
PSYCHOSOCIAL SUPPORT PROGRAMME FOR METHADONE CLIENTS

Evaluation Report

Rumah Cemara - Bandung 2013

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EXECUTIVE SUMMARY

Psychosocial Support Programme that is designed for patients on Methadone Maintenance Therapy (MMT) in Hasan Sadikin hospital has been implemented as a pilot project for two years. In mid 2013, Rumah Cemara (RC) evaluated the programme since its initiation. As a part of operational research design, the evaluation specifically aimed to look at barriers in relation to human resources, implementation and programme management. It also identified how far can the materials and methods of the programme improve patients' life quality. The assessment also enables improvements for the programme to reach its highest quality.

The evaluation was done through qualitative approach with RE-AIM (Reach, Effectiveness, Adoption, Implementation and Maintenance) focus to reach the set goals. Data was collected through in-depth interview and focus group discussion involving 45 participants including clients of MMT receiving psychosocial support, clients of MMT not receiving psychosocial support, closest relatives of clients, MMT clinic officers, and programme implementers.

Findings from this evaluation have revealed that the programme has the potential to support clients for better quality of life, particularly in considering several improvements needed to increase the scope of the programme. Successes have been found in improvements in communication and relationship with family, as well as clients are motivated to be financially independent. However, these successes have not been the programme's maximum and further supports are still required such as, clients' motivation; participants recruitment procedure; programme implementation guidelines; standardised curriculum; success measurement tool; availability and management of human resources from RC; and programme integration with MMT clinic have been important elements for programme improvement.

Psychosocial support programme can be increased in implementation in order to provide bigger impact and more meaningful impact for its participants. Improvements can be done by revising and modifying the initial programme design, sharpening the aim of the programme, strengthening programme participants recruitment system; standardising the curriculum; and documenting the results. Additionally, it is very important to consider the allocation and management of human resources in the programme. Finally, integrating the programme with MMT clinic is highly recommended to ensure programme sustainability in the future.

Chapter 1- OVERVIEW

Background

Rumah Cemara (RC) is a community based organisation founded in 2003 in Bandung. As an organisation, RC directly deals with illegal drug use and touches all aspects of bio-psycho-social. Psychosocial support programme for patients of Methadone Maintenance Therapy (MMT) has been started since 2011 which involves MMT clients of Hasan Sadikin hospital in Bandung. The aim of the programme is to increase therapy retention and to increase clients' quality of life. Psychosocial support is very useful for clients in coping with psychological aspect of illegal drug withdrawal symptoms. Psychosocial intervention is usually applied to resolve cognitive behaviour – the process of gathering knowledge, awareness and feelings through own experience/perspective of one's environment. Dutra et al. (2008) said that psychosocial intervention emphasises on functional analysis and the strategy to change risky situation for people who use illegal drugs in relation to relapse prevention and cognitive behaviour change. The impact, in this context, MMT clients can go through the process of re-entry to social environment in a better way (Acierno, Donahue, & Kogan, 1994). MMT clients' relationships with their social environment such as family, spouses, friends and colleagues are eventually well recovered. Additionally, it will also affect the success of their withdrawals therapy.

There are many psychosocial interventions to support social relationship of clients. Some of the approaches include, motivation interview; contingency management; partner's behaviour therapy; cognitive behaviour therapy; behavioural activation; and cognitive behaviour therapy for depression and anxiety (NTA, 2010). The combination of cognitive behaviour therapy and contingency managements has a higher effectiveness compared with applying only one intervention (Dutra et al., 2008). The success of psychosocial intervention can be indicated through its retention and adherence rate in taking Methadone as well as client's social development.

This programme is a pilot project developed based on initial assessment, observation and discussion with MMT clients. Based on the original design¹, psychosocial support programme is provided for a month divided into 12 group sessions of 10 people. The curriculum provided includes three main aspects, which are: Biology, Psychology and Social. Other than group session, clients are also provided with two alternatives of individual and/or family counseling accompanied by psychologist/counselor based on clients' demand. To further support the clients, case management support is also provided along with coordination support with MMT clinic staff and the development of Methadone support group.

As a trial, it is very important to evaluate how far has psychosocial support programme developed by RC. According to Ovretviet (2002), a good evaluation is done to answer the needs of programme implementers in order to increase the quality of its programme. The perspective of evaluation that RC is seeking is to identify and assess the needs of psychosocial support programme for MMT clients to redesign the programme for better

¹ Source: Internal Rumah Cemara document (2011)

purposes. Comparing programme implementation with the current procedure can also be one of the goals of the evaluation. Supporting and impeding factors need to be identified to allow modification and appropriate improvement (Owen, 2006; Howthorne, 2000; Stufflebeam, 2001). The result of the evaluation can benefit programme improvement and feedback for further development.

This programme evaluation is an initial part of operational research design which aims to improve the strategy and supporting tools of psychosocial support programme. There will be four main stages: 1) Identification of programme benefit, 2) Identification of needs, implementation and organisational capacity, 3) Module improvement and verification, and 4) Trial of the new module. Based on the above study design, this programme evaluation only covers stages one to three. Data was gathered in July 2013 through observation, in-depth interview and focus group discussions. Information was gathered from people who are directly involved in psychosocial support programme such as programme participants, closest relatives of clients, programme implementers and MMT clinic officers. The findings of this evaluation have been made as feedback and input to redesigning the module for future improvements.

Chapter 2 – EVALUATION APPROACH

Evaluation Aims

Psychosocial support programme evaluation approach is made by designing general and specific aims. In order to achieve these aims, the evaluation, in general, aims to identify the process, obstacles and supporting factors and benefit of psychosocial support programme for MMT client provided by Rumah Cemara to improve the module for future use. Specifically, this evaluation aims:

1. To assess obstacles related to human resources, implementation and management of psychosocial support programme for MMT clients;
2. To identify how far have the materials and methods provided in the programme supported the increase in quality of life of MMT clients from the perspective of beneficiaries, closest relatives of beneficiaries, service providers and programme implementers;
3. To improve psychosocial support programme for MMT clients module, including participants criteria, methods and materials and other supporting aspects required by the programme.

Evaluation Question

This evaluation model adopts RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) framework. The framework was developed by Glasgow (1999) and is commonly used to evaluate programme intervention. Evaluation questions are categorised into five dimensions, which are: Reach, Programme Effectiveness, Programme Adoption, Implementation and Maintenance (see table 1).

