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**EVALUATING THE CONTRIBUTIONS OF SELECTED DRUG REHABILITATION
CENTRES IN GAUTENG: TOWARDS AMELIORATING THE DRUG PROBLEM IN SOUTH
AFRICA**

BY

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SUPERVISOR: PROFESSOR S.M KANG'ETHE

04 May 2017

Declaration

I, ABIGAIL MAKUYANA, the undersigned candidate, hereby declare that the content of this dissertation is my original work and that it has not been previously submitted to any other University for any degree, either in part or in its entirety. I also declare that this work fully complies with the University of Fort Hare Policy on Plagiarism and that, as advised by my supervisor, the responsibility for adhering to the ethics of originality and proper referencing is entirely mine.



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Abstract

This study aimed at evaluating the contributions of two (2) selected rehabilitation centres to the goal of ameliorating the substance abuse problem in Gauteng. The study utilized a methodological triangulation approach for data collection, but with greater emphasis on qualitative methods. The study collected its qualitative data from four focus groups conducted with 32 participants and six key informants who were subjected to in-depth interviews. The quantitative aspect of the study made use of a mini-survey in which one hundred (100) questionnaires were distributed amongst the primary caregivers of recovering drug and substance abusers.

The major findings of the study pointed out that rehabilitation centres were unequivocally contributing to the goal of ameliorating substance abuse in Gauteng and, by extension, South Africa. Among some of the outstanding contributions of the rehabilitation centres was the provision of a non-judgmental and supportive therapeutic environment for clients to recover. It was also observed that rehabilitation centres were acting as character reformatories for substance abusers, and, thus, aiding their easy reintegration back into their families, societies and work places. The study also found out that the selected rehabilitation centres were providing ample admission periods and competent counselling services for their clients to navigate their way to recovery.

The study unearthed new trends in the substance abuse landscape of Gauteng. Firstly, it was established that more educated people were falling into substance abuse usage. Secondly, the drugs which were rendering users more amenable to rehabilitation were noted to be highly potent. The high potency was noted to be responsible for extreme difficulties in withdrawal and rehabilitation. This was, therefore, noted to accentuate the imperativeness of the role and contributions of rehabilitation centres in helping drug users to achieve recovery in an environment that was supportive, nurturing and safe. It is, therefore, on the basis of these fundamental findings that this study concluded that the contributions

of rehabilitation centres were not only important in the fight against drug and substance abuse, but were also a necessary precondition in this endeavour.

Conversely, it was established that the contributions of the rehabilitation centres were being thwarted by exorbitant and extortionate treatment fees charged by the rehabilitation centres. More so, rehabilitation centres faced the dire challenge of poor visibility due to the poor marketing of services, as well as their location in affluent or remote areas which are mainly accessible only through private transport. This means that some people, especially the rural and the urban poor, were not equitably benefiting from the services of the rehabilitation centres. The study observed that women, girls and children in general were largely excluded from benefiting from the services of the rehabilitation centres.

The research closed off by recommending to rehabilitation centres that they ought to address administrative gaps such as embracing and practising social, linguistic, dietary and gender sensitivity in their programmes to ensure that they remain relevant to their clients while also reflecting the diversity in South Africa. Recommendations were also made to the government to intervene and moderate the pricing of substance abuse treatment services, by making them reflect the country's socioeconomic inequalities.

Supervisor's Confirmation

I hereby confirm that I have supervised the thesis of the student mentioned below and that it has been submitted with my authorization.

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Dedications

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LIST OF ACRONYMS AND ABBREVIATIONS

Abbreviation	Meaning
AA	Alcoholics Anonymous
ATS	Amphetamine Type Stimulants
CARE	Cooperative for Assistance and Relief Everywhere
CASW	Canadian Association for Social Workers
CDA	Central Drug Authority
DARA	Drug and Rehab Asia
DFID	Department for International Development
DSD	Department of Social Development
EAP	Employee Assistance Program
FAS	Foetal Alcohol Syndrome
GHB	Gamma-hydroxybutyrate
GST	General Systems Theory
HIV/AIDs	Human Immunodeficiency Virus Infection/Acquired Immune Deficiency Syndrome
INCB	International Narcotics Control Board
Institution X	First selected rehabilitation centre
Institution Z	Second selected rehabilitation centre
LSD	Lysergic Acid Diethylamide
NA	Narcotics Anonymous
NASW	National Association of Social Workers
NDMP	National Drug Master Plan
NDMP1	National Drug Master Plan (1999 – 2004)
NDMP2	National Drug Master Plan (2006 – 2011)
NDMP3	National Drug Master Plan (2013 – 2017)
NDSD	National Department of Social Development
NICRO	National Institute for Crime Prevention and Reintegration of Offenders (South African)
NIDA	National Institute on Drug Abuse (American)

NSW	New South Wales
PCP	Phencyclidine
PPPs	Public-Private-Partnerships
PWV	Pretoria-Witwatersrand-Vereeniging
SACENDU	South African Community Epidemiology Network on Drug Use
SACSSP	South African Council for Social Services Professions
SANCA	South African Council on Alcohol and Drug Dependence
SAPA	South African Press Association
SLA	Sustainable Livelihoods Approach
SMART Recovery	Self-Management and Recovery Training
SOS	Secular Organizations for Sobriety
SPSS	Statistical Package for Social Sciences
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TCs	Therapeutic Communities
THC	Delta-9-Tetrahydrocannabinol
UNDCP	United Nations International Drug Control Programme
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
USA	United States of America
WFS	Women for Sobriety
WHO	World Health Organization

CHAPTER ONE

Substance Abuse: The New Curse in Modern South Africa

“When you get into a tight place and everything goes against you, till it seems you could not hang on a minute longer, never give up then, for that is just the place and time that the tide will turn.” – Harriet Beecher Stowe

1.1. Introduction

This chapter presents a general orientation of the study. It outlines the background of the study and, thus, locating the researcher's interest in the subject of inquiry. The chapter also outlines the central research problem, the aims and objectives of the study and the theoretical basis upon which the study was premised. A review of why the subject of inquiry is paramount was launched in the significance of the study section. The chapter ends off by outlining the structure of the thesis.

1.2. Background

The United Nations Office on Drugs and Crime (UNODC) (2013, p.1) estimates that 3.6% to 6.9% (167 to 315 million people) of the global population abuse drugs. The UNODC (2015, par.5) mentions that there are several drug supply routes in the world with the major ones being the Balkan and Northern routes, each with a market share value of US \$20 and \$13 billion, respectively.

Available literature indicates that although the prescribed usage of drugs has some curative and medicinal value. However, abusing, especially the illicit ones, presents horrendous effects (Duke & Gross, 2014). Notably, when drugs are abused, a multiplicity of side effects can occur such as brain damage, body malfunctioning, addiction, loss of productive capacity, propensity to engaging in violence that may result in property damage, murder, family disintegration and increase in vulnerability to contracting deadly diseases (such as HIV/AIDS, STIs, Hepatitis B, and Pulmonary infections) (Granfield and Cloud 1996, 2014;

Duke & Gross, 2014; UNODC, 2013). This is why there have been global, regional and national efforts to stop the abuse of drugs (Dewey, 2008). To this end, available international statistics reveal that many governments, communities, families and individuals are providing huge amounts of money into drug and substance abuse prevention and rehabilitation (Walters, 2013). This is because of the immense loss that the drug problem is ushering into modern societies.

However, although the substance abuse problem is a global concern, its impacts are often heavier and more devastating in the developing countries, where poverty, hunger, social and civil strife take a huge toll (Bergen-Cico 2015). According to Walters (2013), poor social and economic conditions act as fertile breeding grounds for drug and substance dealing and abuse. This is so because people who lack social and economic opportunities may opt to seek solace in substance abuse, while drug dealing presents compelling economic opportunities for the poor and the disenfranchised (Walters, 2013; Bergen-Cico, 2015). In this light, Parry (1998) mentions that since the 1990s, Africa has seen a surge in the number of people who use illicit drugs. This trend has been attributed to the cultural and social acceptance of usage of intoxicants in African societies (Peltzer, Ramlagan, Johnson & Phaswana-Mafuya, 2010). Peltzer et al., (2010) also add that hard drugs such as cocaine, heroin, crystal meth and other modern designer drugs are a product of modernization and globalization, which promotes free trade, thereby, enabling the diffusion of commodities, including drugs, into new territories where they were not available before.

With the exponentially growing drug and substance casualties including permanent injuries, suicides, homicides, psychosis and damages to property, it becomes imperative to assess the contributions of stake holders in the prevention and treatment of drug dependence towards finding lasting solutions for this blossoming problem. This study has, therefore, evaluated the contributions of 2 selected Gauteng rehabilitation centres.

The evaluation mainly focussed on identifying the contributions of the selected rehabilitation centres in the light of the national vision of attaining a drug free South Africa as envisaged in all National Drug Master Plans.

1.2.1. Overview of South Africa and its Drug and Substance Abuse Problem

Drugs present a very big challenge to the vision of transforming South Africa along a sustainable social and economic trajectory (Parry, 2001). The South African Press Association (SAPA) (2013) adds that, if no immediate remedy is found to arrest the exponentially escalating drug and substance abuse rates in the country, the drug problem will soon overtake the impacts of HIV/AIDS. The Department of Social Development (DSD) (2007, p. 7) in the National Drug Master Plan of 2006-2011 estimates that between 7.5% and 31.5% South Africans have a drug or alcohol problem, or are at risk of having such a problem. Moreover, the UNODC (2013) notes that drug abuse rates and the easiness of accessing drugs in South Africa is twice the world norm. Furthermore, the United Nations World Drug Report (2011) adds that South Africa is in the top ten of global narcotics' abusing countries leading the country to gain the infamous title of being called the 'drug capital' of the world.

The United Nations World Drug Report (2011) observed that South Africa loses more than R20 billion to drug abuse annually. This includes costs related to addiction prevention services, treatment and other economic losses due to lowered production as the rate of absenteeism from work rises. In addition, drug abuse can also lead to property damage and loss of lives due to the uncontrollable rage and paranoia during or after intoxication (Emmelkamp & Vedel, 2012). The Naked Truth (2014, par. 1) writes that 65% of the national murder crimes in the country have their origins in alcohol and drug abuse. Additionally, the South African Police Services' (SAPS) national statistics indicate that 60% of all the crimes in the country are committed by persons who are under the influence of drugs, or those working to secure funding for their habits (The Naked Truth, 2014, par.1).

The Central Drug Authority (CDA, par.5) (2009) also mentions that, one in every four Rand in circulation in South Africa is linked to the perpetuation of substance abuse. Additionally, mortuary-based studies found out that on average, 37 % of all fatal road accidents in South Africa are associated with drug and alcohol abuse (Parry, 2001, par. 9).

Fundamentally, the need for greater attention by both the private and the public role players in the prevention and treatment of drug and substance abuse has always been expressed by the South African government since independence (The National Drug Master Plan of 2006-2011 cited by Department of Social Development (DSD), 2007). In his maiden speech in parliament in 1994, the former and first post-apartheid President of South Africa, the late Nelson Mandela, poignantly pointed out that alcohol and substance abuse in the country was a serious social problem which was destabilizing the functioning of individuals, families, communities and the nation at large (DSD,2007; National Drug Master Plan, 2006-2011). The leaders, therefore, call for action to address the drug problem through both preventative and curative measures. To that end, several legislations and committals have since been put in place towards combating the drug problem in South Africa.

1.2.2. Origins of the National Vision of a Drug Free South Africa

According to the Draft Minimum Norms and Standards for Community Based Treatment cited by the National Department of Social Development (NDSD) (2006), the agenda of creating a drug free South Africa was first expressed in the National Drug Master Plan (2006-2011), cited by the DSD (2007). Among other factors, the South African National Drug Master Plan constitutes and spells out the government's plans and commitment to mobilizing social, economic and political resources, including forging partnerships with private organizations (Public-Private-Partnerships) (PPPs), in an effort towards decreasing the availability of illicit drugs and their demand, as well as providing treatment of those who are dependent on drugs (DSD, 2007; Geyer & Lombard, 2014).

As stipulated in the National Drug Master Plan (2006-2011), the DSD is mandated to coordinate the programmes of treatment and prevention of drug dependence in collaboration with other government departments and private stake holders (DSD, 2007).

1.2.3. Challenges encountered in Executing the Vision of a Drug Free South Africa

Geyer and Lombard (2014) propounded that the vision of creating a drug free South Africa has continued to be a pipe dream for far too long. The failure to transform the vision into fruitful programmes has largely been blamed on poor coordination of the efforts of different stakeholders, which often results in poor resource allocation, duplication of efforts and underutilisation of resources, among other technical problems (Jay, 2011). Concurringly, Mbulayi and Makuyana (2017) state that the treatment component of the vision of ameliorating South African environments of drugs is seemingly in a state of disorientation due to the myriad challenges which are currently characterising the drug abuse treatment and prevention sector.

Nyabadza, Njagarah and Smith, (2013) highlight the fact that a drug-free South Africa might not be possible without a competent administration of the vision through effective coordination of service providers and the quality of services they offer. The South African Press Association (SAPA) (2013) asserts that DSD is failing to proficiently ensure full registration of all drug and substance treatment centres and to enforce the minimum standards of service, hence the continued existence of illegal and often substandard treatment facilities. These negate the efforts aimed at ameliorating substance abuse and promote unethical practices and provision of profit motivated services. Concurringly, SAPA (2013) underscores that the drug treatment sector in South Africa has been under siege by private individuals and organizations who are motivated by profiteering rather than helping people to live better quality lives.

Similarly, Hanson, Venturelli and Fleckenstein (2011) note that the cost of accessing drug treatment services in South Africa remains a major bottleneck to sustainable service accessibility and an albatross to the vision of achieving a drug-free South Africa.

Mokomane (2013) mentions that the vast majority of the South African population is largely poor, and survives on limited social hand-outs from the government. This state of poverty diminishes people's affordability of treatment services, which are mainly being offered by private rehabilitation centres and charge exorbitant treatment fees.

According to Peltzer et al., (2010), the problem of the unaffordability of drug treatment services is compounded by the fact that there are very few public treatment centres which offer services for free. Peltzer et al., (2010) reveal that some Provinces of the country do not even have a single public rehabilitation centre. Such Provinces always have to refer addicted persons to other Provinces with public treatment facilities. Moreover, the Naked Truth, (2014) alleges that due to the critical shortage of public drug treatment facilities, admission into one requires vast patience as the waiting lists are often long; hence, patients have to endure several weeks or months before they can be admitted. Additionally, SAPA (2013) writes that the services of public drug treatment centres in South Africa continue to attract negative public perception as they are viewed to be ineffective.

Furthermore, Peltzer et al., (2010) intimate that despite the hype about creating a drug-free South Africa, the government has continued to fail to ensure the availability of equitable drug treatment services in the rural and other disadvantaged areas. This is regardless of the fact that it is mainly in these poor social and economic environments in which drug and substance abusers are agglomerated.

1.3. Problem Statement

Despite the protracted battle against drug and substance abuse in South Africa, available statistics continue to show that the country is still far from achieving its goal of ameliorating the drug problem. This is a direct negation of public and private efforts aimed at improving treatment, reducing and preventing the circulation and consumption of illegal drugs. There are certain institutional, operational, and treatment gaps which are making the prevention and treatment (rehabilitation) of drug abuse in South Africa ineffective (Gonzalez, Maseko & Mvilisi, 2013).

Drug treatment fees are very high and are agglomerated in urban and affluent areas where the poor and vulnerable cannot access them with ease. There are also accusations that, besides this skewed distribution of rehabilitation services, those available are ineffective, inefficient, inadequate and unsustainable (Jeewa, 2006). Moreover, there are perceptions that drug treatment services in the country are mainly customised for male adults at the expense of women and children. This is contrary to established facts that the gender and age gap in drug abuse is fast narrowing in the country. With the above mentioned gaps remaining glaringly unattended, and, at most, sparingly attended to, it is pertinent to empirically evaluate the contribution of selected rehabilitation centres with the aim of making recommendations for interventions that can reduce the drug problem in South Africa. This research, therefore, proceeded with the standpoint that, expensive, inaccessible, inadequate, disjointed and curative rather than developmental rehabilitation services are retrogressive in the fight against drug abuse in South Africa.

1.4. Research Questions

Main Question: Are the Gauteng drug rehabilitation centres meeting the needs of substance abusers?

- What is the nature and potency of commonly abused drugs in Gauteng which render users rehabilitable?
- What is the nature and effectiveness of rehabilitation programmes offered by Gauteng Rehabilitation Centres?
- What are the institutional and operational gaps associated with selected rehabilitation centres in Gauteng?

1.5. Aim of Research

The aim of this study is to evaluate the contribution of selected drug and substance rehabilitation centres in Gauteng Province in combating the drug and substance abuse problem.

1.5.1. Specific Objectives

- To establish the nature and potency of commonly abused drugs in Gauteng which render users rehabilitable;
- To determine the nature and effectiveness of rehabilitation programmes offered by Gauteng Rehabilitation Centres;
- To establish institutional and operational gaps associated with selected rehabilitation centres in Gauteng.

1.6. Study Assumptions

Creswell (2009) propounds that assumptions are the general world views or perceptions regarding the phenomena under study held by the researcher before conducting the study. Creswell (2007) goes on to quote Guba (1990) in postulating that worldviews can be construed as a basic set of beliefs that guide action. Driscoll, Appiah-Yeboah, Salib and Rupert (2007) add that in research contexts, qualitative studies are often informed by assumptions while quantitative studies are premised on hypothesis. On the other hand, Creswell (2009) posits that mixed methods studies use both qualitative and quantitative methods and approaches. This means that methodologically triangulated studies fuse both assumptions and hypothesis as its world view.

However, Driscoll, Appiah-Yeboah, Salib and Rupert (2007) cite Tasha kkor and Teddlie (1998, p.126) in underscoring the processes of data “quantitizing and qualitizing” which involves merging qualitative and quantitative data and reporting it in the best possible way that answers the research questions. Implicitly, a researcher may opt to focus on one world view which is best applicable to his/her knowledge, experience and, above all, applicable to the domain of the study. In this light, this study was underpinned by the following philosophical assumptions as its worldview:

- Rehabilitation services should be accessible
- Treatment should be up to date
- Innovative intervention should match drugs used
- South Africa stands to lose the battle against drugs if the contributions of rehabilitation centres remain unaccounted for.

1.7. Significance of the study

The discourse of creating a drug free South Africa and the subsequent niche occupied by drug and substance rehabilitation centres in this endeavour is an interesting and important subject of inquiry. The current research was of immense value as it helped to bring the subject of drug abuse back on the national agenda. SAPA (2013) writes that, with more pressing economic and service delivery problems, the South African government is increasingly becoming distracted from the virtues of establishing a drug free society. This research can, therefore, help in identifying new dynamics and make necessary policy recommendations in line with prevailing trends and potency of emerging drugs.

Most of the available literature on the discourse of drugs has been focusing on the causes, impacts, and types of abused drugs. However, very little has been researched about the contributions of drug treatment centres and the niche they occupy within the national agenda of making South Africa a drug free country. Parry (2001) admits that it is difficult to find statistics and trends of drug and substance treatment in South Africa due to lack of data. This study, therefore, hopefully, adds to available literature and brings to the fore the often unknown contributions of treatment centres in the fight against drug abuse.

Gonzalez, Maseko and Mvilisi (2013) write that many rehabilitation centres in the country have remained stuck in the past in terms of their therapeutic and operational policies. They contend that out-dated methods and practices are stifling smooth operations in many rehabilitation centres.

This research, therefore, helps in validating Gonzalez et al., assertions and stimulated robust debates on the subject and also prompted the government and the private sector, including non-governmental organisations, to chip in with help, where necessary.

1.8. Delineation and Scope of the Study

This study evaluated the contributions of the selected rehabilitation centres in reducing the drug and substance abuse problem in South Africa. 'Contributions' in this study is operationalized to mean the outcomes of drug treatment as read in the vision and context of reducing drug dependence and in diminishing its social and economic impacts. The study is, therefore, delineated to focus on exploring the work of rehabilitation centres in helping with the progressive and sustainable treatment and prevention of drug abuse by South Africans.

While the drug abuse treatment sector is an expansive field, this study was limited to focusing on in-treatment patients who were receiving treatment at selected rehabilitation centres and those attending aftercare support groups. Furthermore, while the scope of the vision of creating a drug free South Africa was drafted to suit national goals, this study only focused on the contributions of the selected rehabilitation centres in aiding the achievement of this goal. Implicitly, the findings of the study are not necessarily reflective of the national scene, but rather that of the selected rehabilitation centres.

1.9. Delimitations of the Study

In carrying out this study, the researcher encountered several challenges which made the fieldwork an arduous process. However, the researcher undertook some steps in order to mitigate these challenges. These challenges included:

- Lack of funds for timely data collection. This challenge was overcome through mobilisation of funds from family members and friends.

- Some organizations were not willing to participate for fear of negative publicity in the event that the research identifies any negative practice on their part. This was resolved through confirmation that both individual and institutional participants were participating unanimously.
- There were language barriers as some of the participants could not speak English. This was resolved through the use of the services of an interpreter.
- Some participants were not willing to participate as they feared that they would be exposed through their participation in the study. However, these fears were dispelled after clear explanations of the purpose of the study.

1.10. Definition of terms

Drugs and substance abuse: according to Newman (2001), the term drug abuse or substance abuse is defined as the use of chemical substances that lead to an increased risk of problems and an inability to control the use of the substance.

Addiction: the term addiction is defined by the Merriam-Webster online dictionary (2017) as a strong and harmful need to regularly have something (such as a drug) or do something (such as gamble). It is also a compulsive need for and use of a habit-forming substance (such as heroin, nicotine, or alcohol) characterised by tolerance and by well-defined physiological symptoms upon withdrawal (Merriam-Webster online dictionary, 2017). In this light, addiction can generally be defined as the compulsive and persistent use of harmful drugs and substances by an individual despite the known and experienced negative effects of the substance.

Rehabilitation centres: the term rehabilitation is used to explain the return of lost capability and the action used to cure the body from ailment (Hussey, 2008, par.1). Rehabilitation centres according to the Collins English Dictionary (2017) is a centre or clinic where people with an alcohol or drug addiction are treated.

1.11. Structure of the Thesis

Chapter 1: Introduction: This Chapter provides an introduction to the study. It also indicates the research's aim, objectives, and research questions and the research problem.

Chapter 2: Literature review: This Chapter provides a review of literature related to the work of drug rehabilitation centres in South Africa. It also highlights the literature gaps and explored case studies of how other countries in the world are engaging in the global fight against the drug problem. This chapter also provides an outline of the policy framework guiding the drug treatment sector in the world and in South Africa.

Chapter 3: Research Methodology: This Chapter focuses on the research methodology that is the research design, population, and sampling, data collection and methods of data analysis.

Chapter 4: Presentation and discussion of findings: This Chapter presents and discusses the findings of the study

Chapter 5: Discussion of findings, conclusion and recommendations: This Chapter provides a summary and conclusions of the study; it also outlines recommendations of the study.

CHAPTER 2

Overview of the Drug Situation in South Africa: Making sense of the inebriated Nation

2.1. Introduction

Largely, in many countries and contexts, the phenomenon of drug and substance abuse is increasingly becoming a buzz phrase in many modern families and societies (United Nations Office on Drugs and Crime, 2010). Many governments across the world are battling to contain and reverse the devastating impacts of substance abuse and dependence. Not only do drugs impact negatively on the person's wellbeing, but also that of the wider family and society (Myers & Parry 2005). Available international statistics reveal that between 149 and 272 million people aged between 15 and 64 are users or have used prohibited substances (UNODC 2011). Similarly, the World Health Organization (WHO) (2014) states that at least 15.3 million persons have been diagnosed with drug use disorders globally. Moreover, UNODC (2011) poses that an approximately 200,000 of habitual drug abusers succumb to pitiful drug induced deaths annually. Inopportunately, the vast majority of drug and substance abusers are the economically active population groups whose contribution to national and international economies cannot be over- emphasized. Undoubtedly and largely, the substance abuse epidemic is haemorrhaging international and national economies in unprecedented ways (UNODC, 2013).

In South Africa, the drug and substance abuse scourge is wide spread and its toll remains unparalleled. The Department of Social Development (DSD) (2007) unreservedly admits that drug and substance abuse in South Africa is a major contributor to crime, poverty, reduced productivity, unemployment, dysfunctional family life, political instability, and the increase of chronic diseases such as HIV/AIDS and Tuberculosis (TB), injury and premature death. The Central Drug Authority (CDA) (2013) notes that at least 15% of South Africans abuse psychoactive drugs and other substances including cocaine, cannabis, mandrax, opiates (heroin, morphine, other prescription medications, and more recently, whoonga/nyaope

which is a semi synthetic cocktail of drugs with opium as its main ingredient). More devastatingly, available research evidence proves that at least 49% of teenagers including those of school going ages use alcohol, while 13% use cannabis regularly (Department of Social Development, 2007, p. 5). In addition, the South African Community Epidemiology Network on Drug Use (SACENDU) (2010) highlights that younger patients are increasingly being admitted to South African rehabilitation centres for drug related problems.

2.2. The Historical Antecedence of Drug and Substance Abuse

Human beings have, since time immemorial, sought to improve their levels of consciousness by altering or modifying their bio-psychosocial states through sniffing, injecting, smoking, eating and drinking substances which help them achieve their desired states of mind (Abbott & Chase, 2008). This innate desire to improve or modify conscious and unconscious experiences is the core of modern drug and substance abuse. However, Crocq (2007) argues that there has always been a misconception that drug and substance use and abuse are modern phenomenon.

Nevertheless, available archaeological records indicate a long and back dated history of the presence and use of psychotropic substances and plants in ancient civilizations dating back to more than 200 million years ago (Crocq, 2007). Narconon International (2016) indicates that for many centuries, opiates, alcohol and hashish (cannabis) have been used in Egypt. In addition, Narconon International (2016) notes that recent drug tests conducted on mummified remains of Pharaohs in Egypt shows traces of cocaine, thus suggesting its usage/abuse in ancient Africa. Crocq (2007) refers to archaeological records which indicate that about 13000 years ago inhabitants of Timor were using betel nut (Areca Catechu), as did those of Thailand around 10, 700 years ago. Abbott and Chase (2008) allude to the usage and abuse of nicotine in the Australian Aborigines 40000 or more years before the era of European colonialism. More so, the abuse of Khat (Catha edulis) has been recorded in Ethiopia and other pre- colonial North African regions (Crocq, 2007).

Abbott and Chase (2008) note that many ancient oral traditions make reference to the usage/abuse of psychotropic drugs and substances as a source of food and vitality. While, in this current age dispensation, drugs and substances have mainly been used for their medicinal value and not recreationally, their euphoric effects are mentioned in oral tradition records (Marion & Oliver, 2014). Similarly, Abbott and Chase (2008) allude to aversive impacts of drugs and alcohol recorded on ancient Sumerian clay tablets around 4000 BC, thus suggesting a long running history of substance dependence.

Furthermore, Abbott and Chase (2008) argue that the genesis of modern drug and substance abuse is closely linked to agricultural revolution in ancient Mesopotamia (modern day Iran and Iraq) where fermentation was first discovered leading to the brewing of beer and wines for medicinal and later social purposes. On a similar note, Dewey (2008) argues that, in the United States, addiction to drugs was as a result of the usage of drugs like cocaine, morphine and heroin to cure alcoholism. It was only later that they realized that by using these drugs to cure alcoholism, they were creating a worse problem (Marion & Oliver, 2014).

2.2.1. The Origins of Substance abuse in South Africa

In South Africa, the history of drug and substance use and abuse is very difficult to trace due to lack of credible and reliable records. However, Pitorak et al., (2012) mention that only little and incoherent records exist in the country on the subject of drug and substance abuse. On the same note, Parry (1998) observed that much of the available information on illegal drug and substance abuse in South Africa comes from ad hoc cross-sectional research studies often conducted in a single location and from information on police arrests and seizures.

However, Setlalentoa, Pisa, Thekisho, Ryke and Loots (2010) note that the abuse of alcohol and other substances in South Africa can be effectively traced to the early settlement of Dutch farmers in the Cape and their subsequent recruitment of African farm labourers. The farmers introduced the 'Dop' or 'Tot' system in which they would pay part of their labourers'

wages in the form of alcohol. Setlalentoa, Pisa, Thekisho, Ryke and Loots (2010) mention that ever since the age of the dop/tot system, South Africa has been an inebriated nation.

Peltzer, Ramlagan, Johnson, and Phaswana-Mafuya (2010) posit that modern drug and substance abuse in South Africa has its origins in the ruthless Apartheid system of governance. This system actively deprived people of basic human rights, forcing them to seek solace in mood and mind altering substances. Under the racially biased Apartheid system, black people and other disadvantaged races were relegated to socially, economically and environmentally undesirable places called Bantustans where the government was not willing to provide basic amenities (Myers & Parry, 2005). With poor service delivery, Homelands and Bantustans became fertile grounds for illegal dealings, including drug and substance abuse and trafficking. Drug and other crimes were seldom investigated nor prosecuted, as these were perceived to be native problems which the Apartheid government was not willing to spend resources on (Centre for the Study of Violence and Reconciliation, 2009).

More so, Jeewa and Kasiram (2008) aver that the antecedents of drug and substance abuse in South Africa can be explained in terms of the pressure exerted on social capital by rapid modernization, leading to an unprecedented erosion of social and traditional mores. In tandem, Peltzer et al., (2010) note that the radical shift in political, social and economic order in the country has made the country vulnerable to drug and substance use. Peltzer et al., (2010) add that the social and moral decay in the country has been worsened by a national feeling of disillusionment due to slower than the hoped for pace of the economic redistribution. Pitorak et al., (2012) write that poor South Africans had hoped that, with political freedom, their economic situation was likely to change. But, in contrast, poverty and destitution have continued unabated, causing people to continue seeking solace in drugs and alcohol.

Moreover, Myers and Parry (2005) attribute the emergence of careless and extreme abuse of drugs and substances to the wave of political and social transformations ushered in by the attainment of independence in 1994. The democratic dispensation of 1994 gave people more freedoms and allowed the rise of a culture of tolerance for new ideas and behaviours which gradually undercut the moral fibre of the country (Peltzer et al., 2010). Furthermore, political independence, participation in the global economy and the subsequent pronouncement of a rainbow nation by the ANC democratic government allowed for the embracement of diversity and modernity, thereby opening the national borders of South Africa to external and diversified socio-cultural practices, including a culture of drug use (Pitorak et al., 2012).

2.3. The International Drug Control Systems: Conventions and Legislations

Many governments across the world including South Africa have declared drug and substance abuse a national security threat and have since been making frantic efforts to finding lasting solutions to combat this problem. On a global scale, the UNODC (2013) states that the international drug control system is based on three fundamental conventions including the Single Convention on Narcotic Drugs of 1961 followed by the 1971 Convention on Psychotropic Substances; and lastly, the 1988 United Nations Convention against the Illicit Trafficking of Narcotic Drugs and Psychotropic Substances. The 1961 Single Convention on Narcotic Drugs created the international drug control system by recognizing that there were some drugs whose use should be regulated (UNODC, 2013). The Second convention on Psychotropic substances of 1971 amended the scope of the initial convention by adding more psychotropic substances to the list of regulated drugs and substances (UNODC, 2013). Lastly, the 1988 convention not only focused on the control of drug use, but also its movement/ trafficking (UNODC, 2013).

2.3.1. The Enabling Legislative Framework: Drug and Substance Abuse and Prevention in South Africa

South Africa is a signatory to all the international conventions, but it also went a step further by devising its own domestic legislations which provide for the internal control of drugs and substances (Department of Social Development, 2007). According to the Department of Social Development (2007, p. 10), chief among the domestic legislations in South Africa is the National Drug Master Plan, supported by the *Medicines and Related Substances Control Act (No. 101 of 1965)*, the *Drugs and Drug Trafficking Act (No. 140 of 1992)*, the *Prevention of Organized Crime Act (No. 121 of 1998)*, the *Prevention and Treatment of Drug Dependency Act (No. 20 of 1992)*, the *Road Traffic Amendment Act (No. 21 of 1998)*, the *Tobacco Products Control Amendment Act (No. 12 of 1999)* and other relevant instruments and support legislations as listed below:

- Child Care Act (No. 74 of 1983)
- Domestic Violence Act (No.116 of 1998)
- Health Act (No. 63 of 1977)
- Liquor Act (No. 53 of 1989)
- Medicine and Related Substance Control Act (No. 59 of 2002)
- Mental Health Care Act (No.17 of 2002)
- Occupational Health and Safety Act (No. 85 of 1993)
- Pharmacy Act (No. 53 of 1974)
- Promotion of Equality and Prevention of Unfair Discrimination Act (No. 52 of 2002)
- Road Transportation Act (No. 74 of 1977)
- Road Traffic Act (No. 93 of 1996)
- Sexual Offences Act (No. 23 of 1957)
- South African Constitution Act (No. 108 of 1996)
- South African Schools Act (No. 84 of 1996)
- Extradition Act (No. 67 of 1962)

- Witness Protection Programme Act (No. 112 of 1990)
- Extradition Act (No. 77 of 1996)
- Financial Intelligence Centre Act (No. 38 of 2001)
- International Co-operation in Criminal Matters Act (No. 75 of 1996)
- Institute for Drug-Free Sport Act (No. 14 of 1997)

Bills:

- Child Justice Bill, 2003
- Criminal Law (Sexual Offences and Related Matters) Amendment Bill, 2006
(Adopted from the NDMP, (2006 – 2011))

2.3.2. An Overview of the National Drug Master Plans (NDMPS)

Sections 10 to 12(1) of Chapter 2 of the South African Constitution (Act 108 of 1996), provides for the protection of human dignity, promotion of the right to life, and the right to freedom and security of all citizens. It is on the basis of these fundamental provisions that South Africa commits itself to developing strategies to decisively combat the scourge of drug and substance abuse, which in many ways infringes the aforesaid civil liberties. Accordingly, South Africa has since adopted three NDMPs into policy as provided for under the Prevention and Treatment of Drug Dependency Act (No. 20 of 1992). The first NDMP1 (1999 – 2004) was prepared by the Drug Advisory Board for the Ministry of Welfare and Population Development (Drug Advisory Board, 1999). This was followed by the NDMP2 (2006 – 2011) and the revised NDMP3 (2013 – 2017) both of which were commissioned by the Central Drug Authority (CDA) under the guidance of the Department of Social Development (DSD, 2007).

Mbulayi and Makuyana (2017) referred to UNDCP (1997) and defined a drug master plan as a single document that spells out the commitment of the national government and its various departments and stakeholders to preventing, treating and diminishing the demand and supply of drugs and other illegal substances.

In this light, the National Drug Master Plans of South Africa constitutes one of the country's set of responses to substance abuse problems experienced by South Africans. They also echo the provisions of international and regional conventions and guidelines on combating drug and substance abuse. The NDMPs create room for cooperation between and amongst various government departments and other stake holders towards enhancing the fight and prevention of drug and substance abuse (Mbulayi & Makuyana, 2017).

The latest NDMP3 (2013 -2017) mentions that newer versions of NDMPs and their provisions do not necessarily seek to replace but rather to edify existing structures and efforts spelled out in previous versions (DSD, 2013). Consequently, Geyer and Lombard (2014) argue that NDMPs in South Africa seek to inspire confidence in the fight against substance abuse through constantly addressing loopholes and further strengthening partnerships between various stakeholders. Gonzalez, Maseko and Mvlisi (2013) note that approaches to combating drug and substance abuse have in recent years shifted from purely supply reduction strategies emphasized in NDMP1 (1999 – 2004) and NDMP2 (2006 – 2011) to more holistic approaches noted in NDMP3 (2013 – 2017). Jules-Macquet (2015, p. 3) mentions that the three main contemporary strategies adopted in NDMP3 (2013-2017) are demand reduction, supply reduction and harm reduction.

In this regard, Jules Macquet (2015, p. 3) goes on to state that the contemporary vision of a drug free South Africa is hinged upon the fundamental goals espoused in NDMP3 (2013-2017) which include:

- To coordinate efforts to reduce demand, supply and harm caused by substance abuse;
- To ensure effective services;
- To strengthen cost effective interventions;
- To share good practices;
- To provide a framework for monitoring and evaluation; and
- To promote national, regional and international cooperation

2.4. Overview and Categorization of Abused Drugs and Their Potency

The International Narcotics Control Board (INCB) (2014) posits that the term drug takes on different meanings and connotations depending on the purpose, type and its legality. On that note, the UNODC (2012) notes that in a medical sense, a drug is any substance with the potential to prevent or cure disease or enhance physical or mental welfare, while, in pharmacology terms, it denotes any chemical agent that alters the biochemical or physiological processes of tissues or organisms. In the legal fraternity, however, and, in the context of the international drug control system, drugs include any of the substances listed in Schedule I and II of the 1961 Single Convention on Narcotic Drugs, whether natural or synthetic (UNODC, 2012). The following section provides an overview of abused drugs in terms of their effect, type and other qualities. It also provides an overview of the nature of drugs for which many people seek treatment in South Africa.

2.4.1. Opiates

According to the online Cambridge Dictionaries (2017), opium is an addictive drug made from the seeds of a poppy (red flower) that is used to control pain or to help people induce sleep. The opiates group of drugs includes derivatives of opium poppy (*Papaversomniferum*) such as opium, morphine and codeine, and semi-synthetic substances such as heroin (UNODC, 2012). Opiates can also be found in the form of opioids which are wholly synthetic products and include methadone, pethidine and fentanyl (INCB, 2011).

2.4.1.1. Geopolitics of Opium Production and Abuse

Globally, opium poppy is mainly cultivated in three main regions of the world including South-West Asia (Afghanistan), followed by the South-East Asia (Lao People's Democratic Republic and Myanmar) and, lastly, in some of the American countries such as Mexico, Colombia and Guatemala (UNODC, 2012). According to UNODC (2013), a total of 207,000 hectares of land is under opium poppy cultivation globally and the bulk of it is in Afghanistan, which is the main producer, accounting for 63% of global supplies.

The UNODC (2012) writes that there are between 12.9 million and 21 million opiate users in the world. While the general abuse of drugs is a cause for concern in Africa, it is the surging demand and abuse of opium based drugs such as heroine, morphine, codeine and, more recently, nyaope/whoonga which are the greatest cause of despondence (Gonzalez, Maseko, & Mvlisi, 2013). The UNODC (2010) writes that the demand for opiates is on the rise globally.

2.4.1.2. Bio-psychosocial Impacts of Opiates

The International Narcotics Control Board (2014) note that opiates falls into the agonist family of drugs. On this note, the National Institute on Drug Abuse (NIDA) (2016) explains that agonists are chemical compounds which bind to a specific receptor and produce either excitation or inhibition of action potentials. Accordingly, opiate drugs work by way of depressing the central nervous system by increasing the activity of the dopamine-containing neurons which contain inhibitory or excitatory signals and regulate happiness or depression (NIDA, 2016). Alternatively, opiates functions by producing gamma-aminobutyric acid (GABA) which inhibits dopamine neurons, thereby diminishing the secretion of dopamine, which is the happy agent in mood development (UNODC, 2012). For their medicinal value, opiates are used as analgesics (painkillers) to suppress coughs and diarrhoea, while, for non-medical purposes, they are abused as euphorants and as means of reducing anxiety, boredom, physical or emotional pain (Gureje, Degenhardt, Olley, Uwakwe, Udofia, Wakil, Adeyemi, Bohnert & Anthony, 2007)

According to the International Narcotics Control Board (2014), opiates lasts for a period of one to two days in a person's system. However, repeated and unregulated use and or abuse of opiates can result in serious health, social, and economic negativities to the individual user and those around him/her (Gureje et al., 2007). Side effects of high doses of opiates are a reduction in sexual drive and fertility, resulting in impotence in men and severe irregularities in the female menstrual cycle, as well as mood instability, lethargy and anorexia (UNODC, 2012).

More so, the International Narcotics Control Board (2014) states that some of the most severe effects of opium abuse, as in the case of heroin, which is by far the most abused opiate drug, stems less from the drug itself than from unhygienic injecting practices which facilitate the transmission of hepatitis, HIV and AIDS and the wider diffusion of these diseases by sexual contact. Short term effects of opiates include euphoria, insomnia, sense of emotional detachment, loss of appetite, and impaired vision (Gureje et al., 2007).

2.4.1.3. South Africa's experiences with the Abuse of Opiate Drugs

While the international community continues to invest and strengthen international drug control systems, there has also emerged strong drug trafficking cartels whose presence in opium markets is undeniably strong (Pitorak et al., 2012). In South Africa, opiates such as heroine and more recently Nyaope/Whoonga and other prescription medications including morphine, methadone and pethidine are the most abused. Gonzalez, Maseko, and Mvlisi (2013) note that nyaope/whoonga has taken South African streets by storm. Its prominence is buttressed by its relative affordability (costing roughly R20 per sachet) which earned it its infamous street name 'heroin for the poor man' (Gonzalez, Maseko & Mvlisi, 2013). There are also reports of increasing abuse of codeine based cough syrups such as broncleer (Matunhu & Matunhu, 2016). More so, Kan (2009) writes that in South Africa there are emerging convoluted and clandestine heroine laboratories which supply both local and regional markets. Kan (2009) further postulates that accessibility of opiate drugs in South Africa is increasingly becoming easier. In their research, Pitorak et al., (2012) found out that children as young as 10 years old expressed knowledge of how to access or know someone who uses heroine. Gonzalez, Maseko, and Mvlisi, (2013) write that the prevalence rates of opiate abuse are high in Western Cape, Mpumalanga, and Gauteng Provinces.

2.4.2. Depressants

According to the UNODC (2012), depressants are drugs or substances which reduce functional or nervous activity. Depressant drugs include barbiturates, non-barbiturate depressants and benzodiazepines, which are also known as sedative-hypnotics (UNODC, 2012). Depressants are medically used as anaesthetics, anticonvulsants, in the treatment of tension and anxiety, insomnia and some psychiatric illnesses (International Narcotics Control Board, 2014). Barbiturates type depressants were the first synthetic pharmaceutical drugs which were manufactured in the early 1960s and have since been replaced by non-barbiturate sedatives known as benzodiazepines which include methaqualone, among other licit and illicit substances mainly used for their pleasurable intoxication (UNODC, 2012).

2.4.2.1. Bio-psychosocial Impacts of Depressant Drugs

Extended and unregulated usage of depressants has a proclivity towards causing respiratory infections such as bronchitis, emphysema and at high dosages can result in unconsciousness or death through organ failure (Gureje et al., 2007). Narconon International (2016) also refers to the dangers of abrupt withdrawals of sedatives which can possibly result in death. According to the International Narcotics Control Board (2014), abusers of benzodiazepines have a tendency of developing a physical tolerance to higher dosages; hence users are vulnerable to unexpected lethal doses. Among some of its devastating impacts, benzodiazepines can result in loss of cognitive abilities including memory and concentration loss (Narconon International, 2016).

NIDA (2016) writes that the challenge associated with benzodiazepines is that legitimate prescribed users may develop tolerance and, ultimately, dependency if they continue to use them over a long period of time. The International Narcotics Control Board (2014) avers that abusers of benzodiazepines and other sedative drugs may suffer aversive effects such as anxiety, insomnia and restlessness. UNODC (2012) identifies a concerning trend of abuse of benzodiazepines intravenous, which is a high health hazard as these drugs do not dissolve in the blood stream.

2.4.2.2. South Africa's experiences with the Abuse of Depressant Drugs

In South Africa, abuse of depressants is commonly associated with the abuse of benzodiazepines which are often abused for their calming effect after a dosage of 'high' producing drugs such as methamphetamine type stimulants in poly drug use (Gonzalez, Maseko, & Mvlisi, 2013). According to Homer, Solomon, Moeller, Mascia, DeRaleau, & Halkitis (2008), when drug abusers use stimulant drugs, such as methamphetamines, they can use a sedative like benzodiazepines to calm themselves down. More so, Gonzalez, Maseko, and Mvlisi, (2013) pose that in South Africa, abuse of benzodiazepines has a peculiar trend in that it is high amongst females below the age of 17. However, it is still common amongst the males. The problem of abuse of benzodiazepines in South Africa is compounded by the availability of unscrupulous medical practitioners who accept bribes in exchange of prescriptions from the abusers. However, Loue (2005) writes that if the current trend of abuse is maintained, the future of South Africa's health system is doomed. This is because abuse of prescription medication generally means that the country will continue to lose money on undeserving cases while real patients who really need treatment continue to suffer. Andrew (2008) argues that some rural hospitals in South Africa are facing critical shortages of drugs, including antiretroviral drugs and other prescription medications, which are finding their way to illicit markets where they are being abused or used in the production of illegal drugs.

2.4.3. Stimulants

The UNODC (2003) defines stimulants as substances that raise levels of physiological or nervous activity in the body. These include naturally occurring plants such as coca (*Erythroxylum coca*), khat and betel nuts, products extracted from the leaf of the coca bush including coca paste, cocaine hydrochloride and crack cocaine (UNODC, 2003).

Mhlongo (2005) also adds that the range of stimulants also includes synthetic substances including methamphetamines and amphetamine-type compounds.

2.4.3.1. Bio-psychosocial Impacts of Stimulant Drugs

According to UNODC (2003), stimulants such as cocaine have some therapeutic value and are used as analgesics. On the other hand, Dakota and Forks (2003) write that Amphetamine Type Stimulants (ATs) are increasingly being sold on the black market as anorectics (slimming pills). On the open market, stimulants are used for treatment of narcolepsy and attention deficit disorders in children (UNODC, 2003). Stimulants are also abused for their euphoric and excitatory value including mood elevation, wakefulness and work output improvements or enhanced sport performance. Lopez (2001) mentions that stimulants were abused during the Second World War to boost bravado and stamina of fighters.

UNODC (2003) reiterates that some stimulants carry hallucinogenic effects as in the case of methylenedioxy-amphetamines and methylenedioxy-methamphetamines whose primary effects include heightening emotional and sensory perceptions. More so, Mhlongo (2005) notes that abuse of hallucinogenic stimulants may cause psychological problems including confusion, depression, anxiety and paranoia. Physical symptoms include muscle tension, nausea, blurred vision, faintness, chills or sweating (Lopez, 2001).

The effects of stimulants such as cocaine last from a few minutes to less than an hour (UNODC, 2003). On the other hand, Dakota and Forks (2003) aver that amphetamine type stimulants can last for several hours. Methods used in abusing cocaine and other coca products include intravenous injection, snorting and in the case of crack cocaine, smoking (UNODC, 2003). On the other hand, Amphetamine Type Stimulants (ATs) are orally ingested, injected, smoked or snorted. The UNODC (2003) mentions that abuse of stimulants may result in fatalities including death due to overdose, frequent usage and dangerous methods of administering the drug.

Mhlongo (2005) notes that abuse of amphetamines such as crystal-meth may result in extreme decay of teeth, a condition known as 'meth mouth'. More so, abuse of cocaine may result in septal necrosis which entails the erosion of and death of tissue between the nostrils which may result in extreme nose bleeding leading to death (UNODC, 2003). Crack cocaine poses the risk of developing chronic bronchitis and severing pulmonary tissues (Dakota & Forks, 2003). Withdrawal symptoms of stimulant abuse include a state of acute unease or discomfort in the body, depression, fatigue, insomnia and severe and prolonged cravings (Lopez, 2001). Dakota and Forks (2003) note that the negative after effects/ withdrawals from stimulants are more severe and prolonged in the case of amphetamines than they are for cocaine.

2.4.3.2. South Africa's Experiences with the Abuse of Stimulant Drugs

South Africa is currently facing the problem of abuse of stimulant drugs in the form of amphetamines, methamphetamines, cocaine, crack cocaine and other prescription stimulants such as Ritalin, Concerta, Biphertamine and Dexedrine (Mbulayi & Makuyana, 2017; Kaye & Darke, 2012). Peltzer et al., (2010) argue that young people are increasingly abusing stimulant drugs. Kaye and Darke (2012) mention that as young as 16 year olds in high school are reportedly abusing Ritalin which is popularly known as "smarties", "rit" or "kiddie cocaine" in the streets. In addition, Peltzer et al., (2010) write about the disturbingly growing trends of people who are abusing methamphetamines and amphetamine stimulants. These are largely known by their street lingo names such as tik, crystal meth, chalk, glass, and cat or khat. These substances are commonly abused in Gauteng and in the Western Cape Provinces. McKetin, McLaren, Lubman, and Hides (2006) write that abuse of methamphetamine type stimulants in South Africa is associated with risky sexual behaviours such as exchanging sexual favours for money or the drug and unprotected sex, thus increasing the risk of contracting sexually transmitted diseases including HIV/AIDS.

Furthermore, Peltzer et al., (2010) note that the problem of abuse of stimulant drugs such as methamphetamines and amphetamines is growing. This is so because the production of these drugs does not require any sophisticated and specialized laboratories. They can be produced at home using basic household commodities such as detergents (Chouvy & Meissonnier, 2004). Moreover, the recipes for making these drugs are easily available on the internet.

2.4.4. Hallucinogens

By definition, hallucinogens are substances (such as drugs) that cause people to see or sense things that are not real (Levine, 2006). According to Haider (2015), hallucinogens include naturally occurring substances such as psilocybin (from the *Psilocybemexicana* mushroom), mescaline (from the peyote cactus); semi-synthetics such as lysergic acid diethylamide (LSD); and synthetics such as phencyclidine (PCP). The New South Wales (NSW) Department of Health (2011) adds that hallucinogens are a group of drugs that work on the brain to affect the senses and cause hallucinations – seeing, hearing, smelling, tasting or touching things that do not exist. Common drugs in this group are LSD, magic mushrooms and mescaline (NSW Department of Health, 2011).

2.4.4.1. Bio-psychosocial Impacts of Hallucinogenic Drugs

Barker, McIlhenny and Strassman (2012) indicate that, apart from some traditional uses and for rare therapeutic use in psychiatry, hallucinogens are taken illicitly for their mind-altering or 'psychedelic' effects. Most hallucinogens are abused for their perceptual distortions of time and place, visual hallucinations and synaesthesia (a merging of the senses such that sounds are "seen" and colours are "heard") (Levine, 2006). Apart from the sensory distortions for which hallucinogens are often abused, they also carry some physiological after-effects, albeit mild in intensity, and these include dizziness, disorientation, anxiety, depression and distressing flashbacks (Al-Nasrawi, 2014; Levine, 2006). More so, Levine (2006) notes that other feelings associated with hallucinogens are euphoric feelings which

are accompanied by feelings of depersonalization, in terms of reality leading to belligerent paranoia and self-mutilation.

2.4.4.2. South Africa's Experiences with the Abuse of Hallucinogenic Drugs

Johnston (2010) refers to National Drug Use Surveys between 2000 and 2005 and states that the prevalence of hallucinogenic substance abuse in South stands at 0.1% nationally. In South Africa, the commonly abused hallucinogens include cannabis, magic mushrooms and lysergic Acid Diethylamide (LSD). Not much information is available on the trends of LSD and mushroom abuse in South Africa. Cannabis is separately discussed below because of its significance in South Africa's illicit drug markets.

2.4.5. Cannabis

Cannabis is the most abused drug whose prevalence rates have global dimensions. However, Mhlongo (2005) observes that the production and consumption of cannabis is well pronounced in Africa where its usage has socio-cultural connotations and implications. Cannabis also known as marijuana, hashish and weed is mainly used in cigarette form, although there are other means such as swallowing it, and drinking it in the form of extracted oils. Rehn, Jenkins and Cristal (2001) note that cannabis is generally a sedative which has some hallucinogenic effects. The most sought after ingredient in cannabis is delta-9-tetrahydrocannabinol (THC) (Seigal, 2003). In this light, Rehn, Jenkins and Cristal, (2001) mention that the levels of concentration of THC vary between and amongst the various strains grown under different climatic conditions.

Excessive consumption of cannabis may result in the impairment of psychomotor coordination, reduced attention span, and distorted sense of reality (Seigal, 2003). Furthermore, Rehn, Jenkins and Cristal (2001) mention that when taken in higher dosages, cannabis can result in unnatural thirst or hunger, uncontrolled mood swings, talkativeness, impaired perception, disturbed judgment, mind disorders, feelings of wellbeing, anxiety euphoria, panic and or paranoia. According to Rehn et al., (2001), the detection time of one

cannabis cigarette in a person's urine is between one to seven days and for more cigarettes, 30 days or longer.

2.4.5.1. South Africa's experiences with the Abuse of Cannabis

Cannabis remains one of the widely abused drugs in South Africa with intense usage in Gauteng and the Western Cape. Peltzer et al., (2010) note that South Africa is one of the world's largest producers of cannabis. Its prevalence rates, in terms of gender, age and race, shows that it is more prevalent amongst Colored and White adolescents living in urban areas. Jules-Macquet (2015) indicates that in South Africa, 22.55% of crime offenders are abusers of cannabis; while 7.93% have been detected to contain both cannabis and alcohol in their blood system. Peltzer and Ramlagam (2007) found out that the demand for cannabis treatment services ranges from 2% amongst adults to 5% -10% amongst adolescents. There is growing activism at various stages of the South African society calling for the legalization of cannabis production and consumption. Caulkins, Hawken, Kilmer and Kleiman (2012) argue that legalizing cannabis in the country carries vast potential of generating much needed incomes.

2.4.6. Alcohol

Alcohol is a clear liquid that has a strong smell, that is used in some medicines and other products, and that is the substance in liquors (such as beer, wine or whiskey) that can make a person drunk (Provine, 2008). Mhlongo (2005) states that alcohol is one of the most abused legal substances globally. On that note, the World Health Organization (2015) notes that alongside salt, sugar, and tobacco, alcohol stands out as one of the key risk commodities affecting global rates of non-communicable diseases. According to the World Health Organization (2011), global alcohol consumption average stands at 6.13 litres of pure alcohol consumed per person aged 15 years or older. Available research evidence shows that one in every 10 deaths globally is alcohol related.

2.4.6.1. Bio-psychosocial Impacts of Alcohol

Dakota and Forks (2003, p. 120) contend that not all alcohol drinkers develop a state of dependency. Accordingly, these scholars define alcohol dependency as drinking that causes problems with parents, teachers, friends or the law. Hodge, McLellan and Cerbone (2001) highlight that alcohol abuse is very difficult to treat as it is a socially accepted substance whose abusers deny that they are addicted. Alcohol works in the human system as a depressant or sedative and becomes addictive when consumed in large amounts frequently. It slows down the activities of the central nervous system that control bodily functions, causes drowsiness, lack of concentration, slowness in thinking, impaired interpersonal relationships, and leads to economic dysfunction and poverty (Hodge et al., 2001, p. 6).

Dakota and Forks (2003) further highlights other dangers of consuming large amounts of alcohol which include blackouts, convulsions, damage of body organs such as the liver and kidney and permanent damage to the foetus if the abuser is pregnant. Similarly, Levine (2006) posits that alcohol causes slurred speech, forgetfulness, poor judgment, clumsiness, euphoria and loss of inhibitions. Rehn, Jenkins and Crystal (2001) highlight that alcohol could make the individual carefree, impairs motor skills, causes confusion and can result in respiratory paralysis that is connected with the gag reflex. This means that when the individual vomits, he cannot get rid of the vomit because of the comatose state that can easily result in death (Rehn, Jenkins & Crystal, 2001).

2.4.6.1. Alcohol Abuse as an albatross around South Africa's Socioeconomic Development

Kan (2009) writes that South Africa is one of the most drunken countries of the world in which increasingly younger people are getting entangled in risk drinking patterns. This, in part, is because of the deeply entrenched culture of over drinking left by the colonial legacy. Worryingly, the abuse of alcohol remains the most prevalent form of substance abuse in the country.

Harker, Kader, Myers, Fakier, Parry, Flisher, and Davids (2008) contend that the prevalence of alcohol abuse by Provinces is highest in the Western Cape followed by the North West, then Northern Cape which all have prevalence rates above 10%; while the remaining 6 Provinces are below 10%. On the same note, Harker et al., (2008, p.37) contend that the national prevalence rate for alcohol use in South Africa stands at 70.3% for males and 39.2% for females above the age of 15.

The impact of alcohol substance abuse in the country is wide spread. Matzopoulos (2005), as cited by Harker et al., (2008), state that the rate of alcohol-positive deaths due to transport injuries are still unacceptably high in South Africa with Cape Town (57%) recording a higher statistic than Durban (49%), Johannesburg (48%) and Pretoria (49%). More so, Viljoen et al., (2005) argue that, due to the high number of women abusing alcohol in South Africa, the country has one of the highest rates of Foetal Alcohol Syndrome (FAS) which stands at 65.2 – 46.4 per 1000 children in the first grade. Other significant prevalence rates are found in Belarus (69.1), Italy (82.1) and Croatia (115.2) per 10 000 respectively (Viljoen et al., 2005). Furthermore, alcohol abuse has also been found to be strongly linked to high risk sexual behaviours including having unprotected sex. Research has also established that harmful drinking and binge drinking in South Africa is linked to having more than one regular sexual partner and with having irregular partners (Harker et al., 2008).

However, due to deeply entrenched inequalities in terms of resource allocation, access to treatment services for alcohol abuse has remained skewed in terms of race, gender and geographical region – with women, black South Africans and people from rural and disadvantaged communities remaining under-represented in treatment settings (Harker et al., 2008). With treatment needs remaining glaringly unattended, alcohol abuse and dependence continue to cost the country a fortune in terms of property damages, destabilized economic productivity due to absenteeism at work and injuries incurred at work. Moreover, treatment needs for the addicted exerts a lot of pressure on the country's health care systems.

2.5. The Historical Terrain of Drug Abuse Prevention and Treatment in the World

As noted earlier in this chapter, drug use and abuse is an old phenomenon whose prevalence amongst mankind is deep seated and hoisted on innate human desire to consume substances that make them feel relaxed, stimulated, or euphoric (Pitorak et al., 2012). By as early as 6000 B.C when fermentation was discovered in Mesopotamia, its localities also made good discoveries that fomented substances could be used as detergents and as home remedies for identified medical conditions (White, 1998). This, by extension, led to the realization that some organic substances have medicinal value which can be exploited to alleviate pains and other ailments (Marion & Oliver, 2014). During this initial stage, naturally occurring substances, which were not synthesized, were used for home remedies (Marion & Oliver, 2014). White (1998) notes that fermentation led to the discovery of beer brewing which was then followed by a culture of excessive drinking. With the spread of beer brewing and, later on, distillation which produced high potency alcohol, it became apparent that some people needed therapeutic interventions to help them stop drinking (White, 1998). This effectively marked the genesis of modern drug and substance prevention and treatment work in the world.

