

SUHEIMA HOOSEN

**SUBSTANCE ABUSE TREATMENT AND
REHABILITATION PROGRAMMES IN SOUTH
AFRICA: IMPLICATIONS FOR SOCIAL POLICY**

SUPERVISOR : PROF. E.A.MANTZARIS

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ABSTRACT

THIS STUDY EXAMINES SUBSTANCE ABUSE IN SOUTH AFRICA WHICH POSES MAJOR CHALLENGES IN THE AREAS OF ASSESSMENT, TREATMENT, REHABILITATION AND AFTER-CARE. THIS HAS A DIRECT IMPACT ON A NUMBER OF POLICIES DEALING DIRECTLY WITH RESOURCES, BUDGETS, NORMS AND STANDARDS OF / FOR SERVICE DELIVERY.

THIS STUDY FOCUSSES ON THE AGENCIES AND THE INDIVIDUALS BECAUSE BOTH ARE CRUCIAL IN THE INTERVENTION, PLANNING OF TREATMENT AND REHABILITATION PROGRAMMES AS WELL AS IMPLEMENTING POLICY.

THIS RESEARCH INVESTIGATED THE TYPES OF TREATMENT AVAILABLE, THE MULTI-DISCIPLINARY TEAM, ITS FUNCTIONS, AREAS OF NEED AND CONCERNS REGARDING THE CURRENT POLICIES. THE ASSESSMENT OF THE SERVICE DELIVERY ORGANISATIONS REVEALED, DEDICATION BUT ALSO A NUMBER OF ISSUES THAT NEEDED TO BE DEBATED UPON. FEW AGENCIES CHANGED OR USED MORE UP TO DATE INTERVENTION MODELS, WHICH GIVES THE CLIENT FREEDOM OF CHOICE AND ALLOWED HIM/HER TO BE THE MAJOR CHANGE AGENT IN HIS/HER BEHAVIOUR CHANGES. A LACK OF KNOWLEDGE OF CHEMICAL SUBSTANCES AND SUBSTANCE ABUSE LEADS TO INAPPROPRIATE TREATMENT PLANS WHICH IN MANY INSTANCES LEADS TO THE RELAPSE RATES REMAINING HIGH.

A STUDY OF THE MULTI DISCIPLINARY AND INDIVIDUAL TEAM MEMBERS OF GOVERNMENTAL, NON-GOVERNMENTAL AND PRIVATE REHABILITATION AND TREATMENT CENTRES WAS CONDUCTED TO ASSESS THEIR KNOWLEDGE BASE AND ISSUES THEY FACED. AN EXAMPLE WOULD BE THE DUAL DIAGNOSED CLIENTS, WHO HAVE FALLEN THROUGH THE NET

BECAUSE OF LACK OF TRAINING THEORY AND PRACTICE ON THE PART OF THE MULTI-DISCIPLINARY TEAM.

THE STUDY REVEALED THAT THE GAP BETWEEN POLICY AND PRACTICE NEEDS TO BE MORE INTEGRATED TO ACHIEVE THE DESIRED DRUG FREE INDIVIDUALS. AGENCIES DO NOT HAVE THE TIME OR THE ENERGY TO DEAL WITH AND IMPLEMENT NEW AND OTHER POLICY CHANGES. THIS RESULTS BECAUSE OF OVERLOAD, LACK OF FUNDS AND LACK OF HUMAN RESOURCES.

THROUGH THE LITERATURE STUDY A COMPREHENSIVE PROGRAMME FOR TREATMENT AND REHABILITATION IS RESEARCHED TO MEET THE UNIQUE INDIVIDUAL NEEDS OF THE SUBSTANCE ABUSER AND ALSO THE TEAM /INDIVIDUALS WHO PLAN THE TREATMENT.

A LARGE NUMBER OF MODELS ARE DISCUSSED SO THAT THE PLANNING TEAM CAN CHOOSE APPROPRIATE ONES TO MEET THE NEEDS OF CLIENTS. ANOTHER AREA OF ASSESSMENT WAS THE INDIVIDUAL TEAM MEMBERS OPINIONS ON TREATMENT TIME FRAMES AND TREATMENT STRATEGIES. THIS THESIS RESEARCHED EVERY COMPONENT TREATMENT PROGRAMMES AND STRATEGIES AND SHOULD BE USED AS A REFERENCE AND TRAINING GUIDE BY ALL THOSE INVOLVED IN SERVICE DELIVERY IN THE FIELD OF SUBSTANCE ABUSE IN SOUTH AFRICA AND GLOBALLY.

OF SPECIAL EMPHASIS WOULD BE THE UNDERSTANDING OF DUAL DIAGNOSIS AND THE PROVISION OF A SUITABLE TREATMENT PROGRAMME. THE INVESTIGATION INTO SOCIAL POLICIES PROVIDES FOR A MORE COMPREHENSIVE PARTNERSHIP BETWEEN AGENCIES AND GOVERNMENT TO MEET THE NEEDS FO SUBSTANCE ABUSERS IN SOUTH AFRICA AND WORLD WIDE.

Chapter 1

INTRODUCTION:

1.1 THE VISION AND MOTIVATION OF THE STUDY

The vision of this thesis is to contribute to the building of a drug free society through collective efforts and to make a contribution to the global problem of substance abuse.

South Africa has entered into a human rights culture now more than any time in its history. The Government of the country has declared that

“we are in position to devote our energies exclusively to the well being of our citizens. Thus the Government has adopted a far-reaching strategy to create economic opportunities and a better life for all. This is a long way towards addressing the causes of substance abuse”.

It is hoped that the present thesis will be of assistance to this noble mission and vision.

South Africa is a society in transition and the economic, political, cultural and social changes that have taken place in the 10 years of democracy are many and varied. This is also true of important changes in social and public policy matters as well as relevant legislation that have a direct effect on people's lives. The

study of drug abuse as well as its treatment cannot be performed in a vacuum , it needs to be examined within the context of fundamental changes in the social and political terrain of our country.

The examination, empirical study and analysis of individuals and rehabilitation centers that forms the core of this study cannot be done in isolation from their societal context or a thorough understanding of the theoretical foundations of drug abuse, treatment and relapse.

Inevitably then treatment , examination of patients and the whole process of the struggle to rehabilitate a client have direct relations to resource allocation, budgeting, setting of norms and standards, problem-solving strategies and the like. These are all related to the form of intervention of the multi-disciplinary team or its equivalents in the fight against all forms of drug abuse.

The study will focus on both the agency and the individual because both are considered critical players in a number of key intervention strategies.

1.2 THE RESEARCH PROBLEM

The research will attempt to investigate various key issues associated with drug use and abuse, treatment and relapse .In order to determine and examine the various types of treatment and rehabilitation problems available to substance abusers , an empirical study was devised . The local and international literature on the problem was scrutinised regarding various treatment approaches and the use of multi-disciplinary teams . It is well known that various treatment approaches have been adopted in South Africa, but the relapse rates still remain high .There have been several key areas of treatment, such as dual diagnosis

that have not received the attention they deserve ,both in terms of theory, research and implementation.

The thesis examines such problems and attempts to explain the issues identified above in their social and legal contexts and will attempt to establish what treatments suit the substance abuse population of South Africa. Of course this will be done in the context of a case study such as this .In this process both representatives of multi-disciplinary teams operating in agencies , as well as individuals members of such teams were interviewed in relation to these key issues associated with treatment strategies.

In this sense the empirical component of the thesis sought to examine a number of key issues associated with treatment programmes in terms of :

- their functionality and efficiency,
- the composition of the treatment team,
- the perceived or real effectiveness of the team , and
- the utilisation of the various models used in the treatment process and their application to South African conditions.

In fact the key research questions of the study were devised in order to identify the most common substances used by clients as well as the major problems encountered in treatment and the relation of substance abuse with psychiatric disorders . The potential relationship between HIV/AIDS/STDs with substance abuse was central in the study as was the relapse rates and their root causes.

One of the major research aims and objectives of the thesis was to investigate the implementation and applicability of holistic community based treatment programmes with the view of re-integrating the client into society and the role of

the key stakeholders and role- players in this process , especially family and community.

The role of family therapy and its importance in the treatment process was investigated as were the difficulties encountered in such circumstances . In this sense the process of evaluation and its examination became pertinent, especially after the completion of treatment.

One of the key research objectives of the study was the investigation of policy issues associated with drug dependence and their role in the rehabilitation and treatment processes. In this context issues of clarity, efficiency and applicability were examined .

The main focus of the research problem of the study was based on the belief that the marriage between theoretical foundations and empirical realities of phenomena such as drug addiction and treatment is inevitable in order to have a holistic picture of the problems and possible solutions to them.

1.3 OBJECTIVES OF THE STUDY

There were several key objectives in the study which were inextricably linked with both theoretical and empirical realities associated with drug and substance abuse and their relation to professional service, the social and legal context of South African society and the problems clients, family and professionals face in the process of rehabilitation and relapse . Thus:

- There could be no proper examination of such processes without an overview of drug abuse in South Africa.
- The significance of planning of programmes for treatment is inextricably linked with both the theoretical and empirical tenets of the study.
- The utilisation of various models of treatment will be examined.
- The goals of specific treatment are inextricably linked to success or failure rates in treatment patterns.
- The treatment of dually diagnosed clients and its repercussions is of vital importance for the future.
- Relapse patterns and their prevention were examined as was the effectiveness of NDMH .
- The implementation of existing policy of Social Welfare was researched as an integral part of this process
- The evaluation of the programmes formed an integral part of the investigation.
- The existing funding patterns and policies as well as training policy and its effects were examined.

It can be thus said that the relationship between the aims and objectives of the study and the theoretical and empirical roots of the study forms the basis of the holistic approach undertaken in the context of this study.

1.4 DRUGS : DEFINITIONS OF CONCEPTS

Drugs is a danger to society and its very survival .Social, economic and psychological reasons facing individuals and groups coerce or force them into use and abuse with disastrous consequences for them, their families and society at large . There have been many books, monographs, research papers and indeed a vast literature on drugs and its repetition would be really unnecessary . However , it was felt that it is important to at least give a brief definition of the

most important and commonly used in South Africa for the benefit of the reader, although other parts of this thesis will elaborate more substantially on all significant aspects of this phenomenon.

It is important , thus to start this short chapter with the legal drugs that play a key role in addiction and dependence :

*Alcohol is sold in South Africa to people over 18 years of age legally , but everyone knows that alcohol use and abuse in our country starts from school. Alcohol consumption has direct and negative changes to an individual's behaviour especially human co-ordination and judgement . Research has indicated that alcohol leads to aggression , including women and child abuse. Stoppage of alcohol intake produces withdrawal symptoms, anxiety and convulsions, while its continuous usage leads to dependence and ultimately alcoholism .Research has shown conclusively that children of alcoholic parents are at greater risk of ending up alcoholics when compared with other children. Alcohol can lead to brain damage and affects the central nervous system of the individual and leads to problems relating to vital body parts of a person , such as liver, eyes, stomach and the pancreas. It also negatively affects the reproductive systems of both males and females (John Hopkins, 1993).

*Tobacco smoking and addiction is a major cause of deaths in South Africa and Internationally . Despite the various efforts by the Government of National Unity led by the ANC which has taken some strict anti-smoking, anti-tobacco measures the use and abuse of tobacco products continues unabated. International research has shown conclusively that smoking causes cancer, heart disease etc. Chronic , obstructive lung diseases are due to smoking. Smoking during pregnancy causes serious threats to mother and child alike .It is well known that cigarettes contain over 4000 chemical substances some of which are known carcinogens .Nicotine has been described as the most dangerous chemical

ingredient as it reinforces the desire to smoke. It is highly addictive and make it very difficult for smokers to give up the habit (Hepler ,1989).

*Cannabis/dagga/ zol is an indigenous plant which is also called grass, marijuana, joint etc .It consists of dried leaves of Cannabis , which can be found in abundance in South Africa , especially in large areas of the Eastern Cape (in and around Transkei). Large numbers of Indigenous and indigent farmers cultivate it as a livelihood. Cannabis contains more than 400 different toxic substances and has negative effects on the lungs, the nervous system, the brain, and on many occasions it creates psychoses and hallucinations. It has very destructive consequences for pregnant mothers and leads to changes in genetic make-up .It also creates withdrawal symptoms, as well as vomiting, sweating, tremours and sleep disturbances. It is highly addictive and is considered the threshold for other harder drugs , such as mandrax, cocaine etc .(Voth ,1992) .

* Mandrax is a blue or white capsule that contains the chemical methaqualone . It is usually smoked together with dagga/cannabis in what has been called a "white pipe" .It is very popular in some sections of the Indian and coloured communities in South Africa .It leads to dependency very fast and originates from the drug "family" of barbiturates .Its use and abuse has negative effects in the body, especially the activity of the central nervous system .Increased doses produce blurred vision, slurred speech ,loss of time and space , slow reflexes .Overdose causes loss of consciousness and even death .Its mixing with alcohol is extremely dangerous. It has long term serious effects such as chronic Intoxication and depression, psychological dependence, anxiety, insomnia, convulsions and death (Van Eeden ,1994) .

* Cocaine is a powder or comes as "crack" and has become very prominent amongst the highest and middle class strata in South Africa. It is also used by working class and poor people in the country . It is expensive and is considered a

designer drug. Research has shown that it has very strong psychological effects on users and abusers, as it reaches the brain within 4-7 seconds. It is highly addictive and can cause

- strokes,
- heart attacks,
- anxiety,
- panic attacks,
- cognitive impairment,
- depression and
- suicide tendencies

When used during pregnancy it negatively affects the brain of the foetus causing cerebral infarctions, abnormalities of the limbs, malformation of the intestines sudden infant death etc (Youth without Drugs, 1995).

- Ecstasy is a designer drug that is derived from amphetamine and comes in a variety of types and colours. It is used by young people especially and is considered a very strong stimulant. It can lead to serious addiction and influences cells and brain equally. The user feels tired, depressed and moody and causes heart and respiratory failure, dehydration, fever fatigue and irritability. When taken with alcohol or depressants it increases the above mentioned negative effects and even heart failure. Even death can occur when mixing ecstasy with other dangerous drugs (Van Eeden, 1994:29-30)

There are also other drugs that are used extensively throughout the world such as :

- The Depressants
- The hallucinogens, such as the LSD which was the most popular drug in the 1960's
- The Narcotics
- The Designer drugs , and
- The Anabolic Steroids.

However this brief chapter only concentrated on those that are found, used and abused in South Africa. Those are the drugs which are abused by tens, hundreds or even millions of South Africans in all walks of life and they constitute a serious and challenging problem for the government and all people of this country .

1.5 RESEARCH DESIGN AND METHODS OF INVESTIGATION:

The first step undertaken by the researcher was a thorough investigation of South African and International literature on substance abuse, treatment and policies relating to these and an extensive literature study of models of treatment used globally and locally. In this process books, research papers, monographs, journals and popular studies, theses and dissertations as well as the Internet were utilised. Such a start guaranteed that international and national trends and models were understood and laid the foundation for the planning and implementation of the empirical section of the project. These were thoroughly combined with the wide knowledge and experience of the researcher who has been a practicing professional social worker for many years.

The research method of the study is qualitative and quantitative. A small sample was employed for the purpose of asking in-depth questions and examining new insights and ideas.

This descriptive design was suitable for this study despite the fact that there is a significant lack of in-depth information on treatment and rehabilitation programmes in South Africa. It was strongly felt that such an approach would be the best way to uncover existing empirical realities associated with the subject. The study uses a bio-psycho social and spiritual perspective in which the experiences of professional persons are documented and discussed from the settings they practice from.

Sehvandeveldt (1985: 103) states that in less developed areas of the intellectual enterprise exploratory designs should be used because this model allows for

- *Communication between persons,
- *Freedom to observe,
- *Listen and
- *Evaluate given areas by asking questions.

This perspective on gaining information and insight into treatment and rehabilitation of substance abuse in South Africa is mainly used to generate new ideas and perspectives regarding various areas of intervention. It is also used purely because of the small numbers of persons who benefit from treatment on long-term basis. In this process the qualitative methodology is available because it is relatively unstructured and open (Bouma 1995).

Qualitative research uses open ended in-depth interview, documentary research and participant observation as the main methods of data collection (Schurink and Schurink1988). In the present project while the majority of questions were

open-ended, a limited number of structured questions were also utilised in order to compliment the qualitative dimension of the interview.

Two interview schedules were prepared and presented to two distinctive categories of respondents:

- Members of a multi-disciplinary team , who were randomly selected by the researcher from the team, through the utilisation of the purposive sampling method. This method is an internationally recognised non probability sampling method that has been utilised in many research projects of this nature.
- Each multi-disciplinary team of professionals within the agencies . The answers to the questions were provided by a representative of the group identified by the group according to his/her knowledge in answering the question.

This was done on purpose , as it is believed that more innovative and diverse attitudes would emanate from these groups in terms of drug abuse treatment and rehabilitation. It was hoped that the choice of the two groups would elicit a much wider array of responses , which when analysed would enrich the understanding of the dynamics associated with drug abuse treatment and rehabilitation.

In terms of the interview schedule amongst members of the team the following themes were covered:

- Demographic characteristics of the sample.
- Qualifications .
- Training and length of work.

- The pre-treatment stage
- The outcomes.
- The duration of the stage.
- The person/s responsible for its implementation.
- The detoxification process and medical intervention.
- Detoxification outcomes.
- The length of the detoxification process.
- The therapeutic intervention.
- Its duration.
- The person assuming the responsibility for this process.
- After care.
- Its outcomes.
- Its duration

The group questionnaire consisted of questions related to :

- The type of agency.
- The qualifications and professional status of the interviewee.
- The duration of the agency's existence in the field.
- The planning of the treatment programme.
- The treatment plan.
- The role of abstinence.
- The most common model of treatment.
- The effectiveness of the model.
- The positive aspect of the specific intervention.
- The existence of new and innovative models in the agency.

- The most common contemporary trends in service delivery at present.
- Opinions of harm reduction models.
- The variety of recreational drugs of abuse treated .
- Major problems encountered in treatment.
- The work with HIV/AIDS.
- The existence of programmes for dependent persons suffering from psychiatric disorders.
- The type and role of such programmes.
- The attitudes towards the high rates of relapse in South Africa.
- The attitudes towards holistic treatment.
- The role of socialisation in the drug prevention process.
- The importance of family treatment in rehabilitation.
- Evaluation procedures.
- Attitudes and perceptions regarding policy on drug abuse and service delivery.
- Attitudes , perceptions and feelings towards important government documents such as the Drug Master Plan of 1999 and the White Paper for Welfare of 1997.

It can be seen then that the questions covered a wide array of aspects of treatment and rehabilitation , as well as the treatment trends and patterns utilised in the process. They also attempted to capture attitudes, feelings, ideas and opinions of people and groups that have had direct links with the process of treatment and rehabilitation.

The study thus attempted to explore the bio-psycho social and spiritual aspects of treatment as the participants in this instance provided data, explanations and looked at more effective ways of functioning. Thus in the process of the analysis and recommendations the researcher was able to show how professionals and institutions can provide effective services that in the long term would benefit recipients in staying drug free.

According to Bless and Higson- Smith (1995) sampling is used in research when the total population involved in a specified specialized area cannot be reached. Because of restructuring and lesser subsidies for governmental and Non Governmental Organizations there seems to be a flux in the numbers of professionals employed at these specialist institutions. Some employ the full multi-disciplinary team, while others employ some full time staff and part time workers. Presently South Africa's drug abuse treatment centres find that there are grey areas in their service delivery systems. Information acquired from these organizations will be of use to other professionals within the same field or as transformation of organizations takes place. Three state governmental organizations were used, three non-governmental organizations and three community based organizations.

The selection of the sample was done through the purposive sampling method, which is also known as judgmental sampling technique. In this process, the researcher utilised his/ her knowledge of the field in order to choose interviewees that best suited his/her aims and objectives. This is a non probability sampling technique that has been used successfully in many countries (Bouma and Atkinson ,1995)

The sample consisted of nine multi-disciplinary teams and 33 individuals of the multi-disciplinary teams who were selected through the purposive sampling

method as indicated earlier. The main focus of the study was on drug rehabilitation programmes, its effectiveness and policy interpretation.

The researcher felt that this was an adequate sample size considering the qualitative nature of the study. Massive data is yielded by such qualitative data. The teams interviewed, had expert knowledge in the field of substance abuse treatment. They could adequately identify with each question and comment and discuss in-depth. For this target group the sample represented was adequate. Permission to conduct the study was sought from the director of the state rehabilitation centres. The permission for N.G.O. and C.B.O. centres was sought from the director of these organizations. Anonymity was assured for every multi-disciplinary team and each interviewee. Each agency was identified by a code, this was done to maintain confidentiality.

The two interview schedules were used as in-depth tools especially with the multi-disciplinary team. It was filled by members of the team that were available at the time, as many of them were extremely busy with their functions. There were 33 questionnaires filled. The second questionnaire was more structured and was used for individuals belonging to the multi-disciplinary teams/groups. This questionnaire was more quantitative in nature focusing specifically on the time frames of a rehabilitation programme. 28 questionnaires were filled in this group. The researcher developed the questions based on the knowledge acquired through research and also from her own experiences in working in the field of substance abuse. The interviews took place at the respective institutions. Each member of the group who was available filled in a separate questionnaire. This was done on one-to-one basis. The focus was on the experiences and treatment programmes for substance abusers. On many occasions it was impossible for all members of the group to answer the questionnaire as they were involved in their daily and hourly activities within the respective centers. Both qualitative and

quantitative data emerged from the study. Quantitative data focused on demographics and the thoughts, ideas, and feelings of respondents.

ANALYSIS OF RESULTS:

After each questionnaire which was administered to the multi-disciplinary team a final response was read out to the team and corrections and additions to responses made at the same time. This decreased elements of bias from both the researchers and interpreters. A comparison and corroboration with the existing literature was done after the data was analyzed. Questions filled out by individual members of multi-disciplinary team were analyzed more qualitatively and from these the results of the study were established.

RELIABILITY AND VALIDITY:

Many researches believe that research cannot be totally objective. Research must be based on the experiences and knowledge of the respondents who form the basis of the study. Any bias according to Bless and Higson –Smith (1995) should be avoided by the instrument used and the interpretations of the questions. All respondents should be able to interpret questions in a consistent way.

A research assistant also helped with data collection supervised by the researcher. Interviews for qualitative studies must be planned and structured with precision. Non-scheduled structured type of interviews examines a list of issues which has to be investigated and this is done before the interview. This gives the interviewer the freedom to formulate questions as need arises within certain contexts. This also gives respondents the freedom to give her own definitions and answers. (Smith 1995)

Data were evaluated according to the type of programmes, which should be in existence and the meeting of policy objectives. Quantitative data was analyzed using the most appropriate method. Given the relatively small number of interviewees it was decided that the analysis would be done manually.

In a study such as this that puts the qualitative framework as the primary tool of analysis while there are also seeds of quantitative analysis, the question of reliability in its strict sense can be seen as not of primary importance. The selection of the purposive sample and the relatively limited number of people interviewed in the context of the study signify that tests of statistical significance and comparisons that constitute the basis of quantitative reliability do not play a primary role in this project. Alternatively, the key contribution of the qualitative analysis and the results thereof are the primary considerations underlying the significance of this study (Cozby 1981; Brink 1997; Gall 1997)

LIMITATIONS OF THE STUDY:

As in all research, there are limitations. These must be taken into account when interpreting the results: -

- ◆ The study focused on services delivered by governmental organizations and community based organizations. Only organizations which provided in-patient programmes were used in the study.
- ◆ Costs, time constraints and accessibility limited the study because the organizations used was largely from KZN and 4 other provinces.
- ◆ Although rural and urban areas were included in the study, more urban areas were reached than rural areas.
- ◆ A small sample size was used because of the specialist nature of the study.

- ◆ The study was exploratory with a vast area of literature. However, this should not affect the findings of the study.
- ◆ Each agency provides a unique service based on its own size, context and delivery of services.
- ◆ Currently in terms of the dwindling budgets, interviewers might not have been completely truthful.
- ◆ Interviewer bias must be taken into consideration in data collection and the subsequent findings and recommendations.

CHAPTER 2

LITERATURE REVIEW

2.1 DRUGS AND TREATMENT: SOUTH AFRICA AND INTERNATIONALLY

The White Paper for Social Welfare (1997), Section 4: Special Needs and Problems of South Africa states the following:

“ Substance abuse is recognized as one of the greatest health and social problems of South Africa. It has wide ranging consequences, which include physical debilitation, chronic impairment, injuries, marital and family problems, child abuse, violence in families and communities, trauma, depression, crime, traffic accidents, work stress, social misery and economic cost”.

The above statement indicates clearly that substance abuse affects every facet of human life (physical, psychological, social, economic and spiritual).

The Drug Master Plan promulgated by the Department of Social Welfare in 1999 recognizes the fact that substance abuse increase is mainly due to the social

and political transformation in South Africa by becoming part of the international community in the continuous process of globalisation.

The Drug Master plan of 1999, and the White Paper on Social Welfare (1997) recognised the seriousness of the drug problem and looked at ways where worthwhile contributions could be made at primary, secondary and tertiary levels of intervention.

On the 25th March of 1999 the Mercury reported that R30 million worth of mandrax tablets were seized at the Durban harbour. This can be seen as just the tip of the iceberg. The Drug Master Plan (1) also cites the age of first experimentation as having dropped. In view of South Africa's fast growing young population and the high levels of poverty in South Africa it can be deduced that youth are at very high risk positions (Department of Welfare 96/97).

South Africa boasts a large number of supportive, aftercare and treatment centers (Resource Directory 1997)

- 300 Aftercare and Support Centres
- 67 Community Treatment Facilities
- 147 Provincial, Private and Psychiatric Hospitals
- 12 Detoxification Centers
- 25 Inpatient / Halfway Houses

It needs to be said that both internationally and in South Africa, community based organizations need a clear vision; it can be assumed that mission smart goals and interventive approaches may make a difference in the fight against drug abuse. Various levels of interventionist approaches need to be developed with proper collaboration and intersectional work. The Government's responsibility is to create policy environments and ensure appropriate service

delivery at community levels in terms of prevention, treatment and research. This infrastructure is crucial to proper and sustainable community development. (Migdely 1995)

Several researchers cited that a large number of inpatient and outpatient facilities exist, with many shortcomings in providing effective services. One of these has been the dwindling of state funds and serious lack of professionals. The further development of existing services is marked by such realities, and as a result aftercare and reintegration of recovering persons are sometimes not adequate or not available at all (Corwin 1994;Farrow 1990).

Globally few programmes have worked in the eradication and elimination of drug abuse (Levanthal 1996). International research has shown that models of treatment and rehabilitation needs to be as humane as possible and that no one model can be considered as the correct one. A number of models may be used based on the needs of individuals .

Herwig – Lempp (1996) describes this human picture in terms of the client's responsibility for him/herself. The therapist ought to help the client accept new and positive alternatives and rejecting labeling, diagnosis and finding cause and effect. Therapists do not force or coerce treatment. De Shazer (1990, 77) states that respect and politeness most often lead to a relaxed therapeutic situation.

This systemic way of approach to drug problems is but a tool used with other approaches. De Shazer (1990:78) sees systemic therapy as taking the pressure off the client and the therapist.

The Financing Policy on Development Social Services (1999, 31) states that paradigm shifts with social welfare services should also focus on "fragmented services across specialized areas and various sectors to integrated services including special development areas (such as disability, HIV/AIDS and substance abuse) across sectors".

This policy further states that budgeting for services will now be output and outcomes based and facilities will only be financed according to its purpose and results .

The Declaration of the U.N. General Assembly, (17 April 1998) affirm this commitment and determination to ensure that provision is made for treatment and rehabilitation which will promote social reintegration and reinstate dignity and confidence in recovering drug dependent persons for their optional functioning.

A South African Community Network on Drug Abuse)document (SACENDU 1997: 19) shows that a person has a 70% chance of recovery if he/she is involved in a good after-care program. Treatment programmes with a solid aftercare program have much more positive results. It is estimated that 54% of persons who have been for treatment will relapse, 93% will revert to substance abuse in a period of 4 years and 40% of all substance abusers will relapse continuously and seek treatment on this basis.

It is strongly felt that treatment needs should become more community based with in and out patient care making it an affordable commodity. There is also a focus on continuity and co-ordination to ensure appropriate funding and research. Moos Finley 1990.

There are several cases of different models of treatment and the discussion around them would encourage professionals to use the appropriate methods and strategies which would minimize relapse and contribute to policies on substance abuse prevention treatment and aftercare. Such models are examined in the context of this thesis.

It has been stated that :

“The South African National Drug Plan will act as a blue print for South Africa’s response to drug abuse. It will be a means by which existing resources may be harnessed and yet others marshaled, and guided and will set out south African National policies and priorities in the campaign against substance abuse” (NDMP 1999).

Former South African President, Nelson Mandela, in his first opening session to Parliament stated that substance abuse is one of the major social problems that need urgent attention. He said that substance abuse is a leading cause of poverty, crime, job loss, family breakdown, HIV/AIDS, and other life threatening diseases. Mandela significantly made reference to the democratic nature of substance abuse that it cuts across all social, racial, cultural, sexual and age barriers and effects the lives of everyone in the family, community and country .

After the first demographic elections in 1994, the Government doubled its efforts to transform the country and develop a society without the injustices of the past. The department of welfare and population development saw the opportunity to address the substance abuse problem vigorously. This development approach adopted by the Government includes the development of individuals through economic empowerment . This long-term process according to the Government and its new policies would address the root causes of substance abuse in South Africa .

The world's population has doubled over the past forty years. This increase has been noted most acutely in the urban areas where the increase has been fivefold. This decade shows 80% of the global population growth in urban settings. With this growth, informal settlements, slums, lack of infrastructure developed which resulted in the exacerbation of the needs of the poor (UNCHS: 1999; Vol. 5:3).

The same realities are to be found in South Africa. Social welfare, health, education has had to bear the brunt of poverty and all its associated problems. With major advances in all areas of human care, there seems to be almost a loss on how to eliminate or limit illnesses such as HIV/AIDS, TB, Cancer, Substance abuse or common colds.

Substance abuse is one of the social problems that has had a major impact on the physical, psychological, social and spiritual health of individuals, families, and communities. The cost of substance abuse in the U.S.A. is \$76 billion each year (American Medical Association; 1992).

Illicit drug use is costing between \$76 and \$150 billion per year. These are the estimated figures for premature deaths and illnesses, lost wages, losses incurred by victims of drug-related crimes, and law enforcement. Drug abuse is an expensive luxury according to White (1993) who estimated the cost of substance abuse being \$300 billion per year in terms of Health Care, law enforcement and insurance. In the U.S.A., 500 000 deaths per year are caused by alcohol and nicotine and 100 000 deaths are associated with prescription drugs (Epstein 1996).

Much debate and arguments against the use of illegal drugs as being bad and unhealthy has led medical professionals to support the idea that substance abuse is a disease or illness because of its symptoms of addiction. Addiction is universally equated with disease, which is identifiable, chronic and treatable, has no cure, and becomes fatal if left untreated.

The medical discourse isolates the disease from its social context because it separates the person from making rational choices regarding the drug use and treatment. From the disease point of view issues such as race, economic or religious status, employment and social conditions are of lesser importance because addiction is treated as a disease with medical range perimeters.

In most treatment centers, the medical model of treatment has excluded the fundamental rights and freedom of the individual. The individual should identify problems which should be treated. Most centers do not include the family in treatment and rehabilitation programmes (Hoosen; 1999: unpublished research).

Treatment is generally "forced" onto the individual for their own good and people's belief that they have a disease, puts them into a "sick role" where they believe the chronic illness can be a lifelong one because it is equated to diabetes, heart disease, hypertension, etc. This notion guarantees the frequent slips and relapses.

A re-examination at holistic / systemic therapies, which includes psychological, physical, social and spiritual support, should be undertaken as they can provide good alternatives to therapy and treatment at different levels. The context of drug treatment in South Africa has led to many questions being raised:

- Are models of treatment appropriate?

- Why are recovery rates still very low?
- Should we become more spiritually orientated?
- What about the family in treatment?
- The demand for drugs is still very high

The South African drug scene has changed dramatically since the early 1990's when mandrax and dagga (white pipe), which is unique to South Africa, was the leading drug abuse. Thus:

- At this time mandrax comprised 70% of all drugs seized, dagga 20% and other drugs 10%.
- This changed drastically after the 1994 election, when many Nigerians known as major role players in the international drug scene came to South Africa as refugees.
- The main drugs brought into South Africa by the Nigerians are cocaine and heroine.
- Crack is now the fastest growing substance of abuse in South Africa, with the mandrax use decreasing.
- ✓ • Heroine use in South Africa has not escalated like mandrax because South Africa has little culture of Injecting Drug Use (IDU)
- Ecstasy use has escalated remarkably during the past 5 years. Youth are increasingly attracted to this rave drug .
- Mostly sex workers use heroine to come down from the paranoia caused by long crack binges.
- It seems like heroine will be used more and more by the next generation of youth (NEDCOR Crime index; 1999, Vol. 3(5)).

These are problems that need to be treated seriously as the scourge of drug and drug abuse present a major challenge to the new democratic government installed in 1994.

The problem of chemical abuse has been a source of struggle for hundreds and thousands of years. (Doweiko 1996)

The taking of mood altering drugs has been a common characteristic of many diverse cultures, hence societies had to develop norms and rules for themselves (Health News 1990). In the Middle East hashish is used but alcohol is totally prohibited by Muslim Societies. This is the opposite for South Africa where alcohol is used freely but dagga is illegal.

This tradition of drug use in human societies has led to many challenges. Social rules change as societies change. There are many confusing aspects of chemical dependency. The tobacco industry spent millions of dollars in California fighting the anti-smoking laws when the health problems created through smoking are well known throughout the world. (Traynor et al, 1993, 479.)