Table 1: Evaluation Questions Based on RE-AIM

Dimension	Evaluation Questions	Indicators	Source	Methods
Reach	<ul style="list-style-type: none"> - How far has the programme reached its target? 	<ul style="list-style-type: none"> - % of clients with intervention and non-interventions - % of clients completing the intervention 	<ul style="list-style-type: none"> - RC database - Notes from implementation observation <p><i>Result of data analysis (stage 2)</i></p>	<ul style="list-style-type: none"> - Interview - Observation - Secondary data verification
Effectiveness	<ul style="list-style-type: none"> - How far has the programme made the clients survive in their therapy with comfortable dosage and not using other drugs while in their therapy? - How far has the programme effectively increased social participations of Methadone clients? 	<ul style="list-style-type: none"> - Documentation on dosage and therapy duration of MMT clients with intervention and non intervention - Information on other drug use in the last 3 months - Perception of clients with intervention and non intervention regarding self-confidence - Perception of clients with intervention and non intervention regarding social adaptation - Perception of clients with intervention and non intervention regarding their relationship with MMT clinic staff 	<ul style="list-style-type: none"> - Information from clients with intervention - Information from clients non intervention - Information from RC programme implementers - Information from clients' closest relatives - Information from counselor - Information from MMT clinic staff - Clients' dosage data - Pre/post test <p><i>Result of data analysis (stage 1 and 4)</i></p>	<ul style="list-style-type: none"> - Focus group discussion - In-depth interview - Secondary data verification
Adoption	<ul style="list-style-type: none"> - Who are the stakeholders that participate or support psychosocial support programme for MMT clients? - How far have participation and support 	<ul style="list-style-type: none"> - Information on stakeholders' involvement - Information on means of support from stakeholders 	<ul style="list-style-type: none"> - Information from MMT Clinic staff - Information from programme implementers 	<ul style="list-style-type: none"> - Focus group discussion - In-depth interview

	from stakeholders affected the programme?		<i>Result of data analysis (Stage 2)</i>	
Implementation	<ul style="list-style-type: none"> - How far has the programme been implemented as its plan? - How has the programme made based on the needs of the clients? - How have the participants accepted the programme that they receive? - What are the supporting and deterring factors in the implementation of the programme? - What strategies have been made to overcome the problems in the programme? 	<ul style="list-style-type: none"> - Description of programme process - Description of programme modules/curriculum - Perception of clients towards the materials, methods and implementation of the programme - Perception of Programme Implementers towards clients' reaction to the programme - Identification of supporting and deterring factors - Description of strategies 	<ul style="list-style-type: none"> - Information from clients with intervention - Information from RC Programme Implementers - Information from psychologist/counselor - Programme implementation documents <i>Result of data analysis (stage 2)</i>	<ul style="list-style-type: none"> - Focus group discussion - In-depth interview - Secondary data verification
Maintenance	<ul style="list-style-type: none"> - How far has the programme become the main part of Rumah Cemara? - How far has the programme integrated with the current MMT system? - What are the strategies to ensure programme sustainability? 	<ul style="list-style-type: none"> - Description of RC's commitment, funding allocation, resources required from the programme - Information and documentation from meetings with government/MMT clinic staff regarding programme support - Description of coordination and communication between RC and MMT clinic staff in programme implementation - Description of potential resources - Description of strategy for programme sustainability 	<ul style="list-style-type: none"> - Information from programme implementers - Information from MMT clinic staff - Documents of programme implementation - Notes, minutes and documentation of meetings <i>Result of data analysis (stage 2 and 4)</i>	<ul style="list-style-type: none"> - Focus group discussion - In-depth interview - Secondary data verification

Methodology

Qualitative approach was used to answer the research questions in this study. This approach was chosen as it was considered to be mostly appropriate in assessing experiences and needs of clients of psychosocial support programme and stakeholders related to the programme. According to Carter and Litte (2007), the possibility of finding and understanding a contextual situation of the research object can be well facilitated through qualitative approach. Additionally, the approach is very flexible and can allow the study participants to share their experiences and enable the researches to understand the situation (Liamputtong, 2009). Qualitative study is very suitable for this typical study which aims to understand sensitive issues, in this case, issues around clients of Methadone (Bowling, 2002). Empirical method was also used in this study where researchers collect specific primary data based on the needs of the study.

Sample of this study was focused on people who are directly involved in psychosocial support programme such as, beneficiaries and programme implementers. The samples were chosen on purpose (purposive sampling – criterion sampling) based on the design of qualitative study (Liamputtong, 2009). This method was seen suitable with the aim to assess problems and process based on participants' experience where rich information can be gathered (Bryman, 2012). Therefore, sample criteria were made for people who are directly benefited from the programme. The number of informants varied based on the amount of resources involved in each category. The information included documents related to the programme, statements from resource person, observation of activities that can illustrate the fact and opinion of the programme that was evaluated. All information that was gathered made into summary before it was further analysed.

Information that included data and statements was gathered through in-depth interviews to four different people under the following criteria: 1). MMT clients with intervention (joining the psychosocial support programme), 2). MMT clients with no intervention, 3). Closest relatives of MMT clients with intervention, 4). Closest relatives of MMT clients with no intervention, 5). Programme Implementers, and 6). MMT clinic staff. Those criteria were decided based on the needs of information for analysis purposes. In addition to the individual interview, information was also gathered through focus group discussion and activity observation where clients engage and interact. All primary data was audio-recorded and made into transcript. Particularly in in-depth interview and focus group discussion, questions had been designed based on logical framework to meet the needs of the analysis. The questions were designed to ensure that the analysis will contribute to the improvement of the programme.

There were also exclusion criteria for MMT clients who have been in the programme for less than three months.

Information was assessed from two different groups, a) clients who have completed psychosocial support programme and have accessed individual/family counseling, or b) clients who are not involved in the programme. In order to see how far has changes and benefits affected clients' life, confirmation was done to clients' closest relatives. Inclusion criteria for closest relatives included: partner/husband/wife/parents/friends/colleagues that are aware of clients' involvement in psychosocial support programme in the last six months. Each group consisted of five people aged over 18 years old, not MMT patients and live in

Bandung area. The exclusion criteria for this group were for those who are also MMT patients, age less than 18 years old, and have just recently been aware of clients' Methadone use/substance addiction in less than the last three months.

Ethical Conduct in Data Sampling

The study was implemented with the support of research ethical approval from the Ethical Commission of Atmajaya Catholic University, Jakarta (No.561/III/LPPM-PM.10.05/06/2013). All data and information are treated in strict confidential and anonymous. Its use is only for the study purposes. Questions were made in the simplest way in order to be easily understood by the participants. Participation was made on voluntarily basis where participants agreed to take part in the study upon receiving description of the aim of the study including the mechanism and process of the study by RC programme implementers. Participants agreed by signing a consent form.

Chapter 3: FINDINGS

Respondents Characteristics

Data was gathered from 45 respondents which were divided into six different criteria, which are: 1) Clients with intervention; 2) Clients non-intervention; 3) Programme Implementers; 4) MMT Clinic staff; 5) Closest relatives of clients with intervention; and 6) Closest relatives of clients non-intervention. During the data gathering process, the total number of samples was in accordance to what had been estimated, except for the number of clients non-intervention with one person less than the expected target (see diagram 1). This was due to the lack of punctuality in conducting interview sessions.