Marion and Oliver (2014) contend that much of the history of drug and substance prevention and treatment in the world is derived from American records. Consequently, White (1998) argues that the first attempt to control alcohol and drug use and abuse in Western civilizations occurred around the sixth century AD with the first national legislation being put in place in 1494 in Americaas3w3es. The initial preventative approaches before 1800 were predominantly vested in the imposition of prohibitive tax acts (White 1998).

Marion and Oliver (2014) posit that the American society had for a very long time held negative and strong anti-drug sentiments. Provine (2008) adds that not only did the American society resent drugs and intoxicating substances for their health hazards, but there were also strong racial feelings and opinions that alcohol, cocaine and other opiate drugs were making the enslaved African Americans more dangerous and hence the need for restrictive measures. Preventative approaches were strengthened in 1914 through the adoption of the Harrison Narcotic Act which was later on used to banish treatment of addiction through opiates and other sedative drugs (White, 1998). The adoption of the Volstead Act of 1919 gave birth to the modern preventative and prohibitive methods that culminated in the emergence of the Alcoholics Anonymous (AA), which not only changed the perception of alcoholism and drug addictions, but also revolutionized modalities of its treatment (Marion & Oliver, 2014; Provine, 2008).

2.5.1. Emergence of Substance Abuse Rehabilitation Facilities

By 1750 to the early 1800s in America, grew the Washingtonian Society for the treatment and care of hard core cases of addiction (White, 1998). The Washingtonian Society collapsed in the mid-1840s, precipitating the emergence of the largely male gendered Fraternal Temperance Society whose scope was treatment and reform of men (Provine, 2008). During this era, addiction was framed as a problem amongst men. Between 1844 and 1857, first institutions, namely, the Lodging Homes and the Home for the Fallen were opened for the care of inebriates in Boston (Marion & Oliver, 2014). Thereafter, institutional care for addicts and, later, mutual aid societies continued to spread across America (Marion & Oliver, 2014).

Moreover, by 1845, there was increased recognition of substance abuse problems amongst African Americans, which also aided with the call for the abolishment of slavery and adoption of Afro-centric models for addiction recovery (Odejide, 2006).

Furthermore, by 1849, the term *Alcoholismus chronicus* was coined by Magnus Huss (1807 to 1890) to describe a disease resulting from chronic alcohol consumption (Marion & Oliver, 2014; Hillbom, Pieninkeroinen & Leone, 2003). This started the movement that resulted in some of the venerated modern framings of addiction and alcoholism as diseases and not lack of personal will power (Crocq, 2007). By the early 1860s, there were no treatment services specifically for women, but, in 1867, the Martha Washington Home in Chicago was opened to cater for the needs of female inebriates (Saah, 2005). By the 1870s, the disease model and framing of addiction grew with the first journal on inebriation being published by the American Association for the Cure of Inebriety (Marion & Oliver, 2014).

After the 1870s, there grew a strong resentment attitude for drug and substance abusers amongst Americans resulting in inebriate homes and asylums being closed (Taylor-Wickenden, 2015). Those who were in need of treatment services were relegated to city "drunk tanks," "cells" in "foul wards" of public hospitals, and in dilapidating wards of aging "insane asylums" (Taylor-Wickenden, 2015). This period marked a significant deterioration in terms of drug and substance treatment, care and protection of addicts. Marion & Oliver (2014) mention that, during this period, addiction was framed as a self-inflicted problem or as a demon which needed to be exorcised. Religious interventions grew during this period. However, affluent alcoholics/addicts continued to access discrete detoxification in private sanatoriums known as "jitter joints," "jag farms" or "dip shops" (Taylor-Wickenden, 2015).

This could possibly be the genesis of the dichotomous drug and substance treatment for different social and economic population groups which remains visible to date.

According to White (1998), Bill (1895 to 1971) and Bob (1879 to 1950) founded the Alcoholics Anonymous (AA) in 1935, whose therapeutic principles remain vibrant and compelling in modern drug and substance treatment. In addition, White (1998) writes that after the founding of the AA and the publication of its highly adopted AA book, there was a change in focus in terms of treatment regimens and its purpose.

Ideally, post 1985 drug and substance treatment became concerned with providing services to special populations including women, adolescents, the elderly, gays and lesbians, and the dually diagnosed (White, 1998). Also from this point onwards, treatment started to encompass and recognize new dynamics including high relapse rates; hence the integration of relapse prevention and treatment services into treatment modalities (Odejide, 2006).

Since the onset of the 20th century, the world has been experiencing radical shifts in terms of global reactions to the plight of those in need of drug and substance treatment services (Odejide, 2006). In the early 1990s, there was increased acceptance and growth in the usage of internet which led to a proliferation of on-line recovery network groups and services, thereby creating virtual recovering communities which transcend geographical boundaries (Marion & Oliver, 2014). Moreover, around 1999, there was an increase of interest for global funding of local and regional community support projects with greater emphasis on recovery advocacy (Odejide, 2006). More recently, around the early 2000s, there has been a surge in literature which supports medical interventions for drug and substance abuse treatment (Marion & Oliver, 2014).

Additionally, Mbulayi and Makuyana (2017) talk about the growing prominence of ibogaine treatment (herbal treatment) as a modality for drug addiction treatment. Jeewa (2006) also adds that addiction treatment has in the 21st century become diversified to include holistic services which encompass medical, behavioural and spiritual interventions customized into services which appeal to the body, mind and soul.

2.5.2. Drug and Substance Abuse Prevention and Treatment: South Africa's Experiences

The Institute for Work and Health (2015) identifies three levels of prevention and management of anti-social behaviours and the spread of preventable diseases and these include primary, secondary and tertiary interventions. Primary prevention aims at preventing disease or injury before it occurs by means of reducing or limiting exposure of vulnerable groups, altering unhealthy or unsafe behaviours and increasing resistance to disease or

injury in the event that exposure happens (Institute for Work and Health, 2015). Primary interventions, therefore, include legislations, education and immunization which prevent people from falling in need of interventions. Secondary interventions entail activities aimed at reducing the impact of disease or injury which has already happened. Secondary interventions start by providing a diagnosis, followed by treatment to either slow, halt or reverse the spread of the disease or injury (Franzcp, 2007). Lastly, the Institute for Work and Health (2015) note that tertiary interventions seek to promote and maintain new adopted behaviours by availing a nurturing environment and support structures. Tertiary structures and interventions include after care support groups, on-going therapy or treatment, and vocational rehabilitation programmes (Franzcp, 2007). In this study, these three levels of intervention formulate the basis for understanding drug and substance abuse prevention and treatment work in South Africa.

Mayers and Parry (2005) note that drug and substance abuse prevention and treatment work in South Africa is slowly taking shape and gathering momentum since the fall of apartheid in 1994. On this note, Gozalez, Maseko and Mvlisi (2013) state that South Africa has been making frantic efforts since 1994 to de-racialize and decentralize the delivery and accessibility of social services in line with the provisions of the White Paper for Social Welfare of 1997, upon which the current welfare model is based. The White Paper recognized the drug and substance abuse problem as one of the overarching welfare responsibilities of the national government for which the state has to make substantial investments to address (Department of Welfare, 1997).

From an age of outright neglect, the post-Apartheid government of South Africa hastily recognized the extent and possible ramifications of drug and substance abuse and moved to pledge its commitment to stopping and reversing its implications. In this light, Mayers and Parry (2005) mention that the country has, since independence, been widening the scope of its legal, political, and economic resources towards creating an enabled environment to fight against the unruly culture of drug and substance abuse.

According to the Department of Basic Education (2013), modern drug and substance abuse prevention and treatment work in South Africa is premised on four fundamental ideas, including creating an enabling environment for the prevention and management of alcohol and drug use, primary prevention, education and early detection, and, lastly, treatment. All significant legislations, as they relate to the prevention and treatment of drug and substance abuse, have been discussed elsewhere in this chapter. This section will expedite the various strategies and programmes for the prevention and treatment of chemical dependence in South Africa.

2.5.3. Models of Drug and Substance Abuse Prevention in South Africa

2.5.3.1. The Fear Arousal and Scare Tactics Model

The UNODC (2004) mentions that early drug and substance preventive work in South Africa involved the usage of scare tactics in which strong worded messages which appealed to emotions, and relied on shock appeal, were propagated. Myers, Fakier and Louw (2009) argue that scare tactics include dramatic re-enactments of drug use stories often told by recovering addicts, threats to personal safety, and usage of outrageous, fabricated and inflated statistics to justify and induce fear and abstinence. Moreover, Saah (2005) contends that scare tactics are based on the assumption that broadcasting aversive consequences and risks of illegal or bad behaviour will act as a deterrent to repeating or trying out similar behaviours in the future.

Gozalez, Maseko and Mvlisi (2013) note that, in South Africa, drug and substance prevention messages during and soon after apartheid carried strong and often misleading and scaring sentiments accompanied by dramatic visual images of distressed or dying people lying in ditches and wearing tattered clothes. On this note, the UNODC (2004) refers to a 2002 Cape Town Newspaper article which reported that 90% of high school students had experimented with at least one illegal drug.

While this article was intended to induce the government and parents to take hasty decisions towards ameliorating drug and substance abuse in the country, the UNODC (2004) believes this could have possibly resulted in the opposite outcome. Myers, Fakier and Louw (2009) argue that scare tactics, especially those which are not in sync with the reality, may cause people to make wrong inferences and become despondent and apathetic. Accordingly, Gozalez, Maseko and Mvlisi (2013) contend that positive messaging focused on educating people about the harms of addiction, by conveying truthful information and engaging in non-judgmental discussions on the ills of addiction, is more effective than fear tactics or shock campaigns. Henceforth, South Africa has, in the recent past, shifted its focus towards positive framing of drug and substance abuse as a public health concern, whose victims should be supported as opposed to being shamed or punished. This is entrenched in the restorative justice mechanisms adopted in South Africa to deal with juveniles and first time offenders, especially those whose crimes were committed under the influence of intoxicants (Jules-Macquet, 2015). Smook, Ubbink, Ryke and Strydom (2014) contend that debates on the legalization of currently illicit drugs and substances are gaining currency in South Africa and beyond.

2.5.3.2. Educational Programmes: Information-Based Prevention Model

The UNODC (2004) poignantly notes that after the failure of deceptive and scare methods, South Africa adopted an information-based approach whose main premise is the assumption that once people get to know the negative consequences of drug abuse, they would be wise enough to desist from abusing them. Information based prevention efforts thrive on the dissemination of vital information which helps to deter would-be drug abusers from doing so, while at the same time, providing information on where and how to access treatment to the already affected (UNODC, 2004). According to Gonzalez, Maseko and Mvlisi (2013), information based prevention programmes in South Africa include awareness campaigns and life skills programmes such as the Kemoja “I am fine without drugs” programme and the Soul City television programme whose object was to disseminate information and promote

healthy life styles. Largely, many awareness campaigns in South Africa take the form of media campaigns on national television, radio stations, posters, and outreach campaigns. Additionally, life skills programmes have been infused into the country's national educational curriculums at all educational levels including primary, secondary and tertiary levels (Department of Basic Education, 2013).

Furthermore, the Canadian Association for Social Workers (CASW) (2016) underscores that inpatient and outpatient rehabilitation programmes also give comprehensive life skills training aimed at improving the resiliency of chemically dependent individuals to withstand various socioeconomic dynamics in their lives and environments. This is in keeping with Jeewa (2006), who asserts that drug addiction is framed as an adjunctive behaviour, or a subordinate behaviour catalysed by deeper, more significant psychological and biological stimuli. Life skills are, therefore, offered to help addicts to deal with or help them cope with their underlying issues, which, in the first place, would have forced them into abusing drugs.

In addition, Galanter (2007) mentions that, in rehabilitation facilities, life skills are propagated through intensive group sessions structured under the Minnesota 12 steps programme. The Minnesota programme is based on 12 orienting steps to recovery and the 12 traditions of the Alcoholic Anonymous whose tenets cover social, economic and spiritual dysfunctions in the lives of addicts and prescribe spiritual awakening as the basis for recovery (Galanter, 2007).

2.5.3.3. Supply Reduction Model

Gonzalez, Maseko and Mvlisi (2013) write that, apart from talk therapy, primary and secondary substance abuse prevention efforts in South Africa are closely linked to the work of the police which runs distinct drug and substance abuse prevention programmes. Geyer and Lombard (2014) contend that the South African Police Services (SAPS), in conjunction with the South African Revenue Services (SARS), play critical roles in the reduction of drug supplies in the country. SAPSs and SARS are involved in controlling the trafficking of drugs through the national borders and other ports of entry into the country (Geyer & Lombard,

2014). Moreover, the Department of Social Development (2007) notes that the police force is also involved in the enforcement of the Road Traffic Amendment Act (No. 21 of 1998), which provides for stop and search of all traffic at designated road blocks. However, Gonzalez, Maseko and Mvlisi (2013) mention that the effectiveness of police services in effectively preventing drug and substance trafficking and, ultimately, abuse is being seriously compromised by corruption. There are allegations that some senior members of the police force and SARS are involved in clandestine dealings with drug lords and drug trafficking cartels (Mbulayi & Makuyana, 2017). Additionally, Myers and Parry (2005) identified politics as a stumbling block in the development of comprehensive prevention strategies in South Africa. The disbandment of the Narcotics Bureau (SANAB) in 2003, which was a special drug unit vested in the South African Police Service (SAPS), has led to an increase of drug related crimes in the country (Myers & Parry, 2005).

2.5.4. Treatment of Addictions in Modern South Africa

Treatment of substance abuse disorders have come a long way, from the ages of the mutual aid societies, treatment and detoxification in private sanatoriums, to the modern age of the Alcoholic Anonymous (AA) and Narcotic Anonymous (NA), psychotherapies and, more recently, technologically enhanced pharmacotherapy (Marion & Oliver, 2014). In South Africa, drug and substance abuse treatment has evolved from very small racially biased services to the current robust and wide spread treatment options available through public and private facilities including virtual online self-help services (Geyer & Lombard, 2014).

The Minimum Norms and Standards for Inpatient Treatment Centres (2005) define drug and substance treatment as the clinical process by which the patients/clients are assisted in abstaining from their drug abuse/dependency and in participating in rehabilitation to achieve their optimal level of functioning. It also observes that treatment for chemical dependency should be holistic to such an extent where it addresses patients'/clients' (and their families' and caregivers') needs, that is physical, psychological, social, vocational, spiritual, and interpersonal and lifestyle needs (Galanter, 2007).

Drug and substance abuse treatment services in South Africa are provided under the premise of the Prevention of and Treatment for Substance Abuse Act No. 70 of 2008, whose major thrust is on combating substance abuse in a coordinated manner. The Act provides for the establishment and registration of all treatment services, including community based services, and those provided in treatment centres and halfway houses (Minimum Norms and Standards for Inpatient Treatment Centres, 2005). The Act also provides for prevention, early intervention, and after care services towards deterring the onset of and mitigating the impacts of chemical dependency in its early stages.

Remarkably, there is very limited information on drug and substance treatment in South Africa. Most of the researches that have been conducted on the discourse are on prevention and analysis of emerging trends. This is in line with Myers and Parry (2005) who assert that treatment work in South Africa has remained disjointed and uncoordinated. However, Gonzalez, Maseko and Mvilisi (2013) note that there is a wide network of public and private substance-abuse treatment facilities in South Africa whose mandate is to strengthen and motivate the resilience of chemically dependent persons to achieve long term abstinence from drugs.

Jeewa (2006) identifies several drug and substance abuse treatment options, including outpatient drug-free treatment programs, therapeutic communities (TCs), short-term residential programs, long-term residential programmes and methadone maintenance programs. Moreover, Jeewa (2006) adds that there are some other self-help programmes such as the Narcotics Anonymous (NA), Secular Organizations for Sobriety (SOS), SMART Recovery (Self-Management and Recovery Training), and Women for Sobriety (WFS) and NARCONON which provide support to recovering addicts. The ensuing is a discussion of drug treatment alternatives.

2.5.4.1. Types of Treatment Programmes/ Modalities in South Africa

2.5.4.1.1. An Overview of Out-Patient Treatment Programs

Out-patient drug free treatment programmes are community based treatment modalities which entail some amount of daily treatment at designated venues. Jeewa and Kasiram (2008) argue that the logic behind out-patient treatment services is a firm belief that removing people and treating them in artificial environments, where they don't get to face the temptation of their natural environments, limits their growth in recovery. Similarly, Gonzalez, Maseko and Mvilisi (2013) posit that substance dependent persons are not only addicted to the substances they abuse, but also to their dysfunctional environments and lifestyles which constitute their triggers, hence prompting the need for community based interventions that deal with all these dynamics on site. Moreover, Jules-Macquet (2015) adds that outpatient treatments make it easier for women to get treatment and go back home to look after their families every day. Moreover, community based outpatient treatment programmes are much cheaper and convenient to local people who may not be able to travel long distances to seek treatment (Gonzalez, Maseko & Mvlisi, 2013).

Jules-Macquet (2015) notes that out-patient programmes are increasingly becoming a treatment of choice in South Africa. This is because of the difficulty associated with securing a place in residential treatment programmes. Gonzalez, Maseko and Mvilisi (2013) contend that there is a massive shortage of state-run treatment facilities in South Africa, thereby creating a huge deficit of treatment opportunities. This has prompted non-governmental organizations, including South African National Council on Alcohol and Drug Dependence (SANCA), to move and fill this gap through the provision of out-patient treatment options.

Gonzalez, Maseko and Mvlisi (2013) add that the greatest advantage of out-patient treatment programmes is their ability to cut overhead costs such as the need for bedding, larger spaces and food, as patients will only come during the day and go back to their homes at night.

It is as a result of the need to improve the environment of treatment programmes that the South African government has partnered with SANCA and other Non-Governmental Organizations towards building community based treatment capacities. Gonzalez, Maseko and Mvlisi (2013) contend that the expansion of community based programmes could easily result in the easing of the treatment demand pressure which, at present, is marked by long waiting lists. But treatment programmes are also frustrated by high absconding rates amongst patients who attend out-patient programmes (Jules-Macquet, 2015). In his research, Jeewa (2006) found out that lack of pharmacotherapy including methadone and buprenorphine substitutes de-motivated many outpatients in Durban rehabilitation centres, thereby resulting in them absconding. Moreover, Jules-Macquet (2015) mentions that relapse rates among out-patient programme patients are significantly higher than those of clients treated in residential facilities.

2.5.4.1.2. An Overview of In-Patient/Residential Treatment Programmes

Residential drug and substance abuse treatment now occupies a very crucial niche in the treatment of drug dependency disorders. By definition, residential drug and substance treatment refers to treatment given to patients within the confines of an established medical or rehabilitation facility (Underwood, Barretti, Storms & Safonte- Strumolo, 2004). The drug dependent person is required to stay at the designated facility for a specified period. Gifford (2015) argues that residential treatment offers a structured therapeutic environment that begins with detoxification followed by intense psychotherapy and group work.

According to Underwood, Barretti, Storms and Safonte-Strumolo, (2004), residential treatment offers a controlled environment in which patients are supported to go through the process of recovery in a moderated milieu, and with the support of professional medical, emotional and other physical props to lessen the pain and fatalities of withdrawal.

Jeewa and Kasiram (2008) also argue that the basic benefit of residential treatment is the fact that it removes the substance abuser from his/her dysfunctional and often detrimental environment and allows him/her to focus solely on recovery. Similarly, Gonzalez, Maseko and Mvlisi (2013) contend that substance abusers often come from distressful backgrounds and have social or economic relationships which pressurize them into abusing drugs, hence residential treatment confers to them a safe haven in which they can be able to focus on their recovery. Moreover, Rehn, Jenkins and Cristal (2001) argue that during the early stages of recovery, patients face overwhelming experiences ranging from insomnia, depression and physical body pains; hence they require professional and dedicated assistance to go through these otherwise potentially fatal and aversive experiences. Rehn, Jenkins and Cristal (2001) argue that the pain of withdrawals can be traumatic and can possibly result in self-mutilation leading to permanent disabilities, or worse still, suicide. Underwood, Barretti, Storms and Safonte-Strumolo (2004) also aver that residential treatment can offer a subtle structure in which the mind can find comfort and safety which distracts the individual from negative thinking through the provision of a calm and non-judgmental environment.

Furthermore, addiction remains a highly despised disease whose stigma need not be overemphasized. Accordingly, residential treatment offers a comforting opportunity for patients to confront their life situations in the company of others going through similar experiences. Gonzalez, Maseko and Mvlisi (2013) argue that, for addicts, knowing that they are not alone in their fight against addiction can be a motivating experience which permits growth. Additionally, Gifford (2015) notes that residential treatment affords an opportunity for holistic treatment of the person, this is in keeping with the knowledge that addicts often have multiple problems ranging from medical, psychological, social and economic problems. In this light, Jeewa and Kasiram (2008) mention that residential treatment allows for holistic interventions including detoxifications, medical attention, psychotherapy, legal services, family and couples' therapy, reintegration services and vocational services.

Moreover, Gonzalez, Maseko and Mvlisi (2013) argue that residential treatment facilities are increasingly being fashioned in ways which maximize comfort to counter the stressful period of addiction recovery. Accordingly, Underwood, Barretti, Storms and Safonte- Strumolo, (2004) view that it is crucial when choosing a drug and substance rehabilitation facility to seriously consider the quality of services offered, including the living spaces as they often have a bearing on recovery.

2.5.4.1.3. Types of Residential/Inpatient Treatment Programmes

2.5.4.1.3.1. Short-term Residential Programmes

Galanter (2007) mentions that short-term residential treatment programmes involve 3 to 6 week intensive in-patient treatment services mainly based on the Minnesota 12 steps programme. These are often accompanied by on-going participation in after-care support groups. In short term residential treatment programmes, patients are offered group therapy, psychotherapy and, in some facilities, limited detoxification services are provided (CASW, 2016).

2.5.4.1.3.2. Long Term Residential Treatment Programmes

Long-term residential treatment programmes span a period ranging from a few weeks to a year. Long term programmes offer a structured environment often based on the 12-step approach, and includes drug education and different types of therapies including group, individual, and sometimes family or couples' therapy (Jeewa, 2006). In addition, Gifford (2015) notes that one of the strengths of long term residential treatment is its holistic approach to substance abuse treatment. Jeewa and Kasiram (2008) note that most long term residential facilities, such as half-way houses offer detoxification programmes which run along other pharmacotherapy programmes including opioid maintenance treatments.

2.5.4.1.3.3. Therapeutic Communities

According to Jones (2013), a therapeutic community is a type of community where people live together as a form of therapy. Therapeutic community programmes are designed to provide conducive and supportive environments which are highly structured to permit people to explore new lifestyles and reintegrate into a social world (Jeewa, 2006). Jones (2013) further highlights that therapeutic communities are closely associated with milieu therapy in which the environment is used to bring about the desired change of behaviour. For treatment of drug and substance abuse, therapeutic communities originated in 1958 (Drug and Alcohol Rehab Asia (DARA), 2016). The bedrock of therapeutic communities is the strength's perspective which is founded on a firm belief that all people possess inner strengths and capabilities necessary for behaviour change; they only lack a safe environment to explore these inner resources (Jones, 2013). The work of therapeutic communities, therefore, entails promotion of holistic lifestyles which help to identify areas for personal, social, economic, psychological and emotional needs which need to be changed. Additionally, Drug and Alcohol Rehab Asia (DARA) (2016) indicates that therapeutic communities are run on the consensus of community members with a very limited intervention of facilitators.

2.6. Methods/Approaches of Drug and Substance Treatment

There is often a misconception that behavioural therapies and pharmacotherapies are treatment modalities on their own. This misapprehension can largely be attributed to lack of knowledge by people who end up naming a service in terms of its techniques and utilities. Galanter (2007) argues that among some of the venerated substance abuse treatment approaches are behavioural therapies, pharmacotherapies, Life skills training, Vocational training and other listings of remedies including art therapy and aroma therapy. This section discusses the various methods or approaches used in the treatment of drug and substance abuse.

2.6.1. Counselling/Psychotherapy

According to the Merriam Webster online Dictionary (2017), counselling is a professional enterprise of offering advice and support to people to help them deal with problems and in making important decisions. Kazdin and Blase (2011) write that individual psychotherapy is the modality in which a therapist and a client engage in one-on-one interaction towards developing intervention strategies. Psychotherapy, when used in substance abuse treatment, focuses on developing individual treatment plans (Prochaska & Norcross, 2013). More so, psychotherapy is embodied in different behavioural therapies and administered from different theoretical perspectives and orientations including psychodynamic, cognitive, behavioural and motivational interviewing among others (Kazdin & Blase, 2011).

2.6.2. Family Therapy

One of the realities of chemical dependency is impaired personal and interpersonal relationships. It is to this end that Prochaska and Norcross (2013) posit that it is pertinent that therapists working in drug and substance rehabilitation facilities need not work with the addict alone, but also with the family and his/her significant others. This is done to enhance the delivery of effective and comprehensive interventions. Prochaska and Norcross (2013) allude to the importance of using the person in environment approach in the treatment of substance abuse. At a practical level, family therapy is conducted with all or as many as possible family members of the client. The benefit of family therapy is that it helps to reunite the client with his/her family towards redeveloping and reconstituting his/her support structures. Moreover, Kazdin and Blase (2011) reiterate that families often lack knowledge of how to help their loved one, and hence family therapy provides a platform for educating them about the causes and possible impacts of substance abuse and how to support the recovering person. Family therapy is sometimes done in the form of couples' therapy in which it is used to assist a couple to work together as partners through mutually expressing and communicating their love and commitment towards solving their common problems and setting realistic goals and expectations for each other (Prochaska & Norcross, 2013).

Furthermore, family therapy work is done to identify and modify maladaptive or destructive interactional patterns and foster positive mutual communication and respect between and among the family members towards ameliorating identified problems (Kazdin & Blase, 2011).

2.6.3. Group Work

According to Straussner (2013), group work in substance abuse treatment is a form of psychotherapy which is conducted with at least three and up to fifteen patients in one therapeutic session. Group work with drug and substance abusers offers patients an opportunity to share synergies and experiences which allow them to learn from each other (Mehl-Madrona & Mainguy, 2014). By working in groups, in treatment substance abusers get an opportunity to be motivated that they are not alone in the fight against their risky behaviour of abusing drugs (Berger, 2013). Given the social anxiety encountered at the beginning stages of the treatment process, group work helps patients to navigate their roles, expectations and responsibilities in the treatment process (Mehl-Madrona and Mainguy, 2014). Moreover, group work helps patients to confront and challenge the stigma and social anxieties in a moderated environment. According to Straussner (2013), substance abuse therapy group work is conducted in homogeneous groups in which group members share similar concerns and characteristics, thus enabling them to share synergies towards achieving their common goals. In most treatment modalities, the Minnesota 12 steps programme is one of the key group work tools used to stimulate spiritual and self-awareness amongst in-treatment drug abusers (Galanter, 2007).

2.6.4. Life Skills Training

There are several factors including personal factors, social environmental factors and drug factors which increase the proclivity of individuals to abuse drugs (Faggiano et al., 2010). However, in many instances, it is lack of capacity and stamina of individuals which make them vulnerable in the face of the different factors which increase their vulnerability to abusing substances (Merline, Jager, & Schulenberg, 2008).

In this light, Faggiano et al., (2010) aver that it is pertinent when treating drug and substance addiction to focus on equipping patients with knowledge and skills of how to deal with their different life circumstances, which might have been responsible for forcing them into addiction in the first place.

Gifford (2015) contends that life skills' training includes the promotion of responsible behaviour, self-confidence, equality and the prevention of prejudice and abuse. This is especially important, given that most substance abusers come from a background where they would have lost substantially in terms of their social, economic and religious statuses, which, in turn, mean decimated self-esteem and confidence. Life skills' training is, therefore, more about helping patients to work around the drastic changes which would have happened in their lives (Merline, Jager & Schulenberg, 2008). Similarly, Wenzel, Weichold, and Silbereisen (2009) propound that life skills' training in addiction treatment is designed to facilitate the practice and reinforcement of psychosocial skills in a culturally, socially and economically salient way towards promoting necessary adjustments in post treatment life. Among some of the basic life skills which recovering addicts need to be taught are skills for building self-esteem, setting realistic goals, coping with anxiety, resisting peer and social pressure, communicating effectively, making decisions, managing conflict and dealing assertively with social situations in which drugs may be offered (Merline, Jager & Schulenberg, 2008).

Galanter (2007) posits that life skills' training as a method of intervention can be used for both treatment and prevention of substance abuse. The above researcher further contends that life skills' training is more effective if it is synchronized with a comprehensive and on-going health education programme. In addition, Faggiano et al., (2010) mention that, for effectiveness, life skills training should strive to balance the provision of information with the opportunity to develop values and vocational or practical skills.

2.6.5. Pharmacotherapy

The world over, the problem of substance abuse has been described as a public health concern which needs urgent and intelligible interventions (Singer, 2009). This is in recognition of the fact that substance abusers often have physical, emotional and psychological traumas, some of which require medical interventions to stop them from developing into fatalities. To this end, Swendsen et al., (2010) observed that 37% of alcoholics and 53% of narcotic abusers have comorbid mental disorders. This makes drug/medicine based treatments (pharmacotherapy) both a competitive and an important support service in substance abuse treatment (Batki & Pennington, 2014). Below are the fundamental functions of pharmacotherapy in drug and substance abuse treatment:

- Blocking the effects of a dose towards avoiding intoxication/overdose;
- Helping the individual to go through the painful process of withdrawal/detoxification;
- Relapse prevention by reducing cravings for the drug and;
- Treating accompanying mental disorders in dual diagnosis patients.

(Adopted from: Batki & Pennington, 2014)

According to Batki and Pennington (2014), pharmacotherapy is one of the most promising treatment methods for substance abuse. Singer (2009) outlines pharmacotherapy regimens which have so far been adopted and approved for the treatment and maintenance of alcoholism, opioid addiction, benzodiazepines and nicotine dependency. There are also some other medications which are still at trial and pre-trial levels which are appropriate adjuncts in primary care for chemically dependent persons (Batki & Pennington, 2014). However, there are still no pharmacotherapy treatments for cocaine, methamphetamines, hallucinogens, cannabis and solvents/inhalants (Batki & Pennington, 2014).

Among some of the internationally acclaimed pharmacotherapy treatments available are:

- *Disulfiram, naltrexone and acamprosate for alcoholism;*
- *Naltrexone, methadone and buprenorphine/naloxone for opioid addiction;*
- *Carbamazepam and valproate for benzodiazepines addiction withdrawals or discontinuation/tapering; and*
- *Transdermal patch or nicotine gum for treatment of nicotine addiction.*

(Batki & Pennington 2014).

2.6.5.1. Classification and Functioning of Pharmacotherapy Drugs

Julien (2013) posits that medications used in pharmacotherapy are classified into four basic categories based on their potential action to counter or address the effects of drug abuse; and these include agonists, antagonists, aversive and prescription medications.

2.6.5.1.1. Agonists (replacement/substitution)

Petrakis et al., (2014) notes that an agonist is a substance which initiates a psychological response when combined with a receptor. Examples of agonist drugs include methadone, hydrocodone, morphine and oxycodone among others (Singer, 2009). They work by fulfilling a certain psychological requirement which is normally derived from substance abuse (Singer, 2009). The action potentials of agonists, therefore, are to mitigate acute, post-acute or protracted withdrawal and to reduce cravings (Batki & Pennington, 2014). While the intention of agonists is not to substitute the drug of choice, prolonged and unregulated use may result in dependency (Petrakis et al., 2014).

2.6.5.1.2. Antagonists (blockade)

Antagonists are medications that block the receptors that the drug of choice acts on, thus preventing the drug of choice from activating those receptors and thereby reducing drug use and subsequent reward (Batki & Pennington, 2014).

Additionally, Singer (2009) notes that when antagonists are used and the patient goes on to relapse, there could be a danger of overdose as he/she will continue to solicit for the effect of the drug, to an extent of overstepping his/her natural threshold, resulting in serious injury or death. Examples of antagonists are naltrexone and naloxone (Singer, 2009).

2.6.5.1.3. Aversive (negative reinforcement)

Aversive pharmacological drugs work by producing an aversive stimulus for each usage. In many instances, aversive pharmacological drugs cause nausea, irritation, fatigue, disorientation and general body aches when used in circumstances of contraindications (Petrakis et al., 2014). Typical examples of aversive pharmacotherapy drugs include disulfiram and emetine/apomorphine.

2.6.5.1.4. Prescription Medications: (For Correction of accompanying underlying/associated disorders)

Substance abuse may be accompanied by some underlying psychological problems which could be natural to the individual or might have been triggered by substance abuse. Singer (2009) avers that it is pertinent to treat all underlying factors associated or accompanying addiction for all dually diagnosed patients. In this case, medicines are used to treat problems like depression, anxiety, schizophrenia, among others. Examples include buprenorphine, methadone, oxycontin and fentanyl (Singer, 2009).

2.7. A Conceptualization of “Effectiveness” of Drug and substance Abuse Treatment Modalities

Although there is broad consensus in drug and substance treatment settings and among treatment research communities that substance abuse is treatable, there has continued to be an outcry over the dismal performance of available treatment modalities (Emmelkamp & Vedel, 2012).

The low rates of people who manage to sustain their recovery after a supposedly successful rehabilitation process has been used to vindicate allegations that the available treatment options are not effectively treating what they purport to treat. With global addiction treatment success rates revolving below 5% for an intervening period of one year, many stakeholders are starting to lose confidence in the effectiveness of the available treatment modalities (Moos & Moos, 2006). Concurringly, Emmelkamp and Vedel, (2012) aver that the effectiveness of treatment modalities has remained an issue of concern for service providers, service consumers, and governments across the world.

2.7.1. Principles of Effective Drug and Substance Treatment

Substance abuse treatment is a dynamic process whose objectives are diverse and transitional, depending on the extent of the addiction and the bio-psychosocial characteristics of individuals who seek treatment (Sperry, Brill, Howard & Grissom, 2013). This changing and disparate nature of drug and substance treatment goals makes it difficult for researchers and service providers alike to comprehensively and definitively appraise the effectiveness of treatment modalities. In this light, Chandler, Fletcher and Volkow (2009) outline the basic key principles which should inform the analysis and assessment of the effectiveness of any drug and substance abuse treatment programme. These are listed below;

- *Addiction is a complex but treatable disease that affects the brain function and behavior;*
- *No single treatment is right for everyone;*
- *People need to have quick access to treatment;*
- *Effective treatment must address all of the patient's needs, not only his/her drug abuse;*
- *Staying in treatment long enough is critical;*
- *Counseling and other behavioral therapies are the most commonly used forms of treatment;*

- *Medications are often an important part of treatment, especially when combined with behavioral therapies;*
- *Treatment plans must be reviewed often and modified to fit patients' changing needs;*
- *Treatment should address other possible mental problems;*
- *Medically assisted detoxification is only the first stage of treatment;*
- *Treatment doesn't need to be voluntary to be effective;*
- *Drug use during treatment should be monitored continuously;*
- *Treatment programmes should test patients for HIV/AIDs, Hepatitis B, Tuberculosis and other infectious diseases as well as teaching them about steps they can make to reduce the risk of these illnesses.*

(Adopted from: Chandler, Fletcher & Volkow, 2009)

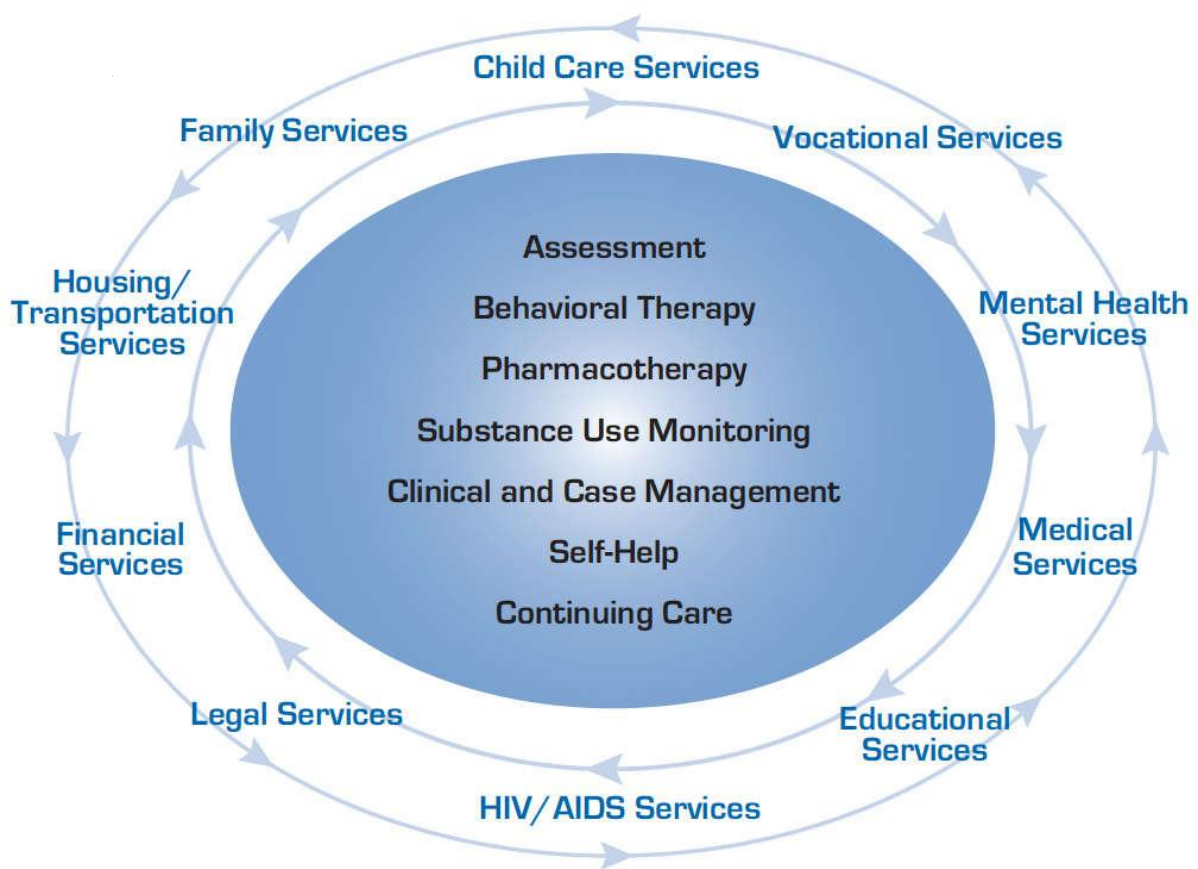
2.7.2. Characteristics of Effective Treatment

2.7.2.1. Focus on Possibilities As Opposed to Normative Outcomes

Breslin, Reed, and Malone (2003) underscore that, contrary to popular credence, the goal of substance abuse treatment goes beyond enabling addicts to stop abusing drugs, but rather to enable them to achieve holistic change in different spheres of their lives. On its own, quitting or stopping abusing drugs is part of the envisaged goals of the recovery process, but not necessarily the end in itself. On this note, Catalan, Hawkins, Wells, Miller, and Brewer (2009) aver that the effectiveness of a treatment modality cannot be measured in terms of the avoidance of recidivism to substance usage only, but the ability of the recovering individual to maintain a healthy lifestyle in a number of sectors of his/her life. This is in keeping with Breslin, Reed, and Malone's (2003) assertion that chemical dependency affects more than one facet of a person's life, and hence the need for comprehensive and integrated interventions. On this note, Jeewa (2006) castigates the blanket approach to treating drug and substance addiction as one of the major reasons why the available programmes have remained ineffective. Rather, he emphasizes that treatment should focus on the unique needs of each client without generalizing.

The following image graphically illustrates the different components of a comprehensive and effective addiction treatment programme.

Figure 2.1: Components of comprehensive substance abuse treatment



Source: NIDA (2013)

2.7.2.2. Inclusive Interventions

Drug and substance treatment research communities concur that people who seek interventions often come from different backgrounds where their reasons for abusing substances and its outcomes thereof are varied and manifold. In this light, Imhoff and Hirsch (1996) posit that, given what is known about the social, medical, and legal consequences of substance abuse, interventions should therefore at a minimum, be assimilated with criminal justice, social, and medical services towards achieving the following outcomes:

- Reduced crime;
- Reduced drug use;
- Reduced domestic violence;

- Reduced behavior at risk for HIV (human immunodeficiency virus) infection;
- Increased days of employment; and
- Positive changes in social values and networks.

(Adopted from: Imhoff & Hirsch, 1996)

2.7.2.3. Person/client oriented interventions

Jeewa (2006) mentions that to ensure effectiveness, addiction treatment modalities ought to be sensitive and responsive to the basic needs of individuals including their health, economics, values, culture and religion, among other important factors. Arguably, there are no two people with identical addiction traits and circumstances, hence programme packaging ought to be attentive to individual needs and recognize their uniqueness (Velasquez, Crouch, Stephens & DiClemente, 2015). Moreover, Wells, Klap, Koike and Sherbourne (2001) assert that the circumstances of substance abusers in treatment continue to shift, hence there is need to continue altering and modifying clients' treatment plans to fit their changing needs. This perhaps explains Velasquez, Crouch, Stephens, and DiClemente's (2015) assertion that tailoring and integrating treatment goals and services in line with identified needs and characteristics of the individual should be the basis of effective and sustainable interventions.

2.8. Weaknesses Associated with Contemporary Addiction Treatment Modalities

Gifford (2015) contends that there are some monumental weaknesses embedded within the structure and practice of most drug and substance treatment programmes. These weaknesses are responsible for the protracted endurance of the drug and substance abuse scourge in the world. Arguably, Jeewa (2006) asserts that modalities which subsume under the broad concept of substance abuse treatment have not significantly changed over the years, resulting in some practical weaknesses given the changing nature and potency of modern drugs.

2.8.1. One size fit all Approach

Despite the growing currency motivating for integrated treatment modalities which can accommodate different needs for different patients, most treatment programmes have not evolved to adopt holistic approaches. According to Jeewa and Kasiram (2008), most treatment modalities have remained stuck with traditional treatment methods which are sometimes not in sync or realistic about the individualized experiences and needs of patients. Patients who are addicted to different drugs and substances are often subjected to similar treatment routines and regiments, thereby overlooking some requisite and unique treatment needs and services required for specific drugs and individuals (Etheridge, Hubbard, Anderson, Craddock & Flynn, 1997). On the same note, Velasquez, Crouch, Stephens, and DiClemente (2015) contend that uniform admission periods across the board are retrogressive given that different drugs require different time periods to clear off a person's system. Larimer and Crounce (2002) underscore that it is pertinent that treatment of drug and substance abuse not only focus on the drug problem in general, but rather develop individualized strategies which focus on the person with the drug problem. Velasquez, Crouch, Stephens, and DiClemente (2015) thus believe that the blanket approach adopted in many treatment programmes makes them potentially defective and ineffective.

2.8.2. Difficulties associated with Accessing Treatment on Time

Gonzalez, Maseko and Mvilisi (2013) refer to the various factors militating against timely drug and substance treatment service delivery as some of the bottlenecks rendering treatment ineffective. Myers and Perry (2005) contend that some rehabilitation centres are affected by bureaucracy which makes it difficult for patients to access timely treatment. On this note, DARA (2016) refers to some treatment centres in Asia, and Africa where those who seek treatment for substance abuse are required to first pass some means test for them to be admitted. The means tests, in some cases, include attending a self-help group for a stipulated time so as to prove willingness and readiness (DARA, 2016).

However, Tims and Ludford (1984) note that this is contrary to the principles of effective treatment, which underscore the need for easy and urgent treatment for those in addiction towards enhancing harm reduction. In addition, Tims and Ludford (1984) mention that some treatment centres are making the mistake of focusing on working with willing and voluntary patients. Ideally, this is against the principle of effective treatment, which stresses that treatment does not need to be voluntary to be effective.

2.8.3. Lack of Integrated Programs and Services

According to Ghitza and Tai (2014), substance abuse treatment programmes ought to be integrated and intersecting with other crucial services. Focusing on a single approach often results in some patients having some of their basic needs overlooked and undermined (Gonzalez, Maseko & Mvilisi, 2013).

Jeewa (2006) mentions that to achieve effectiveness, substance abuse treatment should encompass provisions for social, economic, spiritual and medical services which should be integrated to enhance recovery. Ghitza and Tai, (2014) poignantly add that it is imperious that professionals working in drug treatment settings have knowledge of the available referral resources towards developing an integrated service system for the benefit of their clients.

2.8.4. Shortage of Adequately Trained Substance Abuse Treatment

Professionals

Although the discourse of substance abuse has continued to attract international attention, there has not been corresponding investments in the training of specialized drug and substance treatment professionals (Ghitza & Tai, 2014). Gonzalez, Maseko and Mvlisi (2013) refer to 2005 records, which state that there is 1 psychologist for every 312 000 people in South Africa. Similarly, Abel (2007) cites the Professional Board for Psychology of the Health Professions Council of South Africa (HPCSA) and stated that as of 2007, there were only 256 registered counsellors in South Africa.

More so, Ghitza and Tai (2014), allude to critical shortages of key mental health professionals such as psychiatrists in many developing countries. This leads to the critical unavailability of prescribing professionals and thus undermining the effectiveness of treatment modalities.

2.9. Challenges Stalling Successful Mitigation of Drug and Substance Abuse Prevention in South Africa

2.9.1. The Unavailability of Reliable Data to Inform Effective Interventions and Funding

The first Biennial Report produced by the DSD (2007) states that efforts made by the government to fight substance abuse in South Africa are sometimes hindered by various technical glitches including difficulties in obtaining accurate and up-to-date statistics on the supply and demand of alcohol and other illicit drugs. This, according to Peltzer et al., (2010), is also true about statistics of the demand for treatment services. Perhaps, this gap also explains the reason why despite being one of the modern pressing socioeconomic pathologies, the drug and substance abuse problem has failed to attract national attention and resources it deserves. Accordingly, Whiteford et al., (2013) explain that the allocated national budgets for drug and substance abuse treatment has remained very small in the face of a growing scourge. With limited financial resources, many rehabilitation facilities have folded up their operations leaving many destitute and vulnerable. Whiteford et al., (2013) pinpoint poor funding in the drug and substance prevention and treatment sector as one of the reasons why the sector has for a long time failed to develop capacity to deal with addictions in a sustainable manner.

2.9.1.1. Out-dated legislative framework

The DSD (2007) alleges that South Africa's drug control mechanisms are mounted on an out-dated legislative framework whose scope is limited to such an extent that it fails to address important aspects of drug and substance abuse prevention, treatment, as well as care for the affected persons. The available legislations are mainly geared towards registration of treatment facilities and to provide an oversight function to all stakeholders in the sector. However, the WHO (2001) report suggests that the legislations have failed to evolve over the years and thus failing to effectively deal with the growing problem. Apparently, the legislations have maintained a unidirectional relationship between the government and service providers in which the government plays a managerial role without visible engagement with service providers. From personal experience as a social worker domiciled in a private drug and substance rehabilitation facility, the researcher has observed that government representatives who do monitoring and evaluation of treatment centres seldom come to do their job. They only avail themselves for new registrations and re-registrations.

2.9.1.2. Lack of Engagement Forums for Professionals and Key Stake Holders

Myers and Parry (2005) mention that the socio-economic and political environment in South Africa has continued to offer limited opportunities and platforms for policy makers, donors, development agencies, civil society and government officials to share information towards finding lasting solutions for the drug problem. Apart from the annual Biennial Conference, there is no other professional forum where issues of substance abuse are discussed. Strom-Gottfried and Mowbray (2006) further argues that social workers and other professionals working in drug and substance rehabilitation settings are subjected to isolation as a result of the nature of their job and this makes them susceptible to exhaustion and frustration. Moreover, without any forum to share ideas, professionals working in drug and substance treatment settings cannot take advantage of the synergy from other professionals which can help to enhance evidence based practice.

This is further compounded by serious scarcity of essential resources (human and economic) which limits the capacity of the workers in combating substance abuse.

2.9.1.3. Poor Border Control Systems

Foster and Briceño-Garmendia (2010) note that South Africa's inland and naval ports are strategically located and developed to enhance a better connection on multimodal corridors far beyond the country's national boundaries. Incidentally, the country's geographical location as the main southern gateway between the rest of the continent and the external world makes it a perfect drug trafficking corridor (Mbulayi & Makuyana, 2017). With poorly technologized and excessive corruption at port of entries, trafficking of drugs and other illicit goods is continuing unabated (Mbulayi & Makuyana, 2017). The DSD (2007) mentions that trafficking of drugs and substances in South Africa has been further enhanced by the rapid globalization of the country's economy, including the banking system which makes it easier to move large sums of money at the click of a mouse.

2.9.2. Institutional and Operational Gaps Hindering Effective Treatment of Addictions in South Africa

The goal of substance dependence treatment is to achieve long term recovery (Kaye & Darke, 2012). In many cases, the measure of success is the ability of the individual to say no, or to never touch drugs again (Jeewa, 2006). However, according to the relapse prevention paradigm, relapse is a common experience (Marlatt & Donovan, 2005). Accordingly, Gifford (2015) writes that a multi-pronged approach is needed to instil effectiveness in treatment programmes.

While most of the available treatment modalities are open and flexible to diversity, there have perpetually remained some noticeable institutional and operational gaps hindering effective treatment in the country. The following discussions expound on such gaps.

2.9.2.1. Dilapidated and Unavailable Therapeutic Resources and Infrastructures

The operations of drug and substance treatment centres in South Africa are being seriously compromised by lack of requisite resources and infrastructure. Odejide (2006) refers to dilapidated and unavailable infrastructure, especially in public rehabilitation centres. On this note, Pitorak et al., (2012) argue that due to lack of resources and infrastructure in some treatment centres, clients are crammed in unhealthy living conditions where they are susceptible to contracting diseases. Saah (2005) thus avers that the living environment of addicts is especially important in their recovering process. Odejide (2006) adds that substance abusers usually come from unhygienic and bad living environments; hence a significant change of their living environment can give them an opportunity to make a new start. This, Odejide (2005) believes, is paramount when considered in the context of air borne and other diseases that can spread in public places such as rehabilitation centres. Moreover, Setlalentoa, Pisa, Thekisho, Ryke and Loots (2010) aver that it is international best practice that drug and substance addicts who get admitted into treatment facilities have their right to privacy respected. On the same note, Saah (2005) writes that clean and adequately resourced environments are paramount for the re-socialization of the recovering addict back to social and basic home etiquette.

Moreover, Galanter (2007) notes that to run effective treatment programmes, rehabilitation centres need modern and high-end technology including gym facilities, saunas, drug testers and other recreational facilities. These according to Galanter (2007) are absent in most average and low-cost rehabilitation facilities in South Africa.

2.9.2.2. Long waiting periods before admission

Lack of proper and adequate accommodation and other capacities is arguably a confounding factor in the administration of substance abuse treatment centres. Jules-Macquet (2015) refers to a research by NICRO (2012-2013) which found out that, due to lack of space and capacity in many public rehabilitation centres, service seekers are often

subjected to long waiting lists that can exceed 12 months before they can be admitted for treatment. It is to this end that Mbulayi and Makuyana (2017) argue that, long waiting periods before admission can result in fatalities, including death and permanent injuries, which fundamentally contradicts the increasingly accepted global ideology and approach which underscores harm reduction strategies.

2.9.2.3. Prohibitive Treatment Costs

Myers and Parry (2005) note that there has continued to be significant disparities in terms of the availability of public drug and substance treatment services and this has given rise to a thriving private, for-profit treatment sector whose service charges are beyond the affordability of the poor majority. Warda (2010) states that, on average, most private drug and substance treatment centres in South Africa cost R30 000 upwards for 28 days. Most of the costs are associated with boarding fees, meals, medical treatment, counselling, therapy, consults, lectures and transport.

Myers and Parry (2005) avers that these high costs explain why most high-end rehabilitation centres in the country are increasingly becoming a haven for wealthy international addicts at the expense of local poor people. Gonzalez, Maseko and Mvlisi (2013) add that even when the local poor people get to be admitted in these expensive centres through their medical aid schemes, they often end up running away before they can benefit as they feel out of place and cannot afford other living expenses.

2.9.2.4. Gender and age insensitivity in the admission criteria of rehabilitation centres

It is poor practice that many rehabilitation centres are gender insensitive and appear to view drug abuse as a function of males and, therefore, the human capital tends to harbour attitudes of treating and welcoming only the males. This has attracted research comment from Setlalentoa, Pisa, Thekisho, Ryke and Loots (2010) alleging that rehabilitation facilities have continued to discriminate against women and children.

To this end, most of the available facilities are for adult males at the expense of women and children. However, Setlalentoa, Pisa, Thekisho, Ryke and Loots (2010) in their research found out that the main reason for fewer rehabilitation centres catering for women and girls is because of the overhead costs associated with the special needs in female facilities.

2.9.2.5. Bias in the Location of Treatment Centres: Rural vs. Urban Areas

The location of treatment facilities which tend to favour urban and affluent areas at the expense of rural and low income areas is one of the concomitant factors impeding the successful mitigation of the drug abuse scourge in South Africa.

Myers, Parry and Plüddemann (2004) argue that treatment services have remained agglomerated in urban and affluent areas at the expense of poor and rural areas (Setlalentoa, Pisa, Thekisho, Ryke & Loots, 2010). This incongruous imbalance in the allocation of this crucial resource will remain an albatross around the efforts of establishing a drug free South Africa if not changed.

2.10. Social Work in Drug and Substance Rehabilitation Facilities

Social work remains a venerated profession which emphasizes the intrinsic worth and dignity of all people despite their different social, economic, and psychological conditions and circumstances (CASW, 2016). This renders the work of social workers in drug and substance treatment settings invaluable. Miller (2016) poignantly notes that people who seek treatment in drug and substance rehabilitation facilities do so against a backdrop of shame, guilt, ridicule, stigma, discrimination, segregation and alienation. These largely negative social experiences and labels are often accompanied by feelings of self-doubt, worthlessness, rejection and dejection which makes them resent the process of recovery. Accordingly, the National Association of Social Workers (NASW) (2005) mentions that the greatest role of social workers in rehabilitation facilities is to motivate, diagnose and hold a psychosocial mirror for their clients towards assisting them to regain their self-awareness and dignity.

In this regard, CASW (2016) states that it is the ability of social work practitioners working in the drug rehabilitation centres to empathise and provide holistic interventions which sets them apart from other professionals in similar settings.

Miller (2016) argues that Social workers who are domiciled in drug and substance rehabilitation facilities focus on analysing the causes and impacts of substance abuse among both voluntary/self-referred and involuntary/mandated clients.

There is consensus that addiction to drugs and other intoxicants increases the proclivity of individuals to commit crimes (Walters, 2013). It is from this consensus that many governments across the world now prefer mandatory treatment of offenders who commit crimes while under the influence of intoxicants as opposed to imprisonment (Miller, 2016). This is especially true in the case of juvenile and first time offenders to whom custodial sentences in respect of committed crimes may result in them becoming hardened criminals. In this light, social workers working in rehabilitation facilities assist juvenile and other offenders by recommending non-custodial sentences and providing counselling for clients on parole (CASW, 2016).

Additionally, social workers in drug rehabilitation facilities provide their expertise as counsellors, life skills trainers, problem assessors, inter-mediators, advocates, brokers, and programme administrators (NASW, 2005). Miller (2016) propounds that, in many instances, Social Workers are required to further their studies and obtain certification in alcohol and substance abuse counselling to afford them practice in this field. This is done despite the fact that they would have graduated with Social Work degrees that include substance abuse modules. Moreover, with the exponentially growing problem of drug and substance abuse in the world, in some parts of the world, Social Workers are now increasingly specializing in Clinical Social work and Employee Assistance Programmes (EAP) after which they intervene at organizational level to provide support for addicted employees (Smook, Ubbink, Ryke & Strydom, 2014).

Daley and Feit (2013) note that apart from identifying and assessing problems, drug and substance rehabilitating Social Workers also work directly with drug dependent clients and their families who usually bear the brunt of the addiction. Some of the job descriptions of drug and substance Social Workers include providing individual and group counselling, collecting and recording urine samples, making referrals, tracking and motivating progress amongst their clients along the recovery journey (Daley and Feit, 2013). NASW (2005) highlights that addiction counsellors keep the patient and the family of the patient up to date on treatment information, drug information, and the progress being made. They also educate their clients about drugs, drug treatment and life after treatment (Daley & Feit, 2013). Miller (2016) points out that counsellors working with addiction may arrange treatment at other facilities if needed, such as mental health counselling, healthcare and coordinating services with other members of staff for the patients. Social workers also help their clients and their families to move from a situation of uncertainty, anxiety, and dependency to one of increased confidence, hope and autonomy through assessment and interventions in the areas of psychosocial functioning and discharge planning (CASW, 2016).

However, Miller (2016) mentions that providing care and support for people using substances is a hard task often experienced by social workers and other professionals working in drug and substance rehabilitation centres. Similarly, note that in many instances, Social Workers working in rehabilitation facilities are burdened with high caseloads. On this note, the Substance Abuse and Mental Health Services Administration (SAMHSA) (2010) asserts that in 2009, a total of 23.5 million people required treatment for drug or alcohol abuse and of these, only 2.6 million received care. This, SAMSA (2010) believes, is partly because of lack of capacity including human resources, funding and general lack of requisite infrastructure.

