient Program was effective in changing the quality of life of the individuals as demonstrated by improvement of functioning in different aspects. This was corroborated by high levels of functioning in different areas of functioning among respondents after treatment as compared to before treatment. In addition, the recoverees, and stakeholders FDGs reported significant life improvements among recoverees, including financial control, self-efficacy, spiritual growth, self-awareness, relationship-building, self-respect, and physical recovery. They also regained societal trust, restored employment opportunities, and achieved professional growth, reflecting Bandura's theory of self-efficacy, which links belief in one's capabilities to resilience and goal achievement. Spiritual growth emerged as a key factor, with participants attributing their recovery to newfound faith and engagement in religious activities, consistent with Galanter et al. (2007) and the AA 12-step model emphasizing spirituality in recovery.

St Martin CSA's approach to addiction treatment seeks to address individual and community needs by equipping caregivers, peer supporters, and volunteers with skills, emotional support, and growth opportunities, to improve their capacity to contribute meaningfully to recovery efforts. The

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findings of this study identified that each stakeholder including the target community, plays a unique role; contributing to an integrated support system that fosters sustained recovery. The findings reaffirm use of a mixed and collaborative approach by St Martin CSA addiction treatment program. This explains to some extent the relatively high abstinence rate among people undergoing rehabilitation under the organization. White and Kurtz (2006) argued that collaborative approaches in addiction treatment offer better opportunities for sustained recovery. Similarly, Njeri et al., (2021) postulated that community-based interventions in addiction reduce relapse rates, and enhance social integration, leading to better outcomes in substance addiction rehabilitation.

Generally, findings of this study confirmed that St Martin CSA's Addiction Treatment Approach is comprehensive and effective in treating alcohol and drug addiction, with a success rate of 86%. However, implementation of onboarding and aftercare services should be refined to reduce cases of relapse and improve lives and livelihoods of the beneficiaries.

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CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

5.1. Conclusions

1. St. Martin CSA is serving the economically and socially vulnerable populations in its jurisdiction marked by financial stress among the recoverees, caregivers, volunteers and peer supporters. The program's free and inclusive services have transformed lives and reduced stigma.
2. St. Martin client starts their rehabilitation process at low level of functioning physically, psychologically, socially, economically and spiritually.
3. St. Martin CSA rehabilitation is an intensive community based approach that aligns with global best practices and actively brings together all stake holders being the professionals (Psychologists, sociologists, medical practitioners and spiritual leaders), volunteers, peer supporters, recoverees, donor community, government agencies and caregivers in a strong case management base to effectively address the multidimensional nature of addiction by integrating psychological, social, and community-based strategies..
4. St. Martin CSA rehabilitation program under the name Intensive Outpatient Program is a unique integration of outpatient and inpatient methods of rehabilitation where clients mainly recover in the community with internodes of consecutive 13 weekends' residential experience and aftercare services.
5. St. Martin Intensive Outpatient Program is a three-phase process being: 1) The outreach phase (The program reaches out to those in active substance use and their hosting families and community to heighten awareness, facilitate attitude change and foster contemplation to change. This is done through home visits, peer support system reaching out to active substance users, talks and seminars on addiction and recovery, screening and assessment). 2) The Treatment Phase (Those who accept to change are enrolled into the treatment process. The treatment is done through assessment, 13 weekends residential camp. 12 steps, psychological interventions and relapse prevention and 3) The Aftercare Phase: Peer Recovery Couch, Family Support System, Peer support System, After Care Follow Ups, Livelihood Support, AA and NA Groups and Community Involvement
6. The approach and the program were successful in facilitating the clients' statistically significant improvement in quality of life functioning psychologically, physically, socially and spiritually from very low and low functioning levels before treatment to high and very high functioning levels after treatment, registering high sobriety maintenance of 86% by fostering resilience, awareness, and supportive relationships, aligning with global best practices in addiction treatment.
7. The AA 12 steps and its hosting weekend camp treatment strategies were perceived by clients to be the most beneficial activity by saving them from weekends temptations, fostering reflection and awareness as well as and offering them support in managing week days struggles.
8. Recovery from addiction through St Martin Intensive Outpatient Program seemed to follow a process where they accept the challenge to reassess their lives and admit they had a

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problem then the gained knowledge and self-awareness on addiction and recovery increasing their motivation and achieve cognitive restructuring eventually they acted to change their life situation or cope with them reducing their personal, social and economic problems to maintain sobriety.

