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“STUCK IN LIMBO?”

An unregistered community organisation and treatment provision for substance abuse disorders:

A Case Study in Mitchells Plain

PHILIPPA BUNKELL

BNKPHI001

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COMPULSORY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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## **ACRONYMS**

AOD- Alcohol and other drug

CBO- Community Based Organisation

CDA- Central Drug Authority

DoSD- Department of Social Development

FAS- Foetal Alcohol Syndrome

FBO- Faith-Based Organisation

HDC- Historically Disadvantaged Community

HSRC- Human Sciences Research Council

MA- Methamphetamine 'Tik'

MRC- Medical Research Council

NDMP-National Drug Master Plan

NIDA- National Institute on Drug Abuse

NGO-Non-Governmental Organisation

NPO- Non-Profit Organisation

SACENDU-South African Community Epidemiology Network on Drug Use

STD- Sexually Transmitted Disease

SUDs- Substance Use Disorders

UCT- University of Cape Town

UNODC- United Nations Office on Drugs and Crime

WHO- World Health Organisation

## **ABSTRACT**

This study is an examination of the structures and functions of an unregistered faith-based substance abuse treatment facility, the Recovery Home, run by a Church in Mitchells Plain, a historically disadvantaged community (HDC) in the Western Cape. In addition, the challenges that the Organisation faces in meeting the policy requirements set by the Department of Social Development (DoSD) to obtain accreditation by subscribing to evidence-based practices for an in-patient treatment centre are the main issues upon which this research is structured. Information was collected, through a qualitative case study approach. Methods used were the in-depth interview, observation, documentary research relevant to the registration process and a confidential journal exercise conducted with people being treated in the Recovery Home. A lack of resources and evidence-based practices prevents the Recovery Home from providing adequate treatment services. The Organisation is unable to register as it does not meet the minimum norms and standards set by the Department of Social Development (DoSD) to acquire accreditation. It has been suggested by the relevant authorities that the Organisation fits the description of a half way house. However, no official policy for the registration of such institutions currently exists in South Africa. The Home's definition of the causes of substance use disorders (SUDs) is inadequate in that it is limited to environmental factors, most particularly the unfavourable socio-economic conditions that prevail in the community. The Organisation is providing a valuable service in a community where the state lacks effective intervention capacity. As it is unable to register, however, it remains limited in what it is able to achieve.

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# 1 CHAPTER 1: INTRODUCTION

## 1.1 INTRODUCTION

There are a number of central issues that motivated this research project. The first of these was the problem of substance abuse and substance use disorders (SUDs) in the Western Cape. Secondly, the limited access to treatment for individuals with SUDs in historically disadvantaged communities (HDCs) due to non-structural and structural barriers. Thirdly, treatment being provided by unregistered treatment facilities which do not make use of widely accepted evidence-based practices. Lastly, challenges created by Department of Social Development (DoSD) policy which demands the use of evidence-based practices as a condition for in-patient treatment centres wanting to become accredited facilities. A major focus therefore, is on the issues that exist in the Western Cape around unregistered treatment facilities and the challenges that they face in meeting policy stipulations.

These issues formed the basis for a case study on a specific Organisation, a Church, with a faith-based Christian philosophy which it extends into its substance abuse rehabilitation practices. A supplementary objective was to explore the challenges faced by this institution in meeting the policy requirements imposed by the DoSD, and to consider the clients' and the Organisation's perceptions, experiences and definitions of SUDs.

The first Chapter of this thesis seeks to introduce the reader to the project. It defines SUDs and evidence-based practices, gives a brief discussion on the issue of unregistered treatment facilities and presents the rationale and aims of the study.

The second Chapter, Background, Treatment, Policy and CBOs, examines the consequences of substance abuse in South Africa and, more specifically, the Western Cape. In Cape Town the use of methamphetamine (MA/Tik) has increased and as such attention is given to this substance. It also concentrates on inequality in substance abuse treatment, access to treatment services in HDCs in the Western Cape, the development of unregistered treatment facilities, the role of spirituality in treatment, an

effective treatment approach, and evidence-based practices. Finally, it looks at a theoretical model for treatment focusing on the community-based model which is founded on the Sustainable Livelihoods Approach. Lastly, Government policy, norms, standards and procedures, and community-based organisations are discussed.

The aims and methodology employed in this study are the subjects of the third Chapter which also gives attention to the case study approach, sampling, data collection methods, the analysis of data and the ethical considerations that needed to be dealt with in the completion of this project.

Chapter four provides information on the area in which the Organisation that is the primary subject of this study, the Recovery Home, is situated. It also examines the Home's staff structures and the faith-based method that it uses to treat SUDs, the purposes and organisational structures of the Home are given attention as well as its vision and its mission. In Chapter five, the results and findings that materialised from this research are given.

Finally, the last Chapter, number six, presents conclusions founded on the research that was conducted and the relevance that they have to the aims of this study.

## **1.2 DEFINING SUDs AND EVIDENCE-BASED PRACTICES**

A major reason for this research was to expose the difficulties encountered by an unregistered treatment facility which has failed in its efforts to obtain accreditation mainly because it does not make use of evidence-based practices in its rehabilitation programmes. For this reason, the discussion that follows begins to highlight the importance of evidence-practices. In addition, it defines both SUDs and evidence-based practices. By gaining clarity on the complexities of SUDs, and what can be regarded as acceptable treatment procedures, a clear idea can be formulated on why it is essential, as decreed in the policy provisions of the relevant authority, for organisations that are providing substance abuse rehabilitation treatment to register with the DoSD.



The National Institute on Drug Abuse (NIDA) defines SUDs as a complex brain disease, a mental illness characterised by a compulsion to use substances irrespective of the overwhelming negative consequences. Research conducted by the Institute shows that a considerable number of people with SUDs also have other mental illnesses which means that there is a high rate of co-occurrence between the two. The NIDA expresses the view that it is difficult to distinguish between the symptoms of SUDs and other mental illnesses, which makes diagnosis and treatment complex. Successful and suitable treatment is dependent on the correct diagnosis (2008: 1). Taking this into account it is apparent that it is critically important for professionally trained staff to be employed to deliver effective treatment for SUDs. The NIDA notes that:

“Because drug abuse and addiction have so many dimensions and disrupt so many aspects of an individual’s life, treatment is not simple. Effective treatment programs typically incorporate many components, each directed to a particular aspect of the illness and its consequences” (1999: 5).

In a report compiled by DopStop and the Medical Research Council (MRC) evidence-based practices are defined as follows: “Evidence-based practices are practices, interventions or programmes for which there is a large body of research evidence in support of its effectiveness” (2008: 5).

The report notes that a psychosocial approach, along with medication and clinical interventions, needs to be applied to prevention and treatment approaches to substance abuse and SUDs much the same as HIV/Aids or diabetes. The understanding of SUDs is that they occur along a line increasing in severity. From no use, to occasional use, misuse to abuse and lastly dependency. Each of these different stages requires different levels of care. The report provides information for the DoSD on the evidence-based practices that need to be implemented at each level. The four levels of care are firstly; prevention/raising awareness, secondly; early intervention, thirdly; community-based treatment and lastly; aftercare services. The rationale behind introducing evidence-based practices at each of these levels of care is to better the quality of services and service outcomes (2008: 4).

### 1.3 THE ISSUE OF UNREGISTERED TREATMENT FACILITIES

In HDCs in the Western Cape, one of which is the area in which this study was conducted, there are insufficient treatment facilities. State institutions are over-burdened and private care is too costly. Many people who need treatment are not able to access it (Myers, Louw and Fakier 2007: 158). As a result of this and the havoc that substance abuse and SUDs are causing in communities, a number of community-based organisations (CBOs) have been formed to combat the problem. Some of these, however, are under-resourced and are not able to provide adequate services (Myers et al. 2007: 11). The restricted capacity - caused by many different variables - of CBOs to provide professional services frequently means that no matter how well intentioned they may be, the interventions they make can potentially be of more harm than good to people who enter their care for rehabilitation purposes (Myers et al. 2007: 11).

The DoSD has introduced minimum norms and standards which organisations must meet in order to be legally compliant. This has been done, as noted in their manual, in an attempt to standardise treatment, to ensure organisations are accountable and transparent, to protect human rights and to provide better services to communities (2007: 7).

It has been established that the introduction and management of effective treatment would cost South Africa's economy less than the existing direct and indirect costs of SUDs. The United Nations Office on Drugs and Crime (UNODC) and the World Health Organisation (WHO) state that:

“Even taking into account the requirements for the delivery of evidence-based treatment, its costs are much lower than the indirect costs caused by untreated drug dependence (prisons, unemployment, law enforcement, health consequences). Research studies indicate that spending on treatment produces savings in terms of reduction in the number of crime victims, as well as reduced expenditures for the criminal justice system” (2008 2).

From the above discussion, it is noted that the services being offered by unregistered substance abuse treatment facilities have been questioned. This research confirms that

SUDs are complex, multi-factorial disorders and that for effective treatment, evidence-based practices must be implemented. As noted above, the nature of SUDs demands that professionally trained staff are employed by substance abuse treatment facilities. It is argued, in this report that without adequate evidence-based treatment interventions, unregistered facilities are not providing the best services to their communities.

Unregistered treatment facilities are not accountable to the state. The vulnerable client groups that they serve have no protection. These issues raise multiple concerns over the existence of unregistered substance abuse treatment facilities which need to be addressed.

#### **1.4 PROBLEM STATEMENT**

The significant issue that emerges and which is critical to this research is the plight of institutions providing rehabilitation services in communities where they are crucially needed, and where the state lacks capacity. Several of these organisations are unable to obtain legitimacy because they cannot comply with Government policy enactments. Failure to implement evidence-based practices which are imperative, as previously pointed out to the delivery of effective treatment, raises concerns about the formation of CBOs providing treatment services that are not regulated by the state.

#### **1.5 SIGNIFICANCE OF RESEARCH**

A great deal more work is needed in this area to widen the scope and availability of effective intervention measures. While many of the interventions that they make are frequently useful and successful some of the practices adopted by unregistered treatment centres, most particularly those that do not implement evidence-based practices, can clearly be harmful to the clients that they serve. It is therefore fundamentally important to address the issue of unregistered treatment facilities and additional research into these institutions will be of great significance in this field. It is hoped, that this study will contribute knowledge to this area and that further work will result in more widespread adoption of successful well-tested and correct treatment procedures.

## **1.6 RESEARCH QUESTIONS**

1. What recovery approach does the Organisation follow? What are its objectives and how is it structured?
2. What problems has the Organisation encountered in their attempts to register with the DoSD? What was the Organisation's experience of this process, and the requirement to implement evidence-based practices?
3. How does the Organisation define SUDs? What are the clients' experiences and perceptions of substance abuse and the treatment approach followed by the Home?

## **1.7 PURPOSES AND OBJECTIVES OF THE STUDY**

The purposes of this study were to investigate an unregistered organisation faced with the challenges of acquiring accreditation for its SUDs rehabilitation programme.

The objectives were to examine the functions and structures of the Organisation, the clients that it serves and the treatment approach that it has adopted which, to a considerable extent, is the result of the definition that the Organisation applies to SUDs. The Organisation's definition of SUDs has implications that relate to the application of evidence-based practices and this became an issue that needed to be explored. This was carried out in conjunction with attempts to identify the challenges that the Organisation faces and its attitude and status with regard to the introduction of evidence-based practices.

Accordingly, the study aimed....

- To examine the structures and functions of an unregistered Organisation providing treatment for substance use disorders.

- To identify obstacles that the Organisation faces in the provision of treatment for substance use disorders, to obtain further knowledge of, and to present the Organisation's experiences with, and perceptions of, Government's registration requirements.
- To describe the clients' perceptions and experiences of substance use disorders and to relate these to the Organisation's definition of substance use disorders and the faith-based approach.

### **1.8 LIMITATIONS OF THE STUDY**

The study was limited because it focused on only one Organisation with one approach to treatment. Further research is needed to include other unregistered treatment facilities and to determine different experiences with registration and treatment approaches as well as the implications of not implementing evidence-based practices for the clients being treated by these organisations. As the concentration was on only one Organisation it is not possible to generalise the findings. It is for this reason it is proposed that further research is needed in this area to expand and build on this project. Additional investigation will be helpful in acquiring further knowledge in this field, to expand the volume of information on the activities of community based treatment centres and establish how common is their application of evidence-based practices. All of these issues are critically important, as there is limited access to treatment in HDCs, meaning that, effective treatment measures are urgently needed.

## **2 CHAPTER 2: BACKGROUND, TREATMENT, POLICY AND CBOS**

### **2.1 BACKGROUND**

#### **2.1.1 SUBSTANCE ABUSE IN SOUTH AFRICA AND THE WESTERN CAPE**

Substance abuse in South Africa has increased substantially since the collapse of apartheid. This is the result of increased availability of substances which in turn is due to less rigorous restrictions, a lack of resources in various law enforcement institutions coupled to sophisticated banking, communication structures and geographical location. What has transpired is an increased quantity of drugs at reduced prices and an inability of overburdened law enforcement institutions to cope adequately with the problem (Myers et al 2007: 5). Linked to the increase of availability and access, is a rising need for effective intervention and treatment. This increased demand places significant stress on the limited resources that state treatment centres possess (Myers et al 2007: 5).

One of the major challenges that currently confronts South Africa is a high level of criminal activity. In the Western Cape, drug related crime has increased substantially as Gie reports in an analysis compiled for the City of Cape Town on Violence, Property and Drug related crime. Statistics recorded for 2001/2 show drug related crime figures at 241 cases per 100 000 in comparison to those captured for 2008/9 at 830 per 100 000. Three factors suggested by Gie for this dramatic rise are, better policing resulting in more arrests, poor socio-economic conditions and the increasing use of Tik on the Cape Flats (2009: 14).

In the Western Cape, substance abuse is a pervasive and prevailing problem. A research review by the MRC in the Western Cape 1997-2004 clearly demonstrates this.

The review makes some fundamental points that establish the far-reaching implications of substance abuse in the Western Cape. By referring to the findings reviewed, the social problems created and perpetuated become clear. What it also shows is the way in

which substance abuse is retarding developmental progress in the Western Cape. These findings establish some essential links.

Firstly, the issue of crime: in 2000, the MRC's research found that six out of ten people arrested in Cape Town displayed a positive test result for an illegal drug. It also found that those that tested positive were much more likely to have been arrested in the past than those that tested negative. Secondly, non-natural deaths: in 2003, one in two of these deaths had above average alcohol levels in their blood. Thirdly: in 2001 in trauma units in Cape Town, one in three patients had above average alcohol levels and four out of ten patients displayed positive tests for an illegal drug. Fourthly: alcohol abuse is linked to numerous problems such as absenteeism, an increase in unprotected sex, family violence and academic failure. Fifthly: research conducted in 2003, showed that one in five patients with HIV, when questioned, showed signs of alcohol dependence or abuse. Lastly: from an economic perspective, the MRC establishes that the cost of alcohol and drug abuse to the province is likely to exceed R1 billion per year (2005: 1).

A review of substance abuse trends conducted since 2000 in the Western Cape by the MRC, University of Cape Town (UCT) and the Human Sciences Research Council (HSRC) found that in comparison to other provinces, the Western Cape had the second highest incidence of risky or damaging drinking during pregnancy. The high levels of foetal alcohol syndrome (FAS) in the Western Cape confirm that alcohol misuse among women is a chronic and disturbing problem (2008: 9).

### **2.1.2      *MA/TIK***

Patterns of drug use in Cape Town have changed considerably. Previously, mandrax and dagga were the drugs most commonly abused. Currently, heroin and methamphetamines use has increased substantially. The use of these drugs is more damaging and considerably more difficult to treat (City of Cape Town Draft Operational Alcohol and Drug strategy 2007-2010:11).

An update from the South African Community Epidemiology Network on Drug Use (SACENDU) notes that:

“MA (aka ‘Tik’) remained the most common primary drug reported by patients in Cape Town in 2009, and the proportion increased to 41% in this period. Among patients under the age of 20 years the proportion reporting MA as a primary or secondary substance of abuse increased to 55%. Two thirds of patients in treatment for MA are younger than 25” (2009: 1).

These figures are not substantially reflective of the population because they only represent individuals who are able to access treatment. With a distinct lack of treatment facilities available to serve HDCs, an accurate reflection cannot be ascertained. What is clear, however, is that the problem is drastic.

Plüddemann, Myers and Parry describe MA as a highly addictive substance that affects the central nervous system. It is made from over the counter medication that is not costly and can be smoked, snorted, ingested or injected. In South Africa it is most commonly smoked using a light bulb, the powder/crystal is heated and the fumes inhaled. Reactions induced by the drug include euphoria, increased energy and self-confidence, insomnia, restlessness, irritability, heightened sense of sexuality, and tremors. These occur as a result of the release of neurotransmitters dopamine, noradrenaline and adrenaline (2007: 1). They explain that:

“Prolonged use can result in severe weight loss/anorexia, severe dermatological problems, higher risk of seizures and uncontrollable rage/violent behaviour. Chronic mental health effects include confusion, impaired concentration and memory, hallucinations, insomnia, depressive reactions, psychotic reactions, paranoid reactions, and panic disorders. Long term use also increases the risk of contracting HIV and Hepatitis C due to injection drug use and sexual risk behaviour” (2007: 1).