2.11. Drug and Substance Abuse Treatment: Theoretical Standpoints

In recent years, calls to renew and revive national and international focus and commitment to ameliorating the drug and substance abuse bane has been gaining currency in South Africa and beyond (Wallace, 2013; Boyd, Howard, & Zucker, 2013). Largely, governments across the globe are increasingly seeking to adopt efficient and effective intervention strategies towards addressing the waning public confidence in current intervention modalities (Hanson, Venturelli & Fleckenstein, 2011). Locally, the envisioned goal of establishing a drug free South Africa has revitalized interests by research communities to scrutinize the efforts and contributions of drug and substance rehabilitation facilities (Geyer & Lombard, 2014). This has brought to the fore some pertinent theoretical and practical questions as regards the contributions of rehabilitation facilities in terms of their operations and the effectiveness of their treatment modalities. This section elucidates theoretical lenses through which the discourse of the contribution of drug and substance abuse treatment facilities will be understood, given the backdrop of intensified efforts to create a drug free South Africa.

2.11.1. Operationalizing “Contributions” of drug and substance Treatment Facilities

Before delving into the theoretical underpinnings of this study, it is important to first address some pertinent issues regarding what is meant by “contributions” of drug and substance treatment facilities. The operationalization of the word ‘contribution’ here is important as it helps to locate the core of the study within the dictates of the ensuing theories. Mizikaci (2006) posits the contribution of a service can be conceptualized as an operation involving data collection, observations and analysis which culminates in a value judgment with regard to the quality of the service being evaluated. In this light, contribution is measured in terms of service excellence, fitness for purpose, dynamism, value for money and enhancement, or improvement of service or product towards consumer satisfaction (Department of Basic Education, 2013).

This study is focused on evaluating the contributions of drug and substance rehabilitation centres towards ameliorating the drug problem in South Africa. 'Contribution' in this context, therefore, refers to the nature, quality, effectiveness, reliability, appropriateness, accessibility and sustainability of treatment services offered by the selected treatment centres. These outcomes will be measured through context evaluation, input evaluation, process evaluation and product/service evaluation.

2.12. Theoretical Framework

The researcher entered the research field with a set of orienting inferences of what constitutes social reality in terms of the operations of drug and substance abuse treatment facilities. These guiding principles in the form of theoretical lenses informed the manner in which findings of the study were interpreted and applied. The research used the Systems Theory and the Sustainable Livelihoods Approach (SLA). The following section exhaustively discusses the above mentioned theories and expound on their application in the drug and substance abuse treatment sector as well as some criticisms on the approach.

2.12.1. Systems Theory

The systems theory is one of the venerated trans-disciplinary paradigms whose tenets has been widely adopted and transformed to explain the operations of both animate and inanimate phenomena in various sectors (Onwuegbuzie, Collins & Frels, 2013; Ludwig von Bertalanffy, 1968). Generally, from a systems perspective, a system is construed as a set of interrelated elements that are organized in an orderly manner to constitute a functional whole (Schoeneborn, 2014).

Onwuegbuzie, Collins, and Frels (2013) contend that the systems theory as a trans-disciplinary and integrative framework has been developed to transcend all philosophical and theoretical boundaries that have been set to divide knowledge along methodological lines.

The theory offers an opportunity to reframe the narrative of disparate theories towards integrating them into a single interpretation of social reality regardless of disciplinary orientation (Onwuegbuzie et al., 2013).

Schneider, Wickert, and Marti (2016) mention that the systems theory underscores the study of abstract organization of phenomena, independent of their substance, type, or spatial or temporal scale of existence. Schoeneborn (2014) avers that the systems approach is concerned with explaining the origin, stability, viability, productivity and evolution of systems.

There are several versions of the systems theory which address themselves to different scenarios of social interaction and production. Miller and Page (2007) refer to Kawamoto (1995) in noting that the historical evolution of the systems paradigm unfolded in three distinct generations. In its first generation, the systems theory was primarily focused on creating dynamic equilibrium systems. The first generation theories thus revolved around the concept of homeostatic balance in a system. According to Miller and Page (2007), proponents of the first generation of systems theory included Walter Bradford Cannon (1871-1945), Ludwig von Bertalanffy (1901-1972) and Talcott Parsons (1902-1979).

The second generation theories attempted to explain non-equilibrium systems (Miller & Page, 2007). The focus of these theories was on how systems can create a mechanism of self-organization such that they can continue to flow without the need for constant monitoring from the outside.

Essentially, theories in this cohort were more concerned about how a system could avoid external disequilibrium or shocks and continue to self-organize (Miller & Page, 2007). Popular theoretical concepts within this generation's theories include the concept of 'dissipative structure', hyper-cycle and synergetic from Ilya Prigogine (1917-2003), Manfred Eigen (1927) and Hermann Haken (1927) (Miller & Page, 2007).

The third generation of the systems theory is centred on the works of Humberto Maturana (1928), Francisco Valera (1946-2001) and Niklas Luhmann (1927-1998) of the social

systems theory (Mugerauer, 2013; Seidl, 2004). The main idea within this cohort revolves around the concept of auto-poetic systems which signify a unity whose organization is defined by a particular network of production processes of its elements (Mugerauer, 2013; Seidl, 2004). This research largely draws from the social systems theory, hence below is an in-depth review of the social systems theory. The researcher also attempts to integrate the systems theory with the discourse under study.

2.12.2. Social Systems Theory

As noted above, the social systems theory is a culmination of multiple transformations of the General Systems Theory (GST) which was founded in 1940 by Ludwig von Bertalanffy (Schoeneborn, 2014)). The basic ideology of the theory is the assumption that there are universal principles of an organization, which hold true for all systems. The social systems theory has been widely used as a tool in the assessment of social organizations with its primary focus being placed on the holistic and integrative exploration of phenomena and events (both epistemological and ontological situations) (Xing, Ness & Lin, 2013). In this light, Schoeneborn (2014) avers that the paradigm is mounted on an angling principle of holism, which underscores the notion that the whole is greater than the sum of its parts. Below is an outline and discussion of the various tenets of the Social Systems theory and how they relate to the discourse of drug and substance abuse treatment.

2.12.2.1. Micro-Meso-Macro Interventions

The systems paradigm recognizes three distinct levels of interventions, namely, micro, meso and macro levels (Onwuegbuzie, Collins & Frels, 2013). These theoretical levels work hand in glove with the principle of Holon described below by tracking down the various complexities associated with different components of an organization (Giachetti, 2016; Laszlo & Krippner, 1998). In the context of the current study, the principle of micro-meso and macro interventions levels helped the researcher to develop a holistic conceptual framework of interpreting the contributions of rehabilitation centres at various levels of the society whether local, national, regional and internationally. According to Hollnagel (2012), each

social entity/organization whether large or small, complex or simple, is subliminally a part of a whole and cannot be understood in isolation of its context or relationships.

This tenet of the systems theory allowed the researcher to be able to read the contributions and challenges of rehabilitation centres in the larger context of organizational networks which all contribute to the significance of drug treatment services in South Africa. Ghitza and Tai (2014) underscore that substance abuse treatment services intersect with a number of other social and economic sectors and government departments among which the responsibility for ameliorating the drug problem is mutually shared. In this light, the systems approach has been widely applied to explain various social, economic, biological systems and their interactions (Hollnagel, 2012; Onwuegbuzie, Collins & Frels, 2013) which have a bearing on the deliverables of rehabilitation centres.

2.12.2.2. Systems as holonistic entities

The social systems paradigm is premised on the principle of Holon, which articulates that each entity in an organization is simultaneously a whole (Katina, 2016). A system is thus construed as a complex of interacting subsystems together with the relationships among them that permit the identification of a boundary-maintaining entity or process (Giachetti, 2016; Laszlo & Krippner, 1998). The symbiotic interaction and organization of components, both within and outside identified system boundaries, are responsible for developing the system's character and that of its outputs. On the other hand, the principle of Holon in social systems theory signifies that, apart from being a self-regulating entity, social systems are simultaneously components of higher order systems from which the system get its structure, inputs and regulations (Pahwa et al., 2015). From this perspective, social organizations are viewed as both independent and dependent outfits whose operations are directed by both internal and external factors (Pahwa et al., 2015). In this study, the principle of Holon allowed for the evaluation of rehabilitation centres as independent entities, whose programmes, visions and objectives contribute to the goal of ameliorating substance abuse in Gauteng.

Furthermore, the principle of Holon provides a framework for the evaluation of rehabilitation centres as subsystems of the government as represented by the Department of Social Development (DSD) and other line Ministries which are charged with the responsibility of driving the vision of ameliorating substance abuse in Gauteng and in South Africa as a whole. In this sense, the principle of Holon allowed the researcher to submerge the contributions of the selected rehabilitation centres within the broader spectrum of services, guidelines and resource provisions provided by the government as the supra-system in the fight against substance abuse.

2.12.2.3. Boundaries

The boundaries elaborated in the systems theory signify the extent to which a social organization can either be influenced or influence its surroundings. According to Giachetti (2016), boundaries are responsible for sifting and regulating exchange of resources between organizations. Hanson (2014) denotes that there are three types of boundaries which apply to social organizations and these are impermeable, permeable and semi-permeable boundaries. Pahwa et al., (2015) posit that the most efficient and healthy boundary structure in social systems is the semi-permeable boundaries whose structure allows selective in and outflow of resources. The concept of boundaries in the systems theories was crucial in this study as they help to understand the responsibilities of different stakeholders in the rehabilitation process and the nature of the linkages and influences in the drug treatment sector. This was in consideration that substance abuse treatment is a sensitive domain underlain by multiple confidentiality bottlenecks (Daley & Feit, 2013). Therefore, an understanding of the boundary systems in these facilities allowed the researcher to carefully navigate her way in the field.

Hanson (2014) argues that unlike semipermeable or permeable boundaries, impermeable boundaries disallow movement of resources both in and out of a system. On the other hand, permeable boundaries allow express and unregulated movement of resources in and out of the system (Ludwig von Bertalanffy, 1968; Hanson, 2014).

Excessive free movement of resources through permeable boundaries elevates the risk of destabilizing the system as there will not be any visible centre of power and control (Daley & Feit, 2013; Ludwig von Bertalanffy, 1968). In this context, the boundary concept of the systems theory assisted the researcher in analysing the programmes of the selected rehabilitation centres in the light of their handling of inputs in the form of skills, finances and clients and how this affected their contribution to their primary mandate of treating substance abusers.

According to Hanson (2014), open boundary systems present a high risk of unethical practices, corruption, unaccountability and poor service delivery. Similarly, closed boundary social systems face the risk of failing to evolve with new social, economic, political and technological advancements due to the fact that their boundaries do not allow interaction with the external world (Ludwig von Bertalanffy, 1968; Pahwa et al., 2015). Hanson (2014) therefore underscores that due to closed boundaries, closed systems have no access to new resources, ideas and methods necessary for system revitalization, and this leads to internal exhaustion and breakdown which is known as entropy. This tenet of the systems approach assisted the researcher to focus on the nature and quality of communication networks within and outside participant rehabilitation centres. The principle also allowed the researcher to look into how the rehabilitation centres were embracing new treatment methods, evidence and technology towards ensuring evidence based practice. Furthermore, the counter concept of negative entropy which, according to Giachetti (2016), denotes a state of growth and resilience gathered through the experiences of entropy allowed this researcher to look into how some impermeable boundary systems in the selected rehabilitation centres could have led to better adaptation and interventions.

In general, the principle of organizational boundaries was used to track the flow of resources in the rehabilitation centres such as funds, skills and human resources. It also helped in the demarcation of the extent of influence of external factors such as the natural environment, social and economic policies of the broader context within which the rehabilitation centres were subsisting. The principle also assisted in understanding the various roles and responsibilities of different systems in advancing the vision of ameliorating substance abuse in South Africa.

2.12.2.4. Inputs-Throughput-Outputs

The systems approach postulates that in the same way organic systems take in inputs (food, sunlight and water) and process them to come out with outputs, social organizations also absorb inputs and process them to produce outputs (Daley & Feit, 2013). Essentially, social organizations ingest inputs in the form of funds, clients, and other raw materials which they process using their personnel skills and programmes to produce outputs (goods and services) (Hanson, 2014). According to Giachetti (2016), the input-throughput-output mechanism in social systems is well integrated and mutually functional, to assist the system to achieve organizational goals.

The inputs-throughput-output mechanism of the social systems theory was crucial in this study as it enabled the holistic evaluation of the contributions of rehabilitation centres by looking at all their levels of interaction with service consumers and other stakeholders. According to Daley and Feit (2013), an understanding of the type of inputs in an organization is crucial in determining the nature and level of its contributions to social wellbeing and to achieving organizational goals and objectives. In this light, the inputs-processing-output concept was used in evaluating the nature of the clients, funds, infrastructure, skills and enabling legislations as inputs in the drug and substance rehabilitation process.

Lastly, the inputs-throughputs-output concept was crucial in evaluating the contribution of rehabilitation centres in terms of their outputs. This permitted for the appraisal of service

quality, sustainability, as measured against consumer satisfaction, value for money and ultimately sustainability of services.

2.12.2.5. Synergy driven systems

Fusaroli, Rączaszek-Leonardi, and Tylén (2014) define synergy as the efficiency gained in a system when its components are mutually and optimally functioning to produce superior and sustainable outputs. The concept of synergy driven organizations is best conceptualized by Peltzer et al., (2010) who underscore that the task of making South Africa a drug free country is a shared responsibility between and amongst the government, the private sector and the civil society. Implicitly, from a synergistic perspective, if the “war on drugs” is to be won, efforts and contributions of various stakeholders in the drug treatment sector need to be accounted for. In this light, the concept of synergy augurs well with the task of evaluating the contributions of rehabilitation centres as it provides a theoretical lens for looking at the various efforts of rehabilitation centres and their relationship with the government and other stakeholders in advancing the vision of establishing a drug free South Africa envisioned in the NDMPs.

2.12.2.6. Entropy

Generally, entropy is the tendency of a system to progress toward disorganization, depletion, and death due to lack of adequate injections of new resources (Daley & Feit, 2013). Precisely, Fusaroli, Rączaszek-Leonardi, and Tylén (2014) define entropy as a state in which closed systems exhaust their internal resources, resulting in system failure.

Entropy denotes a system in extreme stress due to the inability to maintain even and balanced flow of social and economic resources (Daley & Feit, 2013). In this study, the principle of entropy was very useful in identifying the challenges which were militating against effective service delivery by rehabilitation centres and it also assisted in shaping the recommendations of the study. Notably, due to the prolonged battle against drugs in South Africa, some role players are despairing, and thereby, giving up on the task at hand.

Jernigan and Babor (2015) write about the dwindling financial investments in the substance abuse prevention and treatment sector, as donors are increasingly becoming disenchanted by lack of tangible progress in the amelioration of this problem.

The principle of entropy, therefore, helped in guiding the study in identifying the factors which were pushing participant rehabilitation centres into a state of entropy.

2.12.2.7. Homeostasis

According to Fusaroli, Rączaszek-Leonardi, and Tylén (2014), the systems paradigm is driven on a grounding principle of homeostasis which denotes the tendency of a system to maintain a relatively stable, constant state of internal balance. The principle underscores that, in the event of any disturbance, the system will readjust itself and regain stability. Zeleny (2015) posits that systems with self-stabilizing and regulating mechanisms are referred to as auto-poietic systems. In the current study, the concept of homeostatic balanced systems was crucial as it helped the researcher to comprehend the resilience and, therefore, sustainability of rehabilitation centres in the face of unpredictable social, economic, financial circumstances associated with their clients. Moreover, the concept helped the researcher to trace the various survival strategies of the rehabilitation centres in the current volatile financial environment in South Africa.

2.12.2.8. Sub-system

The systems theory further underscores the notion of social systems as subsystems of larger systems (Zeleny, 2015). This notion was greatly applicable in this study, given that drug abuse is a subsystem of problems affecting most youths and adults that needs to be addressed. It is also a part of the wider national problem (system). Inversely, rehabilitation is also a subsystem of addressing the national problem of drug abuse, which can only succeed if it is synchronized and synergized with other systems, such as the economic empowerment of the drug abuse clients. In this light, the study greatly benefited from collapsing the work of

rehabilitation centres into different subsets which permitted easy identification of contributions and challenges of these facilities.

2.12.2.9. Role

The social systems theory bestows a certain moral obligation upon role players in the operation and functioning of the social system. This, according to Zeleny (2015), denotes the concept of a role which is a culturally established social behaviour and conduct expected of a person in any designated interpersonal relationship. Each individual involved in a system assumes a role within that system and they cease to be identified as individuals. According to CASW (2016), it is crucial for substance abuse prevention and treatment practitioners to play their roles with dignity so as to instil confidence in their clients. This principle, therefore, allowed the researcher to objectively consider different role players such as therapists, institutional managers, and personnel from the DSD in the light of their professional, moral and social obligations to their clients.

2.12.2.10. Relationship

According to Valentinov (2014), the social systems theory underscores the importance of relationships for the system's survival. This principle draws from the concept of synergistic systems whose relationships create opportunities for higher and efficient functioning (Zeleny, 2015). The Canadian Centre on Substance Abuse (2012) thus posits that relationship in systems thinking signifies a reciprocal, dynamic, interpersonal connection characterized by patterns of emotional exchange, communication, and behavioural interaction. Viewed in the context of the current research, the principle of relationships was crucial as it helped to reflect on the different associations, communications, exchanges and interactions between the various stakeholders in substance abuse treatment. Moreover, CASW (2016) articulates that social work practice is in itself a relationship based approach to problem solving. In this light, the concept of relationships helped to explore the manner in which therapists, caregivers and substance abusers themselves were relating to each other.

Additionally, in this study, the concept of relationships allowed the researcher to explore how rehabilitation centres were enhancing and utilizing their relationship with the society, the government, among others, towards creating a positive feedback loop and also to create an enabling environment for easy reintegration of recovering substance abusers after their treatment in the rehabilitation facility.

2.12.2.11. Equifinality

The problem of substance abuse cuts across several spheres of human life and existence. Therefore, it requires multi-nodal approaches to effectively recompense and remedy the situation (Jernigan & Babor, 2015).

This conception of the problem is best captured by the principle of equifinality which accentuates that there are many different means to the same end (Valentinov, 2014; Ludwig von Bertalanffy, 1968). In this light, this principle enabled the researcher to look beyond the current narrative of rehabilitation centres including their challenges and successes, but to also explore alternative interpretations and ways of enhancing the contributions of these facilities.

2.12.2.12. A Critique of Social Systems Theory

Notwithstanding its practicable and adaptable concepts, the systems approach has some prominent critics. Hanson (2014) argues that while the theory is very elaborate on how to identify system gaps, it offers no solutions for the identified gaps. In addition, Dow (2012) posits that the paradigm makes it seem as if the boundaries which apply to a system are distinct, whereas, at times, it's very difficult to determine the relationships between and amongst systems, especially where the organizations have multiple nodes of interactions and communication. This gap was foreseen to cause challenges in the current study given that the task of ameliorating the substance abuse problem in South Africa is shared amongst several stake holder departments and individuals.

Hanson (2014) also adds that the theory gives little guidance as to which components of the focal systems should be manipulated to achieve policy objectives. This was critical in this study, given that identifying the gaps without a plan of how to remedy it would be retrogressive. Moreover, the theory overlooks the possibility of subsystems in a system being prone to conflict with each other (Hanson, 2014). Lastly, in an endeavour to be simplistic, the systems paradigm fails to recognize the fact that social organizations are contrived systems and may not equate to organic systems as perceived in the general systems theory (Dow, 2012). This poses a possibility of undermining the uniqueness and non-organic characteristics of social organizations. The researcher thus here proffers the sustainable livelihoods approach as a support theory to bridge the gaps or shortfalls of the systems theory.

2.13. Sustainable Livelihoods Approach

The sustainable livelihoods approach (SLA) is one of the key theories supporting inclusive and participatory human development geared towards counteracting socioeconomic problems. The approach provides an exclusive lens through which the fundamental causes and dimensions of a problem are analysed without necessarily collapsing the focus onto just a few already known factors (Erni, 2015). The theory fuses a conceptual framework with a set of operational principles to provide a platform for policy formulation and human development. Biggs, Boruff, Bruce, Duncan, Haworth, Duce and Pauli (2014) propound that the paradigm was developed by the Department For International Development (DFID), Oxfam, Cooperative for Assistance and Relief Everywhere (CARE) and the United Nations Development Programme (UNDP). Since its conception, the SLA has been widely adopted by several governmental and non-governmental projects geared towards poverty alleviation (Erni, 2015), community development (Biggs et al., 2014) and women emancipation (Nair, 2012).

Central in the sustainable livelihoods approach is a focus on developing strategies to enhance people's capabilities so as to enable them to be more resilient in coping with their life challenges (Nair, 2012). To this end, the core of the theory is premised on the assumption that, if people participate in defining and solving their problems, they can better be able to sustainably change their situations or problems. In the light of the current study, which is focused on the contributions of rehabilitation centres to the goal of altering substance abuse, embracing the concept of participation will help to plant the findings of the study in the lived experiences rather than in extrapolated perceptions of non-drug users or those who were not affected by the problem directly. Implicitly, the SLA played a pivotal role in deciding the methodological design of the study.

According to Erni (2015), the SLA is of the view that vulnerable people often have some invaluable knowledge and experience of how to deal with their problems; they only lack necessary resources and opportunities to do so. The paradigm thus prescribes empowerment programmes to disseminate knowledge, skills and the use of organizational connections and influence to link people with their needed resources which can enhance their participation in their change process (Biggs et al., 2014). Participation in the change process is viewed as a necessary precondition for sustainable change. Fisher, Maginnis, Jackson, Barrow and Jeanrenaud (2012) mention that people who lack participation in their change process often lack affinity for it and fail to appreciate its outcomes, thus rendering it unsustainable. In this sense, the SLA was instrumental in assessing the contributions of rehabilitation centres in terms of empowering drug users and their families to be able to sustainably participate in their recovering process.

Additionally, the SLA underscores that empowerment should increase people's access to information and skills which can enable them to make informed decisions and participate in their change process (Wates, 2014; Chambers & Conway, 1992). Fisher et al., (2012) correctly articulate that affording people the right to participate without capacitating them to do the same is retrogressive and defeats the logic of empowerment.

In this light, Waema and Miroro (2014) argue that empowerment should equip people with some vocational skills with which they can create sustainable livelihoods. Wates (2014), therefore, conceptualizes a sustainable livelihood as comprising of the capabilities, assets (including both material and social resources) and activities required as a means of living.

To add to this, Waema and Miroro (2014) argue that the SLA holds that a livelihood can only be sustainable when the individual is able to cope with and recover from shocks and stresses and maintain and enhance his/her capabilities, accumulate assets both in the present and in the future without necessarily depleting the natural resource base. The tenets of the SLA, which underscore the importance of providing skills and enhancing livelihood assets of people, had resonance with the current study as it allowed for the evaluation of the contributions of rehabilitation centres in the context of the improvements of the livelihood assets of drug users.

Furthermore, the SLA underscores that sustainable livelihoods are mutually reinforcing, hence sustainability in one area of a person's life can help transform other spheres of his/her livelihood (Mazibuko, 2013). Viewed from a broader perspective, sustainable livelihoods have a ripple effect, which means sustainability achieved by a particular individual, group or society can be a motivation or catalyst needed to stimulate others to start to desire sustainability for themselves (Rabinowicz & Chinapah, 2014). Accordingly, the SLA stresses the importance of promoting and fostering life skills and other survival strategies at local or community levels. This principle of the SLA created an opportunity and a conceptual framework of evaluating the impact of the work of rehabilitation centres on personal and interpersonal growth and development.

The assumption of the current study was that, if the newly attained recovery amongst substance abusers was mutually reinforcing, then it should reflect in vertical development, that is, in terms of improved personal livelihoods assets and lateral development in terms of communal awareness and wellbeing.

According to Waema and Miroro (2014), the SLA promulgates the development of assets, strategies and strengths of people across various sectors to meet communal goals. Mazibuko (2013) cites the Department for International Development (2007) and outlines the following as the requisite livelihood assets necessary in helping people to craft sustainable livelihoods.

- *Human capital; which entails things such as skills, knowledge, the ability to labor and good health;*
- *Social capital such as networks and connectedness, membership of formalized groups or relationships of trust, reciprocity and exchanges;*
- *Financial capital including available stocks and regular inflows of money;*
- *Physical capital including the basic infrastructure and producer goods (tools and equipment) used to function more effectively; and*
- *Natural capital, which is the natural stocks that can be used in developing livelihood strategies such as land, water, air quality and storm protection.*

(Adopted from: Mazibuko, 2013)

In view of the above, the SLA holds that in order to maintain and strengthen livelihood assets, local and national governments, the donor community and international development agencies need to actively participate in developing the capabilities of vulnerable populations (Rabinowicz & Chinapah, 2014).

The theory proposes that it should be the prerogative of governments and international development agencies to finance and support the work of grassroots/community organizations in their community mobilization and advocacy work (Wilson, 2015). In addition, Wilson (2015) stresses that, if well supported, non-profit and other humanitarian organizations can play crucial roles in empowering their localities towards enabling them to participate in various change initiatives.

The SLA underscores the importance of empowering people targeted by interventions to define their circumstances (Waema & Miroro, 2014). In this light, the paradigm provided a framework for evaluating the contributions of rehabilitation centres in terms of how they are aiding and reconstituting the livelihood assets of their clients. Arguably, drug and substance abusers are often viewed as vulnerable persons or populations groups. However, no substantive attempt has been made to conceptualize and define their vulnerability.

The SLA in this research, therefore, assisted in generating a broad conceptual definition of vulnerability amongst substance abusers. It also helped to engender an in-depth understanding of vulnerability and livelihoods assets which get to be affected in the course of drug and substance abuse. This resonates with Chandler, Fletcher and Volkow's (2009) assertion that any rehabilitation modality worth its purpose should holistically empower substance abusers to regain their basic life assets and enable them to recreate and rejuvenate their lives.

According to Wates (2014) regardless of differences in emphasis by different practitioners, the livelihoods framework helps to identify (and value) what people are already doing to cope with their challenges. This aspect of the SLA enabled the research to be undertaken from a developmental rather than a deficit perspective.

This approach has resonance with the National Drug Master Plan (2013- 2017), as cited by the Central Drug Authority (2013), which articulates that if "the war on drugs" and substance abuse in South Africa is to be won, evaluations of current approaches should not be done with the aim of replacing traditional approaches or current efforts, but to strengthen them. Accordingly, the SLA in this study helped to ensure that the current evaluation not only focused on the negatives of the rehabilitation centres, but also celebrates their positives while also simultaneously seeking to establish connections between factors that constrain or enhance the livelihoods of recovering drug and substance abusers.

CHAPTER 3

Research Methodology

3.1. Introduction

This study was focused on evaluating the contributions of drug and substance rehabilitation centres to the goal of ameliorating the growing substance abuse problem. This chapter, therefore, exclusively covers an exhaustive discussion of methodological issues which pertain to the discourse under study. The chapter opens with a comprehensive discussion on the spatial, socio-economic, and biophysical description of the study area. Thereafter, the chapter develops into a discussion of methodological processes including research design, population of the study, sample, sampling strategies, data collection instruments and methods of data analysis. The chapter closes off with an outline and discussion of ethical considerations and how these were to be applied in the study.

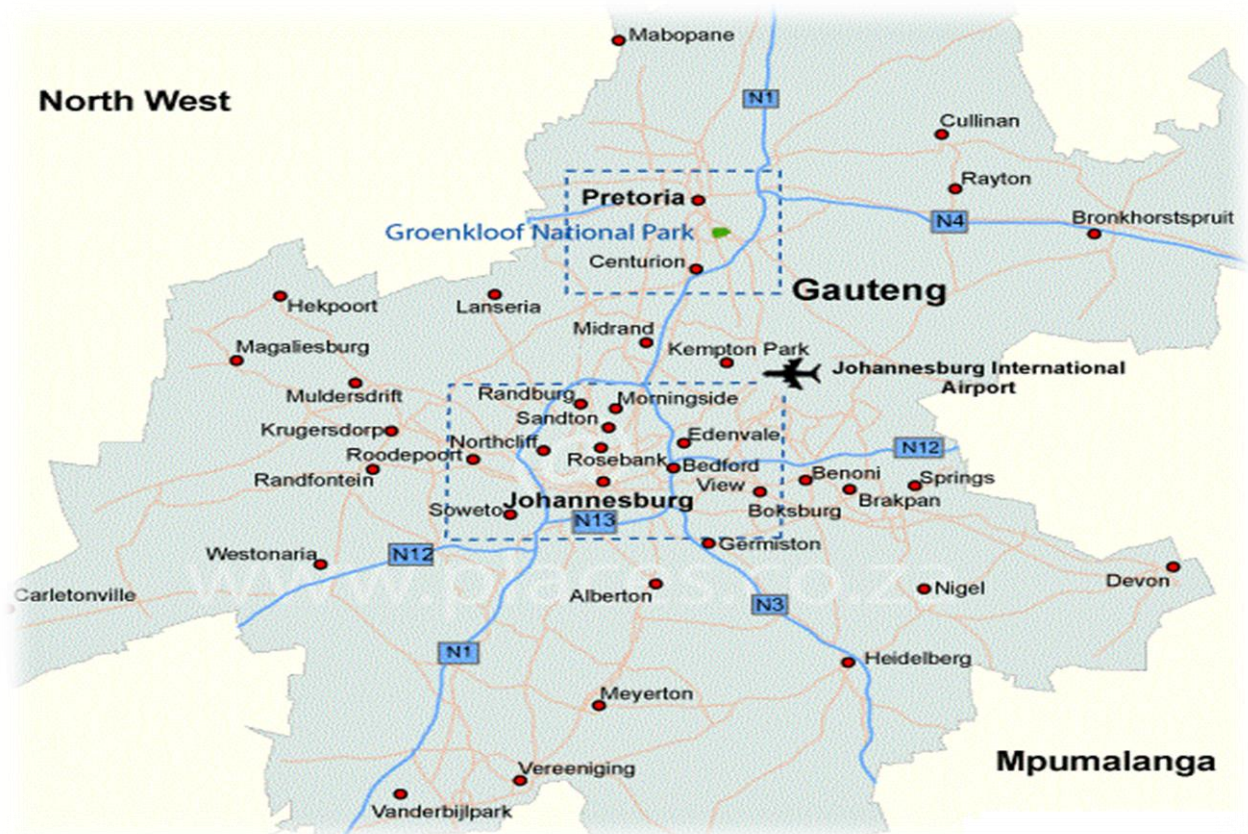
3.2. Description of the Study Area

This study was conducted in Gauteng which is one of South Africa's Provinces. South African Tourism (2016) describes Gauteng as a village that evolved into a commercial and social powerhouse. Notably, Gauteng is the smallest of the country's 9 Provinces and is located at the intersection of four Provinces including Limpopo, North West, Free State and Mpumalanga (Mubiwa & Annegarn, 2013). Prior to 1994, the Province was known as Pretoria-Witwatersrand-Vereeniging (PWV) and it changed to Gauteng in December 1994 (Mubiwa & Annegarn, 2013). According to the City of Johannesburg (2016), the name Gauteng comes from a Sisothe word which means a "Place of Gold" named after rich gold deposits found in its localities.

The Provincial capital of Gauteng is Johannesburg while Pretoria is a national administrative capital (Mubiwa & Annegarn, 2013). Additionally, Mubiwa and Annegarn (2013) write that Gauteng is made up of three metropolitan municipalities which are further divided into 8 local municipalities.

Statoids (2015) states that Gauteng's total population stands at 12,272,263 million and of these, 37% are people from other Provinces and foreign nationals. In addition, City of Johannesburg (2016) mentions that by size, Gauteng is the smallest of all the country's nine Provinces, it is made up of 17 000 square kilometres equivalent to 1.4% of the total land mass, yet it is the most populated and urbanized. Below is a map showing Gauteng Province and its localities.

Figure 3.1.: Map of Gauteng Province



(Extracted from: www.places.co.za)

3.3. Economic Situation in Gauteng

South African Tourism (2016) articulates that Gauteng is the economic hub of South Africa and the entire Southern Africa region. The Province occupies a crucial niche in the country's financial, manufacturing, transport, technology and telecommunications sectors. Additionally, Mubiwa and Annegarn, (2013) note that Gauteng remains the gateway for many overseas companies which seek to invest in South Africa and Africa as a whole.

The Province is richly endowed with vast mineral resources (Mubiwa & Annegarn, 2013). Moreover, most of the Province's economic opportunities are derived from the exploitation of mineral resources. The initial discovery of gold reserves in 1886 is largely attributed to rapid urbanization in the Province (Mubiwa & Annegarn, 2013).

According to South African Tourism, (2016) Gauteng is an integrated industrial complex, harbouring flourishing agricultural, manufacturing, mining, financial, light and heavy industrial productions. It has the most advanced infrastructure, such as state of the art hospitals, roads and shopping malls of international standards. The Province has also been described by City of Johannesburg (2016) as the learning centre of the country, harbouring the highest number of higher education institutions in the country.

3.4. State of Drug and Substance abuse in Gauteng Province

Given its diverse population, Gauteng has become a breeding ground for drug trafficking and abuse. According to Peltzer et al., (2010), Gauteng accounts for 37.9% of all drug addicted persons ahead of Western Cape's 32.3%. Urban poverty and cramped living conditions expose and force young people in Gauteng to seek solace and employment in the drug sector.

Although there are several national and international, including privately owned, drug and substance rehabilitation facilities in Gauteng, demand for rehabilitation services always outstrips available facilities. SAPA (2013) notes that as of 2013, only 9 rehabilitation centres in the Gauteng Province were duly registered, although there were many unregistered facilities which were providing drug treatment services.

3.5. Research Methodology/Approach

Babbie (2004) notes that research is an enterprise dedicated to 'finding out' no matter what you want to find out, though, there will be a great many ways of doing it. On the same note, Creswell (2009) adds that a research methodology is a blue print which spells out all the processes, and procedures to be followed in gathering, interpreting and making conclusions

about a particular subject of inquiry. Similarly, Freeman, Dirks, Erickson, Haruch, and Tomlinson (2016) underscore that the process of laying out a blue print in research amounts to what is known as a research methodology or approach whose goal is to ensure that there is total compliance with the demands of generating knowledge which is true, objective and valid. In order to provide a well-grounded evaluation of the contributions of rehabilitation centres, this study uses both qualitative and quantitative approaches (triangulation). Yeasmin and Rahman (2012) mention that the benefit of using mixed methods (triangulation) in research is that it allows the study to maximize on data validity and reliability which is a function and strength of quantitative approaches while also simultaneously maximizing on data credibility and trustworthiness espoused in qualitative approaches. The use of mixed methods ensures that the results of a research are reliably tested while eliminating methodological weaknesses embedded in linear and single approaches.

3.6. Research Design

De Vos Strydom, Fouche and Delpont (2011) define a research design as a strategic framework for action, which guides the arrangement of conditions for the collection and analysis of data. According to Merriam (2009), it is important to understand the philosophical foundations underlying different types of research in order to make informed decisions as to the design choices available to the researcher in designing and implementing a research study. This study used a mixed methods research design which is also known as triangulation. Tashakkori and Creswell (2007, p. 4) define triangulation as, “research in which the investigator collects and analyses data, integrates the findings and draws inferences using both qualitative and quantitative methods in a single study or programme of enquiry.”

Creswell (2009) identifies five different types of triangulation, namely, methodological triangulation, investigator triangulation, theoretical triangulation, analysis triangulation and data triangulation. These types are operationalized, basing on their focus in the research process.

In this light, this study adopted methodological triangulation as its specific design. According to Guion, Diehl, and McDonald (2011), methodological triangulation subsists where more than one research method or data collection technique is used. In this study, two research methods which are qualitative and quantitative methods alongside three data collection techniques which include in-depth interviews, focus group discussions and mini survey were used.

3.6.1. Justification for using the Mixed Methods Approach (Triangulation)

There has continued to be some idiosyncratic variances in terms of what constitutes social reality and the methods of its measurement in different academic disciplines. These differences have led to the emergence and entrenchment of different methodological ways of conducting research. Creswell (2009) avers that, generally speaking, there are three main research paradigms, namely, qualitative, quantitative and mixed methods research paradigms. However, Neuman (2011) argues that there are some other methodologies which are increasingly gaining credence in research circles and these include historical, emancipatory and desktop methodologies. In this light, Tashakkori and Creswell (2007) mention that, when choosing a methodology to use, the researcher is guided by a number of factors including, world view or assumptions of each paradigm, training or experience of the researcher, psychological attributes, nature of the problem under investigation and audience of the study. The following is an extract from Clarke (2005) explaining the considerations looked at when choosing a research paradigm.

Table 3.1 Research Design

Criteria	Quantitative Paradigm	Qualitative Paradigm
Researcher's World View	A researcher's comfort with the ontological , epistemological, axiological, rhetorical and methodological assumptions of the quantitative paradigm	A researcher's comfort with the ontological, epistemological, axiological, rhetorical and methodological assumptions of the qualitative paradigm
Training and Experience of the researcher	Technical writing skills, Computer statistical skills and Library skills	Literary writing skills, Computer texts analysis skills and Library skills
Researcher's Psychological Attributes	Comfort with rules and guidelines for conducting research, Low tolerance for ambiguity, Time for a study of short duration	Comfort for lack of specific rules and procedures for conducting research, High tolerance for ambiguity, Time for lengthy study
Nature of the Problem	Previously studied by other researchers so that the body of literature exists, is known, along with the variables and existing theories	Exploratory research, variables unknown, context important, may lack theory base for study
Audience for the study, (e.g. journal editors and readers, graduate committees)	Individuals accustomed to/supportive of quantitative studies	Individuals accustomed to/supportive of qualitative studies

(Adopted from: *Clarke, 2005*)

In the light of the above, this study has chosen to use the mixed methods approach for a number of reasons. Although the discourse of drug and substance abuse has been widely researched, it is evident that the focus area targeted by the current study is relatively unexplored, hence the need for exploratory methods espoused in a qualitative methodology. Moreover, according to Ritchie and Lewis (2003), social action and social reality cannot be fully understood outside its natural context, this again makes qualitative methods crucial in this study. However, while the subject of inquiry might be unique, there are some components of it which have been explored before, thus rendering it necessary to check the validity of previous findings in terms of a quantitative approach. Moreover, the nature of the problem under inquiry can best be understood through testing many subjects as permitted by quantitative methods compared to exploring limited cases using qualitative methods.

In this case, qualitative methods increase the risk of coming up with abstract and personalized experiences of the research subjects as opposed to the objective and generalizable results which can be found when quantitative methods are used (Yeasmin & Rahman, 2012). However, using purely quantitative methods in this study would increase the risk of losing some basic social, emotional, cultural and contextual experiences and descriptions of the problem, in favour of maintaining research objectivity and numerical accuracy.

Tashakkori and Cresswell (2007) propound that the choice of a research methodology is also dependent on the training and experience of the researcher; accordingly, the use of mixed methods in this study has been motivated by the fact that the researcher is quite knowledgeable in both the qualitative and quantitative methods. The researcher is flexible and comfortable to use these approaches simultaneously.

An integrative methodology in this study will help to exhaustively explore the subject of inquiry from multiple angles to come up with well-grounded findings on the subject of inquiry. The diverse principles of the qualitative and quantitative methods will be integrated in this study in a complimentary manner to ensure that the strengths of one approach will overlap to cover the weaknesses of the other.

3.7. Population of the Study

Population can be defined as all subjects who bear characteristics which the researcher intends to study (De Vos, Strydom, Fouche, & Delpont, 2011). Bless, Higson-Smith and Kagee (2006) add that population includes all individuals about whom the research project is meant to generalize. In this study, the population includes managers and therapists in drug and substance treatment centres, recovering addicts in Gauteng rehabilitation centres, those who are in outpatient self-help support groups and their respective families. Lastly, the population also includes personnel from the Department of Social Development (Drug and Substance Section) in Gauteng Province.

3.8. Sampling Strategy

According to De Vos et al. (2011), sampling involves selecting individual units to investigate from a larger population. Latham (2007) adds that sampling involves taking a representative selection of the population and using the data collected as research information. Latham further notes that, while it is the wish of most researchers to engage each and every member of the population group, researchers often lack the capacity and/ or resources for such an undertaking, hence they resort to sampling. In this light, this study will combine probability and non-probability sampling strategies. Probability sampling will be used to select samples for the mini survey; while non-probability strategies will guide the selection of samples for the case study.

3.8.1. Probability Sampling

Ritchie and Lewis (2003) propound that there is a major distinction between probability and non-probability sampling. These scholars hold that probability sampling is the most rigorous approach suitable in selecting samples for statistical research. Ritchie and Lewis (2003) mention that with probability sampling, elements in the population are chosen at random and have a known probability for selection. Probability sampling allows for information that has been generated by the sample to be used to provide statistical estimates of the prevalence or distribution of characteristics that apply to the wider population (Tashakkori and Cresswell, 2007). There are several types of probability sampling including simple random sampling, systematic random sampling, stratified random sampling and multistage sampling (Honigmann et al., 1982 cited by Ritchie & Lewis, 2003).

3.8.2. Systematic Random Sampling

Systematic sampling is a type of probability sampling method in which members of the population group are subjected to a rigorous and random selection process which observes a random starting point and a fixed, periodic interval (Creswell, 2007).

Where this sampling strategy is used, the population is divided into specific strata and a systematic interval is determined. Each interval will, therefore, be included in the sample, in this way, a member of each designated strata has equal probability of being included in the sample. Creswell (2009) highlights that random sampling removes elements of doubt or bias in research since it gives every member of the population equal opportunity of being included in the sample.

In this study, systematic random sampling will be used in choosing samples for the mini-survey. The mini-survey is targeted at exploring the perceptions of families and relevant support structures of recovering drug and substance abusers on treatment effectiveness, availability and accessibility. To this end, a questionnaire was developed and administered to all the relevant participants who attended aftercare support groups with their loved ones. A list of all the caregivers was drawn from the authorities, and from these, every second name on the list was selected and requested to participate in the study.

3.8.3. Non-Probability Sampling

By definition, non-probability sampling involves a sampling strategy in which the researcher purposefully limits the inclusion of certain elements of the population from being selected to participate in the study (Ritchie & Lewis, 2003). The population will not have equal chances of being selected into the sample. The idea in non-probability sampling is to pick samples which bear the utmost characteristics which are being sought by the researcher (Guion, Diehl & McDonald, 2011). Additionally, Ritchie and Lewis (2003) explain that units in a non-probability sample are deliberately selected to reflect particular features of groups within the sampled population. Unlike probability sampling, the chances of selection for each element in non-probability sampling are unknown, but, instead, the characteristics of the population are used as the basis of selection (Ritchie & Lewis, 2003, p. 78). As such, Mason (2010) notes that it is such features of this technique that make it best suitable for small-scale studies which require in-depth information. Creswell (2003) indicates that non-probability sampling strategies are suitable for qualitative research studies.

It uses techniques such as purposive sampling/criterion based, theoretical sampling, opportunistic sampling and convenience sampling (Ritchie & Lewis, 2003). In this study, non-probability sampling techniques were used in selecting rehabilitation centres, focus group participants for in-treatment and aftercare support group members, representatives from the department of social development, managers and therapists in rehabilitation centres. The rationale for using this approach was that non-probability sampling allowed the researcher to only pick samples which bear the characteristics which the researcher was concerned about.

3.8.4. Purposive/Judgmental sampling

This study adopted purposive/judgmental sampling as its non-probability sampling strategy. Creswell (2009) points out that purposive sampling is based on the discretion of the researcher in choosing a sample which contains characteristics from which the research will benefit. On that note, Neuman (2011) mentions that purposive sampling requires the researcher to have prior knowledge about the population so as to enable him/her to select cases or samples which possess typical characteristics being sought in the study. Babbie et al., (2001) elaborate that the core of purposive sampling is on making sure that that elements which best fit the description of the research topic, aims and purpose are included in the sample. Ritchie and Lewis (2003) add that the two principal aims of purposive sampling include: making sure that every key constituency of relevance to the subject matter is covered and, secondly, ensuring that there is diversity within each of the key criteria in order to explore the impact of the characteristics concerned.

Using purposive sampling in this study allowed the researcher some flexibility to select participants with unique characteristics which helped in the evaluation of the contributions of rehabilitation centres in the “fight against substance abuse”. As such, specific selection criteria were purposively used to select 2 (two) rehabilitation centres which were used in the study.

Support groups were also selected using purposive methods. Only those support groups which are affiliated to the chosen rehabilitation centres were selected. Purposive methods were used in selecting participants to include in focus groups and these include both members of selected support groups and in-treatment patients. Therapists and managers working in rehabilitation centres were purposively selected, depending on their levels of experience on the job. Purposive selection was used in selecting representatives of DSD, those who work in the drug and substance abuse prevention and treatment section were requested to participate.

3.9. Sample Size

Sinkovics and Ghauri (2008) argue that using a correct sample size is crucial in safeguarding the validity and trustworthiness of the research findings. Sample size basically refers to the actual number of elements/units that has been chosen to participate in the inquiry. Mason (2010) avers that where too small a sample is used; the research may lose its representativeness, while, on the other hand, where a too large sample is used, it becomes difficult to make accurate deductions from it. Since this study used a mixed method research design, three sets of samples were used, that is for the in-depth interviews, focus group discussions and the mini survey. In total, this study had a sample size of 138 units.

In this study, the sample constituted of representatives of six different categories, all of which represent a special interest group whose input was important in analysing the contribution of rehabilitations centres in ameliorating drug and substance abuse. The sample, therefore, included 2 therapists, 2 rehabilitation centre managers, one from each of the participating rehabilitation centres. In addition, the sample included 2 representatives from the Department of Social Development (DSD) who gave insights in terms of the policy positions of the government, among other factors.

Furthermore, 16 in-treatment patients, 8 from each of the selected rehabilitation centres were sampled to form 2 focus groups. In addition, another 16 after care support group members, 8 from each of the selected after care support groups were selected to form 2 focus groups. Lastly, 100 people were sampled and included in the mini-survey. Respondents in the mini-survey included people whose family members or close associates were recovering from drug dependency. Below is a table showing the categorization of the sample and their specific numbers.

Table 3.2: Sample structure and size

Instrument	Type of sample	sample size
Focus group	In treatment patients	16
	Recovering Patients in after care Support Groups	16
In-depth Interview	Managers of Rehabilitation Centres	2
	Therapists	2
	Representatives from Department of Social Development	2
Mini-Survey	Families of recovering drug abusers who once were in either of the selected rehabilitation centres	100
Total sample size		138

3.10. Data Collection Methods and Instruments

Data collection is the systematic process of gathering and measuring information from a variety of sources to get a complete and accurate picture of an area or subject of interest (Merriam, 2009). On the other hand, data collection instruments are devices used to collect data such as questionnaires and interviews (Creswell, 2009). In this research, data was collected using three methods. The qualitative approach used two methods of data collection, namely, focus group discussions and in-depth interviews; while the quantitative approach used a mini survey method of data collection. These methods and their corresponding instruments are explained below and how they were administered.

3.10.1. Mini-Survey

According to Creswell, (2009) a survey is a data collection instrument through which the researcher can elicit people's opinions and establish discourse trends regarding social phenomena. The mini-survey in this study sought to explore perceptions and opinions of primary caregivers to recovering substance abusers on the contributions of treatment services offered to their loved ones. To this end, 100 respondents were asked to fill in a questionnaire. The questionnaire comprised of 32 questions which used a likert scale for the responses. On the likert scale, respondents were asked to indicate the extent to which they agree or disagree to the given statements relating to the contributions of rehabilitation centres. Responses ranged from a) Strongly agree b) Agree, c) Neutral, d) Disagree and e) Strongly disagree. In addition, the questionnaire also had closed ended questions which comprised of fixed responses from which the respondents choose a relevant answer in accordance with their experiences. This enabled the researcher to have a standardized set of responses which made it easier for the researcher to analyse the data statistically.

3.10.2. Focus Groups

A focus group mainly seeks to elicit information about a particular subject within the context of a group of participants who have similar experiences or backgrounds. Kuger (2008), as cited by Merriam (2009), describes focus group interviews as having an interview on a topic with a group of people who have shared knowledge on the topic of inquiry. Hennink, Hutter and Bailey (2011) write that focus groups allow the researcher to work with a relatively large sample. Similarly, Patton (2002, p. 386), as cited by Merriam (2009, p. 94), elaborates that:

Unlike a series of one-on-one interview, focus group participants get to hear each other's responses and make additional comments beyond their own original responses as they hear what other people have to say. However, participants need not agree with each other or reach any kind of consensus. Nor is it necessary for people to disagree. The object is to get high-quality data in a social context where people can consider their own views in the context of the views of others. (p. 386)

The merit of using a focus group is that participants help each other to effectively explain their common concerns. In support, Ritchie and Lewis (2003, p. 37) mention that focus groups provide a social context for research which creates an opportunity to explore the way people think and talk about a topic, how their ideas are shaped, generated or moderated through conversation with others. Emphatically, Moriarty (2011) avers that focus groups encourage participation from individuals who are reluctant to be interviewed one-on-one or who feel bothered that they have nothing to say. Ritchie and Lewis (2003, p. 37) further state that, because group discussions allow participants to hear from each other, they provide an opportunity for reflection and refinement, which can deepen participants' insights into their own circumstances, attitudes and behaviours.

Merriam (2009) highlights the fact that, similar to individual interviewing, purposive sampling should be used in selecting focus group participants in order to include people who are mostly informed about the topic. Merriam (2009), however, underscores that focus groups are not ideal for sensitive topics, such as highly personal and culturally inappropriate issues; these may make participants reluctant to discuss in the presence of strangers. While substance abuse is generally a sensitive topic, this study will be an exception mainly because the focus groups will be formed among people who already know that they have a common problem and no personal issues will be revealed in the process.

Hennink, Hutter and Bailey (2011, p.136) argue that an ideal focus group should consist of between 6 to 8 people. This research comprised of 4 focus groups consisting of 8 people each. A focus group guide was used to facilitate focus group discussions. The guide consisted of a number of questions and topics which the researcher used to guide the discussion in order to maintain its focus on the aim of the research. The focus group guide also ensured that important themes were explored during the discussion. The researcher noted that during the discussion participants were responding to questions haphazardly and not according to the sequence on the guide. As such, the researcher allowed them the flexibility to express themselves without any restrictions.

In this light, the guide only served as a guideline or checklist for the researcher to ensure that all the important topics were discussed. Each focus group discussion took 60 minutes.

3.10.3. In-depth interviews

Bless, Higson-Smith and Kagee (2006) explain that in-depth interviews constitute a research technique that includes conducting intensive face to face interviews with one or a small number of participants in order to obtain their perspectives on a subject. Interviews allow the researcher to gain insight on the experiences, knowledge, opinions, likes and dislikes, attitudes and motivations of the participants (Creswell, 2007). According to Ritchie and Lewis (2003), the key feature of in-depth interviews is their ability to provide an undiluted focus on the individual. They are also interactive in nature.

As such, Moriarty (2011) notes that face to face interviews have the strength of creating a rapport between the researcher and the participant thereby allowing participants to freely express their true sentiments. Using this technique will therefore allow the researcher to observe other gestures and non-verbal cues made by the participant.

Ritchie and Lewis (2003) further note that in-depth interviews provide a platform for detailed investigation of people's personal perspectives, for in-depth understanding of the personal context within which the research phenomena are located, and for detailed subject coverage. In this study, 8 participants were interviewed. The researcher conducted in-depth interviews with various key informants who include personnel from DSD, selected therapists and managers from the selected rehabilitation centres. Extensive interviews with these key informants allowed the researcher to get an in-depth exploration and explanation of how exactly rehabilitation centres are contributing towards ameliorating the drug problem in South Africa and what exactly needs to be done in order to bring about effectiveness in the programmes offered by these centres. An in-depth interview guide was used to interview the key informants. The advantage of using an interview guide in this research was that it enabled the researcher to get detailed responses from participants compared to other methods of data collection such as questionnaires.

3.11. Data Analysis Processes

The goal of collecting data in research is to answer some pertinent questions which the researcher holds about a specific issue or problem. Shepard (2002) thus argues that once data is captured, it is subjected to a systematic and rigorous process of analysis to force it to elicit its meaning, which will, therefore, be used to either refute or uphold the initial tentative proposition about such phenomena. In this light, Bless, Hugson-Smith and Kagee (2006) indicate that data analysis involves bringing logical order and structure to collected raw data. This study used multi-pronged data analysis methods so as to cater for both the qualitative and quantitative data sets which were gathered through the mixed methods approach of data collection. For this reason, the research employed the grounded theory approach and the Statistical Package for Social Science (SPSS) to read and interpret data towards understanding the contributions of drug and substance rehabilitation centres to the cause of ameliorating drug and substance abuse in Gauteng. However, before delving into the procedures and methods to be used, it is pertinent to highlight that, despite using mixed methods, this study was qualitative heavy and quantitative light (Creswell, 2007). A detailed explanation of the procedures used in reading the data here ensues.

3.11.1. Qualitative Data Analysis

As underscored above, the dominant method of data analysis in this study was qualitative analysis using the grounded theory approach. According to Tashakkori and Creswell (2007), qualitative data analysis involves the analysis of qualitative data such as text data from interview and focus group transcripts as well as observed social experiences. Patton (2002) adds that qualitative data analysis is built on the researcher's analytical and integrative skills and personal knowledge of the social context where the data is collected. Simply put, qualitative data analysis involves the subjective interpretation of data from the stand point of the researcher, however, with utmost respect for the social context of where the data would have been collected.

3.11.1.1. The Grounded Theory Approach and its Application

According to Bhattacharjee (2012), grounded theory refers to an inductive technique of interpreting recorded data about a social phenomenon to build theories about that phenomenon. The approach was developed by Glaser and Strauss (1967) and was further refined by Strauss and Corbin (1990) (Bhattacharjee, 2012). In the grounded theory approach, interpretations are grounded (based on) observed empirical data and this is where its name was derived. The approach emphasizes the importance of suspending the researchers' preconceived theoretical expectations or biases before data analysis so as to allow the data to elicit its own meaning towards formulating a theory or explain phenomenon. The process of analysing data in this study followed the grounded theory approach (also known as thematic analysis). This means that analysis was done in three main stages including, open coding, axial coding and selective coding. Bhattacharjee (2012) defines open coding as a process aimed at identifying concepts or key ideas that are hidden within textual data which can help to explain the subject of inquiry. In this study, open coding involved an in-depth review of the accumulated data sets from the focus groups discussions, interviews with drug and substance treatment therapists, institutional managers and representatives from the DSD. This involved a line by line examination of the gathered raw data to identify hidden themes.

The identified themes were then linked to form coding units and these were operationalized by way of giving them names to make them identifiable. These operationalized units were then used to code remaining data. However, in this whole process, the researcher continued to look for new emerging themes and refine the already coded concepts or themes as necessary.

The coded units were then subjected to higher order categorization. This process involved trimming concepts and streamlining them to come up with broader and generalizable constructs which show the generalized contributions of rehabilitation centres to the goal of ameliorating substance abuse in Gauteng and in the country.

This process also involved the cleaning of data towards data reduction which helped in reducing the amount of data at the disposal of the researcher and enhanced the process of identifying the subtle meaning being presented by the data. This was achieved by way of combining similar concepts or themes into either higher order concepts or sub-concepts. This was also achieved by means of submerging the identified concepts into the theoretical directives of the systems theory and the sustainable livelihoods approach, which are the central theories upon which the study was based. However, caution was taken not to directly import the assumptions of the above stated theories and force them to be true when the available data and its meaning were not in agreement.

The second phase of the grounded theory data analysis, according to Bhattacharjee (2012), involves axial coding. In this process, the identified themes in their various categories and subcategories were pitted against each other to identify causal relationships or, more appropriately, the contributions of treatment centres. At this stage, both open coding and axial coding were run simultaneously to ensure that the researcher would not miss an emerging trend or discourse theme.

This was in consideration of the fact that not all data was eliciting its meaning; hence the need for rigorous analysis. Through the process of integrating and pitting the themes against each other, it was expected that some pattern of actions/interactions, which reveal the contributions of drug and substance abuse treatment centres to the goal of achieving a drug free South Africa would be brought to the fore.

Finally, analysis of qualitative data ended by selective coding which involved identification of a central theme or a core variable upon which all other variables were logically explained (Creswell, 2009). Once the core variable was established, new data was then selectively used to validate and refine the research findings. The process of validation and refinement was repeated until it reached a point of theoretical saturation where new data ceased to elicit significant change in the central themes. Where consistence in central themes was not established after validation, the process was redone.

3.11.2. Quantitative Data Analysis

Quantitative research analysis relates an examination of particular phenomenon by means of using complex mathematical and statistical models. The goal of quantitative analysis is to objectively measure certain characteristics of phenomenon so as to predict the future behaviour of such phenomenon. Bhattacharjee (2012) notes that there are two ways of interpreting quantitative data and these include descriptive analysis and inferential analysis. Descriptive analysis involves statistically describing, aggregating, and presenting the constructs of interest or associations between constructs. On the other hand, inferential analysis involves statistical testing of hypotheses (theory testing). Quantitative data in this research was analysed using the descriptive analysis method by employing the Statistical Package for Social Science (SPSS).

3.11.2.1. Statistical Data Analysis

The Statistical Package for Social Sciences (SPSS) was used to analyse statistical data from the mini-survey. The questionnaires were first coded and entered into a computer programme which was then subjected to the SPSS to analyse the data. Coding was then done by way of giving each response from the questionnaire a numerical value which was entered onto a spread sheet for analysis using SPSS software. The software generated some pertinent descriptive statistics which were thereafter presented using simple descriptive methods such as explaining trends, averages, mode, frequency, and percentages. Tables and figures were also used to illustrate and present the findings.

The study also employed univariate data analysis. According to Little and Rubin (2014) univariate analysis, also known as analysis of a single variable, refers to a set of statistical techniques that can describe the general properties of one variable. Information which can be generated from univariate analysis includes statistics on frequency distribution, central tendency and dispersion.

3.12. Ethical considerations

Babbie, Mouton, Vorster and Prozesky (2001) contend that ethical issues or considerations arise from people's interaction with others or with other elements of the natural environment. In simple terms, the word "ethical" can be defined as conforming to the standards of conduct of a given group (Babbie, Mouton, Vorster & Prozesky, 2001). In this light, ethical considerations in research pertain to the various social and moral obligations, including the respect for rights, needs, values and desires of the research informants (Creswell, 2007). Creswell (2007) reiterates that ethnographic research is always obtrusive, invading the personal spaces of informants, and sensitive information is often revealed. In this study, the researcher maintained the utmost possible precautions so as to ensure the safety and humane treatment of participants and also guarantee their freedom of participation. Below is a discussion of the ethical considerations which were observed.