The main focus of this research was to see the difference in the development between clients with intervention and non-interventions, and based on table 2, the demographic data indicates that female participants were only found in clients with intervention. This data is also consistent with the total number of MMT clients at Hasan Sadikin hospital where 95% is dominated by male clients.

An interesting fact was also found when comparing their social development in the context of working and family relationship. It can be seen that clients non-intervention gain more social achievements compared to those with intervention, despite the fact that they have not been receiving psychosocial support. Although this finding cannot be generalised, certain factors such as having an occupation and internal support from a spouse can improve clients' psychosocial aspect.

Diagram 1: Rumah Cemara Psychosocial Support Programme Evaluation Samples

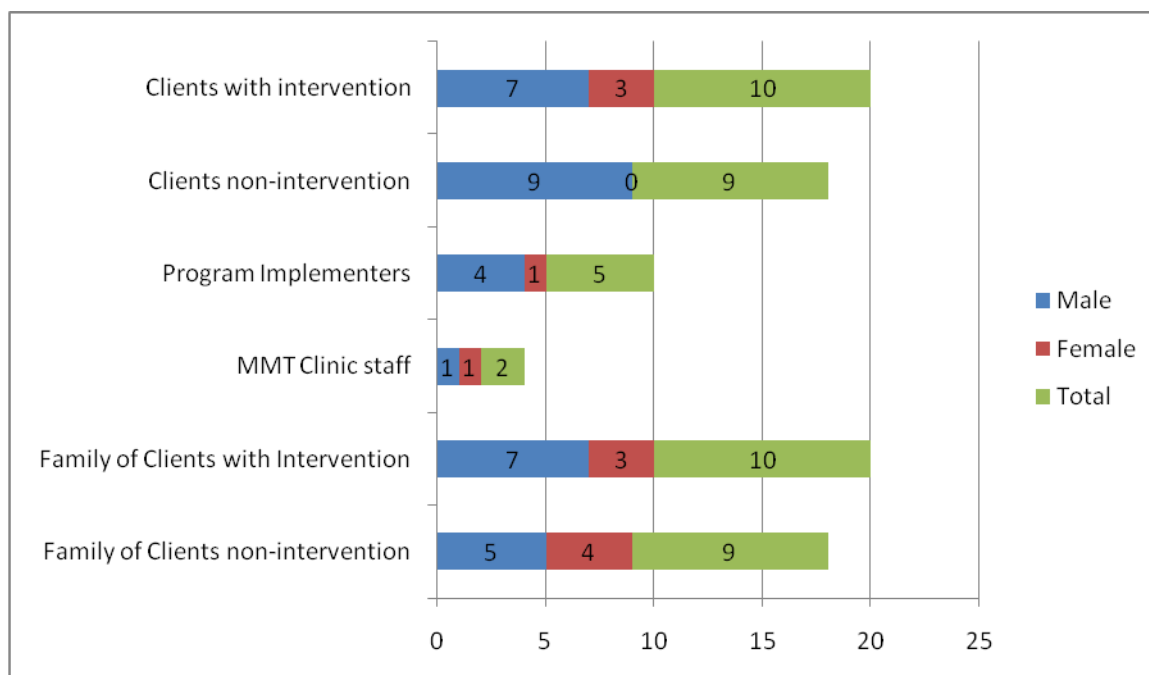


Table 2: Respondents Characteristics of both Clients with intervention and non-intervention (2013)

Characteristics	Intervention		Non-intervention	
	N	%	N	%
<u>Gender</u>				
Male	7	70	9	100
Female	3	30	0	-
<u>Occupational Status</u>				
Employed	5	50	8	88
Unemployed	5	50	1	12
<u>Marital Status</u>				
Married	5	50	7	77
Not married	4	50	2	22
Divorced	1	10	0	0

Reach

The majority of patients registered at MMT clinic in Hasan Sadikin hospital has been involved in psychosocial support programme. The programme started in mid 2011 when the total number of MMT patients at the clinic was 130 people. However, during the evaluation, the number of patients had dropped to 60 people. 80% among the active patients have been involved in psychosocial support programme provided by Rumah Cemara. Although the programme can only accommodate 15 people in each term, the total accumulated number of participants in four terms has reached almost to all active MMT patients in Hasan Sadikin hospital.

Unfortunately, when the programme was audited, it was discovered that RC did not have enough evidence and documents to show the total number of participants from the very beginning including the information on how many clients have completed the programme, the frequency of the sessions. In the first two terms of the programme, there was no clear participation inclusions or exclusions.

"In the first term, there were about 15 or 10 people... then 9 or 8, it decreased until the fourth term, only a few showed up. It began to become more difficult to find new clients. Then, also there were requests from old clients, so they started to come back and hang around here. Sometimes we compromised to mix the group – the new and old clients in the same class." (DKT, Programme Implementer)

"At the beginning, it was three times a week. Now, it is only twice a week." (KI003, Clients with intervention)

Looking closer to the quality of psychosocial support programme received by clients, it can be clearly seen that there is a significant difference between what clients received in the first term and the following terms. In the first term, there was a series of assessment to clients as much as three times a week with very specific duration. However, the situation of MMT clients (quantity) and the limited human resources from Rumah Cemara have forced RC to change the mechanism of the programme. Situations like the change in the number of

clients available, neglected assessment report, hesitation in accessing individual counseling, and clients not completing the curriculum were the results of the first term of the programme.

“There was a staff in-charged of assessment intake, data input and sending clients to (staff’s name), an addiction counselor. Then clients will do WHOSQL assessment as well as mapping their counseling plan and so on. The problem was, at that time, we had a counselor, he was in-charged to facilitate MMT clients’ needs, but then, the availability of the counselor was not consistent.” (DKT, Programme Implementer)

“Most of them did counseling, but then many hesitated to come into the room. Many of them, too, had to be pushed and forced by (staff’s name) to do counseling, otherwise, nobody would have done it.” (PS01, Counselor)

“Because I feel that, at that time, I had no major problem in my life (to access counseling).” (KI001, Clients with intervention)

It can be indicated that the changes happened during each term of psychosocial support programme because there was no fixed guidelines of the programme. This situation made the implementers to take different actions at every different situation they face. On one side, a flexible programme can provide good impact in accommodating the needs in the field. However, on the other side, flexibility can also affect target achievements. For example, there are different ways of measuring clients’ achievement in different terms of the programme. This will create some difficulties in assessing individual success as the tool used is not consistent, and it will also affect to the overall measurement of the success of the programme.

“I don’t really have a tool to measure how far have the clients succeeded in the programme. (DKT, Programme Implementer)

Effectiveness

How far can the effectiveness of psychosocial support programme be measured based on the objectives of the programme? In the context of this evaluation, the comparison factors focused on four aspects: other drug use during MMT therapy compared to MMT comfortable dose, self-confidence, social adaptation and relationship with MMT clinic. In the context of other drug use and comfortable dose of Methadone, it was found that clients with intervention and non-intervention that took part in this evaluation have been involved in MMT for different range of duration; from only three months to seven years. The dosage of clients also varies from 20 ml to 200 ml for both patients who are on Anti Retroviral Therapy (ART) or not. Ideally, the length of MMT contributes to clients’ comfortable dose which can eventually improve their social and psychological aspects.