Bateman notes that tik has a powerful effect on adolescents living on the Cape Flats, a world subjugated by gangsterism, joblessness and poverty. The effects induced by the drug, those of confidence, power and heightened sexual levels, give their users a feeling of being on top of the world, a stark contrast to the reality of their situation (2006: 672).



### **2.1.3            *INEQUALITY IN SUBSTANCE ABUSE TREATMENT***

Although no longer legislatively enforced, racial segregation, which was institutionalised during the apartheid era in South Africa, remains entrenched. Under the apartheid regime, services to HDC, black/African and coloured South Africans, were restricted as treatment facilities were located in urban areas. These facilities were for white South Africans only, and most resources were directed there. In the past, racial segregation was maintained by socio-political factors where currently it has shifted and is determined more fundamentally by socio-economic conditions (Myers et al. 2008: 9).

Although much work has been done to improve health care and service delivery to previously disadvantaged communities, and to reverse racial inequalities, considerable differences between the racial groups remain. Services and facilities for HDCs continue to be under resourced (Myers et al. 2007: 9).

Myers et al note that:

“The race profile of clients at treatment facilities does not reflect the demographics of the general population. In Cape Town specifically there has been an under-representation of Black and an over representation of White South Africans in treatment facilities” (2007: 10).

For most people in HDCs, private treatment facilities are unaffordable.

Shafiek Davids from Sultan Bahu Centre, an established and registered community based treatment facility in Mitchells Plain, stated in his Parliamentary presentation: “Drug rehabilitation in South Africa is as lucrative as drug-running. Both have become multi-million rand industries, all at the expense of the blood and tears of our communities” (14 May 2008).

The need for treatment for SUDs in Cape Town is substantial and it demands significant attention. Research conducted by Myers, et al. shows that the current provision of

services available in Cape Town stands at 2,500 people per year. It is estimated that about 300,000 may be in need of alcohol and other drug (AOD) treatment services (2007: 157). These statistics, accepting their reliability, are indicative of the massive inadequacies that confront the authorities and the desperate need for extra services.

#### **2.1.4 ACCESS TO TREATMENT**

Substance abuse treatment in Cape Town is limited notwithstanding the need and the knowledge that treatment is advantageous. Myers et al define access as such:

“access to treatment is defined as both potential access to services (namely, the degree to which factors that enable a person to use a needed treatment service are present and the opportunity to seek needed services) and/or realized access (or the actual use of the needed services)” (2007: 7).

The research they conducted demonstrates the following:

Firstly: HDCs in Cape Town have limited access to treatment facilities.

Secondly: there is a lack of service delivery, no strategic plan, and poor resources in communities resulting in negative perceptions with regard to treatment.

Thirdly: the state does not provide adequate funding or financial resources for AOD service providers. Waiting lists to state rehabilitation facilities are very long, and access is restricted.

Fourthly: private treatment is unaffordable, community institutions do not have strong ties, partnerships or capacity (skills or resources) to treat these problems effectively, and policy that does exist is poorly implemented. As resources are limited, there is an insufficient range of services and the quality of those that do exist is poor (159: 2008).

### **2.1.5 UNREGISTERED TREATMENT FACILITIES**

As a result of the above and the problem reaching uncontrollable proportions in poorer communities in the Western Cape, a number of unregistered treatment facilities have opened. An article published in the Sunday Argus notes: "Treatment for substance abuse, particularly the use of tik (methamphetamine), is on the increase and a number of centers have opened their doors over the past two years" (6 April 2008).

As previously noted, the lack of treatment facilities in Cape Town available to serve HDCs, those that receive public-funding, in conjunction with an increased need for treatment in the City, has resulted in the formation of a number of non-profit, private treatment facilities. Some of these facilities have professional staff and are accredited. However, there are also a mushrooming number of unregistered facilities being opened by various people in disadvantaged communities. The founders of these institutions have good intentions but few resources, knowledge or skills to treat SUDs. The facilities are more accessible to HDCs, but because they are not accredited, the services they offer are questionable. The accredited, non-profit facilities require individuals to make some payment and waiting lists are lengthy. Both of these factors decrease accessibility (Myers et al 2007: 11).

It is in attempting to overcome treatment accessibility problems, caused to a large extent by inadequate state capacity, that institutions like the Recovery Home, which is the focus of this research, have been set up.

## **2.2 TREATMENT**

### **2.2.1 MULTI-DISCIPLINARY APPROACH TO TREATMENT**

In a province like the Western Cape where many people are deprived of opportunities to adequate education and employment and are exposed to high levels of violence, high HIV/Aids infection and very high crime rates, the savings that would be accrued by

effective treatment would do much to foster social and economic development in the province.

The UNODC and WHO confirm that if properly treated, drug dependence is preventable. They argue that the most effective way to treat drug dependence is by the use of a multidisciplinary approach that employs both pharmacological and psychosocial interventions to cater to different needs. The cost of delivery of evidence-based treatment, they argue, is far less than the detrimental social and developmental problems caused to a society by untreated drug dependence (2008: 2). In spite of these important assertions, access to treatment in HDCs remains under resourced, and as such, severely restricted.

The gravity of the situation that has been exposed in what is set out above is identified by the researcher as a major motivational cause for the establishment of institutions like the Recovery Home. That explains why the first of this study's aims is devoted to an examination of the structures and functions of a facility that provides treatment for people in a HDC who are afflicted by SUDs.

### **2.2.2        *ROLE OF SPIRITUALITY IN RECOVERY***

A Church runs the Recovery Home that this research aimed to investigate; it follows a programme that relies on adherence to Christian principles. Spirituality, as argued below, is a fundamental element of the recovery process. The following discussion is imperative in understanding the role spirituality plays and briefly distinguishes between religion and spirituality.

Many substance abuse facilities in South Africa endorse the 12-step programme of Alcoholics Anonymous and Narcotics Anonymous. These facilities are registered, accredited treatment centres.

The 12-step programme is referred to as a spiritual programme. Belief in a higher power and the occurrence of a spiritual transformation are essential to its principles. The distinction between faith-based and traditional programmes, that include medical and

psychosocial treatments, can be unclear as traditional programmes often include faith-based components and profess that spiritual development forms part of the recovery process. Treatment centres that encourage 12-step programmes often employ staff who are themselves in recovery. There is a similarity with faith-based programmes here in that they use graduates from their programmes at their facilities. However, a significant difference is that traditional programmes more commonly employ trained licensed staff in comparison to unprofessional unlicensed employees at faith-based centres (Shorkey and Windsor 2006: 50). Shorkey and Windsor state:

“We define faith-based programmes broadly in terms of the presence of implicit or explicit religious and/or spiritual content underlying program activities. This follows from the fact that many programs, although not associated with any organised religion, may endorse 12-step conceptions of spirituality and the existence of a higher power” (2006: 50).

Miller points out two defining characteristics that differ between spirituality and religion. Firstly, he notes, that religion is an organised, structured social phenomenon where the trademark of spirituality is unique to an individual. Secondly, spirituality is focused on the abstract and as such, it is difficult to define. Religion on the other hand has clear boundaries, practices, and rituals, which make it easier to conceptualise (1998: 980).

Previous research, as noted by Miller, has demonstrated that alcohol or drug abuse is often associated “with a lack of meaning in life” (1998: 983). Miller also points out that there is confirmation that spiritual or religious participation is linked to a reduced risk in alcohol/drug problems and dependence (1998: 981). Miller adds:

“For as long as history has been recorded, people have found spirituality to be a significant source of healing. A large proportion of people continue to find spirituality, including religious involvement, to be an important source of meaning and sustenance. Simply to ignore a major potential source of healing violates both scientific curiosity and professional responsibility” (1998: 987).

### **2.2.3 AN EFFECTIVE TREATMENT APPROACH**

There are many different treatment approaches, a few of which will be discussed further below. However, as noted above, the argument presented by Miller is one that has significance. The association between religious/spiritual involvement and reduced risk of alcohol and drug problems or dependence is widely acknowledged but, as noted by Dr Bronwyn Myers of the Medical Research Council, there needs to be a combination with evidence-based practices to ensure effective treatment.

“There are many registered facilities that are faith-based (both Christian and Muslim) for example, Hesketh King, Shepherd Field etc etc. An organisation can be faith based, but it still needs to adhere to the requirements of registration - these are very basic. A programme can still be heavily faith-based and adhere to evidence-based practices. These do not necessarily conflict. The programme needs to be open to integrating and learning about what we know about best practice” (e-mail contact 31 August 2009).

Research conducted by Timko, Lesar, Engelbrekt and Moos confirmed that increased treatment services and structure in treatment programmes resulted in better outcomes (2000: 494). The NIDA notes, “Addiction is a brain disease that affects multiple brain circuits, including those involved in reward and motivation, learning and memory, and inhibitory control over behaviour” (2009: 1). Accepting this, it is apparent that the medical component of treatment cannot be overlooked. For treatment to be effective, medication and behavioural therapy need to be combined. An effective process begins with detoxification, followed by treatment and lastly, relapse prevention. (NIDA 2009: 2)

The NIDA suggests the following as effective treatment approaches. Firstly: medication to help patients withdraw from substances. This on its own is not treatment. In order for the process to be effective, patients would need to enter a treatment programme, which includes behavioural treatment. Medication can also assist, as noted by the NIDA, in re-establishing normal brain functioning which can help in lessening cravings and reduce the risk of relapse (2009: 3). There is a variety of behavioural approaches which can be employed in delivering effective treatment. These approaches, as noted by the NIDA, “help patients engage in the treatment process, modify their attitudes and behaviours

related to drug abuse, and increase healthy life skills” (2009: 4). Effective behavioral treatment approaches are outpatient behavioural treatment, and residential treatment which includes therapeutic communities (2009: 4).

There are many different approaches to treatment some of which have been identified above but, what is being argued here is that for treatment to be effective a variety of services needs to be offered. It has been noted that spirituality/religion can have a positive influence on individuals recovering from SUDs. However, it is also acknowledged that in order for treatment to be effective, it is imperative that evidence-based practices are also implemented. What follows is a more in-depth explanation of what evidence-based practices are.

#### **2.2.4 EVIDENCE-BASED PRACTICES**

“Nothing less must be provided for the treatment of drug dependence than a qualified, systematic, science-based approach such as that developed to treat other chronic diseases considered untreatable some decades ago. Many of these diseases are now preventable or treatable thanks to good practice clinical interventions and rigorous therapeutic strategies and cumulative scientific research” (UNODC and WHO 2008: 2).

In order to assist the DoSD in its policy development, the MRC and DopStop developed a report outlining evidence-based practices. The purpose of this is to ensure that any programme implemented or supported by the DoSD has sufficient evidence as to its effectiveness (Myers, Harker, Fakier, Kader & Mazok 2008: 3).

This research is an investigation into a community-based treatment facility providing treatment for SUDs. Emphasis therefore, is placed on levels of care and the appropriate evidence-based practices that need to be implemented.

The appropriate intervention measures for abuse as noted by Jardine, Karassellos, Myers and Parry are: “Brief intervention and out-/or in-patient treatment services” and for

dependence: “Detoxification and in/or outpatient treatment, and sometimes mental health services, as well as aftercare (continuing support) services. Harm reduction services for individuals with chronic dependence” (2008: 4).

NIDA notes that there are a number of principles that need to be adhered to for treatment to be effective. The Institute explains that SUDs are complex but treatable. The abuse of substances affects brain functioning and behaviour, this continues after periods of abstinence, and as such individuals are vulnerable to relapse, despite the devastating consequences that they might have encountered as a result of substance abuse (2009: 4).

Individual needs differ and this means that a single treatment cannot be applied. It is therefore critical that a variety of services are available. Treatment needs to be accessible and cater to a variety of elements. These include, medical, psychological, social and employment and legal components. Treatment also needs to be suited to an individual’s ethnicity, age, gender and culture. Treatment retention and duration increases success. A minimum of three months is recommended (2009: 4-5).

The NIDA explains that the implementation of behavioural therapies is fundamental to motivate and develop skills and interpersonal relationships, including individual counselling, group work and peer support work. In conjunction with behavioural therapies, the administration of appropriate medication forms part of an inclusive treatment programme. Individual treatment plans must be reviewed regularly to ensure that they continue to meet the changing needs of individuals. Patients need to be assessed for other mental disorders, as individuals with SUDs often have co-occurring mental illnesses. Detoxification is the initial step in rehabilitation but alone it is not sufficient for long-term abstinence. Entering treatment involuntarily does not make treatment ineffectual. Individuals need to be tested regularly for drug and alcohol use. Patients should be assessed for other infectious diseases such as HIV/Aids and strategies employed to reduce further risk (2009: 4-5).

In order for a programme to be evidence-based, there are a number of criteria that need to be met. Jardine, Karassellos, Myers and Parry from the MRC list these:



Firstly, they note: “At least one randomised clinical trial has shown this practice or intervention to be effective.” Secondly: “The intervention/practice has demonstrated effectiveness in several replicated research studies using different population groups”. Thirdly: “The intervention targets behaviours or has a good effect on behaviours that are generally accepted outcomes”. Fourthly: “The practice is based on a clear and well articulated theory of behaviour change”. Fifthly: “The intervention/practice can be evaluated”. Lastly: “The practice/intervention addresses cultural diversity and different populations” (2008: 5).

It is critically important that treatment is carried out by professional staff, medical, psychiatric, and social services. It must concentrate on overcoming the negative health and social outcomes caused by substance abuse and dependence and on harm-reduction interventions (Jardine, Karassellos, Myers and Parry 2008: 34).

The Matrix Model, Cognitive Behavioural Models, Twelve-step Models, and Motivational Enhancement Models are examples of evidence-based treatment (Jardine, Karassellos, Myers and Parry 2008: 56). The Matrix Approach consists of the following elements: “individual sessions, early recovery groups, relapse prevention groups, family education groups, 12 step meetings/social support groups, relapse analysis, and urine and breath-alcohol testing”. Treatment facilities in South Africa are encouraged to adopt this evidence-based treatment model, which has been adapted to South African conditions (Community-based model 2006: 9).

### **2.2.5 COMMUNITY BASED TREATMENT AND THE COMMUNITY BASED-MODEL**

Community based treatment is explained in South Africa’s National Drug Master Plan (NDMP) as a programme that is developed from infrastructure in a community to meet the needs of the community in question (Jardine, Karassellos, Myers and Parry 2008: 35). This is in line with the Sustainable Livelihoods Approach and the community-based model for the treatment of SUDs.

The community-based model for the treatment of SUDs is based on the Sustainable Livelihoods Approach.

The National DoSD defines it thus:

“It redefines development in terms of exploring the strength and vulnerabilities of the poor. It promotes a holistic vision of development, and seeks to direct the focus of development thinking towards encouraging clients to use the knowledge and expertise of individuals in their communities and the resources available in their environment creatively and innovatively to address their socio-economic needs” (Community based model 2006: 6-7).

It therefore focuses on empowering people and communities. Relating to this, the community-based model depends on the participation of those affected engaging in the process, working towards an improved livelihood. People affected are involved in the decision-making process, are encouraged in self-help and to access and use available resources to create opportunities and develop initiatives (Community-based model 2006: 4).

It represents a shift away from institutionalization and removal from communities to the implementation of community-based prevention services that are easily accessible. It presents a holistic approach which applies prevention and treatment at primary, secondary and tertiary levels. As noted by the Department, without the commitment of Government and increased funding, the model cannot be successfully implemented. Additionally, civil society and Government need to actively participate together to achieve positive results (Community-based model 2006: 3).

Social and environmental factors in a community based setting can affect the efficacy of treatment and prevention. In the Western Cape where there is a high demand for treatment and prevention, areas are characterised by poverty, unemployment and a lack of service delivery. As a result, social and health problems such as substance abuse, crime and HIV/Aids are prevalent. This highlights the need for structural issues in communities in the Western Cape to be addressed to increase the efficacy of both

treatment and prevention measures. As is stressed by Jardine, Karasselos, Myers and Parry:

“It is often more difficult for individuals to maintain sobriety post-treatment in environments where alcohol and drug use is normalised and in environments where there are limited structures to support recovery” (2008: 7).

## **2.3 POLICY**

### **2.3.1 GOVERNMENT POLICY**

Devoting attention to Government policy is relevant because of the impact that it has on organisations like the Recovery Home, which is the central theme of this research project. The DoSD has introduced minimum norms and standards in an attempt to improve service provision for SUDs in HDCs. The purpose of these minimum norms and standards, as explained by the Department in their manual for implementation, is to standardise services, facilitate transformation and improve the quality of services. These minimum norms and standards provide protection for individuals with SUDs to ensure their rights are protected (2007: 7). However, problems remain.

The manual outlines guidelines for policy and minimum requirements that service providers are compelled to meet. It sets out organisational principles for treatment centres. The intentions are to protect those seeking treatment and to attempt to ensure that service providers accept legitimate standards of accountability, empowerment, continuum of care, restorative justice and family preservation (2007: 7).