Researchers are bound to respect their informants by protecting their identities and personal information which they collect in their line of work. This obligation in research circles is known as ensuring the **anonymity and confidentiality** of participants. De Vos et al., (2011) define confidentiality as not disclosing the identity of research participants and not attributing comments to individuals or institutions to which they are associated, unless they have expressly consented to being identified. Ethical research holds that no harm, physical, emotional or otherwise should be incurred by the research informants and the starting point to protecting them from harm is to ensure that their participation will not in any way tarnish their reputations or social standing in any way (Ritchie & Lewis, 2003). In this research, names of participants and any other information that could have exposed them to any form of unfavourable publicity was neither captured nor included in this write up. All respondents, participants and institutions who participated in this study, did so anonymously. This was done by ensuring that both individuals and the institutions they represented participated under pseudo-names. The pseudo-names were also used in the presentation of findings.

In line with ethical considerations of research, social researchers have an obligation to ensure **informed consent**. Generally, informed consent means that participants in a research project must be made aware of the possible implications of their participation before they can make a decision to either participate or not. De Vos et al., (2011) maintain that research participants must be informed of the nature, purpose, risks and possible implications of their involvement or participation before they can choose to participate. Emphatically, Ritchie and Lewis (2003, p. 66) elaborate that informed consent implies providing participants with information about the purpose of the study, the funder, the research team, how data will be used and what participation will require of them, the subjects likely to be covered and how much time will be required. Informed consent, therefore, guarantees the participant's right and freedom to choose whether to participate or not. In this study, participants were informed of the purpose of the study and all other possible eventualities of their participation prior to their involvement in the study.

This research upheld the principle of **voluntary participation**. Simply put, voluntary participation means that no participant under whatever circumstances is forced to participate in a research (Ritchie & Lewis, 2003). As such, after informing participants about the intent and possible implications of the research on their person and institution, they were further informed that, at any point in the study, should they choose to discontinue, they would do so without any hindrance. In line with this tenet of ethical considerations, no participant in the study was made to participate through coercion or deception. Their decision to participate was confirmed through signing of a written consent form that was put to effect after a full disclosure about the nature of the research and possible implications.

Protection from harm is another principle that was observed in this study. The researcher ensured that no harm of any kind was incurred by the participants. Efforts were made by the researcher to ensure that any possible cause of physical, psychological, emotional, spiritual and social harm was avoided. This included seeking appropriate advice and authorization from the authorities responsible for the participants.

Furthermore, researchers, as a matter of ethics, are obligated to **treat the work published by fellow researchers with respect**. Researchers may not use other people's work without fully acknowledging the original source of such information. De Vos et al., (2011) note that plagiarism can be defined as copying someone's work without acknowledging it, which is a criminal offense. The researcher was fully aware that plagiarism constitutes a criminal offence and a breach of research ethics. In this research, therefore, all material obtained from other sources was fully acknowledged and referenced.

Presentation of findings: ethical research demands that the researchers publish their findings on platforms accessible to other researchers who may want to use them. This is done to further the ends of research validation. In this light, the researcher undertook to publish the research findings through the legal channels to allow future researchers, who may want to undertake similar research, to use it as a base to start from.

As a matter of obligation, the researcher was obliged to apply and obtain an ethical certificate from the university's research ethics committee. Accordingly, before embarking on the study, the researcher applied and was granted an ethical certificate from the University of Fort Hare higher degrees committee.

CHAPTER 4

Data Analysis, Interpretation and Presentation of the Findings

Section A: Presentation of Qualitative Findings

4.0. Findings on the Biographical Profiles of Participants

4.1. Biographical profiles of in-depth interview participants

Interviews were conducted with 3 types of samples drawn from 3 research sites. The samples included personnel from the Department of Social Development, therapists working in rehabilitation centres and, lastly, rehabilitation centre managers. The total sample which was subjected to interviews was 6. Findings on specific characteristics of participants are discussed below in their respective categories.

4.1.1. Characteristics of Interviewees from the Department of Social Development

The table below summarizes the findings in respect of the biographical characteristics of the Department of Social Development (DSD) interviewees. This is then followed up by an in-depth description and analysis of these findings.

Table 4.1: Biographical Characteristics of Representatives of DSD

Characteristics of Representatives from the DSD.		
Characteristic	DSD Participant 1	DSD Participant 2
Gender	<i>Female</i>	<i>Female</i>
Age	<i>26</i>	<i>31</i>
Educational Qualifications	<i>Bachelor of Social Work</i>	<i>Bachelor of Social Work</i>
Marital Statuses	<i>Single</i>	<i>Single</i>
Years of Work Experience	<i>3</i>	<i>5</i>

The findings presented in **table 4.1** above show that 2 officials from the DSD from Krugersdorp district participated in-depth interviews. Both participants in this category were females who were aged 26 and 31 years old, respectively.

Educationally, both participants in this category indicated that they were holders of a Bachelor of Social Work degree as their highest academic qualification. Additionally, in terms of their marital status, both participants indicated that they were single. Furthermore, the participants indicated that they had 3 and 5 years of work experience, respectively.

The department dealing with substance abuse at the Krugersdorp DSD district office was largely dominated by females below the age of 31. The domination of females in this case can be understood as a reflection of the largely held perception in South Africa that Social Work is a female domain. This perception is a global issue in which women are viewed as vessels of love, compassion and patience, which are all the virtues expected of a social worker. Furthermore, the possession of social work degrees as the highest academic qualification of the interviewees could be as a result of the fact that in South Africa, social workers are hardly incentivized to obtain post graduate degrees as these seldom lead to higher incomes. Additionally, the fact that both participants were single, despite being of significantly matured ages can be explained in terms of the growing desire by many young professionals to pursue their careers before committing themselves into marriage. Additionally, the fewer years of work experience displayed in the sample could be as a result of the fact that many Social Work professionals do not stay for long in practice due to poor remuneration in the sector.

4.1.2. Characteristics of Rehabilitation Centre Managers

The sample of managers of rehabilitation centres were drawn from the 2 participating rehabilitation centres. The 2 managers were selected by default of them being institutional leaders for the selected rehabilitation centres. Importantly, for easy identification, participating institutions are here operationalized as institution X and institution Z. The table below depicts the qualities of the interviewed institutional managers.

Table 4.2: Biographical Characteristics of Rehabilitation Centre Managers

Characteristic	Institution X Manager	Institution Z Manager
Gender	Male	Male
Race	Indian	Black
Age	50	47
No of years as institutional manager	16	13
Marital Status	Married	Married
Highest Level of Education	Diploma in Marketing	Bachelor of Social Work

As shown in **table 4.2** above, the management position in rehabilitation centres appears to have landed in the hands of married adult males. While this could be a default rather than design, on the other hand, this gender skewed pattern could herald to a phenomenon that senior management jobs in the drug rehabilitation domain could perhaps be in the hands of males than females, or perhaps the appointment of management positions leaning towards favouring males than females. On the fact of managers being of mature age, this could be because the role of managing rehabilitation institutions is challenging, thereby requiring personnel with both professional and social maturity. This might be necessitated by the fact that managers of rehabilitation centres may be required to stay on site at the facilities which are often located in remote areas.

This dis-incentivizes young, unmarried and female aspirants from taking such positions, as they may feel isolated and are not willing to stay in remote settings where there are limited social amenities. The study further proved that institutional managers of participant facilities had spent prolonged periods at the helm of their respective institutions; they had spent 13 and 16 years in management positions of their organisations, respectively.

The fact that one of the managers is not a Social Worker can be explained by the increased phenomenon of personnel from non-social work profession continuing to cross to work in the social work domain, especially at the management levels. The finding that one of the managers of the centres had a diploma in marketing is, therefore, not surprising, given the high rates of cross employments in the social service sector.

Moreover, the fact that both managers had more than a decade of managing their respective institutions could be a factor of founders running their organisations. It could also be pointing the prevailing economic situation in the country where due to lack of opportunities, people stay in one job for too long to safeguard their economic interests.

4.1.2. Characteristics of the Therapists

Two therapists, one drawn from each of the participating institutions participated in in-depth interviews. **Table 4.3** below provides a summation of their biographical profiles.

Table 4.3: Biographical Characteristics of the Therapists

Therapist Characteristic	Institution X	Institution Z
Gender	Female	Male
Age	37	39
Marital Status	Married	Married
Highest Level of Education	Masters in Social Work	Bachelor of Social Work
Years of Experience in Substance Abuse Treatment	3	2

The findings presented in table 4.3 above suggest a fair gender distribution between males and females among the samples. Strikingly, it emerged that the therapists were of a matured age, averaging 38 years. This heralds a possibility of seriousness in their tasks. However, despite being married and of mature age, both therapists had no depth in terms of work experience in the drug treatment sector. This portrays a serious gap in the substance abuse treatment sector. Moreover, lack of advanced work experience may be explained in terms of the pressure and work related stress involved in working with substance abusers and, hence encouraging staff turnover among the experienced staff.

4.2. Biographical Profiles Of In-Treatment Patients' Focus Group Participants

Two focus groups were conducted with participants who were still resident in the selected rehabilitation centres. Each of the convened focus groups was constituted by 8 participants. The participants of the focus groups were purposively selected to reflect gender and age impartiality.

Furthermore, considerations were made to ensure representativeness of the focus groups in terms of the spectrum of drugs abused in the selected treatment centres. The table below illuminates the gender distribution for in-treatment focus group participants for both institutions X and Z.

4.2.1. Gender Distribution of In-Treatment Focus Group Participants

Table 4.4: Gender Distribution amongst In-treatment focus group participants

Gender	Frequency in institution X	Frequency in institution Z	Combined Total	Percentage
Male	8	3	11	68.75%
Female	0	5	5	31.25%

As shown in **table 4.4** above, the combined in-treatment patients' focus group was dominated by male participants who constituted 68.75% of the total sample while female participants accounted for 31.25%. The gender disequilibrium in this sample was mainly because female participants were largely unwilling to participate. A possible explanation of this gender dynamic could be a reflection of the gendered stigma which views women and girls' addiction as socially unacceptable in comparison to that of their male counterparts. This might have caused the females to feel uncomfortable and unwilling to participate in the study.

4.2.2. Age Structure of In-Treatment Focus Group Participants

Table 4.5 and **figure 4.1** below presents the findings in respect of the ages of the in-treatment focus group participants.

Table 4.5: Age Structure of In-Treatment Focus Group Participants

Age Ranges	Frequency in Institution X	Frequency in Institution Z	Total	Percentage
				%
15 – 20 years	1	0	1	6.25%
21 – 25 years	2	4	6	37.50%
26– 30 years	4	3	7	43.75%
31 years +	1	1	2	12.50%
COMBINED TOTAL			16	100%

Figure 4.1: Age Structure of In-Treatment Focus Group Participants

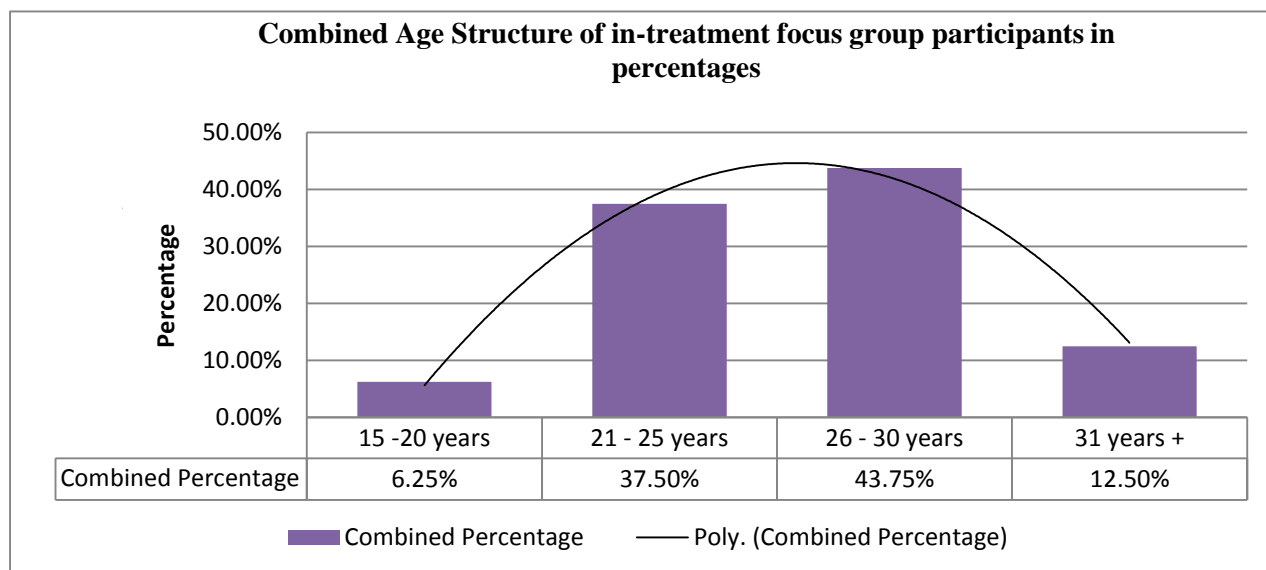


Table 4.5 and figure 4.1 above depicts that the age structure of in-treatment focus group participants was heavier in the middle age range from 21 to 30 years. As can be inferred, the 21 to 30 years age cohort (middle aged) accounted for a combined 81.25% of the total sample. On the other hand, the teenagers ranging in age from 15 to 20 years accounted for 6.25% of the sample, while the mature adults ranging from 31 years and above accounted for 12.50% of the total combined sample. This distribution mirrors the demographic distribution of drug consumption in the country. The significantly lower numbers of young people below the age of 20 abusing the drugs could be because many treatment centres seldom provide treatment to young people below the age of 18. This finding could, therefore, be reflecting the anomaly that shows that drug treatment services are skewed in favour of middle aged adults. Furthermore, the lower percentages of mature adults (31years and above) in substance abuse treatment circles can possibly be because families and other support structures in the abusers’ lives could have abandoned the task of sending them for rehabilitation and they could have written them off as non-repenting.

4.2.3. Primary Drugs of Choice amongst In-treatment Focus Group Participants

Table 4.6 and figure 4.2 below graphically presents the findings regarding the nature of drugs for which treatment was sought by in treatment focus group participants.

Table 4.6: Types Drugs for Which Participants Sought Rehabilitation

Primary Drug of Choice	Frequency in Institution	Frequency in Institution	Total	Percentage
	X	Z		%
Amphetamines	1	1	2	12.50%
Methamphetamines	2	2	4	25%
Heroin	1	1	2	12.50%
Nyaope/Whoonga	2	1	3	18.75%
Benzodiazepines	0	1	1	6.25%
Cannabis	1	1	2	12.50%
Alcohol	1	1	2	12.5
COMBINED TOTAL	8	8	16	100%

Figure 4. 2: Distribution of Primary Drug of Choice amongst In-treatment Focus Group Participants

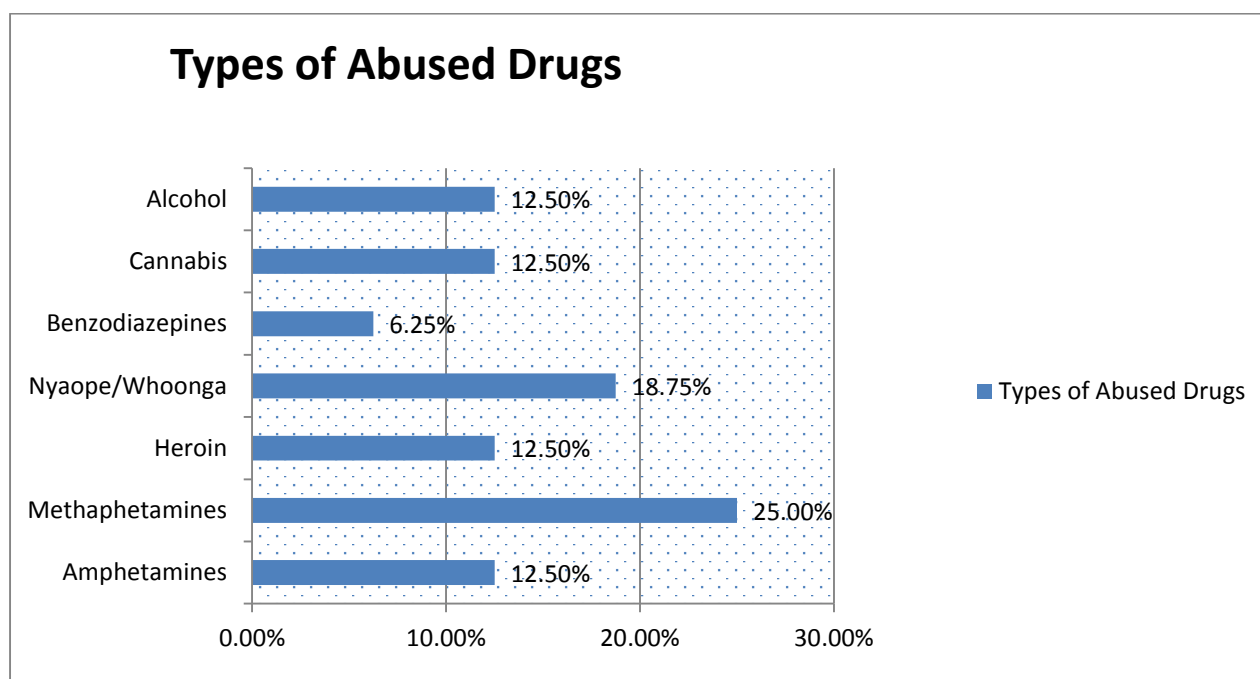


Table 4.6 and figure 4.2 above graphically depict that methamphetamines was the most abused drug (25%) compared with the other commonly abused drugs. This was followed by nyaope which was abused by 18.75% of the sample.

Alcohol, cannabis, heroin and amphetamines were equally abused with a score of 12.50% each. Lastly, benzodiazepines, was the least abused drug with 6.25% representation in the sample.

Apparently, the findings mirror the prevailing national drug abuse statistics in South Africa, with methamphetamine and nyaope abuse being on the increase in the country. Interestingly, the largely equal representation of cannabis, alcohol, amphetamine, and heroin could possibly be an indicator that work geared towards their treatment is progressively becoming effective; hence fewer of abusers of such drugs are now entering treatment circles. The least percentage of abusers of benzodiazepines in the sample could be as a result of the fact that abused benzodiazepines have been put in higher medical schedules and, thus, they are increasingly becoming difficult to access on the market.

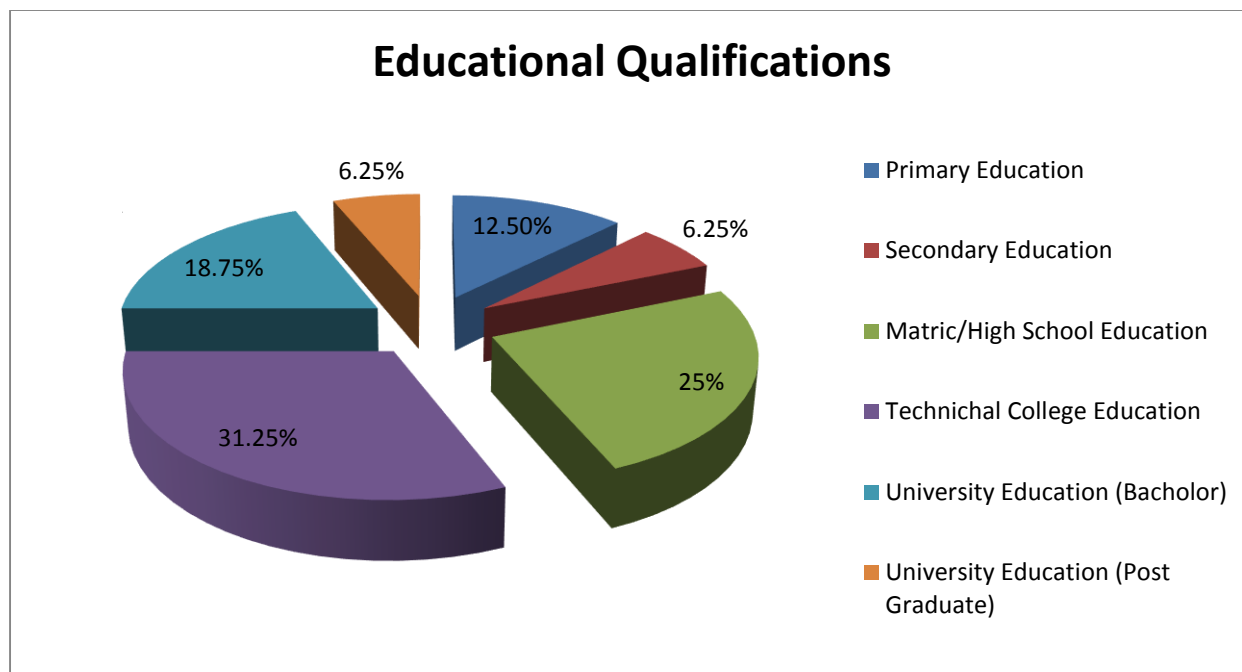
4.2.4. Distribution of Educational Qualifications among In-treatment Focus Group Participants

Table 4.7 and figure 4.3 below summarizes the distribution of educational qualifications amongst the in-treatment focus group participants.

Table 4.7: Educational Qualifications of In-Treatment Focus Group Participants

Highest Education Attained	Frequency	Percentage
Primary School	2	12.50%
Secondary School	1	6.25%
Matric/ High School	4	25%
Technical College	5	31.25%
University (Bachelor's Degree)	3	18.75%
University (Post graduate)	1	6.25%
TOTAL	16	100%

Figure 4. 3: Distribution of Educational Qualifications of Participants



As shown in **table 4.7 and figure 4.3** above, 12.5% of the participants had primary education, while 6.25% had secondary education as their highest academic achievements.

Notably, 25% of the participants had matric as their highest academic qualification. Additionally, the majority of the participants indicated that they had post matric qualifications. These included 31, 25% with technical college certificates/diplomas and 18.75% with bachelors' university degrees. Lastly, 6.25% representing 1 participant who indicated that he had a post graduate qualification.

Remarkably, the findings of this study, in terms of the educational achievements of participants, significantly differs from normative findings which suggest that people who are involved in substance abuse are largely those embracing poor academic achievements. In this study, an accumulative 56.25% of the total sample had post-secondary school qualifications which make them skilled persons. This finding could be indicative of the problem of youth disempowerment effected by lack of employment and other socioeconomic opportunities. Perhaps lack of opportunities is pushing educated young people to seek solace in substance abuse.

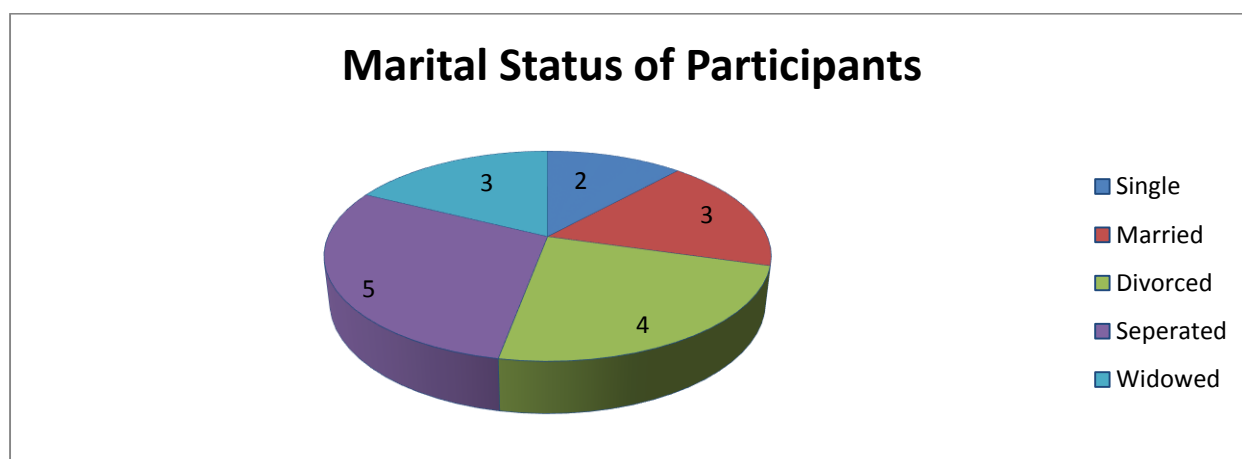
4.2.5. Marital Statuses of In-Treatment Focus Group Participants

Table 4.8 and figure 4.4 below are indicative of the distribution of marital statuses amongst the combined in-treatment focus group participants' sample.

Table 4.8: Distribution of Marital Statuses

Marital Status	Frequency for the combined Sample	Percentage
Single	1	6.25%
Married	3	18.75%
Divorced	4	25%
Separated	5	31.25%
Widowed	3	18.75%

Figure 4. 4: Distribution of marital statuses amongst focus group participants



As indicated in **table 4.8 and figure 4.4** above, five (5) of the participants were separated from their spouses, four (4) were divorced while three (3) were married. More so, another 3 recorded that they were widowed; while two (2) were single. Accordingly, the findings depict a strong relationship between marital statuses and drug taking behaviour with those who are divorced and separated being more prone to drug taking behaviour than those who were single and married. Statistically, 56.25% of the sample were either divorced or separated from their partners. This could be because, while under the influence of drugs, users resort to excessive domestic violence or destruction of family property which results in divorce or separations.

The significantly high number of widowed participants could be explained by possibilities that the drug users are likely to have become paranoid with the result of them being likely to be violent to the extent of committing domestic violence, resulting in murder, or homicide of the spouse.

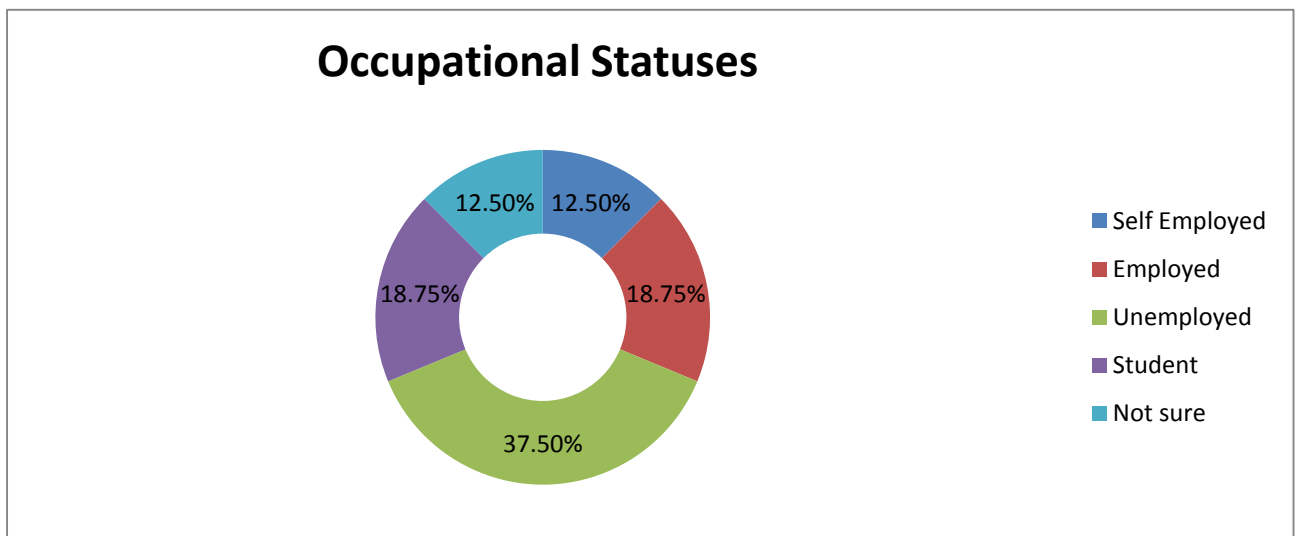
4.2.6. Occupational Statuses of In-treatment Focus Group Participants

In this study, participants were profiled to review their occupational statuses. **Table 4.9** and **figure 4.5** below graphically presents the findings in that respect.

Table 4.9: Employment Statuses of In-treatment Focus Group Participants

Self Employed	Employed	Unemployed	Students	Not Sure
2	3	6	3	2
12.50%	18.75%	37.50%	18.75%	12.50%

Figure 4. 5: Occupational Statuses of In-treatment Participants



As depicted in **table 4.9** and **figure 4.5** above, six participants indicated that they were unemployed, while three mentioned that they were gainfully employed. Furthermore, three participants noted that they were students while two stated that they were self-employed and the remaining two were not sure if they still had their jobs after they got admitted without giving notice at work.

The overall statistical preponderance in the study pointed to a significant relationship between drug taking behaviour and unemployment; and also being a student. This is because the unemployed and those who were students constituted almost 57% of the sample. This finding is not unique to this study as there are multitudes of research evidence indicating a strong correlation between poverty driven by unemployment and drug taking behaviour. It is possible that substance abusers lose their jobs due to absenteeism or poor productivity while they are intoxicated. Moreover, with the stigma attached to substance abuse, drug abusers seldom manage to secure permanent employment.

4.3. Biographical Profiles of Aftercare Focus Group Participants

Biographical data in this category was drawn from 2 selected Aftercare support groups which were affiliated to the selected rehabilitation centres. The qualities and characteristics of participants in this category are presented in **table 4.10** below. The combined sample of aftercare focus groups constituted 16 participants.

Table 4.10: Biographical Profiles of Participants in Aftercare Focus Groups

Frequency					Total
Gender					
Male			Female		
10			6		
Marital status					
Single	Married	Separated	Divorced	Widowed	
3	7	2	3	1	16
Educational Qualification					
Primary	Secondary	Matric	Tech College	University Degree	
1	2	4	4	5	16
Employment status					
Unemployed	Employed	Self employed	Students		
2	8	4	2		16

4.3.1. Gender

As indicated in **table 4.10** above, gender was unevenly spread in the sample. Precisely, the sample was dominated by males who constituted 10 out of the 16 participants while females were only six. The gender imbalance was caused by the phenomenon of unwillingness of the female participants to participate in the study. Probably, the reluctance by females to participate in the study was because of the stigma attached to feminine addiction.

4.3.2. Marital Statuses

As indicated in **table 4.10** above, three (3) participants indicated that they were single, seven (7) were married while two (2) were separated. Furthermore, three (3) participants were divorced while one (1) mentioned that she was widowed. The findings in this category show a greater statistical preponderance of the married status. This could be because during treatment and on-going therapy in aftercare support groups, substance abusers are helped to revive and reconcile with their key support structures including their spouses. Implicitly, those who were divorced or separated may opt to reconcile after realising that circumstances that caused them to separate would have changed. The lower quotient of single persons in the sample could be because recovering substance abusers are sometimes fostered into arranged marriages by their families.

4.3.3. Educational Qualification

The researcher also profiled participants in terms of their educational qualifications. The distribution of educational qualifications in the sample is illuminated in **table 4.10** above. As can be inferred from the table, one (1) participant had primary education, two (2) had secondary education; while four (4) had matriculated and another four (4) had technical college diplomas or certificates. Furthermore, the sample included four university degree holders.

This finding reveals that drug taking behaviour is no longer a preserve of the traditional, poor and uneducated young persons, but also a mainstay of urban, educated, middle class and wealthy individuals. In short, drug taking behaviour has become a common behaviour for all the classes in the society.

4.3.4. Employment statuses

In terms of their employment statuses, the study found out that the majority of aftercare focus group participants (8), with a statistical percentage of 50% of the total sample were gainfully employed. Additionally, 4 (25%) indicated that they were self-employed. Furthermore, 2 participants, representing 12.5% of the sample indicated that they were unemployed while another 2 (12.5%) noted that they were students, thus they were not working. These findings suggest that treatment for substance abusers increases their employability and economic independence.

4.4. Nature of Abused Drugs

4.4.1. Commonly abused drugs prompting admissions to the Selected Gauteng Treatment Centres

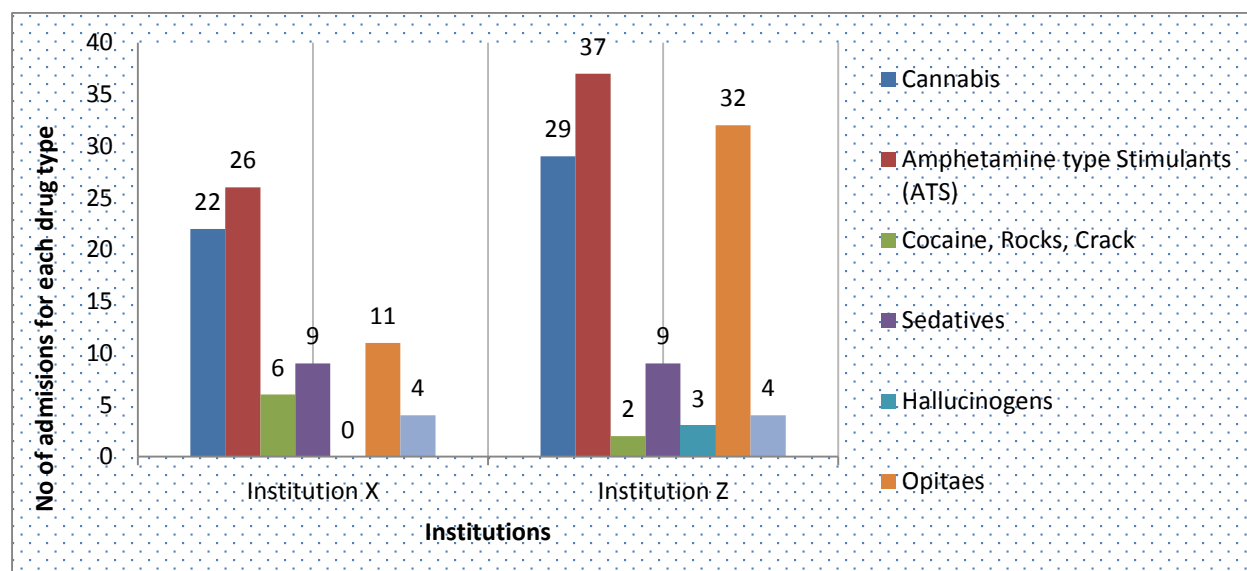
During interviews, managers of participant rehabilitation centres were requested to shed some light on the trends of the drugs for which their clients often sought treatment. It was agreed that the statistics should cover an intervening period of 6 months running from January to June 2016. Institution X specified that for the intervening period they admitted 78 patients while institution Z admitted 116 patients. In total, both institutions admitted 194 patients.

The managers further elucidated that their organizations were mainly admitting their clients for addiction to various drug types. **Table 4.11** below presents findings on the nature of abused drugs in the selected rehabilitation centres over a 6 months intervening period.

Table 4.11: Nature of Drugs driving admissions to Rehabilitation Centres

Drug Type	Frequency of admission in Institution X	Frequency of admission in Institution Z	Combined Total	Percentage
Cannabis	22	29	51	26.20%
ATS (Crystal meth, Cat, Ecstasy)	26	37	63	32.50%
Cocaine, Crack, Rocks	6	2	8	4.10%
Sedatives (Valium, Mandrax, Rohypnol)	9	9	18	9.30%
Hallucinogens (LSD, acid, mushrooms, nitrates, glue, petrol, paint thinners)	0	3	3	1.60%
Opiates (heroin, morphine, methadone, codeine, nyaope)	11	32	43	22.20%
Alcohol	4	4	8	4.10%
Total	78	116	194	100%

Figure 4. 6: Nature of Drugs prompting admission to selected Rehabilitation Centres in Gauteng



As shown in **table 4.11 and figure 4.6** above, amphetamine type stimulants (ATS), opiates and cannabis were reported as the main drug types for which the selected rehabilitation centres admitted their clients in the first half of 2016 financial year. These three drug types/classes accounted for a combined 80.9% of the total biannual admissions for the selected rehabilitation centres. However, cannabis stood out as the single drug type with the highest admissions, accounting for 26.2% of the total admissions. Sedative drugs inclusive of Valium, Mandrax, and Rohypnol were reported to be some of the intermediate causes of admission in the participating rehabilitation centres. These accounted for 9.3% of the total admissions. Alcohol, cocaine, crack, rocks and hallucinogens were reported as some of the drugs which prompted least of admissions, accounting for a combined 9.8% biannually for the two participating centres.

4.4.1.1. Increased abuse of stimulants in Gauteng

The findings revealed that abuse of stimulants was increasingly posing a huge concern in Gauteng. This finding was also echoed by key informants from the DSD who stated that stimulants such as the ATS drugs were overtaking other drug types in popularity in Gauteng drug markets. One DSD interviewee indicated that:

Stimulant drugs such as tik and cat which were traditionally known to be the hosts in the Western Cape are now taking Gauteng by storm. These days we find ourselves processing and placing tik, cat, cocaine and other stimulant drug users in different treatment programmes.

The manager of institution X added that;

As a matter of fact, most of our patients are those who seek treatment for addictions to “high” producing drugs such as cat, crystal meth, acid among others, but above all, I can safely say we are currently inundated by crystal meth admissions....

This finding is not unique to this study as it is synonymous with available literature which posits that South African drug markets are increasingly being flooded by drugs such as cat and crystal meth.

Perhaps this phenomenon could be facilitated by the fact that the production of some ATS drugs, such as crystal meth, do not require sophisticated laboratories or technology; but are often produced in normal households using basic household products and equipment. This increases their accessibility in the market, thus rendering more people in need of interventions.

4.4.1.2. Cannabis as the Single Most Abused Drug in Selected Rehabilitation Centres

Additionally, the findings reviewed that cannabis is the single most drug for which treatment was sought in the selected rehabilitation centres. Regarding the pervasiveness of cannabis abuse in Gauteng localities, one focus group participant narrated that;

To show the extent of the problem, if you go to townships and in schools, young boys in grade 3 can tell you where to buy the best quality of cannabis and how much it would cost you.

The high prevalence of cannabis as a cause for admission into drug treatment centres could perhaps be because cannabis is indigenous to the South African environment; hence it is easily accessible and cheap resulting in its high usage. More so, excessive and long term abuse of cannabis has been found to have damaging effects on the psychological wellbeing of users. This perhaps adds to the elevated need for intervention in rehabilitation centres by cannabis users as established in this study.

4.4.1.3. Growing Demand for Treatment for Opiate Addictions

Findings in this study, as noted in **table 4.11 and figure 4.6**, established that the demand for treatment for addiction to opiate drugs including heroine, codeine, and nyaope/whoonga was on the rise. To this end, the manager of institution X said;

We have been experiencing a steady increase in the number of admissions of opiate patients in the past 7 years or so.

Concurring, the manager of institution Z said:

Since the advent of nyaope/whoonga, we have been battling to contain the situation of opiate users, most of whom are homeless and difficult to deal with

While the advent of nyaope appears to spread like the veld fire, perhaps, it is the low prices of this drug which is incentivizing more drug users to switch to this more affordable option, thus rendering more nyaope users to be in need of interventions in rehabilitation centres.

4.4.1.4. Low Demand for Treatment of Cocaine and Cocaine based drugs

Results in respect of the demand for treatment for cocaine and cocaine based drugs such as crack cocaine/rocks established that there are fewer people entering treatment settings on account of using these drugs. Not surprisingly, therefore, one focus group participant said;

Pure cocaine is expensive, can you imagine that a single gram can cost up to R700 yet for the same amount, you can buy up to 3 days' supply of other stimulant drug types

Notably, the small proportion in admissions for cocaine, crack/rocks could be because these drug types are costly to buy; hence not many people can afford to use them to an extent of addiction. With the current precarious economic environment in South Africa, addiction to cocaine is being incrementally reduced; hence fewer people end up seeking treatment for it.

4.4.1.5. Low Demand for Treatment for Hallucinogenic Drugs

The results of this study, as shown in **table 4.11 and figure 4.6**, established that only few people are entering treatment settings on the premise of wanting to be rehabilitated from hallucinogenic substances. One focus group participant said;

Hallucinogenic substances are normally used for specific purposes; such as when going to a party, they set the mood appropriately. Also, some versions of hallucinogenic drugs such as glue, thinners and petrol are used by poor street children to cope with the harsh living conditions on the streets.

The statement noted above suggests that users of hallucinogenic substances mainly use these substances to tailor their moods for specific social events and circumstances. Firstly, the participant poignantly brought forward the idea that hallucinogenic drugs are used as partying drugs. Maybe the erratic use of this class of drugs (only when partying) makes users of these drugs to be less affected, thus diminishing the need for interventions. Furthermore, the statement also suggests that hallucinogenic drugs are often used as a coping mechanism by vulnerable groups such as the homeless and street children. Perhaps, the low proportion of people seeking treatment for this drug type could be because street children and homeless people, who are alleged to be the main users of this class of drugs, cannot afford treatment in rehabilitation centres and, as a result, fewer users are registered. Moreover, because of its association with homelessness and indigency, users of hallucinogens may opt not to be associated by the drug as they fear that it can harm their reputation.

4.4.1.6. Poly Drug use In Gauteng

The study found out that there was a growing phenomenon of poly drug use among substance abusers who were being admitted into the the selected drug treatment centres. Participants reported that due to financial challenges, they often find themselves using any drug type which would be available to them or at least affordable to them at that point in time. This phenomenon was attributed to the desire for the symbiotic effects of certain drug types whose effects are complimentary. To this end, one participant said:

Although I used to prefer crystal meth, any other drug that I could lay my hands on I would use. In fact, it used to give me a better feeling than when I use one drug type.

Another participant said;

Dependence to more than one drug type is often caused by lack of money, when going through a withdrawal, you can take anything that you can get hold of....however, some end up suffering or experiencing weird thoughts or displaying unusual symptoms

4.5. Prices of Abused Drugs determine the drug's consumption in Gauteng

Participants in focus group discussions were asked about the prices for different drug types in their areas and these were compiled according to emergent price ranges. **Table 4.12** below depicts the findings regarding the prices of different drugs according to their classifications.

Table 4.12: Price range of abused drugs

Drug Type	Price Range Per Standard Quantity
Cannabis	R5 - R300
ATS (crystal meth, cat, ecstasy)	R30 - R200
Cocaine, Crack, Rocks	R50 - R700
Inhalants (nitrates, glue, petrol, paint thinner, etc.)	R5 - R30
Sedatives (Valium, Mandrax, Rohypnol, Pax, Rivotrol, Ritalin)	R10 - R300
Hallucinogens (LSD, acid, mushrooms, microdot)	R50 - R200
Opiates (heroin, morphine, methadone, codeine, nyaope)	R25 - R300

The findings displayed in the **table 4.12** above shows that the cheapness of the drug was a factor in the attraction of many users. To this effect, inhalant drugs such as nitrates, glue, petrol and paint thinners are the cheapest form of drugs whose cost ranged from R5 to a maximum of R30 per minimum standard quantity. The findings also revealed that cannabis is another drug type which can be found in cheaper versions ranging from R5 for the most common type and R300 for laboratory grown and processed variants. Sedative drugs emerged as a class of drugs which can be found in both cheap and expensive versions. Participants revealed that they knew of some sedative drugs which ranged in prices from R10 up to R300 for a standard supply. Additionally, participants indicated that Amphetamine Type Stimulant (ATS) drugs ranged in price from R30 to a maximum of R200 per 1 gram sachet. Participants mentioned that the variations in the prices of ATS drugs were determined by the amount of additives such as baking powder and quinine used to enhance the volume of the drug. Pure ATS drugs are more expensive than those contaminated with volume increasing impurities.

Furthermore, cocaine and its derivative drugs, including coke and crack, were reported to be the most expensive drug types on the Gauteng illicit drug market. The smallest quantity of pure cocaine was noted to cost up to R700 per gram.

Additionally, participants revealed that impure forms of cocaine including rocks and crack ranged in cost from R50 going upwards per minimum standard quantity. Hallucinogenic drugs (LSD, mushrooms, microdot) excluding inhalants were reported to cost between R50 up to R200 per minimum standard quantity. Lastly, opiate drugs such as heroin, morphine, methadone, codeine and nyaope were reported to range in cost from R25 up to a maximum of R300.

4.6. Potency of abused drugs

4.6.1. Amphetamine stimulants perceived to have more drug potency than others.

Focus group participants were asked to state their views and experiences regarding the potency of stimulant drugs. It was established that amphetamine type stimulants embraced more drug potency than many other commonly abused drugs. It was reported that the stimulants such as cat-amino and crystal meth were sold in 1 gram transparent plastic sachets that makes the users to get maximum possible effect after sniffing less than half of the one gram sachet. The following are what the participants said regarding the potency, and length of the effect of ATS drugs. One focus group participant said;

I think that the amphetamine which they are selling these days is highly potent; they are mixing it with other drugs such as heroin which makes it highly addictive....if you use only one gram, it will make you highly paranoid, aggressive, and you cannot sleep for the whole nightIf you sniff more than one gram, it is possible that you may end up not sleeping for up to 3 days.

Another participant added that;

Of all the drugs I have ever used, I am sure that crystal meth was the most powerful, immediately after sniffing some; I started feeling light in my head.

To augment the above finding, another participant brought in another dimension regarding the potency of amphetamine and methamphetamine drugs. The participant said:

I would say, using more than one bag of crystal meth or cat at a time is a sure way of wasting the drug...there is no way you will ever get higher than the normal high...the drug is very potent such that you need to know how much you can withstand and avoid taking more than enough as you can overdose and die.

Participants also indicated that the potency and efficiency of ATS drugs tend to be high for first time users and to those who relapse after a long passage of clean time. This, participants believe, is the reason why some drug merchants target those in recovery and entice them with a free sachet. They know that once the user takes the first drug after a long period of clean time he/she will not be able to stop.

Furthermore, key informants added their perceptions regarding the nature and potency of stimulant drugs in Gauteng. Following here is an extract of what one DSD participant said:

It is without doubt that drugs such as 'crystal meth' and 'cat' are highly potent; the statistics of people overdosing on them are alarming...we know of users of these stimulant drugs who lost their minds to these drugs, they went mad.

As indicated by the various participants above, stimulant drugs are highly potent. The manifestation of the potency of stimulant drugs were argued to include, extreme paranoia, aggression, loss of weight, depression, anxiety, body shakes and impulsivity. Moreover, long term usage of stimulants was reported to cause permanent psychological disorders including psychosis.

4.6.2. Higher potency of opiate drugs

In this study, participants and key informants were requested to share their knowledge and experiences regarding the potency of opiate drugs. The general revelation was that these drugs have a very high potency, are addictive and very lethargic and prompt depression to the abusers. Listed below are some of the excerpts of what participants and informants said. One focus group participant mentioned that:

Heroin and nyaope is hectic, if you use it now, you can spend several hours or days sleeping, feeling lethargic and depressed, and you also experience a burning sensation under your skin... These drugs are also highly addictive such that if you don't get them when you are craving, you start to experience excruciating body painswhen you use it, all your emotions and pains are numbed off.

Another lady in the support group mentioned that:

Heroin is deadly ... you can literally do anything to get a fix... I never thought that I will see a day when I would prostitute myself for money let alone drugs, but when I started smoking heroin I was ready and willing to do anything to avoid the roaster/withdrawal....

Interestingly, another focus group participant noted that:

To show that heroin is one of the most potent drugs on the market, you see many dealers are now lacing other drugs such as cat and crystal meth with heroin to make them more potent and addictive....

Furthermore, the information gathered from the personnel from the DSD indicated that nyaope/whoonga is one of the current biggest social pathology in many localities in Gauteng.

Precisely, one DSD personnel indicated that:

Nyaope abuse is exploding in Gauteng.... Many young people are increasingly getting entangled into the storm of nyaope abuse...Nyaope is a cocktail of drugs such as cannabis and heroin mixed with antiretroviral pills and rat poison...Just the outline of the ingredients tells you that the drug is very potent....many are losing their mind through using it.

4.6.3. The potency of Cannabis dependent on variant

In this study, it emerged that the potency of cannabis is largely dependent on the variant used. Participants largely concurred that laboratory grown cannabis is more potent as compared to other variants. In this regard, one participant said:

I believe the most potent weed types are the indoor, hydroponics, cheese, Durban poison, kush and Afghan kush variants.... These are usually laced with some chemicals and are grown in moderated environments which are designed to increase their potency.

Furthermore, participants expressed perceptions that imported cannabis, especially variants from Malawi and Swaziland, are more potent than local traditionally cultured variants. This argument was proffered on the basis that the climate in which cannabis is grown has a bearing on its potency. In this light, one participant noted that:

I think the Swazi variant from Swaziland and the Malawi gold from Malawi are the most powerful....I think it's because of the climate and type of soil they are grown in which makes them so potent...

Therapists also shared their knowledge regarding the potency of cannabis. One therapist said:

Since the first time I started working in substance abuse settings, I have come across 12 different variants of cannabis including, Local, Majat, Swazi, Durban poison, Indoor, Hydroponics, Cheese, Rooibault, Kush, Purple haze, Afghan Kush and Malawi gold. All these variants are designed to achieve specific potency levels.

The statements above suggest that the potency of cannabis is largely dependent on variant. It also indicates that the different types of cannabis are specially designed and produced to meet specific potency levels. To add to this, another therapist mentioned that:

I have realized that the potency of cannabis is often understated; users often argue that cannabis is a natural herb and it has been used since prehistoric times hence it can't be drastic and damaging, however, we have been experiencing severe casualties including permanent mental disorders and suicides due to this drug...

The statement above denotes that the potency of cannabis can be severe although varying from one variant to another.

4.6.4. Lower potency levels among Hallucinogenic Drugs

In terms of the potency of hallucinogenic drugs, this study established that these drugs generally have lower potency values. Participants largely concurred that hallucinogenic drugs ought to be taken in larger dosages to effect minimal sensory stimulation. Participants also highlighted that, while it takes larger dosages for one to experience the euphoria from hallucinogenic drugs; these drugs tend to have prolonged duration of effect. To shed some light on this, one focus group participant said:

I used to sniff glue for a very long time when I was homeless and staying on the streets, the effects of the drug take long to manifest and also take long to wear off.

Amongst some of the reported long term side effects of abuse of hallucinogenic drugs, according to focus group participants, include loss of appetite, insomnia, dry mouth, tremors, excessive sweating, nausea, loss of appetite, inability to make sensible judgments, acute anxiety or depression, schizophrenia/psychosis.

4.6.5. High potency associated with sedative Drugs

Findings in respect of the potency of sedative drugs largely indicated that sedatives are considered to be some of the most potent drugs. Focus group participants reported that this class of drugs has a proclivity of numbing the feelings and inducing deep sleep over an extended period. Members of the focus group discussions indicated that sedative drugs are largely in the form of prescription medication which includes rohypnol tablets, Gamma-hydroxybutyrate (GHB), Ketamine / Anaket-V, Xanax Halcoin, Valium and Librium. Participants further elucidated that sedative drugs are often used to induce sleep after taking stimulants which deprive the user of good sleep. Additionally, some participants indicated that some sedative drugs have euphoric effects which are desirable.

Furthermore, some participants claimed that they knew of instances where sedative drugs were abused to avoid stress or pain, while others indicated that sedatives are sometimes used as a date rape drug. A date rape drug is a drug which is administered secretly into to a partners' drink or food to render him/her unconscious during a romantic date thereby rendering the individual vulnerable to rape or non-consensual sexual activities. Precisely, one participant mentioned that:

I think sedatives are quite potent in their own unique way. I had a friend who was using rohypnol tablets, they were making him to sleep, and he used to tell me that he won't feel any pain when he uses it...

Another Participant said:

I personally know of a friend who was raped after her drink was laced with a sedative drug by her ex-boyfriend. However, after the ordeal, she couldn't remember a thing about it... the ex-boyfriend just wanted to fix her for ditching him...

The statements above reviews that the potency of sedative drugs mainly manifest in unconsciousness and powerlessness that dulls and impairs the users' minds to an extent of making them become easier prey to those who would take advantage of them, for example, scheming to rape them, or do to them things they would not be able when the users are not under the influence of the drugs.

4.6.6. Hierarchy of the potency of abused Drugs

This study also sought to explore the perceptions of participants regarding the potency of abuse drugs. **Figure 4.7** below depicts the findings on the ranking of abused drugs in terms of their potency, as per focus group participants.

Figure 4.7: Potency of Abused Drugs

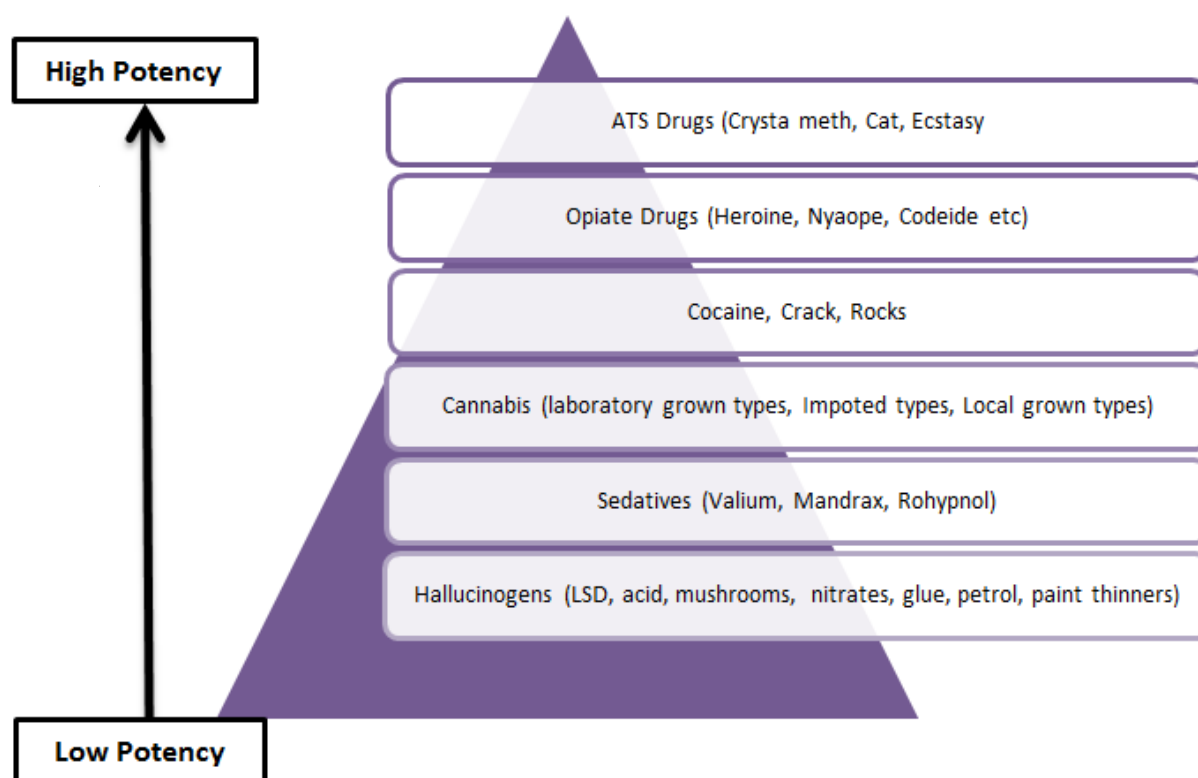


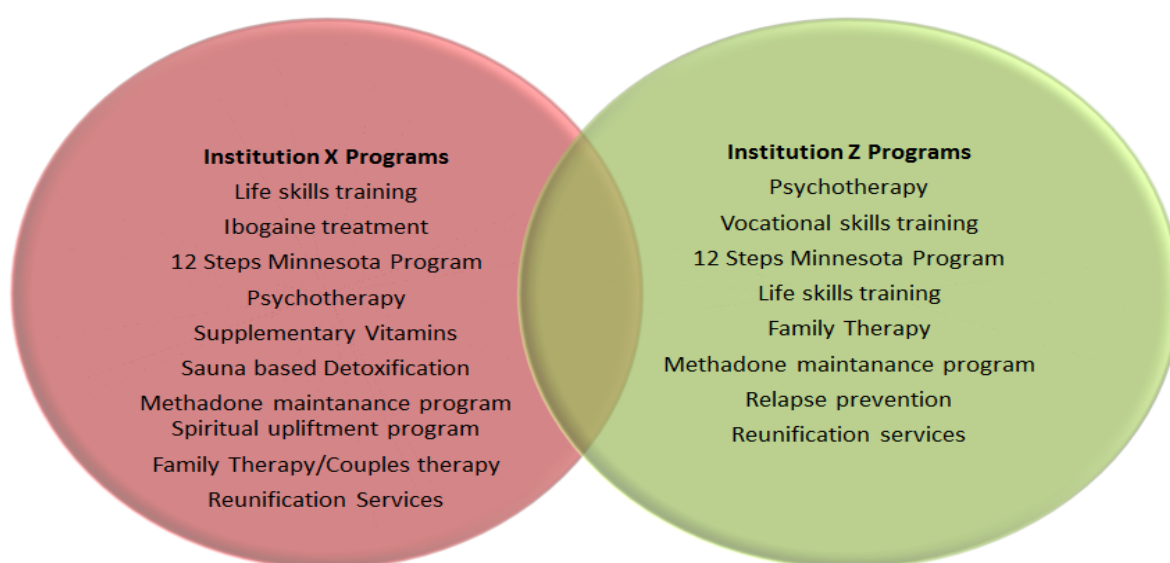
Figure 4.7 above shows that Amphetamine type stimulants were perceived as the most potent drug types. Particularly, focus group participants mentioned that crystal meth was the most potent drug with effects ranging from hyper activity, elevated mood, increased energy, and increased confidence, among others. Opiates were considered as the second highest in terms of potency followed by cocaine, crack and rocks. After cocaine, participants argued that cannabis ranked fourth in terms of potency although this was dependent on the type, with laboratory grown types being the most potent. This was followed by sedative drugs inclusive of Valium, Rohypnol and Mandrax. Lastly, participants ranked hallucinogens such as nitrates, glue, paint thinners, and petrol as the least potent.

4.7. Nature and Effectiveness of Drug and Substance Treatment Programmes

4.7.1. Types of Programmes offered by the selected rehabilitation Centres

Rehabilitation centre managers were asked to comment on the nature of rehabilitation programmes and services they were offering to their patients. **Figure 4.8** below depicts the distribution of drug treatment services in the selected rehabilitation centres in Gauteng.

