A qualitative study of the experiences of outpatient substance abuse treatment in the City of Cape Town, 2010-2015: a service user's perspective

Carla Ederies

2534730

A mini thesis submitted in partial fulfilment of the requirements for the degree of Master's in Public Administration in the Department of School of Government, University of the Western Cape

Supervisor: Senior Professor John J. Williams

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TABLE OF CONTENTS

Declaration

Submission in partial fulfillment for the degree of Master's in Public Administration (MPA).

I declare that *A qualitative study of the experiences of outpatient substance abuse treatment in the City of Cape Town, 2010-2015: a service user's perspective* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

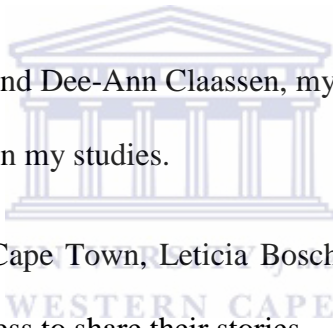Carla Ederies   February 2017

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Acknowledgements

Abstract

Globally, substance abuse has had a profound impact on society, compounding factors around public health and safety, as well as the social fabric of family systems and communities. The substance abuse problem is complex and requires a comprehensive approach to addressing the phenomenon. Treatment for substance abuse is one aspect of addressing the problem and aims to reduce the harm associated with the use thereof. Treatment demand has increased consistently in South Africa over the past few years and the need for services has been articulated in key legislative and policy documents. Substance abuse is a well-researched field in South Africa; however, limited research exists that captures the experience and perceptions of service users that received outpatient treatment. Various studies conducted in Cape Town in the Western Cape have confirmed an inextricable link between substance abuse and the structural challenges present in historically disadvantaged communities.

This study explores the experiences of service users who had completed an outpatient substance-abuse treatment programme in the City of Cape Town's health clinics in Parkwood and Delft South. The objectives of the study are to explore the individual-level and service-level factors impacting on service users' experiences of outpatient substance-abuse treatment, to explore the outcomes of outpatient substance-abuse treatment for service users and to make service-level recommendations and recommendations for further study. Nine research participants for the qualitative study were purposively sampled, as they required certain attributes to respond to the area of study. Data was collected in the form of semi-structured interviews in order to allow for the in-depth exploration into the experiences of service users. Data was analysed with the use of conceptual analysis, where themes were thematically grouped and analysed. Key findings in the study were that the City's outpatient treatment programme is designed exclusively for adult service users. It was, however, found that the age of substance use and the onset of abuse occurred between the ages of 11 and 17-years.

The study highlighted the need for the City to modify its outpatient programme to address the needs of youth service users and children of service users to facilitate their adjustment to a parent in recovery. A further finding in the study was the challenges experienced by service users, particularly female service users. It emerged that female service users experienced more stigmatisation than males accessing the service. The need for aftercare treatment post-treatment was a gap identified in the study. In the exploratory study, participants' experiences and perceptions of the City's outpatient programme were positive. The scope of the study was therefore narrow. Recovery, however, remains a challenge for service users due to triggers brought on by structural challenges present in disadvantaged communities, again highlighting the need for coordinated efforts by all government spheres to address the scourge of substance abuse. As a prospect for further study, it is proposed that the long-term impact of the City's outpatient programme be considered with a larger sample of participants.

Key words

Aftercare

Harm reduction

Inpatient

Outpatient

Recovery

Service-user

Social support

Substance abuse

Treatment

Quality of life

List of abbreviations

APA	American Association of Psychiatry
CBO	Community based organization
CDA	Central Drug Authority
COCT	City of Cape Town
DSD	Department of Social Development
DSM	Diagnostic and Statistical Manual for Mental Disorders
EPWP	Expanded Public Works Programme
FASD	Fetal Alcohol Spectrum Disorder
GDP	Global Domestic Product
HIV	Human Immunodeficiency Virus
HRQOL	Health-related Quality of Life
NDMP	National Drug Master Plan
NPO	Non-profit organization
OQOL	Overall Quality of Life
QOL	Quality of Life
SACENDU	South African Community Epidemiology Network on Drug Abuse
SUD	Substance Use Disorders
UNODC	United Nations Office on Drugs and Crime
WHOQOL	World Health Organization Quality of Life

CHAPTER ONE: SUBSTANCE ABUSE A VERITABLE PROBLEM: GENERAL INTRODUCTION TO THIS STUDY

1.1 Introduction

Substance abuse has been identified as a global phenomenon affecting millions of people across the world (United Nations Office on Drugs and Crime [UNODC], 2014). In 2012, an estimated 243 million people of the world population (aged 15-64) had experimented with an illicit substance in the preceding year (UNODC, 2014: 1). Substance abuse has compounded challenges around health, socio-economic issues and crime and has had a profoundly negative impact on the social functioning of individuals, families and communities.

While the direct cost of substance abuse in South Africa is unknown, international data estimate that the cost of substance abuse in South Africa is 6.4% of the Global Domestic Product (GDP), or approximately R136 380 million annually (Department of Social Development [DSD], 2013). Data available on trends of substance abuse in Africa suggests that cannabis use is approximately three times the global average of 3.8% (UNODC, 2014: 13). This figure is not surprising, as it is estimated that 22% of the global production of cannabis comes from Africa, with South Africa accounting for approximately 28% of cannabis production on the continent (DSD, 2013).

Substance abuse has posed challenges to an already burdened public health system in South Africa. Studies conducted by the South African Medical Research Council identified a positive relationship between alcohol abuse and HIV infection (Neuman *et*

al., 2012). Furthermore, substance abuse has been positively linked to a number of non-communicable diseases, such as cancer, heart disease and psychological disorders (DSD, 2013). The latter is evidenced by a surge in methamphetamine-related treatment admissions in recent years (Plüddeman, Myers & Parry, 2008). In addition, the majority of dual-diagnosis service users admitted to substance-abuse treatment facilities reported mental health problems, with a higher proportion found in the Western Cape Province (Dada *et al*., 2015: 2).

Data on illicit substance use, encapsulating the nature, extent and consequences of substance abuse in South Africa are scant; however, the treatment demand has provided insight into the extent of the substance abuse problem. The Western Cape Province reported the highest number of persons treated during 2008-2010 (DSD, 2013). The South African Community Epidemiology Network on Drug Abuse (SACENDU), a drug-abuse surveillance and monitoring system, reported methamphetamine use and poly-substance abuse as more prevalent in the Western Cape Province (Dada *et al*., 2015).

Substance abuse has placed an immense burden on law enforcement entities, as it poses risks to general public safety. In the Western Cape, drug-related crimes have consistently increased and accounted for 33% of the national drug-related crime statistics (Western Cape Government [WCG], 2015). In a study conducted in a peri-urban community of Delft in Cape Town on the perceived impact of substance abuse, the drug trade amongst rival gangs was cited as a threat to the safety of community members (Watt *et al*., 2014: 222-223).

Under the former apartheid government in South Africa, racial groups were segregated and drug use and trade in historically disadvantaged areas were poorly regulated and treaties not enforced (Peltzer *et al*., 2010). Crime, gang-related activity, high unemployment rates and limited access to services are some of the socio-economic factors impacting historically disadvantaged communities, which further exacerbate the challenge of substance abuse.

1.2. Research problem

The previous section noted the extent of the substance abuse problem in South Africa and the need for interventions to address the phenomenon. Treatment for Substance Use Disorders (hereafter referred to as SUD), is an intervention aimed at reducing the harm associated with substance abuse.

Historically, treatment facilities were situated in urban areas, inaccessible to and unaffordable for the majority of South Africans, particularly from disadvantaged backgrounds (Myers & Parry, 2005: 15). South Africa has reached a crisis point in its attempts to combat substance abuse and its impact on society. The substance abuse problem in South Africa is multifaceted and requires a comprehensive approach to understanding and addressing the social, economic, and health outcomes for those affected (DSD, 2013).

The exorbitant costs of residential treatment and the limited state-subsidised residential treatments have further made treatment elusive for many. Outpatient or community-based treatment services offer an alternative to mitigate the affordability and accessibility of substance abuse treatment, as outlined in the Prevention of and Treatment for Substance Abuse Act (Act No. 70 of 2008). By 2002, 85% of treatment programmes in the United States of America were delivered in outpatient settings (McLellan *et al*., 2005: 450). South Africa has similarly shifted toward this approach to respond to the increasing demand for treatment services. During the period July to December 2014, 71% of service users were treated in outpatient settings (Dada *et al*., 2015: 4).

The City of Cape Town has adopted and rolled out an outpatient service from the USA to address the need for substance-abuse treatment in Cape Town. Outpatient substance-abuse treatment is characterised by service users remaining in their homes while accessing services. The City of Cape Town's Health Directorate currently offers outpatient substance abuse treatment in six clinics across the City; that is, Mitchells Plain, Delft, Parkwood, Milnerton, Khayelitsha and Manenberg (City of Cape Town Media Release, 18 February 2015). The first treatment site was launched in 2008 and the service is fairly nascent. The treatment service has consistently exceeded targets for the past few years, measured based on the number of persons screened at the sites and the number of negative drug-urine tests (City of Cape Town Media Release, 04 April 2014). The study aims to measure experiences beyond quantity, but rather to provide an in-depth understanding of the treatment process for services users.

The study explores the experiences of service users who had been exposed to and completed outpatient substance abuse treatment provided by the City of Cape Town. Although research exists on the effectiveness of the outpatient treatment, research on service users' perceptions of this treatment service remains scant. This is an under-researched field of inquiry in the South African context and with the aid of this study the aim is to contribute to the existing body on the subject of the experiences of persons who had been exposed to outpatient substance abuse treatment.

Furthermore, the study aims to identify those variables and potential challenges experienced by service users pre-, during and post-treatment, which impact on service users' recovery. Following analyses of accumulated data, recommendations for practice as well as recommendations for further study are submitted to address identified challenges or gaps in service delivery to maximise efforts in addressing substance abuse.