A "War on Drugs" in the U.S.A. has been waged in order to show the changes of illicit drug use. (Musto, 1991). Drugs were presented in a negative way so that whoever read or heard about the negative effects of these would automatically not experiment with them. This type of disinformation says Musto almost became the government's official policy for illegal drug use. Hysteria concerning illicit drug use became a trend where the use of cocaine or heroin automatically brought an addiction.

Research has shown that substance abuse has devastating effects on societies but only affects a small percentage of the broader population. (Doweiko 1996)

It is reported that 5.5 million people out of the 260 million American population are addicted to illegal drugs. There is also a trend to refer to large numbers of people as being addicted to drugs. The term "addict" is loosely used in many instances.

(Peele et al, 1991.)

Multiple explanations exist for drug use and abuse but researchers have concluded that various drugs of abuse seem to activate a "pleasure center" in the brain (Restak, 1994).

Research studies internationally show that all forms of drug addiction can be seen as different segments of a single disease. A key aspect is the compulsive use of various chemicals. (Miller and Gold, 1993).

Recently psychiatric units started to focus on substance abuse but mainly on the issue of detoxification with little or no focus on rehabilitation (Galanter, 1993). According to Treadway (1987), diagnostic blindness is not limited to physicians but other health workers. He stated that almost 50% of family counselling cases includes substance abuse as its key problem, yet seldom is this diagnosis made. Yet if addiction remains undiagnosed, therapy fails because the real problem is not identified and treated.

Drug abuse, misuse and addiction as well as HIV/AIDS and STD's are the major burdens of many developing and third world countries. The Australian Drug Foundation (1999) sees early adolescent and teenage children becoming more

and more involved in drug experimentation and addicted. The National D.M.P. (1999) further emphasizes that the main drugs of abuse is tobacco, mandrax , ecstasy, crack-cocaine, dagga and over the counter prescription drugs.

Most policy documents in South Africa, such as the The New Child Justice Bill, the Drug Master ,Plan ,White Paper for Social Workers focus on the vulnerable child, its protection, prevention and therapeutic interventions as far as drugs are concerned.

South Africa in the 21st century is struggling with the most productive members of its societies, children to young people aged between 8-35 years. This group is the future of South Africa and need to be targeted as early as possible in the areas of prevention and socialization (Drug Advisory Board 1997).

Of the 68 000 psychologists registered with the American Psychological Association, 504 cited substance abuse as their primary specialty and 789 as their secondary specialty (Youngstran, 1991, 14) . Whether substance abuse is a true disease or not it is evident that health and mental health professionals have not responded adequately by training practitioners to diagnose, treat and rehabilitate substance abusing patients.

The Drug Trafficking Act of 1992 (Act 140 of 1992) refers to the term of illicit drugs and popularly abused drugs as illicit medicines . Drug abuse has great impact on the world's population. The World Development Report (1993) states that drug related diseases affect 5% - 10% of the world's population annually. In 1990 drug related diseases accounted for up to 2% of the world's disease rates.

The human and economic costs of substance abuse have many faces in terms of violence, accidents, youth problems, loss in productivity, burdens on health and

social care and the general decay of society (Desjarlias 1995: 87). For Southern Africa this scourge of drug abuse has also become a social problem causing crime, unemployment, violence and many other social ills.

It is very difficult to define the nature, extent and consequences of drug abuse in a given society when we consider the multifaceted nature of the problem. According to Desjarlias (1995: 45) it is easier to define the extent and boundaries of drug use than find the appropriate methods of treatment. The attitudes of society make it difficult to define chemical use, social use, drug abuse and dependency. (Health News 1990). Watshton (1990) asserts that even professionals disagree as to what alcohol abuse and alcoholism is, although alcohol is the world's oldest drug substance.

Peele et al. (1991: 133) see addiction as starting from "moderate excess to severe compulsion". This continuum starts from occasional social use through different stages to clear out addiction. Desjarlias (1995:79) sees the similarities of the process and agrees with Peele et al (1993) although the latter define abuse more broadly by stating that the person is abusing drugs when there is functional impairment. The criteria which he uses to acknowledge substance abuse is:

- *Socially and economically the user is functioning at a lower level.
- *Medically the person is impaired and this leads to severe problems.
- *People are forced into drug use for exploitation.
- *All systems around the person are threatened.
- *Abstinence causes physical and psychological withdrawal symptoms.
- *The user still wants drug irrespective of its harmful consequences.

Sellers et al, (1991) define dependency as a continuum of Chemical Stages of Use, Abuse and Dependence that can be described as follows:

- Level 0 - Zero use of drugs
- Level 1 - Occasional social use where no social, medical, financial or legal damage is done.
- Level 2 - Heavy social use: at this stage the individual experiences impairment in his daily functioning. Denial is common at this stage and abuse patterns are usually hidden.
- Level 3 - Heavy use of drugs and early dependence: At this stage there are problems associated with drug use, denial is evident and withdrawal symptoms are experienced at the cessation of drug use.
- Level 4 - Drug Dependence: At this stage the person cannot do without drugs. Denial is still present and all areas of life become impaired. Chronic addiction has developed with the person not being able to do without drugs. According to DSM IV, cognitive, physiological and behavioural symptoms and features must be present when identifying addiction. Withdrawal, tolerance and compulsive drug taking behaviour are the criteria used by the DSM IV . Sometimes these symptoms might be more or less salient.

The World Health Organization developed the International Statistical Classification of Diseases (ICD 10). This manual identifies physical, mental and behavioural disorders, but also classifies substance abuse by five character codes in order to assess the person's use, abuse and dependence.

The ICD-10 document includes four categories.

- ◆ Acute Intoxication, meaning the ingestion of substances that leads to cognitive and behaviour disturbances. With the stop of psychotropic drugs these symptoms disappear.
- ◆ Harmful Addiction, is associated with psychological as well as physical damage.
- ◆ Dependence Syndrome , where there is a compulsive use of the substance with all concentration being on the acquiring of the substance. The level of use increases and tolerance is attained. Physiological withdrawal is experienced and often the length of time for the person to recover is long. Even in this state of unpleasant withdrawal the person still continues to use substances.
- ◆ Withdrawal Syndrome ,occurs when blood or tissue concentrations of substances decrease and the individual suffers symptoms concomitant with physical changes that can be extremely distressing and painful.

These types of definitions do not necessarily label a person as addicted to substances but rather pinpoints a number of related problems associated with drug abuse. Regular users of drugs are not necessarily addicted to drugs. This may be one style of drug use. (Vaillant 1984).

According to various researchers and practitioners, substance abuse is defined according to the undefined impact substances have on a person's life or on the

lives of significant others. Peele is prominent in his belief that a classification of addiction should only be made when tolerance and withdrawal symptoms are present (Peele 1989; Peele Brodsky and Arnold 1991; Pratt 1990).

Peele and his associates (Peele Brodsky and Arnold 1991) presented a continuum of substance use and identified the dangers of dichotomous classification. Their view of substance abuse fall into 6 categories:

Figure 2.1: Continuum of substance use



Peele like other researchers sees the movement between these stages as significant for chronic disorders.

2.2 EXTENT OF CHEMICAL USE, ABUSE AND DEPENDENCY

A relatively new South African document has been devised as a measure for the reduction and harm of drug usage reduction. This document known as the National Drug Master Plan acts as a directory of the South African policy and programmes in the fight and attempts to control substance abuse.

The Diagnostic and Statistical manual of Mental Disorder(DSM IV 1994) which was introduced in 1994 and is seen as the basis of the 1999 Drug Master plan has identified 9 criteria according to which a person has become addicted to recreational drugs , i.e. drugs that are used predominantly by young people.

1. Preoccupation with the use of drugs from one session of use to another.
2. More of the anticipated use of drugs.
3. Development of tolerance.
4. Withdrawal symptoms.
5. Use of drugs to combat withdrawal symptoms.
6. Continued efforts to cut back on drug use.
7. Intoxication when at work or not being able to go to work.
8. Decline in social functioning, work and other activities.
9. Continuation of drug use in spite of physical, social and psychological problems caused by the drug use.

A study undertaken by Kesler et al. (1994) focused on psychiatric illness preceding 12 months of substance abuse. The results showed that 14% of the 8 098 respondents were lifetime alcoholics, 7% dependent on alcohol for the past year, 4% used recreational drugs but were not dependent and +- 7% would be classified as drug dependent sometime in their lives. This study seemed to be somewhat flawed in that there may have been an overlap between drug and alcohol abuse. It is also not clear whether tobacco was defined as a drug of abuse in the study.

Regier et al. (1990), studied the lifetime incidence of mental illnesses in the U.S. These results suggested that 2.8% of the full population met the diagnosis of

alcohol abuse or dependence, 13.5% of the population would meet the criteria of alcohol abuse or addiction during their lifetime and 6.1% would meet the criteria of drug abuse or addiction in their lifetime.

The contrast between these two studies is very interesting and shows that sometime during the lives of individuals, 36.4 million persons would be addicted to alcohol and 18.2million recreational drugs in the U.S.A.

Another study produced by Galanter and Francis (1992) discovered that 15% (39 million) of the U.S. population will be diagnosed as alcoholics sometime in their lifetime and 6% (15,6 million) as drug abusers. It can be seen that these estimates are lower than Franklin's findings (quoted in Galander and Francis 1992: 1067-1068)) that has overestimated these numbers. A lack of clear statistics by rehabilitation programmes/organizations makes it unclear to define substance abusers that receive treatment. Peele (1991) however believes that a small percentage will become addicted.

Alcohol is the most widely used recreational drug worldwide. The American Psychiatric Association (1994) estimates that the 90% of the U.S. population who use alcohol few will become addicted. (Desjarlais et al, 1995 :91).

In a recent survey produced by the University of Cape Town's Department of Psychiatry in 1997, the National Urbanization and Health Research Programme ✓ showed that Grade 11 pupils spent R22 million annually on alcohol, dagga and mandrax. The survey was conducted on all Grade 11 (Std.9) learners in the Western Province (Cape Times 1997).

Prevalence rates of at least experimenting once focused on abuse substances such as cigarettes, alcohol and dagga as well as other substances like mandrax, cocaine, crack, and ecstasy The data was collected during the second and third

terms of 1997 . This survey showed that +- 40% of grade 8 boys smoked cigarettes, 41% used alcohol, 8% smoked cannabis, and 7% sniffed glue. For grade 11's the survey showed the substantial increase in cigarette smoking – 58%, while 66% used alcohol, 32% smoked dagga and 16% sniffed glue. The survey also showed that the differences between girls and boys were not substantially great, as 40.7% of boys and 30.7% of girls had used alcohol at least once. The survey also found that cannabis use had doubled in the past 7 years.

✓ A report in the Cape Argus (20 January 1999) indicated that annually the Grade 11 learners spent R19, 7 million on cigarettes and alcohol and R2.3 million on illicit recreational drugs. This report cited a study carried out by the school's health unit in Exeter which showed that drug taking and drinking in private schools were the same as those of public schools, with easier access to illicit drugs in private schools and alcohol in public schools. In a study of 20 private schools in London it was found that almost a third of pupils have experimented with drugs by the age of 14 years . 2 in 3 boys and 3 in 5 girls used alcohol. Nationally the study found that 1 in 3 14 and 2 in 5 16 year olds have used drugs at least once in their lifetime.

✓ The Parents Resource Institute for Drug Education (PRIDE) produced a study using 129,560 students from 26 states for the school year 1995-1996. This study discovered a dramatic increase in substance abuse among adolescents. A similar study was performed in 1987-1988. An interesting observation was that in the 1995-1996 study 40.8% of illicit drug users fell into the 17-18 years category .The survey discovered a significant increase for 6-12 graders , where 29.5% reported the use of at least one illegal substance in 1995-1996 compared with 18.6% in 1987-1988. This was an increase of 58.6%. The annual use of illicit drugs increased from 24% in 1994-1995 to 29.5% in 1995-1996. This shows a one year increase of 22.9%.

This study clearly indicates an increase in substance abuse in spite of awareness and focus on substance abuse by CIO's, NGO's and CBO's.

SACENDU (April 1997) stated that the use and abuse of other drugs increased by 59% for those in the 13-19 year category. Corroboration with the other studies leads to the conclusion that the age of onset of substance abuse is very young, ranging from as young as 12 years to 19 years. SACENDU's study also highlights the use of illicit drugs - the age of onset is much younger with 59% falling into the 13-19 years age group, with only 9% for 25 years and over. This clearly indicates that substance abuse intervention and treatment should start early.

Desjarlais et al.(1995 :91) concurs by quoting Mexico's drug abuse problem being an urban one with the drug abusers ranging from 12-21 years. Their findings showed that the lower socio-economic youngsters used inhalants and solvents while the more upper class youngsters used marijuana with amphetamines and barbiturates increasing in young adults. For Mexico drug abuse has become the norm.

Pakistan shows the highest use per capita of heroin in the world with an estimated 1.5 million addicts in the country. A survey done in Pakistan concluded that every 19th male is consuming drugs regularly. A Pakistani psychiatrist Asif ✓ Aslin (1996) said that heroin is "the first drug used on a national level by all ethnic groups, all age groups, at all times and occasions." Due to easy access, unemployment, breakdown of the family, homelessness , peer pressure and corruption, many succumb to heroin abuse in Pakistan.

The International Narcotics Control Board (1993) showed that adolescent substance abuse was firstly experimented for recreational use and secondly by persons with serious personal problems who can become addicted users. These

researchers also cited that 5% of the 14-18 year olds have serious drug problems and would ultimately need treatment.

Many researchers believe that adolescents are the priority for any successful community's existence but also that this social category are the most vulnerable to drug use, abuse and dependency. Alcohol and tobacco are cited as the "gateway drugs" because this can lead to other drugs of abuse. This is extremely alarming for South Africa who has been rated as the highest country in absolute alcohol consumption. A study comparing 23 countries showed that South Africa in its annual growth per capita absolute alcohol consumption was 2% over the period 1985-1995. For the years 1996/7 absolute alcohol annual consumption for persons over the age of 15 years was 10.5 liters. Another study covering 31 countries showed South Africa ranking 21st in the world with 8.4 liters consumption. This estimate excluded the use of sorghum beer, which would rank South Africa between 10-15th overall. Studies also found that 30% of males and 12% females aged 14 years over drank on average 5x340 ml. bottles of beer a day (International Control Board 1999)

Tobacco use in South Africa is seen on the decline during the 1990's at a 4% rate per annum. A decrease in adult smoking has been observed from 34% in 1992 to 28,5% in 1997. A national survey showed that 47% of men and 12% of women currently smoke in South Africa. Smoking advertising is also aimed at young adults (12-24years). It is these youngsters who become the target of the tobacco business. (HST 157.16), see Doweiko (1996)

However the new strict anti-smoking , anti-tobacco laws introduced in South Africa since 1992 as well as the heavy "luxury taxes" imposed on tobacco and alcohol products in the last few years could be seen as having positive outcomes in the curtailing of tobacco and alcohol use and abuse. However , the struggle

against hard and illicit drugs needs to be intensified at all levels at present and in the future.

According to Peele et al (1991) there is no clarity as to whether substance abuse , including alcohol and nicotine is a problem or not or whether it is a problem that will be resolved or not. It would be safe to say that only a small number of persons will become addicted to drugs. Simultaneously researches still disagree regarding the scope of abuse and addiction.

In U.S.A. 90% of the population have used alcohol at least once in their lifetime yet various researches have given differing figures on the problem. Ellis et al. (1998) for example have estimated 6 million adults addicted to alcohol, Miller and Gold (1990) have claimed 10 million, whereas the American Medical Association (1999) estimated 12 million adults are addicted to alcohol. These numbers exclude the estimated 1 to 3 million children and adolescents who may be addicted.

In South Africa the primary substance of abuse is alcohol. A study in Cape Town and Durban indicated that an average of 75% of substance abusers used ✓ alcohol as the first substance of abuse. Nineteen percent used other substances, 14% dagga, 15% mandrax and dagga. These percentages were based on treatment demand (SACENDU 1997).

The American Medical Association (1992) estimated that drug misuse/abuse cost 76 billion dollars each year for America. Angell and Kassifer (1994) put the costs of drug abuse between \$76 and \$150 billion annually. This figure includes medical, social and criminal impact caused by substance abuse on the individual, family, community and country.

This luxurious item say Scheer (1994b) and Collier (1989) cost America between \$40 and \$150 billion dollars annually. A large portion of this amount is used for recreational drugs purely for the effects of wanting to relax and feel good. Corwin (1994) states that, this expenditure represents a sum greater than the total combined income of the 80 poorest third world countries.

2.3 THEORIES OF TREATMENT AND REHABILITATION

This section will investigate the key theoretical and practical approaches to treatment and rehabilitation as expanded in International literature. It is important to state that these theoretical positions have a direct effect on the practicalities and implementation on treatment and rehabilitation internationally and in South Africa.

Family workers, researches and scholars have shown interest in the understanding of cultural diversity, family systems and input of religious ideology on families (Haj:Yahia;1995).

The family is mainly responsible in helping the drug addicted person maintain their drug use through enabling and co-dependency.

1. *Enabling*: Doweiko (1996)

Any person who knowingly protects an addicted person from facing up to the consequences of his/her behaviour is termed an "enabler". Most enablers are family members (in this research, mostly mothers).

2. *Co-dependency*: Gorski (1992) identifies co-dependency as: -

- Obsessive attempts of the co-dependent to control the dysfunctional behaviour.
- Over involvement with drug dependent person.
- Influence by external sources that affect the self worth of a person.
- Tendency to make personal sacrifices to cure the addict (This research, mostly mothers).

Regier et al.(1990) see the individual who has not Individuated from the family as remaining emotionally bound and enmeshed with the institution. Madenes et al. (1980) also view the functioning of the family as reinforcing the drug abuse because the user's addiction covers for the other areas of pathology in the family. Drug users are dependently involved with their families and are reluctant to separate from families.

A strong movement exists in the field and social services that aspires to incorporate religious matters into the full assessment and treatment of clients. An earlier study showed that 45% of clients preferred to work with religiously similar therapist, 20% with religiously dissimilar therapist and 15% were not concerned (Wilker, 1989).

Drug abuse treatment and rehabilitation is a process which aims to help individuals to stop using mood altering chemicals which has destructive and harmful effects.

The focus of treatment and rehabilitative programmes is to help the individual develop new, healthier ways of coping with his/her needs/problems. (Donovan, 1992).

Neuro-pharmacological research has indicated that in spite of differences among drugs of abuse they all seem to contribute the pleasurable effects in the brain center(Restak 1994). According to Miller and Gold (1993), this center is known as the Limbic System. For addicted persons craving is a very critical feature because it leads to drug abuse and slips.

A recent study showed that the limbic system was activated during cue-induced cocaine craving. The focus of the study was to see whether this was the same for humans as experiments showed that the limbic brain activation occurred in animals(AMJ Psch-1999: 156 11-14).

A study conducted by Rodgers (1994) on adults who were in outpatient treatment for marijuana use reported that they had experiences of many withdrawal episodes when they abstained from using marijuana. It is also suggested that these abstinence episodes contribute to the development of marijuana dependency and hinder persons to develop drug-free lifestyles. The problem of substance abuse has been researched over many years.

2.3.1 JELLINEK'S MODEL OF ALCOHOLISM:

The evolution of the Medical Model of addiction was based primarily on the work of E.M. Jellinek (1952;1960). Alcoholism through centuries was viewed as a moral or psychiatric disorder. However, Jellinek argued that alcoholism is a disease like diabetes or cancer and that its symptoms were like any chronic but life threatening disease e.g. loss of control over drinking or uncontrollable drinking, progression of symptoms/ and fatal if not treated.

According to Jellinek, becoming addicted to alcoholism involves four stages that the individual progresses through:

1. Pre-alcoholic stage – where the drinking has progressed from social drinking to drinking for relief from social pressures and stress. At this stage loss of control is already evident.
2. Pro-domal phase – here more drinking leads to a pre-occupation with alcohol use .
3. The crucial phase – physical dependence is established with loss of self-esteem and control.
4. Chronic phase – obsession with drinking and symptoms of tremors.

This theoretical model of Jellinek showed specific symptoms like other diseases that affect the physical, social, vocational and emotional upheaval in the individual's life. He described alcoholism as a disease, which is progressive, chronic and fatal if not treated timeously.

Several researchers have attempted to validate this model. In a research of 636 alcoholics who were hospitalized , it was discovered that there was a progression in the severity of problems related to alcohol abuse. 75% of those sampled used alcohol in the mornings and 127 had problems with jobs by their late 20's. Health problems were experienced by their mid 30's. Researchers found that although specific symptoms were different, there was a generalized progression of life problems, which had a direct link to alcohol abuse (Van Eeden 1994).

Schuckit et al, (1994) ` study showed that Jellinek's theory of alcoholism being a progressive disease could be seen as valid. Jellinek's model is used as a standard model throughout the U.S. for the study of alcoholism. This model has also been applied for every other drug abuse pattern without any modifications for the past 30 years.

2.3.2 THE CRITIQUE OF THE DISEASE MODEL

Drug rehabilitation programmes today use the concept of a comprehensive treatment plan which facilitates the process of treatment towards recovery and integration. This large treatment programme makes use of a common pathway theory and sees treatment more as acceptance than demand. In this way the addicted person is helped more in terms of our understanding of addictive disorders.

In this study the following areas will be discussed extensively: -

Firstly ,a detailed discussion will focus on The Scope of Chemical Abuse and addiction within South Africa and other countries globally. Existing research studies will be reviewed. The costs to families, communities and the economy will be highlighted.

Secondly , the area of models of practice is important for effective service delivery. The divisions between theory and practice will be examined. A detailed discussion focusing on the following challengers will be undertaken: -

Many challenges had been levied against the disease model of drug addiction – its effectiveness and failure to produce results. Therapists have looked at developing new practices, which has positive changes for the drug abusers. These “accepting drug work” focuses on forming a bridge between the drug users subculture and new – drug users by being resource directed. This section examines some of the myths of the disease model and the alternative models of practice.

The humane treatment of drug abusers and their families will focus on a Systemic Approach where the client and counselor do not feel pressured to

change immediately. Dowelko (1996) concurs that substance abuse treatment should be able to use common pathway theories that promotes effectiveness and health.

The third area of focus is the assessment, intervention and treatment processes. Assessment should include information as to whether the person is addicted to drugs or not and recommendations made for further treatment (Doweiko 1996).

Generally the first step in treatment is to break through denial so that they can accept that they need help (Johnson ,1980: 49).

Rothenberg (1988) in his pioneering work on intervention states that the intervention is set of by significant others in the persons life where the addiction is brought to the fore as being harmful, destructive and progressive but it is nevertheless treatable. The rights of individuals are very important in the intervention process. The ethics of intervention are crucial in terms of the client knowing his / her rights.

The advantages and disadvantages of treatment have been discussed by a large number of theorists and practitioners. There is not one standard treatment for drug-addicted persons. The different treatment modalities comprise of basic elements e.g. empathy. (Miller et al, 1993:445).

Sciacca (1991) analyses the intense and confrontational methods professionals use in treatment used in order to break through denial. When an addict is admitted for treatment absolute abstinence is required. Another grey area in the treatment of substance abuse is the dual-diagnosed client. Miller and Chapel (1991) examined the relationship between psychiatry and addiction fields. They found many similarities between these two fields as well as differences. The most affected patients in this case were those with a dual diagnosis , which will

be dealt with later. Most often these are not treated in the health or social welfare delivery system and thus fall through the net because of their dual diagnosis being not properly examined.

Dual diagnosed patients often present the practitioner with behaviour issues that prevent them from getting treatment from drug abuse centers and psychiatric hospitals. These do not admit these patients until they have received treatment from a substance abuse center (Fariello and Scheidt 1989, Penick et al 1990).

In South Africa between 30-40% of substance abuse clients are also classified as dual diagnosed clients (SACENDU 1997) and according to Rado (1988) such clients must have specialized treatment that meets their needs.

The Minnesota Model (which will be elaborated upon later in the thesis) with its different stages of treatment is widely used in America and other parts of the world. (Doweiko 1996:341). This model is also widely used in South Africa.

Treatment formats of chemical dependency rehabilitation, the use of in-out patient centers and its effectiveness in terms of rehabilitation and cost is a debatable area (Rado, 1988).

Scheer (1994b) sees treatment as more effective than law enforcement activities. He also stated that although treatment is better than criminal justice there are many problems associated with it. Clients in treatment settings often "test their limits" with their counselor, request secrets, manipulate toxicology test and relapse. There is a large literature component on these practical problems and how clients manipulate counsellors. According to De Jong (1994) the first three months after discharge is a critical period for the person in recovery. Chiauazzi (1990) identified 4 common areas in relapse – i.e. personality traits, substitute addictions, narrow view of recovery and warning signals.

There is a growing number of writers who argue that length of stay does have an impact on relapse and reintegration. (Adelman and Wels ,1989)

Pratt(1990) cites the key of a "Relapse Prevention Programme – RPP" with the clients learning from mistakes. According to Mike Scott (1989), the RPP is a step forward for the recovering person where he/she is actively taking steps to change his/her addictive habits. Of concern today for professionals in the treatment of substance abuse is the one of infections that is HIV/AIDS and other sexual diseases are at particular risk. (Doweiko 1996). Pratt (1990) cites the danger of HIV/AIDS infection for I.D.U.'s . The lack of health facilities in South Africa makes this an area of concern and has major policy implications for institutions, the government N.G.O.'s and Community Based Organisations. Other problem areas are T.B. and Hepatitis B.

South Africa has recently diverted it's attention to Drug demand policies through primary, secondary and tertiary interventions. The South African Development Community (SADC) established a treaty with the main objective been the eradication of poverty that would ultimately lead to the achievement of unity and co-operation between the 12 member states. (SACENDU 1997).

A strong initiative for the SADC is the, "Protocol on Combating Illicit drug trafficking". This would include legislation and social policies for all the member states in order to eliminate drug produce and trafficking. The Drug Advisory Board (1997) researched internationally for the development of a suitable model for SADC, which resulted in the DMP.

The vision of the Drug Master Plan, sums up the government's priority in its one sentence of its vision.

"The vision is to build a drug – free society together and to make a contribution to the global problem of substance abuse". (National Master Plan 1999)

Globally it has been shown that where drug prevention is an integral part of the countries policies in terms of the provision of basic needs ,drug use and abuse are decreased. (Weinstein, 1999) .

The Political Declaration of the United Nations General Assembly states the following:

✓ "Drugs destroy lives and communities, undermine sustainable human development and generates crime. Drugs affect all sectors of society in all countries; in particular, drug abuse affects the freedom and development of young people, the worlds *Most Valuable Asset*. Drugs are a grave threat to the health and well-being of all mankind, the independence of States, democracy, the stability of nations, the structure of all societies and the dignity and hope of millions of people and their families."

(Political Declaration U.N. General Assembly 1998).

It was said that:

✓ "Drug abuse is a time bomb ticking in the heart of our civilization. We must find measures to deal with it before it explodes and destroys us, The monetary value of drug trafficking has recently surpassed that of international trade in oil and is second to arms trade." (Former Secretary General of U.N. Javier Perez de Cuellar, U.N. Document E 1989/72).

The United Nations Drug Control Program estimates that in 1995 ,10% of the international drug trade accounted for 300 – 500 billion dollars per year. Research shows that misuse and abuse of drugs cost countries between 0.5% and 1.3% of their Gross Domestic Product. This would essentially amount to 2.4 –6.3 billion of rands per year for South Africa (SACENDU Report 1997).

Illicit drug use costs between 76 and 150 million U.S dollars per year in America. These are the estimated figures for premature deaths or illnesses, loss of wages, expenditure incurred by the victims of drug related crimes and the enforcing the laws of the country. It was estimated that the cost of the substance abuse being \$300 billion per year in terms of health care, law enforcement and pay out insurance. In America 500, 000 deaths are caused annually through the use of alcohol and nicotine and a further 100, 000 by the use of prescription drugs (Epstein ,1996)

This serious problem has led to the U.N. setting up and funding drug surveillance systems in many countries for the early detection and changing trends of drug abuse and its consequences in physical terms as well as major losses in productivity. Many programmes for the prevention and treatment of substance abuse has been set up in a variety of countries, one such initiative being the ILO/WHO/UNCOD programme that has been set up in Egypt, Mexico, Namibia, Poland and Sri Lanka. This initiative is problem orientated and is based on prevention and treatment (WHO ,1991) .

Because of South Africa's vulnerability to drug abuse and drug trafficking, it has become imperative for government, NGO's and communities to collaborate, develop and strengthen existing educational and treatment centers. It is estimated that dwindling funds will affect seriously the quality of programmes of the 541 centres that treat substance abuse in South Africa, leading to relapse. Internationally relapse rates are very high. It is estimated that a large number of

persons relapse into using substances soon after leaving treatment centers; there seems to be very few who can be totally abstinent from chemical abuse (De Jong , 1994, 682) .

South African relapse rates are also extremely high as it is estimated that 54% of recovering addicts would relapse while 70% of recovering addicts have a good chance of recovery if they involve themselves in professional aftercare (SACENDU 1997).

South Africa has one of the most democratic constitutions in the world .It gives its people the right to have their dignity respected and protects their rights to life , freedom and security. (Constitution of the Republic of South Africa Section 10 to 12 (1) of Chapter 2 ,Act 108 of 1996) For the South African Government it has become imperative that the demand and supply of drugs is reduced.

Today the South African response to the drug problem is fragmented, uncoordinated and haphazard. In November 1993 the first Drug Advisory Board (DAB)was established as a result of The Prevention and Treatment of the Drug Dependency Act of 1992. The present Drug Advisory Board came into existence in 1995 with a new composition. The main function of the Drug Advisory Board is to advise the Minister of Welfare and Population Development on substance abuse, planning, coordinating and promoting effective strategies to prevent and reduce drug abuse and in the treatment of drug abusing persons.

Presently the response to the drug problem is uncoordinated, fragmented and intra and inter sectoral collaboration is absent. This has had a negative impact on the limited funding that is available, by the duplication of certain services and the non-existence of others .New resources cannot be developed according to

the needs of society. The war on wave of drugs cannot be waged positively in the absence of a single, unified, and strategic plan of action.

Hence the Government in 1997 required the DAB to develop a drug master plan for South Africa. This was done in keeping with international protocols. Twelve member states in Southern Africa established and signed a treaty in the Southern African Development Community (SADC- 1996). The main objectives of the SADC is to combat poverty and develop the 12 member states towards unity, peace and economic development.

The Protocol on Combatting Illicit Drug Trafficking (1996) caters for the establishment of a regional institutional framework for eliminating demand for drugs, supply of illicit drugs and corruption within the member states. South Africa has ratified this and would implement joint strategies to eradicate the supply and demand of illegal drugs. It is through research both locally and internationally that the framework for a Drug Master Plan was born.

The Financing Policy for Social Welfare (1999) promotes new financing shifts in terms of refocusing from a quantitative to a qualitative service. In the process, the effectiveness of services will be evaluated against meeting the needs and well being of those who receive the service . The financing of holistic service programmes would enable welfare service organizations to give Insurers and employers informed information about client needs for treatment.

The White Paper for Social Welfare (1997) and the National Drug Master Plan (1999-2005) have been formulated as frameworks that would ensure service delivery which is just and effective. This study will focus on the institutional as well as the type of treatment available through the integration of policy and practice.

Much debate and arguments against the use of illegal drugs as being bad and unhealthy led the medical professionals to support the idea that substance abuse is a disease or illness because of its symptoms of addiction. The symptoms of withdrawal, tolerance and craving are indicative of addiction (DSM iv-R)

Addiction, according to many researches, is unusually equated with disease that is identifiable, chronic, treatable, incurable and fatal if left untreated. Medical discoveries isolate a disease from its social context because it separates the person from making rational choices.

Another focus area will look at comprehensive services which include community based in-patient and out-patient quality care (White Paper 1997). Continuity and co-ordination of care for more aftercare programmes to reduce overall health care utilization is a priority for South Africa (White Paper ,1997).

According to Timco et al . (1994) treatment programmes provide better improvement to clients who enter treatment. It has been documented that persons with longer episodes of in-patient care improve more than those with shorter episodes of in-patient care. Therefore in -patient facilities has been used in this study.

For better matching of patients' needs and treatment delivery it has become imperative that policy makers learn about models of treatment and patients' outcome. This type of evaluation results in better planning for governments and policy development.

It is important for South Africa to link treatment programmes to service delivery, patient recovery and reintegration (Swap Document, 1998).

There is a direct link between policy and practice in this process and this is especially so for South Africa because of the rapid changes in the welfare and health fields. A number of research studies will be examined, with special focus on policy makers, funders and service delivery organizations as well as client's freedom in choosing treatment (De Jong ,1994).

Comparison of in-patient to community residential care is important in terms of continuity of aftercare programmes (Moos 1994)

Moos, (1994) highlighted the importance of effective programme planning policies rationally and for this policy makers should have information from service organizations. As much as individual counselling serves a major focus for therapy, other forms of intervention such as family therapy, groupwork, as well as financial and vocational counselling should be examined in order to establish how these are delivered and how they are affected by organizational changes.

It is in this vein that South African practitioners need to look at effective programme treatment approaches and examine how and why treatment programmes are working or not. Weak linkages in the chain of treatment should be identified and strengthened in accordance with international practices.

This research examines models of practice underlying theories and global research. It is critical for programme evaluators to improve patient treatment matching and provide holistic and effective substance abuse service.

The overwhelming number of relapse calls for a comprehensive, integrated service. (White Paper pg. 77/98). South Africa is both first as well as a third world country and its cultural diversity makes her unmatched to any other country in the world. As it has been said "South Africa must define both the

problem and solution in South African terms" (National Drug Master Plan-1999/2004) .

This study could serve as a basis for developing adequate models of care, evaluation of existing practices and highlighting important aspects of programmes which will have to be attended to by care-giving professionals and policy makers/evaluators in order to contribute to effective treatment and effective reintegration into family and community.