If organisations fail to meet the minimum norms and standards as set out by the Department, they will not be accredited or supported by the Department and will be requested to terminate their services. Organisations that fail to comply will be functioning illegally. The minimum norms and standards guide organisations in the implementation of evidence-based practices (Myers et al. 2007: 12).

As research demonstrates, substance abuse in the Western Cape is on the increase placing pressure on the health, social welfare and criminal justice sectors in the province. With the increase in substance use and the problems it is causing in communities, the demand for service provision, treatment and prevention services in this area has put increased pressure on the DoSD to provide extra services (Myers, Harker, Fakier, Kader & Mazok 2008: 3).

### **2.3.2 POLICIES AND PROCEDURES**

There are various policies and procedures in place in South Africa to guide the implementation of treatment and prevention programmes and to deal with the problem of substance abuse in the country in a structured and co-ordinated manner.

Myers notes that, in order to prioritise access for HDCs to AOD services, the DoSD has put much effort into the development of a comprehensive policy framework. The policy framework, they note, concentrates on service provision to vulnerable and historically under-served population groups (2008: 157).

The Prevention and Treatment of Drug Dependency Act (Act 20 of 1992), as noted in the NDMP 2006-2011, was amended in 1999 to set up the Central Drug Authority (CDA). The DoSD is responsible for administering the Act. The Act sets out the development of programmes and seeks to regulate existing treatment facilities (2006: 11). As noted in the NDMP 2006-2011, the Act provides for the development of Mini Drug Master Plans. These are the operational plans of different departments that need to be submitted to the CDA at the beginning of each financial year (2007: 13).

The CDA is a statutory body in terms of the Prevention and Treatment of Drug Dependency Act. It was instituted in July 2000. Its main function is to supervise and implement the NDMP, and inform Government on drug related issues. The CDA collects information from different departments, facilitates and co-ordinates, and reports to Parliament. It also corresponds with local drug action committees as a means to co-ordinate service integration (Department of Social Development National Drug Master Plan 2006 – 2011: 28).

The NDMP outlines policies and legislation. The DoSD defines it in this way:

“The South African National Drug Master Plan 2006-2011 sets out the country's national policies and priorities in the quest to build a drug-free society and to fight substance abuse. The plan deals with the intensification of the anti-drug campaign, national and provincial departments' inclusion of measures to counter substance abuse in their programmes, and budgeting for these interventions. It also calls for community participation through the establishment and support of provincial forums and local drug action committees” (2007: 5).

The provincial substance abuse forums, as described in the NDMP, function to assist member organisations in implementing their substance abuse programmes and ensuring that substance abuse remains prioritized in public/political agendas in the province. These organisations correspond with the CDA and other forums to maintain and facilitate the flow of information between the different bodies. They are also there to support local drug action committees in carrying out their responsibilities (NDMP 2007: 37).

A local drug action committee, as explained by the DoSD Western Cape Substance Abuse Forum, is a community organisation made up of various role players. These include members of designated government departments, community organisations, local government, business community, youth organisations and labour representatives. Its purpose is to tackle substance abuse at the community level, in a co-ordinated manner (NDMP 2007: 1).

## **2.4 COMMUNITY BASED ORGANISATIONS**

### **2.4.1 NON-PROFIT FAITH-BASED ORGANISATIONS**

The term non-profit faith-based organisation is used in this project to define the type of organisation this study investigates. A close enquiry of the history of this term and past usages, places the term under scrutiny and open for debate.

It is therefore imperative to explore this definition, and to explain why it has been used, in this project. What is inseparable from the definition is the role that these organisations play. This is intrinsically linked to their primary purpose and helps to differentiate them from other organisations existent in civil society. The organisation under inspection in this project exists to serve the community in which it is located.

The term non-profit organisation (NPO) is a broad classification. The use of the term, as noted by Swilling and Russell, is defined as such:

“non-profit organisations is a new - and largely imported - term in South Africa’s sociological lexicon, it is so widely defined that it captures everything from the racially exclusive cultural and welfarist organisations that have always been central to the social structure of white society, right through the entire spectrum of religious organisations to the huge and dense networks of community-based NPOs that hold African societies together” (2002: 3-4).

What is contentious about this broad definition, which seeks to define all NPOs within civil society, is how to differentiate them. South African history, particularly the apartheid era, meant many of these organisations developed in opposition to the state. A question that arises currently is their role and relationship with the state in a constitutionally democratic society. This broad classification does not reflect the exact nature of these organisations and their current relationships with the state or the state’s role in civil society.

As explained by Swilling and Russell the term NPO was not used in the 1980s or the early 1990s, but in the mid to late 1990s it was decided by policy makers that the term NPO be used to describe service organisations in civil society which included both Non-Governmental Organisations (NGO) and CBO. They comment on the reason for this term, “NPO: a nice depoliticised term that transcended the NGO-CBO discussion and delineated the sector from the private sector” (2002: 6).

This, however, is a simplified categorisation and does not do service to the complexity of the various organisations and the roles that they play. Swilling and Russell go further and categorise the various organisations according to their roles. This categorisation helps to differentiate the organisations that are broadly classified as NPOs. They break these down into the following: Co-operatives, Stokvels, Burial societies, Religious organisations, Political parties, Development NPOs, Survivalist NPOs and Oppositional NPOs. They note that NPOs are not mutually exclusive to these definitions and can fit under more than one classification. As well as this, organisations are often subject to change and can therefore move from one categorisation to another over time (2002: 10-11).

The organisation under study can broadly be defined as a NPO, but to be more exact it fits the categorisation of Religious and Survivalist NPO.

This definition is helpful in distinguishing the organisation under study from other types of NPOs. The reasons for calling these specific NPOs, as explained below, is primarily as a means of further distinction.

A NPO is formed by members in the community that work within their own communities to address social issues. This is the primary difference between an NGO and a NPO. Members forming NGOs are often working in communities that they themselves are not from. A NPO's work is not carried out to increase economic gain for its members; rather they work with a variety of social issues such as crime, substance abuse and HIV/Aids, issues that have an impact on the whole community. Work is conducted as a means to uplift the community by providing a social service (Swilling and Russell 2002: 11).

The Organisation upon which this research is based is a Church. It is therefore classified as a religious/FBO. The religious orientation of this Organisation is Christianity, as such, this is the faith-based approach that it follows.

#### **2.4.2 PRIMARY LOCALITY OF NPOS**

NPOs in South Africa are generally based in poor, disadvantaged areas. Development work carried out by Government in these areas focuses primarily on economic development; for example, building schools, roads, houses and the installation of water and electricity functions. These developments are certainly needed, specifically in recognition of the fact that inadequate management of social issues by Government, together with improved infrastructure, results in high levels of alcohol and drug abuse, crime and violence. These, social issues that place a heavy burden on members in communities are primarily addressed by NPOs. As noted by Phaswana-Mafuya et al. "NPOs play a prominent role in filling the gaps in public health care that the state does not meet" (2008: 2). Joshi et al. note:

"Faith-based organisations (FBOs) provide social service programs as a means to serve their communities. These and other characteristics can make FBOs uniquely suited to support individuals and families facing devastating problems, such as substance abuse, domestic violence, HIV/AIDS, crime, poverty, natural disasters, and inadequate housing" (2008:1).

As with other developmental initiatives carried out by NPOs, they play a fundamental role in the substance abuse treatment arena in HDC. The United Nations Regional Office for South Africa on drugs and crime acknowledges the fundamental role that religion has in the lives of South Africans. When developing drug and prevention campaigns, they stress that this fact needs to be taken into account. The Church, they assert, can be an invaluable partner in this process (2002: 5).

NPOs however, are often under-resourced and lack the support they need and the financial capital to run effective organisations, affecting the sustainability of these organisations. An important consideration in this research therefore was to note the



challenges faced by the Recovery Home as a Survivalist NPO, to acknowledge the important role it could potentially have in delivering effective substance abuse treatment as a Religious NPO and lastly to consider the sustainability of its substance abuse rehabilitation facility under the current circumstances.

## **2.5 CONCLUDING REMARKS**

The preceding section has covered a variety of important contributing elements around which this research is structured. It has shown how substance abuse and SUDs are retarding developmental progress in South Africa and the Western Cape. Substance abuse and SUDs cause a myriad of social, health and psychological problems. Defining SUDs as multi-factorial health disorders acknowledges the complexities of these disorders and also highlights the difficulties treatment and health providers face. SUDs often occur in individuals who also have other mental health illnesses, and they occur along a continuum increasing in severity. This makes treating and preventing substance abuse and SUDs difficult, and requires professionals (NIDA 1999, 2008). Fundamentally, it is argued that evidence-based treatment practices are essential in providing effective treatment and intervention for SUDs. Criteria for the implementation of evidence-based treatment are noted.

It was also argued that the implementation of evidence-based treatment would cost less than the direct and indirect cost of SUDs and substance abuse (UNODC and WHO 2007). Access to treatment for HDCs in the Cape Town area remains limited (Myers 2008). The definition and requirements for evidence-based treatment are discussed. This acknowledges that treatment approaches need to be multidisciplinary including psychosocial and pharmacological interventions (UNODC and WHO 2008). An important consideration, as the Organisation under study is a Church, is the role of spirituality in recovery and it is argued here that although it has a central role to play there are other imperative elements that need to be included for a treatment programme to be considered as evidence-based.

The formation of a number of CBOs in Cape Town, which are not accredited by the state, has caused concern and the services they provide have been questioned. As an

attempt to introduce evidence-based practices, the DoSD has introduced minimum norms and standards which organisations need to meet to be legally compliant. A model that includes the incorporation of CBOs in the substance abuse treatment arena is the Community-based model which is based on the Sustainable Livelihoods Approach. A focus on Government Policy around the problem of SUDs in South Africa is given.

Lastly, as an attempt to locate the type of Organisation under study, its position in South African society and the challenges it faces, an examination and definition of non-profit faith-based organisations was presented.

University of Cape Town

### 3 CHAPTER 3: METHODOLOGY

#### 3.1 STUDY AIMS

- To examine the structures and functions of an unregistered Organisation providing treatment for substance use disorders.
- To identify obstacles that the Organisation faces in the provision of treatment for substance use disorders, to obtain further knowledge of, and to present the Organisation's experiences with, and perceptions of, Government's registration requirements.
- To describe the clients' perceptions and experiences of substance use disorders in relation to the Organisation's definition of substance use disorders and the faith-based approach.

#### 3.2 QUALITATIVE RESEARCH

This project is descriptive, exploratory and inductive in nature. These characteristics are typical of qualitative research and as Babbie and Mouton note, the main objective of this approach is to describe and understand (Verstehen) human behaviour (2005: 270). The research is inductive, meaning that the process is intended to generate new hypotheses and theories (Babbie and Mouton 2005: 309). Outcomes of this nature did emerge from the research that was conducted and they will be identified and dealt with in following sections.

An important element of qualitative research is to comprehend actions within the environment that they take place. As a means to accurately understand the occurring events, one needs to observe them in the context in which they take place. The two are therefore, fundamentally linked (Babbie and Mouton 2005: 272).

The research that was done was complex as it was characterised by a number of ambiguous social and cultural issues. In this sense and in an effort to obtain a firm understanding of the functional and strategic imperatives of the selected organisation, the researcher believed that a qualitative research approach would be the most appropriate one to utilise. Secondly, a qualitative in-depth case study was used as only one identified organisation could be reached. This is explained further below. As the single organisation identified lacks capacity, employs very few staff and has a confined organisational structure, it was the researcher's view that it would be inappropriate to conduct a quantitative research exercise on a comparatively small institution with limited infrastructure and resources.

The methods adopted were also intended to achieve the identified aim of gaining further knowledge of recent policy initiatives by the DoSD and the effects that these have on the Organisation. Lastly, an important methodological element of this study was to satisfy the aim directed at clients, their perceptions and experiences. An important contribution made to this research project was the input made by clients receiving treatment at the Home, without which a satisfactory exploration of the Christian treatment approach offered at this facility would not have been possible. Another contribution made by clients was their own experiences of substance abuse. This made the qualitative approach most suitable because it enabled the researcher to extract relevant experiential information.

Four central methods relevant to qualitative research were employed in undertaking this study. They were: the in-depth interview, observation, documentary research and a journal exercise that was arranged with, and confidentiality agreed to, by people being treated for SUDs in the Recovery Home.

From each of these four processes the researcher was able to obtain factual information as well as opinions and impressions that presented opportunity for analysis and the construction of conclusions.

Before looking at each of these methods in more detail, the case study approach used is briefly explained. The sampling process that took place is described, and the problems that arose in this process are identified.

### 3.3 CASE STUDY APPROACH

The research conducted in this study was on a specific Organisation. Babbie and Mouton note that case study designs are best suited when research is being conducted on a “clearly defined entity such as an institution, organisation, family or household” (2005: 279).

The researcher chose to pursue the aims of this research by means of a case study focused on a single unregistered Organisation providing treatment for SUDs in a HDC. Initially, the intention was to focus on more than one organisation of this kind and the researcher attempted to obtain a list of such organisations from the DoSD in Cape Town. A formal letter was written to request this information. This proved problematic because, due to the fact that the unregistered organisations are illegal, access to the information was not granted.

For this reason, a list of organisations providing treatment for SUDs in Cape Town was obtained from the MRC. On this list, there were three unregistered organisations. Only one organisation could be reached. There could be two reasons for this. Firstly, they could have been closed down by the DoSD and secondly, if they had not been closed down, they would be functioning illegally, and may have been uncomfortable with being approached. Due to these complications, a case study was conducted on a single Organisation.

Noor notes that: “Case studies become particularly useful where one needs to understand some particular problem or situation in great-depth, and where one can identify cases rich in information” (2008: 162-3). In line with this the Organisation was selected as it was identified by the researcher to fit the criteria of this project, an unregistered substance abuse treatment facility in a HDC run by members of the community. It provided a case both rich in information and very well suited to gain deeper understanding into an unregistered treatment facility, the primary focus of this project.

Flyvbjerg examines elements of case studies which propose that they are an ineffective method in guaranteeing accurate and reliable information and theory and therefore are not an appropriate way to conduct social research. He then goes on to correct these interpretations and argues that the case study method is a valuable means to conduct social research. He sets out to re-evaluate this method and subsequently argues that it can be used as a reliable way to conduct social research.

General criticism, as noted by Flyvbjerg with regard to the case study method, is that by investigating a single case it is not possible to generalise. Another criticism of this method is that it allows the researcher to be subjective in his/her interpretation. Both these factors would, it can be argued, affect the reliability of the proposed study and consequently place its scientific integrity under question (2006: 221).

A criticism, notes Flyvbjerg, is that context independent knowledge is more valuable and reliable than context dependent knowledge. In arguing against this point, he notes that in order for human learning to proceed beyond a certain level, for the learner to go from amateur to expert, participation and interaction in the learning process in a context dependent environment are required. He contends that, at the centre of expert activity, is context based experience and knowledge. Therefore, the case study method, which is based on the acquisition of context dependent knowledge and experience, is fundamental to the advancement of learning and an invaluable exercise to be applied to transcend the limitations of context independent knowledge (2006: 222).

Yin states that the case study is: “an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used” (1984: 23).

This demands that the milieu in which the research is conducted is described in detail, which is imperative for understanding and interpreting the case study. This includes a thorough explanation of the subjects, setting, data collection and analytical methods employed. This will allow for further studies to be conducted in the same manner which will additionally allow for potential replication in different organisations (Babbie and Mouton 2005: 282).

Accepting that the case study is not a tool to be used to develop hard theoretical facts and evidence, but rather as a means to increase learning about phenomena that exist in the social world, it is the researcher's contention that the case study method was an appropriate choice to achieve the aims of this research project.

Another criticism of the case study method noted by Flyvbjerg, and which requires consideration, refers to difficulties of generalisation and as such the ability of this method to add to scientific development. The argument is that by choosing one case, generalisations cannot be made and universal truths can therefore not be developed. In this context, he expresses the view that case studies cannot be deemed to be scientific (2006: 224).

The counter argument, however, is that a single case can be generalised but this is dependent on the choice and type of the selected case. The choice of design needs to be in line with the proposed aims of what the research hopes to achieve, which will determine what method is best suited (Flyvbjerg 2006: 226). Flyvbjerg says that generalisation in either large samples or in single cases is not the only determining factor in scientific progress, but that the employment of a wide range of skills needs to be applied, of which generalisation is only one (2006: 226). Scientific inquiry is a means to be used to increase knowledge. If cases cannot be generalised it does not necessarily make them redundant in the formation of a growing body of knowledge in a given field (2006: 226).

Eisenhardt explains that the case study is useful to "new research areas or research areas for which existing theory seems inadequate" (1989: 548). As very little has been documented on the selected Organisation which is the focus of this research, an in-depth case study method was deemed to be the most suitable manner to gain further understanding, insight and knowledge. It would not be appropriate to use other methods at this point because there is such limited information available, and because the development of the kind of Organisation that is the subject of this exercise has not yet been comprehensively explored.