1.3. Goal and objectives

Exploring the effectiveness of substance abuse treatment is fundamental in view of the social and economic consequences thereof. The efforts to address the problem require empirical research activities to explore the benefits and challenges of the outpatient treatment services from the service users' perspective in order to inform and provide practical recommendations to improve the treatment experiences of service users. Traditionally, evaluation studies have occurred post-treatment, exploring social behaviour, return to drug use and employment as a *successful* measure of substance addiction treatment and rehabilitation (Emrick, 1975; Armor, Polich & Stambul, 1976;

Hubbard *et al*., 1989; Gerstein & Harwood, 1990; Ball & Ross, 1991; McLellan *et al*., 1993; Finney, Hahn & Moos, 1996; Project MATCH, 1997; Simpson *et al*., 1997, 2002 in McLellan *et al*., 2005). McLellan *et al*. (2005), however, argue that recovery can only occur when service users' addiction is viewed holistically. To facilitate rehabilitation, McLellan *et al*. (2005: 448-449) proposed four outcome indicators to be measured during the course of treatment, namely: the social and health indicators, reduced threats to public health and safety, and reduced substance use.

According to McLellan, successful substance abuse treatment requires that all life domains be considered to reduce substance use, which would ultimately improve the substance user's overall quality of life (McLellan *et al*., 2005). Laudet (2011: 46) supports this view and notes that treatment for substance abuse should consider the overall impact of substance abuse and treatment on the life domains of individuals accessing services. For the purpose of this study, substance abuse treatment interventions are evaluated against these indicators. Combined with this, the perceptions of persons who had been exposed to outpatient substance abuse treatment services rendered by the City are explored to gain insight into the process of treatment from the service user's perspective.

The goal of this study is to explore the experiences of outpatient substance abuse services pre-, during, and post-treatment from the service users' perspective.

The objectives of the study are:

1. To explore the individual-level and service-level factors impacting on service users' experiences of outpatient substance abuse treatment;

2. To explore the outcomes of outpatient substance abuse treatment for service-users, and

3. To make service-level recommendations and recommendations for further study.

1.4. Research methodology for this study

The following section provides an overview of the research methodology utilised for this study. Babbie and Mouton (2007:75) note that the methodology "focuses on the research process and the kind of tools and procedures to be used; that is, a description of how the research will be executed. This section provides an overview of the research approach employed in the study, the sampling technique used, and how data was collected and analysed.

1.4.1. Research approach

This study follows a qualitative approach to substance abuse. The qualitative research paradigm "takes its departure point from the insider's perspective on social action" (Babbie & Mouton, 2007: 270). The research approach aims to understand human behaviour, actions and events in a "holistic" and "naturalistic" manner (Babbie & Mouton, 2007: 270; Terreblanche *et al*., 2006: 47). The inductive paradigm occurs in a

natural setting, where behaviour is understood from the subject's perspective and differs distinctly from quantification which is synonymous with the positivist tradition (Babbie & Mouton, 2007; Terreblanche *et al*., 2006: 47). The qualitative paradigm is considered appropriate for this inquiry and best suited to achieve the goal and objectives of the study, that is, to describe and understand the experiences of substance abuse treatment from the insider's or service user's perspective, within a specific context in a natural setting.

In taking an exploratory approach in this study, the attempt is to ascertain whether service users view outpatient substance abuse treatment as being effective and to offer some insight into how the intervention is perceived by the service users. The qualitative approach employed provides an opportunity to gain insight into the insider's perspective, but also to describe and understand the phenomenon under investigation.

1.4.2. Sampling

The process of sampling is vital in both qualitative and quantitative research, where the researcher has to decide who and what to observe, that is, the source from which data will be extracted. In large scale studies, "sampling is required simply because the researcher cannot observe or record everything that occurs" (Burgess, 1982a; Hammersley and Atkinson, 1995; McCall and Simmons, 1969 in Ritchie, Lewis & Elam, 2003: 77); however, sampling is also required for small-scale studies. As is the case in larger- and small-scale studies; the sample is extracted from a larger population. In this study, non-probability purposive sampling is utilised. Participants are purposively selected who "by virtue of their relationship with the research questions, are

able to provide the most relevant, comprehensive and rich information" (Ritchie, Lewis & Elam, 2003: 49).

Sampling in the study involved the setting of criteria to ensure that the participants in the study are able to respond to the research question. Therefore, non-probability sampling is considered appropriate in this study.

To achieve the goal and objectives of the study, research participants required specific attributes. To this end, criteria for selection were developed and are listed as follows[1]:

- participants who had used illicit substances; unspecified time period;
- must have attended and completed the City of Cape Town's outpatient substance-abuse treatment programme for SUD; and
- sample must be representative in respect of gender.

Five females and four males participated in this study.

1.4.3. Data collection

Data collection involves the method in which the information is gathered. Lewis (2003: 56) distinguishes between naturally occurring data, which includes conversations, observations and documentary analyses and generated data, which primarily includes in-depth interviews and focus groups. Generated data was primarily sought for this study.

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[1] Participation in this study was incentivised and each participant received a lunch voucher of R30.00 on completion of the interviews.

9

The nature and purpose of this study guides the selection of research methods employed; that is, to capture individual experiences of service users who had completed treatment for substance abuse. In this study, in-depth semi-structured interviews as the primary means of data collection were used. Language forms one of the main vehicles that participants use to convey their experiences, which "provide[s] a large part of the data which are analysed in coming to an understanding of the situation" (Dick, 1999: 5). Utilising in-depth interviews, allows for the researcher to "investigate… each person's personal perspective, for in-depth understanding of the personal context within which the research phenomenon is located" (Lewis, 2003: 58).

Interviews are semi-structured and the in-depth, semi-structured interview is guided by a set of pre-determined questions, but allow for the research participants to actively participate in and guide the interview process by providing rich and elaborate responses to the set open-ended questions. The research instrument, an interview schedule, comprises a pre-determined list of open-ended and closed-ended questions. The questions contained in the interview schedule are directly related to the phenomenon being investigated. The use of semi-structured interviews in this study allow for the necessary flexibility in the in-depth exploration of service users' perceptions and in-context experiences during and following outpatient treatment (De Vos *et al*., 2005: 293). Moreover, allows for the naturalistic emergence of salient data and moreover gives the researcher insight from the perspective of the service users into the potential strengths and weaknesses of treatment (Terreblanche *et al*., 2006: 44-45).

1.4.4. Data analysis

The data analysis phase refers to the method in which raw data is grouped and interpreted by the researcher. Babbie and Mouton (2007:101) note that the process of analysing data aims to "interpret the collected data for the purpose of drawing conclusions that reflect on the interests, ideas, and theories that initiated the inquiry". The study is underpinned by the qualitative paradigm and therefor utilises a qualitative data analysis technique, namely content analysis.

Collected data is analysed with the use of conceptual analysis, which is a form of content analysis, where prominent and recurrent themes that emerge from the semi-structured interviews are grouped and analysed (Babbie & Mouton, 2007: 491). The identification of "recurrent ideas or language, and patterns of belief that link[ed] [participants]" with the settings and the phenomena led to an accurate and detailed grouping and analysis of emerging data (De Vos *et al.*, 2005: 338). Conceptual analysis is achieved through the identification of research participants' thoughts, feelings, and experiences as persons in substance addiction recovery, and more importantly, how this contribute to the meanings they attach to their experiences while in outpatient treatment. Recurring data containing the various meanings that research participants ascribe to their experiences of treatment are coded, thematically grouped, analysed and wherever relevant, compared with literature that is considered in the literature review.

Lincoln and Guba (1985, in Babbie & Mouton, 2007) note that good qualitative research is underpinned by the principle of trustworthiness. To enhance the trustworthiness of this study, I remained in the field until data saturation occurred. Data saturation refers to

remaining in the field and collecting data to the point where no new data emerges (De Vos *et al*., 2005: 276-277; Terreblanche *et al*., 2006: 372). To further increase the rigour of the findings and to test the interpretations of the emerging data (with the permission of participants), I engaged in peer debriefing with colleagues who possessed professional knowledge in the field of outpatient treatment. Furthermore, to enhance the credibility and trustworthiness of the findings, the researcher regularly checked in with participants during interviews to gauge if the understanding and interpretation of the data was accurate and congruent with the meaning they attached to the information they were relating (Babbie & Mouton, 2007).

1.5. Ethical considerations

Research participants were purposively sampled and their participation in this study was voluntary. Participants were furthermore informed that they were at liberty to withdraw from the study at any point during the study. In gaining informed consent from research participants, they were informed of the nature, purpose, and potential benefits of this study. Participants agreed to informed consent by signing an informed consent form. Interviews were audio-recorded and participants were reassured that information obtained during interviews would be kept confidential and the participants' names would not be published in the study and would not be used at any point during the study (Babbie & Mouton, 2007).

A core ethical principle when conducting research is to ensure that it does not cause harm to participants (Babbie & Mouton, 2007; Department of Health Republic of South Africa, 2015:15). A venue and time to conduct the in-depth interviews were selected in consultation with research participants. Ethical approval for this study was granted by the Senate Research Committee of the University of the Western Cape and the study was approved by the City of Cape Town's Health Directorate.

1.6. Organisation of the study

This mini-thesis is structured as follows:

Chapter 1 introduces the area of study and provides the background and problem formulation of the study. The chapter further articulates the goal and objectives of the study and outlines the research methodology.

Chapter 2 provides a literature review including a legislative and theoretical framework and studies conducted internationally and locally.

Chapter 3 comprises an outline of the outpatient substance abuse treatment programme of the City of Cape Town's Health Directorate to contextualise the treatment approach.

Chapter 4 presents the research findings that are grouped under salient themes and analysed compared to the pertinent literature.

Chapter 5 includes a discussion section, summarising the findings and comparing these findings with the reviewed literature. The final section of this chapter provides conclusions and recommendations.

CHAPTER TWO: WHAT IS SUBSTANCE ABUSE, SUBSTANCE-ABUSE TREATMENT AND RECOVERY?

2.1. Introduction

The literature reviewed is presented to provide an overview of research conducted locally and internationally. In this chapter, various definitions of substance abuse, namely legislative definitions of substance abuse, as well as psychiatric definitions are considered. In addition various treatment modalities associated with treatment and recovery, encompassing inpatient and outpatient treatment are investigated. The legislative and policy frameworks, which guide substance abuse and treatment, are discussed.

A transversal theme that emerged from the literature reviewed suggests that substance abuse has a plethora of unintended consequences on public health and safety services and puts pressure on already constrained state resources reserved for rendering substance abuse services (DSD, 2013). Notwithstanding the adverse financial burden that substance abuse places on state funds, substance abuse contributes to the erosion of relationships, family systems and support structures (Laudet, 2011) and engenders a growing sense of frustration and helplessness amongst those affected. To highlight the importance of treatment for substance abuse, this chapter will explore the impact of substance abuse on individuals, families and communities in further detail.