South Africa has one of the best law policies in the world where drug abuse is concerned. These policies should be used in practice, while the most important will be examined in a separate chapter:

- The extraction act (67), 1962
- The prevention and treatment of drug dependency act (20) 1992
- The drugs and drug trafficking act (140) 1992
- The criminal procedure act (51) 1977 including the Witness Protection Programmes - section 185 A of 1992
- The medicines and related substances control act (101) 1965
- The extradition amendment act (77), 1996
- The proceeds of crime act (76) 1996
- Institute for drug- free sports act (14) 1997
- Road transportation act (74) 1977
- The International Co-operation and Criminal Matters act (75) 1996

The welfare plan for social welfare (1997) states that it has to be of service to South Africans and at the same time build a self sufficient population in partnership with all key role-players through a comprehensive and well

integrated social welfare system .This would uplift existing opportunities and is equal, sustained, accessible person-centred and developmental (WPSW 1997). These policies have major could implications for delivery systems. Such a system will replace the fragmented and uncoordinated system that existed until now.

The N.G.O. registration is now replaced by the N.P.O. Act and regulations, 1997 (Act no. 71 of 1999). These organizations now have the freedom to operate for the benefit of its recipients. The goals set out in the WPSW (1997) seem not to have been implemented as yet.

The world's population has doubled over the past forty years. This population increase has been noted acutely in the urban areas where it has been fivefold. This decade alone shows an 80% growth in urban settings. With these growth informal settings, news, lack of infrastructure and weak policy frameworks developed which results in increased poverty and basic needs (UNCHS 1999 Vol. 5:3 :!)

The prime focus is that individuals, families and communities need intervention in the form of prevention, education and rehabilitation. This forms the basis of the multi-disciplinary team and effective programme formulation.

2.3.4 THE MULTI-DISCIPLINARY TEAM

The theoretical foundations of treatment are implemented by an array of organisations that become responsible for the processes followed in the various steps necessary for treatment application.

These organizations deal and use different models of practice, approaches and evaluative methods. South Africa has a range of organizations which function with both government and outside funding. Each organization provides services with emphasis on empathy, warmth and genuineness, the core principles of professional counselling. South Africa has 5 state rehabilitation centers nationally for its 40 million population. According to The Prevention and Treatment of Substance Abuse Act (1992), a multidisciplinary team comprising of doctors, social workers, nurses, psychiatrists, psychologists and occupational therapists deliver a service based on the individual needs of the patient.

The purpose of a multi-disciplinary team renders a wider area of services than an individual counselor. Therefore working with special needs clients in areas of specific needs requires the expertise of this team (Doweiko 1996: 341).

Evidence shows that many institutions use the concept of multi-disciplinary approach but fail to prevent relapse. The South African relapse rate of 46% indicates that many treatment programmes are not effective in the reduction of substance use, abuse and addiction.

According to Scheer (1994b) the question is not whether treatment is effective but its cost effectiveness. Moos and Lemke(1994) concurs with this. He found clients were in treatment who showed less substance abuse. The profile of treatment centers shows that they are more urban based with few and far in between in semi-rural and rural areas. (SACENDU 1997).

This transformation and reformation towards more and cost effective services force evaluators to look at creativity, innovative and alternative options of care. Both outpatient and inpatient care have several advantages and disadvantages and many researchers have concluded that the type of treatment and length of stay do not affect effectiveness (Doweiko 1996: 359). Others however have

found a link between length of stay and effectiveness of treatment. (Moos 1994). These different approaches clearly demonstrate a diversity of opinion on this important subject.

Doweiko (1996) and Marks et al. (1987) make reference to the preferred or most acceptable model of treatment, the medical or disease concept of substance abuse. They argue that this model against other more humane models has not had its desired effects on treatment and recovery. There are arguments that drug addiction is a disease and others who insist that it is not a true disease in the medical sense citing that less than 1% of the curriculum of medicine focuses on substance abuse (Selwyn 1993, 70). There seems to be a trend towards psychiatrists being trained on substance abuse treatment ,but Galanter (1993 :8) argues that this is done in the area of detoxification and not rehabilitation. Physicians are often negative about the effectiveness of programmes.

Treadway (1987) asserts this by stating that in 50% of cases presented for marital and family counselling substance abuse is the problem, but this is not diagnosed. This leads to the assumption that "diagnostic blindness" is not only confined to doctors but also to psychologists, family counsellors etc. Such a position is related to the expanding use and abuse of a number of substances, one of the most important being smoking.

Prescription drugs resulted in 100,000 deaths per year. There were 5000 deaths per year associated with illegal drug abuse – heroin, amphetamines and LSD . If these illegal drugs were curtailed such deaths by illegal drugs would be decreased by 1%.and the 99% would be dead by "legal" and "socially acceptable means"(Addictions 1999. 94 (1) 109) .

Research has indicated that smoking by peers is strongly related to the smoking status of the respondents, but peer influences did not directly relate to changes to smoking behaviour and the re-start of smoking(Addictions 1999. 94(6) :920).

Practices that involve sharing smoking between two or more individuals carry a risk of drug related disease transmission both through the act of drug use itself and through related high risk sexual activity . To do a "shotgun" is to engage in a form of illicit drug use involving an exchange of smoke between two or more people. A number of possible motivations exist for this:

1. Rise in inhalation use
2. Availability and use of smokable forms of cocaine.

Drug smoking can increase the risk of transmission of a variety of infectious pathogens by the respiratory tract.

Needle sharing has been found to have both pragmatic and interpersonal motivations(The Journal of the American Medical Association, V282 W09, Sept .1999;Tobacco Dependence Curricula in U.S. Undergraduate Medical Education 825).

A 1991 survey showed that only 21% of practitioners felt that their formal medical training prepared them to help patients stop smoking. The objective of this study was to assess the content and extent of tobacco education and intervention skills in U.S. Medical School's Curricular. 126 U.S. Medical Schools used 122 associate deans for medical education. In 1992 the National Cancer Institute recommended that effective smoking cessation and prevention interventions become mandatory components of undergraduate medical education in every U.S. Medical School by 1995.

A majority of U.S. physicians and medical students are not trained adequately to treat nicotine dependence, the most costly and deadly preventable health care problem in the U.S.

The WHO Bulletin (V77 No.5 1999. (367) estimates that 1.1 billion adults in the world are smokers. In developing countries 48% of men and 7% of women smoke. Furthermore in developed countries 42% of men and 24% of women smoke. One million of the 4 million deaths annually occur in developing countries. This is a reality of major proportions.

It is predicted by 2030, that tobacco will be killing more than 10 million people annually, overtaking HIV/AIDS, T.B., motorcar accidents etc. WHO developed a policy statement, which focuses on treatment approaches to tobacco dependence, which will be used by international health care professionals and the general public. This policy will help deliver treatment for tobacco dependence to people who need them. WHO (1999:367).

Perry and Bennets (1998) state that there are many short-comings in the provision of services in regard to South Africa. They cite the following inadequacies from their findings in the SACENDU report :

- Rural and overcrowded townships have little or no access to treatment.
- Northern Cape is one of South Africa's poor provinces which has no inpatient treatment facility.
- Although the department of health has stipulated that most hospitals are to serve as detoxification facilities in reality this is not so.
- There is severe shortage of funds , professionals lack of efficiency and many services are closing down.
- Little or no aftercare services available.

In spite of the department of health and social welfare commitment to strengthen substance abuse prevention and treatment in all areas, little has been put into practice. This lack of priority has led to further deterioration of services and increased the number of relapses and new addictions. Until a proper assessment of the individual is performed, a holistic treatment programme drawn up and the family is involved at all levels of care, the substance abuse problem will continue escalating worldwide. This struggle should be seen from the primary, secondary and tertiary levels of care.

The analysis of care will be the core of this study with a model on how best to work in the area of substance abuse treatment and rehabilitation programmes.

2.3.5 THE DISEASE MODEL:

Some theorists believe that because of the strong link between substance abuse and biological or personality predisposition, the individual therefore is out of control in abusing drugs. This therefore is a disease and reflects a "disease model" of chemical abuse. Theorists also believe that there is no link between this biological or personality predisposition and that it is a false assumption that chemical abuse is a "disease" (Doweiko 1996).

Doweiko (1996) is of the opinion that there is a genetic loading for alcoholism and if this predisposition exists then it must be so for other addictions as well.

The limited study done by Jellinek, the major exponent of the disease theory as mentioned earlier, i.e. surveys mailed to alcohol abusers or A.A., he received only 98 responses to his questionnaire. He based his findings on these limited

responses and generalized from this limited sample. This disease model has been used to treat countless persons who were/are treated for alcoholism.

Schuckit et al (1993) agreed that there was a progression towards heavier use of alcohol over time; they are also of the opinion that rare social drinkers can become heavy drinkers during times of stress and then revert back to rare social drinkers.

Countless substance abuse counselors use the medical model as a basis to treat chemical abuse. Many on the other hand disagree like Skog and Duckert (1993) that alcoholism is automatically a progressive disease.

Toneatto et al (1991) in the same breath draws attention to the fact that treatment must be leveled at the persons behaviour and social functioning as well as the biological functioning of the person. This conclusion of bio-psycho-social, a holistic perspective to treatment is supported by many.

There has recently been much awareness and scope of the drug problem globally. The expansion of services also produced a host of treatment approaches. There has also been a rethink on certain issues regarding treatment policies. Bennet (quoted in Doweiko 1996)also states that the evaluation of drug services and treatment policies and their implications inevitably influence future treatments and services.

2.3.6 DOWEIKO'S MODELS AND THE DEBATES CREATED BY IT

There are talks regarding the "Myopia of Medical Metaphors".Writers on the topic are of the opinion that the relationship between illegal drugs and medical metaphors is strong. Addiction is equated to the physical psychological

dependence, which in turn leads to withdrawal symptoms when the drug is stopped. This then equals to disease because the person is in withdrawal and cannot stop. His drug taking is considered sick and he cannot make decisions over his/her life.

This moralistic view of disease concept does not take into consideration the social context of disease; it sees disease and the treatment of disease as entities on its own. In the context the person has no control over decisions about the types of treatment he needs or what should happen to his body. Treatment for drug dependency is forced upon people with people getting into the "sick role" because of them thinking they are sick. Many treatment models use the disease concept where they further elaborate the chronicity of drug dependency. Here the use and stress of the abstinence model of treatment enables the relapses or slips to occur periodically, which precludes the controlled use of drugs completely(Waldorf 1983:69-72).

The opinion of many researchers is that people can mature out of addiction. Valiant (1983) stated that factors that contribute to, and treatment of alcoholism was done from a social perspective. Another view held by Rogers (1994 :34), is that human beings reward themselves by deriving pleasure from drugs thereby becoming addicted to this reward system. The promotion of drugs seems strange if it is addictive and thus classified as a disease. This concept of the disease model is described as ironic because of its commercial value and advertising as a pleasurable agent. The Medical World gives more weight to disease than the individual(Siegel 1989 :12).

Pratt (1990 :18), is also of the opinion that once the person becomes addicted he/she is genetically predestined to be afflicted with a disease leaving the individuality of the person out and being medically termed as being ill. Here once again the disease takes front seat rather than the individual in its social context.

Another theory that has been contested by a number of researchers such as Valiant (1983) and Waldorf (1983) is the one by Dole and Nyswande (1965) who are saying that a single dose of narcotics can determine the person becoming addicted and takes away the person's choices in decision-making. People are always taking analgesics for pain with few becoming addicted and crave for these drugs. This challenges the theory of Dole and Nyswande that analgesic users may want more to create euphoria. Blem and Payne (1991) are also advocating that alcoholics crave alcohol thereby becoming addicted. They have used the medical model to devalue the individual's self-determination. Alcoholics on the other hand agree that they can do without alcohol if their reward systems are positive and give them better rewards than alcohol, again casting doubt that the disease model adequately describes the concept of alcoholism.

Slips and relapses are not due to craving alone but also due to a pulse of different factors. For many addicts the good feeling of drugs is felt only after they have gone through pain of withdrawal (Rogers 1994). Individuals are helped towards recovery by experts; many are doctors who are rarely trained in identifying substance abusers or in treating them. Therefore the disease model is under scrutiny with few practitioners knowing how to treat this "disease" and that medicine does not train its practitioners.

Doweiko (1996 :226-227) , states that chemical dependency is called a bad habit. The Howard Medical School Mental Health Letter (1992b,2) states that addiction is termed as bad habits, which is difficult to change. Doweiko further states that individuals have to change non-acceptable habits but this does not make these non-acceptable habits "diseases" because the worst habits can be termed diseases and this can be innumerable.

Les (1990 :16) states that there are many unacceptable behaviours which have become diseases which gives people an excuse to avoid responsibility by being sick. The myth of drug abuse being a disease has been researched by many practitioners in the field of abuse who asks whether there are alternative ways to tackle the problem of drug abuse.

Drugs in society are either hazardous or unacceptable. Most are classified as such because of its religious, social or political value. The war on drugs is a war on human pleasures.

Many researchers have questioned the limitations of the disease model where medical service disregards the freedom of choice of the individual as to what should be treated or not treated. Treatment is forced upon the individual because he/she does not know what is good for him. Hartmann and Millea (1996:2) see the disease model as outliving its political and social usefulness .

Marks et al. (1987) advocate and believe that drug abuse theories and treatment modalities should go beyond the models of abstinence and disease. The researchers are also of the opinion that ethics is important and people must have the freedom of choice regarding their use/abstinence. Therapy should be separated from social control and therapists should display a readiness to accept and work with clients even if they do not abstain from using drugs.

Abstinence should come at the end of therapy and not as a requirement at the beginning of therapy. This high standard of requirement most often is not met by addicted persons; on the other hand abstinence increases suffering and the client thus enters treatment. Perhaps the high expectations of counsellors of the drug-addicted person has very little success, this puts a lot of pressure on the therapist and the client.

Most theories on substance abuse are unfinished and no clarity on how to deal with problems. Attitudes towards drug users play a role in the treatment of substance abusers. Often it is felt that drug users have lost all dignity and therefore should not be treated like human beings.

Herwig – Hempp and Stober (1996) found working with substance abusers and their families very frustrating and disappointing. He is of the opinion that the problem lies in addiction and those persons addicted with this because they are seen as ill and dysfunctional and this impacts on the counsellors working closely with them. Because of the denial they do not see that they need help. Herwig – Hempp and Stober (1996) concur with other researchers that the addiction becomes the priority problem to be treated but on condition that the person maintains abstinence before help can be given.

Abstinence before help is actually contradictory because the main goal of therapy is to become drug free, that is abstinence and how can abstinence be achieved if the client is seeking help because his/her loss of control over drinking. It makes little sense that the disease concept according to definition deals with illness, the solution after treatment would be abstinence but for commencement of treatment the traditional approach requires abstinence.

By asking for abstinence before treatment the measure of success for therapeutic intervention is set very high and we know that success is relevant and very often achieved for a short period of time (Chlauzzi 1990).

Researchers feel that the pressure to conform to criteria and also forcing it onto the client is rarely found in any form of counselling. The researcher's opinion is that it defeats the principles of therapy and infringes on issues such as non-judgmental attitude and self-determination. Because drugs are dangerous the above seems acceptable in view of therapist having to employ rigid criteria.

2.3.7 DISEASE MODEL CHALLENGES

Much confusion surrounds whether addiction should be treated as disease and this is true for the health professionals as well the argument for and against the treatment of addiction in the context of disease is strong. Modern medicine today still does not have many answers in the field of substance abuse.

Medical School curriculum spends 1% of training on substance abuse (Selwyn 1993).

Galanter (1993) further states that psychiatric inpatient modalities are only starting to address substance abuse now and that also focuses more on detoxification and not on substance abuse rehabilitation especially in view of what is occurring in the USA.

Chemical abuse treatment cost up to two and a half times more than the treatment of mental illness. (Group for advancement of psychiatry, 1990). The American Medical Association (1993a) says that either directly or indirectly training and education do not meet the needs of the practical situation where they can identify and treat substance abuse.

A study done by Rydon et al. (1992) found that primary care physicians in a study of 300 alcoholics failed to identify the majority of individuals as alcoholics. These researchers are of the opinion that physicians believe that alcoholism is untreatable.

Irrespective of whether substance abuse is seen as a disease or not, health care professionals fall short of correctly diagnosing or treating substance abuse because training is not adequate to meet these needs. Kaufman and Kaufman (1979) stress that the fact that health care workers have negative attitude

towards drug dependant persons by not accepting addiction and helping to make the social and health circumstances of their lives better.

2.3.8 SOCIAL CONSTRUCTIONIST PERSPECTIVE ON DRUG WORK.

Germany is one of the leading centres where the drug treatment policies and programmes are under review. These changes says Derks and Darrsen (1994), is due to much of the media and professionals debates on issues such as helping the existing care facilities improve and on whether the judicial system in fact works. Herwig- Lemp (1994) sees this discourse aiming at other ways of walking in the drug related fields, the challenges put to what correct ways of treatment are focused on the disease concept and abstinence as treatment models. Here regional and local reforms in policy contribute to alternative ways of treatment. The social constructionist perspective looks at the description of social constructions of reality so that these can be open to discussion(Berger and Luckmann 1966). This according to Bochumer Arbeitsgruppe (1990) helps to put together everyday "myths" on which different ways the drug questions are based. When these are explicated they can be reformed. All societal ways of functioning are built on societal procedures. Hence it becomes easier to establish new ways at looking at drug abuse and treatment of these. Gergen (1990) sees the social constructionist and language and written matter as a means of creating social acceptance of issues at hand. He said that we can see how the media portray these discussions by using common language terms to the "drug problem" in TV talks, news, and papers, etc.

Discourse is dominant, it underlines what we feel and think and do within the constraints of the discourse(Willutzki and Duda ,1995: 342). Individuals in their interaction with others internalize concepts, understanding and of certain cultures and in this way contribute to the structure of concepts . Moves to new context and changes in discourse may lead to new communications and changes

in discourse again leading to change. Peele (1989:61-63) gives a good example of this by examining the high levels of relapse after inpatient treatment and low relapse rates during therapy.

He sees the patient in a realistic linguistic environment governed by rules and constraints, when these are eased, the significance of these rules and regulations are not so crucial for the individual any more. The difference between the therapeutic setting and outside world cause for the individual a huge difference often leading to isolation and Willutzki and Wiesner (1996) see this as two different worlds with different constructions and to bridge the gap between the two can however be done through "accepting drug work". Peele (1989: 62-3)) argues that the disease model perpetuates continuing drug abuse because it draws a very negative picture of the drug abuser; the negativism disadvantages the drug abuser further into drug taking behaviour. The precondition for treatment being abstinence is paradoxical especially if the disease model stands on the notion that the loss of control being one of the definitions of "addiction". Hence the disease model/concept is used because the addict has lost control and all rationality is lost. "Accepting drug work" is the opposite of disease concept and challenges this myth. This has implications both for drug users and helpers.

2.3.9 PROBLEMS ASSOCIATED WITH THE DISEASE CONCEPT.

Peele (1989) says that drug use leads individuals to treatment settings where they learn about the disease myth and the withdrawal symptoms. Researchers have stressed that it is not the drug itself that makes it uncontrollable and addictive but the belief of the great power of drugs. Robins et al (1980 :229) says that from the users point of view, the drug is so strong that it cause euphoria and the users become addicted no matter how careful he/she is.

DeJonk (1994) stressed that young people find it difficult to outgrow drug using because of the beliefs about drugs and its usage and its addiction, people have little/no hope that change is possible. All this is based on the disease concept. The problem is identified according to known definitions and in treatment the users potential in dealing with the drug problem is not considered. Krauss (1985) and Peele (1989) describe these treatment models as totalitarian.

The Disease concept gives the drug abuser the right not to help himself by controlling behaviour. This behaviour can be criminal, destructive or immoral but because of loss of control, the person cannot assume responsibility. This only reinforces negative behaviours. An excuse of is always at hand that blames the disease concept for this. The perspective of the drug addict, the parameters between the "normal" and the world of the addictive sub-culture is very firm, and in the presence of drug abuse leading of a normal life and future is extremely difficult (Peele 1989) Yet, a person who helps his drug use secret leads a normal life until his/her drug taking becomes public. Only when this becomes public does the world of the drug user change to an abnormal one. A negative self-construction is based on the disease myth and the addict has to always fight against his/her real self as addict(Luhmann , 1984)

Pioneering work has been done in Germany where attempts have been made to develop new approaches for working with substance abusers. One of the more positive approaches is the one concept of acceptance and this approach is combined with ideas of systematic therapy and counselling. This also focuses on the humane treatment of substance abusers helping them to maintain autonomy and self-determination. Such practices have been employed in South Africa for a number of years.

Acceptance, in countries such as Germany, is based on the principle of rights of the drug abuser who has rights to health and social conditions that reflect towards set in societies. The therapists are perceived not to be "right", "know what to do", "good" and sensible". The decision as to what to do is left to the drug abuser. The relationship is based on autonomy and no forced or crucial types of treatment is used. The behaviour of addicts should not be attributed to the addiction or dependency but to personal behaviour based on different values and principles from the norm.

In Switzerland, Denmark and Netherlands, there are no set solutions for some of the problems encountered in patient treatment. The argument according to Herwig-Hempp and Stover (1988) is that the concept of acceptance operates on the premises that firstly abstinence is not the aim but the improvement of the quality of the life of the addict (or dependant as has been otherwise called). The improvement of the physical health and social situation of the addict stabilize and improve and also the relationship between the client and therapist is on-going. The essence of this lies in the fact that through this communication that the client starts to make life style changes. Also long term prognosis improved by the prevention of physical, social and health damages. The abstinence way much, damages are done through letting the client go through too much of trauma.

2.3.10 THE SYSTEMIC APPROACH

Systemic approach simply means working in a group or with people who are important to one another and people who are connected to each other like couples, families, groups of interest and groups of people belonging to certain types of clubs, support groups and people working together, all these are considered as a system. A systems approach in therapy considers the people closest to the identified patient as being part of the therapy. Efran et al (1989)

view clients as being autonomous and as having minds of their own and therapist use the systemic approach to enhance this interdependency.

As much as people are different to each other they also exist how they want to and do things how they want to. It is not always that they will do as they say or think they should do. The principle underlying the systems approach is every person is independent; their behaviour makes sense to themselves from their respective points of view.

The systemic therapist respects the client's autonomy in contrast to more traditional approaches where the client is termed "ill".

The premise of the system's structure is based on the following points: -

- ❖ Firstly - the client takes responsibility for his/her own behaviour.
- ❖ Secondly – the client changes his/herself, the therapist cannot influence the client.
- ❖ Thirdly – client has to ask for a systemic therapist so that he/she can be helped to look at alternatives and viable options. Here the therapist broadens the availability of alternatives (the client chooses what suits him). Here the therapist is concerned with the here and now explanations for how this happened is not relevant. Labeling can be responsible for maintaining negative behaviours.
- ❖ Fourthly clients freely for treatment, they define their problems prioritize these and look at strategies to solve these problems. The problem defined by the client is what the therapist works with and no coercing and force is used for the treatment.

- ❖ Finally ,the outcome of therapy is unknown because the therapist only facilitates the process of therapy objectively with the key role player being the client who determines the outcome.

According to De Shazer (1990)

- ❖ Respect for independence eradicates “resistance” and is replaced by co-operation. Different individuals and families have their own styles of co-operation; the therapist recognizes this style and encourages change. Resistance to therapy and change lies in the way a therapist does therapy, clients respond if therapist are in time with them and do not impose their own value systems on them.
- ❖ Respect shown to clients make therapy more relaxed and bring a sense of humor through all the seriousness of the problem.

This concept has both meaning for the therapist and the client. Both acceptance and systemic approaches can be used with clients who have an addiction problem. Clients can now express their problems the way they see it affecting them. Now the stress of a therapist imposing his/her views of the problem onto the client is lessened. Start where the client is and proceed at the pace of the client without jumping or diagnosing an addictive problem. Space and time is of the essence it is not necessary to find solutions to problems that has been there for a long time.

More time gives use to more ideas. View the client as an individual with resources and not having faults or shortcomings. The intensity of the problem should be assessed overtime. Therapists often see the drug abuser and the family as losers because they had little success fighting this problem on their

own. These efforts must be recognized and built upon as quoted research throughout the thesis has indicated.

Small changes are encouraged by the therapist whereby injunctions are given to the family to experience with. Eberling (1989) is of the opinion that fantasy about the future without drugs creates concrete ideas towards change. De Shazer (1990) concurs with this saying that paradoxical Injunctions could be used carefully to e.g. how clients could worsen the future. Clients should be encouraged to take control over the situation that seems to be taken over by the addiction here the therapist can hypothesize with the client different situations.

Set backs must be negotiated and put into planning and discussions, especially in the field of substance abuse is unavoidable, reduce setbacks by acknowledging that this is natural and will happen from time to time. Mistrust has damaging consequences on the relationship. Consider all clients to be adults, who are responsible for their own behaviour, try to work with what the client comes with. The attitude of therapists often in the field of addiction is one of mistrust because of the types of things addicted persons would resort to but this does not warrant controlling clients, if they lie, then there must be reasons for this. Decision and responsibility structures must be discussed openly and clearly with clients although therapists do not want control. In some circumstances control has to be exerted i.e. a child has to be remove from the family, takes the decision making and control away from the family.

The Systemic approach differs from the traditional one in that there is no pressure on the client and the therapist, clients do not have to change instantly, co-operation and politeness leaves lots of space for altering behaviour. (Herwig-Hempp 1994)

2.3.11 DRUG TREATMENT PROGRAMMES:

Substance abuse care falls into 3 main categories. Firstly, there is a need to evaluate the process and outcomes of treatment to drug abusers. Secondly substance abuse care needs to become less expensive to more community based and outpatient care systems. A third category would be on continuity and co-ordination of care amongst professionals will help improve the nations systems of substance abuse care and treatment. (Moos et al.1990).

For South Africa the response to drug problems has been wrought with fragmentation and this has had a negative impact on drug abusers and its treatment outcomes.

In the first instance the duplication or non-existence of resources has led to little resources not being managed properly and much needed resources not developed. The war on drugs has not been gone into effectively because of the lack of a single system nationwide.

South Africa has therefore developed a South African National Drug Master Plan as a blue print to develop a single unified system to deal with substance abuse issues concerning budgets and programmes(SANDMP 3-4).

According to Langenbucher (1994) the health care use of countries may be reduced if substance abusers go for treatment for their chemical abuse problems and this leads to positive improvements.

Emrick et al. (1993) state that treatment which focuses on psychology and behaviour, family and marital therapy, skills training and supportive networks like

the A.A. will help in reducing the intake of chemical substances and reintegrate the person into the family and other areas of social functioning.

It has also been found that those persons who stay in treatment longer than others who stay shorter periods improve better. Individuals who enter treatment also improve better than those individuals who do not go for treatment(Finney and Moos ,1994).

For patients' needs and programmes to be matched appropriately, policy makers need information about the models of care treatment and an evaluation of individuals short and long term evaluations. According to Moos, Finney and Cronkite (1990) treatment outcomes are influenced by the individuals treatment resources before being admitted, how severe the drug problem is by the persons life experiences before, after and during treatment.

For any nation to plan effective substance abuse treatment programmes policy makers must have an indication of the types of services clients require and what is available. Because of the range of other services needed by substance abusers seeking treatment Policy Makers must be able to plan accordingly and programmes must meet the needs of the clients.

The South African government having developed the Drug Master Plan which will act as a barometer towards the commitment and performance of all role players in the arena of substance abuse (Drug Master Plan, 1999: 4).

It was also found that unmet needs of clients in the USA were now much higher in the mid-1990's than 10 years ago. This according to Moos and Finney (1995) could be because larger numbers of people are seeking help, while staff numbers have dropped and other constraints were faced regarding resources .They were

of the opinion that the state and policy makers should advocate on behalf of organizations for expansion of services as well as funding for these treatment units.

Trinko et al. (1994) talk about the importance of developing policies and services characteristics inventory (PACSI). PACSI looks at points and services, it also focuses attention on programmes and what expectations these programmes have for patients and how patients' problem behaviours are accepted. PACSI also assesses policies regarding patient's choices, privacy and participation in progress. Different programmes can be compared – like hospital based to community based and psychiatric settings. Policies and services do influence larger team outcomes.

In an editorial in the A.M. J Psychiatry 156(1) January 1999 it was stated that Science has advanced rapidly and some clinical and popular myths such as initial drug use is voluntary and is a preventable disease. Although drug use leads to drug addiction, it has also been accepted that once the person is addicted to drugs, he/she moves into difficulty. The clinical research community now accepts that addiction is a chronic disease like diabetes or heart disease and that there are relapses and slips from time to time.

The view of many health professionals today is also that no matter how a person develops an addiction, he or she needs treatment. It is widely accepted that drug treatment is beneficial to the individual and community. Through reducing public drain on resources and helping drug addicts stay drug free by reducing infectious diseases, crime and helping drug addicts to be functional once again.

A study was done by the Institute for Security Studies and Medical Research Council(NEDCOR ISS Crime Index Volume 3 (6)99 (10-11).

This study focused on the strong connection between drugs and violent crime in South Africa. 77% of arrestees were arrested for housebreaking, substance abuse offences 71%, arms and crime 56%, robbery and murders 53%, rape 47%. The article also cited that the reduction in the drug use is important and specific policing strategies must focus on drug related crime and how to reduce this.

Many studies have focused on the limbic system and how this affects the brain and the behaviour of persons who are addicted. It is suggested therefore by Childress et al (American Journal of Psychology 156 (1) January 1999 11, that treatment must be leveled at the person's behaviour and social functioning as well as the biological functioning of the person. This conclusion of bio-psycho-social – a holistic perspective to treatment is supported by many.

Infectious diseases are spread through drug dependency. Most of these diseases are spread through the use of intravenous methods. The most serious disease today spread through the needle is HIV/AIDS.

For South Africans the spread of AIDS through needle use is still relatively low because South Africa has not developed a culture of injecting drug users like many of the first world and developing countries(NEDCOR ISS Crime Index No. 5 , 1999 : 3 (Drugs in South Africa) Welconal, a synthetic opiate is one of the the drugs used intravenously in South Africa. There are great concerns that the Heroin use in South Africa can escalate in the next generation and become an epidemic . In order to escape the paranoia of crack/cocaine abuse many sex workers in Johannesburg are resorting to I.D.U. heroin use.

I.D.U.'s often fail to sterilize needles. Cherubin and Sapira (1992:12) cite the most common diseases spread through needles is skin abscesses, pneumonia,

tetanus, Hepatitis B. I.D.U.'s also share needles with other I.D.U.'s . This sharing of needles exposes the next user to infections of the previous user has in their blood. According to King (1994) a very deadly infection that is transmitted through the needle is the virus called Human Immunodeficiency Virus-HIV which causes AIDS.

2.3.12 THE TREATMENT OF CHEMICAL DEPENDENCY:

There is a wide array of different treatment processes for the chemically addicted person. There are no standardized treatment models or programmes but there are common elements, which may be found in all the programmes.

Doweiko 1996:339) is of the opinion that a counsellor should not have any personal issues relating to substance abuse because this will be a hindrance in terms of helping recovering addicts. Effective mental health workers should have characteristics like be warm, be consistent, be available, care and respect for client, clear boundaries between client and worker, client not be threatened by the worker, non-judgemental attitude, see the client as an individual capable of growth with good interpersonal skills.

Drug addiction has been viewed for years as a family-centred disorder. Families play a key role in either sustaining drug dependency or encourage the use of drugs to maintain the family equilibrium.

Research indicates that a large number of young drug users remain at home with the family . The opposite is also true, where co-dependency often develops with addicted parents where the young individual never individuates from the family and becomes enmeshed in the family system (Doweiko:1996). The family is mainly responsible in helping the drug addicted person maintain their drug use

through enabling and co-dependency. However this is a matter that is still been debated thoroughly in research and professional circles at present.

2.3.13.Enabling: Doweiko [1996]

Any person who knowingly protects an addicted person from facing up to the consequences of his/her behaviour is termed an "enabler", most enablers are family members [this research, mostly mothers].

In North America a similar pattern is seen in culturally religious and restrictive families where the primary seekers of help for their children are parents who have unrealistic expectations of treatment (Farrow, 1990). It has been shown that family involvement promotes positive treatment and rehabilitation of drug addicted persons because family support becomes crucial for relapse prevention and aftercare.

Many childhood conflicts and stressors can lead to chemical abuse and the family approach helps the individual to model and interact with the family towards healing (Evans & Sullivan: 1990 : 34-35). Madanes et al. (1980) states that family therapists see drug dependency as first not want to confront other family conflicts and secondly not wanting to separate from the family. The invaluable benefit of family therapy is highlighted in terms of how families are motivated, engaged and assessment procedures, and the cultural therapy in conjunction with group therapy, support groups and evaluation procedures and aftercare.

Madanes (1980) says the family functions in ways that sustains the users drugging by preventing areas of conflict. Family treatment is effective in restoring a balance in the family because every individual in the family contributes to the dysfunctional family member (Bowen: 1985). In family therapy

the attention is on behavioural patterns that undermine individuation hence causing imbalances in the person's drug behaviours.

2.3.14 CO-DEPENDENCY:

Gorski [1992] identifies co-dependency as:

- Obsessive attempts of the co-dependent to control the dysfunctional behaviour.
- Over-involvement with drug dependent person.
- To use external sources of self worth.
- Tendency to make personal sacrifices to cure the addict. [This research, mostly mothers].

There are interrelated factors that connect drug dependency with family and religious practices. Thus Madanes et al . [1980] see the functioning of the family as inter-reinforcing the drug abuse because the user's addiction covers for the other areas of pathology in the family. Drug users are dependently involved with their families and are reluctant to separate from families.