It would be useful for subsequent research to be applied to other organisations of this kind so as to establish wider veracity and enable generalisations to add to a growing body of information in this field. This is an urgent necessity as the problem of substance abuse in Cape Town and the lack of service provision in this area are detrimental to the well-being of society.

One of the advantageous elements of the case study, Flyvbjerg argues, is that because the researcher is interacting in the life world of the selected research phenomena with the participants, views can be tested as they occur. This is a statement that further persuaded the researcher of this project to adopt a case study approach as the methodological instrument for the pursuit and realisation of specific aims (2006: 235). The close contact that the researcher is able to obtain in the field, therefore, when using the case study method is advantageous as information received from informants can influence commonly held notions and beliefs.

A last criticism of the case study is that it produces a lot of narratives which can be complex and difficult to summarise and produce neat scientific theories. The aim of this research, however, is to add insight and understanding in relation to the defined areas of focus. As such, the accumulation of thick descriptive narratives is imperative as a means to learn more about the situation (Flyvbjerg 2006: 241).

### **3.4 SAMPLE**

#### **3.4.1 SITE SAMPLE**

The Organisation that agreed to participate in this research project, the Recovery Home, is based in Mitchells Plain. It fits the criteria of this project. It is a non-profit faith-based organisation, a church, providing treatment for SUDs. It is unregistered and situated in a HDC. Access was granted to this Organisation and this was achieved by writing a letter to the Chief Executive of the Organisation explaining the purpose of the research and obtaining agreements on ethical stipulations. Following these steps the Organisation agreed to participate.



The researcher selected one organisation and the approach that was used to conduct research on this particular Organisation, is referred to as “information-oriented sampling”. The definition of this is: “To maximize the utility of information from small samples and single cases. Cases are selected on the basis of expectations about their information content” (Flyvbjerg 2006: 230).

### **3.4.2 INDIVIDUAL SAMPLE**

As the Home is run primarily by five members of staff, several interviews over a specific period were conducted with each of the members. The interviews were held with the Pastor, who is the Chief Executive, the Director, the Assistant Director, the Operations Manager, and the Programme Manager.

Clients, who were undergoing rehabilitation in the Home, also played an important role in the accumulation of information relevant to the aims of the study. Each of them was given a journal and a pen and asked to write a life story and record their daily activities and feelings. Participation in the journaling exercise was voluntary and it was therefore a self-selected sample. Clients who participated were asked to sign a form permitting the use of the information recorded. A stipulation in line with the ethical agreement made between the researcher and the Organisation stated that all clients were to remain anonymous. This allowed for the clients’ protection as they were requested not to put their names on the diaries.

In completing the journal exercise, female participants provided information on substance abuse and it emerged that the last time they had used alcohol or drugs ranged from between three weeks to six and a half months. The men’s reports on when they last used alcohol or drugs ranged from two weeks to seven months.

The following drugs were mentioned: mandrax, dagga, tik, ecstasy, buttons, heroin, rocks, cocaine and alcohol. All clients mentioned that they had used tik.

The women reported using drugs for between four and seven years. The time ranges applicable to the men were between eight and seventeen years.

Eleven females completed the journal exercise and seven males. The ages of the females who participated in the journaling exercise ranged from 18 to 33. The males' ages ranged from 21 years to 37. Six of the 11 females who completed the journal exercise had children. With the males, the following was reported with regard to children. Two of them had two children, one did not know, another had six children and there were another three with no children

Of the females who completed the journaling exercise, four had not finished school and had, in fact, left before the age of 18. All of the men had finished school apart from one who had left when he was 15.

### **3.5 DATA COLLECTION METHODS**

What follows is a more detailed presentation of each of the qualitative, data collection methods used in this project.

#### **3.5.1 IN-DEPTH INTERVIEW**

The in-depth, semi-structured interview allows interviewees to convey and converse in a way that they would in the real-life world, expressing themselves freely without constraint. As such, the interviews produce a narrative that is in line with interviewees' thoughts and experiences. As explained by Neuman:

“...members express themselves in the forms in which they normally speak, think and organise reality. A researcher retains member's jokes and narrative stories in their natural form and does not repackage them into standardized format. The focus is on the member's perspective and experience” (Neuman; 1997: 372).

The people interviewed, all of them engaged in various activities essential to the functional processes used in the Home, confirmed the values of the sentiments expressed by Neuman. They were consistently forthcoming on issues linked to the research aims, speaking openly about the design and structure of the Organisation as

well as expressing frustrations being encountered and the impediments that they believed were affecting the capacity of the Organisation to more effectively deal with substance abuse problems in the community. In addition, they shared concerns about difficulties around accreditation requirements and the absence of policy governing the existence of half way house institutions.

All interviews with staff members were in-depth and semi-structured. Important themes and topics were explored in relation to the aims and purposes of the study. As there are few staff members employed at the Organisation, the preliminary interviews were used to develop further questions and, following this, further in-depth interviews were conducted with the same members of the Organisation. This helped to develop a sense of both common and different views of members within the Organisation and contributed to information building and narratives which allowed opportunity for the experiences and perceptions of the interviewees to come through.

These processes were most useful as they allowed the researcher to generate further knowledge as well as confirming issues and increasing the likelihood of the reliability and validity of information gathered.

### **3.5.2 OBSERVATION**

For the initial period in which the fieldwork was carried out, the researcher spent two hours a day at the Organisation. This time was used to observe and to talk to clients and members of the Organisation, as well as those who came to take sessions with the clients. In this period, the researcher was able to attend sessions, observe events and get to know and familiarize herself with the Organisation. The sessions attended enabled the researcher to acquaint herself with the faith-based approach that is used at the Home and the discussions that took place with clients and members provided understanding with regard to all of the aims that were formulated for the purposes of this thesis. Furthermore, spending time within the Organisation facilitated the generation of a deeper understanding of its functional structure and also allowed for the observation of people operating in their natural environments.

Essentially, the success of this process was due to the acceptance, helpfulness and openness of the staff and clients at this Organisation. The researcher made detailed notes that subsequently added to the development of questions formulated to interview senior members of staff.

### **3.5.3 DOCUMENTARY RESEARCH**

The Organisation gave the researcher access to all communication between themselves and the DoSD, including e-mails and reports received by them in relation to the registration process. This information proved invaluable in achieving one of the aims of this project, an appreciation of the Home's perceptions and experiences of the registration process. From this information, the researcher was able to develop further questions to include in the in-depth interviews conducted with members of staff. This helped in developing a thorough understanding of the registration process as experienced by the Organisation.

The exchange of documents between the Organisation and the DoSD identified issues that were preventing the Home from achieving accreditation and it enabled the researcher to raise questions, the answers to which were relevant to perceptions about the registration process. It also revealed disillusionment that managers of the Home felt with regard to the effectiveness of Government interventions in the community. A further significant outcome that emerged related to Organisational inadequacies in providing a substance abuse rehabilitation service that complied with Government policy provisions. The most important of these was the Organisation's incapacity to administer evidence-based treatment.

### **3.5.4 PERSONAL INFORMATION/JOURNALING**

The final data collection method used in this report was the journaling exercise which required participating clients to record their substance abuse backgrounds as well as details on their daily activities and feelings.

The reason for choosing this as a method of data collection was as a means to gather basic information about individuals currently participating in the programme and their perceptions. The intention here was to achieve the aim, which sets out to describe clients' experiences of substance abuse and their perceptions relating to the faith-based treatment approach. This allowed them to freely express themselves and prevent subjectivity of interpretation by the researcher.

An additional purpose of the journaling was to extract from the clients their attitudes to the faith-based treatment methods used by the Organisation as well as their understanding of the causes of substance abuse in HDC. Getting this information was relevant due to the insistence by members of the Organisation that SUDs are caused exclusively by the debilitating socio-economic conditions that exist in various parts of Mitchells Plain.

### **3.6 ANALYSIS OF DATA**

The use of these different data gathering methods resulted in the accumulation of thick descriptive narratives in line with both the case study and qualitative research criteria.

The collection and collaboration of data occurred simultaneously. As information was collected, recurring themes and patterns were identified and the information was coded. This meant going through the data many times as a means of understanding patterns and themes that arose from the data.

During the initial phase of fieldwork, various observations were made. In conjunction with these observations and using the set out aims as a guide, initial interview questions were formulated. Following this, various interviews were conducted and transcribed. Following each transcription further themes and patterns were identified, information coded and this led to the compilation of subsequent interview questions. During this process, it became apparent that an extra data collection method needed to be developed to further cover the experiences and perceptions of clients receiving treatment at the Organisation. This led to the incorporation of the journaling exercise.

Following this, the data was coded by the use of selective coding. This led to the development of core categories whereby further in-depth questions were developed for exploration. The core categories included: the Organisation's faith-based treatment (deliverance), evidence-based practices, accreditation/half way house, registration (policies), Organisational barriers, interactions with Government and state incapacities, socio-economic conditions, the client and substance abuse.

The above methods are in line with grounded theory analysis. Babbie and Mouton refer to Strauss and Corbin (1990) and the two main elements which this theory incorporates when the analysis of the data occurs. They refer to the coding and adjunctive procedures. An important process of the coding procedure lies in asking questions and making comparisons and then labeling the text in a meaningful manner. Adjunctive procedures, they note, refer to memos. This is an important process and one that occurred throughout the data collection and analysis procedure of this research (2005: 499).

### **3.7 ETHICS**

“Research involving human subjects should be based on a moral commitment to advancing human welfare, knowledge and understanding. This must include the welfare, knowledge and understanding of the people being studied” (MRC Ethics Committee, Guidelines on Ethics for Medical Research: General Principle).

A number of steps were taken by the researcher to ensure that research conducted corresponded with ethical stipulations. A detailed letter was written to the Organisation explaining the nature and aims of the research and requesting access (Appendix 1). A meeting was held between the researcher, the chief executive and the programme manager. In this meeting the purpose, aims and limitations of the study were communicated.

Once access was granted by the Organisation towards the end of April 2009, the fieldwork started. A letter was signed by the researcher agreeing to protect the anonymity of the clients receiving treatment at the Organisation (Appendix 2).

The interests and rights of those participating in this study were guaranteed at all times. Confidentiality and anonymity were agreed with the Organisation. These agreements were specifically related to information pertaining to the clients. Data collected on clients were not used prior to obtaining the consent of the participants. This was achieved by designing a consent form which the clients participating in the journaling exercise were requested to sign. The consent form explained what the information would be used for. It was made clear that clients would not be identified and their consent was obtained for the reproduction of all details contained in their journals. It was made clear to them that if they were unsure about any of the conditions relevant to their participation in the study, they should not sign the consent form and information they had provided would not be used (Appendix 3).

Before conducting interviews it was clearly communicated to participants what the main objectives of the research were and what themes the interviews would cover (Appendix 5). The participants were informed that they were under no obligation to partake in the interviews if they did not want to.

Prior to using a tape recorder, consent was obtained and if the participant was not happy with this, the equipment was not used. One of the participants interviewed was unhappy with the recording process and in this instance, extensive notes were taken in the interview that was carried out with this member.

All questions were reviewed before the interviews took place. This was achieved by e-mailing questions to participants prior to the interviews.

Careful consideration was exercised with regard to where, and at what time, interviews took place. Before any interview was held, the participant was given an estimate as to the amount of time it would take. This helped to limit disturbances and disruptions to the interviewees' schedules. Prior to visiting the Organisation, times and dates were agreed upon via e-mail to attempt to cause as little disturbance as possible to the environment inhabited by clients and the work commitments of members of the Organisation.

## 4 CHAPTER 4: THE SELECTED CASE

### 4.1 AREA AND CASE PROFILE

#### 4.1.1 THE AREA: MITCHELLS PLAIN

Apartheid legislation required that individuals register their race. This resulted in extensive segregation. The 1950s Populations Act categorised South Africans as White, Coloured, Asian or Native (African) (Bickford-Smith, van Heyningen and Worden 1999: 157). Bickford-Smith et al. state:

“The way was paved for statutory segregation and inequality in every facility imaginable: from maternity wards to graveyards, shop entrances to restaurants, taxis to ambulances, beaches to parks, and park benches to pedestrian subways and bridges” (1999: 167).

The Group Areas Act in line with racial segregation was implemented as an attempt to prevent racially mixed residential areas (Bickford et al. 1999: 159). Approximately 150,000 people predominantly coloureds and Africans were forcibly removed to the Cape Flats” (Bickford et al. 1999: 154).

Mitchells Plain is an urban area created in the 1970s under apartheid legislation. Racial segregation was legally institutionalised in South African society. The coloured population was forcibly removed from the City, as it was reserved for Whites only. The development of Mitchells Plain, a self-sufficient dormitory suburb, was used to provide housing needed as a result of the forced removals and relocation of the coloured population in the Western Cape. As well as being isolated from White areas, it was also separated from areas reserved for Black and Indian population groups. The area was designed to house 250 000 people (Mitchells Plain Nodal Economic Development Profile 2006: 4). Bickford-Smith et al. comment:



“Few coloured, Asian or African families were untouched by Group Area removals, shack demolitions or pass convictions. For many youths, the frequent absence of parental authority or recreational alternatives hastened their graduation from peer playgroups to street defence gangs” (1999: 188).

The current population of Mitchells Plain stands at about 398 650 of which, according to the 2001 census, 95.73% are coloured. The area is home to 10% of Cape Town's population. Some 62% of the population of Mitchells Plain are under the age of 29. The predominant language spoken in the area is Afrikaans (Mitchells Plain Nodal Economic Development Profile 2006: 4). Unemployment levels in the area are high and about 48% of the population live below the poverty line. About 43% of the potential working population are unemployed. There is only limited access to higher education and many individuals leave school early to work or to seek work. Due to its isolation, it is difficult for people to access areas where viable economic activity takes place. Transport costs to central Cape Town are high, and opportunities for employment in the area are predominantly in the retail sector. Public utilities are underdeveloped. High unemployment and a lack of legitimate recreational activity for school going youth are among the reasons given for the high levels of crime, gangsterism and substance abuse in the area (Mitchells Plain Nodal Economic Development Profile 2006: 4).

HIV/Aids is prevalent in the area but not as high as in other parts of Cape Town. Most of the health problems in Mitchells Plain are thought to be caused by a lack of physical activity, unhealthy eating, smoking and alcohol and substance abuse. Diseases caused by these problems are referred to as non-communicable diseases and they include alcoholism (Mitchells Plain Nodal Economic Development Profile 2006: 4).

According to the WC-NDA, people living in Mitchells Plain have identified alcohol and drug abuse as the major contributing factors negatively impacting on their welfare. Foetal alcohol syndrome in the area is prevalent as is exposure to methamphetamines (tik) (Mitchells Plain Nodal Economic Development Profile 2006: 7).

Mitchells Plain is a Historically Disadvantaged Community, created during apartheid as part of the Government's social engineering. It therefore meets the requirements as an adequate site for this particular project. Furthermore, AOD abuse is prevalent in the area

causing many health and social problems. This makes research in this area, and in this particular field, of utmost importance.

#### **4.1.2        *SELECTED CASE: THE RECOVERY HOME***

The information set out in the following four paragraphs was gathered from a single interview with the Programme Manager on 1 May 2009. The Recovery Home was opened in 1995 as an autonomous Church by its Pastor. Prior to this, he worked at Westridge Assembly of God where he was responsible for social relief programmes. He became involved in outreach in Heinz Park, an under resourced community in Mitchells Plain, where he recognised a great need for social intervention. It was here, that he started the Recovery Home. For the next five years, he worked in assisting the area in developing its infrastructure, roads, water and sewage.

He identified a need in this under resourced community beyond those of the spiritual, and hoped that the work carried out here would impact the surrounding areas. The unemployment rate, at the time, in that community was 80%, and as a response to this, the Church started an adult literacy programme and an education initiative for children. Since then the Church has become an established non-profit faith-based organisation and continues to provide outreach and social intervention.

They are involved in a feeding scheme for children. They continue to provide educational development for children. They run a sewing programme for women in the community called Reach One Teach One. This aims to teach women skills that they can then teach other women in the community and use as a means to accumulate an income. They are also involved in a programme for abused women in the community called Cycle-Breakers that works towards breaking the cycle of abuse. The final project that they are involved in, which is the focus of this research, is a drug recovery home.

Having grown up in Mitchells Plain, the Pastor identifies with vulnerable young people in the area who lack positive role models and father figures. Schools in the area are fertile breeding grounds for gangs and drug dealers. With problems reaching epidemic proportions in Mitchells Plain, a main priority of the Church is its Recovery Home.

#### **4.1.3 STAFF STRUCTURE OF THE RECOVERY HOME**

Information pertaining to the staff structure of the Organisation was obtained from an interview with the Assistant Director on 22 May 2009. Pastor is the executive head, occupying the position of chief executive of the Recovery Home.

He is directly supported by the Church Council, of which he is also the head and, at a slightly lower level by the Recovery Home Board. The Church Council was established in 2009.