The prevalence and impact of substance abuse has been investigated by various scholars in South Africa (Flisher *et al*., 2003; Peltzer *et al*., 2010; Ramaglan, Peltzer & Matseke, 2010; Watt *et al*., 2014). As a result, government agencies and organisations have

responded with the use of prevention strategies to address the escalating substance abuse problem in South Africa through awareness campaigns and educational initiatives. Furthermore, the amount of state-funded treatment facilities have increased to provide services to those who cannot afford access to private for-profit treatment facilities. South African literature has highlighted a need for greater qualitative research studies expressing the experiences of service users who had been exposed to outpatient substance abuse treatment services both during and post-treatment. This literature review will seek to identify the key themes identified in the literature pertaining to the nature and treatment of substance abuse in South Africa and explore the elements of treatment experiences locally and abroad.

2.2. Defining substance abuse

The concept of substance abuse encompasses definitions from the field of psychiatry, where substance abuse is diagnosed as a medical condition. The South African legislative definition describes substance abuse as an unlawful act. The interpretation of substance abuse may differ; however, all fields of enquiry note the importance of treatment for substance abuse. The following section provides with a brief description of these definitions.

Substance abuse, as defined by the Prevention of and Treatment for Substance Abuse Act (Act No. 70(1), 2008 [hereafter referred to as the Act]) "means the sustained or sporadic excessive use of substances and includes any use of illicit substances and the unlawful use of substances". It is important to note the distinction between substance

use, abuse and dependence, with the latter encompassing a level of involuntary use. The Diagnostic and Statistical Manual for Mental Disorders (DSM-5) classifies SUD on a continuum ranging from mild to severe use, as well as outlining specific criteria to diagnose the condition (American Association of Psychiatry [APA], 2013).

The American Association of Psychiatry's definition of SUD identifies the limiting effect it has on the individual's social functioning and describes SUD as "maladaptive patterns of substance use leading to clinically severe impairment or distress (in Laudet, 2011: 44). The APA definition of SUD involves the individual-level factors or limitations in respect of social functioning. Persons who use substances may not necessarily be substance dependent, and the SUD, previously termed drug dependence, are diagnosed conditions requiring specialist treatment. Despite the varying and nuanced definitions of substance dependence, scholars in the field of addiction have reached consensus regarding the chronic nature of SUD's (Laudet, 2011: 47; McLellan *et al*., 2005: 450; Strebel *et al*., 2013: 49) and the complications associated with treatment.

Substance use is commonly associated with impaired functioning and judgment; where continued, regular or excessive use without treatment could escalate from mild to severe SUD. The criteria used to diagnose mild-moderate-severe SUD define varying degrees of impaired functioning, with the most severe SUD including symptoms of withdrawal and cravings (APA, 2013). The stigma associated with substance abuse could result from the public perception that persons using substances do so willingly, thus implying that these individuals have some level of control over the patterns of use. This

perception alienates the person using substances, socially excluding the individual using illicit substances and creates isolation from loved ones, community members and society at large. Even though initial substance use is rarely intended to harm those directly and indirectly affected, the impact has created a burden at all levels of society.

2.3. Legislative and theoretical framework

2.3.1. Legislation and policy

The Prevention of and Treatment for Substance Abuse Act (Act 70 of 2008) is the guiding legislative document promulgated to address the substance abuse problem in the South African context. The Act makes provision for the establishment of a Central Drug Authority (CDA) to provide an oversight function in the implementation of the Act and is responsible for the development of a National Drug Master Plan (NDMP) to develop a comprehensive approach to addressing the substance abuse problem. Furthermore, the Act makes provision for rendering of treatment services that are inclusive and comprehensive in addressing the needs of service users.

Interventions aimed at combating substance abuse are coordinated at three levels (The Prevention of and Treatment for Substance Abuse Act, Act 70 of 2008):

- Supply reduction aims to curb the production and distribution of illicit substances and substance-related crime by means of law enforcement and legislative crime-fighting strategies.

- Demand reduction services aim to curb or prevent the onset of substance abuse. Demand reduction strategies encompass prevention and early intervention initiatives aimed at raising awareness, enhancing life skills and creating opportunities for meaningful contribution to society.

- Harm reduction refers to the minimisation and mitigation of the social, economic and health impacts on individuals, groups and communities. Harm reduction includes the treatment, rehabilitation, re-integration and aftercare of a person abusing and/or is substance dependent.

Treatment for substance abuse is aligned with the harm reduction, as identified in key policy documents. The Prevention of and Treatment for Substance Abuse Act (Act No. 70 of 2008), the NDMP (DSD, 2013), and the City of Cape Town's Alcohol and other Drug Strategy (City of Cape Town [COCT], 2014a) are aligned with this study at a harm reduction level. Harm reduction strategies are aimed at combating and mitigating the risks and damage inflicted on substance users, families, communities and affected others. Reducing harm encompasses the successful treatment and rehabilitation of substance users to improve their functioning and social interactions within the family setting and society. The study explores whether outpatient substance abuse treatment contributes to harm reduction by exploring the service users' experiences of the outpatient treatment programme.

The City of Cape Town's Alcohol and other Drugs Strategy (COCT, 2014a) outlines a four-pronged approach to addressing the substance abuse problem in Cape Town, aligned with the NDMP (DSD, 2013):
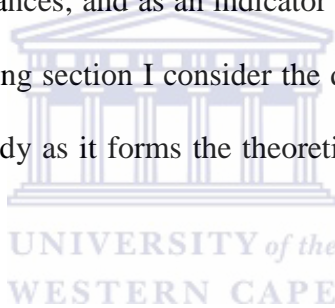
1. *Prevention* is consistent with demand reduction activities and includes targeted interventions aimed at high-risk populations.

2. *Intervention* is consistent with the harm reduction concept. The strategy highlights the need for treatment of individuals who engage in harmful and hazardous substance use.

3. *Suppression* is consistent with supply reduction and involves law enforcement initiatives to curb the distribution of illicit substances.

Coordination aims to facilitate the collaboration of intergovernmental departments to provide a holistic approach to addressing the substance abuse problem. The review of the City of Cape Town's Policy Position on Alcohol and Drugs and Alcohol and Other Drug Harm Minimization and Mitigation Strategy, 2011-2014 (COCT, 2011) encompassed a consultative and participatory process to engage stakeholders and address the lack of intergovernmental coordination in addressing substance abuse. The Alcohol and Other Drugs Strategy (2014) provides broad guidelines for addressing substance abuse in the City and is yet to develop an implementation plan and structures to monitor the strategy.

The key strategic changes in treatment or intervention outlined in the Alcohol and Other Drugs Strategy include the need for increasing the number of substance abuse treatment sites to meet the demand, adolescent-centred treatment and removing barriers to accessing treatment through the subsidisation of transport costs and childcare services (COCT, 2014a). Furthermore, the strategy advocates the expansion of the Expanded

Public Works Programme (hereafter referred to as EPWP) opportunities for service users who complete treatment and participate in aftercare services. The City of Cape Town's Policy on the Implementation of the Expanded Public Works Programme is aimed at reducing unemployment and poverty through the provision of temporary employment opportunities (COCT, 2013).

A common focus area of the various pieces of legislation and policy is the need to enhance service users' social functioning through treatment. Legislation and policy is therefore strongly focused on individuals' quality of life as both a protective factor to prevent dependence on substances; and as an indicator of general well-being during and post treatment. In the following section I consider the quality of life concept further; as this concept is key to my study as it forms the theoretical framework underpinning my study.

2.3.2. Theoretical Framework

Substance abuse has a profound adverse impact on individuals, family systems, and communities. The deterioration of social, economic and health domains is common for persons engaging in substance abuse (Laudet, 2011; DSD, 2013). Persons entering treatment seek a better life and an improvement in life domains which may have suffered during the course of addiction, that is; a good quality of life. The following section provides an overview of the theoretical foundation underpinning this study. The theoretical framework considered in this study is based on Quality of Life (QOL) theory.

The QOL concept is defined as:

> *An individual's perception of their position in life, in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns. It is a broad ranging concept, affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, and their relationship to salient features of their environment* (WHOQOL Group, 1995: 1404 in Camfield & Skevington, 2008: 765).

In 1962, Abraham Maslow introduced the concept of QOL where he purported that individuals reach true happiness when their needs are met. Maslow's theory for development posits that happiness and true being is based on the concept of human needs (Ventegod, Merrick & Andersen, 2003: 1050-1051). Maslow put forward his theory of the hierarchy of needs. Maslow's theory is based on the premise that individuals journey – in a linear manner, through different phases of basic needs (the base of the hierarchy), psychological needs and ultimately transcending into a state of reaching one's personal meaning of life - self-actualization.

Maslow's theory on the QOL has been refined and expanded to include tools measuring life satisfaction and quality of life domains. Two types of QOL have been conceptualised by researchers and include health related QOL (HRQOL) and overall QOL (OQOL), as illustrated in table 2.1.

Table 2.1. Summary of QOL measurements

	Health-related QOL	Overall QOL
Definition	Perceptions of effects of illness on physical, mental and social dimensions of well-being	Perception of one's position in life in the context of values, culture, goals, expectations, standards and concerns
Paradigm	Symptoms, pathology	Wellness
Domains	Physical, mental, social health	Physical, mental (includes spiritual), social health, and living environment (housing, finance, safety, access to care)
What is assessed	Limitations due to disease/illness	Objective functioning and satisfaction with functioning
Treatment focus	Symptom reduction	Maximised social functioning and life satisfaction

Source: Laudet, 2011.

Health related QOL specifically measures impact of disease on services-users' physical, psychological and social functioning. In contrast, overall QOL encapsulates the service-users subjective sense of well-being and general life satisfaction (Laudet, 2011). The World Health organization has developed instruments measuring both health and overall QOL, in the WHOQOL and a shortened version, the WHOQOL-BREF (WHOQOL Group, 1998). The overall QOL instrument includes safety, finances, access to services etc. Laudet (2011: 46) notes that clinicians tend to focus on symptom reduction; however, for service-users recovery involves the optimal well-being and improved

functioning. Laudet (2011: 50-51) further argues that improvements in QOL may influence symptom reduction.

Traditional measures of treatment effectiveness focused primarily on achieving reduced substance use or abstinence post-treatment (McLellan *et al*., 2005). Over the past decade, researchers have made a paradigmatic shift from pathology-focused care to optimal well-being, termed recovery. Recovery "is best conceptualised as abstinence plus improvements in global functioning or, in other words, improved quality of life" (Laudet, 2011: 47). Substance abuse treatment programmes aim to achieve reduced use and more importantly complete abstinence; however, the overarching goal of treatment is to achieve improved quality of life.