Figure 4.8: Distribution of Drug Treatment Services in the Selected Rehabilitation Centres



The distribution of rehabilitation services, as indicated in **Figure 4.8** above, indicates that institution X had life skills, ibogaine treatment (herbal detoxification), 12 Steps Minnesota programme, psychotherapy, vitamin supplements, Sauna detoxification, methadone maintenance programme, family therapy and reunification services.

On the other hand, institution Z was offering psychotherapy, vocational skills training, which was erratic and offered a limited scope of skills, methadone treatment offered at the expense of the individual or his/her family, the 12 Steps Minnesota programme, Relapse prevention services and reunification services.

All the services and programmes were noted to run concurrently. It also emerged that institution X was running a 6 weeks programme while institution Z's programme lasted for four (4) weeks.

Viable Programme Goals of the selected rehabilitation centres

The study further revealed that the central goals of the rehabilitation programmes and services were mainly focused on providing substance abusers with a supportive environment in which they could safely, humanely, and sustainably make the decision to quit drugs. The manager of institution X emphasised their health focus:

Our goal is to promote healthy lifestyles through providing a safe, dignified and kind environment for substance abusers to make the decision to quit abusing drugs and also start implementing that decision.

On the other hand, the manager of institution Z emphasized capacity building:

Our programme is mainly interested in capacitating our clients to be able to initiate and sustain long term recovery. We are mainly guided by a central principle of instilling a sense of self worthy and motivation to our clients given their background of rejection and derision.

The emphasis of the programmes was premised on creating an avenue for recovery which encompasses qualities of safety, human dignity and capacity building. The prioritization of safety, dignity, capacity building, motivation and a sense of self-worth espoused in the programme goals could have been necessitated by the realization that substance abusers are often victims of public judgement which causes their ridicule and rejection.

Moreover the emphasis on capacity building could be because of the realization that the majority of drug users are vulnerable people who lack the skills and expertise to craft lives which they can value; hence they may end up susceptible to substance abuse. Lastly, it is possible that emphasis on safety could be reflective of the availability of illegal and unsafe programmes which expose drug users to more harm than good in their recovery phase. Alternatively, the emphasis on safety could imply that the available treatment options aim to foster harm reduction strategies.

4.7.2. Selected Gauteng Treatment programmes offered ample time to expedite recovery.

Qualitatively, this study established that the current period in which treatment is offered in treatment programmes was adequate to ensure recovery, although it was necessary to strengthen the quality component of the treatment. Focus group participants generally felt that the span of the treatment programmes they were admitted in were long enough to allow them to address most, if not all, of their pressing psychosocial problems which could destabilize them in their recovery. Notably, none of the participants preferred to either increase or decrease the length of treatment programmes. As one participant supported the time frame:

I don't think there is need to extend treatment period, the current terms are good enough, maybe there is need to improve on the quality of programme content.

Another participant added longer time could be harmful:

From personal experience of the previous rehabilitation centres I have been to, after 4 weeks of treatment you will be good to go... In actual fact, staying for too long in the rehab cause complacency which can lead to mental relapse even before one goes out...

When asked to comment on what they think were the important considerations in deciding on the length of treatment programmes, one participant mentioned:

I think duration of admission should be based on pre-set and time bound treatment goals which need to be mutually decided and agreed upon by the individual and the counsellors from the beginning of intervention.

On the other hand, another participant was against predetermined dates:

Predetermined discharge dates causes complacency, especially in the case of court or employer sanctioned rehabilitations; the individual might just pass without working on changing his/her mind-set and wait for his/her date of release. Maybe it could be beneficial to consider improved state of the mind as the basis for discharge.

Additionally, one therapist mentioned that:

I think the current in-patient treatment time frames are good enough.... We might need to improve on what we teach, I don't think focusing mainly on life skills and the 12 steps programme will bring the desired results... we need to be more innovative so that the clients will enjoy and participate in our programmes.....Duration of admission should be informed by needs assessment .

It is apparent from the presentations above that participants in this study felt that the current lengths of drug treatment programmes are adequate to be effective. This is a significant score among the rehabilitation centres in Gauteng. However, the concern about the content of the programmes sends a message that there is need to work towards improving the quality of the programmes.

4.7.3. The Level of involvement of the Department of Social Development in Drug Treatment Programme Packaging

DSD interviewees were asked to explain the position of the DSD regarding the nature and content of treatment programmes offered to substance abusers who seek treatment in rehabilitation centres which fell under their respective jurisdiction. The study found out that the Department of Social Development was neither directive nor prescriptive in terms of programme packaging. However, one DSD interviewee noted:

We do not prescribe particular modality; instead, rehabilitation centres are regulated by legislations provided by the government, our work is mainly to enforce the legislations. However, it is important to note that the minimum norms and standards of residential treatment programmes in some way direct the work of rehabilitation centres.

From the above noted statement, it is evident that the DSD mainly focuses on evaluating the compliance of rehabilitation centres to the set minimum norms and standards.

4.7.4. Unaffordability of Drug treatment Services in Gauteng.

Participants in the qualitative component of the study largely agreed that the cost of drug and substance treatment services were too expensive for medium and low income earners.

One participant noted it was too expensive for people in low social economic status:

While we all accept and appreciate the reasons given as to why we must pay for treatment, I personally feel that the costs are now becoming unaffordable to most people especially of low income class.

Another participant showed concern on the unaffordability of private rehabilitations centres:

By any standard, private drug treatment fees are expensive, just imagine, sometimes even medical aid schemes only pay part of the bill and the individual and his or her family have to cover the shortfall....

Another participant also agreed on the high costs of private rehabilitation centres:

Most private rehabs charge an average of R20 000 for a 3 weeks programme, this is excluding other expenses such as self-sustenance money to buy things like toiletries, and other food luxuries not provided on the institutional menu as well as transport costs. But, what can one do; going to public rehabs is not a good option, their success rates are dismal let alone the arduous process one has to follow to be admitted....

On a similar note, one DSD interviewee mentioned that:

It's true; the charges in some rehabs are beyond the reach of many, however, the government has continued to subsidize the work of some partner organization such as SANCA to ensure that all people can get decent and humane treatment regardless of their financial backgrounds.

The information above suggests that despite the apparent efficacy of private rehabilitation centres in Gauteng, their services are too expensive and hence people of low socioeconomic class cannot afford them. Such people are then forced to go to public rehabilitation centres whose quality is arguably in doubt. This may mean that the rehabilitation services rarely serve the vulnerable population.

4.7.4.1. The need for standardizing the price of rehabilitation services

When asked to comment on alternatives that could be considered in making drug treatment services affordable, participants were largely of the opinion that the government should develop a national policy of standardizing the prices of rehabilitation services across either the public or private rehabilitation centres. This is to make the services of the private rehabilitation institutions affordable. The participants felt that the private rehabilitation centres took advantage of the fact that there were very few public rehabilitation centres. In the light of this, one participant said: I think the government needs to intervene and regulate the pricing of rehabilitation services. Additionally, the manager of institution Z elaborated on the scarcity of rehabs as a reason for hiked prices:

I think we are facing this problem because of the high demand for drug treatment services in the country...there are not enough public drug treatment centres, some Provinces in the country actually do not have a single government rehab.... This allow private players to take advantage and start to charge exorbitant prices...Secondly, I think public rehabs have remained under funded to provide competent services. This forces people to go to private facilities where they are fleeced of their hard earned cash

On the same note, one representative from the DSD hinted on the need to build more rehabs to meet the demand:

I can't give you an official response to that, but to say the least, I think the national government needs to make available finances for building more rehabs to absorb the excess of people in need of treatment... once this is done, prices for drug and substance abuse treatment services will drop significantly

The findings above suggest that the government is providing limited resources for the improvement of public drug treatment initiatives, thereby opening space for private entities to exploit the public by charging exorbitant prices. Accordingly, participants largely felt that the government is better placed to intervene and provide relief in the sector.

4.7.5. Poor Accessibility of Drug and Substance treatment Services

Focus group participants and individually interviewed key informants were of the opinion that drug and substance treatment services are not adequately expedited in Gauteng. Participants raised three main issues which they felt justify their perception that drug and substance treatment services were poor. Firstly, they argued that accessibility of treatment services must be understood in-terms of affluence, and then it must also be understood from the perspective of high demand which outstrips available capacity of rehabilitation centres to service those in need of treatment, and, lastly, in terms of the geophysical location of facilities. The following are opinions expressed by some of the participants regarding the accessibility of drug and substance treatment services:

Accessibility of drug treatment services depends on who one is and where one hails from. If one comes from a well to do family, then he/she can easily get access to private rehabs where costs are substantial. However, if one is poor or average, then access to government rehabs is very limited

Another participant said:

For me, the first time when my family wanted to book me into a rehab, it was hard, they had to report me to police first so that I would be court sanctioned, that way it was faster than trying to apply for admission into a government rehab straight away. But this time around, my mother made a single call to a private rehab and moments later I was on my way there

In contrast, a therapist based at institution X indicated rehabilitations centres mainly focus on making profit:

I personally think that rehabs to some extent are creating an artificial crisis in the sector; they continue to tell the public that they do not have the capacity to improve accessibility of treatment yet, they continue to service patients from overseas. It's a money thing at times, however here we normally take all who apply to be admitted within a space of a day or 2.

Similarly, one representative from the DSD said:

Accessibility of treatment services is high especially through out-patient programmes; the problem is that people prefer inpatient treatment for certain personal reasons. I would urge people to embrace any treatment modality at their disposal and the government I am sure will continue to improve accessibility through other means....

The scenario above indicates divergent and conflicting information, with the majority indicating a huge challenge pertaining to the accessibility of treatment services, especially to those of low socio-economic category. However, some sources also indicated that some rehabs were fussy and turning down local clients while catering for other overseas clients. On the other hand, there is a feeling that inaccessibility of services occurred as many clients preferred inpatient services rather than outpatient ones.

4.7.6. Survival Strategies of the Selected Rehabilitation Centres

The management of the selected rehabilitation centres were asked to comment on the financial survival strategies of their respective institutions. The manager of institution X identified donations as the main source:

Funding is quite a very difficult challenge in this sector. Many rehabilitation centres which open close off in their first year of opening due to financial huddles. However we thank God, we have been able to survive through the money we charge for our services and we also heavily depend on donations from well-wishers.

The manager of institution Z also identified sponsorship and government subsidy as their source:

We are currently going through financial distress, we might be forced to terminate some services and lay off some staff by the end of the year. We have been surviving on sponsorships from the corporate world and a subsidy from the government, but it's not enough....

The researcher further observed that the selected rehabilitation centres were using skeletal professional staff, semi-skilled staff and unskilled labour as financial survival strategies. This could be because unskilled and semi-skilled labour is generally cheap. On the other hand, using skeletal professional staff was a way of legitimising the operations of the centres as it is a statutory requirement of these facilities to operate through professional staff. This has serious implications on the work of rehabilitation centres. This is because the situation of rehabilitation centres operating with skeletal staff could mean that the professionals are likely to be overloaded with caseloads with a possibility of suffering burnout. This phenomenon can disgracefully undercut the quality of services rendered.

4.7.7. Location of rehabilitation centres a deterrent to accessibility of rehabilitation services

Study participants revealed that location of rehabilitation centres especially in the rural areas, negatively impeded accessibility of treatment services. All the focus group discussions argued that location of rehabilitation centres in remote farm areas, where accessibility is only through private cars, makes it hard for substance abusers and their families to access them. Secondly, concern was raised on the urban bias in the location of rehabilitation centres. Participants noted that some rehabilitation centres are located in urban or peri-urban areas where rural populations often have no access. Additionally, participants expressed that locating rehabilitation centres where families cannot easily visit their loved ones reduces the effectiveness of the treatment services and diminishes the willingness of substance abusers to be admitted knowing that they will not see their families for a long time. The following statement supports the finding:

I think, the physical location of rehabilitation centres makes them inaccessible to the general public...they are usually located in secluded areas where no public transport plies, if your family does not have a car then you will not be able to access them...

This point to the need to strategically locate the rehabilitation centres where they are accessible with ease if ever the vulnerable population will get the services with ease.

4.7.8. Poor marketing/advertisement a deterrent to accessibility of rehabilitation services

Focus group participants echoed that there is poor marketing of the rehabilitation services, such that it was difficult for some of those who required the services to easily locate and access them. The majority of the focus group participants also indicated that it was scary for them to accept going to unknown rehabilitation centres. Their fear was prompted by hearsay stories that there are some bogus rehabilitation centres at which patients are subjected to extreme torture and inhuman treatment. One in-treatment focus group participant highlighted poor marketing strategy on the part of rehabilitation centres:

Rehabilitation centres are not marketing their services, and when it comes to such facilities, my belief is never to go to a place which I don't know about personally or have ever heard being talked about in public places, I learnt that there are some fake rehabilitation centres which are after money and they torcher people....

The above noted statement indicates that poor marketing of services by rehabilitation centres makes these services suspicious to the intended beneficiaries and also makes the services remain unknown, hence inaccessible, to the general public. This points to the need for the rehabilitation centres and other stakeholders to start marketing rehabilitation services and to develop a strong public relations strategy which can make rehabilitation centres more appealing to the end users.

4.7.9. Exorbitant prices of rehabilitation services cuts their accessibility

The majority of focus group participants echoed that exorbitant prices of the rehabilitation services in private institutions was a huge bottleneck to sustainable accessibility of substance abuse treatment services. The following statements support this revelation:

Largely, accessibility of drug and substance treatment services is being stifled by exorbitant treatment fees

Another one also highlighted how the high costs disadvantages the poor:

The cost of treatment services in private facilities are too exorbitant, this makes their services inaccessible to the poor and vulnerable.

It is then apparent that unless government forces intervene to lower or regulate the pricing of the rehabilitation services, they are then not going to solve the drug problem in Gauteng

4.7.10. Cultural and religious insensitivity in the administration of the rehabilitation centres

Study findings revealed that cultural and religious dynamics affected the administration of the rehabilitation centres. Participants largely agreed that rehabilitation centres were servicing consumers of predetermined social and economic backgrounds. This means service providers are more sensitive to social, economic, cultural and religious needs of certain target groups at the expense of other service consumers. One man from the focus group discussions highlighted how some rehabs can be religiously insensitive:

For me, I think most of the available treatment centres are culturally and religiously insensitive. In most cases you will notice that particular rehabilitation centres are affiliated to a particular religion and although they accept people from other faiths, they do not provide any support for such people. For instance, I am a Muslim, I always have to eat Halal food, other rehabs do not offer that, this also apply to lecture contents, some rehabs do not teach religiously neutral programmes...this makes such rehabs inaccessible to people from different religious and cultural backgrounds....

This point to a need for government to intervene and regulate the operations of rehabilitation centres so that they can embrace multiculturalism in their services as well as in their service delivery “modus operandi”.

4.7.11. Client perceptions of rehabilitation services not resonating with the Value for Money

Participants were requested to state whether or not they were satisfied with the services they were getting or they got during their stay in different rehabilitation centres. The following are snippets of what participants felt and thought about the nature and quality of services they were getting / got;

It's better than staying on the streets, but I think for the money my family paid, I deserve more. I only get to see therapists once in a week or 2, and when I do see the therapist, it's often for less than an hour.

Another participant mentioned that;

They wrote on their website that they offer medically assisted detoxification, but upon admission, everything changed, they leave you to suffer with withdrawals. Even if you want to complain to your family, they will not hear you out, as this will be read as a sign of ungratefulness, denial or manipulation.

In addition, another participant brought in a new dimension by purporting that;

The problem is that when we try to complain about anything here, no one listens, They just tell us that what we are getting is way better than what we were doing during our addiction time... it's sad, that no one is willing to listen to you simply because you used to lie and manipulate in the past.

Additionally, participants were generally not happy with the monotonous routine they were made to follow throughout their admission period. One focus participant complained about the rigidity of the program:

They taught us the same thing from start to the end of the programme; it was all about life skills and counselling.... I think they should at least incorporate some manual skills such as carpentry, building or anything else to help people to go and do something with their lives once they go back to society...it's not as if we don't know of basic life skills such as being respectful, honesty etc.... we need something to go and start our lives with.

However, some participants were of the opinion that rehabilitation centres were trying their level best under the circumstances of limited finances, infrastructure and other resources.

One focus group participant what was outstanding for him in the program:

I would say the services are not excellent but they are still good enough. For instance, I personally found the spiritual programme, amount and quality of food given and family reunification services to have been of high standard.

Additionally, the manager of institution applauded how rehabs are thriving regardless of poor funding:

To say the services are substandard and therefore unsatisfactory or ineffective is wrong. I think rehabs are trying their best under the circumstances. The quality of services should be read in tandem with the state of institutional coffers. We need funds to be able to retain competitive counsellors, improve on the living conditions of our patients, all these have a bearing on the quality of services and ultimately on consumer satisfaction...

The scenario above, although defended by the institutional managers and a few clients, does indicate that some service users feel the services offered are not satisfactory and therefore failing to resonate with the value of the money charged. This may imply the possibility of the rehabilitation gaps that fail to solve the addiction problems in Gauteng.

4.8. Client perceptions of the benefits espoused in the rehabilitation services offered to them.

Participants were asked to respond to a question on what they appreciated most about the treatment modalities they were attending/attended. The intention of this question was to qualitatively explore elements of treatment modalities which participants believed were beneficial and more helpful in the rehabilitation process. Following are some of the dominant perceptions expressed by focus group participants:

I think that the most important to me was the family therapy sessions; the therapist helped my family to understand the drug problem, especially my mother didn't understand that some of the behaviours in my past was due to addiction, she was blaming me and never wanted to forgive me, but after the family session she understood and now she is my number one support structure

Another participant said;

For me, I think the greatest thing I am getting here is a conducive environment to recover in. I tried to quit drugs alone at home and it was a disaster, I got sick and had to be rushed to the hospital after the withdrawals kicked in, here the withdrawals are less painful

Another participant was more grateful for the medically assisted detoxification, he said;

The methadone they gave me to cope with the withdrawals is what I consider to be the most important component of the programme

Largely, the scenario above depicts the client perceptions that the rehabilitation programmes were worthy and beneficial in a number of ways. They had some immense value, especially in educating the family of the clients and also offering the client an environment they could recover with ease.

4.8.1. Clients' Perceptions on the gaps inherent in the rehabilitations services

In contrast to the positive sentiments expressed above, some participants voiced out some of their dislikes about the treatment modalities which they experienced. Central among the dislikes were issues to do with poor living environments, poor diet, punitive measures and lack of leisure facilities. One of the focus group participants complained about the food when he said, "The biggest challenge here is food, I feel like throwing up immediately after eating...." Additionally, another participant complained about the overcrowded rooms:

For me the biggest turn off are the rooms in which we have to sleep in like children, at times we have to share a room which normally must be occupied by 2 people and we share it amongst 3 or 4 people.

Another participant voiced concerns regarding the capacity of counsellors in discharging their duties. He said;

I detest the use of non-qualified counsellors, at times former drug addicts are used as counsellors.they don't know anything about confidentiality,they often want to force us to recover in the very same way they did themselves and thus fail to acknowledge that people are different. I prefer the previous rehab I went to where only qualified psychologists and social workers were attending to our needs. . .

The sentiments above indicate that the rehabilitation services may be lacking appropriate professionals to drive the services as well as the fact that they face serious psychosocial gaps such as lack of appropriate basic infrastructure to satisfy the clients.

4.9. Contribution of Drug and Substance Rehabilitation programmes to positive behaviour.

Findings from the qualitative component of the study reviewed some mixed experiences regarding the contributions or rehabilitation centres to behaviour/lifestyle changes among participants in aftercare support groups. In general, the majority of aftercare focus group participants felt that they had achieved some level of lifestyle/behavioural change, although some could not directly credit rehabilitation centres for such improvements. Following are quotations of what some participants said regarding this subject:

I don't want to lie; the rehab helped me a lot to change from being a total liar to becoming a better person I am today. I used to lie and manipulate things, but now I can relate to others with a high degree of honesty.

Another participant indicated how rehabilitation helped him stay away from criminal activities:

In the past, I could not spend a month without spending some time in police custody, I am proud of myself, it's been 4 months now without any problem with the law, and I think rehab helped me a lot.

Another participant added that;

I think the fact that in the past 3 months I haven't fought with my wife, my brother or my father means whatever they taught me at the rehab really worked.

Additionally, participants in aftercare focus groups largely confirmed positive improvements in terms of increased work and school productivity, increased presence at work stations or school, improved personal hygiene, reduced tendencies of violence, reduced need for medical assistance, among other improvements. However, some participants felt the change in behaviour and lifestyle was directly linked to the elevated control exercised by their families/primary caregivers after rehabilitation and not necessarily from rehabilitation itself. One man elaborated on this:

To say changes in behaviour/lifestyle are a reflection of the work of rehabs is an overstatement, you need to know that when we went to the rehab we lost our decision making powers, now our families tell us what to do and when to do it. It's not wilful change but rather forced change

The narration above points to the fact that most clients credit the rehabilitation programmes for their positive behaviour change, while some few voices considered it otherwise.

4.10. The positive role of rehabilitation centres in the fight against substance abuse.

Participants of the qualitative study also shared their perceptions on whether rehabilitation centres were contributing significantly to the fight against substance abuse in Gauteng. Following are some of the responses given by focus group participants as well as those who were interviewed. One participant was grateful for the role that rehabilitation centres played in bettering lives:

Rehabs are obviously doing a lot, for me, when one person recovers from drugs, it is a huge achievement.

Similarly, the manager of institution X identified how rehabs use more of the Band-Aid approach:

The thing is, as rehabs, we have continued to use a Band-Aid approach in which we are offering crisis intervention services. We are only dealing with the tip of the iceberg hence our impact is seldom felt or recognized but we are making an impact nevertheless. However, I think we need to ensure that our services are more holistic such that they include both preventative and rehabilitative work,....

During an interview session, one DSD representative appreciated the contribution made by rehabilitation centres:

As the DSD, we appreciate the work being done by rehabs; we know if it wasn't for them, the situation could have been worse. We are one of the countries with the worst drug problem in the world and the government alone cannot win. . . the partnership between the government and private rehabilitation facilities has continued to be beneficial to the general public..

The above noted statements reflect that rehabilitation services were appreciable and largely contributing in the fight against substance abuse in Gauteng, despite several gaps they were facing.

4.11. Meagre impact of rehabilitation centres in fighting drug abuse in Gauteng

Contrary to the above perceptions of the meaningful contributions of the rehabilitation centres in the fight against substance abuse, some participants felt that the contribution of rehabilitation centres is insignificant in the fight against substance abuse. Particular concerns were raised in regard to the manner in which local rehabilitation centres have continued to be elitist. Participants indicated that the prohibitive costs of private rehabilitation centres makes them irrelevant in the national vision of cleaning South African environments of drugs; they only apply to the minute wealthy middle and upper class of the society. Participants further noted that private rehabilitation centres are often given the privilege of registering as non-profit organizations yet, in practice, they remain capitalistic with total focus on profit making at the expense of community development. In addition, participants raised concerns regarding the use of minority languages. They noted that rehabilitation facilities often use English and Afrikaans as their medium of communication. This makes it hard for those who cannot speak or understand these languages to meaningfully engage with programme content.

The above concerns do indicate that rehabilitation centres, due to their ideologies and operational modalities, do not serve all the needy clients but favour some, especially those of middle and higher socio-economic classes at the expense of the poor who are prohibited by factors such as costs, language and attitudes, among other factors.

This environment makes them not to achieve the rehabilitation goals of addressing the general drug problem in Gauteng.

4.12. Challenges Associated With Selected Rehabilitation Centres in Gauteng

The assessment of the contributions of rehabilitation centres in the amelioration of drug and substance abuse cannot be understood in isolation of the challenges faced by these institutions. One of the key objectives of this study was, therefore, to establish institutional and operational gaps associated with selected Gauteng rehabilitation centres. Ensuing are the findings on the gaps and challenges confronting the Gauteng rehabilitation centres.

4.12.1. Poor Infrastructure

Qualitative findings of this study indicate that the selected rehabilitation centres displayed poor infrastructure. Participants, especially those from institution Z, indicated that the state of infrastructure in the treatment centre were deplorable. On the other hand, participants from institution X mentioned that the state of the infrastructure was not necessarily bad; however, they raised concerns regarding its adequacy to meet the growing demand for services and issues about poor maintenance of the available resources.

The manager of institution Z identified poor funding as the main reason for poor infrastructure:

With all honesty, our infrastructure is bad, and in some cases non-existent. Our precarious financial position makes it hard for us to develop our infrastructure;

Another therapist from institution X added that:

It all depends on what you want to call infrastructure, if you mean good accommodation, security and, offices, then we do have good infrastructure, but if you want to talk about therapeutic facilities like saunas, recreational facilities, then infrastructure is a huge hurdle indeed.

Another in-treatment focus group participant pointed on the inadequacy of infrastructure:

The infrastructure here is not too bad; it's only that it's not enough to cater for everyone; imagine that at times we have to sleep 3 or 4 of us in a room normally used by 2 people

Additionally, one interviewee from the DSD said;

We are aware of the challenges of infrastructure in some rehabs, this is why we are promoting community-based treatment programmes which allow people to be treated and go back to their homes thus removing the need for investments in infrastructure.In terms of inpatient treatment programmes, we have a set of minimum standards which each facility need to adhere to before registration, this helps to ensure better quality infrastructures. However, the problem is that once registered, these facilities seldom maintain their infrastructure until next date for re-registration

Therefore poor infrastructure and failure to maintain the existing one is usually a recipe of poor and low quality services.

4.12.2. Gender and Age Bias in the Provision of Drug and Substance Treatment Services

This study found out that one challenge that was being faced by the selected Gauteng rehabilitation centres was lack of adequate sanitary equipment for female patients. From a qualitative perspective, it emerged that women and girl children were underrepresented in treatment settings. Moreover, participants mentioned that women and girl children who get opportunities to be treated in rehabilitation centres often find it hard to survive in these facilities due to non-availability of certain basic social amenities. One woman in after care focus group hinted on how most rehabs on cater for men:

Most rehabs that are available are for men, it's hard to find one specifically for women except in open outpatient programmes.Even if you do find a rehab that accommodates women, the conditions there are not conducive for that purpose; there is a problem in that most rehabs only provide the bare minimum sanitary conditions for female patients

Additionally, one man mentioned that:

Our society continues to parrot issues of gender equality, but still fail to provide for women's needs. Not only are women disadvantaged in not getting rehabilitation centres which can treat them; at home, families treat a boy child's addiction favourably than a girl's, this need to stop.

In addition, the manager of institution X noted some recent improvements and challenges:

As an organization, we noted this gap and we have since moved to establish a facility fully dedicated for the treatment of women and girls. However, the problem we are encountering in our new female rehabilitation centre is that families continue to hide addiction problems of women and girls, they probably fear the stigma that comes with it and how it will affect women in terms of getting married in the future

The scenario above indicates that many rehabilitation centres face a gender gap in the provision of their services and the problem is exacerbated by societal stigma levelled against drug addiction by women and girl children.

4.12.3. The Stance of the DSD regarding Drug Treatment Needs of Women and Children

When asked about the position of the DSD regarding the substance abuse treatment needs of women and children, it emerged that the DSD was aware of the difficulties associated with accessing drug treatment services for women and younger people. On that note, one interviewee from the DSD said;

As the DSD, we are aware that women have remained disenfranchised in many ways and we are happy that there has in the recent past been an incremental proliferation of gender blind services although we still have a long way to go. However, in general, as the DSD we promote treatment for all people suffering from substance abuse disorders, regardless of their gender, age, race or any other consideration...remember social service work should be guided by the Batho Pele principle (people first).

From the above captioned statement, it is apparent that the DSD was aware of the gender skewed drug treatment services. The alleged increase in the proliferation of gender blind services could be as a result of the realization that substance abuse is indiscriminate in its afflictions.

4.12.4. Low capacity for vocational skills training

This research found out that Gauteng rehabilitation centres were lacking capacity enhancing programmes to equip their clients vocational skills through which they would be able to have somewhere to start from after their treatment. This gap was attributed to a number of factors.

The manager of institution X said;

We used to have many empowerment projects here but they are difficult to maintain, we hire people to train our patients and they don't stay for long and we have to start all from the scratch to look for someone again... Maybe the government should deploy their people in rehabs to do the skills training; as it is we have expertise and capacity for life skills training and vocational skills' training is not our strength

Another manager of institution Z said:

The problem is that the DSD want us to implement projects for skills development, but come to think of it, what skill can sustainably be taught to a client within a space of 3 or 6 weeks? ...I think any vocational skill taught in 3 weeks remains elementary and inconsequential at best and cannot have any economic benefit for its beneficiary...the government must take the initiative of training these people after rehabilitation ...

The above sentiments echo the fact that rehabilitation centres lack capacity for the requisite vocational training programmes for the clients. Perhaps the intervention by the government to avail some skills in different vocational centres can help fill the gap.

4.12.5. Poor Visibility of Rehabilitation Centres in the Societies

Participants mentioned that rehabilitation centres and the services they offer faced the challenge of poor recognition. Participants generally attributed this problem to poor marketing of drug treatment services by service providers. One participant mentioned that;

Well, maybe the rehabs don't see the point of marketing their services when they are getting the numbers they want without marketing

Another participant said;

Many people are suffering in silence as they don't know where to get help from, it's so pathetic

Furthermore, another participant mentioned that;

I firmly agree with him, rehabs are not marketing at all; tell me of a day you ever saw on national television an advert telling people where to take their children or themselves for drug abuse treatment?

Additionally, another participant indicated that;

I think someone here once said, rehabs are deliberately avoiding advertising their services in local communities and focus on advertising on the internet, so that they can attract international and wealthy clients who often have access to such platforms and they can pay well. This is very true, I also found out about this program on the internet.

It is pertinent therefore that rehabilitation services are adequately marketed in order to increase their visibility to all the potential beneficiaries.

4.12.6. Dire Shortage of skilled and Experienced Professionals

In this study, it was established that the selected rehabilitation centres were facing a challenge in terms of critical shortages of skilled and experienced professionals to provide competent services. Following is a summation of what participants said. The manager of institution X said;

We are battling with shortages of skilled therapists, if we get some, they stay only to acquire requisite experience needed by overseas organizations, and they go. It's quite a big loss to us, because we would have been training them only to leave us and we have to start all over again

The manager of institution Z added that;

Professionals are easy to come by, but retaining them is very difficult due to poor salaries, here we had about 2 social workers who left the profession, one went to the education sector and the other went on to open his own business... the impact of this is felt in the quality of services rendered to our clients..

The representatives from the Department of Social Development showed concern with the idea that therapists in rehabilitation facilities are leaving their jobs:

Indeed as the DSD, we are worried about the situation pertaining to our rehabs; professional therapists are not staying on their jobs, they are leaving their professions in search of better opportunities elsewhere. I think the salaries in the sector have remained too low to be attractive and to ensure retention of skilled and experienced professionals...

The scenario above points to a glaring challenge of maintaining the requisite professionals in the rehabs, mainly due to professional attrition to the greener pastures. This largely impacts negatively on the quality of services offered by rehabilitation centres.

4.12.7. Heavy Case Loads for Therapists

This study further found out that rehabilitation centres were facing challenges of carrying heavy caseloads. One interviewee from the DSD identified the heavy caseloads that social workers in rehabs have:

When we go for assessment of rehabs, we often find that many a times, social workers in rehabs are carrying heavy caseloads of over the stipulated number per individual at a time.

The connotation of the above stated statement is that, when inundated with caseloads, therapists may resort to providing bare minimum care to their clients and this may result in poor service delivery and, in the process, undercut the significance of the contributions of rehabilitation centres in furthering their mandate of ameliorating the drug problem in South Africa.

4.12.8. Difficult and uncooperative Clients

Furthermore, the study found out that rehabilitation centres were facing challenges in terms of the nature of clients that they have to deal with. Concerns were raised in terms of clients in denial, those who manipulate and, at times, those who cannot afford to pay requisite fees. One therapist pointed out the difficult nature of clients that they work with:

To be honest, working with addicts is a challenging experience; some are rude, ungrateful and paranoid.

They are not like other conventional social work clients. This makes the job stressful and demanding

The statement points to the fact that the state of uncooperative nature and the difficulties thereof largely compromise the quality of the services offered by rehabilitation centres.

4.12.9. Lack of Professional Platforms and Opportunities for Therapists in the Sector to Share knowledge

The study further established that rehabilitation centres were lacking knowledge sharing platforms. The following are some of the extracts on the shortage of these platforms:

As a social worker working in a rehabilitation centre, I often feel isolated, there are hardly any platforms available to share knowledge and experiences, and at times I end up attending workshops on child welfare which adds very little value to my daily work.

On the other hand, one representative from the DSD mentioned that;

It's important that we acknowledge that while the problem of drugs is an ancient one, in South Africa, its treatment is a relatively new domain that is starting to take shape and prominence. The platforms of sharing knowledge are also starting to emerge.

In addition to the above, the researcher concluded that there is lack of cooperation and distrust between and amongst stakeholders in the drug treatment sector. Service providers in the sector elaborated that they perceive their work as social entrepreneurship which should benefit them financially while also contributing to social development in the country. Accordingly, they preferred not to share their programme contents and knowledge with others in the sector. The manager of institution X confirmed this by stating:

Every organization has its signature service clientele which makes each entity unique from others; as such we don't really share our tools with others. I remember that at one time, a certain rehab threatened to sue us on the grounds that one of our social workers had come across a file with information from that organization and started using the material with our clients and they found out, it was really bad, so it's not us only who prefer not to share our methods...

The challenge posed by the environment of rehabilitation centres considering themselves to be social enterprises, prompting them to hide their services from one another, can possibly be handled by government intervention. The failure of the professionals to share their experiences denies them an opportunity to attain professional growth, benchmarking and, as a result, they may fail to carry out evidence based and sustainable practices for the benefit of their clients.

4.12.10. Out-dated and Disjointed Legislative Framework

Key informants who were interviewed in this study opined that another huddle confronting the work of rehabilitation centres are the out-dated and disjointed legislative frameworks guiding the sector. Informants mentioned that the current legislative framework undermines the effectiveness of interventions. Participants further mentioned that due to poorly synchronized legislations, it has remained very difficult to coordinate and implement treatment programmes. Secondly, participants talked about lack of policy direction and proper evaluation of interventions. Ensuing are some of perceptions expressed by the interviewees. One therapist from institution X questioned the relevancy of the legislations:

The legislations are out-dated; they are no longer feasible in the current social and economic environment....

The manager of institution Z how they are not in touch with the policy makers;

The problem is that we only get to see those responsible for implementing policies relating to our sector once in a blue moon. They only come to re-register our centres when our operating licenses are expired, but we understand they ought to be coming regularly to monitor and evaluate our programmes, but they don't come. ...Also, the current policies and guidelines for the registration of new and registration of existing facilities are just ridiculous and unnecessarily arduous... they promote corruption.

Additionally, the manager of institution X also echoed the same sentiments;

We really don't understand what is required of us by the law, we only know of the vision of creating a drug free South Africa as a political mantra, but no one has ever engaged us on how to achieve this if at all it's achievable.

Findings in this category seem to have a ripple effect on the contributions of rehabilitation centres and, more especially, to the national vision of creating a drug free South Africa. With disjointed legislations, rehabilitation centres remain paralysed in discharging certain responsibilities.

4.12.11. Progress of Gauteng Province in Ameliorating the Substance Abuse

Problem

One of the pertinent questions which addressed to the DSD representatives pertain the progress of the DSD in ameliorating the substance abuse scourge in Gauteng Province. To this end, the study established that Gauteng was making huge remarkable progress as a Province in its fight against substance abuse.

Among some of the factors which were indicative of the progress being made in ameliorating the substance abuse problem includes the availability of a wide network of assistive interventions including preventative, harm reduction, treatment and aftercare support structures, which allow early detection and response to substance abuse problems. The DSD representatives alluded to studies carried out in the province which indicated that although the problem of substance abuse was still unacceptably rife; the number of people who are affected has in the last decade remained stable, indicating that there has been progress made in terms of halting the problem from escalating.

In this light, one DSD participant pointed how the drug problem has been stabilised:

The fight against drugs is a unique fight that might never be completely won, however, we are happy that available statistics are suggesting that we have managed to stabilise the situation. Our next move is therefore to mobilise our stakeholders to start the process of reversing the prevalence rates... To me that's progress enough

The statement above portrays that the work geared towards ameliorating substance abuse is slowly paying dividends. This could be attributed to a number of factors including the work of rehabilitation centres, government initiatives to increase antidrug awareness among other factors. However, the finding that the major task now, which the DSD was seriously considering, was reversing the prevalence, seem to place the work of rehabilitation squarely in the door of the centres, as they are the ones who can treat substance abusers and reduce the prevalence of the scourge in the Province.

Section B: Presentation of Quantitative Findings

4.13. An Overview of the Characteristics of the Mini Survey Respondents

This study made use of 100 mini survey questionnaires which were distributed to primary care givers of people who were attending after care support groups. The survey was conducted over a period of 3 weeks. Ensuing are the descriptions of the biographical profiles of respondents to the questionnaire.

4.13.1. Biographical Profiles of Mini Survey Respondents

4.13.1.1. Gender Distribution in the study

Table 4.13: Gender Distribution in the study

Gender	Frequency	Percentage
Males	42	42%
Females	58	58%

Figure 4. 9: Gender Distribution in the study

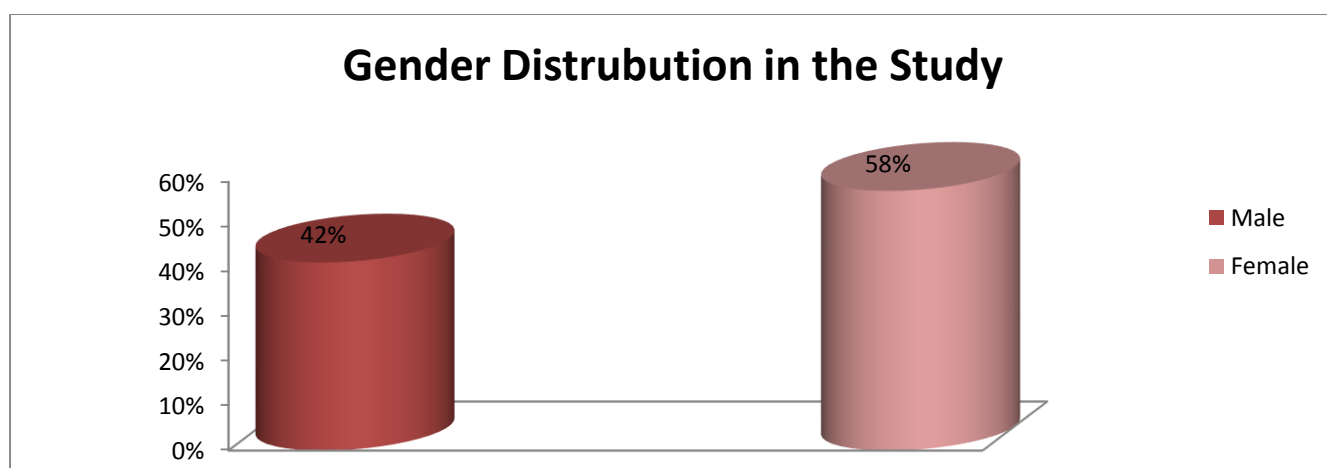


Table 4.13 and Figure 4.9 above depict the gender distribution in the mini survey. Findings were in favour of females who constituted 58% of the total sample while males constituted the remaining 42%. The above stated statistical data suggests that women are the ones who were mainly involved in the provision of care and support to recovering drug and substance abusers.

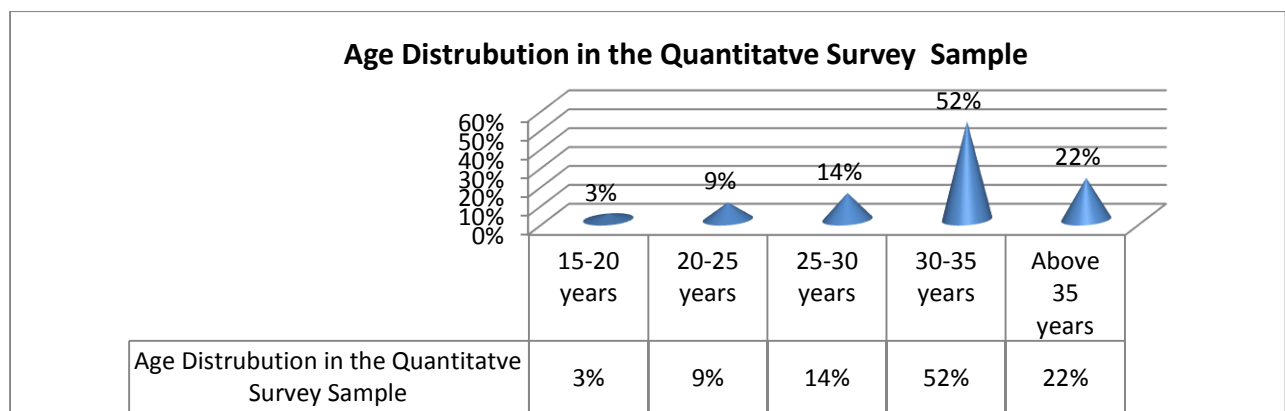
The gender disparity indicated in the findings above carries a lot of implications on the success of recovery and the contribution of rehabilitation centres in the fight against drug and substance abuse. In many African cultures and households, it is men who carry the vision and are the main decision makers regarding many aspects pertaining to the administration of household tasks, whether health care, moral or financial.

In this light, their low number of men compared to the number of women during the implementation of treatment plans for their loved ones may spell a doom to the sustainability of recovery. However, the fact that more women are involved in caring for recovering substance abuse clients mirrors African culture that considers women to be caregivers of patients of various ailments.

4.13.1.2. Age

Figure 4.10 below depicts the age distribution among mini-survey respondents.

Figure 4. 10: Age Structure of Mini Survey Respondents



As shown in **figure 4.10** above, 3% of the respondents were aged between 15 and 20 years while 9% indicated that they were aged between 20 and 25 years. Additionally, 14% indicated that they were between the ages 25 and 30 years. The majority (52%), mentioned that they were aged between 30 to 35 years and lastly, the remaining 22% chose 'other' as their age category.

The findings in this study reveal that caregiving responsibility for persons recovering from drug and substance abuse tended to increase with increasing age. As one grows older, so does his/her likelihood of taking care of a loved one with a drugging problem. This, therefore, depicts an inextricable relationship between increase in age and the probability of being a caregiver to a drug dependent loved one.

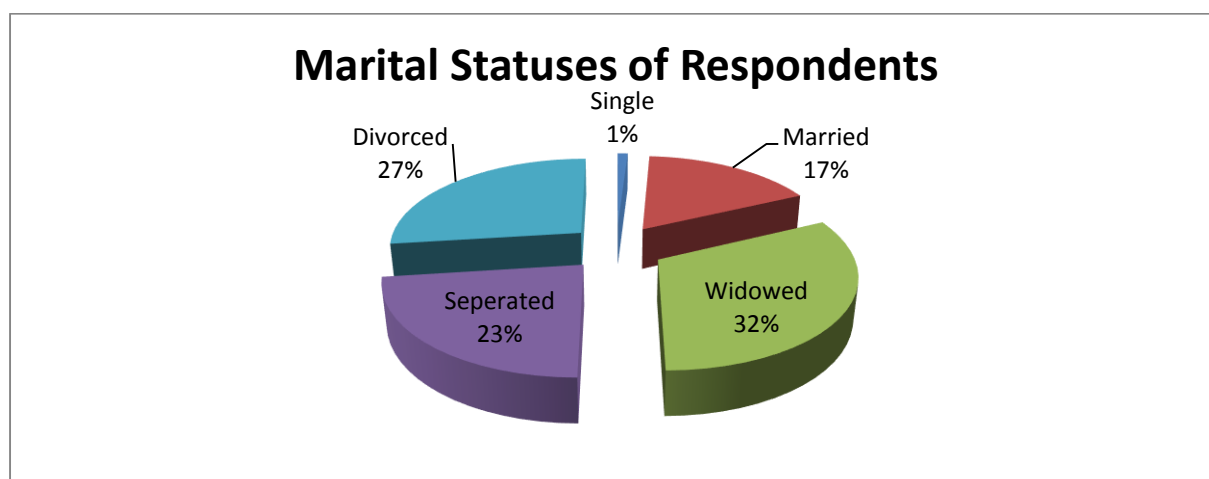
4.13.1.3. Marital Statuses

This study explored the marital statuses of the mini survey respondents. Findings regarding the marital statuses of respondents to the questionnaire are presented in **table 4.14** and **figure 4.11** below.

Table 4.14: Distribution of Marital statuses amongst Mini Survey Respondents

Status	Percentage
Single	1%
Married	17%
Widowed	32%
Separated	23%
Divorced	27%

Figure 4.11: Distribution of Marital statuses amongst Mini Survey Respondents



As indicated in **table 4.14** and **figure 4.11** above, the respondents of the study fell into 5 marital categories namely single, married, widowed, separated and divorced. Specifically, 32% indicated that they were widowed, 27% mentioned that they were divorced while 23% chose separated as their marital status. Additionally, 17% and 1% noted that they were married and single, respectively.

The trends in the findings on the marital status of respondents in the mini survey shows that it is mainly the widowed, the separated and the divorced people who were mostly playing a role in the provision of palliative care for recovering drug and substance abusers.

These findings have multiple implications on the accessibility and sustainability of treatment. Firstly, since the caregivers were close kins of the drug addict clients, it then means that it is in families that are divorced, separated and the widowed that were vulnerable to having a family member who was addicted to drugs addict members. It is also apparent that most of the caregivers were coming from unstable homes - divorced, separated and the widowed. Generally, single parent and /or child headed households are considered as some of the economically vulnerable households whose buying power is significantly lower than those of other household types, this implicitly means that such care givers may not afford all of the requisite recovery maintenance medications and other support for their loved ones. Children from broken homes are mostly believed to have a higher proclivity of abusing drugs and substances. Accordingly, it is possible that the domination of these marital statuses in the caregiving for persons recovering from drug and substance abuse is a reflection of how family background can influence indulgence into substance abuse.

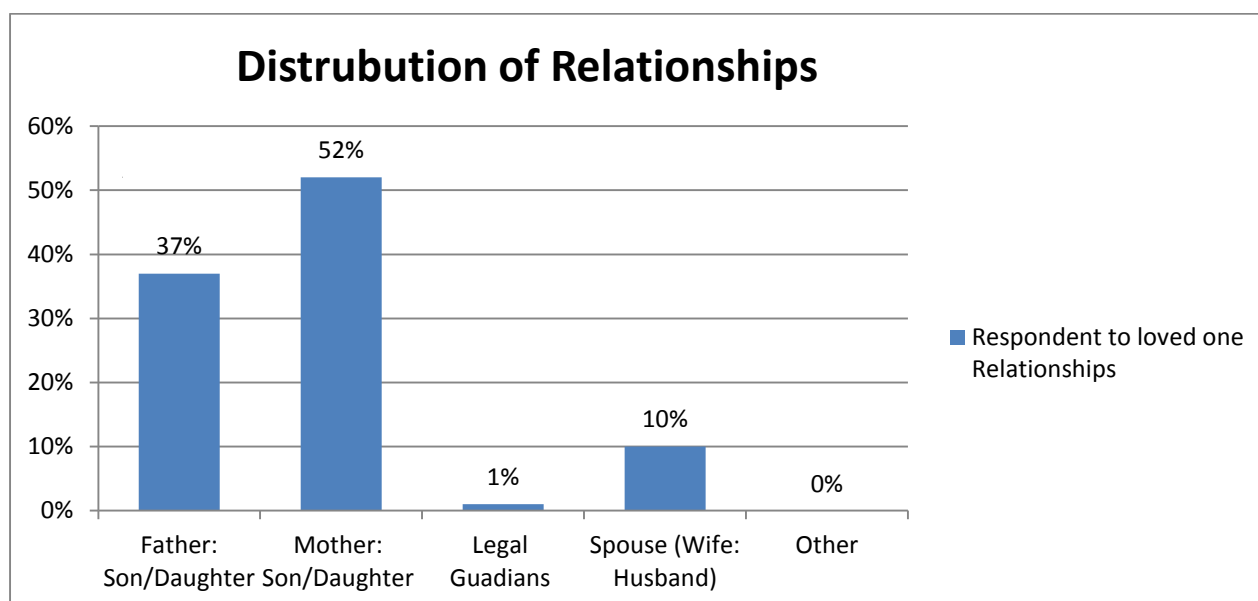
4.13.1.4. Relationships

Findings in **table 4.15** below highlight the nature of relationships between respondents and their corresponding substance abuse recovering loved ones whom they were representing in the study.

Table 4.15: Nature of relationships between respondents and their loved ones

Relationship	Frequency	Percentage
Father	37	37%
Mother	52	52%
Legal Guardian	1	1%
Spouse (wife/husband)	10	10%
Other	0	0%

Figure 4. 12: Distribution of relationships between respondents and their loved ones



As depicted in table 4.15 and figure 4.12 above, 52% of the relationships identified in the sample were mother to son/daughter. Moreover, father to son/daughter relationships were the second most prevalent and amounted to 37%. Furthermore, 1% of the sample indicated that they had a legal guardian relationship with their loved one and their specific relationship was an aunty to nephew. Lastly, 10% of the respondents had spousal relationship (wife/husband). There were no unspecified relationships in the study.

Findings in this category showed that it is mainly parents of substance abusers (mothers and fathers) who were providing palliative care to their children in recovery. This finding is not unusual, given the influence of modernisation which is fast eroding the value of extended families and replacing them with nuclear families. Nuclear families mandate an individual's family of origin to provide care and support for its members in circumstances of need. Additionally, these findings could possibly point the fact that drug and substance abusers destroy their personal and interpersonal relationships and they often find themselves isolated and or alienated.

In this light, it is possible that spousal relationships were underrepresented in the study because such relationships are the first to breakdown due to the attendant effects of substance abuse which includes difficult behaviour, domestic violence, stealing and malicious destruction of family property.

4.13.1.5. Race

Findings on the distribution of race in the mini survey sample are captured in **table 4.16 and figure 4.13** below.

Table 4.16: Race Distribution in the Study

Race	Frequency	Percentage
Black	33	33%
Indian	35	35%
White	21	21%
Coloured	11	11%
Other	0	0%

Figure 4. 13: Race distribution in the study

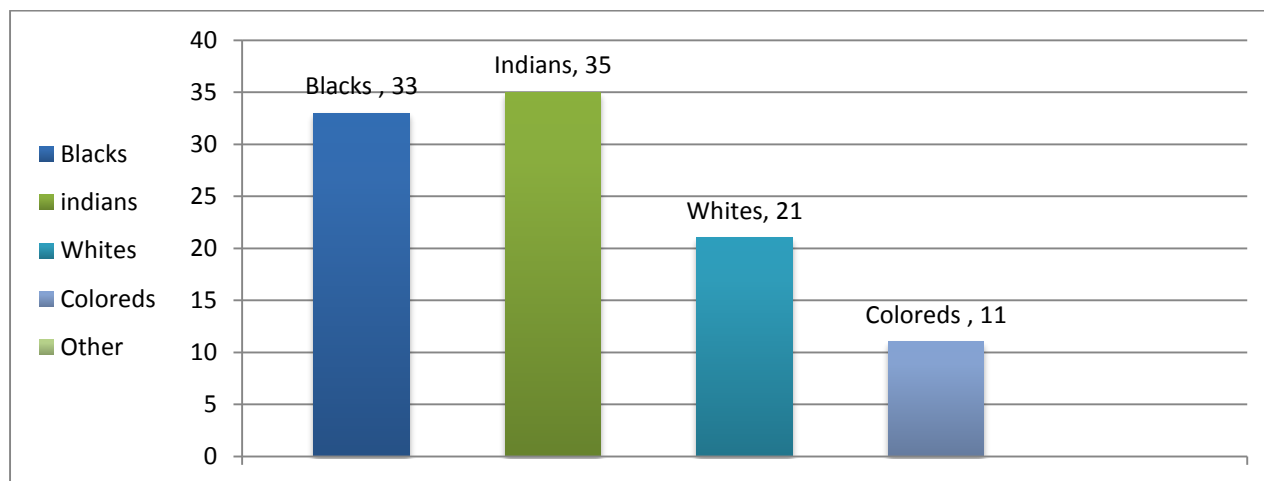


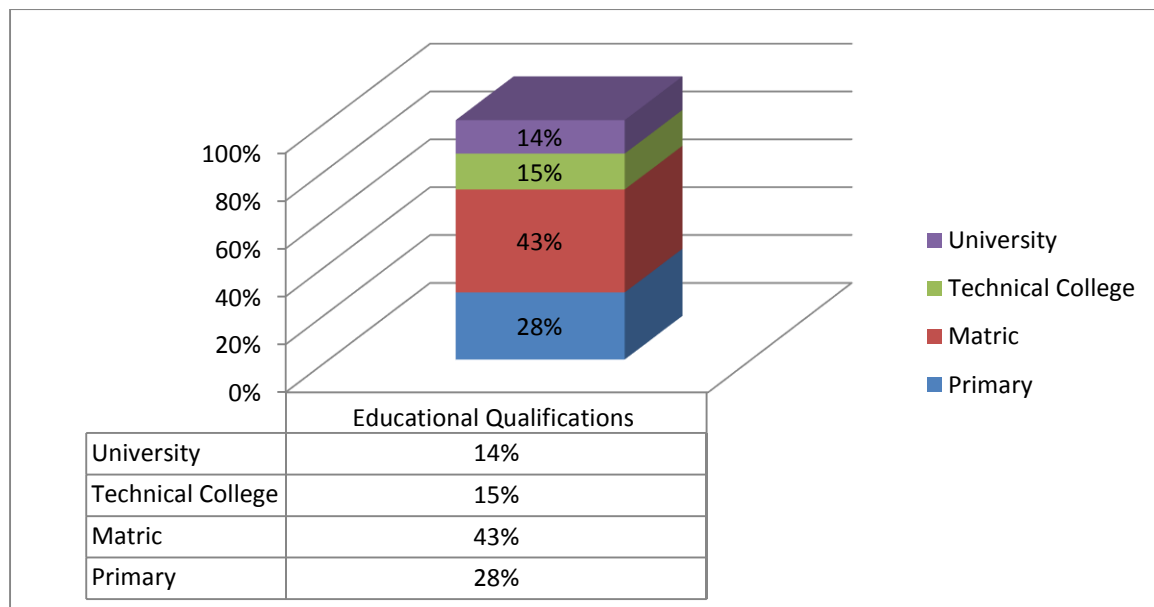
Table 4.16 and figure 4.13 above show the distribution of race in the study. The findings reveal that there were 33 Blacks, 35 Indians, 21 Whites and 11 Coloured respondents in the mini survey. Specifically, these findings demonstrated that more Indians and Blacks are involved in aftercare support systems for recovering drug and substance abusers.

Perhaps, these findings demonstrate the levels of racial attitudes to the drug and substance abuse problem. This may also point to a possibility that the whites and the coloured may harbour the attitude of clients getting whole support from the rehabilitation centres and not from community support.

4.13.1.6. Educational qualifications of respondents

Figure 4.14 below shows the distribution of educational qualifications among the respondents.

Figure 4.14: Educational Qualifications of the respondents



As indicated in **figure 4.14** above, there was a statistical preponderance of matric (43%) as the highest educational qualification amongst the respondents. This was followed by primary certificate holders who constituted 28% of the sample. University and Technical College qualification holders represented 14% and 15% of the sample, respectively. Noticeably, people with basic academic credentials of up to matric were the majority in the sample, thus suggesting that it is largely unskilled and semi-skilled persons who are involved in care giving for recovering drug and substance abusers. This could be because the apparently well-educated and skilled persons are always preoccupied with their careers to be able to spare time to take care of their loved ones in recovery from drug and substance abuse.

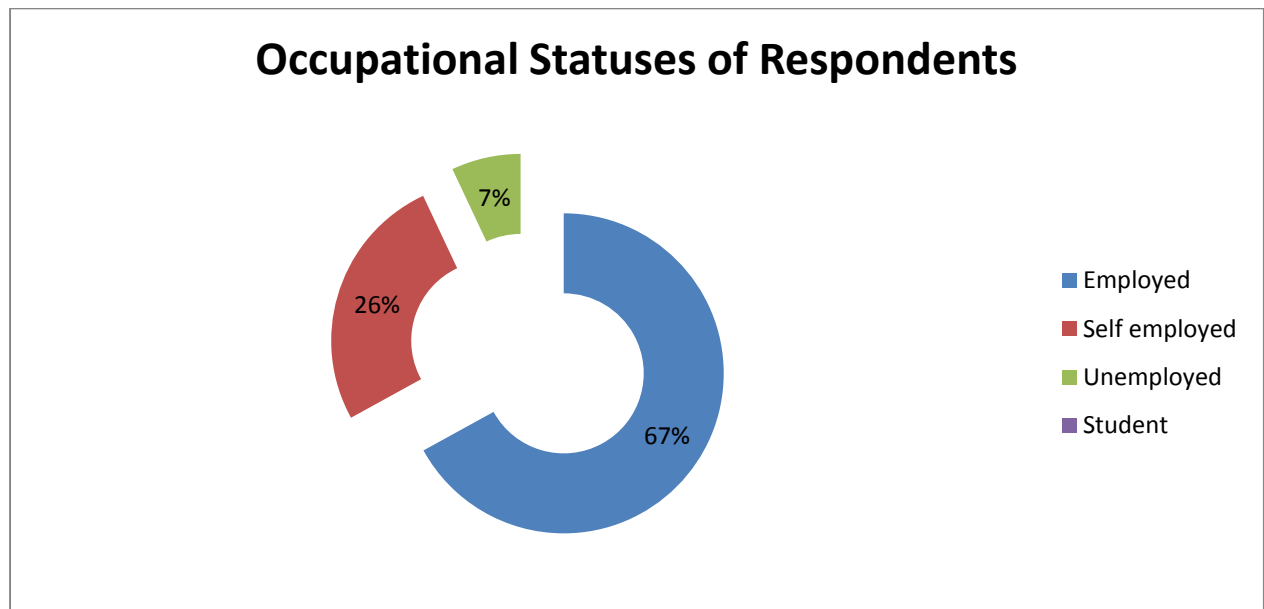
4.13.1.7. Occupational Statuses of the Respondents

Table 4.17 and figure 4.15 below present the quantitative findings in respect of the occupational statuses of the participants.