The function of the Church Council is to ensure that the Recovery Home Board manages the programme in a way that honours the vision and mission of the Organisation. It is also to provide guidance on issues that the Recovery Home encounters, as well as noting and encouraging achievements made, and providing spiritual support.

The Recovery Home Board is there to serve as final oversight on operations and decisions taken by the Director and operations management. In addition, it is tasked with assessing the vision going forward. This takes place at quarterly meetings, which are also held to discuss the mission, and goals set out and needed to be achieved in accordance with the yearly plan. It is also responsible for evaluating the financial operation and funding of the Home.

At the top end of the operational structure is a Director. He is responsible for general oversight of the programme. His other responsibilities include sourcing funding opportunities for the Home, providing guidance to the leadership and the clients as needed and to maintain contact with the DoSD for registration/accreditation processes and developments. He works with the Assistant Director to liaise with the relevant external departments to maintain health and safety implementations and manages the Individual Development Plan of clients as well as overseeing training sessions (e.g.) administrative needs, peer leaders.

Directly below the Director is an Assistant Director who is a trained, registered nurse. She is accountable for the medical welfare of the clients in the programme (on site and referrals). Her other responsibilities include conducting initial medical assessments of each client, assisting the Director and the rest of the Board and Leadership (as needed), liaising with the Department of Social Services on behalf of the Home and conducting interviews and making referrals (as needed). In addition, the Assistant Director has responsibility for writing policies, maintaining the Manual of Operations File and the legislation file for the Home and facility liaison when required, (e.g.) letter writing, meetings etc.

The Operations Manager, a graduate of the programme, is responsible for assisting clients towards the end of the programme, and to act as a mentor to clients completing the programme. At the end of the fourth month he is responsible for conducting assessments of the clients and to develop a strategy for their re-integration. This would include making contact with previous employers and evaluating an action plan. If necessary, he will conduct home visits with the Pastor. He is also responsible for networking with other organisations and managing new network partners. He supports the everyday activities of the clients and provides leadership.

The Organisation's Programme Manager, is also a graduate of the programme and is currently at bible school. He is responsible for the general management and oversight of the facility, the management and operational processes around the recovery of the clients. He helps with client interviews and referrals. He manages the facility's equipment, vehicle and basic finances. He manages facilitators who work with the clients to develop life skills. He provides leadership on the ground and institutes corrective and disciplinary measures for the clients. He provides operational oversight of the female and male homes. He provides spiritual guidance and referrals as needed, writes reports and represents the Home on the Church Council.

Additionally, there is a group of facilitators who are intimately engaged in the processes that have been developed for rehabilitation purposes. These include life skills, family support and peer leadership.

#### **4.1.4 FAITH-BASED APPROACH OF THE ORGANISATION**

The Home's rehabilitation programme is based on acceptance of the Christian faith, and individuals are encouraged to develop spiritually and through this, to recover from SUDs. The Pastor implemented the faith-based approach in his own community in Mitchells Plain in early 2007 (Interview 30 April).

In the period of two years that the Home had been operating, from May 2007 to May 2009, 138 people have entered the programme. Of these, 93 did not complete the programme and 45 graduated, i.e. they completed the six month programme. These figures do not include the ladies home as at this time it had only been open for six months (Interview 30 April).

The faith-based programme, as practised by the Organisation, is founded on the principle of deliverance. The belief in deliverance dictates that once an individual has accepted Christ into his/her life, he/she will be seen as a "new creature in Christ" and will consequently be "saved" (Interview 14 May 2009).

The Organisation has explored the prospect of applying for accreditation as a half way house. In this respect it has received official encouragement from Government but, it finds itself in a difficult situation as there are, at this time, no official norms and standards for half way house registration. Apparently, they are still in draft form.

#### **4.1.5 RAISON D'ETRE**

The main purposes, as expressed by the Organisation, are to provide treatment for substance dependent individuals through a faith-based programme and to achieve abstinence. In addition, the Organisation is committed to providing a safe environment for substance dependent individuals and to help them to overcome the root causes of their problems and become productive members of the community. They view their programme as being holistic, catering for body, mind and spirit (Interview 29 April 2009).

As explained by the Organisation, the programme was started because of the serious drug problem in the community. They note that the issue has had devastating effects on the people, most particularly the youth in the area (Interview 29 April 2009).

The Organisation has three different elements to their programme. These include an out-client component, an in-client component and a re-integration and aftercare component. Each of these elements has different objectives.

Among the objectives of the Recovery Home, is one that is aimed at providing a recovery environment and treatment for disadvantaged substance dependent men and women. This includes re-integration and an aftercare support system.

The two-week out-client component has been put in place by the Organisation for a number of reasons. Firstly, it allows for enough time for the clients to enter the programme with clear urine tests. Clients therefore go through a period of abstinence process before they begin the six-month in-patient programme. Secondly, clients are assessed and observed by the Organisation during this period. This allows the staff and the individual time to decide if they relate to the faith-based approach, and if staff detect psychiatric problems, they refer clients to social services. Thirdly, it prevents the Organisation from wasting valuable resources if clients are not committed or if they are not right for the faith-based approach.

The objectives of the six-month in-patient programme allow individuals to follow a routine and structured day. In doing this, a number of things are achieved. The clients practise personal hygiene and they are provided with three meals a day. As the programme is faith-based, much time is set aside for clients to develop spiritually and practise Christian principles. Through various sessions, the clients are taught new life skills. They are encouraged to develop new ways of communicating and interacting with others. They are encouraged to share their experiences with others in the programme and to support and help one another. Much time is set aside for bible reading, prayer and church attendance. All these processes over time help to change perceptions and modify behaviour. The programme includes disciplinary and correctional processes to reinforce new behaviour.

The reintegration element of this programme aims to help clients to develop new skills. As the programme focuses on giving back, clients are encouraged to work with other youths in the area and through this develop leadership skills. Staff attempt to help clients with employment, to develop curriculum vitae and to set up bank accounts. The Organisation also runs a support group for clients to attend after the six-month programme is complete. They attempt to work with the families of clients to help re-connect and build new relationships (Interview 29 April 2009).

#### **4.1.6 THE VISION AND MISSION OF THE RECOVERY HOME**

The vision adopted by the Organisation is to create a safe environment for substance dependent individuals from the community, to confront the root causes of their problems and to empower them to become productive and constructive members of the community (Interview 29 April 2009).

Their mission, as they describe it, is to present workable principles and programmes that will alter all areas of the individual's life. They state that the holistic approach that they offer covers the body, soul and spirit of man (Interview 29 April 2009).

Because the programme is faith-based and members believe in deliverance, they do not administer any medication to aid detoxification. Clients therefore are not requested to provide a medical certificate after the two-week out-client programme, when they enter the home (Interview 26 June 2009).

The understanding of substance dependence by the Organisation is that it is caused by environmental factors. They see it as a socio-economic problem, the root causes being poverty, low self-esteem of youth, disintegration of families, peer pressure, no safe environment to talk about abuse, conditions people live in, poor education, lack of government subsidised rehabilitation facilities, vicious cycle of crime/prison and powerless authorities (Interview 18 August 2009/ interview 14 May 2009).

Substance dependency affects the impoverished communities by creating a false picture about attaining a desired lifestyle because of the shortcomings in the community. The

façade, therefore, is that substances will help the individual to acquire a better more desired way of life (Interview 18 August 2009).

The rehabilitation belief is that God can deliver the individual from any bad situation or circumstance. (Interview 18 August 2009).

The Organisation sees the faith-based approach to dealing with substance abuse in this community as a strong medium to reach young people. Because of the conditions in which people in the community live, their understanding is that purpose is lacking and as such, youth turn to drug abuse and gangs. By building spiritual beliefs and principles the individual develops a more positive and optimistic attitude. (Interview 14 May 2009).

#### **4.1.7 FINANCIAL STATUS**

Financially, the Organisation struggles. Since they started, they have been funded by the Church. Because they are not accredited they do not receive funding from Government. They are, however, in a better position than they have been in the past. They received two donations to spend on life skills. They have recently started charging clients R200 and about eighty percent of the clients are able to pay this. The other twenty percent are those who cannot afford to pay anything and they will take these clients in at no cost. The target population for the Organisation are people from the street. From the payment made by clients, the Organisation can now afford to cover certain costs such as the rent for the Ladies' Home, and the Church has consequently become less burdened. They are still self-funded. They are attempting to connect with other organisations and access corporate social investment (Interview 10 August 2009).

#### **4.1.8 FUNCTIONAL STRUCTURE**

As the Organisation does not have qualified staff they employ a peer review system. This process works with the involvement of clients who have completed the programme, becoming peer leaders.



Each peer leader is in charge of a group in which there are four or five members. The peer leaders then meet with the staff who are available and give feedback on the members of their group. This is how they go about the client review process. As noted by the Organisation, it is a very informal process and this is the way they go about seeing and monitoring individual clients. The process is subjective, not objective. They use this process to identify clients who are problematic and from there apply disciplinary procedures.

A senior member of staff notes:

“The client case review, what happens is we review our clients, we don’t have qualified staff on the team, so we have a peer leader concept so the peer leaders will give feedback every alternate week in a meeting and then cases are discussed” (Interview 10 August 2009).

As trained professionals are not present, individual interactive sessions do not occur. The programme is therefore not comprehensive and information that is collected and stored on individuals is incomplete. This presents further complications: As explained by a senior staff member:

“It’s not comprehensive in that we don’t really offer much individual counselling. Only when clients need it, and then those are not documented. They would be on an ad hoc basis and so you actually won’t be able to pick up a file, so all his personal information is there his history prior to getting into the programme is there, all his training things. What kind of exposure what kind of facilities, what sessions but we don’t have one-on-one discussions. We have all the correction, all the discipline, all the incidents are documented so when a guy has an incident, that is written up. His recommendation is written up, his correction is written up - all of that - but the other bits, the psychological and emotional and those kinds of components, that’s not. So, in that way I would say it is not comprehensive and I think, that there is a gap. We have identified more than once, besides the funding, for us the big problem is counselling services, one-on-one counselling services for our guys” (Interview 10 August 2009).

The clients' individual files consist of his/her personal information, his/her history prior to entering the programme, any training or education he/she might have had, and a record of correctional/disciplinary incidents. Critical psychological and emotional elements do not form part of the file contents.

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## 5 CHAPTER 5: FINDINGS AND RESULTS:

### 5.1 THE HOME

#### 5.1.1 STAFF ISSUES

The Organisation does not have any professional staff, which results in clients not receiving the minimum standards of treatment.

There are critical gaps when it comes to professional guidance for staff, staff development and in-service staff training.

Individuals are trained at bible school, which is in keeping with the faith-based programme that they offer, but does not provide the Organisation with qualified, accredited substance abuse counsellors or, for that matter, professionals to oversee the counselling of clients and the implementation of an evidence-based programme. The Organisation does not have sufficient skilled staff to provide the best treatment for their clients.

Clearly, these are problems that are not regarded as such by members of the Organisation. A senior member of the Organisation commented that:

“Then the manpower we basically have, the manpower that has been through that kind of lifestyle, that is giving back and can identify with people. So I think we are one step ahead of many of these organisations that just have a theory. We sit with people that know what they are speaking about” (Interview 14 May 2009).

Staff who are not trained correctly are put under extra stress, and the clients are not given the services most likely to accomplish successful rehabilitation.

The Organisation notes that a problem that they experience after clients have left the home is families having unrealistic expectations of the individual. This is indicative of a

need for family education and counselling, so that they have a better understanding of the problem and what it is about. They will therefore be able to be more supportive. However, as the Organisation lacks professional staff and staff capacity they are unable to provide this service.

### **5.1.2 CONSEQUENCES OF STAFF DEFICIENCIES**

Since the Organisation lacks staff and therefore acceptable structural capacity, there are certain fundamental issues that have not efficiently been addressed. One example of this is the client charter. An important matter for clients entering any programme is that they should be made aware of their rights. This is an instrument to protect clients. As the Organisation notes they have not been able to address this issue due to other priorities:

“We drew up a client charter and it is in draft form. That addresses that one, which has been done this year, 2009. We didn’t finalise that because we addressed many things at the same time and then some things just got pushed to the end of the line and some things got pushed up and the reason was that we were, for example, working on our processes at the same time like the out-client component” (Interview 10 August 2009).

There is a misunderstanding of terminology within the Organisation. This represents a fundamental gap in institutional knowledge. Two such examples of this were evident when the Organisation was questioned on prevention. The other was related to the acquisition of medical certificates for clients entering the programme.

When questioned about their prevention strategy, a senior member of staff commented:

“Prevention, in this case as an organisation, we don’t have any or give any substances. By the time the guys enter the programme they can’t have access to anything, even cigarettes, and we know of other programmes where they allow them to smoke and other programmes where they give them tablets like subertex, and those kinds of things. So in our programme, because we are faith-based, we believe in deliverance so we give nothing, so none of our clients are

chemically dependent. The most our guys would get would be med-lemon or disprins when they have the flu, so we don't have a problem with that" (Interview 10 August 2009).

Prevention refers to the situation prior to individuals reaching the dependency stage. This requires organisations to develop literature as a means of preventing the target population from reaching the dependency stage, something that is greatly needed in this specific area. It is the development of brochures and literature by an organisation to help the public to develop awareness and assist in prevention. The Prevention of and Treatment for Substance Abuse Bill states that prevention programmes are:

"services that facilitate the prevention of substance use and contain information, education and communication about the risks associated with the use of substances of abuse and how to avoid the use thereof; and proactive measures that must target individuals, families and communities before the onset of use of substances of abuse, which may lead to abuse and also to prevent persons from moving into the other levels of addiction" (1999: 11).

The Organisation has a misunderstanding of the medical certificate. One of the functions of clients obtaining medical certificates is to monitor their detoxification medication, which the Organisation does not subscribe to. The Organisation, when asked about this matter, made the following comment:

"When necessary we need a medical certificate, one of the guys has seizures, so we asked him to go to the doctor to get a letter to say he is coming in, that he has seizures but that he is controlled on medication and he'll come monthly for his appointment" (Interview 10 August 2009).

The minimum norms and standards for in-patient treatment centres require that when individuals enter treatment they need to have a medical certificate as explained in the manual:

“All admissions of substance-dependent persons to inpatient treatment centres should be accompanied by a comprehensive psychosocial report and medical certificate” (2007: 24).

### **5.1.3 FAITH BASED APPROACH**

As briefly mentioned in a previous section of this report, the Organisation’s reliance on the faith-based approach and exclusion of evidence-based treatment methods, are major reasons why it is not able to obtain official accreditation.

Clearly, unless the Home introduces a system of evidence-based practices, an adaption that is unlikely due mainly to financial constraints and its emphatic belief in deliverance as the primary curative component of the faith-based approach it adheres to, it will not receive official recognition as an accredited in-patient substance abuse rehabilitation facility. In this context, it is the researcher’s opinion that policy formulators should be giving consideration to other measures, half way house establishment provisions for example, which would enable institutions like the Recovery Home to play a more meaningful, and legitimate, role in a community where this kind of involvement is transparently essential.

It is policy deficiencies of this kind that cause people like Pastor to express the view that Government does not have a proper regard for the interests of the people who live in Mitchells Plain.

### **5.1.4 RESEARCHER’S ASSESSMENTS**

An analysis of the factual information presented by staff members and recorded above presents a variety of challenges that limit the Organisation’s capacity to meet the objectives and purposes that it seeks to accomplish.

The most critical of these is the lack of financial support from corporate and Government and the paucity of trained, professional staff. Financial constraints mean they are unable

to maintain the building that they use which could lead to health and safety problems for both clients and staff. In addition, it causes an inability to implement critical procedures.

The Organisation's heavily faith-based approach means that they are rigid in their beliefs about substance dependence, resulting in a negative perception towards implementing certain evidence-based practices that they would need to apply to become recognised and accredited by the DoSD.

The partnerships they currently have are all with other faith-based initiatives. A broader networking initiative would be valuable to the Organisation to widen the scope and understanding of SUDs.

A consequence of the fact that they are not accredited means that the services they are currently offering are not regulated, are illegal and potentially harmful. They lack funding opportunities and because no official half way house policy exists, confusion over definition and expectations is rampant.

The Organisation's staff are dedicated and they have a clearly defined purpose with great ambitions to achieve this purpose. They are committed to providing a community service in this area. The Organisation displays a willingness to bring extra trained staff on board, but as they explain, they lack the resources to do this. However, without professional staff, the Organisation is not providing an adequate service to the community. It is vital that staff are trained and that the Organisation learns to understand that counselling and support from "recovering addicts" is not sufficient. Because professional staff are not present at this Organisation there are deficiencies in capacity, knowledge and vital developmental procedures needed to ensure the safety of clients and the progression of their recovery processes.

In this sense, this lack of capacity to address its functional deficiencies in the most appropriate manner, may at times mean that clients, contrary to receiving the best possible service, are the unintended victims of a disservice.

### **5.1.5 RECOGNISING DEFICIENCIES**

The Organisation has made progress on their admissions system. The one element missing in this regard is that clients with SUDs need to be assessed by professional staff who have had training in this area. The progress that they have made in this area is that they have begun communicating with families and they have standardised this process. So all staff members conducting screening exercises follow the same process. The Organisation then meets and decisions on the client are made collectively. They consider how the client will be supported in his/her process.