While reduced use may be indicative of treatment effectiveness, partial or full abstinence alone does not adequately address the substance use-related social challenges. Recovery can be either enhanced or hampered as a result of these variables. The treatment experiences of service users and the level of engagement, participation, compliance and motivation are factors that influence post-treatment outcomes.

Traditional evaluations of substance abuse treatment programmes typically occurred post-treatment, measuring relapse trends and abstinence (McLellan *et al*., 2005). While this method of evaluating treatment effectiveness has been useful in assisting treatment providers with empirical evidence of efficacy, it was limited in measuring the impact of treatment.

McLellan *et al.* (2005) propose that treatment effectiveness and outcomes could be measured by quality of life indicators (QOL) during treatment, i.e.

- reduced alcohol and drug use;

- improved personal health;

- improved social functioning (employment status, social and family relationships); and

- reduced harm to society

The overall QOL indicators are useful in unpacking the impact of treatment; however, reduced alcohol and drug use remain the key goal in substance abuse treatment programmes. Persons suffering from SUD experience lower QOL compared to persons without the condition (Laudet, 2011). One would expect that reduced or complete abstinence from substances would result in improved QOL; however, studies investigating SUD-symptom remission and QOL found that the most notable improvement has been on mental functioning (Laudet, 2011). Improved mental functioning is meaningful at an individual level, but it does not address the multiple substance-related social issues at an interpersonal, occupational and health level.

2.4. The impact of substance abuse

Substance abuse is often understood as an act or behaviour, involving an individual who performs the act. While this perception is not entirely incorrect, it does not encapsulate the profound contextual factors associated with the use of substances. The act of using substances in itself impacts the individual, social connections/relationships, the

neighbourhood or community and society at large. The following section will elucidate the profound impact of substance use at all levels of society, and how the history of South Africa shaped the social challenges experienced by all citizens today.

Globally, substance abuse has had adverse effects on individuals, families and communities. In South Africa, it is noteworthy to explore the historical context of substance abuse to unpack the complex nature of treatment and recovery for disadvantaged communities. The treatment and recovery process is by no means simpler for white South Africans; however, the socio-economic conditions are important factors to consider, especially in view of the post-treatment experiences of recovery.

The erstwhile apartheid government adopted international anti-substance abuse treaties, with little or no enforcement in disadvantaged communities. The poor regulation of drug use and trade in disadvantaged communities was further compounded by the socio-economic conditions in these areas (Peltzer *et al*., 2010). Substance use and trade flourished under these conditions, and gangs operated freely within the borders of these communities. In addition, the relaxed border control policies that came with the advent of democracy resulted in an influx of harder drugs being imported into the country (Wechsberg *et al.*, 2008; Peltzer *et al*., 2010), further exacerbating the existing socio-economic conditions in disadvantaged communities that are affected by high levels of unemployment, crime, gang violence and limited access to resources. It is important to note that substance abuse cannot be addressed in isolation from social challenges present in society. The impact of substance abuse is inextricably linked to the structural

challenges created by a discriminatory and oppressive system, with residual effects that continue to affect disadvantaged communities today.
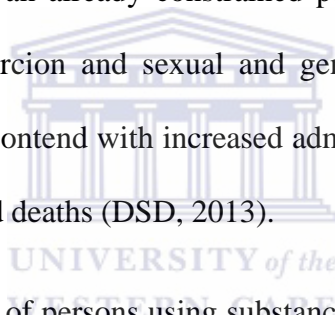
For example, in the rural areas in the Western Cape, farm workers received payment for work performed in the form of alcohol – a practice commonly known as the "dop system". Though the system has been outlawed, the effects of this system persist today; where alcohol consumption is very common among farm workers and now referred to as the "dop legacy" (May *et al.*, 2005: 1191). An indirect consequence of risky drinking has resulted in the growing incidence and prevalence of Fetal Alcohol Spectrum Disorder (FASD) in rural areas and has been linked with risky alcohol consumption (May *et al.*, 2005).

Studies investigating the impact of substance abuse allude to the physical, mental, social and economic consequences of substance abuse (Wechsberg *et al.*, 2008; May *et al.*, 2005; Watt *et al.*, 2014). The impact of substance abuse can be unpacked at individual, family and societal levels.

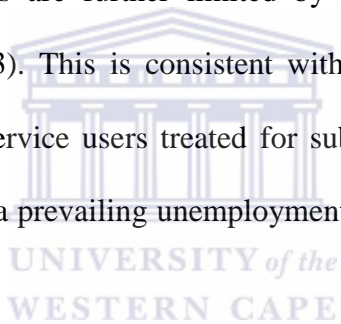### 2.4.1. Individual impact

The historical context of substance abuse indicates that there is no simple solution to the problem. Furthermore, substance abuse treatment is not a cure-all for individuals who use substances due to the complex nature and context of substance abuse. The following section will highlight how the act of using substances affects the person who engages in substance use.

27

Substance use is often associated with impaired judgment and decision-making abilities for the person engaging in substance use/abuse. Wechsberg *et al*. (2008) found a positive relationship between risky sexual behaviour and substance abuse and postulate that women who use drugs are less likely to use condoms. Disinhibition associated with methamphetamine use is a major public health concern and increases the risk of contracting sexually transmitted diseases and HIV. Similarly, the practice of sex-in-exchange-for drugs inevitably increases risks of contracting sexually transmitted diseases and HIV (Wechsberg *et al*., 2008: 133; Watt *et al*., 2014: 222; Neuman *et al*., 2012), creating a burden on an already constrained public health system. Often these sexual practices involve coercion and sexual and gender-based violence. The public health system further has to contend with increased admissions to emergency rooms due to alcohol-related injuries and deaths (DSD, 2013).

While the physical wellbeing of persons using substances may be compromised, various studies found that substance use contributes to a decline in mental health (Laudet, Stanick & Sands, 2009; Weich & Pienaar, 2009: 213; Watt *et al*., 2014: 221). This is evidenced by the surge in substance-related admissions to emergency units and mental health services. Methamphetamine-related admissions have increased significantly over the past ten years (Plüddeman, Myers & Parry, 2008; Weich & Pienaar, 2009: 216) and this co-morbidity has created additional complications in the treatment of substance abuse. Furthermore, co-morbid psychiatric conditions amongst persons using substances have limited positive treatment outcomes for individuals and families.
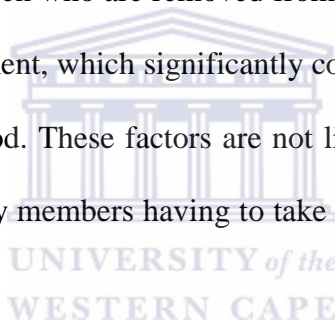
The impact of substance abuse on the individual has far-reaching consequences and is not limited to physical and mental well-being. Socio-economic challenges, such as unemployment, further compound the problem of substance abuse, either as a cause or result thereof. A study conducted amongst an employed population in the USA found that symptoms associated with substance abuse contribute to reduced productivity and absenteeism (Merrick *et al*., 2012), which may contribute to the loss of employment. The unemployment rate in South Africa is largely attributed to the economic climate, a lack of skills, and limited employment opportunities. However, economic opportunities for persons using substances are further limited by their use of and the nature of substance abuse (DSD, 2013). This is consistent with contemporary substance abuse statistics. In South Africa, service users treated for substance abuse during the period July to December 2014, had a prevailing unemployment rate of 51% (Dada *et al*., 2015: 5).

2.4.2. Interpersonal relationships

While the individual is exposed to multiple risks in respect of health and social and economic opportunities, the individual resides within a family and community and the impact of drug use ultimately affects the individual's social support structure (Strebel *et al*., 2013: 41-42; Watt *et al*., 2014: 222). The social connections and human interactions are indirectly affected by the use of substances. A brief discussion on the impact of substance abuse on interpersonal relationships will ensue.

The impact of substance abuse is not limited to those who use, but has far-reaching consequences for families and affected others. The behaviour associated with substance abuse, i.e. aggression, impaired judgment and violence has contributed significantly to the erosion of social relationships encompassing occupational, social, familial and societal relationships. Watt *et al*. (2014: 222) found that children of persons who use drugs are exposed to interpersonal violence, neglect and abandonment, which further reinforces the intergenerational cycle of substance abuse. These findings suggest that children of persons who use drugs have a predisposition to display high-risk behaviour as adults. Furthermore, children who are removed from the primary care of their parents deal with issues of abandonment, which significantly contributes to childhood emotional trauma extending to adulthood. These factors are not limited to the nucleus family, but often involve extended family members having to take on the role of primary caregivers to the affected children.

Similarly, substance use takes preference over the maintenance of social relationships in the family, workplace and/or community. Family problems associated with substance use were most frequently reported amongst a sample of clients accessing social welfare services in the Western Cape (Burnhams, Dada & Myers, 2012: 6). Clients seeking social welfare services cited legal, financial and domestic violence as problems associated with substance use. Social-specific support has been an effective protective factor for service users in treatment and post-treatment recovery (Myers, Pasche & Adam, 2010). In essence, treatment and recovery should aim to rebuild or establish new support structures that could aid sobriety and the recovery process.

The demographics of service users accessing substance abuse services indicate that the majority are male and unemployed (Dada *et al*., 2015: 5). Service users have to contend with limited employment opportunities in the peri-urban communities of origin as a result of the discriminatory policies of the past, where public services were concentrated in areas reserved for White South Africans (Burnhams, Dada & Myers, 2012: 2), further increasing the high unemployment rates amongst persons using drugs. While the employability of persons using drugs is compromised, the behaviour associated with the use of substances, i.e. reduced productivity and absenteeism could result in the loss of employment and subsequently the household income (DSD, 2013).

2.4.3. Societal impact

Substance use impacts negatively on the individual and his/her social connections, as noted previously. The behaviour associated with substance abuse poses a risk to public health and safety, as evidenced by the increase in drug- related crimes over the past few years. The substance abuse problem has created an additional burden on state resources, such as law enforcement and health institutions. The following section will explore the impact of substance abuse on the broader society.

Substance abuse has had an adverse impact on public safety, especially in historically disadvantaged communities, such as the Cape Flats in Cape Town. The drug trade has been strongly associated with gangs who control and distribute drugs in these communities. Communities have been marred by the drug trade and gang violence due

to the competition for areas of operation or territories of various gangs. Watt *et al.* (2014: 222-223) conducted a study on the perceived impact of substance abuse in a peri-urban community of Delft in Cape Town, and cited drug trade amongst rival gangs as a common threat to the general safety of community members. Participants cited police corruption and a lack of trust in the police service as a barrier to eliminating the illegal trade of illicit drugs.