“Since I joined MMT (psychosocial support programme), I felt I have changed. I used to only hang out at Hasan Sadikin hospital doing nothing, and often used heroin and other drugs everyday. Since I am involved in Rumah Cemara, I can minimise my other drug use. Although I am still on and off on drugs, but at least I am not doing it everyday anymore.” (KI008, Clients with intervention)

“My Methadone now is 80 ml, it has been stabilised. I am also now in a reducing programme. Every two weeks, I reduce 5 ml. Before, I was at 120 ml. I am doing this on my own, because if I tell the hospital, the reducing programme forces me to get my urine tested. If they found out that I still have positive marks for my Benzodiazepine and Heroin, they will now approve my reducing request. So, I just reduce my own dose. (KI001, Clients with intervention)

However, without considering whether clients are on their comfortable dose or not, this evaluation found that the majority of clients with intervention were still using other drugs (see table 2). In fact, some of clients with intervention feel that there is no correlation with what they are doing at Rumah Cemara and their MMT at the clinic. On the other side, only a few clients non-intervention were still using other drugs. Generally, the drug use happens during the beginning of the therapy and when clients are trying to reduce their dose.

“The last time I injected heroin was two weeks ago. So this is my first heroin in two weeks.” (KI010, Client with intervention)

“I don’t see the correlation between psychosocial support programme and my MMT dose.” (KI002, Client with intervention)

Table 3: Dosage Comparison and Other Drug Use among Clients with Intervention and Non-intervention

NO	Clients with Intervention			Clients Non-intervention		
	ID Code	Dose (ml)	Drugs > 3 mo	ID Code	Dose (ml)	Drugs > 3 mo
1	KI001	80	Benzodiazepine	KN001	20	Heroin
2	KI002	105	Benzodiazepine	KN002	40	Benzodiazepine
3	KI003	30	Benzodiazepine	KN003	100	None
4	KI004	125	Benzodiazepine + heroin	KN004	95	None
5	KI005	130	Benzodiazepine	KN005	135	Benzodiazepine
6	KI006	7.5	None	KN006	47.5	None
7	KI007	40	No available data	KN007	115	Benzodiazepine
8	KI008	77.5	Benzodiazepine + heroin	KN008	25	None
9	KI009	80	Benzodiazepine	KN009	40	Benzodiazepine
10	KI010*	65	Heroin			

*) Respondents is no longer registered as a patient at MMT clinic in Hasan Sadikin hospital in the last 2 months

An interesting fact was found that many clients said that having secured a job with fixed working hours has helped them to reduce their other drug use. It indicates that clients have

been productive in spending their spare time as long as their need for comfortable dose is met. Additionally, those who are working have to concentrate their time and energy to their responsibilities and therefore they have less time to hang out with other MMT clients. They also know little about drugs availability and have less trigger factors to use drugs. As a result, they have developed a new pattern of life to get used to living life without other drugs. This finding can be one of the most important things to be considered in psychosocial support programme, whether as a supporting factor or a success indicator.

“Generally, those who are working don’t use other drugs as often as the others. It is very clear, and we all can see that.” (PK01, MMT Clinic staff)

“When my emotional condition is good, and when I focus at my work or other activities, my craving for drugs is just gone.” (KN002, Client non-intervention)

In the context of social and personal relationship such as self confidence and relationship re-establishment, it was found that clients with intervention feel more significant improvements than before. Almost all clients with intervention have better relationship with their partner or family. They feel more confident and can interact and be accepted by their family members. Some also feel that their neighbourhood can better accept them. Similarly, non-intervention clients feel that MMT has helped them to re-establish their relationship with their partner and family, as well as socialising with their neighbours and colleagues. Those who have their own business are also becoming more trusted in managing their business. However, despite all the improvements in their social life, both clients with intervention and non-intervention do not disclose their MMT involvement with their family for their personal comfort and reason.

“Thank God, since I started Methadone and psychosocial support programme, I can interact with other family members when we have gathering.” (KI008, Client with intervention)

“I use my time to socialise with other people.” (KN002, Client non-intervention)

“I feel that I am helped a lot to communicate better. I have always felt difficult in communicating with other people in all aspects. Not that I am a private person, but when I speak in public, I don’t feel confident at all. But after being involved in the programme, it has helped me a little to feel better about myself. (KI001, Client with intervention)

This finding is confirmed through interviews with closest relatives of clients with intervention. They stated the benefit that they have felt regarding clients’ participation in the programme, particularly in becoming more open and confident. Unfortunately, almost all closest relatives of clients were not aware that the programme is intended to develop and re-establish client’s psychosocial aspects. Many of them thought the programme was merely for clients to spend time on and for them to learn new things. On the other hand, family and closest relatives of non-intervention clients also feel the benefit of MMT. They see clients have become more focused and organised in their routine activities. It is clear then that family and closest relatives can be potentially supportive to the increase in life quality of MMT clients.

An important note from this study that needs to be considered for further development of the programme in the future is that there has been increase in confidence among clients with intervention, particularly their openness to their partner and family, including their interaction in their big family. However, there is still limitation to their interaction in a bigger community in the society. Clients' daily activities are limited around the community of people who use drugs. They are supported by their family and closest relatives to spend time in their daily activities. On the other hand, although receiving no psychosocial support, non-intervention clients have also felt better social relationship with their family and work environment. They also receive further support to continue their therapy appropriately.

In the context of relationship with MMT clinic staff, both groups of clients with intervention and non-intervention feel "OK". Only a small number of people have felt that they had been treated inappropriately because of the offending language that the clinic staff used. However, most of clients complained the difficulty to meet with doctors to have consultation, difficulty in arranging higher/lower dose, and take home dose technicalities. These have caused many clients regularly come to the clinic without having a sense of the importance of consultation/counseling, and even many of them arrange to reduce their own dose without the knowledge of doctors.

It seems that the situation happens because there is a lack of interaction between psychosocial support programme implementers and MMT clinic staff to synergise the activities and to increase the quality of service for clients. Although there have been no noted stigma or discrimination acts between the clinic staff and the clients, it is clear that communication is severely lacking. This situation has made many clients involved in the therapy without knowing their goals and the mechanism of the therapy itself. Therefore, the benefit of the therapy has not been optimised. It is very essential to accommodate communication and relationship between clinic staff, clients and Rumah Cemara Programme Implementers for future development of the programme.