A strong movement exists in the field and social services to incorporate religious matter into the full assessment and treatment of clients. A study showed 45% of clients preferred to work with religiously similar therapist, 20 % with religiously dissimilar therapist and 15% were not concerned [Wilker: 1989].

There is more limited research in relation to drugs and family, when compared to research done on alcoholism and the family. Cherubin and Sapira (1993) found where one partner is an alcoholic there is a role – reversal between the partners

sometimes spanning over three generations, this is often the case when therapist does a genogram of the family.

The dependency cycle is repeated with family members with members developing a co-dependency relationship with the alcoholic. Individuation does not happen and there is a tendency for persons with similar levels of emotional maturity to end up together according to Collier(1989) .

In many homes where the parents are alcoholics, individuation does not happen because severe emotional enmeshment and unclear role modeling for individuals to deal with their own problems. (Doweiko 1996)

Control seems to be underlying issues in many dysfunctional families to maintain some sense of order. Conditional love dominates unhealthy families and is used as a means of control. Co-dependency model is based on the fact that substance abuse disorder becomes a family centred one, which passes from generation to generation. This is further reiterated by Bowen and Dowieko. The co- dependent person must be taught the difference between concern and responsibility for another person. Enmeshed boundaries must be clarified for the co-dependent person because each family members boundaries become enmeshed and confused. Children in alcoholic homes learn to become enmeshed from an early age, this leads to individuation not happening. In family therapy we see how each member of the family takes responsibility for every other member of the family.

2.3.15 FAMILIES WITH DRUG ABUSE FEATURES

Bless and Higson Smith (1995) has described the following characteristics of families with drug abuse features.

- ≈ Role boundaries not clear if parents abuse drugs, children assume parental role.
- ≈ Role modeling absent from parents. Children praised because of role they assume and this often leads to problems in peer relationships.
- ≈ Parental role taken over by social worker or other agencies, children might have to be removed to protect them.
- ≈ The central problem which is drugs is downplayed by family members and not seen as being the cause of imbalances in the family.
- ≈ Drug addicts become like a child, not taking responsibility to make decisions.
- ≈ Mother – son relationships especially if son is drug addict, is over-involvement and dominant.
- ≈ Children's partners are objected by parents if both are drug addicts.
- ≈ Drugs avoid conflict and treatment, often spark conflict.
- ≈ Fathers who abuse drugs have weak relationships with their drug using sons. Fathers generally are seen as weak and not good role models.
- ≈ Trauma of death is highlighted and drug addicts play role of savior to the family.
- ≈ Relationships survive if both the partners are drug users.
- ≈ Very traditional roles e.g. father is bread winner even if he is involved in negative ways of earning that money. This type of traditional role says Bless and Higgson Smith (1995) reflects the types of life cycles according to which children are socialized.

Family members of alcoholics live with a lot of fear, guilt not knowing the next episode of aggression of the addict. This emotional abuse keeps the family together because this is combined with threats which is used to perpetuate this guilt and is used as a form of control. (Freiberg)1991.

Many adults suffer from raging pain and emotional turmoil by growing up in an alcoholic home. Large numbers of adults have come forward and are in treatment and are known as Adult Children Alcoholics (ACOA) and many treatment centres have been developed to address this problem.

Washton (1990) found that parents who abuse drugs, has led to their children becoming involved in forms of problem behaviour, which predisposes them to abuse drugs. It was found that after a year of family skills training parents showed positive changes in terms of decreased drug use and more structured family management in contrast to children's drug taking behaviour and attitudes. It is concluded that because children were older, they saw family management as restricted and their involvement less positive. They needed more specialized intervention. It was concluded that these family skills training programmes to reduce drug intake, prevent relapse and strengthen the family system.

COMMON FEATURES OF ACOA

- Problems with intimate relationships.
- Contributing in projects, things are left halfway.
- Lying which becomes a way of life.
- Anxious and need to keep busy because of negative image of oneself.
- Constant need of feedback and support from closest members of the family and friends.

The self-help groups of ACOA have also had some criticism from professionals e.g. too much stress on past experiences and pain blocking growth and strength of individuals. Also that it is taken for granted that individuals suffer lasting psychological effects of parents' drugging behaviour.

The co-dependency model assumes that the individual's substance abuse family centred and passed from generation to generation and the practical responses of lasting pain is through ACOA. The above theories have not been tested in practice, and there is a call for much more research in this area, so that clarity and definitions on understanding of chemical addiction impacts on the individual and members of the family can be acquired.

2.3.16 TREATMENT MODEL FOR FAMILY WORK

Family therapy with substance abusing families goes through the following phases.

Initial treatment phase – engaging the family.

TREATMENT PHASES:

1. Entry into treatment
2. Assessment
3. Intervention
4. Homework Tasks and Prescriptions
5. Crisis Phase

These five phases incorporates the whole family where possible

1. Entry into treatment

Parents, mostly mothers of drug addicted persons are the ones who request family therapy services from the treatment unit. After about two initial sessions the whole family including the drug addict come in for family therapy. All the

family members know and discussed the drug use of the individual prior to attending family therapy sessions. The initial treatment phase also helps the family understand that the process of treatment can only commence if all members are prepared to involve themselves.

Doweiko (1996] believes that confrontation does have its benefits but inappropriate confrontation can be damaging. Miller(1991:455), sees empathy for the client as more effective. They also stated that as the therapist's confrontation increases, so does the client's defense and resistance. They further state that a "supportive-reflective" style of therapy is very beneficial .

2. The second phase : Assessment

Because the family accomodates the addict and his/her behaviour, it is easier for the addict to continue that behaviour because he/she is absolved from their responsibility for the additlon or its cure. Since drug addiction evolves over time, the addicted person develops a family support system, which helps the addict maintain the habit (Doweiko 1996]. Therefore, the families in the assessment are asked very important questions on who is the family member who can best talk about the drug problem. For most families, it is the mother. There is a clear indication that the relationship between mothers and sons are very enmeshed and confused.

The history of drug taking is discussed in depth. Here it is very crucial to make an assessment of whether the person is addicted or not. Although many of the substance abusers had sought treatment at other agencies, it is still important to assess whether they were addicted or not. Here the family is used as a source of information. Sullivan [1990:54] states that information for diagnosis should not only be based on the individual's information. Donovan [1992] also concurs by

saying that the nature of addiction is deception. At the assessment sessions, the conflict between the substance abuser and mothers especially is very severe. At Bayt-ul-Nur, an assessment format is used:

- Circumstances of reference
- Drug and alcohol use patterns
- Legal history
- Educational and vocational history
- Developmental and family history
- Psychiatric history
- Medical history
- Previous treatment history

A 3- generational genogram is drawn up with the family assistance.

Institute for Juvenile and Family Justice Development [Juvenile Report: 1999:p.10] states:

"The patients' families are to take an important part in the process of rehabilitation. Since the patients' problems are mostly caused by their families, it is essential for every member of the family to understand and help one another to form restoration in the family".

Family therapy sessions should focus on the parents and other family members. Families focus very much on the negatives of the drug users' behaviour. The

therapist develops a productive atmosphere, which helps minimize guilt, which is attributed to the functioning of the family. A contract is signed with the drug abuser and the family, that the goal of treatment is to try abstinence. The family at this point is also asked to randomly check the urine for drug abuse (a local hospital does this). At this stage the drug addict is told about how much he is loved but his behaviours are not acceptable [Meyer: 1988:7].

At the end of every family therapy session, the family is assigned homework tasks. The therapist develops tasks with the fathers and sons, mothers and daughters and the whole family. This strengthens the bonds between fathers and sons; it also emphasizes the role modeling of the father as an assertive parent.

A prescription is given/read to the family at the end of each session. Highlighting the positives and negatives in the family's functioning. This is placed on the fridge or notice board at home so that each member reads it .

During this time the family continues family therapy sessions. With the addicted person away at therapy, the family members have enough opportunity to talk about other problems experienced. During these sessions, family members have to confront the underlying issues in their relationship. There is a lot of blaming and guilt e.g. fathers blame the mothers entirely for their child's addiction; mothers blame themselves. Therapists also encounter a number of marital problems which are then referred for couple or marital counseling.

Much discussion is based on the drug abuser maintaining a drug-free life style with the support of the family. The family is educated on how to support the drug-free lifestyle of the addict.

The family learns to break the cycle of inter-dependency because the drug addicted person/persons is not at home and the family learns to use coping strategies to disengage from this cycle. For most families, this crisis helps to form clear boundaries between the child and parents and siblings.

2.3.17 BENEFITS OF SYSTEMIC THERAPY: UNDERLYING PRINCIPLES

The systemic approach deals with relationship patterns pertaining to all families irrespective of cultural differences. For some families with strong religious beliefs some different approaches are needed purely because much of the behaviour, responsibility and relationship is based on a cultural and religious lifestyle which gives clear guidelines for everyday living and behaviour.

- The client assumes responsibility for his/herself and what is good and not good. The therapist does not assume responsibility for the client's behaviour.
- The onus to change does not lie with the therapist but with the client. The therapist does not see the client as negative.
- Systems approach does not diagnose [except dual diagnosis clients], label [once a drug addict, always a drug addict] or look for the causes of drug addiction but rather on the best way to function effectively.
- Systemic therapy focuses on the pain of the client and family and as to how they describe it. There is no forced treatment.
- Once the rights of the client are respected, the "resistance" of the family and client disappears. "Every family, single person or couple shows a particular way of co-operating, and the job of the therapist is to analyse the specific ways of that family while co-operating with their style, and in this way encourage changes" [De Shazer:1990:77].

- Religious values are respected and recognised by religious practitioners without families feeling oppressed and undermined as to their value system
 - The systemic approach is not a miracle cure, it is one of the ways of providing effective therapy. It is a tool to lead the family and client to a healthy way of functioning.
-
- Many families are very religiously inclined where they emphasize that drugs were are "unacceptable"
 - Practitioners break the unhealthy functioning of the family and create disorganisation in the first session.
 - With structured therapy the family re-organises themselves to function more effectively.
 - Generally mothers play a very dominant role in their children's lives and this relationship between mothers and their children is normally very enmeshed and disorganised.
 - Many fathers play an "invisible" role in the family functioning
 - Most families want their children to be perfect in every way, religiously and otherwise. This leads to relationship damage.

Families are perceived to be very crucial in the effectiveness of long-term goals. Solutions and interventions should be in keeping with the cultural and religious ideologies of families and the values and goals that are important to those families must be respected. The writer also notes that this type of approach has far reaching therapeutic impact on the Index Patient and his/her family and ultimately benefits the community. Working with the whole family makes the

problem less complex and gives more clarity. Practitioners must understand the dynamic relationships in families is based on three dimensions *cohesion*, *flexibility* and *communication*.

Comments of family members often are as follows:

"Now I understand my son better."

"Family therapy has helped us come to terms with our marital problem."

"We will overcome drug abuse as a family."

"A specialist counsellor understands better."

"Only God can help us."

The writer cautions the practitioner to treat each family as unique, but yet with many commonalities regarding culture, lifestyle, relationships etc. Practitioners should be able to work with families from different dimensions but at all times maintain respect and dignity for the family in a non-judgemental manner.

2.4 SIGNIFICANCE OF DUAL DIAGNOSIS.

The relationship between psychiatric and substance abuse disorders is inextricably linked and the term dual diagnosis is synonymous with these two disorders (Francis Widiger and Fyer 1990). In psychiatry and substance abuse this diagnosis has been singled out because of its significance . Solomon et al (1993) reported that between 25% and 58% of patients with different types of psychiatric illnesses had concurrent substance abuse disorders. Washton (1990)

discovered that up to 80% of substance abusers also had non-substance abuse disorders. Other researchers have written that it is more likely that substance abuse disorders or mental disorders are more likely to occur simultaneously(Waldorf 1983;Twerski 1983).

People with dual diagnosis are more difficult to treat and have poor prognosis for recovery ,hence the stress on careful diagnosis and assessment which will impact on treatment programmes(Boyd et al ., 1984)

Solomon et al (1993) are of the opinion that where the psychiatric disorder is primary and substance abuse is secondary ,the treatment efforts must concentrate on the psychiatric condition. In this instance the substance abuse problem will reside itself and it will be easier to treat once the psychiatric condition is treated. On the other hand the same is true when the substance abuse condition is primary and the psychiatric condition secondary. The treatment of the primary condition, i.e. substance abuse, will result in the resolution of the psychiatric condition.

Issues with diagnosis.

Clinic health workers often fail to address both the substance abuse and psychiatric conditions when they co-exist. Spitzer et al (1990) stated that the initial evaluation should incorporate both the disorders and that clinicians must be familiar with the diagnostic criteria .They also believed that often proper diagnosis is not performed because patients denied the reality of substance abuse and did not report the symptoms of psychiatric condition .

Solomon et al.(1993) wrote that it is crucial to determine the relationship between the two disorders. They maintained that the three relationships that should be considered were:

1. A primary substance abuse condition leads to secondary symptoms of a psychiatric disorder.
2. A primary psychiatric condition results in secondary substance abuse disorders.
3. Both psychiatric and substance abuse systems are both primary and not secondary.

2.4.1 DSM-IV-R DIAGNOSIS OF SUBSTANCE RELATED DISORDERS. **(QUERY)**

The DSM-IV-R (1994) lists twelve categories of substances: alcohol, amphetamines and related substances that have amphetamine like symptoms, caffeine, cannabis (marijuana), cocaine and their derivatives , hallucinogens, inhalants, opioids, Phencyclidine and related substances, Hypnotic Anxiolytics and a number of other substances.

There are basically two types of substance related diagnosis in the DSM-IV-R (1994). Substance induced mental disorders are directly linked to behavioural syndromes caused by the direct effect of the substance on the central nervous system. The other one is directly linked to the pattern of substance use. This effectively is substance dependency or substance abuse.

Many researchers have described the difficulty in defining a clear set of characteristics for dual dual-diagnosed clients. A large number of researchers

according to Cuffer, Herthoff and Lawson (1993) have examined schizophrenic patients and their substance abuse patterns but still disagreed in terms of the defined characteristics of this small group of dual-diagnosed clients.

Several researchers have formulated an understanding of dual diagnosed clients based on their own experiences. Kalathara et al (1998) see the dual diagnosed clients as less impaired but also as being suicidal, impulsive and homicidal when compared to the ordinary psychiatric patient. Doweiko (1996) believed that much of the literature is about schizophrenia and substance abuse but limited information is available for clients with different phobias. Researchers still have a long way to go in terms of the different ways in explaining how substance abuse influences mental illness and vice versa. Zisook et al (1992) are of the opinion that dual diagnosed clients show less psychiatric characteristics but are more intelligent than those who do not use drugs but have similar psychiatric conditions.

Several aspects of poor adjustments, increases in delusions, suicidal attempts and disruptive behaviour have been seen in dual diagnosed clients who use / abuse alcohol (Osher et al., 1994)

Research has shown that dual diagnosed clients do suffer from more generalized problems in their everyday functioning than clients who suffer from only one of these diagnoses. Thus there needs to be a guideline or a set of criteria that will identify the dual diagnosed clients . Researchers have highlighted two broad characteristics in respect of this (Stoffelmayr et al., 1989). Both substance and mental illness impact and influence one another, although they are separate chronic disorders (Carey, 1989).

Brown et al. (1989) discovered that clients who had substance abuse disorders had greater difficulty in maintaining sobriety. Secondly dual-diagnosed clients

were also easily influenced by the effects of drugs. Research by Drake and Wallach (1993) has shown that persons with extreme mental disorders cannot use alcohol for example on a social or recreational basis. For dual-diagnosed clients alcohol abuse became an alcohol use disorder over time. Riley (1994) concluded that these dual-diagnosed clients are irregular rather than consistent drug users. This led to manipulative behaviour often resulting in suicides and suicidal behaviour. (Muese et al 1992).

In accessing treatment facilities for dual diagnosed clients there are dilemmas that need to be considered: -

- Firstly – for mental illness and substance abuse there are different admissions criteria, different treatment programmes for each disorder as well as reimbursement for services. Most professionals knowledge base and training focus only on single specialist service .According to Ridgely et al (1990) professionals are not equipped or prepared to treat symptoms which are not familiar.
- Secondly – the methods of treatment regarding these two disorders are different , In direct contrast and incompatible (Sciacca 1991).

When treating substance abuse denial is confronted and admission to treatment requires abstinence from all substance use and abuse, the client needs to be aware of the problem and acknowledge that treatment is needed. On the other hand treatment of clients with a mental illness focuses on support, non-confrontation and is designed to specifically maintain the client's defenses.

Both the treatment facilities for substance abuse and mental disorders are not geared towards making a correct diagnosis and subsequent treatment, or they

simply turn patients away at the last minute or at the point of admission. (Ridgely, 1990).

Sciacca (1990) is of the opinion that a non-judgmental attitude found in revised treatment models which consider both substance abuse and mental illness symptoms as acceptable and treatable is needed. In this case clients are motivated and assessed as to when they are ready for treatment.

Many authors have questioned as to whether the disease concept of chemical dependency is appropriate to describe drug addictions. Hartman and Millea (1996), view the disease model as having outlived its social and political usefulness.

Much confusion exists within society and modern medicine. Both the response of society and medicine towards chemical use, abuse and addiction is considered confusing. (Doweiko 1996).

In U.S. according to Evans et al (1996) up to 50% of the patients in an emergency room are there because of drug abuse. Evans et al (1990) further state that 1/3 to 1/2 of the patients who are seen for psychiatric emergencies have drug-related problems. Medical treatment of chemical abuse and various consequences of psychiatric disorders accounts for 60% of these cases using the hospital (Moos, 1989).

This is currently a major challenge to professionals treating substance abuse as the above researchers indicate that up to 50% of patients seen in emergency rooms also suffer from psychiatric illnesses (Doweiko 1996). In South Africa treatment for dual-diagnosed clients is inadequate and ineffective. This can be further confirmed by the percentage of relapses amongst addicts. Due to the

non-existence of treatment under one roof a specialized treatment programme cannot be planned. Policy regarding the treatment of dual-diagnosed clients needs to be re-evaluated and the one stop community treatment centres need to be established urgently for patients presented with dual diagnoses, i.e. substance abuse and mental illness (Rado 1988). These two concurrent problems pose many dilemmas for the social and health departments because patients are often unable to discuss their drug abuse because of the symptoms of a psychiatric illness (Sciacca 1991: 45). For both these disorders boundaries are often enmeshed and confused.

Decker and Ries (1998) asserted that there is confusion and a lack of insight regarding the relationship between chemical abuse and mental illness. For many countries the problem of substance abuse in the mentally ill was not addressed and therefore treatment was inadequate. Often mental illness was seen as the primary disease and substance abuse as secondary to mental illness. Carey (1989: 40) adequately defined dual diagnosed patients as those who suffer from mental illness as well as chemical abuse.

For Solomon et.al.(1993) the excessive use of psycho-active drugs can cause psychological and neuro-psychological effects that may seem to be psychiatric in nature. Dowelko (1996) further explained that patients can be in both acute and prolonged withdrawal exhibiting symptoms of depression, psychotic episodes, anxiety and paranoia. Major changes in mood and behaviour such as anger, suicidal ideation, rage, aggression, isolation, withdrawal from social interactions and manic depression are often seen in patients who are under the influence of psychoactive drugs.

The same researchers suggest that dual diagnosed patients must be firstly observed and assessed for between 3 to 6 weeks before an accurate diagnosis can be made.

According to Miller and Chapel (1991) ,early psychoanalysis found that in many instances alcoholics could not be treated through the use of the psychoanalytical approach. At present psychiatrists treat alcoholism with anti-depressants and anxiolytics. Benzodiazepines often lead the patient in becoming dependant on these drugs.

Other researchers such as Tiebout (1962) and Fox (1965) based their approach and treatment on the psychological conflicts to be found in the alcoholic level and in relation to early abstinence. The understanding of this dynamic interaction of psychoactive substances and the mind led to more success in maintaining sobriety. These researchers argued that with the understanding of the dynamics of alcoholism a support system must be put into place. This will result in relapse prevention . It is in this milieu that Alcoholics Anonymous was born and became an integral part of the psychoanalytical treatment of alcoholics (Roper et al 1991). The same principle applies to drug addiction with the support structures of Narcotics Anonymous playing a supportive role in the prevention of relapse.

According to Frances et al (1990) psychiatry moved away from the treatment of alcoholics and simultaneously Alcoholics Anonymous has removed abusers from the field of psychiatric treatment .This process caused the treatment of substance abuse moving outside the area of psychiatry and medicine.

Due to the fact that the disease model is widely used for the treatment of addiction ,it was moved out of the scope of treatment by a psychiatrist. Miller and Chapel (1991) stated that this was done in order to protect the addicted person from the lack of will power and motivation to help him or her in their efforts .It was for this reason that the concept of addiction being a disease was born.

The dually diagnosed client often feels through the net when seeking treatment. Lehman et al (1989) said that the initial assessment must ascertain whether substance abuse and psychiatric symptoms do exist. According to him clinicians

do not always consider the possibility of both problems resulting in one being overlooked. Clinicians should be familiar with diagnosis of both psychiatric and substance use disorders. Initial semi structured interviews can give a thorough evaluation (Spirzer, 1990).

Peele (1989) argues that patients deny drug use and some of them minimize the symptoms of a psychiatric disorder. In this case the best efforts of the clinician are lost because of the under recognition of dual diagnostic areas. The ecological relationship between substance abuse and psychiatric disorders is vital for a diagnosis. The three relationships which can be diagnosed are:

1. Primary psychiatric disorder resulting in secondary substance abuse.
2. Primary substance abuse disorder resulting in secondary psychiatric symptoms.
3. Both the substance use and psychiatric symptoms are primary. (Solomon et al., 1990)

Currently the traditional approach to treatment is to treat the mental illness just after the patient is stabilized and the substance abuse is addressed. Rado (1998) emphasized that dually diagnosed clients require specialized treatment programmes to address their needs.

An alternative to this dilemma is suggested by Layne, (1990). He is strongly in favour of treating both disorders concurrently. This approach leaves open the doors to possible alternatives for treatment centres. This most probably is viable for private organizations but for the state and N.P.O.'s there are still questions of funding as long as state departments function in isolation. Layne (1990) concludes that the first step would be for the client to go through detoxification. In this case the treatment team can identify which symptoms fit psychiatric and which substance abuse disorder.

The basic requirement for the planning of a treatment programme is the multi-disciplinary team approach. In this instance the expertise of different professionals in the same field can be initialized according to the needs of a specific client.

Because of the fact that dual-diagnosed clients needs are different from single disorder clients, the promotion of a holistic approach with the expertise of a multi-disciplinary team needs to be established.

The South African NDMP (1999) verifies this reality by stating that "to date, the South African response to the drug problem has been disjointed, fragmented and uncoordinated".

This negatively impacts on the fight against drugs on two fronts:

- 1) There is duplication of certain services and no existence of others. This led to mismanagement of the dwindling resources available.
- 2) The war against drugs has not been effective or waged on all fronts in South Africa because of the absence of, "a single ,unified strategy", in other words a holistic response(NMDP, 1999).

The boundaries of care for dual-diagnosed clients are as important as the treatment of these clients. Personnel must receive ongoing training through in-service facilities. Research needs to focus on this involvement in therapy for the dual-diagnosed client. The attitudes of mental health professionals in the treatment of dual-diagnosed clients are crucial as a strong link exists between mental health and substance abuse treatment programmes and centres. Resources and workable effective interventions for the treatment of dual-diagnosed are needed.

2.5 THE MINNESOTA MODEL

This model was designed in the 1950's by Dr. Dan Anderson who brought together different people who had knowledge about alcoholism . This treatment team developed the Minnesota model which was designed not only to work with alcoholics but it has also been used in the treatment of drug abuse(Alcoholism and Drug Abuse Week ,1990).

The main principle of the Minnesota Model is that it uses a treatment team comprising of doctors, nurses, social workers, psychologists, AA and spiritual leaders who work with the client during the treatment process. The Minnesota Model is based on different stages of treatment. These are:

1. The Evaluation phase:

Each member of the multi-disciplinary team meets with the client in order to assess the specific team member's contribution to treatment. Recommendations are made by each team member towards the treatment plan.

2. Goal setting stage:

The member who plays a key role in treatment is the chairperson of the meeting who also becomes the client's case manager. The client, his family members and the social worker are part of the treatment plan and contribute towards its success. All treatment goals are discussed and will only be incorporated if they are of value to the client.

3. The Development of a formal treatment plan:

The treatment plan is wide and offers a variety of treatment goals. Problem areas are identified, time frames are set ,and behavioural objectives monitoring and evaluation are established in the process.

2.5.1 ADVANTAGES OF THE MINNESOTA MODEL

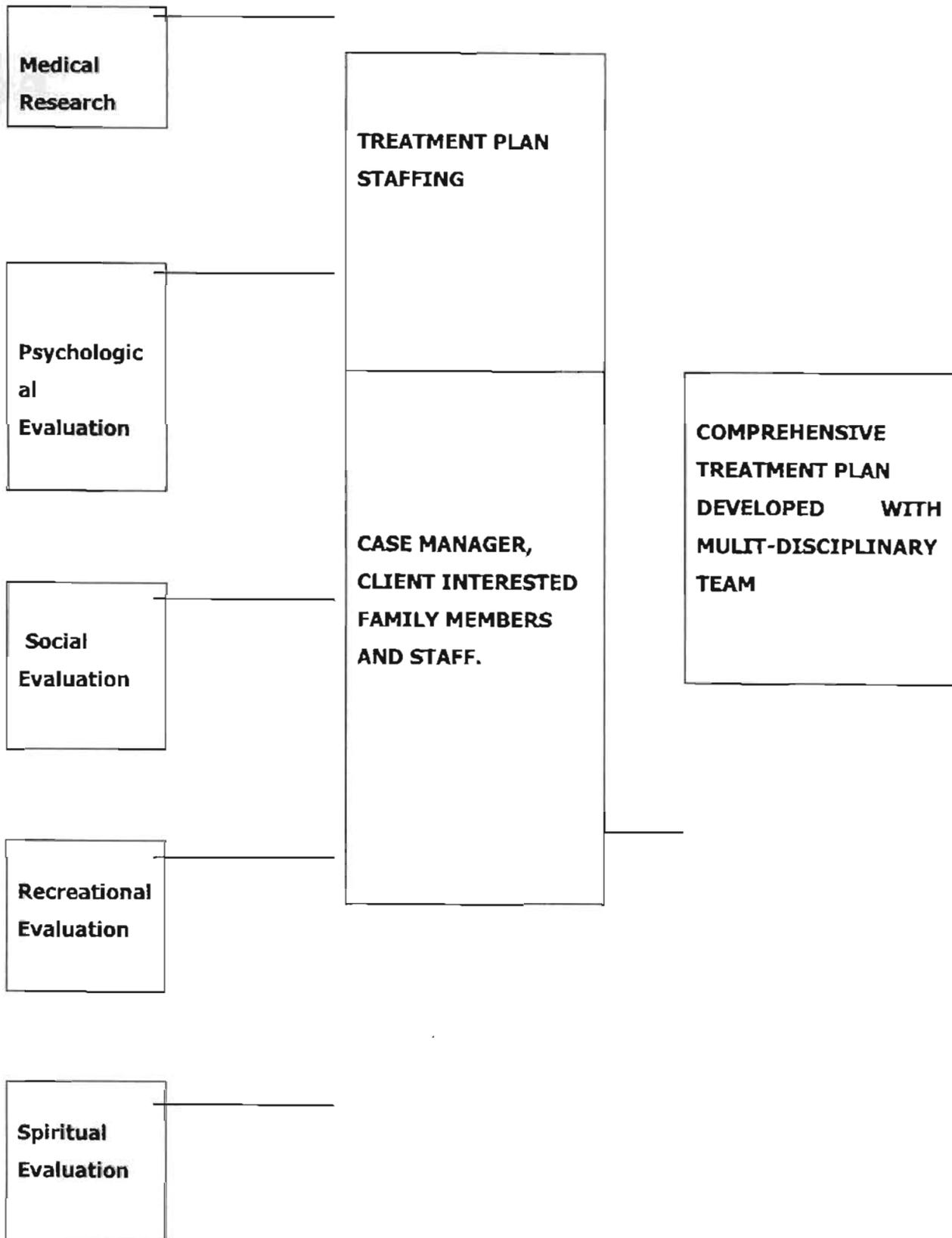
The Minnesota Model has several advantages over other methods of treatment. These are:

- It is a multi-disciplinary approach, which utilizes each panel member's expertise in order to meet the needs of a specific client. In this way a holistic view of the client's problems, strengths and prioritization of needs is established.
- The specialized needs of the client are noted by the different members of the team and this wide range of expert services can identify the variety of client needs instead of one professional. This contributes towards a more positive rehabilitation of the client.

Doweiko (1996) strongly stresses the multi-disciplinary feature of the Minnesota Model and believes that this makes it one of the most favourable models for the treatment of chemical dependency.

Figure 2.2:THE EVALUATION OF THE TREATMENT PLAN

There are various steps associated with the treatment plan that appear in the following diagram :



The nucleus of the treatment programme lies in its treatment goals which include

- problem statement;
- short term goals;
- long term goals;
- methods of measurement; and
- target date.

According to the Alcoholism and Drug Abuse Week the Minnesota model was initially developed in order to provide the opportunity to professionals to work with Alcoholism and inpatient treatment. It comprises of 28 days, a fact which is not widely supported by other researchers. Many researchers are of the opinion that detoxification cannot be called treatment on its own. Detoxification says Miller et al .(1988) should meet the criteria as set out by state departments and physicians trained in the field of substance abuse and assess what type of treatment modality will meet the needs of the client. Researchers are strongly of the opinion that detoxification should be done on an inpatient basis depending on the types of drugs used. In this instance it is believed that detoxification forms part of a rehabilitation programme and is done in the same facility.

2.6 HARM REDUCTION MODEL AND THE PROGRAMME FOR ADOLESCENT LIFE MANAGEMENT:

The Harm Reduction model is different from the Minnesota Model in that it is based on the judiciary of intervention. The Harm Reduction model uses the

principle of reducing damage caused by drugs and at the same time therapy is offered so that the goal of abstinence can be achieved.

The Programme for Adolescent Life Management (PALM) was developed by the Alcohol Centre and Drug Foundation and the Ted Wolfs Foundation. The PALM model uses a comprehensive and social development approach. It acknowledges the difficulty to stop drug taking over a short period of time that incorporates detoxification and in/out patient treatment programme (Spooner et al 1998a; 1998b).

The Harm reduction model employs a cognitive restructuring approach treatment model, which is used together with therapeutic interventions. The reduction of harm caused by uncontrolled drug support structures around the individual. This model is used mainly in Australia, Denmark and Norway.

Practitioners and professionals in South Africa have had many debates on the decriminalisation of drugs such as cannabis with no definite answers to this as yet. The Drug Master Plan also emphasizes that drug legalization and harm reduction are two different entities, as has been stipulated by the International Council on Alcohol and Addictions (ICAA). The 1994 ICAA'S discussion paper emphasised that the main aim of harm reduction is to reduce and prevent the harmful effects of the use of substances.

It is widely accepted that it is difficult to attain a drug free society and abstinence . Thus, different strategies are used in secondary and tertiary prevention i.e. needle exchange, methadone maintenance etc.

The Dutch Drugs Policy is not emotionally laden and it acknowledges drug abuse and its effects as a social reality. Certain drugs have been legalized and regulated by law enforcement. Certain known legalized places sell and are used as places for smoking cannabis. In this instance treatment programmes are based on the principles of non-judgmental attitude and acceptance. There are three principles underlying this model namely

- *Separation and reduction of demand.
- *Treatment is based on simplicity and
- *Normalization of the treatment of drug abuse..

Overall it can be said that in this model drug abuse is seen as part of the overall problem of society. (Duncan et al 2000).

2.7 The Multidisciplinary staff:

Generally there is a number of substance abuse professionals who work with the drug abusers (psychiatrists, medical doctors, nurses and social workers).

The Prevention and Treatment of Drug Dependency Act 1992 13(1)a, states that the Director General may appoint staff necessary for effective management consisting of a social worker, medical doctor, psychiatrist, psychologist or nurse. Anyone of these may be seen as the superintendent whose responsibility will be the training and treatment of patients as well as the determination of treatment and training for the other members of the multidisciplinary team.

Without effective treatment staff, such programmes will not meet their goals. Dowieko (1996) advocates a similar stance to that of the Prevention and

Treatment of Drug Dependency Act of 1992. One individual within the multidisciplinary team takes over the case management. The Minnesota Model of treatment similarly emphasizes this aspect of treatment so that continuity is not broken. Patients with personal issues and substance abuse problems should only work with substance abuse if they have dealt with their issues positively.

Aldeman and Weiss (1998) discovered that health professionals who had good interpersonal relationship skills achieved more success than colleagues who had poor interpersonal relationship skills. In comparing these two groups of the study also indicated that staff with poor interpersonal relationship skills had a higher relapse rate amongst their clients.

Rogers (1961) , in an earlier attempt, also stressed the importance of well adjusted and accepting counsellors having a high success rate with their clients. He emphasized the characteristics of effective mental health counsellors as that of being warm, dependable, consistent, caring and sharing respect, having clear boundaries between staff and clients ,being non-judgmental and seeing the potential to affect a change on the client.

Larson (1982: 52) concurs with the above researchers in terms of the multidisciplinary team being under one roof and that these characteristics are important aspects that develop the treatment programme. The White Paper on Social Welfare (1997 Section 4) recommends that multi-professional treatment and after care programmes must focus on effective reintegration of the abuser into the community.

All treatment programmes must have rules that govern the therapeutic relationship between staff members/professionals and clients. Clear boundaries need to be set and in most instances this is noted . A time chart for treatment shows the time frame, appointments, goals to attain and this is given to clients in

order to ensure consistency and responsibility. Often clients test the worker to ensure that the professionals adhere to these rules.