The Minister of Community Safety in the Western Cape, Dan Plato, expressed grave concern with the release of the National Crime Statistics 2014/15. Minister Plato noted that drug-related crime had increased by 3.8 % in the Western Cape compared to the 2.4% national average, and accounted for 33.2% of national reported cases (WCG, 2015). The incidence of drug-related crime in Cape Town has consistently increased at an average of 24% annually over the past decade (COCT, 2014b). Drug-related and alcohol-related crime remains a key challenge and threat to public safety. This highlights the importance of communities in the treatment and rehabilitation of service users. The treatment of persons using drugs is, however, complex, which requires innate desire to seek treatment.

People presenting for treatment may decide to access services after having already experienced the adverse social consequences and the impact of use. Laudet (et al., 2009) postulate that treatment-seeking in itself is a means to an end, where the social functioning and relationships have deteriorated as a result of substance use. Persons seeking treatment often do so with the expectation that treatment would solve social challenges associated with substance abuse. Understanding the social impact on the

individual, family and community contributes to goal-setting in treatment and aids in recovery. These social factors either contribute positively or negatively to the recovery process.

Myers *et al*. (2010) found that social-specific support contribute to treatment completion. Most treatment programmes incorporate family support as an integral part of treatment. The aim of the family component in treatment is twofold – it rebuilds strained social relationships and provides an educational component for families to understand addiction from a biological perspective and gives families tools to aid the recovery process. Families often view treatment as the solution and cure for substance abuse and SUD, but it is merely the first step in the overall recovery process.

The impact of substance abuse, as highlighted in this section, demonstrates the complexities of treatment and recovery. Nearly all life domains are impacted by the use of substances. Laudet (2011: 48) notes that treatment seeking behaviour is largely influenced by the deterioration in these life domains and require consideration in the treatment process.

2.5. Treatment for substance abuse

Treatment for substance abuse is vital in the light of the complex individual-level and structural issues presented in the previous sections. Treatment is not a cure-all for the substance abuse problem; however, the rehabilitation of service users stands to alleviate some of the social challenges associated with substance use. The following section will

provide a brief overview of treatment modalities and substance abuse treatment experiences locally and abroad.

2.5.1. Inpatient and outpatient treatment

Substance-abuse treatment programmes offer inpatient treatment and outpatient treatment. Inpatient treatment is residential-based and service users generally live in the facility for a fixed period. Outpatient treatment allows the service user to attend sessions weekly at a facility and to return home once sessions are concluded. Both treatment modalities are time bound and service users exit the programme after completion. A brief discussion on treatment modalities will suffice.

The Prevention of and Treatment for Substance Abuse Act (Act No. 70, 2008) makes provision for the establishment of outpatient and community-based services that are situated in under-served areas. The impetus for these services is to provide access to substance abuse treatment services to persons who need it within their family and community of origin. The Act promotes accessibility of services, with specific emphasis on vulnerable groups, i.e. women, children, youth and the disabled. Furthermore, the Act mandates that registered treatment facilities meet the minimum norms and standards to ensure that treatment programmes offer a quality service in line with national standards.

Outpatient treatment is characterised by treatment being delivered by a multidisciplinary team of healthcare professionals, such as social workers, psychologists, occupational therapists and psychiatrists (The Prevention of and Treatment for Substance Abuse Act 70 of 2008). The multi-disciplinary model of treatment is intended to provide holistic

and comprehensive treatment in that it provides an array of services to support service users in social and family aspects, psychological counselling and group interventions, occupational-specific interventions and diagnostic interventions and medical treatment, which are essential dimensions of treatment required to address social, health and occupational aspects that may have been neglected during the course of substance use. The multidisciplinary approach is consistent with the concept of recovery, where service users are able to address the consequences of substance use. However, the period of formal treatment is not sufficient to address the multitude of challenges experienced by service users.

Although treatment services have become accessible to low-income and unemployed individuals, it is unclear whether outpatient services are effective in reducing substance use and producing similar outcomes to inpatient treatment. Furthermore, there is limited empirical data available comparing outpatient programmes as the preferred mode of treatment, a gap that requires further investigation.

2.5.2. Treatment trends

Globally, a shift from residential treatment programmes to outpatient settings has occurred; firstly, to address the increased demand for treatment services and secondly, to provide affordable treatment for persons requiring substance abuse treatment. By 2002, 85% of treatment programmes in the United States of America were delivered in outpatient settings (McLellan *et al*., 2005: 450). Similarly in South Africa, the mode of treatment has shifted to outpatient settings to deliver substance abuse treatment services

that are affordable and accessible (DSD, 2013). In the period July to December 2014, 71% of service users in treatment made use of outpatient services (Dada *et al*., 2015).

In apartheid South Africa, substance-abuse treatment services were situated in urban areas, reserved for Whites. The remnants of separate development are evident in the dearth of substance abuse treatment services in disadvantaged communities (Myers & Parry, 2005; Peltzer *et al*., 2010; Burnhams, Dada & Myers, 2012; Watt *et al*., 2014). The unequal distribution of services continues to affect South Africans, despite the proliferation of redistribution policies geared towards redressing these inequalities post-1994. Myers and Parry (2005) found that black South Africans are under-represented in specialist substance abuse treatment facilities in Cape Town and the Gauteng province. The patterns of service utilisation among black South Africans requires further investigation as the statistics may not accurately reflect the need for treatment amongst this population group.

Women remain under-represented in treatment facilities in South Africa (Dada *et al*., 2015: 5). In Third World countries, such as Brazil and Mexico, where socio-economic conditions are akin to those in South Africa, access to substance abuse treatment and service utilisation for women is frustrated by factors, such as gender roles, childcare issues and social prejudice associated with substance use (Elbreder *et al*., 2009: 353; Guerrero *et al*., 2014: 2). Women are subjected to severe stigmatisation and discrimination and societal expectations of women as the primary caregivers of children and the family may affect women having the courage to seek treatment.

In South Africa, the majority of service users in treatment are male. It is unclear whether these statistics accurately reflect the number of persons using illicit substances in terms of gender. Ramaglan (*et al*., 2010: 47) posit that women may be "hidden" substance users, who do not necessarily present to treatment facilities. The perception that substance use in terms of gender may be ascribed to socialisation or gender roles could be problematic as it assumes that women do not engage in substance use. South African legislation is progressive in espousing and protecting women's rights, but has not addressed the cultural and societal gender roles ascribed to women, which may limit treatment-seeking behaviour.

Treatment experiences of women are of interest, particularly in the light of the under-representation of women in treatment facilities. Wechsberg *et al*. (2008: 137) conducted a study investigating the substance use and other risk behaviour among Black and Coloured South African women and found that patterns of use differed amongst the two racial groups. While both groups reported risky sexual practices during intoxication, Black women were more likely to use condoms. Even though the patterns of substance use and risky sexual practices differed in the sample, the brief behavioural intervention reduced such practices in both groups. Risky sexual practices and promiscuity are practices commonly associated with women who engage in substance use (Watt *et al*., 2014: 222; Myers, Fakier & Louw, 2009: 220; Wechsberg *et al*., 2008: 133).

In contrast to the under-representation of women and black South Africans in treatment facilities, the need for treatment for the youth has escalated significantly in recent years (Flisher *et al*., 2003: 61-62; Ramaglan, Peltzer & Matseke, 2010: 48; Carstens &

Eigelaar-Meets, 2014; Van Heerden *et al.*, 2009: 365). In Cape Town, admissions to treatment facilities for the under-25 age group accounted for 40% of admissions during the period July to December 2014 (Dada *et al*., 2015: 6). The prevalence and incidence of adolescent substance use in South Africa is a cause for concern as it may divert the youth from achieving a good quality of life and hamper their socio-economic outlook in adulthood.

In spite of the high levels of substance abuse, service utilisation has remained low in Cape Town. Myers, Louw and Pasche (2010) found that geographic access barriers, awareness of treatment options and competing financial priorities were some of the predictors of service utilisation. Furthermore, non-structural factors, such as negative beliefs about treatment and stigma towards persons using drugs contribute negatively to service utilisation and act as a barrier to treatment particularly in historically disadvantaged communities (Myers, Fakier & Louw, 2009: 220). Addressing structural and non-structural barriers to treatment requires a comprehensive response involving stakeholders from government departments, as well as the NPO and CBO sectors.

2.5.3. Substance-abuse treatment experiences

The skewed perception that treatment or rehabilitation is a cure for substance abuse is common amongst the public. Individuals entering programmes seek treatment to reduce and ultimately abstain from substance use; however, the experiences amongst this population are unique to every person. This section seeks to identify those variables that

influence treatment experiences, both locally and internationally. Individual-level and programme-level factors will be explored in the treatment experiences of service users.

The primary goal of treatment is to reduce and/or abstain from substance use. However, treatment programmes should consider the individual- and programme-level factors that impact on the experiences of service users and the overall outcome of treatment. Lee (*et al.* 2007: 313 in Laudet, Stanick & Sands, 2009) note that "patient perspectives on treatment may have a role in treatment outcomes and should be explored as a dimension of the treatment process". Service users' perceptions of treatment effectiveness could provide useful first-hand information to clarify expectations during the initial phases of treatment and improve retention and ultimately the overall outcomes.

Laudet (2011: 44) notes that individuals seeking treatment for substance abuse or SUD "seek help quitting drugs not as an end in itself, but as a means to escape [these] negative consequences and to gain a better life". Understanding the pre-treatment challenges and reasons for entering treatment is noteworthy to assist with goal-setting but also to address and identify the expectations of the service users. This aspect of pre-assessment would ultimately impact on the overall experiences and success of treatment programmes. Laudet and White (2010) found that recovery priorities among service users in a community-based treatment programme included employment, education and housing issues.

The literature reviewed indicates that while service users enter treatment to reduce or abstain from substance use, associated social needs may not be addressed during

treatment (Laudet, Stanick & Sands, 2009; Laudet, 2011; Strebel *et al*, 2013). The effectiveness of treatment is thus not measured by the patterns of use alone but extends to other life domains that may have been affected during the course of substance use. Laudet and White (2010) found that service users were more likely to drop out of treatment if their social needs are not addressed during treatment. This is indicative of the need for holistic interventions during and post-treatment. Treatment episodes are time-bound and it is an unrealistic expectation that social needs be addressed during treatment.