Adoption

Based on the initial design of the programme, coordination and communication mechanism with stakeholders have been made by RC. The main stakeholder is MMT clinic staff, including all the policy decision makers; clinical staff; and research staff of Hasan Sadikin hospital. This mechanism has been planned in the logical framework as MMT clinic in Hasan Sadikin hospital is the main actor that provides Methadone in Bandung. The clinic was also involved in the initial stage of the programme in designing and selecting participants for the programme. This process is seen as a positive step for future programme sustainability. Unfortunately, along with the implementation of the programme, coordination has slowly lacked. This is further severed by the irregularity of communication between Rumah Cemara and MMT clinic staff in Hasan Sadikin hospital.

"Participants were recommended by the clinic and from Methadone clients too. I was also involved in coordination meeting with them, something like a case conference with MMT clinic staff. The concept of the programme was provided to them, and even we worked together with IMPACT, the research division of the clinic. We consulted with them and built the concept together. At that time, we talked

about having a Case Manager in MMT clinic to accommodate the coordination and communication between RC, clients and the clinic.” (DKT, Programme Implementer)

“I have heard about this programme but not in details. Personally I feel it is great, especially to fill in the gap of psychosocial support needs that the clinic cannot provide. I generally know what Rumah Cemara provides, but not specifically about this psychosocial support programme. I only overheard from clients or meetings.” (PK002, MMT clinic staff)

On the other side, expectations from family and closest relatives of both clients with intervention and non-intervention on this programme to be further developed is high. Especially as they see this programme as a door for clients to be able to gain more skills in hopefully getting a job, especially for clients with intervention as most of them have not gained significant social life development. Looking at programme sustainability, it is very important to ensure that this programme can be implemented even without the support from Rumah Cemara. At this point, psychosocial support programme seems to be a one-off project with no integration to the other programme from stakeholders. In addition to that, optimisation of other stakeholders have not been done. Concrete follow-up steps to develop new partnership with different stakeholders is necessary. The high expectations from family and closest relatives should also be made as motivation for clients and RC Programme Implementers to further develop psychosocial support programme to accommodate the needs of MMT clients.

“At this point, I can only say that (a name of client) has been given many positive activities. I hope there will be more, something that can generate income and keep her busy. She is now unemployed, so does her husband.” (KLOT008, family/closest relatives of clients with intervention)

In order to ensure programme sustainability, support from different sectors is essential. Network of coordination and partnership need to be developed by Rumah Cemara to other than MMT clinic in Bandung. Relationship with local AIDS Commission, Health Department or Social Affairs Department can become the next target. Concrete steps need to be taken to build new relationship with other institutions to further increase quality of the programme and to maximise the benefit for the clients.

Implementation

Initial design of psychosocial support programme was done based on the needs of the beneficiaries. Field assessment was done to see the gaps that the programme can offer. Needs assessment was done through focus group discussion with clients and discussion forum with Methadone Community (Komet) and MMT clinic staff. The meeting with the community was also set up based on clients’ schedule on taking Methadone to ensure the quality of the discussion. Inputs were taken and mapped into programme implementation work-plan. As a result, the first stage of the materials includes Bio-Psycho-Social aspects (see table 4). The number of participants involved in the programme was between 10-15

people who met three times a week for one month. Rumah Cemara also provided snacks and transportation remuneration as much as IDR 25,000.

“Before this programme was implemented, we did some assessments. One of them was focused group discussion with Methadone clients in Bandung.” (DKT, Programme Implementer)

Table 4: Initial Stage Materials of Psychosocial Support Programme

BIO	PSYCHO	SOCIO
• Hepatitis C	• Self acceptance	• Communication skill
• SRHR/STI	• Art feeling	• Survival skill
• HIV/Methadone	• Potential assessment	• Resource access & referrals
• HIV/TB	• Stress management	• Stakeholders’ roles
• Harm Reduction	• Group meeting	• Family outing
	• Motivation	• Critical awareness

Source: Result of discussion on initial assessment. Evaluation with RC Programme Implementers.

During the evaluation, programme design has been changed. The number of participants was still maximum 15 people in each session, but there were no clear guides of materials that were given. The number of participants also varied and session was not based on the people who attended, as they could be just anyone who could attend the session. This situation was caused by the limited availability of clients to participate in the programme that made a mixture of new and old clients in the same class. Therefore, some basic materials in Biology aspect became irrelevant to be redelivered. This decision affected the level of knowledge among clients and materials became less adequate.

“The counseling was always about the same thing again. I personally feel that I should discuss about other things. Maybe try to find new materials and methods.” (KI009, clients with intervention)

“When it’s full, there are 15 people, but sometimes only 7 people. No matter how many shows up, we always have the session.” (KI009, client with intervention)

“Maybe I can attend if the schedule is changed. Maybe to Saturday or Sunday?” (KI010, clients with intervention)

These changes in the programme design appeared to be caused by the non-existence of clear guidelines and procedures to implement the programme. Therefore, in the implementation, there were often loss of focus and track from the overall aim. Consequently, the programme has become partial and adapted to on-the-spot decision.

Each activity in the programme seems to stand alone, not as a big part of a comprehensive programme.

"I am not aware of the details of the big plan of this programme textually." (PS01, counselor)

"I am often asked, and don't know what to respond. I cannot assess how far has it developed because I don't have a guideline." (DKT, Programme Implementer)

Looking more closely into the programme, there are many factors that contribute to the current implemented programme which also affected to the achievement of the programme (see diagram 2). Inconsistent recruitment system; no exclusion criteria of participants; unavailability of programme guidelines and modules; high rotation of staff, which affected the understanding of programme description and aim among Implementers, in addition to lack of human resources and programme management which has not been well documented among the staff, for example: counseling has not been done effectively. This has also contributed to the availability of allocated time for clients to have individual counseling. As a result, clients lacked motivation to further involve in the psychosocial support programme. One of the external factors that further damaged this situation is unmaintained relationship and communication with the MMT clinic in Hasan Sadikin hospital.

Diagram 2: Contributing Factors to Psychosocial Support Programme Implementation



Source: Result of data analysis from evaluation

Apart from those factors mentioned above that need to be carefully considered in programme implementation, clients perceive the programme well. Majority of the clients stated that they have benefited from the programme. This statement is also approved by similar statements from clients' family and closest relatives. However, in its implementation, the programme has paid little attention to the dynamic of the development. Psychosocial support meeting has become a regular and common peer-to-peer support meeting for MMT clients. This is crucial as clients' progress has become difficult to be measured. Furthermore, because the frequency of the meeting was not limited, clients have less opportunity to develop their social life outside their community. Clients' motivation also needs to be increased to a level where they understand the aim of their participation in the programme. One of the ways to ensure this is to optimise counseling as part of psychosocial support programme.