Table 4.17: Distribution of occupational statuses of mini survey respondents

Employment Status	Frequency	Percentage
Employed	67	67%
Self Employed	26	26%
Unemployed	7	7%
Student	0	0%

Figure 4. 15: Distribution of Occupational statuses amongst respondents



As depicted in table 4.17 and figure 4.15 above, the study found out that out of the total sample of 100 respondents, the majority (67%) were employed in some capacity while another significant proportion (26%) indicated that they were self-employed and a small percentage (7%) noted that they were unemployed and there were no students in the sample.

The high proportion of employed and self-employed statuses recorded in this study is a significant plus to the caregiving predisposition in that, all factors being equal, they are more likely to economically support themselves and their loved ones in recovery from substance abuse. The unemployed caregivers face a challenge in caregiving predisposition as they are not likely to economically support themselves and their loved ones they were taking care of.

4.13.1.8. Income Levels

Table 4.18: Distribution of monthly incomes amongst the respondents

Range	R000-R3000	R3000-R6000	R6000-R9000	R9000- R12000	R12000++
Frequency	29	33	16	13	9

Figure 4. 16: Distribution of monthly incomes amongst respondents

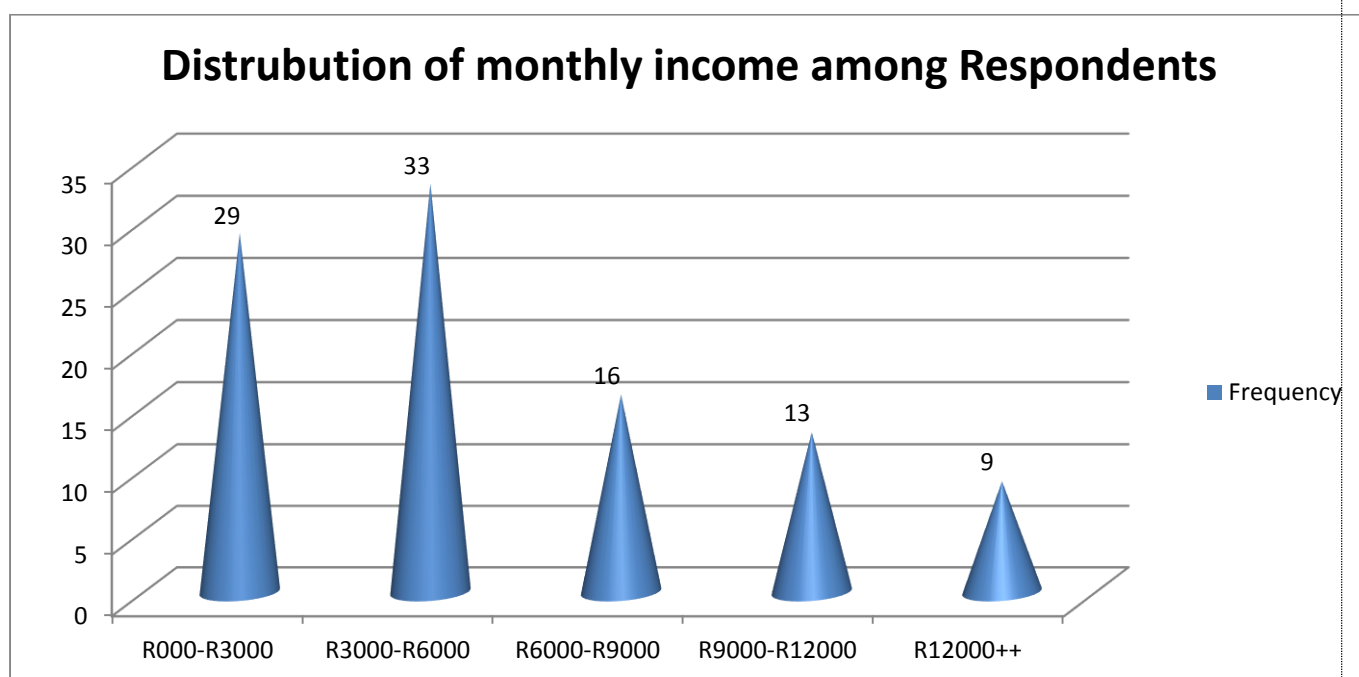


Table 4.18 and figure 4.16 above shows the distribution of income levels among the respondents of the study. Findings show that the majority of the participants fell into low income ranges of between R3000 up to R6000 per month. Precisely, 29% of the participants indicated that their estimated monthly income ranged between R000 to R3000. Another 33% indicated that they earned between R3000 to R6000, while 16% reported that they survived

on between R6000 and R9000 monthly. Additionally, 13% indicated that they fell into the R9000 to R12000 income range while only 9% earned R12000 and above per month.

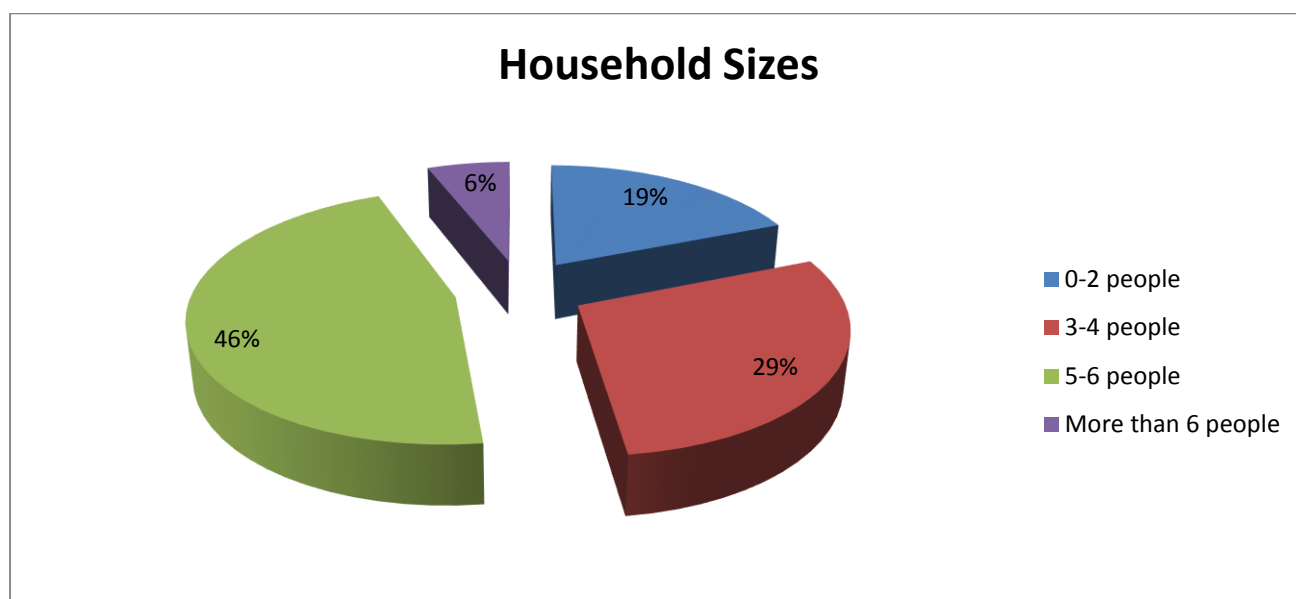
With the majority of the respondents (29% + 33%) earning below R6000 per month, their affordability of aftercare support services for their loved ones is questionable. This points to poor affordability of care services including affordability of recovery maintenance resources.

4.13.1.9. Size of Households

Table 4.19 Household Sizes

Range	Frequency	Percentage
0- 2	19	19%
3- 4	29	29%
5- 6	46	46%
More than 6	6	6%
TOTAL	100	100%
AVERAGE	4.66	

Figure 4.17: Distribution of Household Sizes amongst Mini Survey Respondents



In this study, participants were asked to choose a range which best described the estimated size of their households. It emerged that the average household had 5 to 6 members; while the least recorded that they had 2 members.

These findings as stated in table 4.19 and figure 4.17 above demonstrates that the probability of people from larger households to be taking care of substance abusing loved one is higher compared to smaller households. There is also a probability that larger households due to more emotional, social, economic and financial problems, their members are likely to suffer increased levels of stress prompting many to seek solace in substance abuse, thus rendering them in need of interventions as compared to smaller households.

4.13.1.10. Type of Housing

Table 4.20: Distribution of types of housing amongst respondents

Type of Housing	Frequency	Percentage
Informal houses	28	28%
Formal houses	72	72%

Figure 4. 18: Distribution of types of housing amongst respondents

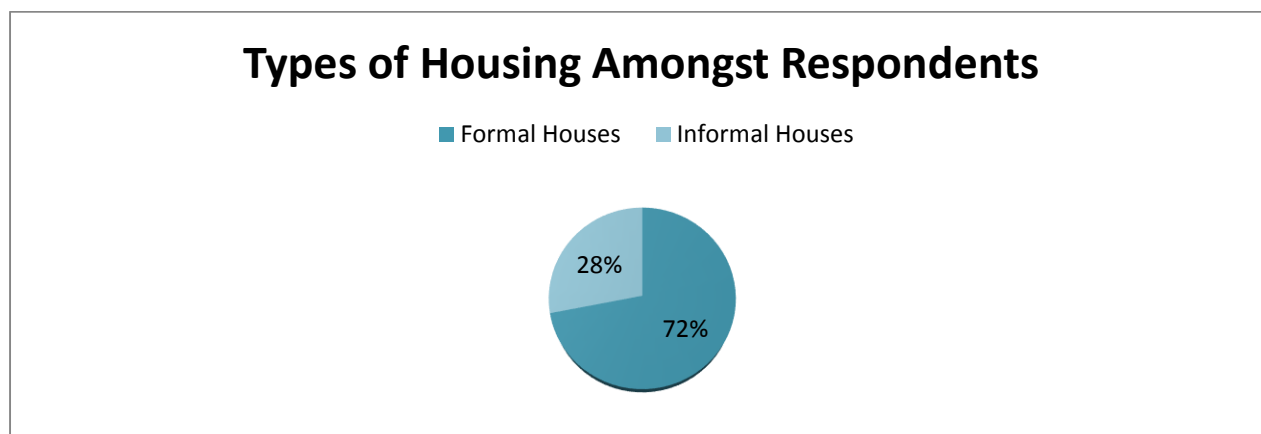


Table 4.20 and figure 4.18 above shows the distribution of housing types among the respondents. The results indicated that almost three quarters of the participants stayed in formal houses while the rest indicated that they stayed in informal houses. More specifically, 72% of the respondents indicated that they were staying in a formal house while 28% indicated that they were staying in an informal house.

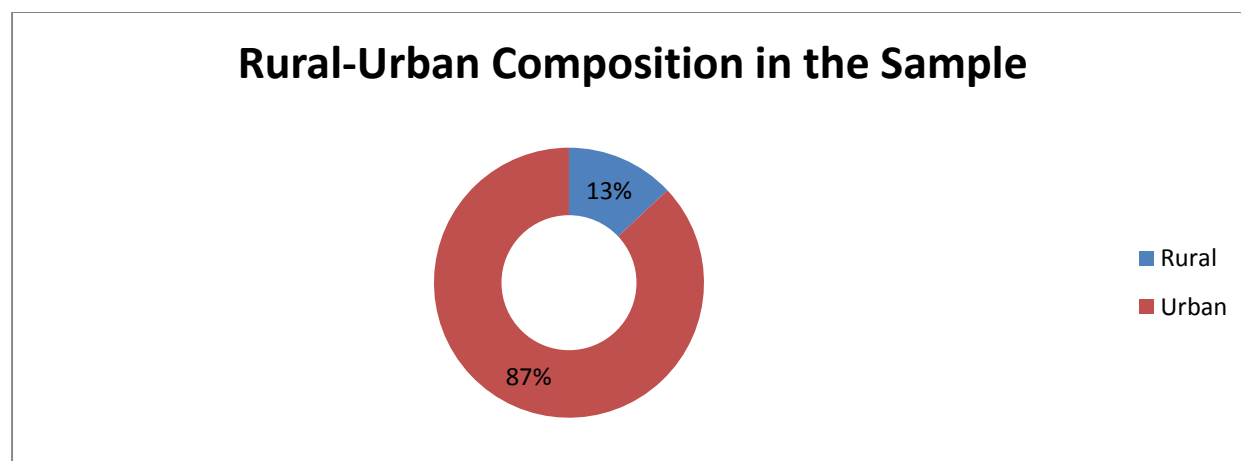
The findings in this category could be explained in terms of the government’s RDP housing initiative which provides decent accommodation for the less privileged. Moreover, perhaps the phenomenon of 28% living in informal settlements which in South African context are those inhabited by the people of low socio-economic backgrounds increases the possibility of more drug abuse in these circumstances.

4.13.1.11. Rural – Urban Population Representation in the Sample

Table 4.21: Distribution of participants between rural and Urban Areas

Rural	13%
Urban	87%

Figure 4.19: Distribution of participants between rural and Urban Areas



As highlighted in **table 4.21 and figure 4.19** above, the statistical preponderance in the research was in favour of urban dwellers in comparison to rural dwellers. 87% of participants indicated that they stayed in an urban area while only 13% indicated that they stayed in rural or farm areas.

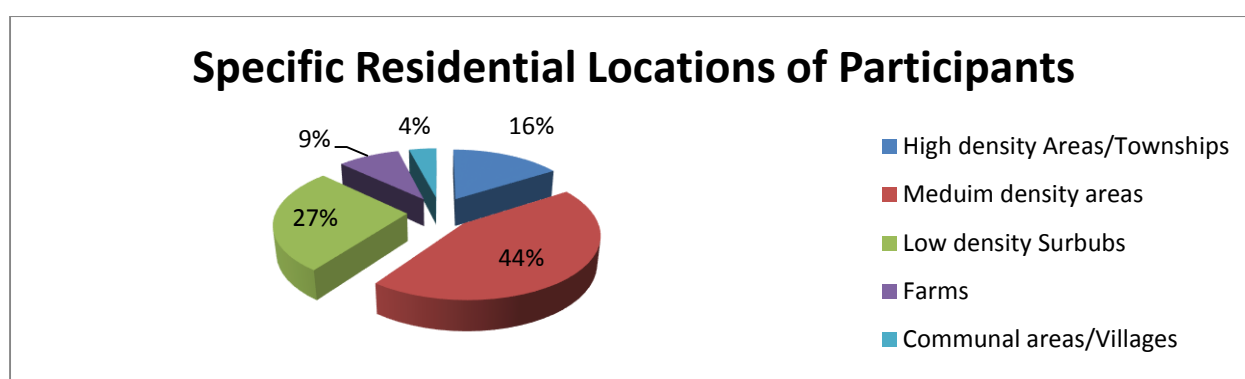
The findings in respect of the rural-urban population representation in the care givers sample of this study provides an indirect reflection of how rural settings are under serviced by rehabilitation centres. Perhaps this is due to poor economic opportunities in rural areas which make rural dwellers unable to afford treatment in rehabilitation centres, hence they remain underserved.

4.13.1.12. Geographical Locations of Respondents

Table 4.22: Distribution of Specific Residential Locations among Respondents

Specific Geographical Location	Frequency	Percentage
High Density Areas/Townships	16	16%
Medium Density Areas	44	44%
Low Density Suburbs	27	27%
Farms	9	9%
Communal Areas	4	4%

Figure 4.20: Distribution of Specific Residential Locations among Respondents



This study enquired about the specific residential location of respondents. Respondents were thus asked to choose their appropriate location among five given options ranging from high density areas (Townships/Kasi) to Communal areas (rural villages). Notably, it emerged that 4% participants stayed in communal areas while 9% came from farms. The majority, 44% indicated that they came from middle density suburbs, 27% indicated that they stayed in low density areas while the remaining 16% chose high density/townships as their specific locations.

The high prevalence of middle and low density dwellers in the findings suggests that substance abuse is increasingly shifting to affecting the middle and high income class communities as opposed to other socioeconomic classes. However, the low prevalence of rural and high density dwellers could be because people from these areas cannot afford treatment in conventional treatment settings, hence they are underrepresented in aftercare

platforms. Usually, rural people prefer traditional methods of treating ailments; perhaps this explains their poor visibility in conventional drug treatment settings.

4.14. Nature and Effectiveness of Drug and Substance Treatment Programmes

4.14.1. Duration Period of Treatment Programmes

Table 4.23: Distribution of Lengths of Drug Treatment Programmes

Program Length	Frequency	Percentage
1-2 weeks	3	3%
2-3 weeks	8	8%
3-4 weeks	33	33%
4-5 weeks	0	0%
5-6 weeks	56	56%
More than 6 weeks	0	0%

Figure 4.21: Distribution of Lengths of Drug Treatment Programmes

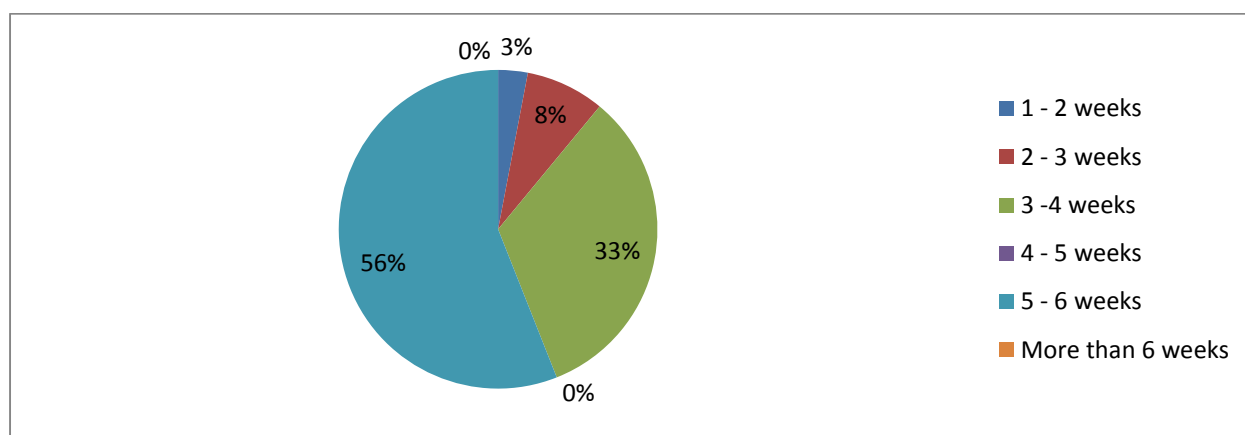


Table 4.23 and figure 4.21 above graphically present the quantitative findings in respect of the question on the duration of treatment programmes in which respondents had admitted their loved ones. While three percent mentioned that their loved ones were treated in one to two weeks programmes, eight percent were treated in two to three weeks programmes. In addition, 33% indicated that they got their loved ones treated in three to four week programmes. There was no one who reported their loved one to have been treated in four to five weeks long programmes. Lastly, 56% indicated that their loved ones attended five to six weeks programmes and there was also no one whose loved one was admitted in a programme of more than six weeks.

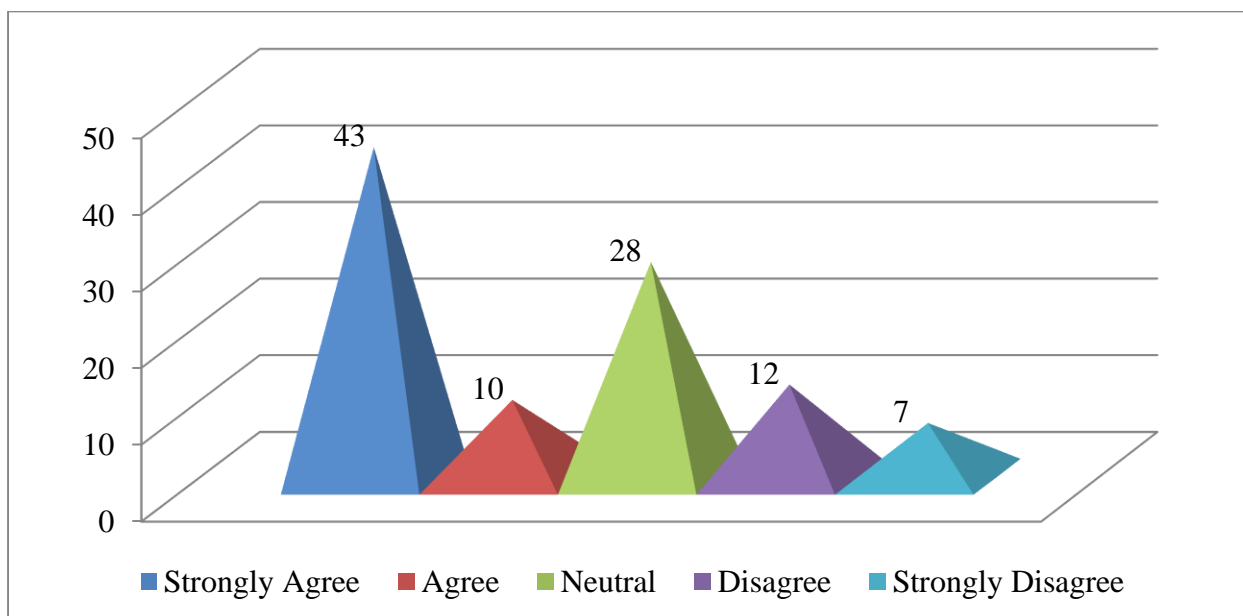
This indicates that most rehabs were treating the clients in both the three to four and five to six weeks programme. This also indicates a relatively good time for interventions to work. While this period, especially the five to six weeks programme was popular and could point to a degree of effectiveness of the programme interventions, it could also point to the time some popular programmes are tailored to take. However, the phenomenon of lesser time the programme took (1-2 weeks, 2-3 weeks) could be a pointer of probability of less intensive interventional programmes and thus low quality interventions. This could also point to a possibility of programme ineffectiveness.

4.14.1.1. Perceptions on the adequacy of Treatment Periods

Table 4.24: Distribution of Perceptions of adequacy of Programme lengths and their Efficacy

Extent of Agreeing	Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	Total
Frequency	43	10	28	12	7	100

Figure 4.22: Distribution of Perceptions of Programme lengths and their Efficacy



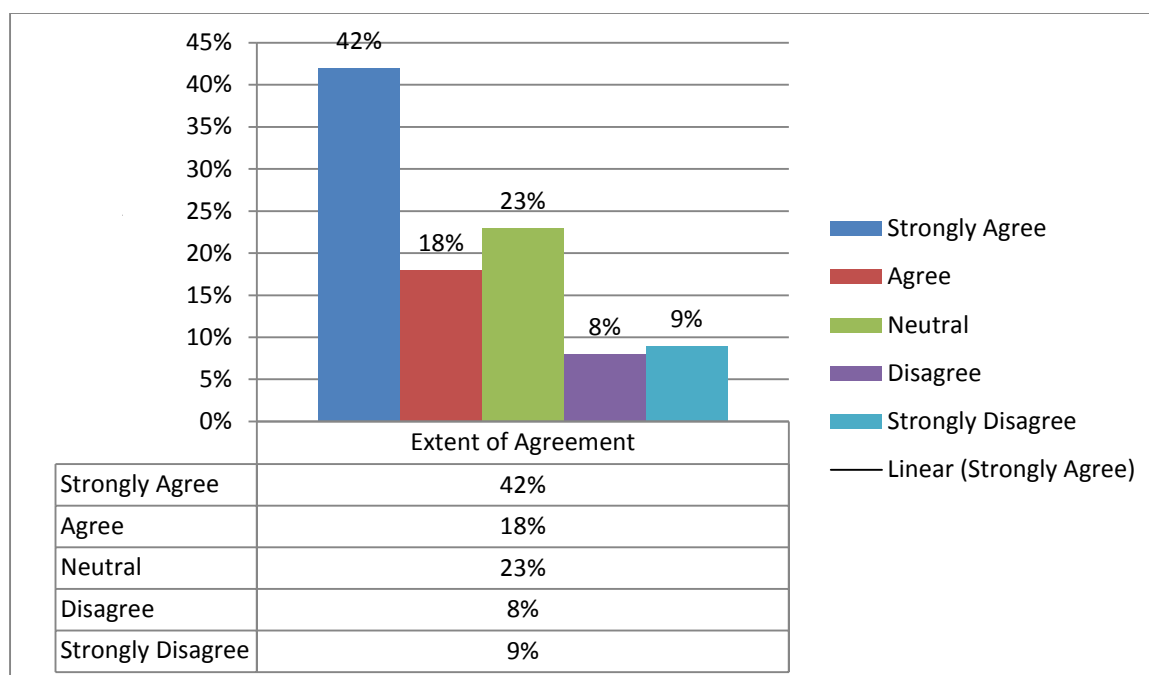
Respondents were asked to share their perceptions on whether the current programmes were long enough to cater for the needs of their loved ones. As shown in **table 4.24 and figure 4.22** above, 43 respondents strongly believed that drug and substance treatment programmes were too short to treat patients effectively. In addition, 10 respondents indicated that they agreed that treatment programmes were too short while 28 chose neutral as their response to the question. Moreover, 12 and 7 respondents disagreed and strongly disagreed, respectively, that the duration period afforded to patients who enter rehabilitation programmes were too short. In other words, they felt that the lengths of available treatment programmes were perfect for their objectives.

The reason why the above half of the respondents believed that the treatment period was too short could be based on the timeframe that their loved ones were in active addiction. Most families suffer emotionally, psychologically, physically and even socially during the active addiction of their loved ones. As such, they expect their loved ones to stay longer in rehab while they also recover from the pain they were put through.

4.14.2. Unaffordability of Drug and Substance Treatment in Gauteng

Participants in the study were asked about their opinion regarding the affordability of the cost of drug and substance treatment in Gauteng. The opinions of the respondents of the mini survey questionnaires are graphically captured in **figure 4.23** below.

Figure 4.23: Perception regarding the affordability of drug treatment costs



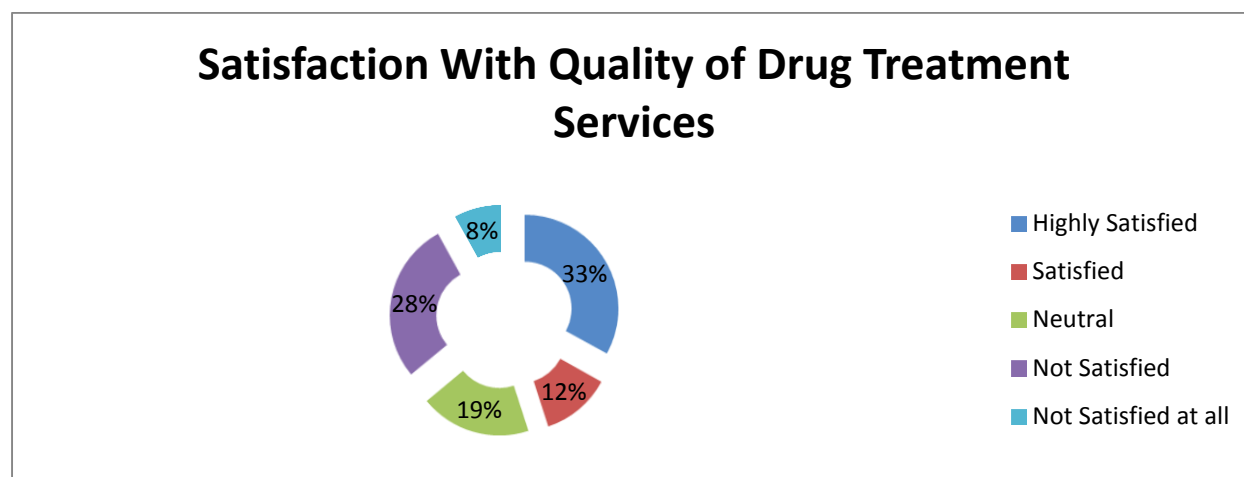
As depicted in **figure 4.23** above, 42% of the mini survey respondents strongly agreed that drug and substance treatment services were expensive, while 18% simply agreed that the cost was too high to be affordable. Furthermore, 23% indicated that they were neutral, meaning they neither agreed nor disagreed that the costs were too high for affordability. In addition, 8% of the respondents disagreed that the costs were unaffordable while another 9% strongly disagreed that the services were expensive at all.

These findings could imply that the majority of people who felt that treatment centres are expensive were sending their loved ones to private rehabilitation centres and those that felt that they were not expensive at all were sending their loved ones to public institutions which are normally free. Most private rehabilitation centres tend to be expensive as they also aim to make profit. In contrast, the considerable percentage of neutral responses could be because, in some instances, the government intervenes and subsidize drug treatment services.

Table 4.25: Rehabilitation services do not resonate with the Value for Money Paid

Satisfaction With Quality of Drug Treatment Services	
Highly Satisfied	33%
Satisfied	12%
Neutral	19%
Not Satisfied	28%
Not Satisfied at all	8%

Figure 4.24: Perceptions on Service quality Satisfaction



When the question of consumer satisfaction and value for money was posed to respondents, the majority responded that they were largely satisfied with the outcomes on their investments in rehabilitating their loved ones. Precisely 33% stated that they were highly satisfied with the result of the rehabilitation process and most of their expectations were met. Another 12% indicated that they were simply satisfied while 19% choose neutral as their response. On the other hand, 28% indicated that they were not satisfied while 8% mentioned that they were not satisfied at all.

The percentage of respondents who were satisfied by services offered to their loved ones during their admission period in treatment centres in relation to the value of the fees were more compared to those who were not satisfied. This finding could have been influenced by the contributions of rehabilitation centres in reforming clients' physiological states and thus giving families' satisfaction for the value of money they paid.

In many instances, drug users enter treatment centres in deplorable physical and psychological states; hence any positive change manifesting among clients is usually welcomed by families as a good indicator and measure value for money.

4.14.3. Contribution of rehabilitation services to positive behaviour and lifestyles change.

Study findings reflected a majority of the respondents agreeing that rehabilitation services did contribute significantly to clients' positive behaviour change and lifestyles. **Table 4.26** below presents findings in respect of behavioural/lifestyle changes amongst recovering drug and substance abusers, as observed and reported by their primary caregivers who participated in the mini survey.

Table 4.26: Observed lifestyle/behaviour change of loved ones

Targeted behaviour/Lifestyle	Frequency of "Yes" response	Frequency of "No" response
Reduced episodes of violence	73	27
Reduced incidences of being arrested by police	61	39
Improved presence at school/work	88	12
Improved School/Work Output/productivity	51	49
Improvement in personal hygiene and self-upkeep	68	36
Reduced need for medical assistance/admission in hospital	93	7
Weight gain	61	39
Improved personal and interpersonal relationships	88	12
AVERAGE	72.875	27.625

As indicated by the findings presented in **table 4.26** above, an average of 72.875 respondents believed that their loved ones displayed some remarkable positive changes in the selected facets of their behaviour/lifestyles. On the other hand, an average of 27.625 indicated that they did not observe any significant behavioural or lifestyle changes after their loved ones were discharged from rehabilitation centres, where they were treated for drug and substance dependence. This provides adequate evidence that rehabilitation centres bring appreciable positive changes to those who receive their services.

4.14.3.1. Reduced Violent Predispositions after Rehabilitation

The study established that the work of rehabilitation centres in Gauteng was aiding the reduction of violent predispositions by recovering persons after treatment. Precisely 73 respondents reported that they noticed significant reductions in violent behaviour in their loved ones after rehabilitation, while 27 mentioned that there was no significant change in the violent component of their loved ones. This indicates that, with increased interventions of the rehabilitation services, Gauteng is likely to reduce violence and its attendant effects including injury, homicide and murder associated with drug and substance abuse.

4.14.3.2. Reduced Criminal Behaviour and Activities after Rehabilitation

Furthermore, the study found out that after treatment in rehabilitation centres, caregivers of recovering substance abusers reported that they had noticed a significant reduction in criminal behaviour amongst their loved ones. Notably, as shown in **table 4.26** above, 61 respondents noted that their loved ones had significantly not been involved in criminal behaviour hence they had not yet had any encounter with law enforcement agents after their discharge from the rehabilitation centres they were treated. On the other hand, 39 respondents noted that their loved ones had not significantly changed in terms of their criminal behaviour and had carried on clashing with authorities even after rehabilitation.

The findings in respect of the reduced criminal tendencies by recovering substance abusers could be as a result of the change in the mind-set of the recovering individuals induced by intensive motivational interviewing and cognitive behavioural therapy provided in treatment centres. The finding gives hope that, with more interventions and possibly an increase in rehabilitation services, the crime rate in Gauteng was bound to record a dramatic decrease.

4.14.3.3. Improved Attendance and Productivity in Primary areas of Production after Rehabilitation

In addition, and as shown in **table 4.26** above, 88 respondents reported significant changes in terms of their loved ones' presence at work/school, while only 12 caregivers indicated that their loved ones had not improved in their attendance of work/school. This gives hope that, with increased interventions in the form of rehabilitation services, school dropout are bound to decline in Gauteng. Moreover, it is possible that with increased interventions, the work output of companies in the Province can improve thereby prompting economic growth.

The respondents were, furthermore, also asked to comment on their loved ones' work/school outputs/productivity. As shown in **table 4.26** above, 51 respondents expressed that there has been observable improvement in the productivity of their loved ones in their areas of primary production and focus while a corresponding 49 indicated that there had not been observable improvement in the productivity of their loved ones after their rehabilitation. Perhaps this was because school and productivity is a slow process and is informed by presence for a prolonged period of time.

4.14.3.4. Drug and Substance Abuse Treatment Promotes Physiological Wellbeing of Recovering Persons

This study established a strong relationship between substance abuse treatment in rehabilitation centres and improved personal hygiene, positive health outcomes resulting in reduced need for medical interventions in hospitals and health weight gain amongst those who received treatment. Notably, 68 respondents noted that they observed some positive changes in terms of personal hygiene and self-upkeep of their loved ones after their treatment in rehabilitation centres; while 36 felt that there has not been any improvement worth mentioning.

Additionally, the study found out that the greatest positive lifestyle change has been recorded in terms of the need for medical assistance and admission in hospitals amongst recovering substance abusers post their treatment in rehabilitation centres. Apparently, 93 of the respondents noted that there has been a significant reduction in need for medical interventions for their loved ones.

On the other hand, only 7 respondents indicated that there have not been significant improvements in terms of the medical needs of their loved ones. In terms of observed weight gain, 61 respondents noted that they had observed healthy weight gain on their loved ones while 39 mentioned that they was no significant weight gain on their loved ones.

The findings recorded above generally indicate that the services of the rehabilitation services contributed significantly to ameliorate different facets of the lives of the addicts, ushering in many positive changes that contributed meaningfully to their social, emotional and physical wellbeing. This proves the bona-fide benefits of the rehabilitation services.

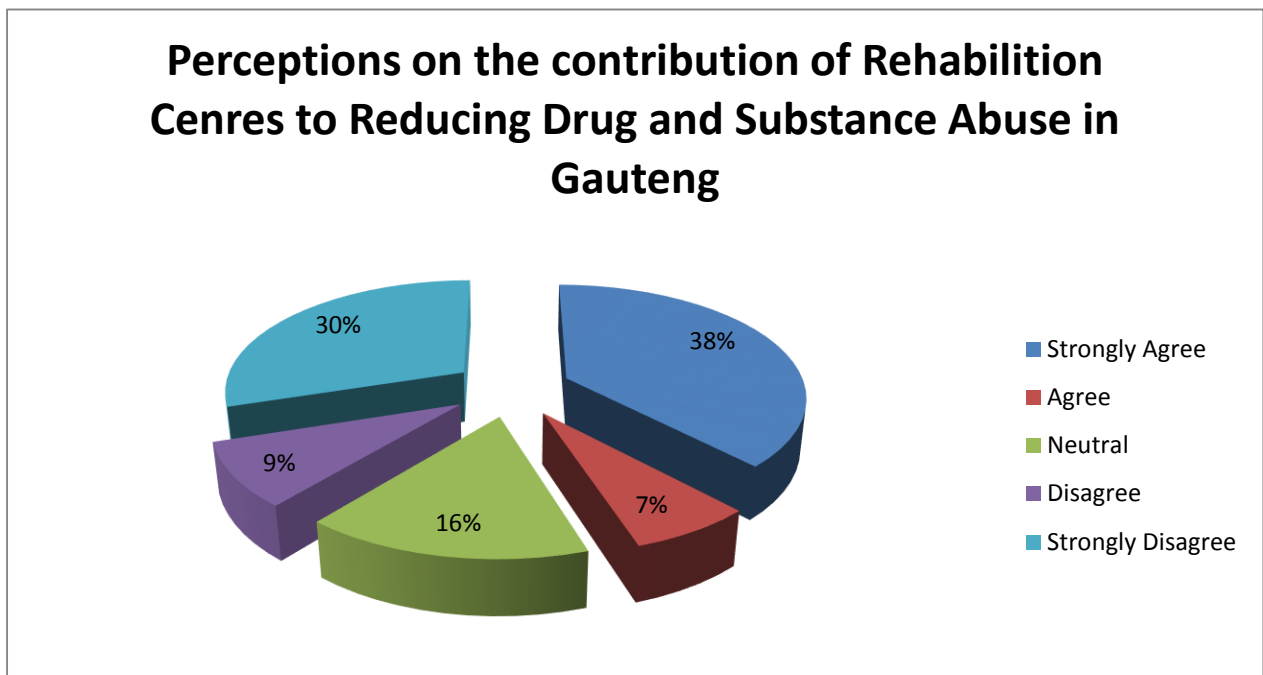
4.14.3.5. Rejuvenation and Development of Personal and Interpersonal Relationships

This research established a strong correlation between admission and treatment in rehabilitation centres and improved personal and interpersonal relationships. Notably, 88 respondents noted that they witnessed a great improvement in their loved ones' personal and interpersonal relationships. On the contrary, 12 noted that their loved ones had not improved in terms of their personal and interpersonal relationships. This is evidence that rehabilitation services contribute immensely to the building of personality that clients lost after falling victim to addiction. This could imply that the clients regain all the consciousness of becoming socially good citizens.

4.14.4. The contribution of Rehabilitation Centres in fighting Drug and Substance Abuse in Gauteng

Figure 4.25 below presents finding regarding the perceptions of the mini survey respondents regarding whether they believed that rehabilitation centres in Gauteng were playing any significant role in the fight against substance abuse in the Province.

Figure 4.25: Perceptions on the contribution of Rehabilitation centres in reducing Substance abuse in Gauteng



As shown in figure 4.25 above, 38% of the mini survey respondents indicated that they strongly agreed that rehabilitation centres were playing significant roles in ameliorating the drug and substance abuse pandemic in Gauteng, while 9% simply agreed. In addition, 16% of the respondents choose neutral as their response to the question. On the extreme, 30% noted that they strongly disagreed, while another 7% simply disagreed that rehabilitation centres were playing significant roles in reducing drug and substance abuse in Gauteng.

With a statistical preponderance of a combined 47% of positive perceptions against 37% negative perceptions, it can be argued that rehabilitation centres in Gauteng are playing a vital role in diminishing the substance abuse scourge in the Province.

The generally positive perceptions found by this research in favour of the contributions of rehabilitation centres in the fight against substance abuse could be because of the observable work of rehabilitation centres in the areas of harm reduction, positive reformation of behaviour and lifestyles of recovering substance abusers, restoration of mental and physical capacity and spiritual awakening. Furthermore, the high numbers of neutral responses found in this study maybe suggestive of the ignorance of people regarding the work of drug and substance rehabilitation centres. On the other hand, the significantly high numbers of respondents who felt that rehabilitation centres were not playing any significant roles in ameliorating the drug problem in Gauteng Province could be because many people are generally frustrated by the difficulty associated with accessing the services of rehabilitation centres due to their exorbitant treatment fees, gender and age biases and their geophysical locations which, in many instances, are difficult to access by public transport.

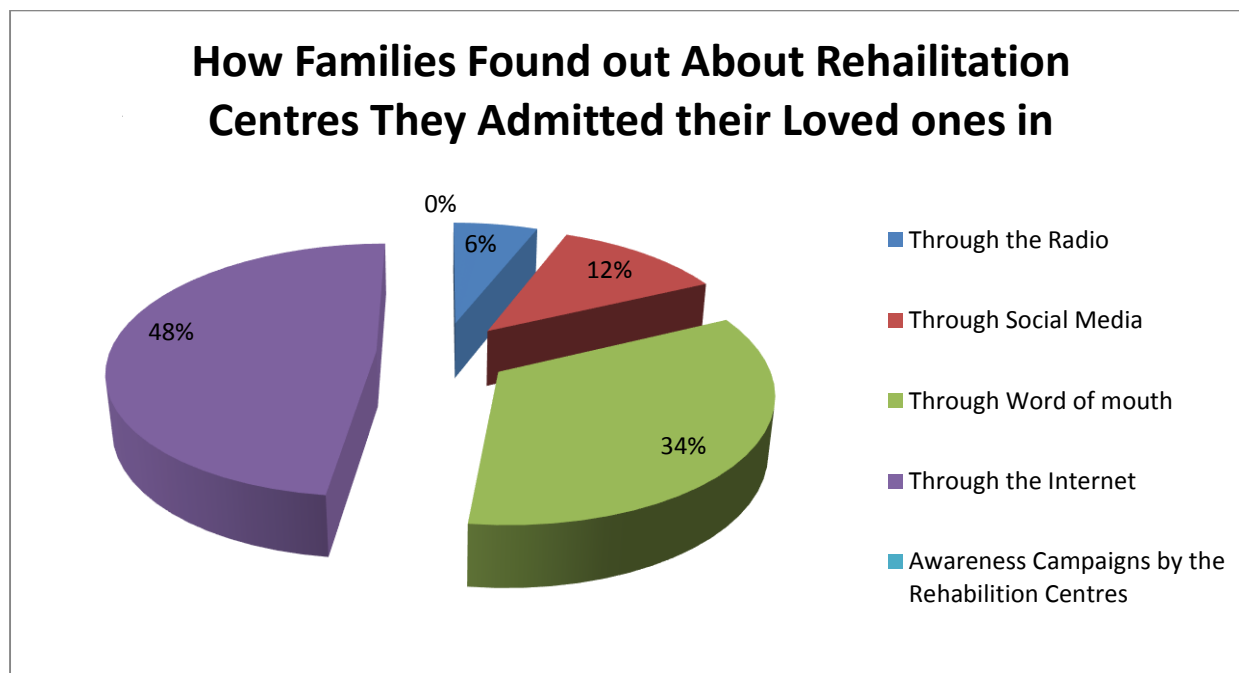
4.15. An Overview of Challenges Associated With Gauteng Rehabilitation Centres

This section of the chapter presents the findings regarding the gaps and challenges encountered by the Gauteng rehabilitation centres as per the perceptions of the mini survey respondents.

4.15.1. Marketing Strategies of Rehabilitation Services by Gauteng Rehabilitation Centres

Figure 4.26 below depicts the findings pertaining to the various communication mediums through which respondents got to know of the treatment centres they got their loved ones admitted.

Figure 4.26: How respondents knew about the rehabilitation centres they admitted their loved ones



As depicted in **figure 4.26** above, 34% of the participants indicated that they knew about the rehabilitation centres where they got their loved ones admitted through word of mouth. In addition, 48% mentioned that they had learnt about these centres through the internet while 12% mentioned that they knew about the rehabilitation centres through social media. Furthermore, none of the respondents reported that they had heard about the centres through awareness campaigns by the respective rehabilitation centres.

Lastly, only 6% of the respondents mentioned that they knew about the centres they sent their loved ones to through their local community radios. This implies that the government, the rehabilitation centres and other drug friendly stakeholders have not done any advocacy and marketing efforts for the message of the availability of the rehabilitation services to reach many potential clients.

4.15.2. Infrastructure as a Hurdle in Gauteng Rehabilitation Centres

Table 4.27: Perceptions on the state of infrastructure in rehabilitation

Do Rehabilitation Centres in Gauteng Display Poor Infrastructure		
Response/Opinion	Frequency	Percentage
Very Poor	17	17%
Poor	19	19%
Neutral	40	40%
Good	15	15%
Excellent	9	9%
TOTAL	100	100%

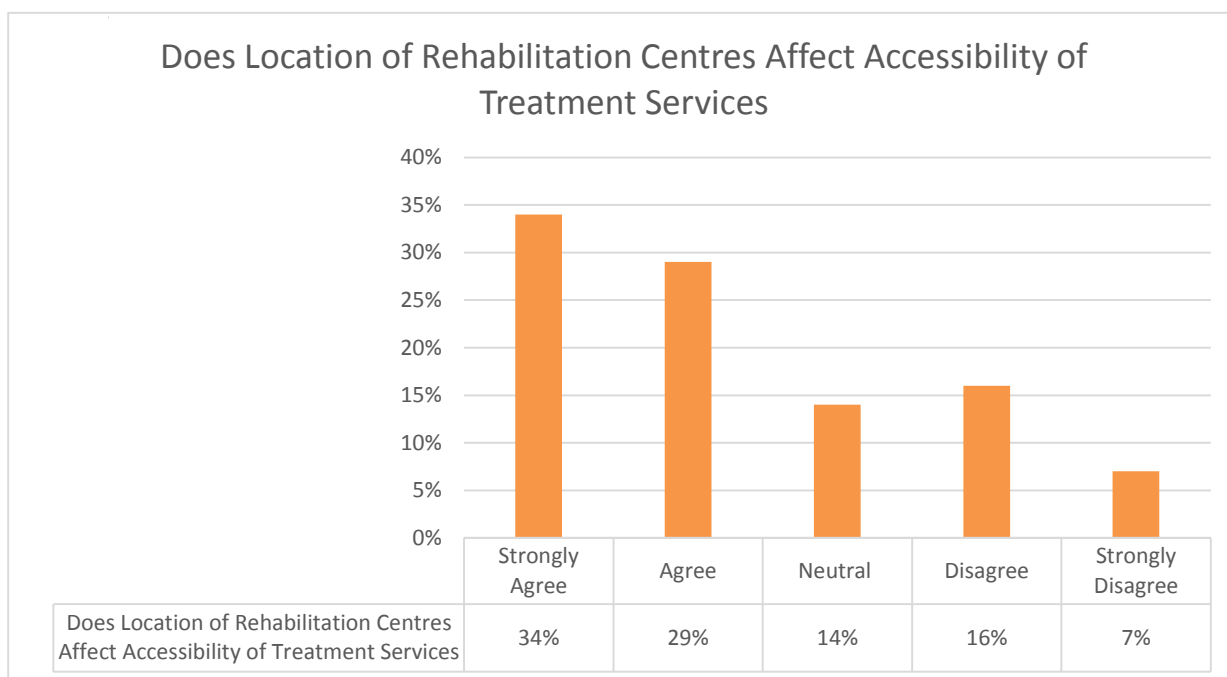
Respondents in this study were asked to comment on the nature and quality of infrastructure in rehabilitation centres they had contact with. As shown in **table 4.27** above, 17% of the respondents indicated that rehabilitation centres they knew about displayed very poor infrastructure while 19% noted that the infrastructure was poor. A staggering 40% of the respondents neither believed that the infrastructure was poor nor good, they choose to remain neutral. On the other hand, 15% indicated that the infrastructure was good and another 9% were adamant that the infrastructure was excellent.

These findings indicate that the percentage of respondents who were not happy with the infrastructure in the facilities to which they got their loved ones admitted was higher than that of those who were happy.

However, findings also showed that a greater percentage of the respondents were neutral, that is, they were indifferent about the infrastructure. The high percentage of respondents who were not happy with the infrastructure at rehabilitation centres could be because the respondents could have been disappointed by the infrastructure, especially after paying substantial amounts and realising that the standards of the facilities were not meeting the value of money they paid. The findings regarding the poor infrastructure in rehabilitation centres possibly points to compromised quality of the services rendered by these facilities.

4.15.3. Geophysical Location of Rehabilitation Centres and their Accessibility to the Public

Figure 4.27: Perception on the effect of the physical location of rehabilitation centres on their accessibility

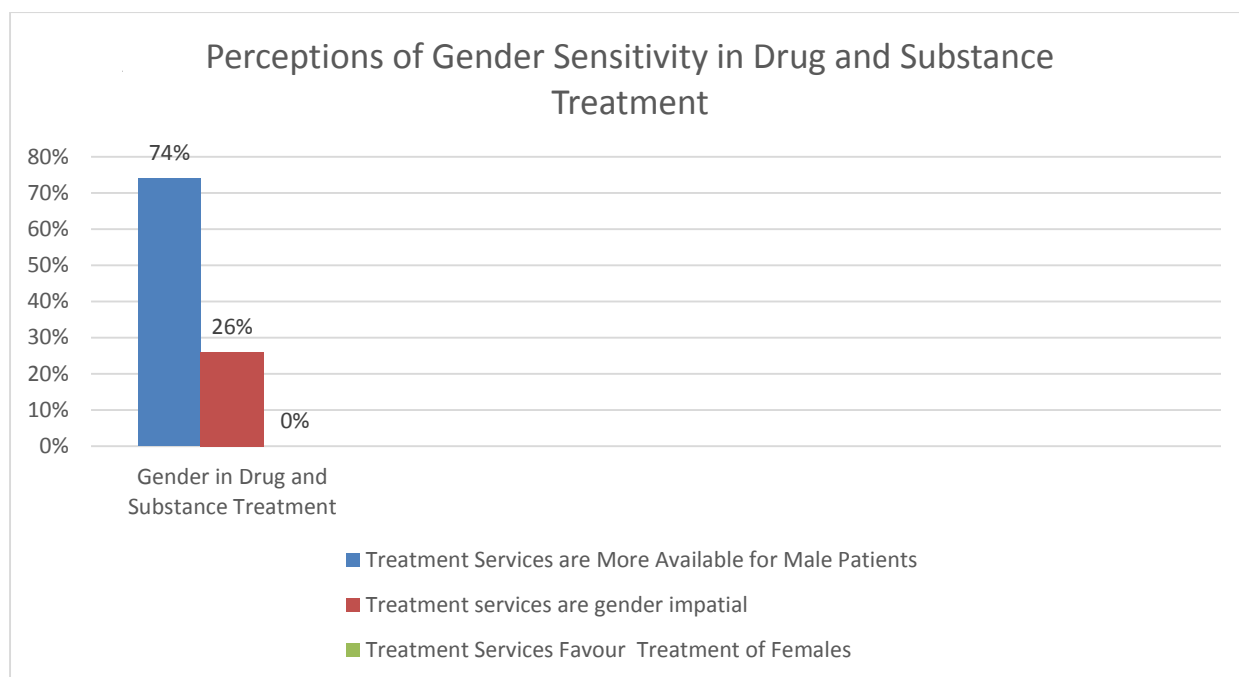


Respondents of mini survey questionnaires were asked whether they agreed or disagreed that the geophysical location of rehabilitation centres were making them inaccessible to some people who require their services. As shown in **figure 4.27** above, 34% of the respondents strongly agreed that the location of rehabilitation centres were affecting the accessibility of drug treatment services. Another 29% simply agreed that the location of the facilities had a hand in the poor accessibility of treatment services. Moreover, 14% of the respondents choose neutral as their response while 16% and 7% indicated that they disagreed and strongly disagreed respectively.

The high prevalence of respondents who believed that the location of rehabilitation centres affects accessibility of treatment services could be because most drug treatment centres are located in remote or highly affluent areas where access to them is only through private transport. This makes the services of these facilities inaccessible to those without private transport.

4.15.4. Gender and Drug and Substance Abuse Rehabilitation in Gauteng

Figure 4.28: Perceptions of gender balance in substance abuse treatment services



Respondents were asked to answer some pertinent questions on how gender dynamics affected the accessibility of drug treatment services in Gauteng. The findings in respect of this question largely confirmed that drug treatment services have a gender dimension which favours the treatment of males at the expense of females. In this regard, of the 100 respondents to the mini survey questionnaire, 74% viewed that drug treatment services were more customized for the treatment of male patients while 26% believed that treatment was available for everyone regardless of gender. None of the respondents believed that drug treatment services mainly favoured the treatment of female patients.

These findings indicate a huge gap pertaining accessibility of rehabilitation services to women in Gauteng. This problem has been identified as one of the reasons stalling the transformation of South Africa along a sustainable drug-free trajectory.

Apparently, the gender gap in drug and substance abuse is fast narrowing, meaning that more women are increasingly becoming in need of rehabilitation services. However, the treatment scales have continued to be skewed in favour of males at the expense of females.

4.15.5. Cost of Drug and Substance Rehabilitation as a Barrier to Accessing Rehabilitation Services in Gauteng

Figure 4.29: Perception on the effect of the cost of drug treatment services on accessibility of treatment

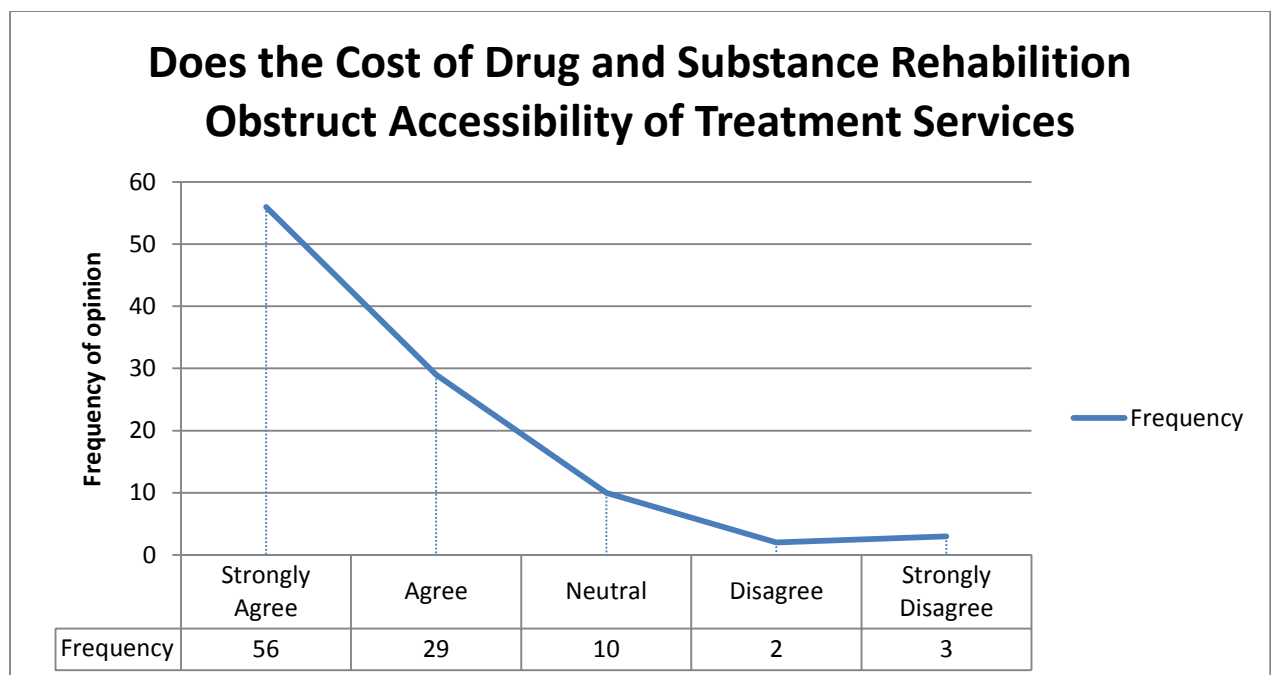


Figure 4.29 above depicts that 56 of the respondents strongly believed that the costs of drug and substance treatment services were obstructing the easiness of accessing treatment by those who required it. In addition, 29 agreed that the costs were a significant barrier in accessing treatment services. Additionally, 10 of the respondents chose to be neutral while 2 and 3 disagreed and strongly disagreed, respectively.

These findings bring to light that the costs of drug and substance abuse treatment hinder most people from accessing treatment. This is probably because most of these respondents have sent their loved ones to private facilities which are expensive.

However, some of the respondents that strongly disagreed and those who simply disagreed probably sent their loved one to government institutions that are free of charge. All in all, the study established that the cost of the rehabilitation services negatively reduced the accessibility of the rehab services.

CHAPTER 5

Discussion of the Findings, Conclusions and Recommendations

“Though no one can go back and make a brand new start, anyone can start from now and make a brand new ending.” – Carl Bard

5.1. Introduction

Three main research questions which addressed the contributions of two selected Gauteng rehabilitation centres were discussed in this study. The questions were: What is the nature and potency of commonly abused drugs in Gauteng which render users rehabilitable? What is the nature and effectiveness of rehabilitation programmes offered by Gauteng Rehabilitation Centres? And what are the institutional and operational gaps associated with selected rehabilitation centres in Gauteng? These research questions formed the bedrock upon which the entire chapter on findings was premised. The current chapter submerges the research findings into the wider context of literature on the work of rehabilitation centres and the general fight against substance abuse, both in South Africa and globally. The chapter will then close off with an exploration of the implications of the study findings for future policy formulation and implementation as well as the general practice of substance abuse treatment.

5.2. Discussion of Research Findings

The data used in this study was collected from a total sample of 138 participants and respondents. The qualitative participants of the study included key informants from the DSD (2), managers of rehabilitation centres (2) and therapists (2) who were subjected to rigorous interviews. Furthermore, the study gathered its qualitative data from 4 focus groups which cumulatively had 32 participants.

Lastly, a mini-survey using 100 questionnaires was conducted with the primary caregivers of recovering drug and substance abusers. The study was conducted using the methodological triangulation approach. The mixed methods of data collection used in the study led to the accumulation of both quantitative and qualitative results which are discussed in this chapter.

5.2.1. Biographical Information

5.2.1.1. Characteristics of Representatives from the Department of Social Development

The findings of the study regarding the biographical profiles of the DSD representatives revealed that they were young unmarried females. In terms of their professional standing, it was noted that both participants had a bachelor of social work degree as their highest academic qualification and they also had an average of 4 years' work experience.