The reasons for entering treatment may vary amongst treatment seekers; however, scholars in the addiction field have cited motivation and change-readiness concepts as key prerequisites, which positively impact treatment experiences and outcomes (DiClemente *et al*., 1991; Carbonari & DiClemente, 2000; CSAT, 1999; Projects MATCH Research Group, 1997; Joe Simpson, & Broome, 1998 in DiClemente *et al*., 2008; Laudet, Stanick & Sands, 2009). The motivation levels of individuals influence the participation, retention and overall outcome of treatment. While motivation and commitment to abstinence is a predictor of reductions in substance use, service providers are challenged with the task of retaining service users in treatment to maximise the impact of treatment. Service-user retention has presented an enormous challenge for affected others, service providers' funders and planners.

Outpatient treatment facilities contend with high drop-out rates where the retention of clients to complete treatment is often challenging. Studies conducted locally and abroad have indicated that the frequency and completion of treatment results in improved

40

outcomes (Lu & McGuire, 2002; Myers, Pasche & Adam, 2010). Qualitative data is limited on factors impacting on drop-out and retention rates in South Africa; an area that requires further exploration to understand the experiences of service users who do not complete treatment and to assist with developing strategies to improve retention rates in outpatient treatment programmes. Studies conducted in the USA found that increased treatment periods result in better outcomes (McLellan *et al*., 2005; Lu & McGuire, 2002). The benefits of treatment are therefore drastically reduced for service users who drop out of treatment prematurely. It is therefore beneficial to understand the experiences of service users, to explore the protective and service-level factors that contribute to compliance and the completion of treatment and to negate the possibility of early dropout to maximise the impact of treatment.

Laudet (et al., 2009) conducted a qualitative study capturing the experiences of service users who dropped out of treatment and their recommendations to improve an outpatient substance abuse treatment programme. Service users identified a number of individual-level factors, most notably substance use during treatment and returning to environments that are conducive to substance use. The programme-level factors indicated that the unmet social service needs, i.e. unemployment, homelessness and skills development were a key reason for leaving treatment. Service users had an expectation that these needs would also be addressed in treatment. Other programme-level-factors that contributed to early dropout were poor therapeutic alliance with the assigned therapist. The intensity of the programme resulted in no flexibility and service users having to

neglect other aspects of their lives and practical issues, such as transportation and childcare issues. Service users in the study identified five priorities at intake interviews:

1. Abstinence   50.2%
2. Finding employment   28.3%
3. Obtaining education/training   24.1%
4. Childcare issues   18.7%
5. Housing   17.1%

The priorities identified in this sample of American respondents reflect the socio-economic challenges experienced by many South Africans, including those who do not engage in substance use. Furthermore, in South Africa, socio-economic conditions are considered to be causal factors that contribute to the substance abuse problem. For example, in Cape Town ten police precincts identified as most affected by drug-related crimes were also areas most affected by gang violence in 2014/15 (WCG, 2015). These statistics are indicative of the intricate and complicated context in which service users are required to recover from substance abuse and SUD's. The substance abuse problem in Cape Town and most historically disadvantaged communities in South Africa require holistic interventions that also address these structural conditions that are conducive to substance abuse.

Abstinence during outpatient treatment greatly impacts on the treatment experiences of service users. Outpatient service users are not institutionalised and therefore remain in the household and community during treatment. In essence, service users have to

reintegrate back into society while receiving substance-abuse treatment and have to manage abstinence and cope with triggers that could contribute to relapse, particularly over weekends (Strebel *et al*., 2013: 44). The successful treatment of substance abuse is a challenging task due to the risk of relapse. As a result, service users may struggle to maintain abstinence during and post-treatment. Furthermore, service users who had more than one prior admission and a co-morbid psychiatric condition are at higher risk of relapse (McLellan *et al*., 2005: 450). Abstinence during treatment has presented a challenge to substance abuse service providers globally. Laudet (et al., 2009) found that substance use during outpatient treatment was a key individual-level factor resulting in early dropout from a US-based treatment programme.

The therapeutic alliance between therapist and service user could strengthen the service user engagement and provide benefits to treatment. In a study conducted in a residential treatment programme, Meier *et al*. (2006) found the therapeutic alliance to be a strong predictor of length of retention. The therapeutic alliance in the early stages of treatment is critical to achieve meaningful change. If the service user's subjective sense of wellbeing is realised, it is likely that they will remain in treatment (Miller *et al*., 2006). Studies conducted in the USA and the UK found that treatment retention or longer periods of treatment improves overall outcomes for service users (Lu & McGuire, 2002; Meier *et al*., 2006; Laudet, Stanick & Sands, 2009).

The treatment alliance in outpatient settings similarly strengthens the retention and inadvertently the outcomes of treatment. Furthermore, treatment experiences of the therapeutic alliance could offset or mitigate drop-out rates. The therapeutic alliance has

been investigated extensively abroad, with limited empirical data available in South Africa. The concept of therapeutic alliance is vital in achieving positive results, especially in view of the fact that it improves overall outcomes for individuals. It is, however, important to note that South Africa is a developing country and the treatment approach should be adapted to that context.

Social-specific support in the treatment process has yielded positive results for service users, ultimately improving the outcomes of treatment (Myers, Pasche & Adam, 2010; Laudet, Stanick & Sands, 2009). Positive social relationships and interactions contribute to abstinence or at least reduced substance use. Scholars in the addiction field have shifted from a pathology-focused model and recognised that services should be holistic and include affected others in the treatment process. Family involvement in treatment remains a challenge for service users and providers. For example, an outpatient programme in the Western Cape Province reported a family attendance rate of less than 40% (Strebel *et al*., 2013: 45). A lack of social support increases the risk of early dropout and relapse.

Substance abuse treatment is generally delivered within a specified timeframe in both in- and outpatient settings. Treatment completion alone will not guarantee abstinence for most individuals struggling with substance addiction. Moreover, once treatment programmes conclude, individuals have to return to their families and communities and start rebuilding certain aspects of their lives that may have suffered during or as a result of substance abuse. It is estimated that between 40%-60% of persons suffering from SUD are likely to relapse post-treatment (National Institute of Drug Abuse, 2006 in Van

der Westhuizen *et al*., 2013: 2). Considering the chronicity and relapsing nature of SUD, aftercare services become vital post-treatment to aid the recovery process.

2.5.4. Aftercare

Aftercare services "refers to ongoing support to addicted persons and their families following formal treatment to increase the recovery potential and thereby limiting the need for re-admission to treatment centres" (Rosenberg, 2008: 126 in Van Der Westhuizen *et al*., 2013: 2). The Prevention of and Treatment for Substance Abuse Act, section 30(1) (Act No. 70 of 2008) makes provision for aftercare services to integrate "a service user into society, the workforce and family and community life". The Act, however, does not define the role of treatment service providers to deliver such services and it is therefore perceived as "add-ons or extras" within an already burdened system (Maluleke, 2013).

Aftercare services are rarely institutionalised within treatment programmes, possibly due to a lack of capacity and/or resources, and individuals and families are often referred to self-help social support groups. While this service offers support post-treatment, it is limited in addressing social-specific challenges that may require individual and/or family interventions. Furthermore, the therapeutic alliance between service users and therapists may strengthen the aftercare and recovery process if delivered within a continuum of care. Even though aftercare services may have been neglected somewhat in the treatment process, individuals embark on a journey of recovery post-treatment.

Substance abuse treatment is generally a time-bound process, where service users are introduced and equipped with coping skills and tools to aid abstinence. The chronic nature of substance abuse indicates that the individual contends with triggers and the possibility of relapse. The post-treatment experiences or recovery process extends beyond the time limit of formal treatment.

Treatment episodes are by no means a cure for substance abuse or SUD. Substances are addictive in nature and as a result individuals who have undergone treatment may be at risk of relapse. The during-treatment focus is to achieve reduced or abstinent behaviour and to obtain coping skills and tools to maintain sobriety. It can be argued that recovery from substance abuse occurs post-treatment, when service users return to their daily routines and have to start rebuilding personal, occupational and societal relationships. This process is far from linear and may involve multiple attempts at achieving these outcomes.

2.6. Conclusion

Historically, substance-abuse treatment services were concentrated in urban areas reserved for White South Africans. The advent of democracy and relaxed border control policies resulted in an influx of new drugs into the country. The impact of substance use has had a devastating effect on individuals, families and society, particularly in terms of health and safety. The escalating use of illicit substances and the subsequent social challenges it created resulted in an increased demand for substance abuse treatment services.

Access to treatment services has been a challenge for poor South Africans, more specifically Black South Africans. A shift from residential programmes to outpatient treatment facilities has been made to make provision for services that are affordable and accessible, both locally and internationally. However, it is unclear whether these services are more effective than traditional inpatient treatment. Moreover, service users remain in communities that are conducive to substance abuse and have to contend with complex structural challenges during and post-treatment.

The service-user experiences both locally and abroad indicate that individuals seeking treatment contend with multiple social needs that had been neglected during the course of substance use. Abstinence during treatment remains a key challenge for both service users and service providers, and contributes to the high drop-out rates in treatment facilities. Women are under-represented in treatment facilities and contend with issues, such as traditional gender roles and childcare issues.

There is a dearth of qualitative data expressing the treatment experiences of service users in South Africa; however, studies conducted locally identified a number of treatment challenges. Cultural and language barriers are key programme-level challenges for service users. Furthermore, the City of Cape Town adopted an American manualised outpatient programme. The need has been identified to adapt this programme to the local context for implementation. Indirect costs, such as transportation and distance travelled may contribute to early drop-out. The aim of treatment is to become drug-free but ultimately to improve the individual's quality of life.

The literature reviewed highlighted the complex nature of substance abuse and treatment. Causal factors that contribute and predispose individuals to substance use/trade include a number of social challenges in South Africa, i.e. gang activity and crime, unemployment and a lack of skills and development to complement substance prevention efforts. While the decision to use substances rests with the individual, these socio-economic conditions are symptomatic of the substance abuse problem in Cape Town and across South Africa and need to be addressed to alleviate the burden of substance abuse.

CHAPTER THREE: FEASIBILITY OF OUTPATIENT TREATMENT IN CAPE TOWN

3.1. Introduction

The City of Cape Town has rolled out, from the United States of America (USA), an outpatient substance abuse treatment programme for implementation in eight sites across the City. The evidence-based 16-week intensive programme was first introduced in 2008 in response to the increasing demand for substance-abuse treatment services that are affordable and accessible. This chapter seeks to provide the background to the programme and an overview of the service and implications for treatment.