"I really want to be in the programme longer, if possible, don't stop now. I really feel that I need it, very much." (KI005, client with intervention)

"I feel better. I think more positively, less negative thinking. I know now that every problem has a solution. I can talk about it. I learn so much from my circle of support." (KI009, client with intervention)

In order to accommodate the needs of the clients in the programme, Rumah Cemara needs to respond to the inputs from this evaluation. RC needs to fix the recruitment system, re-build the module, re-design the curriculum for session and counseling along with the measurement tools, and re-develop measurement tools for programme and client's individual achievement. These basic elements can affect the operational and management of the programme as a whole. Client's perception, although in a small scale, needs to be utilised as a motivation to better programme. Responding to these will create a bigger impact of the programme. Other than that, RC also needs to be more sensitive and responsive in seeing the dynamics of the clients' needs, even though it takes to re-modify the programme plan, it is essential to increase the quality of the programme delivery.

Maintenance

A well-maintained psychosocial support programme has a potential for its future sustainability. Programme maintenance can be seen from its position in Rumah Cemara's overall programmes, sustainability strategy, internal communication and coordination, funding availability and potential strategy that supports its sustainability. Based on the evaluation, it is clear that Rumah Cemara tries not to make psychosocial support programme exclusive by referring clients to all different programmes in the organisation. For example, clients are involved in sports for development activities and peer support group related to HIV. This method has affected positively to clients as they have the opportunity to get involved in a bigger community in the society and to put their skills in practice. Though, it is very unfortunate that psychosocial support programme has still not been integrated to the programme in MMT clinic in Hasan Sadikin hospital. Coordination and communication happened only at the initial stage of the programme and not well-

maintained for further development. However, MMT clinic staff generally welcome the programme and expect for further concrete partnership in the implementation. This is one of the most important aspects that needs follow-up from Rumah Cemara to ensure programme sustainability.

"Rumah Cemara's psychosocial support programme really supports the gaps in the whole programme, it supports our service." (PK002, MMT clinic staff)

Looking more closely to the management of the programme, Rumah Cemara is still struggling with utilising its human resources with adequate competent to implement the programme. Position for Case Manager has not been filled until this evaluation was made. Other than that, programme implementers do not have clear job description. Documentation process of programme achievements has been affected as a result. This situation appears to have been caused by the high rotation of staff and double jobs among programme implementers, which made responsibilities are vaguely divided among different programmes (outreach, volunteers, counselors and buddies). Counselors and psychologist involved are very limited which they have not been able to provide optimal service. Furthermore, until this evaluation was made, there has been no commitment and certainty of future funding for programme development other than the existing funding from the International HIV/AIDS Alliance. This situation has forced RC to seek for other opportunities locally such as, the government budget and Corporate Social Responsibility funding.

"It was very difficult to find the right person for the position. Human resources is very lacking." (DKT, Programme Implementer)

"Many of us have double job and double responsibilities in other projects." (DKT, Project Implementer)

"I did not know the details of the programme as a whole." (PS01, Counselor/Psychologist)

Some strategies that are necessary based on the findings here are: capacity building to increase the understanding of psychosocial support programme among all staff (see also findings in Reach and Implementation); a more responsive team to fill the gaps and the needs of the programme and human resources; better communication and coordination to synergise the programme with MMT clinic programme to increase the quality of both programmes, as well as the benefit of the programme; increasing the knowledge among participants regarding Methadone Maintenance Therapy and developing better relationship between clients and MMT clinic staff; and more comprehensive coordination with MMT clinic and other stakeholders to ensure programme sustainability.

Chapter 4: DISCUSSION

Evaluation Result and Programme Improvement Factors

Evaluation made to psychosocial support programme by Rumah Cemara cannot be determined in absolute. This is because the findings of the evaluation indicate that there are mix-results of programmes implemented by RC. Theoretically, the achievements can be seen from how far has the programme reached its initial targets. However, it is difficult to make an absolute assessment of the programme as there are no adequate documents as evidence to measure the programme's achievement. Based on table 5, programme assessment result shows variety of results with no significant difference between clients with intervention and non-intervention.

Table 5: Matrix of Psychosocial Support Programme Evaluation Result, 2013

	Evaluation ↑	Evaluation ↓
Reach	- Programme reach >80% of the total of MMT Clinic patients ²	- No documentation of clients who have completed the programme
Effectiveness	- Better relationship with family* - Increase in self-confidence - Social adaptation is in place	- Continuous other drug use* - Relationship with clinical staff only as far as service providers*
Adoption	- Programme plan is socialised to stakeholders - Good relationship between RC and MMT clinic	- No follow-up meetings with stakeholders - Involvement of MMT clinic only as far as being aware of, not direct participation
Implementation	- Initial consultation process for clients at the first stage of the programme - Clients feel comfortable with the method - Programme implementation based on clients needs	- No operational procedures/documents of the programme - High rotation of staff
Maintenance	- High commitment from RC to work with community of people who use drugs	- Incidental coordination - Financial stability relies on funding from donors

*For both clients with intervention and non-intervention

However, psychosocial support programme has a strong potential if it is done with more perfections. This is indicated by the initial investment that has been made such as: the level of trust from MMT clients to Rumah Cemara; Rumah Cemara's background as a community based organisation; evidence in progress in quality of life of clients; and good relationship between RC and MMT clinic. Improvement over the programme can be done through re-designing the logical thinking of the programme and provide solutions based on the input of

² The number of active clients registered at MMT clinic in Hasan Sadikin hospital in 2013

the evaluation. This combination will become the basis of the new programme design which will also become important sources to decide the materials and means of support that need to be included in the programme.

Important materials that can help focus the programme design can be gathered from initial programme documents and evaluation findings which can be summarised to proposed solutions for improvement. This aligns with one of the aims of the operational research mentioned in the research proposal. Identification of problems started by analysing through the initial design of the programme made by RC. Generally, clear goals of a programme will help its implementation to focus. However, the initial document of this programme only stated the components of the programme rather than having clear goals and expected outcomes³. Findings from focused group discussion with Programme Implementers can be made as preliminary reference to formulate the mission of the programme. At least, expectation from each staff involved in the programme can be formulated into collective goals of the programme.

Goals that are summarised from collective expectations can potentially develop the programme stronger as staff members will also develop high sense of belonging to the programme. After goals are set, activities that will support the programme to reach its goals are also defined as part of integrated programmes. One of the advantages of combining psychosocial support and pharmaceutical therapy such as Methadone is to reduce the drop-out rate and Opioid use during the therapy (Amato et al., 2008). This advantage should be one of the programme success indicators. Additionally, support can be provided to increasing clients' motivation to succeed in their therapy. Comprehensive efforts to reach the programme goals can be indicated from the sessions and activities delivered to clients.

Another important information that can help the re-designing of the programme is to look at the willingness of beneficiaries, including learning their situation, condition and needs. Findings from the evaluation indicate that there are no significant differences in the impact between clients with intervention and non-intervention. Looking more closely, supporting factors of clients non-intervention are family and closest relatives, and new environment outside of Methadone community which has made a lot of improvement in their social life. Support from family and closest relatives, employment, understanding about addiction, and developing social life outside Methadone community can become important points to be added into the programme.