For any country to plan effective substance abuse programmes and interventions, policy members must be aware of what types and forms of services are available for clients and how these can be obtained. Most researchers contend that the nucleus of treatment is counselling. Service provision for substance abuse must be seen as comprehensively incorporating services for medical, psychological, family, financial and vocational care. It must be borne in mind that it is important to examine as to what extent such facilities are available, how they change or are stable and what organizational services decline in terms of quality. For policy makers to make decisions based on client needs they must primarily acquaint themselves as to what is available. Finney and Moos (1994) strongly suggest that policy makers and providers must possess solid information regarding the main models of substance abuse care, its treatment and its short and long-term outcomes. This according to Finney and Moos (1994) is what is needed to effectively match the needs of clients and the services provided to clients through the development policy.

Aftercare involves treatment issues, which need to be ongoing after the in-patient treatment (Doweiko 1996). Treatment does not end when the individual is discharged from the centre. The recovery programme should actually continue for the rest of the individual's life. AA & NA support groups also form part of the recovery programme. Preferably the aftercare should be accompanied by a placement in a halfway house and all specialized needs of the client should be met. An effective aftercare programme should have the following elements

- Take care of the chemical dependency problems which were identified in treatment.
- Address issues that could lead to relapse and do preventative work.
- Help the patient to maintain sobriety and monitor efforts to stay drug free.
- Evaluate the process of recovery from time to time. (Doweiko , 1996).

After the inpatient treatment, which in most instances is very brief, patients are not ready for thorough reintegration into the family and community. Moos et al (1990) argue that brief therapy does not address all the issues of substance abusers and that follow-up and support should be an ongoing element in the process of treatment. This idea of a halfway house was implemented over 30 years ago. However, little is known about the halfway houses especially in terms of what types of treatment models they employ. Different types of Halfway houses provide treatment of psychiatric disturbances as well as other types and forms of disturbances.

Moos and Lemke (1994) researched 3 models of residential community care for substance abusers. These included a psychosocial model of care, a supportive rehabilitation model and an intensive treatment model. All these models had health and treatment provision as their underlying principles but these were varied, as found in their policies, activities and treatment areas of specialty.

It was discovered (Randolf 1991, Finko 1995) that the psychosocial model did not provide much in the area of health facilities. Residents did not partake in the governing of the facility and hence there were few on site activities. Scant attention was paid to issues such as rehabilitation, medical problems, family issues and dual diagnosis. Support groups such as the AA and the NA were encouraged ,but the general lack of therapeutic groups, individual counselling and life skills training, led residents to more specialized and comprehensive inpatient treatment centres.

It was discovered that these facilities emphasized rehabilitation, behaviour modification and cognitive restructuring, family work, specialized areas as well as skills development and training. On site training and skills programmes were provided. The difference between the psychosocial and supportive rehabilitation facilities is that the latter provided more directive services for treatment and provided a variety of different activities.

This facility strongly emphasised the medical aspects of treatment and family treatment. In this case family counselling, stress management and general life skills training helped residents to cope with everyday living. Professional staff in this situation did not accept the problem behaviour of residents because they expected residents to behave well.

Mowbray (1992) feels that if patients are properly screened before admission to these facilities, staff can maintain control because they can select suitable residents for intensive treatment.

Moos and Lemke (1995) are of the opinion that because large numbers of patients today are chronic patients with psychiatric and substance abuse disorders, supportive and intensive treatment facilities are more appropriate for them. There seems to be little matching between the patients' needs and types of facilities available.

Condelli and De Leon (1993) are of the opinion that drop out rates can be reduced if risk patients are put into support programmes which will in turn help

with integration into programmes. A case manager can help on an individual basis in terms of orientating the individual to the functioning of the facility.

Moos (1988) is of the opinion that the effectiveness of treatment programmes can be further enhanced if treatment centres use the community residential care facilities as a referral and as an ongoing part of treatment. If treatment centres have all the information of residential care facilities they can make informed choices as to how best to satisfy the client needs. Kramer et al. (1990) suggest that residential facilities should provide all other services, besides psychiatric and medical care on site, so that the continuum of care is integrated and meets patient needs. Carling (1993) emphasized the fact that the limitations of community care must be considered and the need for continuous better programmes must be developed to make the reintegration into the community better for patients.

At present the need for the evaluation of the processes and outcomes of treatment is regarded as crucial by service providers and insurers in an attempt to assess the need for treatment for substance abusers. Due to scarcity of funds, it is envisaged that clients could benefit equally from community care facilities rather than acute inpatient care, which is expensive.

De Jong (1994) argues that effective substance abuse treatment in effect takes the burden off health care which is struggling with a wide variety of other diseases currently e.g. HIV/AIDS, TB, etc. This treatment gives rise to other positive areas of functioning, such as marriage, work and life skills development.

Mc Lellan (1993), found that individuals who have inpatient treatment improve better than those who did not have treatment and that long stay in a treatment facility resulted in more positive outcomes than those with shorter periods of stay.

Moos et al. (1990) are also of the opinion that policy makers need to know about the models of care, treatment and their process and what the patients' benefits are in terms of short and long term treatment.

The same authors described a paradigm which takes into consideration the outcomes of treatment based on

- *How severe the substance abuse was before admittance,

- *What resources were available to the client prior to treatment ;and

- *Factors influencing individuals functioning before, during and after the treatment ,and

- *Another area that is evaluated is the experiences, the time spent in treatment and the quality of treatment.

Most centres only provide drug abuse counselling. Although this is not ideal there seems to be no other alternative but to focus on substance abuse counselling leaving out the other crucial areas, such as psychological counselling, family services, legal issues, financial services, etc. The breakdown of community infra structure could be another contributing factor for declining quality services.

Vaillant (1983) questions whether today's clients have greater needs than perhaps 10 years ago. She indicated that this may be due to the patients needs not being met. In view of decreasing resources and fewer services available, the needs of an increasing number of clients cannot be met. The study also discovered that programmes in fact have access to services and resources to need this increasing demand for treatment.

In defining relapse the literature describes the phenomenon as occurring when the person slips back into a former state of behaviour, a return into negative behavior or a return to a symptom of the previous behaviour after treatment.

Research into substance abuse and particularly relapse rates (Arneman 1992) discovered that many individuals do not complete in or out patient treatment. Relapse can occur because of stress, interpersonal conflict, anger, social pressure and substance abuse. Because the individual sees himself as out of control, relapse occurs more frequently. He has argued that the disease model sees abstinence and relapse as complete opposites of each other with strict boundaries between the two. He is of the opinion that relapse can be prevented or dealt with an approach that has coping mechanisms built into it and where abstinence and relapse are seen as a continuum. In this instance relapse is seen as a normal occurrence as the person proceeds towards abstinence.

Marlett (1985) stresses the point that drug abuse must not be seen as the situation where the person loses complete control, because this leads to negative self-construction. This makes it very difficult to for him/her to lead a normal life.

Treadway (1987) see relapse prevention as a decreasing addictive pattern of drug abuse. They argue that traditional methods focus on initial changes relapse prevention that emphasise the maintenance of changing habits. This cognitive behaviour therapy is a more viable approach rather than the disease models, because the training is based on a range of skills development in different situations that can be instrumental in preventing relapse.

Many researchers have argued the self prophesy of relapse whereby one drink or chemical abuse pulls the person down into the spiral of loss of control ignoring all the hard work done thus far in therapy.

Chiauszi (1990) sees common elements in persons who relapse; personality traits that interfere with abstinence e.g. where behaviour has an underlying mental disorder like compulsiveness, passivity, aggressiveness or narcissism. These traits can prevent persons from seeking help when needed. Another identified element says the same author is that addicts substitute addictions by their work, sport or a relationship for drugs no longer used. These types of substitutes could underline the process towards a relapse.

Chapter 3

THE LEGISLATIVE AND STATE FRAMEWORK

There cannot be a comprehensive understanding of the problem of drug abuse and rehabilitation in a particular society without the proper knowledge and critique of the existing legislative and other frameworks that determine crucial parameters of the phenomenon and the repercussions associated with the processes at play. Inevitably, in a country such as South Africa, facing an onslaught that threatens to uproot the very foundations of a new democratic society, one would expect that the state and its various organs and apparatuses would be fully utilised in order to contain and ultimately remedy a very serious situation.

It is true that there are several important documents and laws that attempt to tackle the foundations of drug abuse and rehabilitation at both the theoretical and practical levels. The same is true of burning issues in the country such as HIV/AIDS, education, housing and the like. The fundamental challenge facing the Government, however, exactly as every other government in the world is the thorough implementation of laws in the arena of social and public policy (Social Policy Programme 2002).

Thus it is important to understand the dynamics of legislation and other social policy issues associated with the Government ideas and actions , before the empirical realities expanded later pinpoint the successes or failures of the implementation measures undertaken in the elimination of this phenomenon.

In this section the documents that are considered instrumental in the understanding of the Government's intentions are analysed so that a clearer picture can emerge in the ultimate "marriage" between legislation, theory and practical realities on the field.

Before recent legislation is examined , it was deemed appropriate that the "historical" laws are examined.

1.THE DRUGS AND DRUG TRAFFICKING ACT 140 OF 1992

The Act begun by defining the various categories of drugs as well as the diversified drug and economic offences associated with the phenomena of drug and drug trafficking.

It describes the use and possession of drugs and the role of professionals in the health sector such as medical practitioners and pharmacists .The relationship with the Medicines Act is established .

It is declared that no person or persons shall deal with any dependence-producing substance or any dangerous , dependence-producing substance or any undesirable dependence-producing substance , unless he has acquired or bought any such substance for medical purposes from a medical practitioner, pharmacist or other designated medical or health professional .The Director General :Welfare can buy such substances in accordance with the Medicines Act and distribute it according to the laws and professional and business ethics. Medical practitioners, health professional and/or other designated persons can buy or distribute such substances according to the law.

The designated officers comprise of every commissioned officer of the South African police Service assigned to the South African Narcotics Bureau . The general public have an obligation to report certain information to the police if the owner, occupier or manager of any place of entertainment, or any other person in control of any place of entertainment that he supervises allows the possession or distribution of drugs in the premises. The same is true of any stockbroker as defined in Section 1 of the Stock Exchanges Act of 1985 or any financial instrument trader as defined in Section 1 of the Financial Control Act of 1989. This suspicion must be reported to designated officers of the law together with the particulars of the suspected offender.

The designated police officers are given sufficient powers by the law to inspect any premises , vehicle, vessel or aircraft or any container in which such substance, drug or property is suspected to be found. A police official may in the exercise of his powers require any vehicle, vessel or aircraft to be stopped , or request the master, pilot or owner of any vessel or aircraft to sail or to fly any such vessel or aircraft or to cause it to be sailed or flown to such harbour or airport as may be indicated by the police official.

There shall be interrogation of persons under warrant of apprehension , following a series of steps involving the prosecuting authorities, the magistrate, and/or the public prosecutor .The person under suspicion shall be detained under a warrant of arrest until the time of release be determined by the magistrate . There shall be thorough interrogation of the arrested person within 48 hours from his detention, and there must be a satisfactory reply to all questions put to him. No person other than the designated state authorities is entitled to be present during the period of such interrogation.

Any person who places any drug in the possession or on the premises, vehicle, vessel or aircraft of any other person with the intent that the latter person be charged with an offence under this act, contravenes various provisions and clauses of the act shall be guilty of an offence. Additionally, any person who fails to report alleged or suspected acts of drug use abuse or trafficking shall be guilty of an offence. However no prosecution shall be instituted in respect of an offence without the written authority of the attorney general concerned.

Any person who refuses to comply with any request for information by a police officer or fails to answer to the designated authorities that exercise their powers, or wilfully furnishes information to any police official which is false or misleading, is guilty of an offence.

There are various penalties associated with the contravention of the act such as imprisonment that varies according to the severity of the offence, fine, or both. The prison sentence fluctuates between five to 15 years depending on the severity of the offence and the subsequent behaviour of the offender. The heaviest sentence in this case is 25 years.

In certain cases it is stipulated that if the drugs are found in the immediate vicinity of the accused it shall be presumed that the accused was found in the possession of such drugs. There are also various presumptions relating to dealing with drugs. Thus if an accused is found in possession of more than 115 grams of dagga (cannabis) or found in possession of any undesirable dependence producing substance other than dagga, or if he is found within any school grounds or within a distance of 100 metres from a school it shall be presumed, until the contrary is proven, that the accused dealt in such dagga or substance. If dagga plants are found on a specific day on cultivated land, if the accused is the occupier, owner, manager or person in charge of the said land, it shall be presumed, until the contrary is proved, that the accused dealt with such dagga plants.

Such clauses can be described as rigorous , well-meaning and strict . This becomes even so when it is stated further that if the accused is found in possession of any property which was the proceeds of a defined crime it shall be presumed that the accused knew at the time of the acquisition of such property that it was the proceeds of a defined crime .This unless he acquired that property in good faith .

The same principles apply in terms of the provision of information related to accused who are owners, managers or occupiers of places of entertainment where the use , abuse or distribution of forbidden substances occurs. The employers or/principals are also liable in circumstances where employees or agents are thought to act in protecting the use or abuse of drugs or other substances in such places of entertainment.

A declaration of forfeiture shall not affect any interest of any person other than the convicted person if he proves that he acquired the interest in that property in good faith or that the circumstances under which he acquired the interest in that property were not of such a nature that he could reasonably have suspected that it was the proceeds of a defined crime. Any person aggrieved by a determination made by the court may appeal against the determination as if it were a conviction by the court making the determination . Such appeal may be heard either separately or jointly with an appeal against the conviction as a result of which the declaration of forfeiture was made, or against a sentence imposed as a result of such conviction.

A magistrate's court shall have jurisdiction to impose any penalty as prescribed in the law even though that penalty may exceed the punitive jurisdiction of a magistrate's court.

The Act stipulates In its various schedules following its text a large number of illegal substances of various types , which have had various amendments in the Government Notice R344 of 13 March 1998 and by Government Notice R 521 of 15 June 2001 (Drugs and Drug Trafficking Act 140 of 1992).

2.PREVENTION AND TREATMENT OF DRUG DEPENDENCY ACT 20 OF 1992

The Act begins with the various definitions of concepts to be found in it, especially regarding those of the various health professionals associated with the prevention and treatment of drugs as well as the authorities and institutions instrumental in its application and implementation.

The establishment and functions of the Central Drug Authority is the next step .The body will be appointed by the Minister and will include representatives of a wide array of Ministries associated with issues of welfare, safety and security and the like, as well no more than 12 other members who have an expert knowledge and experience in the problem relating to abuse of drugs or are able to make substantial contributions to the combating of such problem. All these will be appointed for a period not exceeding 5 years. The Board will have a chairperson and a vice-chairperson , and will be obligated to submit a report to the Minister as well as a comprehensive description of its efforts to combat , reduce and eliminate the abuse of drugs . The Board will have a Secretariat consisting of the Director and two assistants .The Secretariat shall be assisted by the officers of the Welfare Department and officers of any other department as deemed necessary.

The Drug Authority shall give effect to the National Master Plan , advise the Minister on any matter affecting the abuse of drugs , may plan and co-ordinate measures relating to the prevention and combating of drug abuse and the

treatment of persons dependent on drugs, shall review the National Drug Master Plan , arrange conferences and symposia etc.

The Executive Committee has limited legal powers and other committees will be established when deemed necessary .Their numbers will be determined by the Drug Authority , which will also determine the appointment of the chairpersons of such committees.

The Minister may establish or cause to be established programmes that are aimed at :

- *The prevention of drug dependency,
- *Information to the community on the abuse of drugs,
- *The education of youth concerning drugs ,
- *The observation , treatment and supervision of people who are in a treatment center,
- *Have been released from a treatment center , and
- *The rendering of assistance to the families of persons detained in a treatment center or registered treatment center.

Additionally the Minister may establish, maintain and manage treatment centers for the reception and treatment, including training of drug users and abusers . The Minister may at any time abolish such treatment centers.

The patients of a treatment center shall be retained there in order to receive treatment , including training and to perform such duties as the Director General may in consultation with the management from time to time determine, either generally or in a particular case.

All institutions catering for the rehabilitation of drug users and abusers need to be registered in terms of the law after they apply .The Director General has the final say in the registration process of such institutions after an investigation regarding treatment centers .If the institution does not comply with the existing legal requirements it needs to re-apply until such time the requirements are met. Registration certificates can be withdrawn if investigations show that the institution does not meet the legal requirements of registration. The registration certificate is in no way transferable.

The Minister after consultations with the Minister of State Expenditure (at present the National Treasury) may establish, maintain and manage hostels for patients who have been released on license from a treatment center or have been granted leave of absence, or persons who are receiving or undergoing treatment for dependency on drugs in an institution of a provincial administration or who have received or undergone such treatment in any institution approved by the Director General.

Hostels associated with drug abuse and rehabilitation need to be registered and managed and administered by lawfully designated persons , who if they fail to comply with the existing legal requirements are liable to prosecution and could be found guilty of an offence and convicted to a fine or and imprisonment for a period not exceeding 10 months or to both such fine or Imprisonment.

The registered treatment centers, registered hostels , institutions and places must be inspected by a social worker, medical officer or any other person authorised by the Director General or any magistrate . All relevant documents associated with patients or administrative and similar functions will be inspected. A certificate will be furnished to that effect , and any person who obstructs or hinders such inspection or who fails to provide the required documents shall be

guilty of an offence and liable of conviction to a fine or to imprisonment for a period not exceeding 12 months or to both such fine and such imprisonment.

The staff necessary for these institutions is appointed by the Director General , subject to the laws governing the public service. This staff is responsible for the proper management and control of such treatment centers , which must be operative with a social worker, medical practitioner, psychiatrist, clinical psychologist or nurse as a superintendent. The latter will be assisted in the treatment and training of patients by the other professionals employed at the institution .

Volunteers can be appointed at such centers and can have the powers to perform duties if they are sufficiently qualified professionals , have successfully completed the prescribed course and have signed an agreement with the Director General. They will only be able to perform their designated duties if they are in possession of their certificate of appointment. Their termination is at the discretion of the Director General and can result from the non-performance of duties, false statement or statement or if the services of the volunteer are no longer required. Their remuneration is at the discretion of the Minister and depends on the availability of financial resources allocated to him. The payments are to be processed after claims for expenses are to be made .No payments are to be made if the volunteer has been already compensated from another source for such expenses.

There are several strict procedures for bringing persons eligible for admission to a treatment center or registered treatment center .In this the social worker's testimony plays a key role . If there is a person in the jurisdiction of a magistrate who is dependent on drugs and endangers the peace of his family or community , the legal process will unfold through a warrant of arrest according to the provisions of the Criminal Procedures Act (Act 51 of 1977).

The processes regarding a person that needs to be committed to a treatment center or a registered treatment center after an enquiry has to follow a series of legal steps that are related to a series of other laws such as the Criminal Procedure Act of 1987 and the Magistrate Courts Act 3 of 1994 .This is done in order for the rights of all concerned are not compromised in any way .There is a stipulation regarding the information provided by the person and its validity as well as the steps to be undertaken in terms of the inquiry and the professional involved in it. Following these requirements the person needs to submit himself to supervision and the prescribed treatment as the magistrate shall determine. The person can be discharged if this is deemed necessary by the Director General or any other designated person.

There are also stipulations regarding the temporary custody of persons pending enquiry or removal to treatment center or registered center . The inquiry can be postponed if this is deemed necessary by the magistrate and the person concerned may be held in custody in a treatment center hostel, registered hostel , prison , police cell or lock-up. Such detention in custody cannot exceed 28 days. The detention in such centers is valid until the person on inquiry is released on licence or discharged or transferred or returned to any other institution in terms of any provisions of the act. This release is preceded and followed by a series of legal steps involving the Director General and the magistrate . If any person under the age of 18 is in terms of the provisions of the act to be detained in a treatment center , the Director General may direct that he may be detained in a place of safety , and, if he is so detained , such place of safety shall in relation to such person be deemed to be a treatment center or registered treatment center for the purposes of this act.

The transfer of patients from and to treatment centers and registered treatment centers can take place after consultations between the Director General and the

relevant authorities and a decision that will determine whether such a move will benefit the patient in terms of his treatment and training in the long run. On the other hand the transfer of persons from prison to a treatment center is based on the dictates of the Correctional Services Act of 1959 and its amendments and stipulates that it might be desirable for the person to receive or undergo treatment in a registered center before his return to the community.

In terms of transfers from children's homes, schools of industries or reform schools to treatment centers or registered treatment centers the Child Care Act of 1983 is to be taken into account and it is the prerogative and decision of the Director General to justify the receiving of undergoing treatment in a registered center before the return to the community .

The provisions of the Mental Health Act 18 of 1973 are instrumental in the retransfer from institution to treatment center or registered treatment center, while the management of such a center may and shall if so directed by the Director General grant to any patient leave of absence therefrom for such periods and on such conditions as may be prescribed, and may at any time revoke such leave and direct the patient to return to the treatment center.

The management of a treatment center may with the approval of the Director General release the patient on licence. During that period the patient must be under the care of a social worker until such licence expires . A revocation of licence occurs when the patient has not been proved capable of adjusting himself properly to the normal life of the community . In different circumstances the patient might be held in custody .

There are stipulated methods of dealing with absconders from treatment centers. They might be arrested without warrant by any police officer , social worker or member of the staff of any treatment center and presented to a state magistrate

. It is up to the magistrate to decide the return of the absconder to the treatment center or keep him in custody, before the final verdict on his future is given.

There are clauses in the act determining the admission of voluntary patients to treatment centers. This follows the application of the volunteer patient to enter the institution , which is examined by the superintendent . On occasions the admitted patient has to carry the necessary expenses for the treatment .Any person admitted to a treatment center shall be detained therein for such period not exceeding 6 months as the management concerned may determine.

The patients of a treatment center shall have the right of personal access to the management and the latter will have a similar access to the patients . The discipline at the treatment centers needs to be of the highest order and patients are obligated to follow a strict rule of obligations and procedures that would guarantee the smooth functioning of the establishment. A series of punishment measures need to be in place for the disciplining of patients who do not follow the prescribed disciplinary codes.

There are strict stipulations regarding admission to treatment centers of persons from territories outside the Republic of South Africa . These can be achieved through agreements signed by the Minister with his respective counterparts. The prospective foreign patients are to follow the same prescribed procedures and regulations regarding their treatment, release or license. The management concerned shall not grant to such person leave of absence without the approval of the Director General. His discharge can only be approved by the Director General.

The Minister can make regulations relating to :

- The form of any application, authority, notice, order, register, process or subpoena in terms of the act
- The books, accounts, registers or records kept by management.
- The establishment, maintenance management and control of treatment centers.
- The constitution, procedures and regulations .
- The powers and duties of staff members at all levels.
- The registration of institutions.
- The terms and conditions under which patients are to enter treatment centers.
- The terms of release and licence of patients.
- The maintenance of good order and discipline at the centers.
- The free religious worship of patients.
- The discharge of patients.
- The duties of patients in the treatment center.
- The conditions under which voluntary patients live.
- The disposal or sale of any property owned by treatment centers.
- The penalties resulting from misbehaviour of patients.

The Act repealed a large number of laws and it was itself repealed by the Prevention and Treatment of Drug Dependency Act (Act 14 of 1999) .The amended sections appearing in the 1999 Act were completely insignificant and only replaced several definitions such as that of the "Board" , and gave more impetus to the much debated National Drug Master Plan and made it more central to the act and the treatment and legal status of drugs in terms of welfare and safety and security .

3. THE WHITE PAPER ON WELFARE

Social policy in South Africa needs to be seen as an arduous process leading to the complete transformation of a society ravaged by the injustices of apartheid into a country where democracy , no-racism and non-sexism will become paramount. It is in this vein that it is believed that the people and the government of the country have a great opportunity to build a more humane and caring society based on the foundations of political democracy and economic redistribution .

In such an eventuality the glaring imbalances of the past in terms of delivery and provision of service need to be addressed seriously and comprehensively , and a collective effort led by the political and administrative leadership of the country needs to be undertaken . As the economic and fiscal priorities have changed significantly since the adoption of the Growth Employment and Redistribution policy (GEAR) (Social Policy Programme 2001; 2003), there is no doubt that welfare policies will be seriously affected , both in the short and long terms. However , one needs to understand the realities included in the fundamental legal prerogatives of the ANC-led government , such as the Constitution of the country, and the Bill of Rights .

It is in this vein that the White Paper on Social Welfare (hereinafter WPSW) needs to be seen and analysed. In such a document the developmental social policy prerogatives associated with social welfare are outlined and the foundations of their future implementation are underpinned. Such a document paves the way in which the macro is intertwined with the micro-level in order to rectify past injustices and lead to a development path in the terrain of social welfare. In this conjuncture the racial inequalities of the past welfare system need to be replaced by high levels of empowerment of individuals and communities , especially amongst the historically disadvantaged. This despite the fact that several communities even within apartheid South Africa had developed welfare agencies that still play a prominent role in the country and its various social segments.

The Constitution of the country is the most important legislative measure that guarantees equity and equal opportunities to all citizens of South Africa. In the constitution, considered by many as one of the best in the world, it is stated that everyone has the right to health care services, and social security, including, if they are unable to support themselves and their dependants, appropriate social assistance (Constitution of the Republic of South Africa 1996;13-14). It is in this vein that one would expect subsequent laws and White Papers to be structured and implemented, including the WPSW. (WPSW 1997).

The WPSW was the result of wide consultation amongst key role players and stakeholders. It was adopted after serious research, debates and considerations with considerable participation by role players and stakeholders. It advocates a developmental approach that can be seen as instrumental in leading the transformation process forward. The introduction of national strategic management teams was supplemented by various technical committees associated with the finer functions of welfare, including financial, human resources and organisational aspects associated with the process and its subsequent implementation at all societal levels. All these committees, reinforced by the participation of the public were instrumental in shaping the final draft of the Paper.

The WPSW advocates a developmental approach to welfare policies in South Africa, by utilising a holistic, almost "revisionist" approach in the understanding of social problems. In this sense, it can be understood that the dominant theoretical and implementation paradigms of the residual model and the institutionalisation of the past have been substituted. The main aim of the WPSW is the creation of a comprehensive and holistic system of social services, facilities, programmes and social security that would promote social development, social justice and social functioning of the people. In this milieu, and given the structural economic and social problems in South Africa such as unemployment,

poverty and the spreading of HIV/AIDS , the Paper can be seen as an effort for the introduction of state policy that can adequately address such ills . There is a perceived emphasis on strategies and policies that can play an important role in rectifying social problems , creating thus the opportunity for access to existing resources , more equitable access to services and delivery, as well as the creation of new networks of support , capacity building and equity.

In short the WPSW sought to create a vision of an alternative welfare that broke away from the past and attempted to pave a new way to change from the mindset and practices of apartheid and through examining the root causes of existing social problems that emanate from the structures and functions of an unequal society. It was seen as an attempt to move away from the incremental and fragmented understanding of the past into a more holistic outlook.

Such an approach , however, posed a series of fundamental questions related to the role of social workers, psychologists or medical practitioners associated with an assortment of social problems, including substance abuse. Developmental work is important , but new capacity-building initiatives need to be in place , as most professionals have been historically trained in more or less clinically-orientated environments and curricula . Thus a more holistic, systems approach is vital in this process in order for professionals to comprehend the relationships of poverty, economic development issues, appropriate uses of indigenous knowledge methods and the like. Sensitivity to social, cultural and traditional ways and modes of thinking is also of paramount importance in such a process , that would facilitate and encourage new methods of intervention.

Social development can be seen as the vehicle of social change through people centered interventions, and subsequently the WPSW advocates the re-orientation of social welfare programmes through the community development approach . Such an approach includes capacity-building, active participation, and the

empowerment of communities. However it is important to pinpoint serious impediments in the realisation of such a vision as the problems of illiteracy, apathy, and a culture of dependency and entitlement are phenomena that pose serious challenges for the new political and economic rulers of South Africa.

The national aims and objectives as identified in the WPSW include:

- The strengthening of the social partnership of the key role players and stakeholders including the Government, communities ,NGOs , CBOs and other organs of civil society as well as the private sector in order to achieve solid services and delivery.
- The promotion of inter-departmental and sectoral efforts towards social development through the co-operation and collaboration of departments, ministries and non-governmental role players .
- The acceptance and implementation of all international agreements and conventions that the government has agreed upon and signed which are important to social development .
- The realisation of the aims and objectives of the Constitution of the country and the Reconstruction and Development Programme (the RDP).
- The facilitation of the provision of developmental social services to all South Africans especially to the poorer sections of the population , the vulnerable and the needy ,especially those with special needs.
- The provision of services that are rehabilitative and preventative ,and include developmental and protective services and facilities .
- The provision of social security, social relief and social care programmes .
- The enhancing of social functioning.

(WPSW 1997:6-7)

The last three items can be described as having been associated with substance abuse amongst other programmes , as the document talks of developmental and protective services and facilities, preventative and rehabilitative services and the enhancement of social functioning .All these aims and objectives are directly related to substance abuse, its effects and rehabilitation in society .

The guiding principles of the WPSW include :

- *Equity.
- * The securing of basic services to the whole population.
- *Non discrimination.
- *Democratic principles.
- * Human rights for all.
- * Sustainability.

Financial cost effectiveness.

- *Quality services.
- *Accessibility to the needy.
- *Responsive services.
- *The practice of **ubuntu**.
- *The practice of mutual support.

(WPSW 1997:8-9).

The WPSW accepts that poverty has been one of the most important social and economic characteristics of our country and is the root of a multiplicity of problems stemming from it . The lack of proper service and delivery to all people is seriously determined by these economic and social indicators that point to the development and growth of welfare policies and implementations that will re-shape a more humane society .

Given the complexities and particularities of the welfare terrain, however, the question remains whether the developmental goals, aims and objectives of the proposed system are attainable. Welfare for example is provided to the people of South Africa by a multiplicity of Departments, such as Welfare, Health, Correctional Services, Prisons, Education etc. All of them have different administrative and organisational functions and structures , although the Department of Welfare is directly involved with alcoholism and drug abuse . However the problem of substance abuse is also prevalent in prisons , schools and other societal formations and institutions.

Such problems are exacerbated by the various structural constraints associated with the allocated responsibilities of the various delivery agents. Thus the South African Constitution dictates that the national Welfare Department is responsible for setting the national goals related to welfare, while both departments share equal responsibilities for welfare services. The provincial departments are responsible, together with the national department for planning, development and rendering of services at all levels of society (WPSW 1997: 21-22). In this relationship the national department allocates the financial resources to the provincial government and attempts to maintain a co-operative relationship with its counterpart . It is stipulated that provincial welfare departments have the prerogative to prioritise their budgets according to the needs of the citizens of their province .

However the document in its well-meaning sense has not taken into account the particularities of specific cases. In the KwaZulu Natal Province for example that is led by the Inkatha Freedom Party its senior member Prince Gideon Zulu, the Minister of Welfare , has accused openly his national counterpart on reneging on a series of agreements and promises regarding budgets, financial responsibilities and programmes in relation to HIV/AIDS treatment, old age pensions and child

grants (KZN Budget Statements 2001-2002; 2003-2004) . These debates have their roots in political, ideological, financial, administrative and organisational weaknesses in the sphere of welfare , which are not tackled sufficiently in the White Paper.

Such disagreements and debates pinpoint one of the major implementation weaknesses of the WPSW . The lack of financial resources associated with the cutting down of even crucial social spending as promulgated in the GEAR economic policy has direct negative effects at two crucial levels of operation:

- The lack of financial resources are felt by both professionals and rehabilitating agencies .
- The poor conditions to be found in most communities , especially in the rural areas make the delivery of services in the welfare field extremely difficult.

Thus despite the fact that the White Paper, on similar lines of the RDP purports to be based on redistributive and social welfare foundations where the state plays a key role ,the reality is somehow different . Thus while there is mention of the close collaboration of all levels of the state with organs of civil society (WPSW 1997:11-12) , the promised and expected collective responsibility is not close as the Minister of Welfare in the KwaZulu Cabinet himself admitted (KwaZulu Natal Budget Debates 2003-2004:196). In fact such prerogatives are difficult to be translated into action because the subsequent collaborative efforts need to be based on the principles of understanding and pluralism , where all major stakeholders and role players , such as the state, voluntary organisations, civil society and the private sector operate in a transparent, open and professional manner. Additionally, the distribution of resources needs to be equitable and as widespread as possible. The White Paper is adamant that the recognition and contribution of civil society is in fact a stepping stone towards the building of a democratic culture in the welfare terrain.

The WPSW , while maintaining the role of the state accepts that there are serious and fundamental problems in the existing partnerships amongst stakeholders, despite the fact that given the historical circumstances and diversity of the sector there is a wide array of knowledge, skills and expertise available that if utilised properly the terrain will definitely shift towards improved levels of service and delivery. All these need to be harnessed by government and state institutions as well as all potential partners within the integrated welfare system (WPSW 1997 : 23-24).

The key question of resource allocation is not clear in the White Paper, despite the fact that there is a clear demarcation of responsibilities between the various levels of government . One needs to understand the dynamics of voluntarism, allocation and utilisation of resources as well as the fragility of the state/voluntary organisations/civil society realities . Potential solutions can be attainable in the case of a synergic and co-operative collaboration between the various stakeholders , but there are serious examples of the mistrust of the ANC-led government towards even massive civil society movements such as COSATU (the Congress of South African Trade Unions), which is the strongest component of the Tripartite Alliance. One would ask , if the ruling party cannot agree on fundamentals such as GEAR with its leading partner , how can it trust and have confidence in other organs of civil society that can be critical of its rule in the sphere of welfare and other public and social policy initiatives?