3.2. Background

The City of Cape Town's substance-abuse programme was adopted in 2008 from the USA. The programme has been successfully implemented in the USA. This section seeks to provide the background of the programme and how it developed.

The outpatient substance-abuse treatment programme employed by the City of Cape Town was first developed in the USA in the 1980s to respond to the crack, cocaine and methamphetamine epidemic. The programme was initially intended to treat individuals who did not respond to conventional methods of treatment (Rawson & McCann, 2005). The intensive programme has been researched and revised over the past two decades to include the treatment of other drugs and alcohol and has seen useful benefits for service users in the USA. The programme is derived from clinical research literature and evidence-based practices, encompassing elements of various therapeutic approaches,

including cognitive-behavioural therapy, motivational interviewing techniques, relapse-prevention research, psycho-educational concepts and 12-step involvement.

The first evaluation of the outpatient programme was conducted in 1985 with cocaine dependent persons (Rawson *et al* in Rawson & McCann, 2005). The study evaluated relapse rates amongst service-user groups that had accessed inpatient treatment, self-help groups and the outpatient programme respectively. The findings revealed that the relapse rates were significantly reduced in the outpatient programme compared to the other treatment modalities.

A 300-page manual was developed and tested in a controlled trial over a period of two years. Cocaine-dependent individuals were randomly assigned to the outpatient programme under investigation and services grouped under "other available community resources", which included inpatient, outpatient and self-help treatment (Rawson *et al*., 1995 in Rawson & McCann, 2005). Increased treatment periods provided positive results for the outpatient programme, i.e. an increase in urine negative results, improvement in employment and family scales, compared to the group accessing other community resources. Similarly, in a study conducted by the Center for Substance Abuse Treatment in the USA in 1998, the results revealed that the outpatient programme was superior in retention and completion rates, and a decrease in self-reported methamphetamine use which was supported by negative urine results (Rawson & McCann, 2005).

The outpatient programme has seen positive benefits in the USA and has been extended to different cultural groups, adapted to countries outside of the USA and translated into other languages. In view of the substance-abuse problem in South Africa, and Cape Town in particular, the programme was introduced by the City of Cape Town to address the increased demand for substance-abuse services.

3.3. Service components

The treatment model used by the City of Cape Town's outpatient substance abuse programmes includes individual, family and group interventions. Service users are required to attend the programme three times per week, as illustrated in the table below. The City's outpatient treatment programme is very structured and intensive, its sole aim being to provide service users with an effective and feasible alternative to inpatient treatment, which 1.) is a very expensive treatment option that marginalises those who cannot afford it and 2.) provides service users with the opportunity to rehabilitate within the community and deal with daily stressors and also to retain employment. The table below is intended to provide a schematic overview containing a breakdown of what service users can expect to experience whilst in treatment. For a more detailed summary of the programme, refer to appendix I.

Table 3.1. The City of Cape Town's substance abuse treatment programme schedule.

Monday	Wednesday	Friday
Early Recovery Skills Weeks1-4	Family/education Weeks 1-12	Early Recovery Skills Weeks1-4
Relapse Prevention Weeks 1-16	Social Support Weeks 13-16 Continues past week 16	Relapse Prevention Weeks 1-16

Source: **Rawson & McCann, 2005.**

In the South African context, substance-abuse treatment has historically been inaccessible to disadvantaged groups (DSD, 2013; Peltzer *et al*., 2010; Myers & Parry, 2005). Broad challenges, which precluded disadvantaged population groups from accessing substance-treatment opportunities, were limited community resources and the unaffordability of treatment. The main impetus for the City to adopt and roll out its outpatient treatment programme was to circumvent the exorbitant costs associated with treatment and to make treatment more accessible by situating it in the community.

What is implied by the above table is that service users are able to attend sessions three times per week for a period of 16 weeks. In this study the clinics where the outpatient treatment programmes are presented are situated in impoverished communities with high crime rates (WCG, 2015). Thus the implications for service users accessing the treatment service are economic, a risk to safety and in the case of single parents, honouring parental responsibilities.
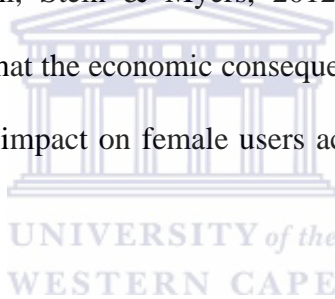
The City's outpatient treatment programme lasts a period of 16 weeks. The City's outpatient treatment programme is presented with no cost to the service user. Although this treatment programme is free, it has significant indirect economic implications for the service users. Over the course of treatment, service users are expected to attend sessions three times per week. Statistics released by SACENDU (Dada *et al*., 2015: 5) state that 51% of service users that accessed outpatient treatment services in the Western Cape during 2014 were unemployed. This suggests that the need to secure and retain employment presents a threat to treatment completion. Even people who are employed would have to negotiate time off with employers in order to attend treatment sessions.

If a service user were to access outpatient treatment, he/she would require money for transportation to the site, possibly have to arrange and pay for childcare (in the case of single parents) and if the service user were unemployed, he or she would have to deal with the constant pressure of having to provide for his/her family. The economic responsibilities placed on the individual accessing outpatient treatment would create stressors that could trigger a relapse episode or contribute to further use. The service user would have to weigh up the benefits of treatment against the adverse economic consequences.

Service users accessing treatment within the community are faced with many barriers and potential triggers to relapse. In the communities of Parkwood and Delft, poverty, unemployment, poor infrastructure, a lack of housing and, limited access to opportunities for quality education present significant barriers to treatment and abstinence. Patriarchy with its sexist view that it is more shameful for females to abuse

drugs or alcohol presents another barrier for females wanting to access outpatient treatment in their communities.

Literature on outpatient treatment states that the number of males versus females in treatment is strongly disproportionate (Ramaglan *et al*., 2010: 43; Dada *et al*., 2015). Statistics in the Western Cape support the statistic that women are under-represented in treatment. Authors have found that women, referred to as hidden users, do not access outpatient treatment due to having to fulfil traditional gender roles and due to stigma associated with women who use drugs (Elbreder *et al*., 2009: 353; Ramaglan, Peltzer & Matseke, 2010: 43; Sorsdahl, Stein & Myers, 2012: 7; Guerrero *et al*., 2014: 2). Literature strongly suggests that the economic consequences of accessing treatment have a significantly more adverse impact on female users accessing treatment as opposed to males.

The City's outpatient substance-abuse treatment sites are situated in the communities of Parkwood, Delft, Mitchell's Plain, Khayelitsha, Manenberg and Milnerton. The rationale for having the sites in these areas was to increase accessibility and to make it more affordable for prospective service users (DSD, 2013). The majority of these areas are notorious for gang violence, robberies, violent crimes, murders and assault. The latest crime statistics released by the office of the MEC for Community Safety revealed that several of the aforementioned communities were hotspots for the above-mentioned crimes, as well as drug-related crimes (WCG, 2015). Safe passage to access treatment in these communities presents a significant threat to accessing treatment and also to

completing the 16-week treatment programme, which compels one to ask whether the service is truly accessible.

A further challenge to the feasibility of the outpatient treatment programme being a viable treatment option as opposed to inpatient treatment, is the stigma associated with drug use and having to disclose that one has a drug problem in the community. Substance abuse has a negative connotation and is perceived as damaging to one's social standing in the community (Myers, Fakier & Louw, 2009: 219). Being labelled and judged as a drug user could then create a major barrier or deterrent to accessing treatment within the community.

3.4. Conclusion

This chapter included the background information regarding the City's programme, and the programme's relevance in the South African context. The City adopted a substance abuse outpatient programme from the USA where the programme was found to be effective for the abuse of multiple substances. The feasibility of the City transplanting (and duplicating its success) this outpatient programme from the US context to the South African context was considered. The unique structural challenges endemic in the historically disadvantaged communities in the Western Cape were highlighted. The rationale behind the City's outpatient programmes being presented at specific sites in disadvantaged communities was to increase accessibility for service users that could not afford inpatient treatment.

By looking at accessibility, the potential barriers service users may encounter in considering this substance treatment option were explored. The most prominent barriers were the economic implications for both employed and unemployed service users, the structural challenges female service users might encounter should they consider this treatment option, and the safety of accessing treatment in communities identified as hotspots for violent crime. By exploring these factors, the implications these challenges would have on the accessibility and affordability of service users to this service and in turn the services' success were critically appraised.

CHAPTER FOUR: OUTPATIENT SUBSTANCE-ABUSE TREATMENT: CITY OF CAPE TOWN
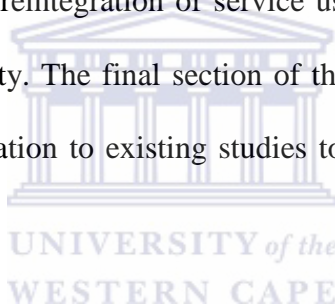
4.1. Introduction

This chapter presents the research findings and will be structured around themes that emerged from the semi-structured interviews. Nine semi-structured interviews were conducted with service users who had completed an outpatient substance abuse treatment programme in two of the City of Cape Town's primary health clinics, namely Parkwood and Delft.

The chapter comprises three sections. Firstly, the participant profiles will be summarised to reflect the age, gender, employment status and the number of drug-free months of research participants at the time of interviews. The second section of this chapter will outlines themes and sub-themes derived from the raw data. Themes will be grouped chronologically, that is, pre-treatment, during treatment and post-treatment to emphasise the process of substance abuse and recovery.

Understanding participants' reasons for entering treatment allows for an exploration into a number of variables that increases the likelihood of treatment compliance and completion; tersely put, these are the City's indicators for successful treatment. Due to the City's outpatient programme being a nascent service, this research seeks to provide foundational qualitative data expressing the experiences of service users and to identify the protective factors contributing to compliance.

Post-treatment experiences and treatment outcomes, which may be compared to QOL indicators prior to entering treatment will be analysed. Substance abuse has had a profound impact on individuals, families and society. Erstwhile substance-abuse policy and strategies focused on demand and supply reduction and failed to address the plethora of social-specific challenges associated with substance abuse.

The Prevention of and Treatment for Substance Abuse Act recognised the harm associated with substance abuse and interventions aimed at combating substance abuse extending to harm reduction activities, as articulated in the NDMP (DSD, 2013). The treatment, rehabilitation and reintegration of service users promote the harm reduction concept at all levels of society. The final section of this chapter will draw conclusions from the data analysis in relation to existing studies to draw comparisons and identify gaps in the literature.