The above noted findings carry some strong and pertinent messages regarding the government's work on drug and substance abuse prevention and treatment. The generally shallow work experience exhibited in the sample of the DSD representatives, who were in the leadership of the supposedly high priority segment of the DSD dealing with substance abuse, raises some pertinent questions regarding the capacity of the DSD to sustainably deal with the exploding substance abuse problem in the country. Moreover, with only a bachelor's degree as their highest academic qualifications, it is possible that these DSD staff members lacked the depth and craftiness required in driving programmes and projects of this magnitude and importance.

These findings seem to resonate and vindicate the Department of Labour's (2012) assertion that there is a growing human resource lacuna in many government Departments, caused by the toll of HIV/AIDS, which is wiping away experienced personnel, and thus exacerbating inefficiencies in public service delivery systems.

However, the finding that participants in this category were generally young (below 31 years) inspires hope for long-term stabilization of the work geared towards ameliorating substance abuse in the country. Employment of young people has been found to promote tactical, operational and strategic planning in organizations (Checkoway, 2011; Nabben & Hill, 2004). Checkoway (2011), Nabben and Hill (2004) further contend that while young people might not have requisite skills for a job in the short term, they have a chance to learn and perfect their skills, thereby making fresh contributions and will be able to work for longer periods before retirement. Additionally, young people tend to have wide and current experiences and knowledge of current affairs and technologies which could help to enhance efficiency in service delivery. On the contrary, this is not always a compliment in that, as the International Monetary Fund (2016) points out, young people have been found to be more likely to engage in corrupt activities which undermine service delivery.

5.2.1.2. Biographical Profiles of Rehabilitation Centre Managers

The findings of the study established that the 2 managers of the selected rehabilitation centres were both males, both of mature age; and were married. Moreover, the study revealed that institutional managers of the selected rehabilitation centres had weak academic qualifications which bring to scrutiny their capacity to run these strategic facilities. Furthermore, it was established that the managers had spent very long periods of over a decade managing their respective facilities. Apparently, the management of social service entities requires some crucial operational and administrative knowledge to ensure efficient running of these facilities for the benefit of service consumers (Department of Labour, 2012). Considering that the drug treatment sector in South Africa has for a very long time been battling with funding problems, having rehabilitation centre managers without substantive financial skills necessary for seeking funding and managing available funds in a sustainable manner, defeats the contributions of these facilities. Jules- Macquet (2015) underscores the fact that financial sustainability remains one of the pressing challenges for many non-governmental entities.

On the bright side though, the finding that both managers of participant institutions had on average spent 14 and half years at the helm of their respective institutions, on the one hand, can be a blessing if these managers can be proved to be visionary, effective and embrace a high degree of efficiency. But viewed from the other side of the coin, the phenomenon also presents a possibility of poorly articulated succession policy in these facilities. Most probably, this presents the risk of recycling and propagating old, redundant and ineffective approaches which could, subsequently, be undermining the contributions of rehabilitation centres.

Rothwell, Jackson, Ressler, Jones, Brower (2015) argue that some organizations lack a clear succession policy such that one person runs the organization as a personal property. This tends to create and perpetuate a culture of preservation of orthodox and, at times, ineffective ideas which no longer resonate with the prevailing social, economic and technological advancements.

5.2.1.3. Biographical Characteristics of Therapists Working in the Rehabilitation Centre

The biographical profiles of therapists who participated in this study revealed that the participants were middle-aged with their ages averaging 38 years, and were both married. In terms of their academic and professional standing, both therapists had qualifications in social work, with one having a Master's degree in social work, while the other had a general bachelor of social work degree. The study further elucidated that the therapists had limited work experience in substance abuse treatment (2 and 3 years), respectively.

The age profiles of the therapists in the selected rehabilitation centres portrays a good picture of mature adults who can be able to objectively conduct effective counselling sessions with clients of diverse social and economic backgrounds. However, their somewhat brief work experience (three and two years) in the field of substance abuse suggests that these professionals might not be equal to the task at hand.

This may be supported by the CASW (2016) which posits that experienced therapists are a key resource in substance abuse treatment as they are the ones who provide direct treatment services to clients. In this light, Bartlett, Brown, Shattell, Wright and Lewallen (2013) aver that well-trained, compassionate, and versatile therapists are crucial for instilling confidence into the rehabilitation process. Without confidence in the capacity of the therapist to provide competitive services, drug users may become resistant and may not open up easily.

On the other hand, Azim, Bontell and Strathdee (2015) argue that drug and substance abuse is a multifaceted problem whose causes and attendant effects are dynamic, thus requiring holistic interventions. In this light, the presence of social workers as the only professional therapists in the rehabilitation centres means that clients whose problems require specialized skills and interventions, such as those who suffer from comorbid disorders, would possibly not get the necessary help they deserve. Perhaps this vindicates Setlalentoa, Ryke and Strydom's (2015) assertion that, in South Africa, there is a critical shortage of specialized substance abuse treatment professionals.

5.2.1.4. Biographical Characteristics of In-treatment focus Group Participants

The findings of the study indicated that the majority of the in-treatment focus group participants were males who constituted close to 69% of the sample, while females constituted the remaining 31%. In terms of their marital statuses, the research found out that there was a statistical preponderance of the divorced (25%) and separated (31.25%) marital statuses. Additionally, the study showed that, in terms of their ages, the majority of in-treatment focus group participants were aged between 21 up to 30 years (81.25%). Academically, the study also found out that the majority of the in-treatment focus group participants had post-secondary school education with those with matric/high school recording 25%, technical college qualifications 31.25%, university (bachelor degree) (18.75%) and university (post graduate) (6.25%).

The least educational qualifications were recorded amongst primary and secondary school certificate holders who represented 12.50% and 6.25%, respectively. Lastly, in terms of their occupational statuses, the study found out that the majority were unemployed.

An overview of the biographical characteristic of the in-treatment focus group participants above paints a dual gloomy picture. The finding that very few young people below the age of 20 were represented in the study suggests a general attitude of ageism in the distribution of drug treatment services in Gauteng. Furthermore, the research participation showed a skewed gender pattern in favour of male drug users, this elevates the need for gender blind approaches in dealing with the challenge of drug abuse and rehabilitation thereof. To this end, Atkinson and Sumnall (2016); Azim, Bontell and Strathdee (2015) note that the gender gap between males and females in substance abuse is fast narrowing and therefore implying a greater need for governments across the globe to design gender blind treatment models to bridge this gap.

Of greater concern was the finding that it was largely young adults (21 to 30 years) who were populating the selected drug treatment centres. Not only is this age cohort crucial because of potential economic contributions they ought to be making to the national economy, but these young people could be young parents bearing the care giving responsibility of their own children. According to Granfield and Cloud (1996), the indulgence of young people in substance abuse causes despondence and leaves a trail of suffering not only for the drug users themselves, but also for those living in their environments.

Additionally, the finding that the majority of the in-treatment focus group participants had post-secondary school qualifications leaves a lot to be gleaned from the situation. It is apparent that the drug abuse phenomenon is slowly gravitating towards affecting the learned. This could be a new dynamic in the substance abuse landscape in South Africa and perhaps presents a contrary picture to that usually presented by the available literature that it is largely the uneducated people who hugely abuse drugs (Nasir, Khan & Tabassum, 2015).

Perhaps embracing this new phenomenon and using these educated drug users to launch a new and reinvigorated campaign against drug abuse could be a visionary endeavour. In their study, Ebersole, Miller-Day and Raup-Krieger (2014) found that using new contingencies including finding new and appealing mediums to carry the anti-drug abuse message could possibly change its outcomes.

5.2.1.5. Biographical Profiles of Aftercare Focus Group Participants

The findings of the study regarding the biographical profiles of aftercare focus group participants illuminated that more males than females frequented the aftercare support systems. It was also proven that people who use the services of aftercare support groups were largely married and employed or self-employed. Lastly, in terms of their academic profiles, the study revealed that the majority of users of aftercare support services had tertiary education.

The findings of the study cast a positive light on the work and contributions of rehabilitation centres in the fight against substance abuse. Firstly, the finding that there was a statistical preponderance of those who were married in the sample of aftercare focus group participants suggests that the selected rehabilitation services were helping their clients to reconstitute their social systems. This can be directly contrasted with the picture painted by the marital status of in-treatment focus group participants which indicated a preponderance of 'divorced' statuses.

This might indicate that drug users enter treatment circles with broken relationships and exit with amended relationships or the capacity to establish new relationships. This perhaps speaks to the contribution of rehabilitation centres. Moreover, the finding that more males than females were receiving aftercare support services upholds Myers and Perry's (2005) assertion that drug treatment and general mental health services are still to percolate the patriarchal societies of many developing countries.

Additionally, Peltzer et al., (2010) posit that if the gender discrepancy in substance abuse treatment is not addressed, it might be impossible to meritoriously ameliorate the drug problem. This is so because available research evidence attests that, increasingly, more women and girls are being ensnared into the cobweb of substance abuse (WHO, 2015; Peltzer, 2010).

Furthermore, the general finding that aftercare focus group participants were mostly employed or self-employed echoes the findings of Dunigan's et al., (2014) research which established a strong co-relationship between substance abuse treatment and improved economic conditions attributable to income generated from employment or self-help activities.

Another significant but mystifying finding of the study pertained the finding that the majority of the participants had tertiary academic qualifications as their highest academic achievements. This finding could suggest that substance abuse is gravitating towards encompassing the well-educated members of the society. However, this presents a great opportunity to enhance the contributions of rehabilitation centres as Jiloha (2009) underscores the fact that it is easier to treat educated drug users as compared to those who are not educated.

5.2.2. Biographical Profiles of Mini-Survey Respondents

5.2.2.1. Gender Distribution in Substance Abuse Caregiving

The study succinctly established that the majority of the mini-survey respondents were females (58%). This finding is also displayed in Kang'ethe and Manomano's (2015) study which found out that women in Africa are more involved in the palliative care for their ailing loved ones. Kang'ethe and Manomano (2015) posit that, in many African cultures, women are viewed as vessels of love, compassion and care and, hence they often bear caregiving responsibilities to sickly members of the family and the community at large.

This finding presents dual implications and possibilities to the goal of ameliorating substance abuse in South Africa and, more precisely, in Gauteng Province. Firstly, the fact that fewer males were involved in the caregiving process deals a fatal financial and moral blow to substance abuse rehabilitation. James, Boyle, Bennett and Bennett (2012) articulate that men remain the main financial, health and social proprietors in their households. Therefore, their conspicuous absence in caregiving circles could imply that the recovery process of substance abusers could be financially, socially and morally hamstrung.

On the other hand, the preponderance of women in caregiving circles raises the prospects of growing the social capital necessary for stimulating sustainable recovery amongst drug users. Notably, the phenomenon of women as caregivers is hailed by Kang'ethe and Manomano (2015) who underscore that women are excellent caregivers whose love, care and dedication is crucial and stimulating to the recovering person. This raises the possibility of harnessing women as community-based caregivers to recovering substance abusers. This could, significantly, aid the work of rehabilitation centres in driving the goal of ameliorating substance abuse in Gauteng and South Africa.

5.2.2.2. Marital Statuses of Substance Abuse Caregivers

The study revealed that there was a strong relationship between broken marriages and substance abuse caregiving responsibilities. The research indicated that the majority of the caregivers were widows (32%), divorcees (27%), and those who were separated (23%). This finding can be validated by a study by McCarroll's et al., (2016) which identified broken homes as fertile grounds and a huge contributing factor for substance abuse. Similarly, James, Boyle, Bennett and Bennett (2012) found out that the process of marital disintegration causes a lot of emotional, social and, in some instances, physical distress which might cause either of the divorcing parties or the children to resort to substance abuse to numb the pain associated with the breakdown of relationships.

Fortunately, this study found out that rehabilitation centres were providing family therapy sessions to help with marital problems that might impinge on the success of recovery for substance abusers hailing from broken homes.

5.2.2.3. Age as a factor in caregiving associated with substance abuse

Another important finding of this study was that the caregiving responsibility for recovering substance abusers was largely borne by middle and old aged persons. Specifically, 52% of the caregivers were aged between 30 and 35 years while those who were aged above 35 constituted 22% of the sample. This finding is not unique to this study as it is echoed in Wallace's (2013) findings which identified that middle and old aged persons were mainly involved in administering and supervising their loved ones who were on methadone maintenance programmes in the USA. Remarkably, James et al., (2012) mention that substance abusers have a tendency of being deceitful, manipulative, and conspiratorial, hence the need for mature, well-groomed and vigilant caregivers who can be firm and unflinching in their caregiving.

5.2.2.4. Caregiver to Recovering Substance Abuser Relationships

The study established that in terms of caregiver-recovering substance abuser relationships, it was mainly parents (mothers and fathers) who were involved in providing care for recovering drug and substance abusers. This finding suggests that drug users who are without the support of their natural families might lack requisite support after rehabilitation and this might undercut their chances of retaining their recovery and, therefore, unsettle the contributions of rehabilitation centres. Singh (2016) poignantly mentions that criminal offenders and, by extension, substance abusers who exit treatment facilities are often dumped into hostile communities where they hardly get adequate support and opportunities to prove themselves. Perhaps, rehabilitation centres and the government need to rehabilitate the social environments into which recovering substance abusers are ushered after treatment.

Singh (2016), for example, is critical of how society and government take a back seat role in helping rehabilitated persons to find their place in communities after treatment.

5.2.2.5. Racial attitudes and involvement in substance abuse caregiving

The findings of this study proved that caregiving responsibilities and involvement in Gauteng aftercare support forums had a racial dimension. Notably, the study found out that more Indian and Black people were involved in caregiving for recovering substance abusers as compared to White and Coloured people. Wallace (2013) attributes this disparity to varying cultural beliefs.

He notes that in nuclear family-oriented cultures such as that of White people, the individual supports themselves firstly and when they fail, the nuclear family will then intervene. On the other hand, James et al., (2012) propound that in cultures where extended families are prioritised; a wider network of support is often available for the individual in times of distress. This finding suggests the need for rehabilitation centres, when packaging their anti-drug awareness campaigns, to address embedded racial attitudes towards promoting easy reintegration for recovering substance abusers after treatment. This will significantly improve the long term contributions of rehabilitation centres to the goal of ameliorating substance abuse in Gauteng and possibly in South Africa.

5.2.2.6. Poor Academic Qualifications amongst Caregivers of Recovering

Substance Abusers

Educationally, the study underscored that caregivers of recovering substance abusers had lower academic qualifications with the majority having matric (43%) and primary education (28%) while a combined 29% had tertiary education (university (14%) and technical college (15%). These findings can be justified by similar findings found by Mehl-Madrona and Mainguy (2014) whose research established that the majority of primary caregivers display poor academic achievements. This finding has multiple inferences when read in the context of the fight against substance abuse.

Initially, poor academic qualifications point to a possibility that the caregivers lacked the capacity to dispense high standard services as a result of them failing to understand addiction and this might result in high relapse rates, thus undermining the contributions of rehabilitation centres.

Furthermore, this finding has resonance with Jiloha's (2009) assertion that poorly educated and scantily trained community-based substance abuse and mental healthcare caregivers complicate the recovery process of their patients. Perhaps, this calls for rehabilitation centres to invest in training community-based coaches to facilitate post treatment caregiving to recovering substance abusers.

5.2.2.7. Occupational Status and income Ranges of Caregivers

Although the research established that the caregivers were predominantly employed or self-employed, the study demonstrated that these employment statuses were not necessarily translating to higher incomes as the majority (62%) of the respondents were earning less than R6000 per month. Swendsen et al. (2010) opine that it is regrettable that most of the people who bear the noble task of caregiving to persons suffering from mental health and substance abuse are often in poorly remunerated jobs which hardly allow them to carry out their caregiving responsibilities with dignity and sincerity.

5.2.2.8. Rural–Urban Dichotomy in the Distribution of Substance Abuse

Caregiving

The study confirmed that most of the caregivers were domiciled in urban areas (87%) while the balance (13%) hailed from rural or farm areas. This finding indirectly points to the biased distribution of substance abuse treatment services in South Africa. Peltzer et al., (2010) poignantly mention that rural populations are often overlooked when it comes to social services and this exposes them to fatalities which could be averted if services are availed to them.

Perhaps the low presence of rural dwellers in the caregiving for recovering substance abusers could be attributed to the fact that their loved ones were not receiving treatment in rehabilitation centres, and, for this reason, could not be meaningfully represented in caregiving settings. If the goal of ridding South African society of drugs is to be realised, however, it is imperative to provide an equitable distribution of drug treatment services in both rural and urban settlements.

5.3. Extortionate prices of rehabilitation services cuts their accessibility

One of the main findings of this study was that substance abuse rehabilitation was an extortionate process that made treatment largely inaccessible to the vulnerable groups in the society. The study indicated that the selected rehabilitation centres were charging a minimum of R20 000 for a period of 6 up to weeks. The study also proved that there were very few public rehabilitation centres which offered free treatment services to the public and access to them is highly competitive, resulting in applicants to these facilities having to endure long waiting lists before they could be admitted. This finding is similar to what Saah (2005) found in his study on harm reduction strategies for promoting the welfare of mental health patients in Africa. The study indicated that in many parts of Africa, mental health patients who deserved to be institutionalized could not do so because of critical shortages of facilities to absorb the surging demand. Ironically, despite the national vision of ameliorating substance abuse in the country, Myres and Parry, (2005) mention that there are provinces in South Africa without public drug treatment centres or halfway houses. Regrettably, with the continued economic slump in the country, the unavailability of free or, at least, affordable drug treatment services in South Africa could remain an albatross around the success of efforts geared towards ameliorating the drug problem in the country. If the contributions of rehabilitation centres are to be anything worth mentioning in the fight against drug and substance abuse, it is then imperative that rehabilitation centres start to devise means of reducing their treatment fees to ensure that they are in sync with the prevailing economic situation in the country.

5.3.1. Location of rehabilitation centres as a deterrent to accessibility of rehabilitation services

The geophysical location of participant rehabilitation centres suggests a proclivity of rehabilitation centres being located in remote, outskirts, plots/farm areas or at the centre of affluent urban areas. These findings resonate with Peltzer's et al., (2010) findings that due to the location of rehabilitation centres in areas which are difficult to reach, their services are often inaccessible. Similarly, Myers and Perry (2005) add that being located in farm areas where the condition of the roads require certain type of vehicles makes it impossible for some people without these special vehicles or transport to access treatment from rehabilitation centres located in such areas. The same scholars propound that in affluent urban areas, it is often difficult to get public transport and, as such, poor people who do not own private transport remain disenfranchised from accessing treatment in these areas.

The situation painted above demonstrates that the contributions of rehabilitation centres were being undermined by their geophysical locations which are largely inaccessible to some sectors of society. The Canadian Centre on Substance Abuse (2012) poignantly states that many drug users often navigate an array of disconnected services, most of which are not easily identified and located. In this context, the Canadian Centre on Substance Abuse (2012) proposes the adoption of systems thinking in the design, location and delivery of substance abuse treatment services. This implies emphasizing on connecting fragmented or disconnected parts of the system, towards identifying and closing gaps. In the context of this study, systematic thinking implores the government to put into place land planning laws that govern the location of rehabilitation facilities in a manner that demonstrates the purported pro-poor stance often indicated in many public policy documents.

Both the qualitative and quantitative components of this study confirmed that rehabilitation centres were scantily marketing their services to the public. Regrettably, the study established that in addition to the message of the availability of drug treatment services not being adequately disseminated, participants of the study felt that the advertisement that was

being disseminated was mostly done on affluent and largely inaccessible platforms, mainly the internet. This was read by some participants as a deliberate strategy by rehabilitation centres to attract international and overseas clients at the expense of local people. This finding mirrors the contention by UNODC (2010) that argues that one of the main challenges militating against and undermining the impact of social service programmes in many developing countries is the issue of the poor marketing of services to their intended beneficiaries. Moreover, the finding that the advertisement of substance abuse rehabilitation services on the internet was cutting their accessibility seems to have resonance with Nyirenda-Jere and Biru's (2015) assertion that despite the increasing penetration of internet services in Africa, the majority of the rural and the urban poor are yet to enjoy this life changing service due to exorbitant internet data costs and lack of requisite gadgets to access the internet. To compound this, Nyirenda-Jere and Biru (2015) articulate that internet data charges in South Africa are still unacceptably high when compared to the rest of the world.

The gravity of this finding to the task of ameliorating substance abuse in South Africa, and more specifically Gauteng, is daunting. If rehabilitation centres are to remain invisible in communities which they are designed to serve, the task of ameliorating substance abuse in the province and, by extension, in the country could remain insurmountable. Perhaps if the contribution of rehabilitation centres is to mean anything in the fight against substance abuse, these institutions need to start prioritizing local populations by publicizing their services through locally popular communication mediums such as radios, televisions, open-air broadcasts and posters.

5.4. Infrastructure as a Hurdle in Gauteng Rehabilitation Centres

This study found many challenges associated with the state of infrastructure, with different participants airing different contentions. This finding points at some serious impediments to the contribution of rehabilitation centres to the goal of ameliorating substance abuse in South Africa.

According to Matunhu and Matunhu, (2016), serious resource constraints make the work of rehabilitation facilities unnoticeable in many developing countries. Incontrovertibly, without requisite, adequate, and well maintained infrastructure, the selected Gauteng rehabilitation centres would not adequately discharge sustainable services to their clients. Worryingly, the state of poor and ill-maintained infrastructure raises concerns about the safety and the well-being of clients.

5.5. Cultural and religious insensitivity in the administration of rehabilitation centres.

The findings of this study illustrated that there were some embedded cultural and religious prejudices which were attached to the nature of services rendered in the selected rehabilitation centres. The researcher observed that although the rehabilitation centres were opening their doors to people from other religions and cultures, the terminology used in some parts of the programme such as reference to the “Higher Power” was inclined towards reflecting the affiliation of the institution to a particular religion. Furthermore, the unavailability of inclusive religious infrastructure and support services, such as a place for worship that can accommodate people from other religions and provision of special catering services in line with the dictates of other religions, left much to be desired in terms of religious pluralism in the selected rehabilitation centres. As the systems theory would advocate, it would be good if the wall between different role players constituted by different religious backgrounds is made permeable (Nose, Korunka, Frank & Danes, 2017). This means working to dilute religious and cultural orientations so that all the clients are treated with ease and consistency. The findings above are echoed by Provine (2008) who articulates that there has remained some idiosyncratic differences and intolerance amongst people of different races, ethnic groups, religions, culture, political affiliations, gender and social backgrounds. This scholar goes on to assert that these differences are confounding with equitable delivery of services at many levels of the South African society.

However, the principles of effective substance abuse demands that treatment services should be holistic, all-encompassing and above all, should accommodate the unique needs of individuals. This further supports the systems theory that advocates for holism in approaching the interventions to address a problem (Schoeneborn, 2014).

Given the above, it is apparent that if rehabilitation centres in Gauteng are to start to meaningfully contribute towards the amelioration of substance abuse, there is a need for these facilities to rethink and redesign their handling of religious and cultural issues. This is especially important considering that South Africa is a rainbow nation, one in which people of different races, nationalities, ethnicity, cultures, religions, political affiliations and sexual orientations are co-existing (Cilliers & Aucoin, 2016). An attempt to divide the task of ameliorating substance abuse along these differences would serve to worsen the problem and probably fuel hatred and religious intolerance in the country that has been enjoying peace for so long.

5.6. Gender and age Bias in the Provision of Drug and substance Treatment Services

South Africa has been described as one of the leading countries with high levels of gender and age based discrimination (Peltzer et al., 2010; Myers & Perry, 2005). True to this observation, this study found out that drug treatment services were gender and age skewed in favour of adult males at the expense of women, girls and children in general. Notably, very few females and no children were represented in the samples drawn from the participating rehabilitation centres. It was regrettable that women were mainly serving as caregivers yet their own treatment needs were scantily addressed in the participating rehabilitation centres. This finding reaffirms Gonzalez, Maseko and Mvlisi's (2013) remark that despite the narrowing gender and age gap in substance abuse, treatment statistics for these categories continue to show poor investments to save these vulnerable groups.

Additionally, Greenfield Back, Lawson and Brady (2010) posit that even in facilities which offer feminine substance abuse treatment, sanitary conditions for females are often pathetic and repulsive, thereby dis-incentivizing women from admitting themselves in these facilities. Concurringly, Greenfield et al., (2010) note that female substance abusers are often mothers; any residential treatment programme that accommodates them should make available complimentary services for them and their children. These may include provision of kindergarten facilities, and bolster security for their children, among others (NIDA, 2013).

There was yet another peculiar finding in the study that families were prioritizing treatment needs of males while simultaneously hiding female addictions. This anomaly was largely attributed to the fear of tarnishing the girl child's reputation. It was perceived that entering into a rehabilitation facility would scuttle any prospects of future marriage for the girl. Accordingly, female substance abusers were reported to be locked up at home and forced to endure painful and at times mortal withdrawals. This is because of state of stigma associated with females taking drugs, especially in many African societies (Matunhu & Matunhu, 2016). Given the foregoing, the study further elucidated that some rehabilitation centres which were fully set up for females were struggling to attract female substance abusers to come for treatment. This finding is archetypal of Kabeer's (2014) findings which underscored that women and girl children in South Africa have remained some of the most disenfranchised population groups. UNICEF (2013) attributes the status quo to the treatment of women as unequal partners in the home, the work place, and even in service provision, to an unpalatable and repugnant culture of patriarchy in many developing countries.

The findings displayed in this section have far reaching and important implications on the contributions of rehabilitation centres to the "war on drugs", as articulated in the National Drug Master Plans of South Africa. Firstly, if the "war on drugs" is to be won, it is imperative to ensure that services reach all sectors of the society, regardless of their gender, age or any other consideration. Ideally, prioritizing treatment needs for addicted females carries some long term benefits to the goal of ameliorating substance abuse in the country.

Available literature shows that in Africa, women such as mothers, grandmothers, sisters and aunts are the largest source of child socialization (Kabeer, 2014). Perhaps providing drug treatment interventions which observe and promote the treatment of women will, in the long term, produce some crucial spinoffs in terms of ensuring critical care and socializing of children, thereby reducing their proclivity to ending up abusing drugs and warranting a need for their treatment. Additionally, if the work of rehabilitation centres is to gain any currency in Gauteng, and perhaps the entire country, more awareness needs to reach communities regarding the prospects and possibilities of providing professional substance abuse treatment to women.

5.7. Low capacity for vocational skills training

With the incremental employment paucity in South Africa, it makes sense for rehabilitation centres to provide vocational training to their clients to enhance their self-sustenance once they leave treatment facilities. Incidentally, this study found out that the selected rehabilitation centres had a low capacity for vocational training for their clients. It emerged from further probing by the researcher that the main challenge was the unavailability of vocational skills training specialists willing to work in rehabilitation centres. Using the input-output component of systems theory, poor input in terms of having low skilled human resource to bolster vocational skills is a foolproof litmus test of low performance of rehabilitation centres (Jeewa & Kasiram, 2008). This makes them detract from their goals and objectives of focusing on the healing of the drug addicts. Furthermore, the research established that there is a prevalent perception is that the time frame for rehabilitation was too short to allow sustainable vocational training for admitted substance abuse patients. These findings concur with Voskuil (2015) who argues that most rehabilitation centres in the Western Cape lack a skills development component in their programmes.

Notwithstanding the wide scholarship on the social benefits of vocational training for substance abusers, capacitating them with employable or self-help skills has great resonance with the sustainable livelihoods approach which underscores the importance of poverty eradication in an effort towards boosting the livelihood assets of individuals. Indisputably, poverty and lack of employable skills constitutes some of the many faces of substance abuse, especially in South Africa where the levels of inequalities are very high. In many instances, young people who lack employable skills find themselves drowning their sorrows in substance abuse or, worse still, considering drug dealing as a lucrative economic avenue for generating much needed incomes (Mhlongo, 2005).

Taking note of the fact that in South Africa substance abuse treatment services and supports are provided within a complex environment in which health, social, legal and many other sectors intersect, it is crucial to allow each sector to play its part and not overburden rehabilitation centres with both the therapeutic and vocational training of substance abusers. This call for the synergy advocated by the systems theory where different sectors need to intervene through offering the requisite rehabilitation service, each according to its levels of comparative advantage (Schoeneborn, 2014). To this end, the findings above present an opportunity for policy refinement towards strengthening efforts and contributions of rehabilitation centres and their associate partners in a synergistic manner towards ameliorating substance abuse in Gauteng and possibly the whole of South Africa.

Perhaps allowing rehabilitation centres to focus on building the psycho-social well-being of substance abusers will improve the outcomes of these facilities and thus strengthening the quality component of their services. However, trying to force rehabilitation centres to competent all facets of human well-being is equivalent to the adage that says, “Jack of all trades and master of none” (Bond & Morrison-Saunders, 2009). It is crucial that rehabilitation centres be allowed to specialize in what they can do best and perfect their art in that area if their contributions are to mean anything in the fight against drugs.

5.8. Dire Shortage of skilled and Experienced Professionals

The findings of this study proved that rehabilitation centres were facing a critical shortage of skilled and experienced professionals to run drug treatment programmes. As shown elsewhere in this chapter, the biographical profiles of therapists who were employed in the two selected rehabilitation centres had shallow work experience and were drawn from one professional background (social work). The study further indicated that these weak professional profiles were a result of the exodus of experienced professionals to greener pastures overseas or in other sectors where remuneration was better. This was causing the selected rehabilitation centres to operate on skeletal staff and, in some instances, to rely on non-professionals to run treatment programmes.

Similar discoveries to these are reported in Gonzalez, Maseko, and Mvilisi's (2013) study which noted that some rehabilitation centres in South Africa were using ex-addicts to run programmes based on their experiences of recovery. Correspondingly, South African Press Association (SAPA) (2013) writes about unregistered rehabilitation centres which run unscrupulous programmes using semi-trained or non-trained personnel who often cause more damage than good to unsuspecting clients who get admitted in these facilities. This scenario then fits into the input-output component of the systems theory by indicating that if the inputs in the form of semi-trained or non-trained personnel are to be used in rehabilitation centres, the output or the treatment services are bound to be weak and, therefore, likely not to meet the goals and objectives of the rehabilitation centres at large (Jeewa & Kasiram, 2008).

Myers and Perry (2005) underscore the fact that the shortage and the poor employee retention capacity displayed by the rehabilitation centres is a serious cause for concern; given the important niche occupied by these strategic facilities to the goal of ridding South African environments of drugs. Without an experienced and diversified staff complement, rehabilitation centres will not be able to dispense holistic services to ensure the sustainability of treatment. For example, a substance abuse rehabilitation facility with a staff complement

of only psychiatrists is catastrophic to the social and medical needs of the patients, yet very good in the assessment and diagnostic component (Gonzalez, Maseko & Mvlisi, 2013). Implicitly, there is a need to ensure balanced competences in all sectors of rehabilitation facilities. Various professionals need to make up the staff complement of rehabilitation centres on permanent basis to ensure harm reduction and sustainable interventions.

5.9. Heavy Case Loads for Therapists

This study ascertained that rehabilitation centres were facing challenges of heavy caseloads for therapists. It was noted that while the Department of Social Development had pegged 20 cases per therapist at any given time, therapists reported that, in some instances, they ended up with at least twice as many.

The issue of heavy caseloads has been noted by Earle (2008) and the Department of Welfare (1997) as one of the most frustrating phenomenon in the social service sector in South Africa and the developing world at large. In her study, Earle (2008) established that social workers who were employed by child welfare organizations were inundated with heavy caseloads of up to 6 times more than what they should be handling, as per the DSD directive.

Additionally, McCarroll et al., (2016) emphasize that the phenomenon of heavy caseloads is associated with poor work outcomes and poor employee retention. Perhaps the high caseloads are responsible for the low years of work experience exhibited amongst the therapists of the selected rehabilitation centres and possibly explain the high relapse rates in rehabilitation centres. Ideally, the relapse rate of the substance abuse clients fits into the state of entropy that is espoused by the systems theory (Jules- Macquet, 2015).

With heavy caseloads, the quality of interventions offered by rehabilitation centres is likely to remain low with high probability of discharging semi-treated patients who will always find their way back to substance abuse. If Gauteng rehabilitation centres are to make an impact, and help to halt and reverse the spread of substance abuse in the Province, it is crucial for

them to improve their therapist to client ratios. McCarroll et al., (2016) warn of the effects of poor therapists to client ratios as causative of therapist burnout which can result in poor job performance.

5.9.1. The phenomenon of difficult and uncooperative Clients

Working with substance abuse clients is not like working with any other conventional social work clients who are often voluntary, rational and in most cases, able to decide for themselves what they want and how they want to achieve it. This study found that one of the key challenges faced by the rehabilitation centres was the issue of difficult, uncooperative and, at times, psychologically disturbed clients. Similar findings were reported by Jeewa and Kasiram (2008) who found out that involuntary heroin clients who were admitted in Durban rehabilitation centres were causing a lot of problems, including escaping, being disruptive and undermining the authority of programme staff.

Inopportunistically, the discourse of difficult and uncooperative clients suggests that productivity in the rehabilitation centres was being unnecessarily disrupted on account of unruly behaviour of some clients at the expense of others who were serious about their recovery (Gonzalez, Maseko & Mvlisi, 2013). Accordingly, if the contributions of rehabilitation centres are to pay dividends, it is pertinent to reduce such disturbances in the workings of the rehabilitation centres. This might be done by creating a pre-rehabilitation centre facility that focuses on holistic assessments and detoxification of clients before they may be accepted in the formal treatment programmes of rehabilitation centres. However, this should be done in consideration of the principles of effective drug and substance abuse treatment which underscores the need for timely interventions to reduce fatalities (Galanter, 2007). Without a clear policy of dealing with difficult clients, the contributions of rehabilitation centres will remain at stake.

5.10. Lack of Professional Platforms and Opportunities for Therapists in the Sector to Share knowledge

In this study, key informants indicated that one of the central challenges militating against the successful implementation and development of substance abuse interventions was lack of opportunities and platforms for therapists to share knowledge towards enhancing evidence based practice as well as the personal and professional growth of therapists. This challenge was further compounded by the protectionist approaches taken by rehabilitation centres which considered their work as social entrepreneurship and, hence, were choosing to be discrete about their methods and approaches. Any movement of information outside the boundaries of the institutions was considered as espionage and, in some instances, would attract threats of legal action by one rehabilitation centre to another.

These findings seem to agree with various studies carried out on the discourse of knowledge protection in social entrepreneurial organizations (Luke & Chu, 2013; European Commission, 2013). Moreover, similar findings regarding the lack of professional platforms to share knowledge has resonance with Peltzer et al.,'s (2010) assertion that apart from the biennial conferences, substance abuse professionals in South Africa have no other knowledge sharing platforms.

Given that recurrent research evidence has continued to underscore the imperativeness of evidence-based practice and continual growth of professionals, the lack of knowledge sharing platforms and the deliberate knowledge protectionism found in this study suggests that the contribution of rehabilitation centres seem not to be working in their best interest in the long term. This echoes the phenomenon of organizational entropy espoused by the systems theory (Hanson, 2014). However, without avenues of sharing new evidence of how to treat and support clients, and even discussing emerging trends in the sector, it is difficult, if not impossible, for rehabilitation centres to meaningfully contribute to the noble task of ameliorating substance abuse in Gauteng and South Africa.

In addition, a lack of knowledge sharing platforms makes it hard to coordinate the work of rehabilitation centres, thereby weakening the bargaining power of these facilities in seeking public funding from the government, or even making substantive recommendations regarding rehabilitative work. Perhaps, this gap is responsible for the lack of coherent statistical evidence regarding the prevalence, treatment demands and documentation of contributions of rehabilitation centres, making these vital institutions seem irrelevant in the efforts of ameliorating substance abuse in Gauteng. Perhaps authorities in Gauteng ought to adopt the system used in the Western Cape and develop a data base of all rehabilitation centres and create a local forum to discuss pertinent issues in the sector (van Zyl, 2013; Harker et al., 2008).

5.11. Out-dated and Disjointed Legislative Framework

This study gathered that the work of rehabilitation centres was being frustrated by the absence of an enabling legislative framework. Study participants and informants indicated that not only were legislations outdated, disjointed and poorly enforced but they were also poorly funded. To further compound this issue, the study found that there was poor and erratic supervision of rehabilitation centres by the DSD to ensure that they retain the minimum norms and standards as per the Blueprint, Minimum Norms and Standards for Secure Care Facilities in South Africa published by the Department of Social Development (DSD, 2010).

Vividly, the phenomenon of poorly funded, coordinated and outdated policies has been found to be a recurrent concern in South Africa and has been presented as one of the top reasons for sector underperformance and poor service delivery in the country (Cilliers & Aucoin, 2016; Stein et al., 2017). In the context of substance abuse, Mbulayi and Makuyana (2017) observed that while the NDMPs have continued to poignantly single out monumental flaws derailing efforts aimed at ameliorating substance abuse, these policy documents, in their numerous versions, continuously fail to provide sustainable solutions and close identified gaps.

For example, issues regarding the exorbitant costs of drug treatment services and the plight of vulnerable groups such as gays, lesbians, women and children have remained glaringly unattended. Zawaira (2009, p. 13) adds that there are low budgetary allocations for addressing drug and alcohol problems in Africa; this is negatively impacting on policy implementation. Deductively, while there are legislations supporting the fight against substance abuse in South Africa, these legislations seem to be neither to be in sync nor reflect the magnitude and seriousness of the problem at hand. Concurringly, Mbulayi and Makuyana (2017) propound that the attention received by the majority of policy documents guiding the fight against substance abuse in South Africa is disproportionately less than the magnitude of the problem they have been devised for. If rehabilitation centres in Gauteng are to start to make meaningful and sustainable contributions to the vision of ameliorating substance abuse, it is crucial that they acquaint themselves with the available legislative provisions including the national visions and goals set to achieve this target.

5.12. Survival Strategies of the Selected Rehabilitation Centres

The study found that funding for the operations of the selected rehabilitation centres was one of the major challenges which were undercutting the contributions of the selected rehabilitation centres. This finding finds credence from the elaborations of the Central Drug Authority (CDA) (2013) which underscores the need for broad based funding of substance abuse prevention and treatment efforts. Similarly, the South African Press Association (SAPA) (2013) writes about the precarious financial situation obtaining in the drug treatment sector which is forcing rehabilitation facilities to resort to unethical practices which often compromises the quality component of their services. Perhaps embracing systems theory thinking, in which all sectors of the country's economy are statutorily required to provide funding for substance abuse treatment, can help to solve this problem, given that substance abuse is a national problem, one which, if left unattended, can potentially affect the economy and society.

5.13. Meagre impact of rehabilitation centres in fighting drug abuse in Gauteng

The study also identified a negative perception held by participants and respondents of the study regarding the impact and contributions of rehabilitation centres. It emerged that substance abuse treatment service consumers largely felt that the contribution of rehabilitation centres were insignificant in “the war against drugs” in the Province. These perceptions were justified on the grounds of 4 considerations including: that rehabilitation centres were elitist; their treatment fees were unaffordable and prohibitive; their services were capitalistic at the expense of community development and; their programmes were being disseminated in minority languages.

These findings have resonance with Jules-Macquet’s (2015) and Andrews’ (2008) findings which indicated that the majority of drug users in South Africa end up worse off because they fail to get help during the initial stages of their addiction mainly due to financial constraints. The Central Drug Authority (CDA) (2009) as well as Isobell, Kamaloodien and Savahl (2015) posit that some of the common features of rehabilitation facilities in South Africa are; long waiting lists which drug users have to endure before admission; requirement for one to pass some means test to be admitted for treatment and; the requirement for full treatment fees upfront before admission. These factors reduce the relevance and utility of rehabilitation centres, especially considering the volatile and unstable economic conditions in the country. Jeewa and Kasiram (2008) mention that early detection and treatment of substance abuse disorders elevates the chances of long term recovery and help to reduce associated fatalities (harm reduction). Implicitly, cost factors and administrative bureaucracy in rehabilitation centres were making their contributions to the task of ameliorating substance abuse insignificant.

Additionally, Isobell, Kamaloodien and Savahl (2015) refer to language barriers as some of the major constraints rendering efforts of ameliorating substance abuse in South Africa a challenge. According to the Trade Policy Training Centre in Africa (2010), South Africa has 12 official languages, all of which are fairly used in everyday communication at home.

However, for business communication, the country adopted English as a medium of communication. In this light, Prah (2007) mentions that in South Africa, English is not as common, especially among native population groups who prefer to use their indigenous languages. In their study on the easiness of doing business in South Africa, the Trade Policy Training Centre in Africa (2010) found that the language barrier was one of the major business constraints in the country. Given the foregoing, the usage of English and Afrikaans as the main mediums of instruction in rehabilitation centres defeats the purpose of interventions as some target groups might fail to understand these languages.

According to Prah (2007), a significant percentage of the South African population cannot speak, write nor understand English language while a very minute segment of the native population speaks Afrikaans. Perhaps, it is high time that rehabilitation centres in Gauteng indigenize their programmes so as to accommodate local people. Two ways of doing this if the policy is adopted is to 1) employ bi-lingual or native speakers and 2) employing interpreters.

5.14. Viable Programme Goals in the selected rehabilitation centres

The study revealed that the goals espoused in the programmes of the selected rehabilitation centres revolved around providing safe, dignified, sustainable and humane drug treatment options which promote long term recovery. Notably, Mbulayi and Makuyana (2017) cite the NDMP2 (DSD 2007) and NDMP3 (CDA 2013) in underscoring that the vision of ameliorating substance abuse in South Africa should be framed on harm reduction strategies, re-socializing drug abusers and capacitating drug abusers to create and sustain their own social and economic needs. From the perspective of this researcher, even though the goals of the programmes of the rehabilitation centres were seemingly not in direct sync with the vision of a drug free South Africa as espoused in the National Drug Master Plans, they still capture the essence of ameliorating the substance abuse problem in a subtle manner.

This, therefore, can give credence to the perception that rehabilitation centres in South Africa contribute immensely to the goal of ameliorating the problem of substance abuse in Gauteng and South Africa in general. However, perhaps it is crucial for rehabilitation centres to use sustainable livelihoods lenses to look at the future of their contributions to the “fight against drugs” so that they may realize the need to adopt community mobilization as one of their key goals. This will help to redefine the work of treating substance abusers as a communal responsibility and this, in turn, will lead to a reduction of factors that precipitate the prevalence of substance abuse.

5.15. Contribution of rehabilitation services to positive behaviour and lifestyles change

The general and major finding of this study illustrated that the biggest contribution of rehabilitation centres was vested in their character and capacity reconfiguration functions. Both qualitative and quantitative findings of the study proved that rehabilitation centres had strength in the character modification and the re-socialization of substance abusers, thereby improving their capacity for work, relationships and general productivity. Notably, strong positive co-relationships were established between the work of rehabilitation centres and adjustments in lifestyles of substance abusers.

5.15.1. Reduced Criminal Behaviour and Activities after Rehabilitation

As noted earlier, the study elucidated that substance abuse rehabilitation in Gauteng was strongly associated with decreasing criminal behaviour and activities. In a similar study, Sullivan et al., (2014) found a drastic reduction in criminal behaviour amongst rehabilitated drug using juvenile offenders who were treated in regimented treatment facilities in China. Similarly, NIDA (2012) reports of positive outcomes in the criminal behaviour of first time drug using offenders who were court-ordered to undergo treatment in designated inpatient drug treatment programmes.

The finding of reduced criminal behaviours of recovering substance abusers who received treatment in selected Gauteng rehabilitation centres supports Jeewa and Kasiram's (2008) assertion that substance abuse rehabilitation involves the reprogramming of the cognitive and behavioural aspects of the drug user to allow him/her to attain new personal and interpersonal experiences and adopt new functional approaches to life. According to Sullivan et al., (2014), most criminal behaviours displayed by drug abusers are survival strategies which allow them to cope with their significantly expensive habit of abusing drugs. Perhaps the cognitive behavioural therapy provided by rehabilitation centres assisted the drugs users to unlearn the criminal behaviour they learnt during their active addiction and assist them to develop a new narrative and meaning for their lives.

Implicitly, the above noted finding indicates that rehabilitation centres contribute to character refinement of substance abusers and, thereby, add to the social development of drug users and their respective families and communities. In most instances, drug users are rejected by their families and communities because of their indiscriminate criminal tendencies. Hence, a reduction in criminal behaviour will surely give impetus for their acceptance and easy reintegration which, according to NIDA (2012), are some of the critical elements of successful recovery.

5.15.2. Drug and Substance Abuse Treatment Promoting Health outcomes and Wellbeing of Recovering Persons

The study established that substance abuse treatment was closely linked with positive health outcomes, including a reduction in the need for hospitalization or medical interventions and improved personal hygiene and self-upkeep. These findings seem to indirectly vindicate NIDA's (2012) study on the health benefits of early intervention and treatment of substance abuse, which indisputably stated that reduction in the need for hospitalization as one of the major benefits. Perhaps, the findings also validate Chandler, Fletcher and Volkow's (2009) assertion that substance abuse rehabilitation can significantly reduce the strain on public health facilities and resources emanating from the medical emergencies related to

substance abuse as well as from the general abuse of prescription medications. In reference to the health benefits of mental health and substance abuse treatment, Sullivan et al., (2014) allude to improved personal hygiene as a cornerstone health benefit whose effects have multiple advantages to the general well-being of the individual.

Viewed from a health perspective, the contributions of rehabilitation centres in Gauteng had multifold benefits to the process of ameliorating substance abuse in the Province. Firstly, by helping to reconstitute the physical wellbeing of drug users, the rehabilitation centres instilled personal confidence of drug users that they could achieve more than just personal health outcomes in being sober if they were to stop abusing drugs.

More so, given that poor hygiene and personal grooming are some of the manifest hallmarks of substance abuse on the streets, the ability of rehabilitation centres to re-socialize drugs users into maintaining personal hygiene and self-upkeep could act as a morale booster to the general public and other substance abusers that there is hope in quitting drugs, and hence fostering acceptance of drug users in communities and families. This could also help to dispel the myth in many South African communities that substance abuse is a curse which can only be exorcised by death.

5.15.3. Reduced Violent Predispositions after Rehabilitation

Encouragingly, this study found a strong correlation between substance abuse treatment in the selected rehabilitation centres and a reduction in violent predispositions amongst recovering substance abusers. According to Granfield and Cloud (1996), one of the many factors which make substance abusers undesirable in society is their unpredictable short temper which is often marked by raging aggression, destruction of property and, in extreme situations, self-mutilating behaviour. In agreement with the findings of this study, Gonzalez, Maseko and Mvilisi (2013), in their study, established that substance abuse treatment, which includes intense detoxification; psychotherapy and group work scored high in terms of reducing violent episodes amongst cocaine users.

Paradoxically, in her study, Mokomane (2013) found that it was mainly children who were raised in families with substance abuse related domestic violence who displayed the poorest social skills which compromised their learning in school and their ability to form strong and secure friendships bonds with their peers. From the discussion above, it is apparent that substance abuse and violence often produce a deadly combination which causes the drug users to be shunned by their families and communities; and secondarily, stun the social development of children in homes where it happens. These two factors have far reaching implications on the efforts aimed at ameliorating substance abuse in South Africa.

If the “war against drugs” in Gauteng and, by extension, South Africa is to be won, it is important to induce communities to open their homes and hearts in welcoming and embracing recovering drug users so that they may not only perceive but also experience that they are wanted and supported (Mokomane, 2013). In this regard, a reduction in violence of drug users could be the first huge step towards their acceptability in communities.

Mokomane (2013) articulates that another most effective means of curbing future substance abuse is to ensure that we create conducive environments for children to grow and, thus, minimize possible damage done to them that may render them to become in need of future interventions. Consequently, a reduction in violence by recovering substance abusers should be read as a positive contribution of rehabilitation centres as it presents opportunities of preventing future substance abuses by young people living in the environments of the recovering substance abusers.

5.15.4. Improved Attendance and Productivity in Primary areas of Production after Rehabilitation

Substance abusers are known for poor attendance and efficiency in their primary areas of production and focus, such as school work for those of school going ages, and employment responsibilities, for those who are employed.

In this study, however, it was proved both qualitatively and quantitatively that drug users who were treated in the selected rehabilitation centres had improved work and school attendance and also had moderate improvement in their productivity after their treatment.

The above noted findings validate Hanson, Venturelli and Fleckenstein's (2011) assertion that substance abuse treatment helps to stabilize the psychological wellbeing of drug users, thereby allowing them to become more productive. Similarly, Gomez, Jason, Contreras, DiGangi and Feffari (2014) found that one of the many strategies of improving work place productivity used by big organizations involves regular drug tests and mandatory rehabilitation for those who are addicted.

Furthermore, Chetty (2011) writes about improved work outputs amongst recovering police officers who underwent treatment in rehabilitation centres. Furthermore, Wenzel, Weichold, and Silbereisen's (2009) study established a strong co-relationship between treatment of substance abuse amongst adolescents and improved school outcomes and achievements.

The results discussed above presents a wide range of opportunities for all stakeholders working on ameliorating substance abuse in the Province. The evidence of improved attendance and productivity after rehabilitation can be used to attract funding from companies to fund treatment for those individuals who are not able to pay for their own treatment. Secondly, the finding that rehabilitation can result in improved school outcomes and productivity can be used to rally parents and other child friendly organizations into supporting and developing child friendly rehabilitation facilities. This will go a long way in improving the contributions of rehabilitation centres to the amelioration of substance abuse.

5.15.5. Rejuvenation and Development of Personal and Interpersonal

Relationships

The study found out that the contribution of rehabilitation centres scored high in the area of socializing substance users and buttressing their capacity for personal and interpersonal relationships.

Contrastingly, Kazdin and Blasé (2011) revealed that the findings of their study regarding the challenges associated with multiple substance abuse relapses identified challenges to do with reviving drug users' personal and interpersonal relationships as well as re-establishing a basis for trusting and stable relationships post rehabilitation.

Mehl Madrona and Mainguy (2014) poignantly state that substance abuse is a debilitating disease which causes the individual not only to feel shunned, rejected and inept, but also experience a strong feeling of isolation and alienation. In their research, Catalano et al., (1991) highlight that breakdown of personal relationships makes drug users to lose hope and faith that they will ever emerge from the current circumstances.

Each rejection or lost relationship is interpreted by a drug user to mean that he/she is undesirable, hence they go and seek acceptance in unconventional places or company which often exacerbates their drug usage. In this light, Ghitza and Tai (2014) suggest that substance abuse treatment should be about helping the drug user to rejuvenate and re-establish his/her personal and interpersonal relationships in a manner that allows him/her to revitalize a sense of belonging and purpose.

Systematically thinking, if rehabilitation centres are to increase their presence in local communities and advocate for recovering substance abusers to be given a fair chance to recover without being shunned, ostracized and rejected, it is possible that rehabilitation centres could add more value to the prospects of ameliorating substance abuse in the Gauteng. Given the social capital enjoyed by rehabilitation centres in Gauteng, it is very possible that they can motivate local communities to accept drug users and thus set them up along a sustainable recovery trajectory. Moreover, if Gauteng rehabilitation centres are to adopt sustainable livelihood thinking in their engagements with substance abusers by emphasizing on equipping them with coping mechanisms and skills such as tolerance, conformity, patience and humility, it is possible that drug users will find it easier to reintegrate back into their families and communities with ease.

Evidently, continued attack and rejection of drug users by their loved ones is retrogressive to the goal of ameliorating substance abuse in the country.

5.15.6. Improved Employability and Ability to Retain Employment after Rehabilitation

It was established in this research that there were improved chances of securing employment and capacity to retain employment longer amongst recovering substance abusers who received treatment in the selected rehabilitation centres. To corroborate these findings, Smook, Ubbink, Ryke and Strydom (2014) report of a debilitating trend of penury and destitution amongst drug users which often results from their inability to secure a job or retain it when they get one.

Additionally, Matunhu and Matunhu (2016) write about the extreme stigma attached to substance abuse, which often militates substance abusers from securing employment and, in some unfortunate circumstances, their loved ones to be discriminated against. Similarly, Mogorosi (2009) refers to companies in South Africa incurring huge financial losses due to employee absenteeism, low production and work place accidents caused by poor workmanship linked to drug and substance abuse.

With the growing number of drug using, indigent and homeless people in the streets of Johannesburg and other parts of Gauteng, the finding that the selected rehabilitation centres were improving the employability of substance abusers breathes a sigh of hope into the exponentially distressing situation. Johnston (2010) notes that without a positive reason to change for, drug users might lack motivation to quit drugs. Perhaps a means of income and self-sustenance could be reason enough for drug users to choose differently and opt to stop abusing drugs.

The challenge, however, is that not many companies are willing to employ recovering substance abusers, mainly because of the stigma associated with them. Perhaps it is time that the South Africa government takes a bold stand and embraces a sustainable livelihood approach, which, among other things, will include creating a wider scope of opportunities for income generation as well as opening space for young people, including those coming from a background of substance abuse to enter into the mainstream economy of the country. This argument, therefore, validates the choice of the researcher to consider the Sustainable Livelihood Approach as an ideal theoretical frame for this study. This can be done by decentralizing vital services to other provinces and thus diminishing the bright lights syndrome which lure many young people to come to Gauteng in search of better opportunities, only to be confronted with a life of indigence and destitution which drive them to seek solace in substance abuse. This research suggests, creating more opportunities for employment could help to revitalize the dying hope of the many disillusioned young people who throng Gauteng in the hope of getting better opportunities.

5.16. Nature and Potency of abused Drugs

The study revealed that the main drug types for which users were mainly seeking treatment included Amphetamine Type Stimulants (ATS) (32.5%), Cannabis (26%), Opiates (22.2%), Sedatives (9.3%), Cocaine (4.1%), Alcohol (4.1%) and hallucinogens (1.6%). This finding supports and largely concurs with findings from other studies which place cannabis, opiates, cocaine and alcohol as the main substances of abuse in South Africa.

The WHO (2011) report posits that cannabis, heroin and alcohol use in South Africa are the three most consumed substances, with alcohol consumption accounting for between 20.1 and 34.9 litres of pure alcohol per capita. Similarly, UNODC (2013) articulate that cannabis abuse in South Africa accounts for between 30% and 40% of total admissions in rehabilitation centres nationally.

Some of the findings regarding the nature of drugs which were rendering users rehabilitable, however, contradicted what has been established by other researches. Notably, the finding that ATS drugs were the most prevalent cause for admission of patients into the selected rehabilitation centres goes against Peltzer's et al., (2011) ranking of drugs according to their prevalence in South Africa which ranked ATS drugs in the fourth position with a prevalence rate of 0,2% after cannabis' 9% , cocaine/crack 0,3%, mandrax/sedatives 0,3%. Another significant contrast in terms of the nature of abused drugs in the selected rehabilitation centres was presented in the findings regarding the prevalence of persons seeking treatment for addiction to hallucinogenic drugs in the selected rehabilitation centres. The findings of the study suggested that these drug types effectuated the least admissions into the selected treatment centres. These findings sharply contrast with the findings of three national surveys referred to by Peltzer et al., (2011) which underscored that prescription medication and hallucinogenic drugs are the most prevalent drug types in South Africa.

The above noted findings have drawn attention to the reality of a rapidly shifting drug abuse landscape in Gauteng and possibly South Africa as a whole. It seems Gauteng is gravitating towards becoming a haven for Amphetamine Type Stimulants, and opiate drugs.

5.17. Price of Drugs as determinants of Drug Consumption Patterns in Gauteng

The study proved that drug consumption patterns have financial and social dimensions. Notably, the study found out that the drugs which were rendering users rehabilitable ranged in price from R5 to R700 per standard unit of 1 gram. Apparently, costly drugs such as cocaine, crack, laboratory grown variants of cannabis and a selected range of sedative drugs, were not as prevalent due to the cost factor attached to them. On the other hand, drugs such as nitrates, glue, petrol, paint thinners, nyaope/whoonga and some indigenous variants of cannabis were generally considered as 'drugs for the poor' and the 'homeless', hence some users seldom wanted to be associated with them.

The findings in this category are not unique to this study as there are other studies which also proved that drugs have a financial and social component. Johnston (2010) underscores that, in some instances, the onset of substance abuse is in itself a function of wanting to fit into a desired social class which is generally associated with abuse of certain drug types. WHO (2015) concurs with Jules-Macquet (2015) in propounding that low cost drugs have a strong correlation with homelessness and poverty. These scholars elucidate that drug use amongst vulnerable populations is high as it enables them to numb the painful realities regarding their pitiful circumstances and allow them to cope with stress and deprivation.

These findings have ripple effects on the goal of ameliorating substance abuse in Gauteng and perhaps in the country at large. Firstly, it is evident that the cost factor of drug usage is in itself a motivating factor for drug users to either abstain or persist using. This is best explained in the rational choice model which underscores that drug users make rational choices if they realize that the cost-benefit of using the drug outweighs the pleasure outcomes, they will choose wisely (Krstić, 2013). Perhaps this vindicates recent debates which are calling for the legalization of narcotics with the view that once they are placed in the public domain, users will be able to make rational choices regarding their usage or abstinence.

Additionally, the finding that users of some cheap drugs seldom want to be associated with these drug types upon entering treatment centres, undercuts the contributions and effectiveness of interventions offered by rehabilitation centres. According to Chandler, Fletcher and Volkow (2009), substance abuse treatment ought to be premised on the socioeconomic, cultural and personal truths of the drug user if the intervention is to succeed. Similarly, Franzcp (2007) posits that substance abuse treatment therapists ought to help their clients to develop individualized treatment plans which should speak to the varied circumstances of individual clients including the dynamics associated with their drug(s) of choice and recovery maintenance goals and indicators.

In this light, the misinformation by drug users to therapists regarding their drug(s) of choice complicates the intervention process and thus systematically weakens the outcomes of the treatment plans as they will be based on lies.

5.18. Nature programmes offered by the selected rehabilitation Centres

This study proved that the selected rehabilitation centres were providing a wide scope of programmes and services including psychotherapy, 12 steps Minnesota programme, pharmacotherapy, spiritual awakening programmes detoxification services, among other programmes, and services which were running concurrently during the admission period of clients.