Given the secondary role that the state has been assigned in the terrain of social welfare in the first years of the new millenium internationally due to the triumph of neo-liberalism and the "New World Order" , one could argue that the developmental emphasis to be found in the White Paper can be described as optimistic , given the limited role of the state in previously welfare-based social systems, the capitalist metropolises as well as the remnants of the collapsed

Stalinist regimes in Europe and elsewhere. Of course there are still the examples of “statist/ welfare” societies such as Cuba, China and Vietnam , as well as some Muslim states, but the question is for how long such social policies can be maintained given the attack of the leading superpower of our time towards such regimes. It can be said that the active participation and intervention of the state in the welfare field is inescapable and necessary.

The broadening of the scope of welfare statutory bodies and voluntary associations as expanded in the WPSW has led to the participation of such bodies in the state decision making bodies , and this includes the revamped Social Work Council which has been renamed the South African Council for Social Service Professions and encompasses an assortment of social services professionals such as care workers, prison and probation workers, and community development workers. Additionally, the Paper has catered for appropriate , legally-structured and effective governance structures that have been described as Instrumental in the application and implementation of a progressive welfare policy.

The developmental nature of several key areas of welfare such as early childhood care centers, after care and job creation projects that are identified as priorities in the White Paper cannot be overlooked (WPSW 1997:56) , but there is a very wide array of other problems that could have been included in the specific aspects and activities described in the document .While job creation and poverty alleviation are crucial aspects of a more humane society , the reality is that social workers and other professionals have been trained in a variety of fields and problem solving of equally crucial aspects of life such as substance abuse, alcoholism, psychological instability, relapse and depression.

The client evaluation is one of the important tenets of the WPSW .This process needs to develop a bottom-up approach and transparency within the delivery

agencies. This means that there is a serious paradigm shift from the analysis of the quantitative bulk of agencies to the qualitative aspects of service and delivery. Effectiveness in this respect is seen as a key issue for professionals to consider as being of importance. However the key issue in such a process is how standardised this evaluation can be and what are the instruments used in such an exercise. The lack of capacity in many areas of such endeavours exacerbates the problems faced in the evaluation and developmental cycle.

Another problem facing the WPSW is the possible inability to solve successfully the urban-rural divide which is accepted as a very serious problem in the document (WPSW 1997 :5-6). It is mostly the rural communities that are underprivileged and poor and thus in need of accessible service delivery .Despite the fact that there has been an improvement at some levels of operation, the inability of the state and its agencies and departments to attract suitably qualified , experienced and eager workers has proved to be a serious impediment to the developmental imperatives of the envisaged programmes (KwaZulu Natal Budget 2001-2002).

The ideological and practical shift from the residual to the development paradigm as engulfed in the WPSW posed serious questions of implementation at community level as it has widened the scope of the practicing professionals' methods of dealing with patients. For example it is important to ask as in case of alcoholism or substance abuse whether casework needs to be completely abandoned . Is the macro intervention the only way to deal and solve individual cases ? The WPSW (1997: 22) maintains that rehabilitative and specialised services are still necessary components of social work practice . This is firstly negated by the overtly generalised developmental emphasis as well as by the reality that a professional cannot really rehabilitate an alcoholic from poverty .In fact what she/he can do is attempt consciously to offer professional services to the patient to the best of his/her ability . It is up to the professional or the group

of professionals to save the patient from relapse with the hope that the latter will once again be a valuable member of the community. Alcoholism and substance abuse , as well as other fields such as child abuse demand individualised attention , and this is a reality that cannot be ignored.

In this milieu the capacity building and re-training of social workers as advocated in the White Paper is of paramount importance. As the complexity of our society becomes an inevitable reality , the development of existing and future resources will pave the way for positive action, especially in the areas where Africans are the majority as in townships, informal settlements and rural communities. In this situation the professional is empowered to undertake various types of projects that engulf both individualised and integrated endeavours including casework, rehabilitation as well as developmental priorities (WPSW 1997: 55). The marriage between the attention given to social as well as individual conditions of communities and their members is of great importance in the realisation of the goals, aims and objectives of the WPSW.

Overall , it can be said that the WPSW was written as a prelude to impending legislation on social services and welfare and certainly sets a series of serious goals to be attained for the benefit of the wider community. Despite its various generalised outlooks that has shifted the emphasis from the residual to the developmental model of service provision and delivery , it provides both communities and professionals with a vision for the future that cannot be ignored .However, it needs to be said that the realisation of its goals depend on an urgent and well-planned mobilisation of human and financial resources.

THE NATIONAL DRUG MASTER PLAN

The draft of the National Drug Master Plan was completed in 1999 after consultations and debates amongst a large number of role players and

stakeholders such as government agencies, NGOs , experts and the like. It acknowledged that South Africa, together with the whole world faced a serious challenge in its efforts to fight against a serious drug situation exacerbated by the poor living condition of the largest section of the country's population . While it was acknowledged that substance abuse in South Africa varies according to age, class, school status gender and geographical location, there was a general agreement that tobacco and alcohol were the most commonly used substances in South Africa followed by the others , including cannabis , crack cocaine, opium and a variety of pills . The drugs are categorised scientifically according to use and frequency .

The Drug Master Plan aspired to summarise the national policies to be adopted In order to apportion responsibilities for the drug-control efforts undertaken by the state and communities at all levels of society. It would serve as a blueprint for action and a response to drug abuse and propose the steps forward in combating drug abuse. It originated from the establishment of the Drug Advisory Board (DAB) , which was asked by the Minister of Welfare and Population Development to draft the plan. After extensive research into national and international trends and a series of extensive workshops throughout the country the draft was prepared.

Its vision was to build a drug-free society and make a contribution to the global problem of substance abuse .This would have an impetus on the government's strategy that could encompass both short and long-term priorities to combat this serious social problem.

Its priorities and aims concentrated on a series of social problems such as :

- *Crime.
- * Youth

- *Community health and welfare
- *Research and information dissemination
- *International involvement
- *Communication

The plans for implementation included an opening of a communication channel between the affected communities , Parliament, the Central drug authority , the secretariat as well as the provincial Substance Abuse Forums and the Drug Action Committees. The establishment of a central Drug Authority was the ultimate goal that would be independent, answer to Parliament and have as the main priority the implementation of the master plan.

The CDA should have a high profile head and have representatives from most ministries as well as the private sector and the national intelligence services and trade unions. It would implement, monitor and evaluate the master plan through a cycle of five years:

*During the first two years it would

- concentrate on strengthening the existing human resources available,
- set up the drug action committees and
- request all government departments to draw up anti-drug action plans.

*In the second cycle its responsibilities would include the monitoring and evaluation of the master plan and preparations for the drafting of the second master plan.

One of the key priorities is the setting up of Local Drug Action Committees whose main functions would be to draw action plans, which would be in line with the national priorities, the implementation of action plans and the drafting of reports to the Secretariat and the Central Drug Authority.

The Provincial Drug Forums would involve all stakeholders as well as the business community , and needed to be led by persons who would be responsible for the following :

- Treatment and after care.
- Prevention and education.
- Community development , and
- Legislation and Research and Information dissemination

(Master Plan 1999:12)

There are five areas of focus that deal with the material manifestations of drug abuse in all walks of life and are determined by the process and effects of the phenomenon. They were identified earlier as crime, youth, community health and welfare, research and communication and international involvement (Master Plan 1999;13-45).

All these aspects are analysed in relation to the prevailing circumstances in the country , and in the existing legislation that is associated with drugs and substance abuse .In the case of **crime** for example the various permutations include the involvement of SANAB (the South African Narcotics Bureau)as well the dictates of the National Crime Prevention Strategy , promulgated in 1996 .In this process most relevant ministries and state departments were involved , including the active participation of the national intelligence agency. The Vision 2000, the brainchild of the Department of Justice was also thought to be an important component of the anti-crime initiatives with its monitoring of the attainment of various strategic roles associated with the functions and systemic initiatives of the department. The issue of decriminalisation of several substances , especially cannabis was also raised in the examination of the circumstances of crime as was the issue of harm reduction (Master Plan, 1999:13-19).

The Master Plan expressed very serious concerns regarding the situation of the **youth** and its relationship to drugs , and the statistics produced in the document paint a very serious and challenging reality. Several research findings by national and international scholars indicate the dire consequence of drug use and abuse by young people and the involvement of the Departments of Welfare, Education and other statutory bodies is outlined and identified . It is evident then that there have been some efforts to deal with the phenomenon , but it is unclear what achievements have been recorded in this respect (Master Plan ,1999:18-25).

Community Health and Welfare need to be protected from the consequences of substance abuse, and the master plan identifies the number of various institutions that provide services to communities throughout the country according to the various categories of delivery. Inevitably in the process associated with health and community welfare , the relevant departments and their line and other functions at all levels of delivery are of importance. Their activities and functions regarding the victims of substance use and abuse are outlined as well as their efforts to provide adequate prevention to individuals and communities. There is also an examination of the efforts undertaken by various other state departments and ministries. The economic prerogatives of GEAR are also part of the overall strategy associated with health and welfare as the economic policy is described as a system that would create an abundance of jobs , enhance redistribution benefits to the poorest sections of the population and facilitate a new economic system that ensures a competitive and fast growing economy. Training and capacity building are also identified as key ingredients in the enhancement of community health and welfare (Master Plan 1999, 25-30).

In terms of **research and communication** it is envisaged that there needs to be a serious mobilisation of all existing intellectual resources, statutory bodies as well as tertiary institutions in order to ensure the production and dissemination

of relevant findings, recommendations and suggestions to the appropriate authorities. The research needs to be of high quality and of different types and forms so it can be of help to the Master Plan and its implementation at all levels of society. Thus the proper scientific intervention can be achieved . SACENDU (the South African Community Epidemiology Network on Drug Abuse) is quoted as a very valuable group of academics and researchers from various disciplines that has produced serious research on the topic of drug use and abuse in its applied sense. Various other such bodies have been mentioned as Integral parts of a nationally-based network of professionals that play a key role in improving the management and co-ordination of substance abuse research in South Africa (WPSW 1999: 30-34).

The country's **international involvement** is seen as a catalyst in the fight against drugs and drug abuse given the proliferation and center stage importance of importing , exporting and distributing drugs. The fight against global drug syndicates needs to be intensified , and be strategically planned with the regional fight as a key priority. The proliferation of cocaine, cannabis, ATSS and other drugs requires serious border and other control mechanisms as well as monitoring, the establishment of reliable data bases, the co-operation between the law enforcement agencies and all relevant stakeholders. Money laundering and judicial co-operation are key ingredients of a successful combating strategy that needs to be reinforced by capacity-building and human resource development at all levels of the anti-drug fight . South Africa has been a signatory of a series of regional and international agreements associated with the fight against drugs , their use and abuse and is committed to the implementation of all international multilateral drug conventions .This implies the prevention and reduction of illicit demand for drugs, the constant control of supply, action against illicit trafficking as well as treatment and rehabilitation. The various regional strategies need to be adhered to by all countries and authorities involved and there is a necessity for constant communication with agencies such

as the International Criminal Police Organisation (INTERPOL) (WPSW 1999:34-45) .

The drafting of the Master Plan was seen as the first step of a long process guiding and coordinating the fight against drugs . There was a hope expressed that the ideals and guidelines of the plan would ultimately become a tangible reality in the near future as drugs presented a real challenge to South Africa , the Southern African region and the world at large.

The plan despite being the obvious product of debates and research fails to delve deeply into the heart of the problem facing whole communities. It abounds of generalisations and proposes a bureaucratic and complicated system of organisation and administration that has little chance of success . The tangible reality is that even the setting up of committees, forums and strategic task teams cannot really tackle the challenges facing whole communities and individuals in their quest for fight and survival against drug use and abuse . The battle against drugs cannot be won only through research , communication and international networks , precisely because it is the battle of good against evil.

Chapter 4

ANALYSIS OF RESULTS

As described in other chapters the decision of the researcher was to base her empirical component on a dual interviewing strategy, i.e. to utilise a group questionnaire and a separate schedule for members of multi-disciplinary teams. It was strongly felt that such an approach would enrich the data analysis and the subsequent acquisition of knowledge. It was felt that such an approach could be more helpful in sharing information, help the researcher in shaping comparative attitudes, opinions, attitudes and experiences shared by these two groups in a comparative perspective.

THE GROUP QUESTIONNAIRE

Nine agencies were selected nationally to respond to the questions set by the researcher. These were:

- Jullo Center (Serenity Addict Treatment Unit) /1.
- The Shekina Care Center/2.
- The Baytul Nur Center/3.
- The Victory House/4.
- An Anonymous Center in Cape Town (the respondent group refused to divulge their identity for what they considered ethical and professional reasons)/5.
- The Lulama Center in Durban/6.
- The Newlands Park Rehabilitation Center/7.
- The Department of Welfare and Population Development in Gauteng/ Magaliesoord Center/8.
- An Anonymous Center in Port Elizabeth (the group did not wish to reveal its identity for professional and ethical reasons)/9.

Thus two of the agencies were governmental, three non-governmental, three private and one (the Baytul Nur Center) was community based.

The people in the groups who were interviewed were:

- *Three doctors.
- * Six psychologists.
- *Nine social workers.
- *Seven nurses.
- *Four occupational therapists, and
- *Four others.

Seven were inpatient facilities and two were outpatient.

The years of existence of the nine centers was as follows:

- Unit 1 existed for two and a half years.
- Unit 2 for 28 years.
- Unit 3 for 15 years.
- Unit 4 for 52 years.
- Unit 5 for 9 years.
- Unit 6 for 15 years.
- Unit 7 for one year.
- Unit 8 for 5 years.
- Unit 9 for 23 years.

It can be gauged thus that there is a wide diversity in the years of existence amongst the various centers. This means that there could be different approaches to the rehabilitation programme, the treatment patterns and other processes associated with the rehabilitation trends followed.

THE TREATMENT TEAM PLAN AND PROGRAMME

One of the key initial questions regarding the rehabilitation process was the composition of the treatment team and its plan, as these are essential steps that determine the holistic or not approach to the programme and its potential success.

In terms of the question When in the assessment process is the programme planned? , six of the nine groups replied that the steps were planned simultaneously from the beginning of the process. It has been shown that this is the appropriate approach to be taken in the rehabilitation and treatment process, because the two steps (assessment and programme planning) are interrelated and intertwined. They could be considered as two separate but equal parts of the same process that ultimately leads to a well-thought plan for the rehabilitation of the patient.

Regarding the question By whom is the treatment programme planned? , the following responses were received:

- Six groups indicated that a multi-disciplinary team undertook the treatment programme plan .
- In Unit 4 the team undertaking the planning consisted of the medical doctor and the social worker.
- In Unit 5 the doctor and the social worker planned the treatment.
- In Unit 6 a clinical team undertook the task consisting of the social worker and the psychologist.
- In Unit 1 while the multidisciplinary team was in charge of the planning , it was established there was a more or less standard plan followed in the process , which was a 4-work cycle programme.

It can be seen that although most of the treatment centers utilised the existing multidisciplinary teams in the planning of the treatment programme , the key person in all instances was the social worker .In the interview process with the groups throughout the country , it became evident that this professional was considered the key group member in all cases .This can be seen as the confirmation of the belief that the social worker in such establishments takes the ultimate responsibility for the implementation of the plan through case work intervention. It is true that the multidisciplinary group of professionals in most cases has the overall treatment planning responsibility , as the diversity of knowledge and expertise is vital for the final success of such an endeavour. Hence the practice undertaken in the cases where two or three professionals are entrusted with this task instead of the whole interdisciplinary team could be questioned ,as the treatment programme plan could not present a holistic undertaking. However it needs to be said that the possibility of overwork, shrinkage or non-availability of financial resources or/and the multi-faceted responsibilities of other group members in their everyday tasks and objectives

could be seen as reasons for the non utilisation of the whole disciplinary team. Financial and resource constraints facing such centers seemed to be an increasingly serious problem that is a barrier to the smooth and uninterrupted function of many of these centers.

The question Who does the treatment team comprise of? , attempted to assess the composition of the treatment team , as the literature review undertaken earlier pinpointed the variations as well as the advantages and disadvantages of the differing views and realities associated with such a process .

In terms of inpatients:

- In Unit No 1 the team comprised of :
- The Director.
- The Social worker.
- The care workers.
- The professional nurses.
- The psychologist.
- The doctor , and
- The counselor.

Thus it can be gauged according to the responses obtained from the interviewees in Unit 1 that the whole team was responsible for the treatment of the patients, a fact indicating a more or less holistic approach to treatment . The process and various steps undertaken in terms of treatment comprised of two sessions daily as well as :

- Educational lectures.
- Awareness education.
- Nutrition.

- Communication/family orientation.
- Stress management.
- Group therapy sessions.

In Unit 2 the whole team was responsible for the treatment and the various aspects and processes associated with it and this indicates a more or less holistic approach to patient's treatment.

In Unit 3 the following staff comprised the treatment team :

- The doctor.
- The Social worker.
- The psychological nurse.

In Unit No 4 the team comprised of :

- Two doctors.
- The psychiatric nurse.
- One social worker , and
- Two chemical experts.

In Unit No 5 the staff associated with the treatment comprised of :

- The Doctor.
- The Social Worker.
- The nurse , and
- The sessional psychologist

In unit No 6 the team comprised of :

- The Doctor.
- The Social Worker.
- The nurse , and
- The psychologist.

In Unit 7 the team was much more varied as it comprised of :

- The social workers.
- Pastoral consultants.
- Professional nurses.
- The District surgeon.
- Occupational Therapist.
- Social Auxiliary workers.
- A psychologist (the position was vacant at present) , and
- A psychiatrist (the position was at present vacant)

It can be seen, then , that in this particular unit , the responsibility for treatment is based on a holistic and wide team. The fact , however, that the key positions of the psychologist and the psychiatrist were vacant created a serious vacuum in the treatment process. This fact became very evident in the interviews with the team , who expressed their dissatisfaction with the existing reality. It was established that the non-appointment of these two key members was a serious impediment to the holistic approach to treatment in this unit and there were aspects of the treatment that were dysfunctional because of these two vacancies.

The treatment team in Unit No 8 comprised of:

- The nursing staff.
- The medical officer.
- The psychologist.

- The Social worker.
- The Occupational Therapist , and,
- The Assistant Occupational Therapist.

Additionally the following individuals, groups and organisations participated in the team:

- Representatives of the City Health Department.
- The Alcoholics Anonymous (AA)
- Religious leaders who serviced and helped the patient and the family.

In Unit 9 the following professional were part of the team:

- The medical officer.
- The psychologist.
- Nursing staff.
- The social worker.
- Auxilliary staff.

Overall it can be said that all Units represented in the sample indicated that the treatment teams comprised of solid and wide ranging teams with a combination of a wide variety of professionals associated with the different aspects of rehabilitation and treatment as well as a variety of religious leaders who looked after the spiritual needs of the patients . Such a reality indicates a more or less holistic approach to treatment that was on several occasions in a weaker position due the lack of some key professionals in several units . Such a process , was in most cases based on financial constraints, and would ultimately create a vacuum in terms of holistic treatment . It is understood that every team member has stipulated that there was a set of well defined roles and objectives identified by the aims and implementation of the existing treatment plans. In such a well-

planned and defined project the absence of key professionals in the treatment team composition can create problems , especially regarding the smooth functioning of several aspects of the treatment process .

In terms of outpatients the following patterns were evident:

In Unit 2 the whole team participated in the process.

In Unit 4 it was only the doctor who undertook the task.

In Unit 6 the team comprised of :

- The Occupational therapist.
- The Doctor.
- The Social Worker.
- The Psychiatrist.
- The Psychologist , and
- A spiritual person .

It can be seen then , that there were different patterns of participation by professionals in terms of the outpatients in the various units under investigation.

In regard to the question : What does the treatment plan comprise of? the following responses were obtained from the groups operating in the units under investigation :

- In Unit 1 the following were undertaken :
- Educational lectures /especially awareness education.
- Nutrition
- Communication and Family orientation
- Stress management.

- Group therapy sessions.
- In Unit 2 :
- Relapse prevention.
- Group work therapy with individual focus.
- Attempts to achieve a co-operative environment between the patient and the team.
- In Unit 3:
- Detoxification.
- Ongoing therapy.
- Assessment.
- Relapse prevention.
- In Unit No 4
- Detoxification.
- Bio-psychological , social and spiritual reconstruction(also described as lifetime continual care).
- In Unit No 5 :
- Detoxification.
- Therapeutic intervention.
- After care.
- In Unit No 6 :
- Assessment.
- Detoxification.
- Therapy
- In Unit No 7:
- Detoxification.
- Assessment.
- Therapy.
- Intervention.
- After care.
- In Unit No 8

- Detoxification.
- Group therapy and individual therapy with special focus on orientation.
- Self esteem building.
- Personality enrichment.
- Empowerment of social skills.
- Unit No 9 :
- Detoxification.
- Group therapy.
- Life skills education.
- Individual therapy .
- Family therapy.
- Religious upliftment.
- Sports and recreation.
- Support groups.

It can be gauged then that the majority of units under investigation basically utilise similar treatment plans in order to look after the patients. It has become clear that the existence of resources (especially human) plays an important role in the diversity of the various treatment plans and their actual practice that in the end benefit the patients . Inevitably the more the existence of solid and diversified the human resources the more diversified the treatment of the patients.

In the question of *Whether abstinence is a precondition for treatment* , which was set in order to determine the relationship between abstinence and the treatment process, six groups answered YES and 3 answered NO . Such a response can be seen as an interesting diversification of opinion and practice within the units , and thus the next question sought to identify and clarify the basis of the answers.

The next question was thus structured as follows: *If YES specify*. The following responses were obtained :

- The respondents in Unit No 1 said that the Center makes use of a holistic approach , i.e. the patient is seen in his/her totality.
- The respondents in Unit 2 said that YES was their answer as they considered abstinence as a *sine qua non* of an effective treatment.
- The interviewees in Unit No 3 stated that in most cases they required abstinence , but the situation was different when they treated drug addicts *per se*.
- The Unit 4 group said abstinence was imperative if the treatment was to be effective.
- The Unit 5 group indicated that abstinence was important for the motivational levels of the client.
- The respondents in Unit 6 indicated that tests were undertaken continuously in regard of the patients.

In short it can be said that the responses were more or less identical and pinpointed the existence of abstinence as an integral necessity in the success of any future treatment.

Regarding the key issue of the model utilised in the treatment in particular agencies (the question being *What do you feel is the most commonly used model of treatment in your agency?*) , the responses were as follows:

- The group in Unit 1 indicated that the staff in the center used the holistic approach, i.e. they treated the patient as a "total being". All social, psychological and sociological aspects associated with the patient were taken into account in the treatment process.
- The disease model was used in Unit 2.

- The spiritual/therapeutic model was used In Unit 3.
- The minimisational model was used in Unit No 4.
- The disease model was used in Unit No 5.
- The cognitive behavioural model was used in Unit No 6.
- The disease model and the bio psychosocial approach were used in Unit No 7.
- The JULLO Model , i.e. a self-developed minimisational model was used in Unit No 8.
- Unit No 9 utilised the following:
 - The problem solving approach , i.e when all role players , including the patient are involved in solving the problem.
 - The behavioural modification model , where the role players attempt through the treatment process to modify the patient's behaviour.and
 - The conflict resolution model , where role players together attempt to solve the problem through the intervention of a mediator.

It can be seen then that a wide variety of treatment models were utilised in the various centers , and this was obviously a conscientious decision on the part of the treatment teams , as they felt that the chosen path to rehabilitation was the correct choice , as the next question attempted to establish.

In regard to the effectiveness of these models in the treatment of drug addicts (the question posed: *Do you feel this model effectively helps drug addicts stay drug-free?*), the majority of respondents felt that the models of treatment were effective, with only one negative response being noted. The negative response was expressed by a nursing sister who is an integral part of the treatment team and felt that the adopted treatment model was not the appropriated one as it did not look at the treatment process holistically enough and the solution was left at the hands of a very limited number of individual professionals.

Such a response indicated the belief of the interviewees that their choice of treatment was correct , as the plan and implementation of their methods were considered successful.

When questioned specifically on the models of treatment (the question posed was: *What is most positive about this model of intervention?*), the responses were as follows:

- Unit 1 felt that the holistic approach taught the client to take responsibility for his /her own life and choices. This was seen as a very crucial aspect of this process.
- Unit 2 felt their model took into account everything about the client, i.e. his/her social, existential and psychological circumstances that played an important role in the treatment process.
- The spiritual model employed by unit 3 focuses on all aspects of the person's life, with special focus on the spiritual manifestations of one's existence as an individual and/or as a member of a group in society.
- Unit 4 saw their model as a holistic model.
- Although unit 5 saw the disease model as their guiding focus, they described their choice as based on an ongoing process. They felt that drug addiction and use can be controlled.
- Unit 6 saw the strength of their preferred model as a given due to the international acclaim bestowed upon it. They saw this model as one lending to immediate help that was direct and down-to-earth. This was to the benefit of the client both in the short and long term process of treatment and rehabilitation.
- Unit 7 felt that their model looked at the person holistically, reinforcing the strengths of individuality found in the person , together with the causes that strengthen or weaken this individuality.
- The empowerment of the person and family was seen as the greatest positive by unit 8

- Unit 9 saw their model as practical to implement and simple to understand.

The responses obtained from these groups indicate a solid understanding of processes associated with the treatment patterns and initiatives undertaken by the various teams, who in the final analysis have demonstrated a strong commitment and wide knowledge of their particular choice. It can be understood that the wider the knowledge of the selected model the stronger the possibility and probability of success in such endeavours.

When questioned on the converse (the question posed: *What is most negative about this model of intervention?*), the responses were the following:

- Unit 1 admitted that their model could not be applied to illiterate and unschooled people. Obviously such a reality would ultimately have a negative effect in the future as such social groups would inevitably comprise significant proportions of clientele of such agencies.
- Follow-up was not always feasible in Unit 2's chosen model, with clients often not returning to the agency. It is obvious then that there could be serious problems in such circumstances, firstly because there could be financial implications for the institution, while the client could be in serious danger of relapse.
- Unit 3 felt that their model needs adequate support systems to be effective.
- Unit 4 felt the lack of understanding on the part of the patients was their major stumbling block.
- Unit 5 felt the programme was too short, and this created problems in the process.
- Due to time constraints, Unit 6 felt that their approach was not optimally effective. Also, the families often did not see the problem as a disease, while patients thought there was a cure. This created impediments to the process undertaken.

- Unit 7 claimed that it was difficult to motivate the families to support the patients.
- Unit 8 lamented that people sometimes saw their model as "far-fetched".
- Unit 9 did not respond.

It can be gauged then , that the respondents belonging to the various units had an understanding of the problems associated with treatment and their negative aspects that led to serious impediments to the processes of rehabilitation. In this sense it became evident that their main aims and objectives would be to minimise the negative effects and processes and strengthen the positive aspects of their efforts.

In response to whether they had employed any new/innovative models/approaches in the treatment of drug addiction, 8 units responded positively, with only one unit replying "No". Specifically, some responses were:

- Unit 1 introduced redoxation therapy, especially in relation with stress management.
- Neuro-biology, presentology and NLP were some new ideas employed by unit 2.
- Unit 3 offered acupuncture and reflexology. Unfortunately, there was no follow up on these treatments. This was due to various reasons and had a negative effect in the long run.
- Changes are always made in the axis models employed by unit 4.It was felt that they had positive effects.
- A combination of personal growth and skills development was part of unit 5's model. The representatives of the unit felt that this was a positive step forward in the process.
- Unit 6 used life skills and personal growth models.

- Unit 7 responded according to the development of the individual, as they saw the patient in a holistic manner.

In response to the question: *What are the contemporary trends in service delivery today for drug abuse/dependence in South Africa?* the representatives of the units answered thus:

- Unit 1 saw a decline of substance abuse with new methods employed to handle "new" drugs.
- Unit 2 noted the trend towards private care and holistic treatment and an understanding of the problem as a disease rather than as a moral weakness. Obviously such a response pinpoints to alternative ways of seeing the process of treatment .
- Unit 3 noted the work with the youth and the aged as important aspects .
- The linking of no other organisations, Employment Assistance Programmes , the covering of families and ACOA were seen as new trends by representatives of unit 4. These indeed have been some new and serious developments and trends in the field that could provide additional food of thought to everyone associated with the existing and future programmes.
- Unit 5 saw detoxification therapy and aftercare as great improvements in the lives of patients , and trends that added more value to old and well established methods.
- Unit 6 was excited by the developments in detoxification , such as neuro-biology and reflexology..
- Unit 7 did not respond.
- Unit 8 noted that people were subjected to inpatient status by force only through family or employer instruction.
- Unit 9 appreciated community education and involvement, as well as outpatient facilities as important new developments and trends in the field.

When asked: *Do you think drug addicts can take drugs and lead a productive life?* the response was:

- Unit 1 said "No"
- Unit 2 said "No"
- Unit 3 felt it depends on how the drugs used affected the users' daily lives. It was determinate on their tolerance levels towards the drugs taken.
- Unit 4 said "No"
- Unit 5 said "No"
- Unit 6 was undecided. They agreed that the user could lead a life, but was concerned with the quality of life lived.
- Unit 7 did not see drug abuse as a long-term decision. They felt that it was to the detriment to the users' health.
- Unit 8 said "No"
- Unit 9 said "No"

In response to their opinions on the harm reduction model, the responses of the representatives were as follows:

- Unit 1 felt that it was relevant to today's problems and needs practice to be implemented well. This is a correct response to a model that needs to be implemented with care and with attention to detail.
- Unit 2 felt that there is a place for this model in the treatment process.
- The model is effective, according to Unit 3, provided people are educated about it and know how to apply it to particular situations. It also has to be taken seriously in terms of supply reduction, but does not decrease the number of addicts.
- Unit 4 did not agree, stating that one cannot take one drug away and give another instead. This could create problems in both the short and medium term .

- Unit 5 focussed on the goal – total abstinence, which they considered their first priority. This model was therefore not their first choice.
- Unit 6 did not see the model as very effective, emphasising the need to eliminate the problem instead.
- Unit 7 felt that harm reduction therapy can create hard-core addicts, but in conjunction with therapy things could improve.
- Unit 8 stated that harm reduction therapy does not take the drugs away, it is very expensive and therefore only for developed countries.
- Unit 9 felt that it is symptomatic treatment and not problem solving.

It can be seen then that the attitudes , ideas and opinions regarding the harm reduction problem varied and were expressed according to the existing ideas and approaches of the various agencies towards their plans and implementation of their trends of treatment and their relation to the patients.

The units were asked what their most important goal of treatment in their agency was , and responded as follows:

- Unit 1 strives for sobriety with optimal personal functioning of the patient.
- Unit 2 wants abstinence , that would ultimately lead towards reintegration.
- Unit 3 tries to help addicts lead a productive life and the ultimate reintegration into family and community.
- Unit 4 focuses on helping the patient understand his/her problem/s, building his/her confidence and reintegrating them into society.
- Unit 5 aims for relapse prevention and reintegration. This was the first time that relapse was mentioned in response to this question .This is important , as relapse can be seen and accepted as a very serious aspect of drug addiction and rehabilitation.
- Unit 6 works towards the patient's understanding of what substance abuse is and how to maintain sobriety.

- Unit 7 wants a change in lifestyle of the patient without the abuse of drugs.
- Unit 8 focuses on the integration of the patient into society, with him/her taking responsibility for his/her life as an integral part of this society.
- Unit 9 introduces the patient to religion, aiming for a commitment to God in the holistic treatment of drug dependence.

It can be seen then , that there are no real differences in the approach of representatives of agencies regarding the final aims and objectives of the units in relation to rehabilitation of the patient and the process of re-integration within society.

As has been described earlier , one of the new and most important aspects of drug abuse in contemporary South Africa is the continuous and increasing use and abuse of recreational drugs .Thus it was felt that this was one of the most crucial aspects of the present project that needs to be investigated thoroughly.

As an overview of what recreational drugs are treated and how commonly, the following table illustrates how many units treat dependence on these substances and to what frequency.

	Most Common	Common	Least Common	None
Nicotine	1	2	2	3
Marijuana	7	2		
Alcohol	7	2		
Mandrax	6	3		
Cocaine	6	1	1	
Crack Cocaine	6	2	1	
Heroin		2	6	1
Amphetamines	1	3	2	2
Prescription Medication	4	4		

Ecstasy		3	3	1
Solvents	1	1	3	3
Codeine	1			
LSD	1			
Other (Specify)			1 ("Speed")	

(Some of the total do not add to 9 (the number of the agencies as not all drugs are treated in them).

It can be gauged then that the variety of the recreational drugs used is wide , and certainly similar trends would have been completely unknown several years ago. The use of abuse of cocaine ,crack cocaine, mandrax , heroin and Ecstasy in fact substantiate the data presented in other parts of this thesis, especially the literature review . The trends found in this table are in fact frightening , because of the variety and frequency of drug use and abuse, but real.

In response to the question, *What are the major problems encountered in treatment?*, the responses were:

- Unit 1 cited resistance to treatment as a result of lack of insight, motivation and outside support systems. Denial, unemployment and poor aftercare were also listed as hindrances.
- Unit 2 saw abscondment and lack of motivation as major problems.
- Unit 3 saw dropouts and no family involvement as problems.
- Unit 4 mentioned lack of motivation, especially as the programme progressed.
- Unit 5 cited lack of motivation, ambivalence and pretences forced by employers.
- No motivation on the clients, in part due to expenses, saw clients from Unit 6 regressing to old habits.

- Unit 7 mentioned denial, lack of family support, unemployment and poor finances. This was seen more commonly in the younger patients, many who had criminal offences. There is low motivation to change, due to lack of support services in block areas. There is also the problem of dual diagnosis.
- Unit 8 struggled to retain the patient in the first week. They also saw lack of funding as a problem.
- Unit 9 complained of denial, lack of motivation, financial implications and lack of insight on behalf of the patient into his problem.

There were then, common roots and effects in the problems associated with treatment , and these had direct implications on the planning and implementation of strategies adopted by the units in their treatment efforts.