The Organisation has also started documenting this process, an element that was previously not in place. The screening process, they note, is also to assess the suitability of the programme they offer, the faith based concept, as well as looking for any psychiatric problems, whereby referrals are made.

A senior member of staff commented:

“We don’t do the psychiatric diagnosis, we don’t have the ability to do any of those so our patients are assessed more on what they say to us, their self disclosure. Then based on that we will then observe them for two weeks so the staff can see, then we have a meeting to discuss the out clients and make a decision if they are suitable to come in, having met with the family and the guys individually. Anything else that comes up, the psychiatric component, we are not doing here, we refer them out. We have one formula and it works. It may not work for everybody, and so we happily refer those that we feel that we cannot help” (Interview 10 August 2009).

### **5.1.6 ADDITIONAL CHALLENGES**

The Organisation sees their faith-based approach as being a barrier to getting counsellors. As they note, they would not accept anyone with alternate beliefs. They also see a problem in the fact that they have not been able to tap into free resources. Another impediment in this regard is to be found in their fee structure. Since they do not charge



their clients very much, or anything at all, they cannot afford to pay trained staff. Their target group is the disadvantaged, those who cannot afford treatment, so in this respect it would go against their principles to impose heavy charges on their clients.

One member of the Organisation notes:

“Our lack is staff training, we are starting team building activities, we will start there. We have not tapped into social service training. We have not had much training as a group. Social services offers various training for various types of things but we have not, maybe it’s part of the accreditation thing because they then let their people know what is happening when, we have not had any of that. So, we are hoping to address that now through the Local Drug Action Committee. We have registered with them. We are doing a presentation tomorrow for our ward. So, we are hoping to push that through with them and see if they can access training for the guys. So, challenges and barriers, I think, has been lack of funding, lack of knowing what is available, lack of connecting to the right people who are offering these things for free. Funding is our limitation, it limits us in everything. We can’t do as we wish” (Interview 10 August 2009).

Training is therefore an issue. Because they are not funded, they cannot pay for training or trained individuals. Not being accredited, they feel that they also could be missing out on training opportunities offered by Government and Social Services.

“So you see once we get funding and accreditation we can do the training bit, we can hire staff, and the counselling bit then lots of our barriers will be removed and our challenges overcome because the things that we are struggling with are the things that we don’t have money to pay for. In the two and a half years we’ve still done a lot of good work, helped more than forty drug addicts to become productive, and that’s with no funding” (Interview 10 August 2009).

The Organisation hopes to address these issues through the Local Drug Action Committee which they are communicating with and through representing themselves at various events to increase knowledge about what they do and what they hope to

achieve. They are hoping to access training for their staff through the Local Drug Action Committee.

## **5.2 THE REGISTRATION PROCESS**

### **5.2.1 BRIEF DESCRIPTION OF THE REGISTRATION PROCESS**

With the introduction of minimum norms and standards for in-patient treatment provision, the Organisation complied with the law and they made a formal application to register. On 14 May 2008, the Organisation received a letter from the DoSD noting that:

“The Department of Social Development is responsible for the administration of the Prevention and Treatment of Drug Dependency Act, No 20 of 1992 (the Act). The Act provides a legal framework for the establishment, management and monitoring of inpatient treatment centres in the country” (Letter to Recovery Home dated 14 May 2008).

They then go on to explain the minimum norms and standards for inpatient treatment centres,

“The minimum norms and standards for inpatient treatment centres has been developed to standardise service, facilitate transformation and improve quality of service. It seeks to prescribe an acceptable quality of care for substance dependent persons at these centres. The manual enables an objective assessment and comparison of existing services in order to regulate and support the development and delivery of services” (Letter to Recovery Home dated 14 May 2008).

They informed the Organisation that a formal application needed to be submitted to the DoSD by 30 May 2008 (Letter to Recovery Home dated 14 May 2008).

The Organisation submitted a formal letter to the DoSD to register as an in-patient treatment facility. The Organisation was assessed by the Department on 16 October 2008.

On 10 December 2008, a meeting was held between the DoSD and the Organisation to give the Organisation feedback on the assessment.

The Organisation was notified that it did not meet the minimum norms and standards for an in-patient treatment facility and that therefore it could not continue rendering the service it was at that time providing. It was additionally informed that it did not comply with legislative and operational requirements and that a letter would be sent to the Organisation requiring them to terminate services provided.

The Department provided the Organisation with a report recommending that they implement various procedures, despite explaining to them that they would be required to terminate the service that they were providing. However, without support and funding it is impossible for the Organisation to implement the Department's recommendations.

The report given to the Organisation provided a detailed explanation of the criteria it was assessed on and recommendations on what needed to be done in order for the Organisation to register.

These recommendations refer to the following areas: human resources, treatment or consultation rooms, emergency trolley, occupational health and safety, client accommodation, kitchen facilities, general recommendations and policy and procedures.

Firstly, with regard to human resources, they recommended that personal files needed to be kept current and secure. Job responsibilities and employment contracts needed to be available in writing and signed off by senior members. That personnel should be committed and able to attend continued educational courses. That only clinical staff make final decisions on treatment approaches to be followed, and that a medical practitioner supervises and consults on medical issues, and that this is formally agreed to with the Organisation and that person in writing.

They note that a treatment or consultation room and area needs to be established whereby in the event of an emergency, resuscitative procedures can be preformed. They note that each client needs to have a clinical record and that this needs to be stored in a

secure place. Medication needs to be given by a qualified member of staff, and medication administered needs to be recorded.

The current emergency trolley existent at the organisation at that time, the report noted, was not adequate. The current accommodation facilities were not suitable to provide optimal care for clients. It was noted that a health care professional was needed to oversee the preparation and diets of clients to ensure optimal nutritional requirements. And, that all policies and procedures needed to be signed, dated and contain review dates.

They point out that the current building does not provide the best therapeutic environment. There is a shortage of space that does not lend itself to suitable consulting and counselling purposes whereby the clients privacy can be guaranteed. They note that the building is in need of general maintenance.

In conclusion, they remark that the Organisation provides a recovery environment rather than a rehabilitation treatment facility that makes use of therapy. As such, the definition of the function and related capacity of an Organisation of this type needs to be made by the relevant authorities to ascertain the minimum norms and standards of recommended registration requirements, for such a facility (Assessment Report from the DoSD to Recovery Home: 10 December 2008).

### **5.2.2 THE ORGANISATION'S RESPONSE TO REGISTRATION**

The response by members of the Organisation to the unsuccessful registration process, which demonstrates serious levels of confusion, emerged during interviews conducted by the researcher.

The assistant director of the Organisation made the following comment.

“We are doing what we are supposed to do, I think. We are going to keep trying. Obviously, we can't do the in-client thing and we can't do the out-client thing so we are just going to keep asking and pushing. We don't want to move away from

what we do well so this bit we do well, because we can't do that bit. We are overlapping at the moment but our strength, for example, one of them said why don't you register as a shelter. Now we don't want to do that, we don't want to lose the essence of who we are. So, we just keep plodding along" (Interview 10 August 2009).

The Organisation states that it accepts that it does not fit the description and does not have adequate facilities to provide an in-patient service, as they do not meet the requirements of the minimum norms and standards set out by the DoSD. However, it continues to operate, in defiance of registration requirements, as an NPO with an out-client, in-client and aftercare programme.

The assistant director observed:

"The DoSD knew we had a residential component and that we did not have a detox and medical facility, this was the basis of the closure letter. We have made numerous requests for application as a half way house though, which has not been possible because of the lack of policy. We are, therefore continuing to, operate as a NPO with an out-client, in-client and aftercare phased programme as a second stage residential recovery home and not as a treatment facility" (Interview 31 August 2009).

An additional major problem that exists is that Government has provided no clear definitions, roles and organisational purposes for half way house institutions. When the Organisation was assessed by the DoSD in their report, it was noted that the Organisation provides a recovery environment rather than a rehabilitation treatment facility. Members of the Organisation express the view that the recovery environment, as opposed to the practices of treatment and rehabilitation, should be institutionalised by Government as a primary objective of half way house establishments. If this was done they believe the Organisation could become compliant as a half way house facility and operate in a properly regulated and legitimate fashion.

Founded on these views, it is the researcher's opinion that there is a clear need for the relevant authorities to provide policy guidelines, which set out minimum norms and standards for the establishment and operation of half way houses

In the circumstances in which the research for this project was conducted, including an absence of policy governing half way house facilities, the Organisation continues to function as it did prior to the inspection. This makes both its existence and its operational practices illegal.

What is more disconcerting is that the Organisation is not equipped to provide clients with the services they need when entering treatment. They do not have detoxification and medical facilities and, as previously pointed out, do not subscribe to these evidence-based practices. This is potentially hazardous to the safety and well being of their clients.

Personal observation and interviews conducted by the researcher to achieve the aims of this study also uncovered a misinterpretation by members of the Organisation of fundamental knowledge with regard to treatment provision. A final concern exists in the fact that the Organisation continues to operate in the knowledge that they have been requested to terminate their services, in the health and safety interests of their clients.

For the researcher, this presents doubt as to whether the Organisation and its members do in fact accept that they do not fit the in-patient treatment facility description. While there is sound basis for criticism of the Organisation and its management as recorded above, there is also good reason to appreciate their frustrations and confusion, which emanate directly from their interactions with Government.

When the Organisation, for example, requested that it be permitted to register as an out-patient facility so that it could continue its work, they were notified by the DoSD that the policy for registration for out-patient facilities was still in draft form and because of this, the DoSD were unable to enforce any regulations. They further informed the Organisation that they could continue with this programme with caution. They reiterated, however, that no clients could sleep at the facility.

As expressed in a letter to the Organisation from the DoSD:

“The Department does not have the norms and standards as yet for the outpatient. However, the new Act requires that all programs be registered. We are unable as yet to enforce that as regulations and standards are not set as yet. You may proceed but please exercise caution. Remember out patient, no one sleeps on site. The Half way house was a great idea. I hope you are not throwing it out completely as there is none in this province” (e-mail to Recovery Home from the DoSD 23 June 2009).

From the Organisation’s perspective, these kinds of responses are unhelpful. They want to be accredited. They see themselves as law abiding and transparent. They see accreditation as a way to overcome their barriers. If the Organisation attained this status, they could get funding. Once they received funding they could implement a number of improvements, such as staff training, hiring staff, providing counselling services and improving the building. They would like to move to a bigger building where they could create various supplementary amenities (Interview 14 May 2009).

The Organisation maintains constant contact with the DoSD, requesting the half way house policy so that it can register. The Organisation were encouraged by the DoSD to keep this idea going as there were no institutions of this kind in the Province. There are private half way houses that are registered with DoSD, under in-patient facilities. There are no institutions of this kind, however, with regard to state rehabilitation facilities.

Pastor commented when asked about the registration process:

“The registration process, firstly I said to our guys that we want to be law abiding in the process of dealing with the drug rehabs and drug recovering but the registration, it is basically the requirements. For example, when it comes to the rehab, or the norms and standards for rehab, we have made peace with that now but we don’t meet their criteria. So we still continue with the recovery approach or the second stage of rehab. They call it the second stage of rehab, the things that we are doing. We now have to fall into the category of a half way house, and the state don’t have a documentation or a policy in place for a half way house. So,

we are caught now just hanging, suspended now while they are debating and trying to sort out their cobs. But we just continue to keep our doors open” (Interview 14 May 2009).

The Organisation continues to provide services for substance abuse in this area. Service provision is lacking, there is a problem when it comes to individuals from this community accessing treatment. The disadvantaged people this Organisation serves cannot afford state or private rehabilitation. In the absence of Government capacity, the Organisation sees the service they offer as vital in this area.

It is pointed out by Pastor:

“The human rights of the individual, the individual has a right to choose what kind of treatment he wants and where he wants it. So we offer help, we offer treatment. It’s the choice of the individual to come here, we don’t go out there and recruit people to come here, it is their choice. Secondly, if Government cannot deal with the problem and if Government does not have facilities to deal with it, it is the right of the individual to get health care and support. We are doing that for them” (Interview 14 May 2009).

The Organisation has developed a sense of mistrust with regard to Government’s procedures and policies. It perceives Government to be failing the people in the community. The Government has not succeeded in implementing adequate service provision in this area. It also failed to carry out assessments of current clients after the inspection. This failure to carry out procedure led the Organisation to take matters into their own hands.

The assistant director says:

“We were asked to send all the names of our then current clients to them for assessment and placement elsewhere. The names were sent, but no assessment or placement was done (11 Feb 2009). We had to refer all new clients to Social Services. This process proved to be hampered by various things on their side and we communicated this to them. We then started our own



assessment. We referred clients who could not be assisted at our recovery home (e.g.) psychiatric problems, does not accept a faith-based option etc to Social Services but continued the recovery home service, not accredited by Social Services but as a registered NPO, while still communicating with Social Services and Environmental health etc” (Interview 27 August 2009).

“As noted in our response letter, we are in the process of sorting out our operational issues. When would we need to send our current clients for assessments? Also, we want to apply for the half way house status as soon as possible, so that we can continue helping people. Please advise how we apply for this status?” (e mail to the DoSD from Recovery Home 2 March 2009).

The Organisation was also asked to refer new clients to Social Services. This process resulted in a negative perception of the effectiveness of the capacity of Social Services.

The Organisation’s frustrations were conveyed in a letter to the DoSD:

“We have been referring people coming from the streets for help to our facility to you since December 2008. We had a report from a mother and son, who returned to us, saying they spent the day there and were not helped. We also had two other reports from people who were not helped. We have had no written communication from your office stating why. As a church we are really struggling with turning hurting people away. Please advise what we should do with people returning to us? Do we refer them back to your Mitchell's Plain office? Please give us guidance on this” (e mail to the DoSD from Recovery Home 2 March 2009).

“We are feeling dejected that this referral process is failing the very people who are coming to us for help” (e mail to the DoSD from Recovery Home 25 March 2009).

### **5.2.3 A WAY FORWARD**

The Organisation feels that many of the requirements of the Department's minimum norms and standards are unattainable for them. In a community with few resources and a lack of service provision people in the community are taking action.

A senior member notes:

"I think they will have to tone down their stipulations. I think they will have to revisit all their policies and procedures around this thing and they will have to put a slack on this thing. Because there are many people prepared to do something about it but it's almost like you know, they are not concerned about the results. They are concerned about policies. They are not concerned about outcome, they are more concerned about policies, and they are missing the mark when it comes to the people" (Interview 14 May 2009).

The Organisation expresses a desire to work with and communicate with Government on these issues, as Government has not been able to implement and enforce procedures. The Organisation continues to provide a much needed service to its community. With an apparent lack of communication responses from Government and the way Government has gone about implementing relevant processes, the Organisation feels that valuable resources have been wasted and Government does not take the people in the community into account, or properly consider their views.

Pastor says:

"We have a top down approach here. Government decides what needs to be done and then they come and impose it on our people, so it's a top down approach. That has not been working and I have seen how money has been wasted in the past. We have this one programme here, one of them went to look at that programme and said that is what we need. They came here with the Matrix Model and said that this is what we are putting up for you. So it's a top down approach and it's not working for our people" (Interview 14 May 2009).

“I don’t think what Government took into account, I don’t think they took context, a programme will work in a context okay, you take that same programme and put it into another context it might not work. That is my problem they have not evaluated context, and most of them that did this don’t live in the area you know. So, I’ve been fighting them because they come with a top down approach and just impose things on our people. This is what you need, so just take this, and that for me is a money waster” (Interview 14 May 2009).

A senior member of the Organisation explains his view of the need for all role players to work together to uplift the community:

“I feel that, you know, there needs to be a co-operative system. What I mean by that is we need Government, we need corporate. We have the community there already wanting help. But, I think it should be a partnership because there are things that Government can do that we can’t do. When it comes to service delivery for our people, when it comes to creating jobs and all those things, investments into our communities, those things Government can do, we can’t do that. So, I would think that if a system is developed where all role players come together, then I think that we would have a system that would help” (Interview 14 May 2009).

#### **5.2.4 RESEARCHER’S ASSESSMENTS**

The views expressed above re-emphasize the researcher’s previous assessments which stress the need for Government to search for imaginative policy directives that do not exclude organisations like the Recovery Home from delivering a valuable contribution, albeit in a different way, in seeking to overcome the devastating effects of substance abuse in Mitchells Plain. Policy makers must be urged to be innovative so that the interventions of the Home, and others like it, are encouraged and legitimized rather than being restricted or even terminated by policy provisions that they are unable to comply with.

The people who run the Recovery Home and its rehabilitation programme are supportive of Government's Sustainable Livelihoods Approach. They applaud the concept of people-driven programmes but they are sceptical, a trend firmly articulated in interviews that were conducted, of Government's sincerity in dealing with substance abuse in Mitchells Plain. The Sustainable Livelihoods Approach fits the Recovery Home's contention that substance abuse is the product of socio-economic deprivation. The Home's management personnel emphatically believe that in co-operation with Government they are well positioned to mobilise community efforts to fight and inhibit the abuse of substances. In the interviews conducted it became clear, however, that they were doubtful of Government's ability and commitment to introduce and implement policy provisions that will deal efficiently with the serious substance abuse problems that prevail in Mitchells Plain. They accuse Government of adopting an authoritative, "top down" approach that seeks to impose unilateral conditions that have no regard for the attitudes of concerned and long-standing members of the community.