9. The weak link in the program was the aftercare phase that was found to be depreciating with time in terms of monitoring, aftercare follow ups, peer support system, livelihood support, AA/NA groups and community involvement. At the treatment weak link was in relapse prevention and Marriage and Family therapies.
10. Caregivers, volunteers, and peer supporters play pivotal roles in recovery but require structured training, clearly defined roles, and ongoing support to enhance their contributions.
11. Delays in feedback due to understaffing and limited expertise hinder program implementation and volunteer engagement at the outreach and aftercare phases of recovery.
12. The lack of structured aftercare services and outpatient rehabilitation limits sustained recovery and increases the risk of relapse.
13. Persistent stigma, community reluctance to support beneficiaries, and dependency on external resources highlight the need for community sensitization and empowerment strategies.
14. St Martin CSA's approach to addiction treatment is a holistic approach that is effective in treatment of alcohol and drug addiction.

5.2. Recommendations

1. There was need for improvement in staff establishment by having at least one resident professional counselling psychologist with training in addiction counselling working in the program, in addition to the part time professional counselor manning the weekend program and other involved counsellors within the institution. Other staff members in the rehabilitation program need at least basic training in addiction counselling to bolster their effectiveness and ensure provision quality services and control.
2. There was need to develop comprehensive training programs for volunteers, caregivers, and peer supporters, emphasizing role clarity, technical skills, and emotional resilience to boost their capacity as paraprofessionals in the recovery process.
3. There was need for sufficient monitoring of all program activities through proper documentation of individual clients' progress from onset without compromising confidentiality, proper documentation of all rehabilitation activities, frequent program activity reports and case conferencing. Such documentation and consultation among staff and other professional stakeholders would enhance consistency in service delivery and timely identification of gaps in services, as well as prompt response to challenges.
4. There was need to introduce outpatient rehabilitation services as an entry point to the Intensive Outpatient Program, ensuring broader access to rehabilitation for individuals in active addiction.

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5. There was need for efficient case management after graduating from 13 weekends program. Client engagement in terms of identifying emerging needs and connecting the clients to services to minimize the feeling of abandonment. This may be achieved by introducing structured aftercare programs, including professional addiction counseling, and follow-up support to reduce relapse risks as well as developing systematic method of ensuring all mental health volunteers, caregivers and peer supporters as well as clients are reached out within a specific reasonable period of time.
6. There was need to facilitate accessibility of peer support systems by exploring ways of devolving AA and NA groups, may be by facilitating formation and effectiveness of such groups through mobilizing those recovering from addiction to form local chapters, negotiating with established institutions such as churches to provide facilities such as venues and connecting new groups in clients' vicinity to resource persons for guidance and reading materials. Further, establishment of closely monitored WhatsApp groups for recoverees in a cohort to foster connectedness and needed support from each other may strengthen the peer support system.
7. There was need to expand the concept of livelihood support to include vocational skills, align the clients' expectations to program's capacity for financial support, equitable distribution and reduce over reliance on St. Martin CSA livelihood program financial support for beneficiaries and caregivers to alleviate financial stress, promote sustained recovery and improve their reintegration into society.
8. Organize stigma-reduction campaigns and initiatives to foster greater community ownership and reduce resistance to supporting beneficiaries.
9. Owing to the effectiveness of St Martin CSA's addiction treatment approach, the organization should invest on further research and dissemination of the outcomes. First to contribute to the wider literature in community-based addiction treatment approaches and second to upscale its use.

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