When asked *Do drug dependants present HIV/AIDS/STDs?* 8 units said "Yes", with only 1 unit answered in the negative. Such a response indicates the prevalence of the virus and the disease as well their influence on drug use and abuse of individuals.

When asked how they worked with HIV/AIDS patients, the responses were:

- Unit 1 saw no differentiation between patients.
- Unit 2 also claimed that they would treat HIV/AIDS patients the same way as patients who were negative.
- Unit 3 sought proper counseling and would refer patients to respective authorities.
- Unit 4 provided AIDS education, discussed lifestyle changes, VIT injections and counseled patient and family.
- Unit 5 motivates HIV/AIDS testing, works on issues of lifestyle, education on the limitations of treatment and refers patients to respective authorities.

- Unit 6 echoes Unit 5's response, but with added attention to physical and mental quality of life.
- Unit 7 treats positive patients with precaution and care . They also provide counseling and referrals before and after testing.
- Unit 8 adopts a non-judgmental approach, incorporating an HIV module into the programme.
- Unit 9 inspires individuals to test themselves and is very preventative. They have an AIDS programme at the institution.

It can be seen then that although there are several different approaches to the treatment of patients with HIV/AIDS , generally the common features of treatment are more prevalent than the differences.

A large number of dependant persons also suffer from psychiatric disorders , which create additional problems to the units on many fronts . When asked if they had specialty programmes for these patients, 6 units responded affirmatively, while three said "No". When asked what these programmes comprised, the responses were:

- Unit 1 does not usually accept patients with psychiatric disorders. As they do not have a psychiatrist on staff and feel that they are not qualified to provide adequate treatment. Such a position indicates an honest approach to treatment as the unit's authorities feel they do not possess the necessary skills to treat the patient comprehensibly.
- Unit 2 has a life management programme, as well as psychiatric evaluation and treatment.
- Programmes are adapted to suit individuals in Unit 3. These patients may be removed from the general programme, and it is felt that such an initiative can solve the problems associated with such circumstances.
- Unit 4 has therapeutic groups and exercises medicine control.

- Mental health assessment and proper care of medicines and prescriptions are some ways in which Unit 5 deals with psychiatric patients.
- Unit 6 has depression and anxiety support groups. Their programmes do not cater for extreme psychiatric disorders, though, and patients suffering from schizophrenia, for example, will not be admitted.
- Unit 7 only caters for depressed patients.
- Unit 8 does not cater for patients with psychiatric disorders.
- Unit 9 treats depression with medication.

It can be said then that there are different reasons that play an important role in the decision of a unit to admit or not a psychiatric patient . These decisions are usually associated with real issues of substance, staff and economic shortages as well as lack of fundamental weaknesses as assessed by the unit's personnel and management.

In looking at *underlying treatment orientation that characterizes drug abuse programmes*, the following table illustrates the orientation and models of care undertaken by the units .

This question needs to be seen as qualitatively different from a previous one That dealt with the feelings of respondents regarding the most commonly used model of treatment in the agency , as it examines the **underlying treatment orientation and models undertaken by the units**. In other words the present question relates the theoretical orientation of the unit with the implemented model.

Underlying Treatment Orientation	Different Models of Care
1. Substance abuse is a disease	Disease model
2. Disease	
3. Drug free	

4.	
5. Group volunteers	Therapeutic groups
Improving self image	Life skills development
Behaviour change	Behaviour modification
6. Use of group work	
Improve self esteem	
Addressing development tasks	
Behaviour modification & Bio-psycho social	

It can be seen then, that there is a variety of underlying treatment orientation that characterises drug abuse programmes . These are determined by the whole approach, aims and objectives and overall outlook of the agencies and their treatment philosophies . In other words all aspects of diagnosis and treatment implementation are interrelated and intertwined.

The relapse rate in South Africa is regarded as being very high. When asked why they thought this was occurring, the units responded as follows:

- Unit 1 blamed the lack of outside support and family counseling. The community was not properly educated and drugs were available too freely outside the programme.
- Unit 2 felt that patients did not follow the instructions and advice given to them when they left.
- Unit 3 felt that there was a lack of proper after-care and follow-up. There was also no family integration treatment.
- Unit 4 saw a lack of support services and no proper after-care leading to low motivation by the patient.

- Unit 5 blamed inadequate training and the lack of ongoing support.
- Unit 6 felt that the after-care support systems were inadequate. The poor economic conditions and unemployment also lent to relapse.
- Unit 7 saw no real commitment from the client and insufficient support and after-care.
- The programmes were not developed properly, according to Unit 8, citing no integration into family structures and no after-care.
- Unit 9 felt it was a universal problem, but the mixture of first and third world conditions led to a lack of adequate support services. First world solutions are being forced into third world conditions. There is a need for more community services finance.

When asked *Are support services today more likely to meet the needs of patients who are reintegrated to prevent relapse?* 4 units replied positively, while 5 responded in the negative.

When asked what these needs are, the responses were:

- Unit 1 felt the need for after-care services, employment and home security.
- Unit 2 affirmed the need for proper after-care.
- Unit 3 saw that, with ongoing training, support and motivation and attendance at church services brought success in small groups.
- Unit 4 cited the need for dignity, respect and acceptance.
- Unit 5 felt these needs are proper support systems, employment, accommodation and integration into the family and community.
- Unit 6 mentioned employment, with community structures to promote training.
- Unit 7 saw the need for jobs and support groups.
- Unit 8 stressed the importance of a supportive environment.

- Unit 9 also stressed the need for support, with attention paid to educating the family and involving stress management.

The respondents were asked if they thought if *a holistic community-based treatment programme with the view towards reintegrating a person into society and preventing a relapse* would work. They all agreed it would work, but one unit noted that some initiatives had failed while similar ones had recorded good success figures. The approach, they felt, was important.

When asked to identify some of these programmes, the responses were:

- Unit 1 mentioned AA and NA as community-based programmes and support groups. They also knew of religious organisations.
- Unit 2 stressed education for the family and community. They cited proper treatment procedures, after-care and follow-up.
- Unit 3 said that it is a substantial programme that must be relevant to the needs of the individual.
- Unit 4 saw support groups, recreational groups, spiritual groups, and preventative organisations.
- Unit 5 mentioned Unit 1, the Jullo Center, which was devised and evolved by their own doctor and medical team.
- Unit 6 felt that such groups could only exist successfully with a strong financial base and proper understanding of the problem.
- Unit 7 cited the existence of therapeutic support groups and EAP programmes within the workplace.
- Unit 8 mentioned halfway houses. For example, the AA utilizes Bill's Rooms; Drug Wise Marshals and religious organisations also have programmes like PAGAD rehab center.

Thus it became obvious that despite their own operational work the groups also kept their eyes open for possibilities for treatment and rehabilitation outside their own domain. This is an encouraging development as the knowledge and experience of a variety of organisations and methods could only prove beneficial in the future of both patients and institutions.

When asked if they believed that co-responsibility for drug prevention and treatment rests with schools, family, society, religious organisations and government [White Paper: 1997], the response was unanimous in the positive. However it is important to mention here that such initiatives need to combine both theoretical and practical knowledge and levels of implementation in order for the processes to be successful.

When asked if this responsibility is acted upon, the following responses were recorded:

- Unit 1 stressed that it did not, stating that everything is fragmented.
- Unit 2 said "No".
- Unit 3 saw this as a constant challenge. They are striving for this and have seen some improvement. Their organisation has been in existence for a long time and does receive co-operation. They felt that reputation and integrity helped.
- Unit 4 responded negatively.
- Unit 5 saw the challenge in its infant stage.
- Unit 6 felt that to an extent it did occur, but needed improvement.
- Unit 7 said "No"
- Unit 8 felt that no holistic approach is seen in the process. There is a lack of understanding of substance abuse in the community and family.
- Unit 9 said the feeling was that the state should provide for this problem to be solved and that was not working. There is no co-operation between

organisations due to poor networking. There needs to be a redress of whose problem this is.

It can be said that although there are several signs that there is some movement regarding such initiatives, there is a strong feeling that there is not much effort in alleviating the existing problems.

On a continuum, [1] most common, [2] common, [3] least common and [4] not common at all, the were asked how they saw the following disorders:

Disorder	1	2	3	4	Percentage of Patients		
					1	2	3
Depression	4	1		1	33%	60%	28%
Schizophrenia		4		3	20%	1%	15%
Phobias		4	2	1	10%	20%	5%
Mania		4	1	2	10%	-	-
Anti Social	1	1	2	2	-	99%	-
Personality Disorders	1	4		2	5%	-	20%
Panic/ Anxiety	1	3	2	2	10%	60%	15%
Obsessive Compulsive		3	1	2	10%	5%	15%
Somatization			3	3	15%	50%	-

The columns on the left show the attitudes of the respondents regarding common psychiatric disorders and it is evident that if the number of responses are less than nine there was a lack of response regarding the particular disorders.

The right hand three columns represent the percentage of responses regarding common psychiatric disorders amongst dependents as expressed by the professionals .

Thus it can be seen that depression is seen as the most common psychiatric disorder , followed by panic/anxiety and somatisation. Anti-social behaviour is also seen as very common psychiatric disorder amongst drug users and abusers.

When asked how important family therapy is in the treatment process, the responses were:

- Unit 1 felt it was very important. The addict does not affect other people, but the family does not always realise this.
- Unit 2 stressed the importance, claiming that without family understanding and support, the addict will not change his/her behaviour.
- Unit 3 agreed that it was very important.
- Unit 4 said it was imperative.
- Unit 5 felt it was very important.
- Unit 6 stressed that it was very important.
- Unit 7 admitted that family therapy is difficult, but said that support is given telephonically and by referrals, especially when "tough love" action is taken by family members, which sometimes makes the problem worse.
- Unit 8 agreed that it was very important.
- Unit 9 did not answer.

Thus it is obvious that the vast majority of respondents understands the importance of family support in the process of treatment . This is significant in itself as the patient cannot be seen isolated from his/her social environment , of which the family is an integral part.

The respondents were asked what difficulty is encountered in providing family therapy services.

- Unit 1 cited time constraints by the family and the organisation. Also, accessibility to the centre was problematic in terms of transport, finances and denial.
- Unit 2 felt that the process is too expensive and not all therapists are trained in family therapy. It is also time constraining, as families do not have the time to participate.
- Unit 3's major difficulty lays in their geographical positioning, with transport to the centre being difficult. Most families are poverty-stricken and referrals are expensive, however necessary, as staff is not fully trained.
- Unit 4 struggled to get the family to recognize that a problem exists and respond accordingly.
- Unit 5 finds it difficult to motivate family to come to therapy.
- Unit 6 has a communication problem. Their guests are from other regions, e.g. Namibia, Botswana, and Zimbabwe. Staff cannot communicate with the families.
- Unit 7 cites distance and emotional withdrawal from the family as major problems.
- Unit 8 feels training is too costly. Social workers aren't properly equipped to handle family therapy.

It can be gauged that similar problems facing the units are in the center of the lack of family therapy as an integral part of solving the patient's problem. It is the researcher's opinion that family therapy is as important as the treatment process itself, because without the support and solidarity of the family in the therapy process there is scant possibilities for rehabilitation of the patient.

When asked if they thought that patients respond more positively to a more positive self evaluation of treatment and counselors more positive evaluation of the patient, hence reducing the risk of relapse, the responses were:

- Unit 1 agreed, adding that modeling was very important.
- Unit 2 was less positive, warning that the risk of relapse is always a possibility.
- Unit 3 felt that a positive approach is preferred, but warned that any evaluation has to be an honest and realistic appraisal.
- Unit 4 said, "Yes".
- Unit 5 also replied in the affirmative.
- Unit 6 agreed, stressing that this is a treatable disease.
- Unit 7 was also affirmative, believing that if the counselors are positive and believe in change, it can happen.
- Unit 8 was more reserved, but admitted that the positive approach is sometimes successful.

Although there was a variety of attitudes regarding the question, the positive attitudes outnumbered the negative significantly.

In response to the question, *What evaluation procedures do you use to examine treatment outcomes and follow-up on re-integration?* the units answered as follows:

- Unit 1 used feedback from referring agencies and assessed through contact with the patient.
- Unit 2 conducted weekly assessments. They utilised before and after treatment questionnaires and kept in contact during after-care.

- Unit 3 has a Program Evaluation Record. It comprises weekly continuous care for the patient and spouse for life and a monthly family meeting with the patient and concerned family.
- Unit 4 Issues post-treatment questionnaires.
- Unit 5 utilizes multi-disciplinary team evaluation and after-care reports.
- Unit 6 has an after-care follow-up system, where someone is in daily contact with the patient after discharge. The patient fills in a questionnaire 28 days after discharge. Then there are 3 month, 6 month and yearly monitors chosen by the patient.
- Unit 7 issues 2 questionnaires. The first is issued in the first weekend after discharge. They are then involved in a group discussion, which is urged to be frank and open. The second is issued in the third week and the process is repeated.
- Units 8 and 9 did not respond to this question , for their own reasons.

It can be seen thus , that the units utilise both administrative , organisational and scientific methods in the evaluation process , and this obviously equips them for their future endeavours.

When asked how they would update the programme effectiveness and programme development, the responses were:

- Unit 1 would like to proof track evaluation methods, for example 6 weeks of feedback.
- Unit 2 felt that it is important to update according to new information and studies as to which methods are the most effective.
- Unit 3 felt it was necessary to consult internationally, re-evaluate their programme and adapt foreign methods for the local climate.
- Unit 4 would update by consulting journals and other publications, attending workshops and seminars.

- Unit 5 prefers to research and evaluate the treatment response.
- Unit 6 favors continuous assessment.
- Unit 7 would like constant review and feedback plus weekly staff training.
- Unit 8 feels the need to update continuously.
- Unit 9 did not respond.

It is obvious that comparative paradigms and scientific evaluative research is of importance to the agencies in their attempts to plan and implement more advanced methods and criteria in their understanding and practice of rehabilitation and treatment.

When asked if they thought that the training received in tertiary institutions in the specific fields was adequate to provide specialized services in the field of drug work, 7 units responded negatively, while two responded affirmatively. The two positive responses came from interviewees who have received training in occupational therapy. The negative groups comprised of professionals who had received training in the fields of social work, nursing and medicine. Thus it became clear that the combination of theory and practical experience are of vital importance for the future success of any treatment and rehabilitation programmes.

Specifically, the groups were asked if they would like to see tertiary institutions offering courses in this area.

- Unit 1 felt there was a need.
- Unit 2 felt a balance was needed. The student could specialize if the doors were open.
- Unit 3 stressed that specialized modules were necessary, as this is a highly specialized field of practice. Ongoing programmes for development are needed.

- Unit 4 wants the establishment of a faculty or seat in addiction medicine, incorporating care, addiction medicine concepts and inter-disciplinary concepts.
- Unit 5 felt the need for more programmes or therapeutic intervention.
- Unit 6 offered that students who wanted to specialize should receive practical training in this field.
- Unit 7 wants more counseling skills, an update on research and more family focussed work.
- Unit 8 would like more practical experience offered.
- Unit 9 did not respond.

Overall these ideas open new ways of understanding in the field both in theoretical and practical terms , and the relevant authorities need to look at such suggestions seriously.

When asked if policy makers and service providers need more information about the main models of drug dependence care, 8 units responded positively. Specifically:

- Unit 1 felt they need to know more about the disease.
- Unit 2 stressed that they need to know what happens at “grass-roots” level. All ministries need to collaborate in a coordinated and integrated manner.
- Unit 3 felt they need to be in contact with the latest developments in the field both nationally and internationally.
- Unit 4 saw the need to evaluate present programmes ,so that the necessary steps need to be undertaken.
- Unit 5 felt that they need to be educated before they can properly plan for legislation and programmes, and fund these accordingly.
- Unit 6 felt that their role needs to be made relevant. Policy makers must link up with organisations.

- There needs to be communication with the service providers, according to Unit 7. First world models are being used in third world situations.
- Units 8 and 9 felt that they were unable to answer the question adequately.

The need for a well planned and integrated model that will utilise scientific knowledge was thus the key issue associated with the question and the responses received in the process.

In response to the question, *What is your drug dependence programme policy about? Where does the focus lie?* the units answered:

- Unit 1 felt their focus was on prevention and on the youth.
- Unit 2 focuses on the holistic person and aims to encourage the addict, while instilling spirituality in the youth.
- Unit 3 saw their focus on prevention, treatment and re-integration into society.
- Unit 4 states that addiction is a chronic illness, which is in need of a life management programme to maintain remission, and their focus lies on the disease concept.
- Unit 5 feels strongly about prevention, but their focus is on treatment.
- Unit 6 focuses on prevention and community awareness.
- Unit 7 feels that the focus lies in the organisations.
- Units 8 and 9 felt that prevention and treatment were equally pertinent.

It became obvious that the key issues associated with the question were related to the deeply-rooted philosophy, practice and understanding of the treatment process and their aims and objectives of the various centers as identified in their programmes.

When questioned on their policies on readmission after relapse or abscondment, the responses were:

- Unit 1 chose to simply start the process afresh.
- Unit 2 only readmitted the patient if they felt he/she is sufficiently motivated.
- Unit 3 will only readmit after community sources have been exhausted, i.e. at least three months after release. If the patient absconds, they follow the procedures set out in Section. 29 of Act 20 of 1992.
- Unit 4 considers commitment. If a patient has been out for a minimum of three months, he may be readmitted, but he /she is only allowed 2 readmissions. Readmission must be voluntary and the patient must be sober for six months after discharge to be considered for readmission.
- Unit 5 will only readmit a patient once. There are no conditions, but the patient must pay again. This would depend on the decision of the patient's medical aid scheme.
- Unit 6 will readmit if they feel the patient is willing to be helped.
- Unit 7 will allow readmission, but if the assessment concludes that the patient is not motivated he will be denied admission until he is willing to accept treatment.
- Unit 8 is open to the concept of readmission. They provide a two-week refresher model for patients who have relapsed within 6 months. If a patient has relapsed at a later date, he may be kept for a month. Observers must motivate in writing as to why the patient needs to be readmitted, but the final decision lies with the doctor.

Thus it is evident that the centers use different models , rules and procedures regarding readmission after relapse . This is obviously based on their policies adopted and the philosophies underlying their operational and organisational principles.

It is widely accepted that a possible relapse may be a positive reaction towards rehabilitation. This is because dependents realise in such a situation that they need assistance and cannot overcome their condition on their own. Thus, re-admittance becomes necessary.

When asked the minimum age for in-patient treatment at their centers, the response was:

- Unit 1 normally only accepts adult in-patients, but will consider younger patients with special permission.
- Unit 2 will accept patients who are 16 or 17, but prefer adult in-patients.
- Unit 3 will accept persons 13 years and older.
- Unit 4 does not place an exclusion on in-patients due to age.
- Unit 5 accepts persons 12 years and older.
- Unit 6 accepts persons 17 years and older.
- Unit 7 accepts persons 14 years and older.
- Unit 8 accepts persons 19 years and older.

It can be seen, then that there is an emphasis on youth as it became obvious in other parts of the thesis that this social category face serious drug problems. This does not mean that other social categories do not feature in the programmes.

When asked if in-patient treatment should be provided for persons younger than 18, 8 groups felt it should while 1 group felt it should not. Specifically:

- Unit 1 felt that it becomes a juvenile matter. They feel there should be a separate ward for youth.
- Unit 2 feels that, as the disease is more prevalent with the youth, they should be admitted.

- Unit 3 admits youth as they have no separate staff and facility.
- Unit 4 feels that as drug trafficking escalates, the target market is becoming younger.
- Unit 5 agrees that more youth are using drugs than adults are.
- Unit 6 admits youth in-patients, but has a separate wing for them.
- Unit 7 feels it necessary as most substance abuse starts at an early age.
- Unit 8 feels that there is a growing need for a facility to cater for adolescent addicts.

Such responses confirm the problems facing the youth and the various rules, procedures and policies associated with such processes.

When asked to comment on the quote, "*Planning, policy formulation and Legislation should be regularly updated with the relevant role players.*" [SWAP:1998], the comments were:

- Unit 1 was in definite agreement.
- Unit 2 agreed, as new developments are being made and new drugs enter the market.
- Unit 3 was also affirmative, stating that there needs to be an understanding of the complexity of this area of work.
- Unit 4 felt that only when this statement is realized will policy be relevant. The policy makers need to understand the world of substance abuse.
- Unit 5 felt that this statement was relevant to prevent loopholes in policy and legislature.
- Unit 6 stated that it was very important but not realized. The policy makers are not working in the field.
- Unit 7 responded positively.
- Unit 8 agreed.

The overall agreement with the statement did not stop the respondents from being somehow critical of the existing state of affairs in terms of policy implementation as has been outlined by the researcher in Chapter 3. It became evident in the interviews that the representatives of the units were aware of the policies and their implementation.

With the decrease in funding, respondents were asked if they felt the number of patients had increased, whereas other areas of service have decreased, e.g. family therapy, after-care, education, etc. They were also asked for alternatives.

- Unit 1 did not see much change. The need they felt ,would always be the same.
- Unit 2 did feel a change and suggested community-based models as alternatives.
- Unit 3 affirmed the increase in patients with the congruent decrease in services. They feel that state welfare does not see drug abuse as a priority.
- Unit 4 felt that the number of patients has increased due to the lack of funds to private institutions.
- Unit 5 felt that the holistic approach is lost because of a breakdown of a comprehensive services.
- Unit 6 denied a decrease in service, but would welcome more staff.
- Unit 7 blamed a lack of funding coupled with a high number of debtors for this phenomenon. They are also not adequately staffed.
- Unit 8 is not subsidized and doesn't want to be dependent on government. They feel organisations need to train community role players to maintain service delivery.
- Unit 9 indicated that it faced financial difficulties.

Despite the variety of responses, there was evidence of a discrepancy regarding the role and actions of the state in terms of treatment and rehabilitation programmes.

Emerging documents talk about one-stop community service delivery. Respondents were asked their opinion on this.

- Unit 1 does not agree. They do not think service delivery will be as effective.
- Unit 2 believes it is a very good idea. Substance abuse is about the multi-disciplinary approach, where longer after-care can take place.
- Unit 3 feels that it could work if implemented properly and there is proper collaboration.
- Unit 4 agrees that it is a good idea, but it must cater for all the needs of substance abuse.
- Unit 5 believes that for the chronic dependant, isolation is important.
- Unit 6 is not in favor.
- Unit 7 feels that careful consideration needs to be given to planning and design of such a facility. Existing facilities should not be used; for example NWP should not be used to administer pensions, etc.
- Unit 8 thinks it's an excellent idea. The multi-disciplinary approach is ideal.
- Unit 9 did not respond.

There was a variety of responses to the question, which are obviously based on the philosophy and practice of the centers under investigation. It became apparent that the majority of agencies were open to new ideas of which one-stop community service delivery was one. There is some reluctance, however, to new ideas amongst a small number of the respondents.

The Drug Master Plan [1999] and White Paper for Welfare [1997/1998] have direct bearing on policy development. Respondents were asked what, in their

view, are the implications of the decrease of funding on the development of policy in respect of drug abuse/ addiction/ treatment and rehabilitation.

- Unit 1 feels that the decrease in funding means that there is a lack of resources to implement new modules and models of treatment. This results in limited room for growth and expansion of treatment programs. This in effect have negative results for patients at all levels of life.
- Unit 2 believes that while treatment and rehabilitation are costly in the short term, they are not in the long term. There is a need for the "function force" model to be applied to substance abuse. Budget cuts impact on the number of staff and there needs to be reinforced budget constraints.
- Unit 3 stresses that drug and alcohol treatment programmes need to be based on good business plans to be self-sustaining and need to be innovative in fund raising.
- Unit 4 did not want to be drawn into the question.
- Unit 5 felt that more centers will close, fewer staff will be employed and no new programs implemented.
- Unit 6 feels that more staff is needed to provide an effective service.
- Unit 7 believes that the lack of resources will break down the existing service delivery. Treatment will be less intensive due to greater demand, and therefore less effective. There will be more cases of substance abuse as new drugs are introduced.
- Unit 8 agrees that the impact will be negative. With a lack of funding, it is impossible to implement policies.
- Unit 9 refused to be drawn into the question.

Respondents were allowed to make any additional comments or suggestions.

- Unit 1 stressed that South Africa is very much a third world country that has unique problems. These cannot be solved using western methods. To prevent

abuse, programmes must be initiated in schools. This is a must for curriculum development.

- Unit 2 reiterated that staffing must be addressed to ease the burden.
- Unit 3 believes that prevention must start with the youth at an early age. Treatment centers must be comprehensive and multi-disciplinary.
- Unit 4 felt that not all questions could be answered with a simple “yes” or “no”. They also found that dual questioning is difficult to answer. There is a difference between psychiatric disorders and psychiatric symptoms. Psychiatric disorders are not treated at this center.
- Unit 5 stressed the importance of innovations in the field. Have rehabilitation centers tested these innovations? If not, why? There is also a need to look at new models of treatment.
- Unit 6 felt that longer questions needed to be broken down into shorter sections.
- Unit 7 believes that :
 - Drug policy and rehabilitation policy needs to have input from all cultures.
 - One plan does not cater for everyone.
 - Service providers and role players need to take responsibility in understanding the disease and many people’s lives are dependent on adequate treatment of a patient.
 - There needs to be an end to moral judgement and a promotion of empowerment of spouses and families to stop enabling the disease.

The unit wants to also point out that all personnel at the center are all involved in the center’s treatment of alcoholism, drug dependence and gambling addiction.

These were very important interventions and thoughts that need to be seriously explored, researched and investigated at all levels of government and concerned institutions that care for the patients of all walks of life , cultural and religious

backgrounds and the like .It is important to re-examine and re-invent the culture of understanding and serious and comprehensive implementation with all their theoretical and practical connotations and presuppositions.

The representatives of units 8 and 9 were not prepared to make additional statements.

4.2 THE MEMBERS OF THE MULTI-DISCIPLINARY TEAM

As has been already stated it was felt appropriate that individual members of the multi-disciplinary groups associated with each of the centers should be interviewed on various aspects, stages and processes of treatment as well as their repercussions . It was felt that such a research initiative would open the researcher to new interpretations, thoughts , attitudes and ideas. Thus while it is understood that a center could operate as an entity where the collective aims, objectives and effects would be streamlined and widely agreed upon , in the case of the individuals new angles and perspectives could surface. This because even in the case of a principled and uniform center position, individual and professional ideas, positions and initiatives could lead to a more mature, innovative and successful treatment .

It needs to be said that within the principled and unified position of a center , individual ideas and practices applied in the treatment process can be invaluable ingredients of success, hence the decision to seek the empirical manifestation of their positions . This despite the fact that in most cases in the center's choice of treatment the collective will and decisions supercede those of the individuals in most , if not all, cases.

The vast majority of respondents were well educated professionals including :

- * 9 Nurses
- * 9 Social workers
- * 5 Occupational therapists
- *5 Doctors

This reality alone indicates that the group of individuals chosen randomly as explained in the methodology section had the necessary credentials, professional and educational capabilities , as well as the experience ,in order to give their ideas, attitudes, opinions and feelings regarding drug addiction, its characteristics, aspects , angles and complications , thus enriching the validity and viability of the present project. Nine of them had their work experience at their present place of employment, while the rest in various other units and centers.

Of the twenty eight professional interviewed 3 were between 20-29 years of age , 12 were between 30-39 years of age, 5 were between 40-49 years of age and 8 were over fifty years of age . It can be seen then that this was a relatively young group of professional with experience in rehabilitation and treatment.

In the question *Did you receive any specialist training in the field of drug abuse treatment and rehabilitation?* , 21 answered in the affirmative and seven said "no". This question is of importance as generally professionals in the field are in constant need of upgrading their existing training as new theories and practicalities become available both nationally and internationally . This means that in many ways it is important that professionals at all levels of the hierarchy become accustomed to new specialist forms and ways of training on the field. In

our case the majority of positive answers pinpoint a high level of knowledge and specialised training in the field of drug abuse treatment and rehabilitation.

Four respondents had worked between 1 and 2 years , 7 between 3-4 years, 6 between 5-6 years and 11 had worked more than 7 years . This array of experience indicate a more or less youthful group of individuals with certain levels of service and maturity in the field.

The researcher stipulated in the first page of her questionnaire that "the treatment process for drug abuse /addiction should be focused on positive outcomes, prevention of relapse and re-integration into society . For this a holistic programme of treatment is needed".

This is a "generalist" statement based on the belief of the researcher , upon which the rest of the questions were based . It is a general statement that epitomises the wider context associated with rehabilitation and treatment generally. The first set of questions were associated with the pre-treatment stage , which preceded those associated with the various stages of treatment and rehabilitation generally.

THE PRE-TREATMENT PHASE

The pre-treatment stage is very important in the process of rehabilitation as has been stipulated earlier . Thus it was thought that a number of questions would identify the opinions, ideas and practices of the individuals chosen within the centers groups in relation to this vital process.

The first question ('What are the issues to be discussed here?:') meant that the researcher expected answers (including possible multiple responses) regarding

the issues pertaining and discussed amongst the members of the team during the pre-treatment phase.

There was a variety of responses associated with the question , which indicates that there have been differences in the approach regarding this stage. There were multiple answers to this question, which are recorded below . The answers are recorded as given in the questionnaire that appears in the Appendix.

TABLE 4.4 ISSUES DISCUSSED AND CONSIDERED DURING THE PRE-TREATMENT PHASE

Motivation for treatment	6
Details of programme	1
Preparation for admission	2
Examination of rules of the center	2
History of patient	4
Family history	2
Psychological profile of patient	5
Resistance	2
Expectations for treatment	4
Family involvement and support	6
Education of patient	3
Disease denial	5
Referral considerations	2
Type of drug abuse	4
Previous intervention	4
Effects on family life	1
Ability to pay fees	2

Agreement to stay for prescribed time	1
Social aspects of disease	1

It can be said that the majority of issues discussed and considered during the pre-treatment phase constitute the foundation of a solid continuation of the treatment process , as it has been discussed earlier. The fundamental tenets of this phase are important in the planning and implementation of the treatment process , and its ultimate success or failure.

The majority of responses were related to the psychological profile of the patient in combination with his/her family history as well as the family involvement and support. It was stressed that the family component and element, especially in this phase was equally important to that of the psychological assessment and profile of the patient. In fact , it was said that these two key elements could not be really separated , as they were integrally related to the progress and development of the treatment.

Disease denial was described as an important part of this phase . It was considered obvious that if the patient was in denial of his/her condition it could be difficult to even start contemplating a viable treatment process. It was said that there were many cases where the denial of the reality on the part of patients was evident .This was a serious impediment to the process of planning and implementation of a solid treatment .Disease denial has been considered a vital deterrent of progress in such cases , because in professional circles that

consider abuse as a disease there are not really other alternatives of planning and implementing treatments of a different kind.

The motivation for treatment is considered an vital component of the pre-phase although 6 respondents mentioned it. This is because the patient and the people in his/her surrounding environment need to have certain levels of motivation for the treatment to be successful . As one of the interviewees said :

“The relationship between motivation and desire for treatment with the pre-phase component is of crucial importance , as it gives the impetus to the professional team , both individually and collectively to assess the situation and plan accordingly. If it is felt that the motivation is in fact lacking , it is important to make alternative plans, to think accordingly and thus, plan accordingly. In most ways it is well-known to professionals that these phases are Inter-related and have their own intertwined dynamics , but the individual motivation as well the family motivation in this process are of vital importance. There can be no forward planning without this”.

The type of abuse as well as the type of drugs used was considered an important aspect of this phase, and it can be understood that such situation bears serious significance to both processes and outcomes. One would agree that there is such a wide variety of drugs on the market at present , and although in the end they have the same disastrous repercussions for the abuser, the reality is that some do more damage and harm individuals than others . Hence the type of abuse and the type of drugs abused is widely considered an important aspect of the pre-treatment phase.

The history of the patient is seen as an important aspect of the pre-treatment phase because the professional teams and individuals associated with the process can make more accurate assessments based on the recorded data and

past realities of this history. Evidently a patient with a history of relapse will be considered differently from one who has not faced such a reality. The professional team sees the history of the patient as an integral part of the process that also includes:

- Previous Intervention.
- Assessment of the problem .

These two steps were also mentioned and considered seriously in the pre-treatment and admission phase as they are directly linked to the holistic understanding of the patient's situation. Previous interventions are important fields of study and understanding of the steps undertaken as well as the success or failure of such endeavours. The lessons of past historical experiences in this sense are considered of vital importance in the pre-treatment and admission phase as they are considered determinants in the future direction of the addict's and his/her family's life.

The assessment of the problem is obviously another integral part of the same process as these steps are interrelated and intertwined . It is difficult to imagine a parallel and not an intertwined process in relation to these steps both in the pre-admission , as well as the admission process.

Referral considerations and the examinations of the rules of the center were mentioned by a number of individual respondents as considerations of the pre-admission phase. These are serious considerations of a professional nature , which in the end can be seen as procedural , or even bureaucratic in nature. In effect it is understood that even health professionals associated with the scientific and humane treatment of drug abusers are obligated to follow the prescribed rules and procedures of their center . Referral is a very important professional issue and decision that requires knowledge and concentration .It is

difficult to admit someone for treatment if the rules and regulations of the professional establishment are not followed.