A currently active programme should also monitor how far it has achieved the targets. Monitoring is very important not only for Programme Implementers to measure the success of the programme; but also, for RC to evaluate the programme. Rumah Cemara decided to start psychosocial support intervention based on the facts gathered from the field that there was no support for Methadone clients which was not fulfilled by the clinic. Unfortunately, after two years running, the successes of the programme have not been well documented. This has caused Programme Implementers great difficulty to measure how much it has affected the beneficiaries.

Learning from the findings, the programme should be able to document all programme achievements. Measurement of clients' development and programme success indicators

³ See document "Rumah Cemara CAHR implementation strategy 2012-2014"

should be well documented. Programme success indicator can be made based on the goals and expected outcomes decided when designing the programme. For example, if the goal is to help clients reduce their multi-drug uses during their Methadone therapy, then one of the indicators can be through observing before and after the programme and the number of times clients use multi drugs. However, by considering that each individual has various problems and situations, it is very important to discuss the target of the programme together with the clients. This can help them to also be responsible to their problems as well as guiding them to solve their problems. In this context, psychosocial support intervention by Rumah Cemara can become a stepping stone for clients to pull their life together and it can also be made as a self-empowering programme for clients.

Other than individual targets, initial assessment of clients' addiction and mental condition also considered important to be done. Through assessment, clients' progress can be well documented which can also affect positively to the evaluation. Some indicators that are commonly used in medical field can also be used or adapted based on the needs of the programme. For example, in SP-36 Health Survey made by Ware, Kosinski and Keller (1994), can be used as a basis to assess different aspects such as, physical function; physical role; and body pain. These aspects can be adapted based on what clients feel under Methadone therapy related to comfortable dose. As for the mental aspect, general indicators such as mental health; emotional role; social function; and vitality can be used to measure the clients' progress before and after the programme.

In performing assessment, indicators that see physical and mental health need to be added as programme success measurement. From some physical and mental health indicators that are included in SP-36, in respect to the results of the evaluation, there are two approaches that can be combined in designing a programme that enforces clients to become self-empowered – group and individual support.

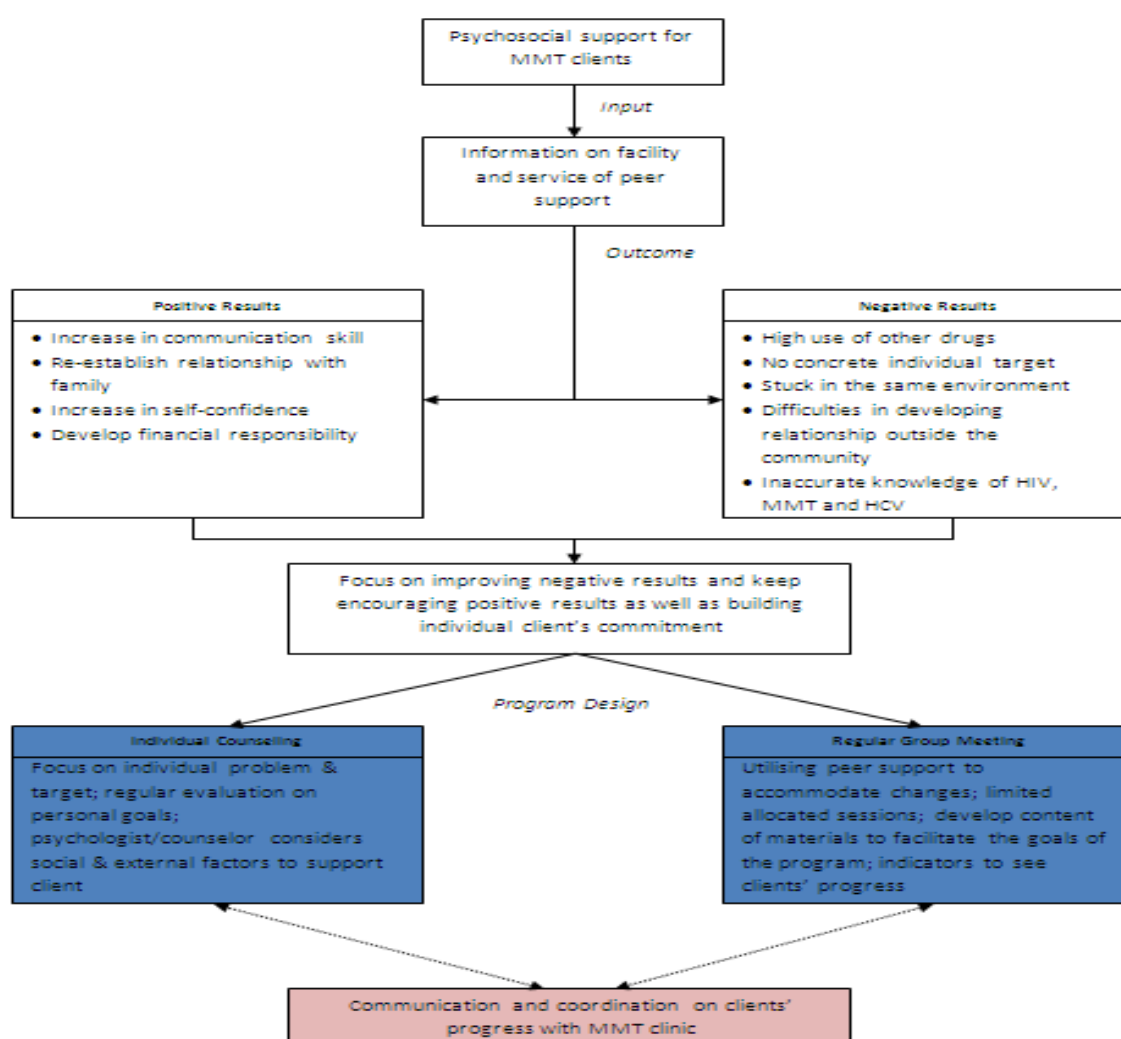
Based on the evaluation, clients have stated that they have developed more confidence and communication skills through group discussions. Therefore, group support approach is an important element of the programme. Important information related to substance addiction and health can also be facilitated through group learning. Discussion method can activate the process of learning new things and generate questions in an informal context which can increase personal understanding and participation in the programme (Barry et al., 2011). Materials provided in group meetings can be delivered by a facilitator or an expert speaker, depends on the materials required. It is also important to remember that the quality of facilitator or speaker is very important to ensure knowledge learning process and skills development among the clients. Additionally, the duration of the meeting should be well-adjusted to the clients' effective learning time. High number of meetings can create the clients to become too dependent to each other which can hinder their social development outside of Methadone community.