### **5.3 SUBSTANCE ABUSE AND THE CLIENT**

#### **5.3.1 LIMITATIONS RELATED TO THE ORGANISATION'S UNDERSTANDING OF SUDs**

The next section of this research project continues the discussion around the Organisation's understanding of SUDs and, to meet the requirements of its third and final aim, looks at the clients' experiences and perceptions of their substance abuse in conjunction with the faith-based approach to treatment.

The Organisation's definition and understanding of SUDs revolves around the socio-economic factors in the community. In the opinion of the researcher, this narrow interpretation negatively affects the Organisation's capacity to administer effective treatment.

The Organisation defines SUDs as follows:

“Addiction is a socio-economic problem that affects our impoverished communities and creates a façade around a desired lifestyle because of shortcomings in the home (no education, poverty etc). We believe that God can deliver anyone from any situation or circumstance, therefore, we do not think of substance abuse as a chronic disease” (Interview 18 August 2009).

A senior member notes:

“If purpose is not understood abuse is inevitable. So, in other words if man does not understand that God has created him for a purpose any kind of abuse is inevitable” (Interview 14 May 2009).

One client confirmed a belief in this description stating that after abusing substances for so long, he felt that his life lacked purpose. He notes:

“Life was not that good for me anymore, I felt that I had no purpose in life anymore and I wished I was dead. I did not know what way to turn until some people came and spoke to me whilst on the streets and convinced me that there is still hope for me and they were willing to help me and I ended up at the Recovery Home” (Client Journal extract April 2009).

It is clear that the religious development of the clients is encouraged in the programme to help them develop a sense of purpose. One client expresses it thus:

“Went to church and the pastor’s service was good. Now I understand why I should fight the battle. Going through the programme is sometimes difficult but I must go through with whatever I’m feeling. I must deal with it for the sake of a better life with Christ. Want to find my purpose in life” (Client Journal extract April 2009).

Although socio-economic problems do play a role in development of SUDs it needs to be noted that these disorders occur across race, gender and economic lines, and that people who live in the same communities and under the same circumstances do not all develop SUDs. The NIDA notes that, “Risk for addiction is influenced by a person’s

biology, social environment, and age or stage of development” (2008: 3). Therefore, the cause and definition cannot be solely attributed to socio-economic factors. However, it is also clear from clients’ responses that various socio-economic conditions do contribute to substance abuse in this community and result in the development of further social problems.

The statement below depicts how one client experienced his environment. He expresses a desire to fit in and feel powerful, effects commonly induced by the use of tik (Bateman 2006: 627). This statement also reflects that substances were readily available in the environment in which this individual lived, and that in order to “fit in”, he was not able to show any emotions.

“I was living in an area which you could call a ghetto where gangsters and drug smugglers thrive. Well I wanted to fit in so I developed different characters which later evolved into me having a status or reputation which I had to maintain. This basically means that I could not show that I was a soft hearted person. I was then known as “ALLEY CAT”, a ruthless cold hearted person that never showed remorse or pity to anyone. People really feared me and the feeling of power really felt good.” (Client Journal extract April 2009).

Another client said:

“I drifted away from my family and started hurting them. I lost my job due to drugs. In order to feed my habit I started stealing from my family and getting involved in the underworld. My mom hated the person that I became. The truth is I got pulled into that way of life because I thought it was cool” (Client Journal extract April 2009).

Both of these statements make it clear that the individuals’ initial understanding of their abuse was to attain a different lifestyle. The Organisation’s explanation for this desired lifestyle is that it stems from what individuals lack in their environments due to socio-economic factors. A direct connection can be observed here between substance abuse, the underworld, gangsterism and crime.

From the clients' journals it becomes apparent that their substance abuse led to the deterioration of other areas of their lives and resulted in them taking part in other deviant behaviour.

The majority of the clients in this programme began using drugs while still at school. It is clear from these statements that the education of these individuals was interrupted or abandoned as a result of their substance use. It also illustrates a disturbing issue existent in this community relevant to the age profile of substance abusers. As pointed out previously "Two thirds of patients in treatment for MA are younger than 25" (SACENDU 2009:1).

This is shown by way of the following statements:

"I started smoking dagga a lot. It really became a habit and I got suspended a lot from school" (Clients Journal extracts April 2009).

And:

"I started drugs when I was 16 and the drug choice at that time was ecstasy. After a year of ecstasy, alcohol and dagga the drug known as tik came out. I then tried tik and got hooked instantly. Every weekend I would sleep out, would go to parties and come home the Monday morning. Sometimes I would attend school but sometimes my hangover would be so worse that I didn't care at all" (Clients Journal extracts April 2009).

Another client says the following:

"I was on drugs for four years. I started using drugs while still at school during Std. eight. I eventually dropped out of school that same year because of drug and sex abuse" (Clients Journal extracts April 2009).

Many of the clients report that as their substance abuse worsened they began to engage in illegal and high-risk behaviour. One of them notes:

“Over a six year period I experimented with cocaine as well as dagga, but tik was my main addiction. I would even use drugs when I was alone. I stole, lied and manipulated to feed my habit. I sold my car and the money I received for it was mostly used for drugs. As a result I lost my job and was at home. My mother supported me and unbeknown to her I was addicted to tik, and so I found ways of getting money out of her to feed my habit. I started to become an introvert and did not socialise with my friends any longer” (Client Journal extract April 2009).

A number of the women clients disclosed that they became involved in prostitution. These statements depict how substance abuse correlates with the spread of HIV/Aids. Once again, it stresses the need for the availability of professional staff to counsel clients who might have contracted the virus or other sexually transmitted diseases.

One of the female clients recorded the following comments in her journal:

“I was totally rebellious and my everything revolved around drugs and getting high. I stole and sold everything of value in our house. Nobody, not even my family, wanted me to come even close to their houses. I had jobs but got fired from the jobs also for stealing to support my habit. Afterward, my drug addiction got even worse because I had no income and nothing to steal. So having no means of supporting my habit I started selling my body to men for drugs or money and even robbed them while having sex with them” (Client Journal extract April 2009).

Another client explains;

“I left home, that was the beginning of December. I have no idea why I would make such a decision. When out on the streets I just became worse. Went deeper into drugs, I came to live in Mitchells Plain again and made my worst mistake to go back on heroin. Slowly but surely I started losing everything including respect for myself I slept around and even had sex for drugs just so I don't feel the turkey” (Client Journal extract April 2009).



### **5.3.2 ABSENCE OF ROLE-MODELS AND ABUSE**

A common theme expressed by the clients, and identified by the Organisation, is the lack of role-models mostly with regard to a father figure. They also express problems with relationships and past abuse.

The NIDA lists three risk factors in families for substance abuse later in life. They are: “A lack of attachment and nurturing by parents or caregivers, ineffective parenting and a care giver who abuses drugs” (2003: 8).

The abuse of substances is seen as a contributing factor to coping with difficult life circumstances, compounded by socio-economic factors.

One client expresses in his story that he was abandoned by his parents at the age of five, as they obviously did not have the means to care for him. He notes:

“I can remember moving around a lot with my folks and four other siblings. My mother’s two sisters was living with us. My parents do not have a easy life. My dad had a tough time being the sole breadwinner. I remember being asthmatic and my parents had let me go live by my dad’s brother in Hanover Park because they were moving such a lot and could not afford to rush me to hospital because that was often the case when I got attacks. My parents told me they were going to the shop quick, they will be back shortly. I’m standing on the field looking out for them to return. It’s been a long while. It’s getting late, it’s almost dark and they are not returning. I am five years old. I am scared. I don’t really know this people. It is the first time I met them” (Client Journal extract April 2009).

Another client explains her abuse:

“Things started when I was nine years old. I was sexually molested and in the same year my father passed away and everything was just going wrong. I was only but a nine year old and did not really understand what was happening in my life. Nine years later the same man that molested me raped me” (Client Journal extract April 2009).

Clients often refer to observing a member in their family taking or experimenting with drugs. Most of the clients in the programme also have children. As noted above, the risk of developing SUDs in adulthood is increased in these situations.

One client said:

“My uncle coming every night very (dik gerook). High on mandrax so I didn’t have an idol in life. No one to look up to” (Client Journal extract April 2009).

Another explained:

“Ran away much more. When I was 16 I ran away and went to my granny in Mitchells Plain (my biological dad’s mum) and at that time my dad was selling drugs and I experimented with heroin and I could do it with my dad so I did it more” (Client Journal extract April 2009).

Substance abuse is directly linked, as observed in these situations, to gangsterism, crime, loss of productivity both at school and work, family disintegration, prostitution and, in all certainty, the spread of HIV/Aids and other sexually transmitted diseases (UNODC and the WHO 2008:2). Foetal Alcohol Syndrome is also prevalent and all of these conditions detrimentally affect progressive development in this community. Clients express experiencing difficult life circumstances, a lack of role-models, abuse, death and, as a means to cope with these issues, substances are abused as a way to escape.

This research presents evidence that the debilitating socio-economic factors in this community contribute to the abuse of substances. In combination, they make it more difficult for individuals to transcend their disadvantages, illustrating that the abuse of substances causes and perpetuates drastic social problems in this community.

### **5.3.3 RELIGIOUS CONTENT**

With a lack of state rehabilitation facilities, the Organisation is providing a place of safety where individuals can receive treatment. They provide the only accessible treatment option for poor people in this community who cannot afford alternative treatment. Many of their clients, and their target group, are people off the streets and once they are in the programme there is considerable emphasis on the acceptance of Christian religious content as a curative method.

One client reports:

“At night I would often cry myself to sleep and say to myself how is my life going to change, how can I get help. My mom cannot afford rehabilitation for me. Not knowing that God answers prayers, God answered my prayer and brought me to the Recovery Home. Today I find myself six months in the programme, six months I am clean. In the process that I have been here I have found God. God has helped me right through and he is still helping me to deal with certain issues. When I am in God’s presence I feel so relieved. God helps me deal with my pain that I have been carrying for all these years.” (Client Journal extract April 2009).

With adequate resources, and the adoption and integration of best practice, the service provided by this Organisation would be invaluable. Although some contradictions exist, the Organisation has expressed a willingness to communicate and work with Government and other role players.

Spiritual development is an important element of all recovery programmes and as noted by Miller a fundamental foundation for healing (1998: 987). However, for it to be fully effective, it is imperative that evidence-based practices are also applied. This helps clients to develop a deeper understanding of their substance abuse and enables them to develop skills to apply once treatment is complete, acknowledging that SUDs are complex and multi-factorial and that a multidisciplinary approach needs to be applied to research, prevention and treatment (UNODC WHO 2008: 1).

The statements made by Dr Bronwyn Myers, of the Medical Research Council, and which are more fully expressed in an earlier section of this report have relevance here.

It is the researcher's belief that one of the most problematic issues the Organisation faces with regard to implementing best practices is their understanding and definition of SUDs (More comprehensively outlined elsewhere in this study). The Organisation's incorrect understanding of SUDs detrimentally affects the implementation of treatment procedures. The Organisation's treatment procedures are exclusively based on Christianity and deliverance. In consequence, it is questionable whether their clients will ever develop a proper understanding of all the factors that contributed to their SUDs. It also questionable whether the Organisation will be open to integrating and learning about evidence-based practices.

This is clear from the following observations made by a senior member of the Organisation on evidence-based practices:

"The first problem I have with that is their approach to this problem. They say to the individual "once a drug addict always a drug addict". So in other words they tell the patient or the client that you are going to be dependent on us until you die, so that is a major problem for me. They don't understand the language that we speak. We speak about deliverance, we speak about a new start, we speak about being a new creature in Christ. They don't understand that language so there I see a major problem because what happens is that you are offering somebody something and you are also telling him that, you know, ultimately what I am offering you won't deliver you or set you free from your problem so it's like basically just giving a person a false hope" (Interview 14 May 2009).

Examination and analysis of information produced by the research makes it clear that the Organisation's methods and curative approach are at odds with Government's stipulations and guidance for treatment. This raises a fundamental issue of concern. It suggests a disbelief in evidence-based practices and scientific understanding of SUDs. Although the Organisation portrays a clear understanding of the problems in the community, and as such the social, economic and spiritual problems, they deny the biological factors that contribute to SUDs. In this context, the Organisation fails to see

SUDs as multi-faceted problems that ought to influence the treatment provision they offer.

It is clear to the researcher, however, that this Organisation is impacting many lives positively and that it is providing an environment that is generally conducive to recovery. This is all achieved and maintained by a reliance on the belief of a Christian God. Although this programme is having a positive influence on the lives of those in it, it needs to be made clear that the faith-based programme is not suitable for all members of the community and therefore it does not reach and help as many people as it could, which is a factor that decreases accessibility. The recognition and acceptance of spiritual principles is a part of all recovery processes and what comes across from the clients in this programme is that their development and growth are strengthened by their religious beliefs.

The importance of spiritual development in the recovery process is most notable in the clients' comments. This resides in the development of a relationship with God, and the faith that they feel gives them the "strength, courage and hope" to change their lives. Their responses suggest that they are better equipped to constructively deal with painful emotions that they previously said they had blocked, and escaped from, by abusing substances. One client said:

"The one thing that made me so goal orientated is that I see everything in a more positive light. The reason that I felt down in the past is because I could not deal with things so then I run every way because the bad experiences made me doubt a lot of things. The one thing that made me feel that I can go on with life is the faith that I have in Jesus Christ, my saviour and the one that I trust in with my whole heart" (Client Journal extract April 2009).

Similarly:

"That is when my life started to change. I came in on 5 January and on 11 January, I gave my life to the Lord, my personal saviour. Ever since then my life started to become right. Everything about me is changed. I can feel that it's only God that can do that. But I know the real testing is still to come when I go out

there in the world but I trust in God that I will be prepared for the world” (Client Journal extract April 2009).

An additional example:

“I found myself going nowhere slowly but surely. So that made me decide to come to the Recovery Home. When I came here my mind was made up. I want to change but I’m not going to give my heart to the Lord. But things changed dramatically and today I’m saved. Nearly six months and I am drug free and focused on going forward in life and it’s all to the glory of God. So now I am planning on going to a college next year to finish school and get a degree” (Client Journal extract April 2009).

Clearly, the programme is working for a number of clients and they are aware of the challenges they will face when leaving the Home. The statements above portray this and indicate a commitment to change and to improve their lives. They also illustrate that as they have progressed in the programme and maintained abstinence from substances, they have experienced positive results. Additionally, they reiterate the reliance the clients have developed with regard to their religion, and that through the faith they experienced, they look forward to a better life.

The researcher is in possession of many other accounts from clients that convey similar sentiments but in the interests of keeping the narrative concise, they are not included here. What they all serve to confirm, however, is the clients’ belief in the curative capacity of the faith-based approach and the acceptance of deliverance in the methods used at the Recovery Home. Clearly, some successful outcomes are being achieved. For just how long people who have successfully completed the programme and who have returned to the community are able to maintain their abstinence from substance abuse is an obvious question, but one that the research conducted in the compilation of this thesis was not designed to answer.

Assessments made by the researcher are dealt with in what follows.

## 6 CHAPTER 6: CONCLUSION

### 6.1 FINAL OBSERVATIONS AND IMPRESSIONS

There is a considerable volume of well researched literature that documents the evidence and effects of substance abuse in South Africa and in the Western Cape in particular. The Recovery Home, which is the focus of the investigation and the research conducted, is just one institution established in Mitchells Plain - an economically deprived dormitory suburb of Cape Town - to confront the substance abuse scourge and attempt to rehabilitate some of the people who are the victims of it.

With reference to the first aim of this study, it can be stated that the Recovery Home is a well established institution with a faith-based rehabilitation approach. While it is clearly limited in what it is able to achieve relevant to the pervasive presence of substance abuse in Mitchells Plain, the research illustrates that the rehabilitation activity that is undertaken at the Recovery Home is well intended. Furthermore, and in spite of their restricted capacity, the objectives pursued by the Home present an admirable service in what is an overwhelmingly beleaguered community.

In the context of the second of this project's aims, the research identifies a combination of factors that inhibit the Recovery Home in its efforts to expand its role and become a more valuable and effective community service provider. In the first instance, and linked to its exclusive emphasis on faith-based treatment methods, clients receive no exposure to universally accepted evidence-based curative processes. While it is common cause that spirituality can be a critical component of the substance abuse recovery pathway it is more than equally important to acknowledge, as emphasised by recognised and qualified authorities, that it is no more than a single facet. Individuals suffering from SUDs, when they are receiving treatment, need also to be exposed to evidence-based treatment practices and to be assisted in developing an understanding of all the factors that contribute to their dependency. This is a deficiency that is clearly conveyed in the journaling exercise that was used to meet the requirements of the third and final aim of this project. Clients are strongly encouraged to accept the Organisation's faith-based curative practices as well as their reasoning for the existence of SUDs. While all of the

clients who participated in the journaling activity expressed confidence in the concept of deliverance to overcome their dependencies, accepted scientific research, as noted above, shows that exclusive reliance on a faith-based approach is insufficient.