These findings find support conclusions in the work of Gretschel (2016) who underscores that rehabilitation centres in South Africa tend to offer a wide range of services although their packaging is often poor in quality. The same scholar emphasizes that despite differences in service quality, availability of services in substance abuse treatment centres is a huge step in the direction of embracing international best practices. To add to this, NIDA (2012) mentions that effective substance abuse treatment requires a wide range of services that can be tailored to suit individual clients and their circumstances.

In this light, the findings of this study indicate that the range of programmes rendered by the selected rehabilitation centres was wide enough to be able to capture and service the different needs of their clients. This finding demonstrates that, to some extent, the selected rehabilitation centres were embracing systems thinking as espoused by Hanson (2014), who underscores that systemic drug and substance abuse should fuse together different approaches and methods towards increasing the wellbeing of the patients. This notion of systems drug and substance abuse treatment also finds credence in Azim, Bontell and Strathdee's (2015) assertion that the substance abuse phenomenon is multidimensional thus it requires integrated treatment methods that address all facets of the problem in tandem.

5.18.1. Gauteng Treatment programmes offered ample time to expedite recovery

The findings of this study revealed that the rehabilitation centres were offering ample treatment time for clients to expedite recovery. This finding paints a brighter future for substance abuse treatment and, ultimately, the goal of ameliorating substance abuse in Gauteng. According to Chandler, Fletcher and Volkow (2009), one of the central principles of substance abuse treatment demands that treatment programmes and plans should be long enough to deliver effective and sustainable treatment. In this context, NIDA (2012) found that a minimum of 28 days is requisite for effective and sustainable substance abuse treatment and is synonymous with international best practice. Read against the international best practice as acknowledged by NIDA (2012), it is apparent that the selected rehabilitation centres in this study were providing ample time for recovery to their clients. Deductively, it can, therefore, be argued that the selected rehabilitation centres were providing effective services and thus, significantly, contributing to the goal of ameliorating substance abuse in the country and, more specifically, in Gauteng Province.

5.18.2. Contentious Quality of Substance Abuse Rehabilitation Services

The findings of the study established that the quality component of rehabilitation services was a contentious issue with the majority of qualitative participants arguing that the services were not resonating with the value of money they paid while mini- survey respondents were highly satisfied with the outcomes of the rehabilitation services offered to their loved ones. These findings have great resonance with many public service sectors in South Africa where the quality component of rendered services is always contentious. In Johnston's (2010) study, it was established that perceptions of service quality had many determinants including sociocultural, economic and political considerations. From a consumer perspective, Foster and Briceño-Garmendia (2010) underscore that service satisfaction is construed as a function of service utility, efficiency, good public relations, dependability, transparency and sustainability.

These findings have multiple implications on the work of rehabilitation centres and also on the goal of ameliorating substance abuse in Gauteng and South Africa. Notably, the qualitative finding that poor programme packaging was compromising service quality suggests that maybe the offered treatment services were not relevant to the needs of service users and possibly explains the poor recovery success rates referred to by Harker et al., (2008). However, the satisfaction of service quality expressed by the mini-survey respondents illuminates the public confidence in the drug and substance treatment sector. But perhaps the differing accounts of service quality between the caregivers and the direct service users (substance abusers) illustrates some veiled practices by rehabilitation centres which make their services to be ostracized by some and welcomed by others. Conceivably, this marks the need for systematic evaluation of rehabilitation centres to ensure that all synergies can be pooled into the single goal of ameliorating substance abuse in the country.

5.18.3. The Level of involvement of the Department of Social Development (DSD) in Drug Treatment Programme Packaging

Findings of the study indicated that the DSD did not prescribe the content and methods used by rehabilitation centres; rather, they mentioned that the National Department of Social Development (NDSD) provided the Minimum Norms and Standards for Residential Drug and Substance Treatment. The Minimum norms set the basic level above which rehabilitation centres are bound to deliver their services. This finding has been described by Cilliers and Aucoin (2016) as one of the pitfalls of government departments, especially in developing countries, where there is a tendency of focusing on enforcing compliance with service delivery targets at the expense of service quality.

It is crucial for the DSD to develop a competent system of evaluating both service targets alongside its quality demands. This should hopefully be done with the realization that it is upon the framework of quality drug treatment services that the war on drugs could be won (Wallace, 2014; Duke & Gross, 2014).

5.19. Poly Drug Use in Gauteng

The findings of this study elucidated that there is a growing phenomenon of concurrent usage of various drug types by substance abusers. It was noted that individual drug users reported using more than one drug type at the same time with the intention of tapping into the complimentary effects of the drugs. Furthermore, the study found that, in some cases, poly drug usage was not by choice, but most drug users were tricked by drug dealers/merchants and given a drug which they would not have requested. The phenomenon of poly drug abuse is growing in South Africa and the rest of the world. Harker et al. (2008) write about the concurrent usage of cannabis and benzodiazepines in the Western Cape. Furthermore, Peltzer et al. (2010) underscore that due to poly drug abuse, new symptoms and fatalities of substance abuse are emerging amongst drug abusers. This poses a serious challenge and burden to the already struggling public health system in the country.

5.20. Potency of Abused Drugs

This study demonstrated that the crop of abused drugs were highly potent. In the absence of clinical tests to test potency, the research found that drug users largely measured the potency of drugs through an exploration of physiological effects of the drug as well as the 'duration of effect' (total amount of time during which the effects of the drug is experienced).

Drugs with longer duration of effect were considered to be more potent as compared to those whose effects are short lived. The study also noted that the potency of a drug was largely construed in the context of time lapse between drug consumption and the initial onset of the effects of the drug. Drugs with shorter onset effects were regarded as more potent than those which take long to react and give effects. The study established that amphetamine type stimulant drugs were considered as the most potent followed by opiates, then cocaine, cannabis, sedatives and, lastly, hallucinogens.

5.21. Progress of Gauteng Province in Ameliorating the Substance Abuse Problem

The study made the finding that Gauteng as a Province was making remarkable progress towards ameliorating the substance abuse problem in its localities. It was established that progress was comparatively perceived in terms of the quality and quantity of intervention infrastructure and opportunities in Gauteng as compared to other Provinces. It was also established that progress was understood in the light of research evidence which suggested that substance abuse prevalence in Gauteng has been static in the last decade. These findings are echoed by the UNODC (2013) which argues that, internationally, the rate of substance abuse has been constant in the past 2 decades. Similarly, Peltzer et al. (2011) articulate that the overall substance abuse prevalence rates in South Africa have been stagnant in the past 7 years although there have been intermittent surges in the usage of certain drug types at certain intervals.

However, the perception that the availability of support structures and infrastructures is reflective of progress in the fight against drugs is dismissed by UNICEF (2013) which posits that a true test of programme impact can only be measured in terms of the change in life circumstances of the target group of the interventions and not by looking at the availability of infrastructure to help them. This is true if understood in the light of the findings of this study, which proved that although rehabilitation centres were available, they were largely inaccessible to those who required their services due to cost, location, religious orientations, and gender skewedness, among other factors.

In the light of the sustainable livelihoods approach which underscores the notion that sustainable livelihoods have a ripple effect, implying that sustainability in one area of life should inspire sustainability in other spheres of people's lives (Rabinowitz & Chinapah, 2014), it is crucial to harness the current progress in Gauteng and diffuse it to all parts of the Province and country at large.

More importantly, the progress that has been identified in Gauteng in terms of ameliorating the substance abuse problem should not only focus on reducing the burden of substance abuse but also actively seek to diminish the factors that impel people to use drugs as well as improving the livelihoods of those who are recovering.

5.22. Reflecting on Study Objectives towards Building Conclusions

This section of the thesis aims to ascertain the extent to which the results of the study have met the study's aim, objectives as well as validating whether the study agrees or disagrees with the study's assumptions. This is important because a study that adequately meets the researcher's aim and objectives is deemed to be a worthwhile study enough to add valuable literature into its domain.

The research has so far provided an in-depth exploration of the contributions of rehabilitation centres and engaged several local and international debates regarding the work of rehabilitation centres and the extent to which they contribute to efforts of ameliorating the drug problem in South Africa and beyond. This has significantly helped to strategically position the findings of the study in a manner that reflects the extent to which the central objectives of the study have been met. As stated elsewhere in this thesis, the central aim of this study was to evaluate the contributions of two (2) selected drug and substance rehabilitation centres in Gauteng Province in combating the drug and substance abuse problem. Largely, the researcher is unequivocal that the aim of the study has succinctly been achieved because the study terrain has led to a thorough evaluation of two selected drug and substance rehabilitation centres. Fundamentally, all the possible contributions have been realised from both in-depth interviews and questionnaires. The study has also brought to the fore all the possible hurdles that confront the services of the rehabilitation facilities. A lot of recommendations emanating from this study succinctly indicate that the aim of the study has been achieved.

5.22.1. Pitting the study's objectives against the study findings

Perhaps a thorough validation of the extent to which the study has met its objectives can only be justified if each of the three objectives that premised the study is pitted against the study findings. The following discussion, therefore, will be made against each of the three objectives.

5.22.1.1. Objective 1: To establish the nature and potency of commonly abused drugs in Gauteng which render users rehabilitable

This study has fully met the objective of determining the nature and potency of abused drugs which were rendering users to seek rehabilitation in the two selected rehabilitation centres. The study made an inventory of all the drugs for which users were being rehabilitated. More specifically, the study revealed that Amphetamine Type Stimulant (ATS) drugs, including crystal meth, cat-amino and ecstasy were the most commonly abused drugs for which users were seeking treatment in the selected rehabilitation centres. Other drugs which were found to significantly cause admission of users in the selected rehabilitation centres, in order of their prevalence, included cannabis (natural and laboratory grown types), opiates (heroin, morphine, methadone, codeine, nyaope), sedatives (Valium, Mandrax, Rohypnol), hallucinogens (LSD, acid, mushrooms, nitrates, glue, petrol, paint thinners), Alcohol and Cocaine, Crack and Rocks.

In exploring the potency of abused drugs, the study found out that all the abused drugs generally had high potency. It was revealed that, among the drug users, the potency of a drug was generally construed in terms of the duration period of the drug's effects, time lapse between consumption of the drug and the onset of its effects, and also the physiological damages to the body attributable to the drug. In this light, users ranked Methamphetamine Type Stimulants as the most potent drugs followed by, opiates, followed by sedatives, and then followed by cannabis and alcohol; and, lastly, the hallucinogens.

5.22.1.2. Objective 2: To establish institutional and operational gaps associated with selected rehabilitation centres in Gauteng

Among its core focus areas; this study had set out to investigate institutional and operational gaps which were derailing the work of the selected rehabilitation centres. This objective has also adequately been met. This is because the study has been able to bring to the fore all the operational gaps including issues around poor visibility of the rehabilitation centres in local communities, lack of adequate and sustainable funding, heavy caseloads for therapists, lack of qualified personnel to run programmes and unsustainably quick turnover of professionals. It was also noted that the operational environment of rehabilitation centres was being stifled by outdated and disjointed legislative frameworks which made substance abuse rehabilitative work arduous. Other gaps which were identified pertain to the issues of exclusionary religious, social, linguistic, and dietary practices which favoured certain social groups over the others.

Towards fulfilling the objective of establishing institutional and operational gaps associated with the selected rehabilitation centres, the study further identified that, even though the gaps were there, they were surmountable, especially if synergies between the government and the rehabilitation centres were synchronised and pooled together towards fighting the drug problem in Gauteng and in South Africa as a whole.

5.22.1.3. Objective 3: To determine the nature and effectiveness of rehabilitation programmes offered by Gauteng rehabilitation Centres

I believe that this study has managed to meet its third objective which sought to determine the nature and effectiveness of rehabilitation programmes offered by the selected rehabilitation centres. This can be justified by the outcomes of the study which managed to illustrate the successes and milestones of the selected rehabilitation centres.

Towards fulfilling the requirements of the third objective (determining the nature and effectiveness of rehabilitation programmes), the study found out that the selected rehabilitation centres were of moderate sizes with both institutions having a combined capacity to accommodate 194 patients biannually and this translated to between 13 and 19 patients per month for institution X and Z, respectively. The study also managed to determine that the selected rehabilitation centres were providing programmes which included life skills training, psychotherapy, ibogaine treatment, vocational skills training (although with a limited scope of skills), pharmacotherapy (Methadone treatment although at individual expense), supplementary vitamins, 12 Steps Minnesota programme, sauna based detoxification, relapse prevention, reunification services (family therapy, couples therapy, community awareness programmes) and spiritual awakening programmes.

The study indicated that the rehabilitation programmes which were offered by the selected rehabilitation centres were successful in mitigating unsustainable lifestyles. To this end, the study proved that after partaking in the treatment programmes of the selected rehabilitation centres, recovering substance abusers showed positive improvements in terms of their capacity to work and retain employment, reduction in criminal involvements and violent predispositions, reduction in the need for medical assistance or hospitalisation, weight gain and improved personal and interpersonal relationships.

In further demonstrating the effectiveness of treatment programmes, the study made it clear that the selected rehabilitation centres were effective and unequivocally made significant contributions to the goal of ameliorating substance abuse in Gauteng localities and beyond. Rehabilitation centres were creating and providing non-judgemental opportunities for substance abusers, most of whom are disliked, ostracised, shunned, despised and stigmatised by their families and communities. Towards enhancing the lives of substance abusers, the selected rehabilitation facilities were intervening and providing physical, emotional and spiritual absolution for their clients and, thereby, allowing them to find meaning, acceptance and tolerance in their communities.

However, some perfidious factors which were militating against the effectiveness of the evaluated substance abuse treatment programmes were identified. These included issues of poor accessibility of treatment programmes due to high treatment fees, location of rehabilitation centres in difficult to access places, gender and age skewed services which favoured males at the expense of women and children and religious orientations which caused religious divides in the distribution of drug treatment services.

5.23. Pitting the study's Assumptions against Actual Findings

Although this study used mixed methods in data gathering, the predominant approach was qualitative and, therefore, the bulk of interpretations and discussions in this study were informed by qualitative methods. This justifies the researcher's consideration of the assumptions and not any set of hypothesis.

This finds support from the work of Creswell (2009) who underscores that, at times, a researcher may opt to use methodological triangulation for data gathering purposes, but retain one main approach for interpretive and reporting purposes. In this light, instead of using both hypothesis and assumptions, this study was only grounded in some orienting assumptions which were being tested. This section of the paper systematically pits the preconceived study assumptions against the findings.

5.23.1. Assumption 1: Drug and substance rehabilitation services are inaccessible to those who require them

The findings of the study vindicated the researcher's assumption that drug treatment centres in Gauteng were largely inaccessible to those who required their services. The findings of the study demonstrated that accessibility of drug treatment services were being thwarted by high cost factors, poor visibility due to poor marketing of services, gender and age skewed services, and inaccessible location factors. To this end, it was noted that the majority of the drug users and their families displayed poor affordability of drug treatment services. Furthermore, the study revealed that rehabilitation centres were generally not visible in local

communities as they were located in places where the majority of local people did not have access. This challenge was further compounded by the fact that rehabilitation centres were located in remote rural or affluent urban areas where accessibility was a challenge for the poor majority who did not have private transport to access these areas. In agreement with the researcher's assumption, the study findings further pointed that accessibility of drug treatment services had a gender and age dimension, which made treatment services to be skewed in favour of adult males at the expense of women and children.

There are also a host of other factors such as lack of adequate free public rehabilitation centres, religious and cultural insensitivity in selected rehabilitation centres, which were also militating against an equitable accessibility of drug treatment services in Gauteng.

5.23.2. Assumption 2: Out-dated drug treatment methods and policies render treatment efforts ineffective

The researcher's assumption that outdated drug treatment methods and policies render treatment efforts ineffective was moderately justified by the findings. The findings of the study illustrated that there were several policy gaps such as poor coordination and marketing of drug treatment services by service providers. Secondly, the research poignantly pointed out that, in terms of their work experience and academic qualifications, the personnel at the Department of Social Development lacked adequate capacity to efficiently drive the programme of ameliorating substance abuse in its current magnitude. Additionally, the study indicated that the currently available legislative resources were outdated and underfunded to be able to create an enabling environment for rehabilitation centres to contribute meaningfully to the goal of ridding South African environment of drugs.

5.23.3. Assumption 3: The nature and potency of commonly abused drugs calls for new and innovative treatment approaches

The study was commissioned under the assumption that the nature and potency of abused drugs require new intervention approaches to improve efficiency in treatment and motivate long term recovery. This assumption seem to greatly resonate with the findings of this study, which demonstrated that generally all the drugs which rendered users rehabilitable were highly potent, with possibilities of causing permanent mental disorders, triggering severe cravings which lead to relapse after treatment and being mortal if consumed in excess of tolerance levels. The potency of the drug was also indicated to cause some severe physiological damages to users such as meth mouth for those who use crystal meth, extreme paranoia and anxiety for those who abuse prescription medication among others. The findings of the study further indicated that there was a growing phenomenon of poly drug use which was leading to new unfamiliar symptoms and negative treatment outcomes. The nature and potency of the abused drugs suggests an urgent and greater need for the reconfiguration of approaches used by rehabilitation centres in order to reduce fatalities associated with these drugs as well as improve their treatment outcomes.

5.23.4. Assumption 4: South Africa stands to lose the battle against drugs if the contributions of rehabilitation centres remain unaccounted for

The researcher entered the research field with a strong conviction that Gauteng and, by extension, South Africa stood to lose the war on drugs if the country fails to account for the invaluable contributions of rehabilitation centres. This conjecture was bolstered and endorsed by the findings of this study which underscored that the problem of substance abuse was exponentially growing with new trends of substance abuse emerging, thereby vindicating a transition in the drug abuse landscape for the worst. The study findings proved that new trends of highly potent drugs such as amphetamines, methamphetamines and opiates, which are difficult to treat, are emerging, creating a trail of suffering for drug users and their families.

Moreover, the proliferation of poly drug use as a growing phenomenon in Gauteng suggests a bleak future, if no immediate remedial action is taken. The study found that poly drug use was ushering new outlandish harms, symptoms and relapse rates which are at odds with available treatment approaches and causing despondence among drug users and their families. Furthermore, the study proved that the delivery of drug treatment services in Gauteng was skewed in favour of males, thereby leaving out women and children. This is despite the apparent reality that the scourge of substance abuse is now affecting everyone across the spectrum regardless of their age and gender. Additionally, the finding that the poor majority were not able to access treatment due to an array of factors including high costs of treatment fees, location of rehabilitation centres in inaccessible places and poor marketing of services in local communities seem to prove the aforesaid assumption that the country will most likely lose the battle against drugs if the problems affecting these facilities remain unaddressed.

5.24. Implications for social work practice

Social work is increasingly becoming a key profession in many sectors of modern economies with some practitioners being employed in child and youth care settings (Reyneke, 2010), corporate settings as Employee Assistant experts (Strom-Gottfried & Mowbray, 2006), old age homes (Tshesebe & Strydom, 2016), correctional service Departments (CASW, 2016), academic settings as lecturers and, lately, in public health settings. Appreciably, the widening scope of social work practice indicates that the profession is growing. However, this growth is seeing social workers increasingly working in unfamiliar territories in which they are confronted with new experiences, demands, expectations and clients.

This study proved that social workers in substance abuse rehabilitation facilities were treading on relatively new ground in which new methods and approaches were required to effectively provide competent services. Their challenges were further compounded by lack of professional platforms for knowledge sharing towards enhancing interventions as well as for personal and professional growth.

The study further elucidated that the social workers in rehabilitation facilities were finding themselves having to deal with involuntary, relapsing, aggressive, psychotic, conspiratorial, diseased and suicidal clients who are generally dissimilar to conventional social work clients. Implicitly, social workers in these settings find themselves questioning their aptitude to provide sustainable and effective interventions. Moreover, being isolated in a domain which is traditionally reserved for medical practitioners, psychologists, physiotherapists and psychiatrists, social workers in drug treatment settings makes the social workers vulnerable to exploitation in terms of their salary scales as they lack a strong bargaining power.

If social work as a profession is to thrive in the drug treatment sector of South Africa, more needs to be done in terms of equipping social workers with necessary skills, motivation and tools to improve their deliverables in the sector. This needs to start at a conceptualization stage, where the vision of ameliorating substance abuse in the country is infused, firstly, into the social, moral and professional consciousness of social workers. This can be achieved through a serious realignment of current social work curricula with the vision of ameliorating substance abuse. With improved consciousness, knowledge and skills, social workers can better comprehend and accept the arduous task of fighting addictions with pride, wisdom and confidence.

As the South African society moves beyond, the country's educational sector ought to realize and appreciate the need for improved knowledge on addictions. It is regrettable that, despite the exponentially growing substance abuse problem, local Universities are failing to realize the need for specialized education on substance abuse in social work.

Worse still, social work researchers are slowly despairing and thus embracing the myth that substance abuse is now an exhausted domain whose facets have exhaustively been explored. The reality is that much still needs to be researched about modern substance abuse and, more especially, the role of social work in this domain. This researcher is optimistic that if social work positions itself correctly in the field of substance abuse, it is possible for the profession to achieve its goal of helping those who cannot help themselves.

Moreover, with many qualified social workers being unemployed, the drug treatment sector presents a huge employment avenue. Additionally, with the substance abuse field cutting across a number of social, economic, political and religious domains, achieving effectiveness in this sector is poised to bring about positive change to the general welfare and development of people in many other spheres of life.

5.25. Recommendations

This study established various contributions of the selected rehabilitation centres to the goal of ameliorating of substance abuse in Gauteng. In establishing these contributions, the study identified many legislative and operational gaps relating to the work of rehabilitation centres in the war against drugs in South Africa; and, more specifically, to the practice of rehabilitative social work in drug treatment settings. The study demonstrated that the contributions of the selected rehabilitation centres were adding value to the vision of a drug free South Africa as envisioned in the NDMPs, although there were some inherent challenges. Perhaps if the challenges and constraints of these facilities are addressed, the work of rehabilitation centres will make substantive contributions to the goal of ameliorating substance abuse in Gauteng and South Africa as a whole. This section of the thesis explores the possible recommendations that could help to improve the contributions of rehabilitation centres to the vision of a drug free South Africa.

5.25.1. Recommendations to the Government

5.25.1.1. *Decentralize Services and Opportunities to other Provinces to reduce Migration Pressure into Gauteng Province*

Gauteng remains a place of opportunity and hope for vast population groups, thereby triggering external migrations into the Province. However, due to resource scarcity, many end up worse off than they were before coming to the Province of the bright lights, and, as a result, economic pressure forces them to indulge in substance abuse to numb the painful realities of their lives.

Perhaps if the government takes initiative and attempts to reduce the influx of people to Gauteng by creating attractive economic opportunities for young people in their respective Provinces, this researcher is optimistic that the phenomenon would diminish their need to migrate to Gauteng. Hopefully, that would go a long way in reducing the problem of substance abuse.

5.25.1.2. *Improve easy Accessibility of Substance Abuse Treatment Services*

The study established a host of factors which undermined the ease and timely accessibility of drug treatment services in Gauteng. These factors were noted to elevate the harms that can be incurred by drug users and those living in their immediate environments. If South Africa is to win the fight against drugs, it is crucial for the country to radically improve the accessibility of drug treatment services for those who require them. This might imply that the government makes good its promise of building more public rehabilitation centres.

It is crucial, however, to note that while outpatient drug treatment services are considered to provide both an easier and a cost effective means of providing treatment services to a population, the services of outpatient programmes cannot replace the need for residential programmes as there are some complimentary benefits associated with the later that cannot be found in the outpatient programmes. These include milieu therapy, the removal of the drug user from the intoxicating environment, availability of assistive medical, emotional and dietary supports which might not be available in outpatient programmes.

5.25.1.3. *Need for Standardizing Drug Treatment Fees*

The government can also increase accessibility of drug treatment services by benchmarking treatment fees charged by rehabilitation centres in line with the prevailing economic conditions in the country. Another alternative is to call upon all private rehabilitation centres to offer treatment to a set number of clients on a pro-bono basis annually as a policy requirement. Ensuring affordability of drug treatment services would greatly improve on the accessibility of treatment to those who deserve them.

5.25.1.4. *Create an Enabling Environment through Designing Implementable, Measurable and Enforceable Legislations*

The study found some legislative gaps which impact negatively on the administration of rehabilitation centres. It was noted that, in some ways, the DSD and respective rehabilitation centres lacked capacity to run the substance abuse amelioration programmes. Moreover, in themselves, the National Drug Master Plans (NDMPs) seem to be too ambitious, yet ambiguous and unmeasurable. Trying to create a drug free country is seemingly impossible, but perhaps reducing the number of people affected and infected could be a more realistic vision. Perhaps this is the reason why the vision of a drug free South Africa, as espoused in the NDMPs, is failing to amass adequate financial, social, economic, political and cultural currency for success. A feasible, enforceable, well-funded, culturally salient, and gender sensitive legislative framework should be developed to guide the work of rehabilitation centres.

5.25.2. Recommendations to Rehabilitation Centres

5.25.2.1. *Increase Visibility of Rehabilitation Centres in Local Communities*

The results of the study proved that rehabilitation centres were operating mutedly in local communities. This was noted to defeat the principle of harm reduction as local people endured long and undeserved suffering which, in some instances, could be mortal simply because they did not know of the availability of treatment options. It is therefore recommendable that rehabilitation centres increase their visibility in local communities through choosing to locate them in easily accessible areas, advertising their services in local newspapers, television stations and conducting drug awareness campaigns aiming to inform the people about the availability of curative services. Furthermore, new players could also be incorporated in the system to exploit the neglected niche.

5.25.2.2. Ensuring Socio-cultural Sensitivity in the Administration of Rehabilitation

Centres

Therapeutic work, upon which all the services of rehabilitation centres are constructed, demands a high degree of sensitivity to people's plight. This is especially true if viewed from the perspective that modern trends of substance abuse are cutting across racial, tribal, social, economic, gender, age, literacy, sexual orientation and political divide. It is, therefore, important that rehabilitation centres socialize themselves to be receptive of all people of South Africa and appreciate their diversity. This can be demonstrated by the provision of appropriate social, economic, religious, linguistic, catering and cultural services which embrace the diversity of clients.

5.25.2.3. Lobby for the Provision of Vocational Training for Recovering Substance

Abusers

This study proved that rehabilitation centres were lacking in terms of equipping their clients with employable skills through which they could earn a living after rehabilitation. Viewed from a sustainable livelihood perspective, discharging recovering substance abusers to go back to their impoverished life where their livelihood assets cannot bankroll their needs is equivalent to setting them up for failure. It is, therefore, crucial that rehabilitation centres use their social capital and connections to persuade the donor sector and the government to help capacitate drug users who lack tradable skills through which they can earn a living.

5.25.2.4. Addressing Racial and Gender Attitudes towards Cultivating Receptive Societies for Easy and Successful Reintegration of Recovering Substance Abusers

The study established that there are inherent racial and gender attitudes which complicate the easy and successful reintegration of substance abusers back into their families and communities. It was noted that fewer White and Coloured people as well as African males were involved in aftercare support structures and this was described as an exhibition of racial and gender attitudes in communities. However, given the confidence pledged by caregivers and other participants of the current study in the work of rehabilitation centres, it is evident that rehabilitation centres are enjoying a huge social capital which can be used to challenge the racial and gender attitudes which stall the process of reintegration.

5.26. Recommendations for Further Research

This study evokes some pertinent and focused questions regarding possible areas where further research regarding the role of rehabilitations centres in ameliorating substance abuse in Gauteng and beyond may be undertaken. It has been established that accessibility to timely residential substance abuse treatment has a positive impact on the lifestyle of drug users. Could more research be carried out to ascertain feasible ways of increasing timely accessibility of treatment and to what extent could timely accessibility of interventions enhance treatment outcomes? The research also found that the distribution of drug treatment services was skewed in favour of adult males at the expense of women and children. Could it be possible that an assessment of the experiences of women and children with a substance abuse problem could shed more light on the treatment needs of these vulnerable and excluded groups? The study further revealed that the drug abuse landscape in Gauteng is gravitating towards encompassing educated young people. Is it possible that this new phenomenon could be linked to educated drug users using some specific drug types and what could be the reason behind this seemingly new phenomenon?

It was demonstrated by the findings of this study that a significant number of drug users in the selected rehabilitation centres were poly drug users. Is it possible that rehabilitation centres have no capacity and knowledge of dealing with poly drug users given that it is a relatively new phenomenon? Lastly, a host of challenges were found to be confounding with the work of the selected rehabilitation centres. Could it be possible to carry out a comparative study to view if these challenges are similar across the board in both public and private rehabilitation centres? These questions could constitute a number of researchable topics which can help to refine and position the work of rehabilitation in the fight against substance abuse in South Africa.

5.27. Study Conclusion

This research has irrefutably demonstrated that the selected Gauteng rehabilitation centres were immensely contributing to the goal of ameliorating substance abuse, although there are some challenges which threaten to thwart these contributions. Moreover, rehabilitation centres were acknowledged as pertinent and relevant vehicles for the establishment of a drug free South Africa as they have been noticed to assist in strengthening clients' resolve to quit drugs through the promotion of health lifestyles, provision of helpful therapeutic environments for recovery and the provision of medical services to assist with aversive withdrawals, among other factors. However, the study also pointed out some critical challenges which were undermining the contributions of rehabilitation centres. The research has unequivocally proved and substantiated the initial assumptions which were advanced by the researcher. Finally, with the nature and quality of contributions of rehabilitation centres and the resources at their disposal, the researcher believes that the goal of ameliorating substance abuse in Gauteng and South Africa in general is surmountable. This, however, might require various stakeholders to address some monumental operational and legislative gaps.

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Appendix 1: Ethical Clearance



University of Fort Hare
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ETHICAL CLEARANCE CERTIFICATE REC-270710-028-RA Level 01

Certificate Reference Number: KAN151SMAK01

Project title: **Evaluating the contributions of selected drug rehabilitation centres in Gauteng towards ameliorating the drug problem in South Africa.**

Nature of Project: PhD

Principal Researcher: Abigail Makuyana

Supervisor: Prof S.M Kang'ethe

Co-supervisor: N/A

On behalf of the University of Fort Hare's Research Ethics Committee (UREC) I hereby give ethical approval in respect of the undertakings contained in the above-mentioned project and research instrument(s). Should any other instruments be used, these require separate authorization. The Researcher may therefore commence with the research as from the date of this certificate, using the reference number indicated above.

Please note that the UREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the document
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research

The Principal Researcher must report to the UREC in the prescribed format, where applicable, annually, and at the end of the project, in respect of ethical compliance.

Special conditions: Research that includes children as per the official regulations of the act must take the following into account:


Note: The UREC is aware of the provisions of s71 of the National Health Act 61 of 2003 and that matters pertaining to obtaining the Minister's consent are under discussion and remain unresolved. Nonetheless, as was decided at a meeting between the National Health Research Ethics Committee and stakeholders on 6 June 2013, university ethics committees may continue to grant ethical clearance for research involving children without the Minister's consent, provided that the prescripts of the previous rules have been met. This certificate is granted in terms of this agreement.

The UREC retains the right to

- Withdraw or amend this Ethical Clearance Certificate if
 - Any unethical principal or practices are revealed or suspected
 - Relevant information has been withheld or misrepresented
 - Regulatory changes of whatsoever nature so require
 - The conditions contained in the Certificate have not been adhered to
- Request access to any information or data at any time during the course or after completion of the project.
- In addition to the need to comply with the highest level of ethical conduct principle investigators must report back annually as an evaluation and monitoring mechanism on the progress being made by the research. Such a report must be sent to the Dean of Research's office

The Ethics Committee wished you well in your research.

Yours sincerely


Professor Gideon de Wet
Dean of Research

15 June 2016

Appendix 2: Letter for Seeking Permission (supervisor)

Faculty of Social Sciences & Humanities

*Department of Social Work &
Development*

Private BagX1314

Kina Williams Town Rd



11th April 2016

To Whom It May Concern

Dear Sir/Madam

Re: Data Collection for Abigail Makuyana (Student Number: 200909479 - Passport Number: BN123578).

This is a support letter to confirm that Abigail Makuyana is a 2nd year PhD student at the University of Fort Hare. Her proposal has been accepted and approved by the Faculty Higher Degrees Committee. She has also obtained Ethical Clearance for her to collect data. Her project is entitled **“Evaluating the Contributions of Selected Drug Rehabilitation Centres in Gauteng towards Ameliorating the Drug Problem in South Africa”**.

Feel free to contact me if you have any grey areas concerning her data collection process as I am her supervisor.

Any assistance accorded to her will highly be appreciated.

Thank You.

Yours Sincerely,



Prof Simon M Kang'ethe

National Rated Social Work Researcher. (0027787751095; skangethe@ufh.ac.za)

Appendix 3: Informed Consent Form



University of Fort Hare
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FACULTY OF SOCIAL SCIENCES & HUMANITIES

ETHICS ANNEXURE 1

ETHICS RESEARCH CONFIDENTIALITY AND INFORMED CONSENT FORM

Please note:

This form is to be completed by the researcher(s) and signed by the interviewee before the commencement of the research. Copies of the signed form must be filed and kept on record.

Our University of Fort Hare / Department of Social Work is asking people from your organization / sample / group to answer some questions, which we hope will benefit your community and possibly other communities in the future.

The University of Fort Hare, Department Social Work/Social Development is conducting research regarding ***the Contributions of Selected Drug Rehabilitation Centres in Gauteng towards Ameliorating the Drug Problem in South Africa***. We are interested in finding out more about the role being played by rehabilitation centres, your perception of the effectiveness of interventions provided by these facilities and your perception of the challenges associated with these institutions in their pursuit to ameliorating the substance abuse problem in Gauteng. We are carrying out this research to help the policy makers, rehabilitation centres, government and the department of social development to adjust, reformulate or restructure policies towards achieving the goal of ameliorating the substance abuse problem in Gauteng and in South Africa in general.

Please understand that you are not being forced to participate in this study and the choice whether to participate or not are yours alone. However, we would really appreciate it if you do share your thoughts with us. If you choose not take part in answering these questions, you will not be affected in any way. If you agree to participate, you may stop me at any time and tell me that you don't want to go on with the interview. If you do this there will also be no penalties and you will NOT be prejudiced in ANY way. Confidentiality will be observed professionally. I will not be recording your name on the interview schedule or audio recorder and no one will be able to link you to the answers you give. Only the researchers will have access to the unlinked information. The information will remain confidential.

The interview will last around (40 to 60) minutes (*this has been tested through a pilot*). I will be asking you a questions and ask that you are as open and honest as possible in answering these questions. Some questions may be of a personal and/or sensitive nature. I will be asking some questions that you may not have thought about before, and which also involve thinking about the past or the future. We know that you cannot be absolutely certain about the answers to these questions but we ask that you try to think about these questions. When it comes to answering questions there are no right and wrong answers. When we ask

questions about the future we are not interested in what you think the best thing would be to do, but what you think would actually happen.

If possible, our organization would like to come back to this area once we have completed our study to inform you and your community of what the results are and discuss our findings and proposals around the research and what this means for people in this area.

INFORMED CONSENT by Participant

I hereby agree to participate in research regarding the contributions of rehabilitation centres to the goal of ameliorating substance abuse in Gauteng. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop this interview at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project whose purpose is not necessarily to benefit me personally.

I have received the telephone number of a person to contact should I need to speak about any issues which may arise in this interview.

I understand that this consent form will not be linked to the questionnaire, and that my answers will remain confidential.

I understand that if at all possible, feedback will be given to my community on the results of the completed research.

.....

Signature of participant

Date:

I hereby agree to the tape recording of my participation in the study

.....

Signature of participant

Date:

Appendix 4: Data Collection Tool: Interview Guide with Institutional Managers



University of Fort Hare
Together in Excellence

Interview Guide for managers

Dear participant

Substance abuse in South Africa has remained a topical issue whose deleterious effects have continued to ravage homes and lives. One of the acknowledged and helpful stakeholders involved in the fight against substance abuse are rehabilitation centres. However, their contribution in this noble fight has remained largely untested, unchallenged and uncelebrated. This research, therefore, is aimed at evaluating the contributions of rehabilitation centres in selected Gauteng rehabilitation facilities. It is in this light that I, Abigail Makuyana, under the supervision of Prof Kang'ethe would like to humbly request your participation. The current study is part of my PhD studies in Social Work which I am doing with the University of Fort Hare. Allow me to hasten to mention that your voluntary contribution in this research will go a long way in helping the South African society at large in developing suitable and sustainable modalities for fighting and reversing the impacts of substance abuse.

During this interview, you are requested to respond to a number of questions. All the questions are about your perception and experience of the effectiveness of the rehabilitation centre in which you are working. At most, the interview will take 45 minutes of your time. Your participation in this research is completely voluntary, and you have the right to withdraw from further participation without any questions asked. You might be interested to know that your participation is strictly confidential. At no point will your name or that of your loved one, or any information that may be linked to you shall be published or be seen by a third party save for my supervisor. In case of any questions please do not hesitate to contact me via this email 200909479@ufh.ac.za

Yours Sincerely

Abigail Makuyana: Principal Researcher

Section A: Biographical information

1. <i>Gender</i>	
2. <i>Race</i>	
3. <i>Age</i>	
4. <i>Marital Status</i>	
5. <i>Highest academic qualification</i>	
6. <i>Number of years in the management of the Rehabilitation centre</i>	

7. **Nature of Rehabilitation Programmes Offered In Selected Rehabilitation Centres**

- What rehabilitation services do you offer to your patients
- How long is your programme?
- Who administers this programme?
- What are the goals of the said programmes?

8. **Effectiveness Of The Treatment And Intervention Programmes**

- Do the programmes which you offer also involve capacity building amongst your clients in terms of skills training?
- Do you have a monitoring and evaluation programme to measure your success/relapse rates?

9. **Programmes' Flexibility In The Face Of Ever Changing Drug Abuse Landscape**

- What are the main drug types which most of your patients seek help for?
- Do you offer any detoxification programmes?
- Do you have outreach awareness campaigns or after care services?

10. **Institutional and Operational Challenges in Rehabilitation Facilities**

- Do you think that this facility has the necessary infrastructure insofar as recovery is concerned?
- In such a precarious financial environment, how do you fund the running of this facility?
- Do you think the location of this facility is suitable for the purpose for which it was established?

Appendix 5: Data Collection Tool: Focus Group Discussion Guide with Aftercare Patients



University of Fort Hare
Together in Excellence

Focus Group Discussion Schedule

With Aftercare Focus Group Participants

Dear Participants

I would like to thank you all for agreeing to be part of this research process. My name is Abigail Makuyana and with me today is my research assistant Paul. Our research team has, in the past few weeks, been entrusted with the task of collecting information from various sources including you to validate the contributions of rehabilitation centres in the fight against drug and substance abuse in Gauteng Province. This group discussion has thus been customized to get information to enable this evaluation.

It is our belief that you might be having some uncertainties regarding how we are going to go about the scheduled discussion. To this end, let me tell you a little about how we are going to conduct our group discussion today. As we have already established, participation in this discussion is voluntary, as such, if at any point you feel uncomfortable, you are free to discontinue your participation without any problems. However, we would want you to know that your opinion in this process is invaluable, thus we hope that you will stay and share your views. Let it be known that whatever we are going to discuss in this group will remain confidential and will be used for the sole purpose of this research only. At no point will your participation in this study bring your reputation and health into any disrepute. Given human uniqueness which often shapes our experiences and subjective perception of social reality, you need to know that there are no wrong or right answers in this discussion, we simply are asking for your opinions and experiences so please feel free and comfortable to say what you really think. We would like to hear as many points of view as possible so feel free to disagree with someone else and share your own view but also respect the view of others.

During the discussion, my colleague and I will be taking down notes. Please don't be limited to say experiences which are strictly in line with our questions, you can say anything as long you believe that it has relevance to the subject we are talking about. Nonetheless, so that we do not have to worry about writing every word on paper we would also like to record the whole discussion. The reason for recording is so that we don't miss anything that is said. Our discussion will remain confidential. The discussion will probably last about any hour. Do you have any questions before we start?

TOPIC 1: Group Characteristics

Participant ID	Q1	Q2	Q3	Q4	Q5	Q6
	Gender	Age	Primary Drug of Choice	Highest Level of Education	Marital Status	Occupation
A-T.1.						
A-T.2						
A-T.3						
A-T.4						
A-T.5						
A-T.6						
A-T.7						
A-T.8						

TOPIC 1: Length of treatment programmes as a function of their effectiveness

- Do you think the current lengths of drug treatment programmes are long enough to be effective?
- What do you think influences or should influence the length of a drug treatment programme

TOPIC 2: Affordability of drug treatment programmes

- What do you think about the cost of drug treatment costs?

Topic 3: Accessibility of drug and substance treatment services

- Would you say drug treatment services are easily accessible in Gauteng?
- What factors do you think affects easy accessibility of drug and substance abuse treatment services

Topic 4: Service Satisfaction

- Would you say you are happy with the services you received during your stay in the rehabilitation centre you were admitted in?
- What would you consider as the worst part of your experiences in this facility?
- What would you consider as the best aspect of you experiences in this facility?

Topic 5: Role being played by Rehabilitation Centres in the Fight against Drug Abuse

- What contribution do you think rehabilitation centres are making in reducing drug and substance abuse in Gauteng?
- Would you say being in the rehabilitation centre had any impact in terms of
 - (i) Reducing your tendencies of being involved in violence
 - (ii) Improving your work/School focus, and productivity
 - (iii) Increasing your presence at work
 - (iv) Improving your personal hygiene and self-upkeep
 - (v) Reducing your clashes with the law/police
 - (vi) Gaining weight
 - (vii) Reducing the need and frequency of being admitted in hospital
 - (viii) Improving your personal and interpersonal relationships.

Topic 7: State of infrastructure in Rehabilitation Centres

- What do you think about the infrastructure in the rehabilitation centre you were treated in?

Topic 8: Gender and Substance Abuse Treatment

- Do you think rehabilitation centres are offering women and girl children equal opportunities for treatment?

CONCLUSION

We are now reaching the end of the discussion. Does anyone have any further comments to add before we conclude this session?

Closing

I would like to thank you all for your participation in this discussion, your experiences and opinions are very valuable to assist in improving the quality of services of rehabilitation centres towards enhancing their deliverables to the wider context of achieving a drug free South Africa.

Appendix 6: Data Collection Tool: Focus Group Discussion Guide with in-treatment Patients



University of Fort Hare
Together in Excellence

FOCUS GROUP DISCUSSION SCHEDULE

With in-treatment Focus Group Participants

Dear Participants

I would like to thank you all for agreeing to be part of this research process and for availing yourselves today for this purpose. My name is Abigail Makuyana and with me today is my research assistant, Paul. Our research team has, in the past few weeks, been entrusted with the task of collecting information from various sources including you guys to validate the contributions of rehabilitation centres in the fight against drug and substance abuse in Gauteng Province.

It is our belief that you might be having some uncertainties regarding how we are going to go about the scheduled discussion. To this end, let me tell you a little about how we are going to conduct our group discussion today. As we have already established, participation in this discussion is voluntary, as such, if at any point you feel uncomfortable, you are free to discontinue your participation without any problems. However, we would want you to know that your opinion in this process is invaluable thus we hope that you will stay and share your views. Let it be known that whatever we are going to discuss in this group will remain confidential and will be used for the sole purpose of this research only. At no point will your participation in this study bring your reputation and health into any disrepute. Given human uniqueness which often shapes our experiences and subjective perception of social reality, you need to know that there are no wrong or right answers in this discussion, we are simply asking for your opinions and experiences so please feel free and comfortable to say what you really think. We would like to hear as many points of view as possible so feel free to disagree with someone else and share your own view but also respect the view of others.

During the discussion, my colleague and I will be taking down notes. Please don't be limited to say experiences which are strictly in line with our questions, you can say anything as long you believe that it has relevance to the subject we are talking about. Nonetheless, so that we do not have to worry about writing every word on paper we would also like to record the whole discussion. Our discussion will remain confidential. The discussion will probably last about any hour or so. Do you have any questions before we start?

TOPIC 1: Group Characteristics

Participant ID	Q1	Q2	Q3	Q4	Q5	Q6
	Gender	Age	Primary Drug of Choice	Highest Level of Education	Marital Status	Occupation
<i>I-T.1.</i>						
<i>I-T.2</i>						
<i>I-T.3</i>						
<i>I-T.4</i>						
<i>I-T.5</i>						
<i>I-T.6</i>						
<i>I-T.7</i>						
<i>I-T.8</i>						

TOPIC 1: Duration of treatment programmes

- For how long are you going to be admitted in this facility?
- Do you think the admission period is long enough to cater for all your needs?
- Would you propose to increase/decrease the duration period of drug treatment programmes?
- What do you think influences or should influence the length of a drug treatment programme?

TOPIC 2: Affordability of drug treatment programmes

- What do you think about the cost of drug treatment services you are getting?

Topic 3: Accessibility of drug and substance treatment services

- Would you say drug treatment services are easily accessible in Gauteng?
- What factors do you think affect the accessibility of drug and substance abuse treatment services in Gauteng?

Topic 4: Service Consumer Satisfaction

- Would you say you are happy with the services you are receiving here?
- What would you consider as the worst part of your experiences in this facility?
- What would you consider as the best aspect of you experiences in this facility?

Topic 5: Role being played by Rehabilitation Centres in the Fight against Drug Abuse

- What contribution do you think rehabilitation centres are making in reducing drug and substance abuse in the Gauteng?
- Would you say being in the rehabilitation centre is making any impact in terms of:
 - (ix) Reducing your tendencies of being involved in violence
 - (x) Improving your focus, and productivity
 - (xi) Developing some form of consistency and positive routine in your life
 - (xii) Improving your personal hygiene and self-upkeep
 - (xiii) Gaining weight
 - (xiv) Improving your personal relationships.

Topic 7: State of infrastructure in Rehabilitation Centres

- What do you think about the infrastructure in this facility?

Topic 8: Gender and Substance Abuse Treatment

- Do you think rehabilitation centres are offering women and girl children equal opportunities for treatment?

Topic 9: What is the cost of abused drugs in Gauteng?

- How much were you paying for the following drugs?

Drug Type	Price Range Per Standard Quantity
Cannabis	
ATS (crystal meth, cat, ecstasy)	
Cocaine, Crack, Rocks	
Inhalants (nitrates, glue, petrol, paint thinner, etc.)	
Sedatives or sleeping pills (Valium, Mandrax, Rohypnol, Pax, Rivitrol, Ritalin)	
Hallucinogens (LSD, acid, mushrooms, microdot)	
Opiates (heroin, morphine, methadone, codeine, nyaope)	

Topic 10: Potency of Abused Drugs

- Which types of drugs do you think are the most potent?
- What factors do you think affect a drug's potency? Please explain in terms of the drug which you were using?

CONCLUSION

We are now reaching the end of the discussion. Does anyone have any further comments to add before we conclude this session?

Closing

I would like to thank you all for your participation in this discussion, your experiences and opinions are very valuable to assist in improving the quality of services of rehabilitation centres towards enhancing their deliverables to the wider context of achieving a drug free South Africa.

Appendix 7: Data Collection Tool: Interview Guide with DSD Representatives



University of Fort Hare
Together in Excellence

Interview Guide for DSD key informants

Dear participant

Substance abuse in South Africa has remained a topical issue whose deleterious effects have continued to ravage homes and lives. One of the acknowledged and helpful sectors involved in the fight against substance abuse are drug and substance rehabilitation centres. However, their contribution in this noble fight has remained largely untested, unchallenged and uncelebrated. This research, therefore, is aimed at evaluating the contributions of rehabilitation centres in selected Gauteng rehabilitation facilities. It is in this light that I, Abigail Makuyana, under the supervision of Prof Kang'ethe, would like to humbly request your honest participation. The current research is part of my PhD academic study in Social Work under the auspices of the University of Fort Hare; hence there are no perceivable negativities to your person or anyone related to you. Allow me to hasten to mention that your voluntary contribution in this research will go a long way in helping the South African society at large in developing suitable and sustainable modalities for fighting and reversing the impacts of substance abuse.

During this interview, you are requested to respond to a number of questions. All the questions are about your perception and experience of the effectiveness of the rehabilitation centres. At most, the interview will take 45 minutes of your time. Your participation in this research is completely voluntary, and you have the right to withdraw from further participation without any questions asked. You might be interested to know that your participation is strictly confidential. At no point will your name or that of your loved one, or any information that may be linked to you be published or be seen by a third party, save for my supervisor. In case of any questions, please do not hesitate to contact me via this mobile phone number: 0743889516 or email 200909479@ufh.ac.za.

1.

Participant Characteristics.		
Characteristic	Participant 1	Participant 2
Gender		
Age		
Educational Qualifications		
Marital Statuses		
Years of Work Experience		

2. Rehabilitation Programmes Offered In Selected Rehabilitation Centres

- ❖ Do you prescribe or provide any guidelines as to which programmes are to be offered in rehabilitation centres under your jurisdiction?
- ❖ What is DSD's stance on the treatment needs of women and children?

3. Effectiveness Of The Treatment And Intervention Programmes

- ❖ According to my understanding, DSD is charged with the responsibility of registering and monitoring the work of rehabilitation facilities, as per your experience does DSD have the capacity for this function?
- ❖ The DSD has been working with various stakeholders, including the Central Drug Authority, towards establishing a drug free South Africa, how far has Gauteng as a Province moved towards achieving this vision?

4. Institutional and Operational Challenges in Rehabilitation Facilities

- ❖ As the assessing authority, what are the operational challenges being faced by rehabilitation facilities?

Appendix 8: Data Collection Tool: Interview Guide with therapists



University of Fort Hare
Together in Excellence

Interview Guide for managers and therapists

Dear participant

Substance abuse in South Africa has remained a topical issue whose deleterious effects have continued to ravage homes and lives. One of the acknowledged and helpful sectors involved in the fight against substance abuse are drug and substance rehabilitation centres. However, their contribution in this noble fight has remained largely untested, unchallenged and uncelebrated. This research, therefore, is aimed at evaluating the contributions of rehabilitation centres in selected Gauteng rehabilitation facilities. It is in this light that I, Abigail Makuyana, under the supervision of Prof Kang'ethe would like to humbly request your honest participation. The current research is part of my PhD academic study in Social Work under the auspices of the University of Fort Hare hence there are no perceivable negativities to your person or anyone related to you. Allow me to hasten to mention that your voluntary contribution in this research will go a long way in helping the South African society at large in developing suitable and sustainable modalities for fighting and reversing the impacts of substance abuse.

During this interview, you are requested to respond to a number of questions. All the questions are about your perception and experience of the effectiveness of the rehabilitation centre in which you are working. At most, the interview will take 45 minutes of your time. Your participation in this research is completely voluntary, and you have the right to withdraw from further participation without any questions asked. You might be interested to know that your participation is strictly confidential. At no point will your name or that of your loved one, or any information that may be linked to you shall be published or be seen by a third party, save for my supervisor. In case of any questions please do not hesitate to contact me via this mobile phone number: 0743889516 or email 200909479@ufh.ac.za

1.

Therapist Characteristic	Institution X	Institution Z
Gender		
Race		
Age		
Marital Status		
Highest Level of Education		

2. Rehabilitation Programmes Offered In Selected Rehabilitation Centres

- ❖ What rehabilitation programmes do you offer to your patients?
- ❖ How long is each of these programmes?

3. Effectiveness Of The Treatment And Intervention Programmes

- ❖ If you were to suggest any changes to the current programmes, what would they be?
- ❖ Do the programmes which you offer also involve capacity building amongst your clients in terms of skills training?

4. Programmes' Flexibility In The Face Of Ever Changing Drug Abuse Landscape

- ❖ Do you think the available programmes are effectively addressing the different needs and diversity of your clients?
- ❖ What are the main drug types which most of your patients seek help for?
- ❖ Do you have outreach awareness campaigns or after care services?

5. Institutional and Operational Challenges in Rehabilitation Facilities

- ❖ What challenges are you facing as a therapist insofar as your work is concerned?
- ❖ Do you think working here can enhance your professional growth in any way?

Appendix 9: Data Collection Tool: Mini survey Questionnaire for Caregivers



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QUESTIONNAIRE

My name is Abigail Makuyana; I am a PhD student in the Department of Social Work/ Social Development at the University of Fort Hare. I am conducting a survey on the contributions of drug and substance rehabilitation centres to the goal of ameliorating the growing pandemic of drug and substance abuse in Gauteng. The study frames 'contributions' as effectiveness of treatment, measured in terms of the nature, quality, accessibility, cost effectiveness and appropriateness of services rendered by the treatment facilities. This questionnaire has thus been formulated to obtain the perceptions and experiences of the family members of recovering substance abusers to answer some pertinent questions. You have been selected to participate in the study; hence you are humbly requested to answer the following questions with your utmost honest. Please rest assured that your participation in this study and your responses thereof will remain confidential. The findings of the study will solely be used for academic purposes. Thank you for your cooperation

Yours Sincerely

Makuyana Abigail (Ms)

A handwritten signature in black ink that reads 'Abigail Makuyana'.

Instructions: Please tick the option you think is most applicable to you

SECTION A: BIOGRAPHICAL INFORMATION

1. What is your gender?

- 1. Female
- 2. Male

2. What is your age?

- 1. 20 – 25 years
- 2. 25 – 30 years
- 3. 30 – 35 years
- 4. other

3. What is your marital status?

- 1. Married
- 2. Divorced
- 3. Separated
- 4. Widowed
- 5. Single

4. What is your relationship with the recovering substance abuser?

- 1. Father
- 2. Mother
- 3. Legal guardian
- 4. Wife
- 5. Husband
- 6. Other

5. What is your race?

- 1. Black
- 2. Colored
- 3. White
- 4. Indian
- 5. Other

6. What is your highest level of education?

- 1. Uneducated
- 2. Primary
- 2. Secondary
- 3. FET College
- 4. University

7. What is your occupation status?

- 1. Employed
- 2. Unemployed
- 3. Self-employed
- 4. student

8. What is the range of your household's income per month?

- 1. R0 - R3000
- 2. R3000 - R6000
- 3. R6000 - R9000
- 4. R9000 - R12000
- 5. R12000 and above

9. What is the number of people staying in your household?

- 1. 0 - 2
- 2. 2 - 3
- 3. 3 - 4
- 4. 4 - 5
- 5. More than 5

10. What is the type of your dwelling/housing?

- 1. Formal
- 2. Informal

11. You stay in?

- 1. Urban area
- 2. Rural area

12. You stay in a

- 1. High density residential area (township)
- 2. Medium density residential area
- 3. Low density residential area (suburbs)
- 4. Farm
- 5. Communal area

SECTION B

To determine the nature and effectiveness of rehabilitation programmes offered by Gauteng Rehabilitation Centres

13. How long was the admission period for your loved one?

- 1. 1 – 2 week
- 2. 2 – 3 weeks
- 3. 3 – 4 weeks
- 4. 4 – 5 weeks
- 5. 5 – 6 weeks
- 6. More than 6 weeks

14. Would you agree that the admission period was long enough to help your loved one?

- 1. Strongly agree
- 2. Agree
- 3. Neutral
- 4. Disagree
- 5. Strongly Disagree

15. Would you say drug and substance abuse treatment is expensive?

- 1. Strongly agree
- 2. Agree
- 3. Neutral
- 4. Disagree
- 5. Strongly Disagree

16. Would you say treatment services for drug and substance abuse are easily accessible?

- 1. Strongly agree
- 2. Agree
- 3. Neutral
- 4. Disagree
- 5. Strongly Disagree

17. Would you say your expectations regarding the treatment outcomes of your loved one satisfied you?

- 1. Highly satisfied
- 2. Satisfied
- 3. Neutral
- 4. Not satisfied
- 5. Not satisfied at all

Did you notice any significant change in terms of the following aspects of your loved one after rehabilitation?

	Yes	No
18. Positive Change of behavior		
19. Reduced Criminal activities		
20. Arrest by police		
21. Improved presence at work		
22. Improved interests in self-development		
23. Improvement in personal hygiene and upkeep		
24. Reduced need for medical assistance/admission in hospital		
25. Weight gain		
26. Reduced domestic violence		

27. Would you say drug and substance rehabilitation centres are significantly contributing to the reduction of the drug and substance abuse problem in Gauteng?

- 1. Strongly agree
- 2. Agree
- 3. Neutral
- 4. Disagree
- 5. Strongly Disagree

SECTION C

To establish institutional and operational gaps associated with selected rehabilitation centres in Gauteng

28. How did you get to know about the services of the centre you sent your loved one to?

- 1. Through local community radio
- 2. Through internet
- 3. Through social networks
- 4. Through word of mouth by someone
- 5. Through community awareness campaigns by the Centre's personnel

29. There are suggestions that rehabilitation centres display a poor infrastructure, do you agree?

- 1. Strongly agree
- 2. Agree
- 3. Neutral
- 4. Disagree
- 5. Strongly Disagree

30. There are insinuations that the location of drug and substance treatment facilities makes them inaccessible to many, would you agree?

- 1. Strongly agree
- 2. Agree
- 3. Neutral
- 4. Disagree
- 5. Strongly Disagree

31. Would you agree that drug and substance abuse treatment in Gauteng favors the treatment of adult males at the expense of children and women?

- 1. Strongly agree
- 2. Agree
- 3. Neutral
- 4. Disagree
- 5. Strongly Disagree
-

32. Some people claim that the current cost of drug and substance treatment in South Africa hinders many people from accessing treatment, do you agree?

- 1. Strongly agree
- 2. Agree
- 3. Neutral
- 4. Disagree
- 5. Strongly Disagree

The end

Thank you for your participation

Appendix 10: Proof of language and Grammar Editing


EDITING/PROOFREADING CERTIFICATE

To whom it may concern

This serves to certify that I, Jabulani Mkhize, have proofread and/or edited Ms. Abigail Makuyana's doctoral thesis to ensure that the language, grammar, punctuation and spelling are academically sound and appropriate, by rectifying errors, wherever these have been identified, and rephrasing sentences that would possibly make one lose sight of the flow of the argument.

Thesis Title: "Evaluating the contributions of selected drug rehabilitation centres in Gauteng: Towards ameliorating the drug problem in South Africa."

Editors Name: Jabulani Mkhize

Signature : 

Date : 30 April 2017

Contact Details: jmkhize@ufh.ac.za or gorky511@gmail.com

Qualifications: PhD (English)