Educational planning as a pre-requisite before admission is directly related to all aspects and steps identified above and could only be decided upon if the resistance of the patient is not evidently strong . In such a case it is very difficult if not impossible to even plan , let alone implement educational steps and initiatives that could lead to treatment and rehabilitation. As one of the interviewees said:

“Resistance on the part of the prospective patient in the pre-admission phase is very important to be determined , because without a clear understanding of its levels and tenacity it would be difficult to make future plans of the educational and other components that follow the pre-admission phase. Life has tough us that there are different levels of resistance in such situations and this is the effect of past history, life and family circumstances and the like . It is impossible for us to even contemplate educational steps without having assessed the resistance levels of the patient , even in the pre-admission phase. In fact in most cases professional centers ensure that the existing levels of resistance, if any, need to be determined very early in the process”

The ability to pay fees and the agreement on the part of the prospective client to agree in staying in the institution for the prescribed time were seen as of importance by a small group of individual respondents. These are realities associated with the financial existence and viability of the several institutions within the community and society at large as well as the determination of the prospective patient to commit herself/himself to stay for the prescribed time in the center. These commitments are seen as real and tangible , because they are a measure of the determination of the prospective patient in achieving the cooperation with the institution in all phases of treatment and rehabilitation .The

economic/financial issue is of vital importance as one of the interviewees indicated:

'There is no more vital issue for the vast majority of centers in the province and the country than the financial viability of the various centers and institutions. In most of them the situation is so bad that the real first question we ask the prospective patient is whether they have the money to pay for the treatment. We are not prepared to compromise our ethical or professional standards and morality , but there is the inevitability of financial survival of the existing staff. There are programmes and centers that operate with skeleton staff , and people who still have a job ask for how long this situation will continue. We all believe that these are questions that need to be asked honestly if professionals are serious , as they are about their duties. The financial questions relating to the structures , functions and outputs of centers are of central significance”.

The preparation for admission and the details of the programme to be followed were also considered by a small number of interviewees as important aspects of the pre-admission phase. It is obvious that these are directly related to other intertwined aspects of this and subsequent phases in the treatment process. The details of the programme are inevitably linked with the other interrelated aspects of the pre and after admission realities, procedures and criteria.

It can be said , that, overall there was a wide variety of expressed feelings regarding issues discussed and considered during the pre-treatment admission phase . It became evident that even in cases where the interviewees did not really make the connections of all these different aspects obvious , overall there was a strong relationship between these aspects . A holistic comprehension in this sense is of importance in understanding these intertwined realities in the pre-admission phase.

Every stage in the treatment cycle has inevitable outcomes and results that determine its success or failure in the rehabilitation process. Thus the next question to the individuals participating in the study (*What should the outcome of this stage be?*) was structured in order to assess the attitudes , opinions and ideas of the respondents regarding this important aspect in this process. The following responses were recorded :

TABLE 4.5
OUTCOMES OF THE PRE-DETOXIFICATION STAGE

Acknowledgement of the problem	6
Commitment to treatment on the part of the client	8
Admission	4
Holistic approach to treatment	4
Definite booking	1
Assessment of client	3
Coherence between social history and diagnosis	3
Abstinence	2
Cooperation on the part of the client	3
Treatment plans	3
Preparation entry into the programme	2

It is thus obvious that commitment to the treatment on the part of the patient is considered the most important outcome of the de-toxification stage. This is important in the sense that the life , experiences and tribulations of a patient are

of crucial significance in the decision to commit oneself to treatment. As one professional put it:

" Only those who have been involved in such experiences as professionals can really talk of the problems evident in the various stages of treatment , especially the first one. This is a very vital stage , I would say the foundation of a proper building of confidence and potential success. If the first stage leads to commitment on the part of the patient , the forthcoming battle has been almost won. It is important for the professional and the team to win the commitment in this phase and this coupled with other aspects of the problem such as the acknowledgement of the persons condition could make a difference in the efforts ahead".

The acknowledgement of the problem is also considered a key outcome of the first stage as in many cases the patient as well his/her immediate family environment are on a "negation/denial phase" , they refuse to understand and acknowledge the existing condition even in cases where the situation can be described as serious. This is due to a multiplicity of reasons, and creates serious impediments to the forthcoming process. As one senior social worker commented:

" In most communities there are beliefs that the patient is not that bad , his/her situation does not warrant treatment, In many cases the patient is in denial .For these reasons a key issue for the process to continue and be successful is the acknowledgement of the problem. This is a big step forward as it becomes the start of things to come, it presupposes the commitment of the patient and his/her family that will ultimately led to successful treatment. Denial of the condition is an international phenomenon that has been seriously studied and a serious hurdle to both diagnosis and treatment".

Admission to the treatment was considered the outcome of the pre-detoxification stage by several respondents as was the holistic approach to treatment. Obviously admission to treatment would be the outcome of several other key issues such as commitment on the part of the patient , acknowledgement of the problem and the like , while the holistic approach to treatment could be seen as a natural step towards the comprehensive face-to face attention of the treatment programme.

Assessment of the client and coherence between social history and diagnosis of the client are interrelated aspects considered important steps regarding the outcome of the stage under consideration. Assessment of the client inevitably incorporates coherence between social history and diagnosis , which in turn is directly related to the cooperation of the patient . These are in fact “links of the same chain” of events, inputs and outcomes in the complex relations associated with the de-toxification process As one practitioner of many years admitted :

“ The realities of the situation in the first stage inevitably lead us to a series of thoughts and plans that need to be implemented in the process. Each patient has his or her own history , differences, outlook , family circumstances and the like . It is up to us and the patient to streamline the relationship from the outset, to examine the particularities of the case, to ensure commitment and determination to treatment before the admission and the implementation of the plans. Then the economic issue needs to be solved , because most centers face serious financial problems and there must be commitment and understanding all around. When these things are decided upon then the decision to start the process is taken and the professional team is prepared to start the effort”

The responsibility for the preparation and implementation of this stage was the subject of the next question (*Who should be responsible for this stage?*). The

question was set in order to ascertain who were the people or groups considered to be responsible for the process that pre-empts detoxification. It is asserted that different centers/units assign a variety of individuals or groups the responsibility to undertake the process before detoxification .The following were the responses:

TABLE 4.6 PEOPLE OR GROUPS RESPONSIBLE FOR THE PRE-DETOXIFICATION STAGE

The patient	6
The family	6
The therapist	3
The Administrative Secretary	3
The Doctor	5
The Superintendent	1
The multi-disciplinary team	8
The employer of the patient	2
The in-house social worker	3
The outside social worker	2
The referral agent	4
The assessment worker	3

It is evident from the responses to the question that there are different ideas, opinions , attitudes and philosophies at work in relation to this aspect of the research. The variety and multiplicity of answers indicates different mindsets indeed, ideas that are influenced by a variety of perceptions, beliefs and shapes philosophical and life experiences and circumstances.

Contrast for example the majority of respondents (N=8) who said that the "multi-disciplinary team" should be responsible for this stage , and those who mentioned "the Administrative Secretary" (N=3). These are responses emanating from completely differing philosophies , as the latter one underlines a financial, administrative and generally technicist understanding of the process , while the former looks at the reality of the first stage and its proper social and human dimension. Inevitably , however , such diverse opinions and understanding of an arduous and painstaking process are understandable.

The role of the family (N=6) is considered important by the interviewees , as are the input of the therapist (N=3), doctor (N=5), the in-house (N=3)and outside social worker(N=2) , the referral agent (N=4) and the assessment worker(N=3). All these persons play key roles according to the individual respondents in carrying responsibility for the stage under investigation.

The employer of the patient has also been mentioned in this context as he/she would possibly be responsible for the financial aspects of the stage and the various other work-related details such as special leave and the like. For two interviewees the role of the patient's employer is a key ingredient for the future success of the effort in the future. Eight respondents mentioned the multi-disciplinary team as a key element of the process.

In regard to the length of the detoxification process (which will be examined in more detail later)14 respondents indicated that it should be between 3 to 6 days, 10 stated that it should be between 6 and 10 days and only two said that it should be between 9 and 12 days. It can be gauged then that the different approaches and philosophies advanced by the various individuals operating in the centers are evident . In some ways it has been argued that possible financial consideration could be seen as having an influence in such decisions . As one of the interviewees pointed out:

“One would not expect all individuals and agencies to have a uniformed opinion on such matters , and this is the result of a different understanding of the drug addiction as a social phenomenon. However in the last few years several agencies and their leadership teams have changed their attitudes and procedures , especially in terms of the various stages of the treatment , including detoxification. There is strong evidence that instead of a five day detoxification period a 10-day period has been adopted and one of the strongest motivations for such a change is financial considerations .This is not even disputed by such agencies , as the economic burden is a threatening factor in our functions and the society we operate within. Several years ago we would not say no to poor people who could ill afford to pay their fees , but circumstances today are very different . We cannot help our case by retrenching our own people and have no staff when society needs our help, however the reality is that we have to also live like human beings and our agencies deserve to survive because of the work we do”.

These were the exact words of the interviewee , despite the fact that it is well known that the detoxification process becomes more expensive when extended.

DETOXIFICATION/MEDICAL INTERVENTION

This section of the empirical work will concentrate on the analysis of the process of detoxification/medical intervention as an integral part of the treatment process. It follows the first stage already analysed in the previous section , and will concentrate on the understanding of the respondents of what does

detoxification consist of and what the outcome of this process should be. These are key elements for the researcher to understand in order to empirically examine the various attitudes, opinions and ideas of the respondents as well as their feelings in relation to the anticipated outcomes . The last part of the analysis will assess the opinions of the interviewees regarding the length of the detoxification period.

The first question in this section (*What does detoxification consist of?*) was set in order to assess the ideas, opinions and beliefs of the respondents regarding this important aspect of the treatment process.

The responses were as follows:

TABLE WHAT DOES DETOXIFICATION CONSIST OF?

Mental intervention	1
Treatment of physical symptoms	1
Medication to help patient	7
Drying out of person	2
Non-addictive medication	9
Referral to hospital	3
Resuming their normal stage	1
Group therapy	1
Vitamin therapy	1
Occupational therapy	1
Vitamin replacement therapy	1
Education and motivation	1
Blood tests/Physical examination	1
Motivational groups	2
Acceptance of programme	1

It can be seen that the majority of respondents have considered non-addictive medication as the main ingredient of detoxification , while the second most popular response was medication to help the patient. Obviously even in this case the most possible understanding of the concept medication ought to mean "non addictive medication". However for the sake of categorising the opinion of clearly defined medication the two responses were separated. In their meaning however , these two responses are similar as it is evident that in both cases the underpinning desire is the correct treatment of the patient and his/her complete recovery. The categorisation of the two different responses in conceptualising medication was described by a medical doctor as follows:

" In such a question , it is difficult not to have confusing signals as regards medication. Medication to many people is very important to detoxification, it all depends on the programmes and the ideas of the team leadership, its outlook to things , the patient and the treatment. However one cannot expect a qualified medical doctor to talk with the same scientific language as a social worker who has a very broad generalist knowledge of drug abuse and she is possibly much better than the doctor in therapy , but lacks the details of the chemical treatment , including the medicines. Non-addictive medication to a specialist could mean simply medication to a professional non specialist"

The referral to hospital is another approach to the question , which is possibly also directly related to the provision to medication . This obviously differs substantially from the position of one respondent who called for 'mental intervention', and another one who called for the treatment of physical symptoms .There are positions that are clearly correct, as it is true that

detoxification ought to vary from person to person as the process needs to take into serious account the experiences, historical conditions and particularities of the patient.

Group therapy, vitamin therapy , occupational therapy, vitamin replacement therapy , education and motivation, motivational groups and counselling constitute realities that can be seen as integral parts of a detoxification process by a large number of researchers and practitioners. The mere fact that they were mentioned by very small numbers of interviewees when compared with the much larger numbers of those who considered medication as an important ingredient of detoxification, indicates differences of opinions, philosophies and approaches evident amongst the individuals interviewed. This is a reflection of a wide variety of educational and intellectual attainment of the people represented in the sample that were interviewed in the context of the empirical study.

Directly related to the question of what detoxification consist of is the follow up issue of what should the outcome of detoxification be. This was the subject of the following question that elicited the following responses :

TABLE 4.8 PROSPECTIVE OUTCOMES OF DETOXIFICATION

Physical and psychological readiness	5
More balanced person	5
A more stable person	6
A motivated person	4
A more settled person for treatment	4

These were responses that could be seen empirically as very similar in nature. In fact it can be said that the expected outcomes of detoxification as seen by the

respondents concentrated on the positive side following the detoxification process . Thus the response “physical and psychological readiness” is basically synonymous with a rehabilitated addict who has reasonable emotional stability.

On the other hand , a “balanced person” signifies a detoxicated person who feels relaxed and in a state of equilibrium without physical or emotional discomfort. A more stable person means someone without significant symptoms of withdrawal and committed to changing of his/her previous lifestyle. This is also synonymous to a certain degree of motivation to succeed , which will be a barrier to a possible relapse.

Regarding the length of the detoxification process :

*14 respondents said that it should be between 3-6 days.

*10 respondents Indicated that it should be between 6 and 9 days.

*Two respondents said that it should be between 9-12 days.

It is evident that the respondents have a variety of opinions regarding the length of the detoxification process, while it is widely accepted that a period of between 6-9 days can be considered the optimal option depending on the condition and response of the individual patient to the treatment.

Detoxification is a vital process in the treatment cycle and its success has direct positive effects on the patient. This means that the group or individual/s who run the process are instrumental in the success or failure of such an exercise. Inevitably the next question to the individual practitioners was who should assume responsibility for therapeutic intervention and why. The responses have been reproduced in two separate tables below:

TABLE 4.9 WHO SHOULD BE RESPONSIBLE FOR DETOXIFICATION

Multi-disciplinary team	6
Doctor	5
Medical team	2
Professional nurses	6
Social worker	6
Psychiatrist	3
Family and client	5
Psychologists	4
Councillors	2
Religious leader/mentor	1
Referral agency	1

It is obvious that the majority of respondents , who do not even constitute half of the sample, believed that the multidisciplinary team should be responsible for the detoxification stage. This is followed by the belief that social workers and psychologists should hold the responsibility for the process.

Another group of respondents felt that doctors and medical teams should have the responsibility for the detoxification process. This pattern of responses indicates a strong belief on the part of the interviewees that detoxification is an integral part of the "disease" treatment .Medical teams assume responsibilities for diseases and hence they need to be in charge of such detoxification processes. As one of the respondents advocating this responsibility said:

" In our center there is no doubt in our minds who has the responsibility for the detoxification process. Although we are aware that a multi-disciplinary team has

a role to play in the long run , the immediate and most important responsibility is with the medical team. This because detoxification is seen a vital process in the treatment of the disease and highly qualified and skilled practitioners need to be leading the process. The reputation of our center is our first priority and we cannot afford to let things slip from our hands , we need to give the best to our clients at all levels and we have decided that the best we can give them in terms of detoxification is the responsibility of the medical team”.

The multi-disciplinary team was named by a good number of respondents as the team responsible for detoxification, while social workers and nursing sisters were also mentioned in the responses. Two interviewees indicated that a psychiatrist should assume responsibility for the detoxification process , while one respondent stated that the client and his/her family should be responsible.

TABLE 4.10 REASONS GIVEN FOR THE RESPONSES

Multi-disciplinary team is holistic	3
Medical personnel avoid complications	2
Observation is crucial	4
There must be personnel who will be able to give injections	5
There must be proper medication offered	6
Personnel must be trained thoroughly	3
Safety must be ensured	2
Patient must make decisions	3

There was a variety of reasons given for the responses recorded earlier:

- The multi-disciplinary team was considered the best option in assuming responsibility because of its holistic composition and approach. This means that the fact that the team consists of members of different and diversified professionals guaranteed service delivery of high quality. Having expertise in a variety of fields associated with treatment allows the patient to be looked after in this process in a thorough, scientific and professional way. It was said that each member of the team had a positive contribution to the well-being of the patient and an impact on the overall therapeutic process.
- The medical team and the medical doctor alone which were quoted as responses earlier were seen as necessary for the observation of patients and the dispatching of proper medication. Initially the doctor and/or existing medical teams have the expertise to assess the physical damage of the patient adequately, unlike the other professionals, so they can provide the necessary help.
- Those who believed that the patient and his/her family were ultimately responsible for this stage meant that without their commitment and dedication to a serious and final treatment this could not be achieved. This was precisely because the patient and his/her family were ultimately responsible for their change in behaviour and attitude.
- The other professionals and practitioners mentioned as being responsible for the detoxification process were identified because of their diversified skills and expertise. It was thought that the variety of professional help on the part of such experts could have a beneficial and positive effect on the patient and could help him/her in the expected endeavours.

THERAPEUTIC INTERVENTION

Therapeutic intervention is another stage in the struggle against drug addiction and the road to rehabilitation. Thus it was inevitable that the researcher would identify, examine and analyse key issues and aspects of this process . The first question associated with this thematic section was "What is therapeutic intervention?"

The responses appear in the table below:

TABLE 4.11 WHAT IS THERAPEUTIC INTERVENTION?

Sessions between therapist and patient	4
Support groups	3
Treatment programmes	5
Counselling	8
Group sessions	6
Individual sessions	4
Input of professional groups	2
A holistic approach to a patient	6
Intervention by a group	2
Attempt to modify a patient's behaviour	1
Helping a person	1
Structured therapy	1
Responsibility enabling the patient	1

It can be seen that there is a wide array of opinions and attitudes regarding therapeutic intervention . It can be seen that the most quoted "definition" of therapeutic intervention was "counselling" (N=8), followed by "group sessions" and a "holistic approach to a patient" (N=6) respectively. A practitioner or researcher who understands the inner dynamics of the concept and its practical implementation cannot really see much difference in these definitions , but it was evident that therapeutic intervention can be also understood as the intervention of various professional groups who attempt to modify the behaviour of the addict through some forms/s of structured therapy.

Therapeutic intervention as a stage of the treatment and rehabilitation process is expected to produce outcomes in relation to the patient. The interviewees were asked what were their anticipation of these outcomes. The following were the responses:

TABLE 4.12

PERCEIVED OUTCOME OF THERAPEUTIC INTERVENTION

Improved functioning	5
Balanced lifestyle/sobriety	4
Coping skills	4
Motivation	2
Change of behaviour	5
Knowledge acquisition	4
Abstinence	4
Positive outlook	3
Improved self-esteem	4
Increases understanding	4

Improved functioning was the most anticipated outcome of therapeutic intervention , while sobriety with a balanced lifestyle was also prominent in the responses. Such reactions are basically associated with the ultimate achievement of family re-integration, which is also the result of the acquisition of multi-disciplinary coping skills on the part of the patient. One needs to understand however, that such acquisition is not easy to be achieved .

Motivation and change of attitude on the part of the patient is very important , because these are instrumental against the denialist tendency with a change in lifestyle and the resultant pattern of societal interaction on the part of the patient. As one medical practitioner with many years of experience said:

“ The patients acquisition of knowledge of their disease is important in that they learn about themselves and thus they become motivated to succeed .There are of course different attitudes and reaction to the various stages of treatment , but the educational processes generally equip the patient with coping skills and better insight on themselves. This aspect of treatment is not sufficiently emphasised in the various academic and practitioner debates, because improved functioning is a complicated process , and things need to be done thoroughly and professionally in order to arrive at such a successful stage” .

One of the expected outcomes of this stage of treatment is the continuous improvement of the self-esteem of the patient that leads to self-belonging and the re-establishment of family ties .These ultimately lead to the enhancement of coping mechanisms both within the family and societal contexts.

The presupposition of such achievements is that there is accountability in the implementation of therapeutic intervention , coupled with abstinence and the rejuvenation of a positive outlook to life. A better equipped person is possible in the case of successful implementation of this stage of treatment, a person who can face reality and deal with his/her own problems adequately through a balanced lifestyle.

The prevention of relapse is a vital link in such a sequence of achievements as the restructuring of the cognitive and material behaviour of the patient becomes a tangible reality .

In relation to the question "How long should this stage be?" 16 respondents indicated that it should last between 3 and 6 months , 5 said that it should be between 9 and twelve months and three that it should be between six and nine months.

Therapeutic intervention , like all aspects and stages of treatment and rehabilitation needs to be specifically aimed at targets associated with implementation outcomes. Different practitioners , obviously have diversified perceptions and ideas regarding this aspect of the treatment process. Thus the next question was set in order to identify these opinions and perceptions (Who/What should therapeutic intervention aim at? Why?) .

The responses , including the reasons advocated by the interviewees appear in the following tables. If the number of responses do not sum up to the number of respondents (N=28) , it must be assumed that there was a number of interviewees that did not answer the question.

TABLE 4.13

TO WHO/WHAT THERAPEUTIC INTERVENTION SHOULD BE AIMED AT?

Help patients deal with addiction	1
Patients who are able to function at a certain level	2
Problems that are caused by addiction	1
Patients	7
Family	
Other role players	5
Educating the patient	1
Enhancing coping skills	1
Prevention of relapse	1
Recovery	2
Abstinence	2

These responses can be categorised as follows:

- One category of responses is identified as the person/s at who the process is aimed at , and this received the support of the majority of the interviewees. In this category the patients , family and other role players , such as friends and acquaintances and employers are included . It is obvious that these are the most important physical entities at who the processes are aimed at .
- The second category of responses is associated with functional or structural requirements and processes associated with this stage of the treatment, such as the education and commitment of the patient, the enhancement of his/her coping skills and the prevention of relapse that will ultimately lead to abstinence and potential recovery .

- However these two categories of responses are inextricably linked in a causal and inevitable relationship . It is precisely these people involved in the treatment programme , together with the attributes and skills acquired that would ultimately make the difference that could lead to recovery and the prevention to relapse.

TABLE 4.14 REASONS GIVEN FOR WHO/WHAT THERAPEUTIC INTERVENTION SHOULD BE AIMED AT

Help patient to look after himself/herself	1
Patient can reach better understanding of processes	3
Will change his/her life	3
Will motivate participation in programme	3
Will help patient participate actively	1
Will re-examine behaviour	2

The reasons given are easy to understand as they are directly related to the positive aspects of such a process , as every stage in the treatment planning and implementation are designed to help the patient to re-examine and change his/her behaviour and lifestyle and reach better understanding of the various stages and outcomes of the treatment. For these to be achieved active and constructive participation in these processes are of key importance.

AFTER-CARE / PREVENTION OF RELAPSE

After-care and prevention of relapse are stages in the process of treatment that would stamp the ultimate success or failure of the plans and implementation of the various stages that have been examined so far . The key issue is that there cannot be successful treatment in the wide sense of the word if there is relapse. In other words a successful treatment, which presupposes successful step by step implementation will eliminate the possibility of relapse .

The questions associated with this section of the thesis sought to examine various key aspects of after care and relapse prevention and the prevailing relationships between the main role players .The first question was "What is after care and relapse prevention?" .The responses appear in the following table:

TABLE 4.15 WHAT IS AFTER CARE AND RELAPSE PREVENTION?

Maintaining sobriety	4
Services provided by referral agency	1
Assessing programme of client after discharge	3
Management of client after treatment	2
Steps to ensure that patient stays sober	3
Helping client to maintain abstinence	2
Helping client to maintain a healthy lifestyle	1
Education of the client	2
Addressing client's vulnerable behaviour	2
Provision of support services	1
Follow up on the condition of client	3

Support and encouragement to client	2
Assessing and helping the client to a new life	6
Mptivation of the client	3
Guidance of client towards a balanced lifestyle	2

Although there is a variety of responses/categories created in the analysis of the replies of the sampled practitioners, the maintenance of sobriety (N=5) and the assessment and help of the client(N=6) are the most frequent responses .These signify in the words of the respondents the devising of a monitoring system that assesses the progress of the client after his/her discharge from the particular center. Relapse prevention is associated with steps undertaken by the institution in collaboration of the family and the patient in order to ensure the continuation of sobriety achieved during the treatment.

These steps and processes can be achieved through the continuous contact with the client and his/her family environment , and serious efforts to educate him /her in handling problems , stress and physical and psychological problems.

Continued supportive and well-structured action on the part of all role-players involved can enable the client to operate independently , be able to control a potentially vulnerable situation and not fall into the relapse trap. All these are integral parts of an aftercare strategy .In such a process whenever possible the patient keeps in touch with support groups outside his/her family environment , including NGOs such as SANCA or even as an interviewee suggested Alcoholics Anonymous.

The patient at this particular stage needs to be reminded strategically of the continuous hurdles in the road to complete sobriety and the arduous path that leads to the prevention of relapse. It has become obvious from the responses that the social worker has a key role to play in this process as he/she is in most cases instrumental in organising after-sessions held to discuss pertinent issues of the problem/s the patient faces in the outside world.

It is not easy even for a rehabilitated patient to achieve sobriety without an uphill battle .Thus ongoing moral, spiritual and psychological support are important ,and motivation of the patient and his/her family play a key role in this process. This needs to be seen in the context of addiction, which is the result of an uninterrupted series of events and conditions that does not occur overnight. In the same vein it cannot be treated overnight, and the patient needs professional and family guidance in order to prevent relapse.

The role of the community can also be seen as important , because the way the people will react toward the patient will play a role in the future prevention. Peer and neighbourhood groups can turn either into support or counterproductive influences. In this sense the family and spiritual leadership of the patient needs to be alert to the existing realities of the social situation in the community.

The next question of the section was "Who/what should after-care be aimed at?". It was a general question that was set to assess the opinions of the practitioners . The categorised responses appear in the next table:

TABLE 4.16 WHO/WHAT SHOULD AFTER CARE BE AIMED AT?

Helping client to sobriety	4
Patients	13

Families	11
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The responses as can be understood revolved around the individual (the patient) , the group (families) and the “end result” (helping client to sobriety). Within these categorised responses , however, a wide variety of meanings, attitudes and opinions are concentrated. The re-adjustment to society on the part of the patient for example means a concerted effort for his/her incorporation and acceptance into the wider community as a sober person that has defeated the addiction. This cannot be achieved without the recreation and maintenance of close supportive relationships amongst themselves. The role of the community and spiritual leadership accepted by the person/addict are of equal importance.

The outcomes of after-care was the subject of the next question , as it is obvious that after care and the ultimate success of relapse prevention depend on the outcome of after care .The responses to the question are found in the following table:

TABLE 4.17 WHAT SHOULD THE OUTCOME OF AFTER CARE BE?

Abstinence	9
Improved family life	2
Change in behaviour	2
Evaluation	1
A better, drug-free person	1
Support and care of the client	4
Long term support systems	1
Decrease in relapse rates	3
Recovery	3

Building an active citizen	2
Client can cope with pressures of society	2

It can be seen that abstinence is seen as the main outcome of after care (N=9) , followed by the response "support and care of client". These in their own way can be seen as slightly different from one another as response categories. However , In fact they are not ,as support and care of the patient are in actual fact a *sine qua non* of abstinence. This because abstinence , or its ultimate achievement is not an easy process as family support and motivation, as well as evaluation of the patient's situation are vital in the process of rehabilitation.

The support and care of family as well as other role players can lead to sobriety and thus address seriously the question of possible relapse .In this the building and maintenance of support systems can lead to the successful management of problems and thus decrease the possibility of relapse.

The rest of the responses reflect these important realities that lead the person to the strength to cope with everyday pressure and the increasing demands of life and thus prolong sobriety and avoid relapse that could lead to new , more serious problems .

Regarding the question "How long should the after-care programme be?" 17 respondents indicated that it should be between 12-14 months, 6 said that it should be between 24 and 36 months and 3 believed that it should be between one and 12 months. Two did not answer.

The question "Who should assume responsibility for after care and relapse prevention?" was of importance as it was set to identify the opinions and

attitudes of the respondents towards this key aspect of the post-treatment period. The responses are recorded in the following table :

TABLE 4.18 WHO SHOULD ASSUME RESPONSIBILITY FOR AFTER CARE AND RELAPSE PREVENTION ?

Family	10
Church/Religious institution	3
Community	6
Patient	10
Social worker	9
NGOs like SANCA	1
Psychologist	2
Councillors	1
Relevant Agencies	2
Support groups	3
Referral agency	2
AA	1
Therapeutic multidisciplinary groups	4

An equal number of respondents (N=10) mentioned the family and the patient as those destined to assume responsibility for the after care and prevention/ rehabilitation process. The other person mentioned in almost equal frequency (N=9) was the social worker , while the role of the community was also emphasised (N=6). The same cannot be seen of multidisciplinary therapeutic teams (N=4) as well as the church, NGOs , relevant agencies, and referral agencies.

It is thus understood that the three most important aspects and forces to drive a successful after care and relapse prevention are individuals or groups of individuals , especially in a combined effort to achieve the required and desirable results. In this respect it needs to be mentioned that after care social workers are considered an almost indispensable source of support .Community based organisations are also seen to play an important role by some respondents.

Overall it can be said that although there is a wide variety of respondents regarding this particular question the majority of interviewees saw the combination of family, the patient and social workers as the most vital ingredients of a successful after care and relapse process.

It is well known that the treatment process is a complex and arduous task for everyone involved .In the last question the interviewees were asked what time frame should the drug addict/abuser prepare him/herself for?

There was a variety of responses with 9 practitioners advocating a 12 month period, 12 a 24-month, 2 a 36 month and 3 a 46 –month period. It is obvious that such positions have been the result of tangible, on the job experience on the part of these interviewees , whose opinions and ideas on the matter have been shaped by such circumstances .

CHAPTER 5

CONCLUSIONS

The dual interview strategy advanced by the researcher revealed a series of interesting and challenging results both at institutional and individual levels.

The treatment team plan and programmes regarding assessments and the role of the multi-disciplinary teams play an important role in the day to day treatment, but there is a sign of conservatism evident in the responses. While the composition of the teams follow international patterns it was evident that the adoption of a series of different models that are somehow out of line with modern progressive thinking can be seen as impediments to the treatment and rehabilitation of the patient. Higher education institutions should keep up to date with international patterns and also at the same time what best practice models they can adapt to their treatment and rehabilitation programmes.

It seems that the focus needs to be on the qualitative service delivery rather than on quantitative expectations. The reliance on the funding policy is a real issue, better equipped and trained professional staff become an asset to rehabilitation institutions. This leaves room for in service training, attending local and international conferences and workshops, thus bringing to institutions new and creative ways of working with substance abusers.

The move away from negative connotations like "illness, disease complete abstinence" and using positive connotations like "knowledge,

support” to empower clients to take responsibility for their own healing.

The study basically examined substance abuse in South Africa by utilising a case study of a number of treatment centers in the country and the challenges posed by drug use and abuse and the treatment and rehabilitation processes at play. These pose a number of serious challenges for South African practitioners at all levels of assessment, treatment, rehabilitation and after care , which have a direct impact on policies, rules and regulations associated with resources, budgets, norms and standards at all levels of service delivery.

In short the thesis focused on both the agencies and the individuals as they are considered vital in the intervention process, the planning and implementation of treatment and rehabilitation .

In the context of the thesis a number of theories and practical assessments was presented and evaluated with emphasis on the various types of treatment, Dubeiko’s theories, the systemic model as well as the functions and responsibilities of the multi-disciplinary team, its types and functions , areas of need and concerns regarding present policies in place.

The assessment of service delivery and its direct relationship with the theoretical paradigms revealed a number of associated problems facing various agencies especially in terms of the implementation of various intervention models that provide the client with the freedom to choose and allows him/her to be the major agent of change in his/her behaviour .

The empirical research indicated beyond reasonable doubt that the ignorance of chemical and other substances leads to inappropriate treatment plans that in the end lead to increased relapse cases .

The study of multi-disciplinary teams as well as individual members, NGOs and private and state rehabilitation centers indicated a variety of responses regarding knowledge and dynamics associated with treatment and rehabilitation , especially in relation to dual diagnosed clients who have fallen through the net due to lack of training theory application and implementation on the part of the multi-disciplinary team.

This process is the direct result of a separation between theory, policy and practice that are not integrated into a holistic pattern that will ultimately lead to rehabilitation and the absence of relapse . It was revealed that agencies do not have the knowledge, skills and time to implement thorough, innovative and new models and policies due to a number of reasons:

- Lack of resources.**
- Overload of work.**
- Lack of knowledge of the theoretical and practical experiences both nationally and internationally.**

Inevitably the only way out of such deadlocks is a comprehensive, innovative programme of treatment and rehabilitation that will meet the unique individual needs of the patient. In this context it is hoped that the comprehensive examination of the various theoretical and practical models presented will be of help for the future.

Large gaps between urban and rural service delivery becomes a policy issue, where the numbers of individuals with pathology and services available needs to be assessed, evaluated and developed. Policy development to meet the needs of those affected are welcomed, but the actual delivery needs much to be desired. (DMP) Institutions carry heavier burdens as the social problem of drug abuse increases. But with little or no extra resources and yet they have to render services according to policy.

It became clear the life circumstances of most patients tie up with the burning realities facing hundreds of thousands of people in South Africa , and that the situation of both individuals and groups in our society deteriorates by the day. This is precisely why crucial and innovative strategies for treatment and rehabilitation are needed for this process to be reversed. Here the goals of policies (WDSW, DMP) aimed at the developmental aspects of society cannot be achieved.

The wide acceptance on the part of the groups of interviewees that drug addiction is a disease dictates the patterns and trends of rehabilitation and treatment. The researcher's exploration of the debates on the issue pinpointed the problems associated with such an approach. The client must be given opportunities for self development and have an equal state in his / her treatment plan.

The application of the step-by step treatment and rehabilitation in the institutions under investigation showed that there is a wide agreement

on the processes as identified in the literature review and subsequent chapters. Thus the commonalities of such processes were evident in the empirical research. This does not mean that the motivational aspects of treatment and rehabilitation showed that there is a compassion for clients amongst the practitioners , but also indicated conclusively the paramount importance of the paucity of financial resources available to many of the centers under investigation. Hence the state policies becomes crucial to the treatment and rehabilitation programmes especially in the state rehabilitation institutions.

The role of the family was proved to be central in the treatment process as was the history of the patient. However a holistic approach was not very common in a number of these agencies. The state at the macro, mezzo and micro levels should shoulder the responsibility of co-ordinating holistic services.

The only hope for the future of humane and scientific treatment and rehabilitation amongst patients in South Africa rests on the scientific understanding of drugs and drug abuse and a holistic treatment plan that stems from this understanding. Circumstances and history of patients differ throughout the world , but the main issue at stake is our common humanity, the Grace of God and the dictates of progressive and humane Science.

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