These are significant impediments to the growth potential and future effectiveness of the Home as its management not only confines the scope of its work to faith-based healing interventions but also is convinced that the debilitating socio-economic circumstances that prevail in Mitchells Plain are the exclusive cause of substance abuse in the community.

This is quite evidently fallacious as it is established fact that the abuse of substances is a phenomenon that exists, to a lesser or larger extent, across all levels of society.

Also linked to the second aim of this project is the inability of the Home to acquire Government accreditation and this is a supplementary blight on its profile as a useful community asset. Government's refusal to recognise the Home as an acceptable drug rehabilitation facility is understandable. The Home does not come close to adherence to the norms and standards that are encapsulated in official policy to ensure the proper governance of in-patient treatment centres and to protect the best interests of individuals who are admitted for treatment.

The accreditation issue imposes damaging consequences in relation to funding. Justifiably, Government departments and agencies will not provide funding for institutions that fail to meet legitimate policy provisions and from a corporate perspective, it is highly unlikely that business institutions - regardless of whether or not they sympathise with the cause - will donate cash to finance activities that do not enjoy legal sanction.

The Recovery Home finds itself, therefore, in an invidious situation. Even if it did take a decision to change its fundamental direction and introduce evidence-based practices as a feature of its treatment activity - a deviation which the research suggests is unlikely - for as long as it remains unaccredited, the funding that would be essential to facilitate the adaption would still not be forthcoming.



People running the Home show no reluctance to collaborating with the relevant authorities but they feel let down by them and they are struggling to find a mutually acceptable manner in which co-operative engagement can take place.

A possible escape from the impasse exists in the prospect of the Recovery Home acquiring official recognition as a half way house facility. It demonstrates a willingness to achieve such an outcome and in interactions that the Home's management have conducted with officials in the DoSD, this is a concept that has attracted encouragement. It is evident, however, that there are no state accredited half way house institutions in the Western Cape.

Insofar as the half way house situation is concerned, it is apparent that in existing circumstances it is just another cause of frustration for the people who are running the Recovery Home. While being encouraged on the one hand by the authorities to play a half way house role, it emerges on the other hand, that this is not possible as the state has not yet formulated or implemented policy or regulations to govern the establishment and operation of half way house facilities.

Coupled to the problems encountered with referrals - a subject covered more extensively in the main body of the accompanying text - it is easy to understand why the proprietors of the Recovery Home have come to believe that Government is not adopting the correct approach to the massively damaging problem of substance abuse in Mitchells Plain.

There is a feeling that the needs, health and welfare of members of the community are not being effectively addressed by Government. Founded on the evidence uncovered in this research, this is a view that the researcher is persuaded to support. While there can be no advocacy for adoption of an approach that calls on the state to lower its accreditation standards and thereby increase the risk to which substance abuse rehabilitation patients are exposed, there is most emphatically a need for more urgent and effective state intervention in communities like Mitchells Plain. A movement away from the "one size fits all" model may well be worth considering.

Instead of enforcing policy provisions that inhibit the activities of institutions like the Recovery Home, it is the researcher's belief, founded on the research conducted in the

area, that policy makers need to be applying their minds to the origination of governance directives that can specifically be applied to institutions like the one that has been the primary focus of this exercise. Rapid development of practical policy guidelines for the half way house concept would be a useful start. Such a development could serve to legitimise the functional existence of the Recovery Home, create the opportunity for the institution to acquire funding and enable it to enhance its value to the community that it is so fundamentally committed to serving.

Failure to find productive and agreeable ways forward will mean that the Recovery Home will carry on providing a service which, although beneficial even in existing circumstances, will be restricted in its success because of exclusive commitment to faith-based rehabilitation methods and will continue to be in contravention of legal policy provisions. It is a situation in which the ongoing survival of the institution will remain under constant threat and, as a consequence of the one-dimensional treatment approach administered by inadequately trained staff, will perpetuate potentially negative impacts on client recovery prospects.

At this time, the Home is truly “Stuck in Limbo” and until it is empowered to remove its shackles, its potential to optimise the role that it plays in the community in which it operates will be impeded.

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## 8 APPENDIX

### Appendix 1 Access letter to the Recovery Home

March 2009

To the Recovery Home

I am currently a Masters student at the University of Cape Town, and am in the process of conducting a research project for the completion of my studies. The focus of my proposed subject is Community Based Organisations in Historically Disadvantaged Communities, who have or are providing treatment for Substance Use Disorders in Cape Town.

As your organisation fits the profile of my desired research, I am writing to you to request your involvement. This would include a number of interviews with certain members over the period of a time.

I understand that this information needs to be treated with care and respect. With this understanding, and in terms of University policy, in conducting this research I am bound to following a stringent Code of Professional Ethics. I would be very happy to prepare and sign an undertaking to comply with any ethically appropriate conditions you may wish to specify.

This research will, it is hoped, build onto previous work on substance abuse treatment services in South Africa, and add insight and understanding into Community Based Organisations and the roles they have played and might play in the future in treating Substance Use Disorders.

Many thanks

Philippa Bunkell

Appendix 2 Confidentiality agreement with the Organisation



We would hereby like to confirm a confidentiality agreement between yourself and the Recovery Home.

You may have access to, or have disclosed to you, confidential information relating to the clients in the programme.

We would ask you, therefore to hold this confidential information, whether disclosed to you in writing or verbally, in the strictest confidence and not to disclose the confidential information, or any part thereof, to any other person or company; without express permission of the leadership of the Recovery Home.

We should be grateful if you would indicate your acceptance of the above conditions by signing and dating both copies of this agreement.

For and on behalf of the Recovery Home:

Name of Director: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Accepted by:

Name of employee/volunteer: \_\_\_\_\_



Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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Appendix 3 Client consent form

INFORMED CONSENT FORM

- The nature of my participation is an interview with my story being recorded and then typed up.
- At the time of the interview my permission will be sought to digitally record and transcribe the interview.
- No digital recording will be made public.
- And as such, under no circumstances will information be used to incriminate you or violate your safety or the safety of this organisation. Any information of a sensitive nature will require your consent, and confidentiality will be protected under all circumstances.
- My participation is entirely voluntary and I understand that I can withdraw my consent at any time within the next month. In the event that I decide to withdraw consent, this will be confirmed in writing and any wishes for data collected to be destroyed will be fulfilled.

Consent: Please tick if agreed:

I give my permission for the information I am about to give to be used for publication in a research report with strict preservation of anonymity (if I prefer this).

Participant Name: .....

Participant Signature: .....

Date:.....

Compiler (signature) ..... Date:

.....

Appendix 4 Method and brief description

Date	Method	Brief description
29 April 2009	Interview	The questions that were asked in this interview are attached below. As an introductory discussion the purpose was to gain a broad overview of all themes developed from observation in conjunction with the set out aims, developed through a thorough examination of the literature.
30 April 2009	Interview	The focus of this interview was an in-depth investigation into the Organisation's strategic objectives, its history, vision, mission and background.
01 May 2009	Interview	The main focus of this interview was the development of this Organisation. It looks closely at how it came into being, as well as the community in which it is based.
09 May 2009	Interview	The programme
14 May 2009	Interview	This interview is attached below.
22 May 2009	Interview	The development of staff structures and staff roles.
26 June 2009	Interview	Discussed in this interview were the half way house issue, policy, registration and the programme.
10 August 2009	Interview	This interview focused on various evidence based practices, the reasons why the Organisation could not be accredited, and how it was continuing to function at that time.
18 August 2009	Interview	The client, the faith based approach and the emphasis on Christianity.
27 August 2009	Interview	The registration process, half way house, and current relationships.
31 August 2009	Interview	This interview was used to thank the organisation and to review some final

		questions.
30 April 2009	Observation	Life skills session held once a week. This particular session was on anger management.
05 May 2009	Observation	Fundraising dinner, for Organisation's second anniversary, presentation on the Organisation and substance abuse in the community.
28 May	Observation	Attend session with facilitator/ pastor, four sessions a week on the bible. This session was about peacekeeping.
28 May	Observation	Attend introductory session for new clients where rules of the Home are conveyed.
26 June	Observation	Attended a Church service
25 May	Journaling	Proposal for journaling
29 May	Journaling	Meet with clients to explain exercise facilitated by Lucien
03 June	Journaling	Finalise consent form with organisation with regards to use of journals
12 June	Journaling	Collect Journals
12 June- 6 July	Journaling	Transcribe Journals
14 May 2008- 23 June 2009	Documentary	Study of communications between the DoSD and HARH

#### Appendix 5 Example of an interview schedule

Interview schedule for organisation:

This is an investigation and exploration into SUDS and the treatment provision provided by an unregistered community-based organisation. It focuses on one selected case: the Recovery Home.

I would therefore like to ask you some questions around the Organisation, the problem in the area, Organisational and community resources/services and the skills and knowledge that you have and draw on. To look at the methods of treatment/ treatment programme you use. And lastly, to discuss the registration process and your experience thereof.

This information is to be used in a thesis that I am writing for the completion of my Masters Degree. The interview should take no longer than thirty minutes. I would like to record the interview. Would you be comfortable with this?

The Organisation's profile

Please give an overview of your Organisation.

How would you categorise this Organisation, as a community-based organisation, a non-governmental organisation or a non-profit organisation/ service provider?

Please give a reason for your answer to the above question.

Can you give me a description of your vision/ vision statement?

Your mission?

Your main objectives?

Theme: Problem identification:

What are the main problems that arise in this community as a result of substance abuse?

Why do you think people abuse substances in this community?

What is the main problem drug/s in the community and what types of problems are associated with substance use?

Can you give some examples relating to the following? And an indication in each as to the extent/ size of the problem.

Crime

Violence

STDs

FAS

Absenteeism

In your view how does substance abuse affect the family of the abuser?

In your view why do individuals in this community start using substances?

Theme: resources/ services:

What kinds of resources (services) do you have to address substance use disorders in this community?

What kinds of services does this organisation provide?

Do you think this organisation has enough resources to provide the planned for services?

Do you have adequate financial resources?

Do you have adequate staff capacity, skilled staff and or links to medical professionals?

What problems do you face around a lack of both service and resources in the community or and in the organisation?

Theme: Skills and knowledge

Can you give me a detailed description of the services you provide?

How many people are you able to provide treatment for?

Do you use the 12 step programme and, if not, what programme or process do you follow?

Do you provide aftercare for previous patients?

How do you encourage previous patients to continue their recovery?

How many staff members do you employ?

Do you have any volunteer staff? If so how many?

What, in your view, needs to be done to improve skills, knowledge and capacity among people in the field?

Theme: Registration and Department of Social Development

What was your experience of the registration process?

What difficulties are you experiencing, if any?

How do you feel with regard to registration?

Theme: challenges and barriers

What challenges and barriers does your Organisation face in meeting the registration criteria?

Appendix 6 Extract from an interview

Extract for an interview with participant 1

When did the Recovery Home open?

The Recovery home opened in 2007 by Pastor who visited America and had contact with a programme over there. When back he was approached by an individual struggling with drugs. He explains that he has no capacity to help the individual gave his house for use and so the Recovery House opened.

Can you give me some ideas of the extent of the problem in this area?

The area that I came from every second house had a drug addict or two in the house within the family which will give you at least a picture of how it has infested the area. In my house hold it was my brother and myself, our neighbour had two people two doors away another two people as well just to give you a picture, it's massive.

What are the main problems that arise in this community from substance abuse?

The problem that I would say is that the kids growing up, the effect I don't think the drug addict or user realises the effect or damage he has on the kids growing up in the community, it might be in his own home, or his neighbour. Because not only is he killing himself he is killing that child because ultimately that kid will see what he is doing and the percentage would become much higher so thus the death of the community, or to go further the family. If you think, I do drugs, my son does drugs, the whole family might end up in jail or getting killed for that matter.

Why do you think people abuse substances in this community?

There are many at times financially, no hope, lack of education that stems also from having no hope, abuse alcohol extends to a lot of abuse, coping mechanisms rape taking place. It's just a whole variety of things it is multi faceted.

Extract for an interview with participant 2



What has been the success rate?

The success rate um out of the 50 guys who have graduated I would say that about 10 have relapsed, but you see the guys that have relapsed they have come back, restoration, either through our programme or for three months but on their choice, so the success rate has been much higher, than state rehabilitation centres.

What is the most accurate way to describe the hopes of this Organisation, do you have a vision statement?

Our vision statement is that we can, I speak under correction, we can make an impact we want to make an impact in the community hence us speaking with government because we believe that faith, God, Jesus has the answer we believe in deliverance, which medical people do not so there in lies our vision that we can.

Extract for an interview with participant 3

We still don't have a half way house policy so we can't apply, we just mail them every now and again and they just say we still don't have a half way house policy so we definitely don't fall into the treatment centre, the in-patient one. We don't technically run an out-client programme, so we have never registered for that, our out-client component is because they want to come in so its about washing out and its about the faith based concept so in essence we don't have an out-client programme. You go to a facility and ask for a one month or six week out-client programme, like Sultan Bahu, we don't have that so we can't apply for that.

The out-client component has been set up to observe clients for the first two weeks. That is the initial detoxification period, as well as seeing if they can relate to the faith based concept, and the guys need to show how serious they are so we don't waste resources, by taking on clients who are not committed or do not suit faith based programme.

Extract for an interview with participant 4

What strengths does a faith-based organisation have when dealing with substance abuse in this community?

Firstly, the strengths a faith-based organisation have and I think it is under estimated the faith-based approach to dealing with humanity because we believe man consists of a body soul and spirit. We believe that man is a tri-cotamy being where you know he feeds the body and he will get hungry again. He feeds the soul, for information the mind but there is always a quest for more information. The spirit dimension, is a dimension, where you are dependent upon your creator for every day life, how to do life and that basically I felt was a missing element in the recovery, so I would say faith-based organisations have a great, I think they get better results than any other organisation that I've seen and also when it comes to qualitative and also quantitative because I see more people going through the church, you know, in my context now seeing them grow as a person and not resort back to the old type of life style. So I see Faith Based Organisations as a powerful medium to reach young people.

What limitations do you currently face as an organisation, in dealing with substance abuse?

Firstly the experts out there they don't recognise or see the work that the faith Based Organisations do if we detect that somebody that comes to us for help and we detect that that person has a mental problem we refer that person to a psychologist or psychiatrist. But, when they get clients, I'm generalising now, they won't refer somebody to come to us as Ministers because they can't detect that spiritual dimension in my view. So, there are a lot of limitations that we have, resources is one and Faith Based Organisations don't normally get that kind of support from corporate so I think that's the limitation we have. Then the man power we basically have the man power that has been through that kind of life style that is giving back and can identify with people so I think we are one step ahead of many of these organisations that just have a theory. We sit with people that know what they are speaking about.

Extract for an interview with participant 5

After the assessment by Social Development it was decided by the Department that the home could not register as an in-patient treatment facility, but that the option for registration for the home decided on by the Department was that of a half-way house. However no policy exists currently for facilities to register as half-way houses. The policy is in draft format and has been for the last two years. The Organisation can therefore not register as of yet as a half way house. We therefore are not eligible for funding from the Department of Social Development. The Organisation does not have adequate facilities in accordance with the minimum norms and standards for in-patient treatment facilities to carry out the detoxification period, which is 28 days. The clients coming to the Organisation for help therefore attend as out-patients, for the duration of two weeks before they can become in-patients.

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## Appendix 7 Journal instructions and questions

### Purpose:

Collect basic information of those currently in the programme.

To allow clients to describe or tell their story.

To record client's daily processes.

### Instructions:

If you feel uncomfortable sharing any of this information, and it makes you uncomfortable, do not do it.

Please note: You do not have to take part, unless you would like to.

Everything you write will be respected and kept anonymous, please do not write your name in the book. It is just an exercise so it does not need to be neat or perfect. If you need any help, or have any other questions I will be around during the day, or Colleen will be here in the evenings.

### Exercise one: Basic Information

Age

Gender

Are you single, dating, married or divorced?

Do you have any children?

How old were you when you left school?

Did you go to university or college?

What jobs have you had?

Are you living at the Church or are you living at home?

How long have you been doing the programme?

Drugs/ Drug of choice

For how many years did you use drugs?

How long since you last used drugs?

Why do you think you started using drugs?

Have you had any other treatment?

If so, how is this treatment different?

How has your belief in God helped you so far?

Exercise 2: Life story

If you would like to tell your story please use this journal to do so. What was your life like before entering the Church or beginning this programme, and what is your life like now?

Exercise 3: Document your day

Write each day on a separate page, what the time is, what day it is and the date.

Write exactly what you do each day, and what you felt about the day's activities. What feelings came up for you and how you acted differently to how you would of acted in the past. Write down what you think is helping you and if there are things that you do not think are helpful please make a note of those.