Individual support in psychosocial support is essential to ensure focused assistance provided to the clients to help them achieve their personal goals. Clients with the background of drugs and substance dependence are psychologically damaged which affects to their lives (Kalivas & Volkow, 2005; Kreek & La forge, 2007). This means that problem solving process and social approach will be done differently than people who are not dependent on drugs. Thus, intensive individual support is required to solve personal problems which often

require psychological intervention. Counselor's role will be very useful to support the process of problem solving and reaching personal goals of clients.

Unlike group support that aims to increase the understanding and skills of clients, individual counseling mainly aims to help clients in planning and reaching their personal goals. Self assessment method in making decision has made direct and indirect positive effects in the behaviour of people who use drugs (Kerr, et al., 2004). Target can be chosen based on the problems that the clients face through the help of a counselor. Based on the research from Joe et al. (1995), it shows that people who use drugs who undergo individual counseling at least twice a month have shown some reduction in their drug-use during their Methadone therapy. Documentation of clients' development can be done in each meeting to measure the progress as well as a note to psychologist/counselor as a personal guide.

Diagram 3: Findings and Proposed Solution to Psychosocial Support Programme for MMT Clients



Managerial Consequences

Changes in psychosocial support programme design will have direct effects to the resources which eventually will impact the management of Rumah Cemara. As currently RC only relies on one person to manage psychosocial support programme, based on the evaluation result, the required human resources will change. Having individual counseling programme means that RC needs to allocate adequate number of counselors available and responsible to monitor clients' development. Implementing staff is still required in the selection process of the participants, arranging meeting schedule and ensuring the arrangement of facilitators or speakers for sessions. Good coordination between implementing staff and counselors is also required to report against clients' development. Coordination should involve information about clients' regular interactions, group session schedule, counseling schedule, target and clients' development.

The increase in human resources will automatically affect the cost of the management. Financial needs depend on the number of staff allocated for the programme, the length of the programme, and operational cost of the programme. For organisation with limited sources of finance, it is very important to have the right strategy of resources allocation. For example, limiting the number of group session will automatically reduce the operational cost of the programme. Other than that, counseling scheduling and the number of clients receiving counseling should be managed efficiently. Since the programme requires both group and individual support approaches, the most ideal strategy would be limiting the number of clients in each term. This will greatly affect the burden of the resources and management as there will be less work-load in documenting and monitoring.

Programme Sustainability

Another important aspect that has been identified in this evaluation is the position of the programme sustainability in the future. Initially, psychosocial support programme in Rumah Cemara was designed to support MMT programme in filling in the gaps of psychosocial needs that have not been met. In the implementation, RC acts as the implementer financially supported by international donor. In order to ensure the programme sustainability in the future, it is very important that RC together with MMT clinic in Hasan Sadikin hospital to develop collective vision to include psychosocial support programme as one of the service components that clients will receive when accessing MMT clinic. With an independent vision of the programme, partnership that is developed will not only focus on coordinating clients' progress, but also including advocacy for programme sustainability which requires more intensive and consistent approach. In this context, Rumah Cemara as the pioneer of psychosocial support programme, once the programme is integrated with the MMT clinic programme, RC can start expanding or replicating similar approach to other MMT clinics in other cities.

Several advocacy approaches can be done by Rumah Cemara to ensure the sustainability of psychosocial support programme. In the introduction of the programme, RC can share the work-plan and goals of the programme as a whole. It is important to ensure that the meeting is attended by stakeholders competent in both decision making and MMT service provision. Then, regular meetings can be done during the process. This time, the aim of the

meetings will be providing further assistance to the progress of the programme development. It is very important to ensure that there are discussions around comfortable dose of Methadone, counseling needs, and medical referrals for clients. Meetings with stakeholders should not discuss about clients' personal life which is strictly confidential. The later stage is to provide sustainable assistance to ensure programme adaptation as part of MMT clinic services. This process can take a long time, depends of the approach that RC chooses to do. During advocacy, stakeholders need to be ensured on how much psychosocial support programme has affected clients' life development. Additionally, it is also important to negotiate and adapt the programme design with the resources and system in the MMT clinic.

Another positive note that if Rumah Cemara can make it happens is to work together with other stakeholders to provide further benefits to the programme participants, such as: Department of Labour, Department of Social Affairs; private companies, etc. With more concrete partnership, more MMT clients will be interested in joining the programme which will also build more motivation among the participants to reach the goals of the programme.

Chapter 5: SUMMARY AND RECCOMENDATION

Summary

Generally, psychosocial support programme for Methadone clients implemented by Rumah Cemara is very beneficial and has strong potential to be further developed with some improvements. Although it is not documented, the result of the evaluation has shown that there is strong willingness from clients with intervention to increase their life welfare. Motivation to change economy condition, communication skill, relationship with family and reduction of Methadone dose as a way to reach abstinence have been seen in most of clients in the programme. Unfortunately, these motivations have not been well encouraged by the programme comprehensively. This is indicated by the high rate of multi-drug uses among clients during MMT, limited understanding of Methadone, and limited social life scope which focuses only among Methadone clients.

Although clients' motivation is one of the most important elements to the improvement of this programme, there are other factors that need equal consideration such as: participant recruitment system, standardised programme guidelines and curriculum module, success measuring tools, availability and management of human resources in RC, and partnership for integrated programme with MMT clinic.

Mechanism that can be offered based on the findings of the evaluation is to re-design the goals of psychosocial support programme and re-develop the system to support the goals. The focus can be aimed to minimise negative factors and to maximise the positive factors in the programme. Certainly, in order to be able to measure the impact of the programme, clients' success indicators on both knowledge and psychosocial aspects needs to be regularly monitored and evaluated at the end of the programme. Additionally, Rumah Cemara as the implementing organisation needs to be prepared for the managerial consequences which may be caused by the improvement of the programme in the future.

Recommendation

Based on the findings of the evaluation, there are several recommendations that can be offered to improve the programme in the future. These have been summarised into the following ideas:

- ⊕ Modification and revision of implementation guidelines of the programme in the context of concept, participation, documentation and development of specific monitoring and evaluation plan in order to increase the reach of the programme;
- ⊕ Allocation of adequate human resources involved in the programme for better management;
- ⊕ Development of comprehensive psychosocial support integrated with MMT clinic through partnership and concrete support from different stakeholders as part of MMT programme as a whole.

Detailed explanation about the recommendation above can be found in a separate document, *Design of Technical and Implementation Guidelines of Psychosocial Support Programme for Methadone Maintenance Therapy Clients*. This document has been made based on the findings and analysis of the two phases of operational research on psychosocial support programme implemented by Rumah Cemara, where in the design of the study, the development of this document will be included in the third phase of the study. Designing the revised module is expected to correct all the drawbacks in the current implementation as an effort to increase the quality of the programme and to optimise the benefit that will be received by the clients.

Following the design of revised module, trial of the new programme will be done. During the trial, it is important for implementers to concentrate on what is not appropriate to be adapted reflecting to the capacity of resources in Rumah Cemara. With the completion of trial of the new module, then it concludes the fourth step, and the last step of this whole operational study.

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