4.2. Participant profile

The following section will summarise the profile of the research participants in relation to age, gender, employment status, dependents and number of months drug-free. The quality of life domains for persons who engage in substance use generally deteriorate during active use and the process of recovery encompasses improvements in the socio-economic conditions of service users. These improvements are useful in measuring the outcomes for service users and provide insight into the level of harm reduction for those affected.

The age of onset of substance use amongst the research participants ranged between 11-17 years, which is consistent with local literature suggesting that the age of initiation of

58

substance experimentation starts in early adolescence (Flisher *et al*., 2003: 61-62; Van Heerden *et al.*, 2009: 365; Ramaglan, Peltzer & Matseke, 2010: 44; Carstens & Eigelaar-Meets, 2014). The participants' ages at interview ranged between 22-43 years with a lifetime substance-abuse history of more than five years and number of months drug-free ranging between 5-42 months, as illustrated in Table 4.1.

Table 4.1. Demographic profile of participants

Participant	Gender	Age	Age of onset	Dependents	Employment status	Number of months drug-free
1.	Female	25	15	2	Contract EPWP	20
2.	Male	31	11	1	Contract Driver	10
3.	Male	24	14	0	UE	10
4.	Female	31	16	0	Employed Child Care	5
5.	Female	38	16	1	Contract EPWP	15
6.	Male	22	16	0	Employed Chain Supermarket	12
7.	Female	31		4	UE	15
8.	Male	43	12	0	Self-employed electrician	33
9.	Female	26	16	1	Contract Guesthouse Cleaner	42

Note. **From authors fieldwork, November 2015.**

Five females and four males participated in this study. The national and provincial statistics of service users reveal that males are more likely to access substance abuse

treatment than their female counterparts (Dada *et al*., 2015: 5). The literature suggests that the under-representation of women in treatment facilities is compounded by issues, such as gender roles and socialisation (Elbreder *et al*., 2009: 353; Guerrero *et al*., 2014: 2). Female service users were particularly recruited to participate in this study in order to explore the experiences of women and to identify gender-specific factors to address the gap identified in the literature. The exploration into gender-specific issues in outpatient treatment provided insightful information in understanding treatment experiences based on gender.

Seven out nine participants were employed at the time of the interviews, either on contract or informally and one was self-employed. Employment status is an important QOL indicator in recovery. Of those who were employed during active use, all participants reported having lost employment and/or having struggled to maintain jobs. Merrick *et al*. (2012) found a reduction in productivity amongst an employed sample of persons who engaged in substance abuse. The unemployment rate for persons in treatment during the period July to December 2014 was 51% (Dada *et al*., 2015: 5). The early school drop-out rate coupled with long periods of unemployment during active addiction further compounds the employability of service users following formal treatment.

Three participants were employed under the Expanded Public Works Programme (EPWP) post-treatment. The EPWP is a government-wide employment programme, which aims to create job opportunities and promote skills development and work experience (COCT, 2013). Research participants employed under this programme

conducted outreach activities to raise awareness about substance abuse and the City's outpatient treatment programme. These research participants were able to work and secure an income in a sheltered environment where their principals had a good understanding of the challenges experienced in recovery. Furthermore, participants placed immense value on their role as EPWP workers and being able to reach out to others who suffer the same fate and reported feelings of purpose and being of service to others.

Two employed participants reported not having disclosed their substance use history and recovery to their employers. Participants feared being victimised and worried that employers may treat them differently. One employed participant disclosed this information to his manager but experienced difficulty in explaining recovery to his colleagues. It is evident that employment for persons in recovery presents unique challenges, such as fear of being discriminated against and at an individual level re-socialising in the workplace. Sheltered employment, albeit the City's EPWP programme, eased the transition from treatment into adjusting to the workplace.

4.3. Themes

The following section will provides an analysis of the themes that emerged from the qualitative data. Themes and sub-themes have been grouped and follow a chronological order to illustrate the process of substance abuse in the initial stages of experimentation, harmful use, dependence, treatment and recovery. This is summarised in Table 4.2.

Table 4.2. Treatment phases

Chronological category	Themes
Pre-treatment	Early onset
	Treatment entry
In-treatment	Psycho-education and social support
	Compliance and abstinence
Post-treatment	Aftercare
	Recovery

Note. **From authors fieldwork, November 2015.**

4.3.1. Pre-treatment

Substance use is rarely intended to cause harm to individuals, families and communities. The use of substances may initially be ascribed to a number of factors that require some consideration. Ramaglan (*et al.*, 2010: 44) posit that socio-economic factors, such as unemployment, poverty, a lack of recreational facilities and the active substance use in communities contribute to the substance abuse problem. The research participants in this study come from predominantly disadvantaged communities, where these socio-economic conditions are prevalent. The following section will explore and highlight the experiences of participants before entering treatment.

4.3.1.1. Early onset

The research participants in this study experimented with substances for the first time during adolescence between the ages of 11-17 years. Research participants identified peer pressure and curiosity as core factors contributing to the use of illicit substances, as articulated in the following statements:

P1: I was about 15 turning 16 there around… it was festive time and stuff and she's [friend] like 'come we go see why they find it so interesting and just to experience' [using substances].

P2: It actually started with like…uhm like everybody's gateway drug, which was alcohol. Alcohol, I started drinking at the age of 11, 12. And I actually started picking up drugs at the age of 15, that's when I started with weed. Ja [yes], like you know it felt like…like a sense of belonging with friends. What's that word now? Peer pressure.

P3: I first picked up marijuana, dagga…I first picked that up. I was about 14, yes. It was with friends obviously, they were trying it out…or not trying it out, they were using. I had been in the company of people using before and I got curious and I wanted to try it out.

P8: I also need to, to drink to be sociable, drink to have confidence, drink to…to do certain stuff otherwise I won't fit in with the crowd. So peer pressure is also involved there.

P9: And ag, you know how curious kids are…wanting to fit in, wanting you know to be popular in a crowd and everybody was using it and everybody was so secretive about this drug.

While curiosity and peer pressure were identified as catalysts to experimenting with substances, participants alluded to the high prevalence and accessibility of substances in their communities. Research participants reported having initially experimented with socially acceptable substances, such as alcohol and dagga, which escalated to harder

drugs, i.e. tik and mandrax. The notion that *softer* drugs are socially acceptable is problematic and poses a challenge in eradicating the belief that licit substances are less harmful. In fact, the belief that alcohol is less harmful than illicit substances has been disproved and challenged, considering the alcohol-related injuries and deaths recorded in South Africa annually (DSD, 2013). For participants in this study, experimentation with *softer* drugs escalated to *harder* drugs and ultimately severe SUD, requiring specialist treatment.

The nature of substance use and behaviours associated with the use thereof is often overlooked in the early stages, particularly with the use of socially acceptable substances. All the research participants in this study noted that family members only became aware of their drug use when they displayed physical and behavioural changes, at which point participants were already experiencing symptoms of dependence. Even though family members and affected others accepted that their loved ones had had a substance abuse problem, research participants expressed that family members were initially in denial of their substance use until their behaviour became problematic and undesirable.
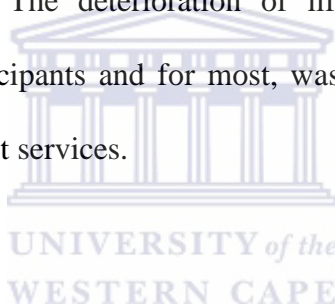
Myers, Fakier and Louw (2009: 219) offer insight into the delayed response of family members and posit that stigma towards a person using drugs and the need to maintain a positive social image, are some of the factors contributing to denial. Furthermore, treatment for substance abuse is perceived as being ineffective, a notion commonly held in historically disadvantaged communities. The negative treatment beliefs coupled with the stigma associated with substance abuse acts as a barrier for early symptom

recognition and intervention, which ultimately impacts on the escalation of substance abuse.

All research participants alluded to isolating themselves from social and family interactions to hide their substance-using patterns, but most notably because substance use became an integral part of their daily lives. Social isolation extended to all non-using activities, which participants engaged in prior to the onset of substance use. In this participant group, the use of substances contributed to seven out of nine research participants dropping out of school, which limited access to skills and career opportunities in adulthood. The deterioration of life domains at all levels posed challenges for research participants and for most, was the catalyst in considering and ultimately accessing treatment services.

4.3.1.2. Treatment entry

Treatment entry is often a means to an end, where service users decide to access treatment to escape the negative consequences of substance use (Laudet, 2011). It is important to note that the damaged caused in all life domains may impact on the experiences of service users during treatment. For example, it is common for social relationships to deteriorate as a result of substance abuse, particularly in the family system. In this instance, it becomes difficult to garner support during treatment and recovery, where social-specific support improves the outcomes for service users (Myers, Pasche & Adam, 2010).

All participants described conflictual relationships with family and affected others and in some instances participants experienced pressure from family to enter treatment. Participants expressed varying reasons for choosing to enter treatment with the most common being the notion of hitting rock bottom, the realisation that they have limited to no support, no income due to unemployment and their career opportunities were limited due to early school drop-out or a lack of skills and training. Two out of nine participants admittedly entered treatment as a means of appeasing the family, and not necessarily as an inherent motivation to access treatment.

Even though treatment entry may involve external pressures from affected others, the majority of participants acknowledged that their substance use contributed to the deterioration of their quality of life domains and social interactions and offered the following explanations to the question "What made you decide to enter treatment?":
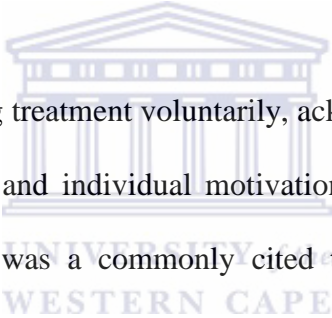
P4: I was afraid cause I was gonna lose everything again. I was working myself up nicely. And I was afraid I'm gonna lose it all again because of where I was, I was a manager and I had like a good job, stable job and I just messed it up. And I knew from my past experience, the drugs is gonna fuck up, make me fuck up.

P5: I don't know what came over me but I fell to my knees crying, snot en trane, and I said 'God, please I can't anymore, I need to make my life right, I need…I need your help desperately'.

P7: I think I reached my rock bottom, emotional rock bottom. I was tired of this life. I was, I was miserable. I didn't wanna use anymore but I didn't know how to stop on my

own. No, I was tired of always having to think of how am I gonna get my next fix and having to lie and destroying relationships and I was just tired of that kind of life. Having to steal and I just looked at myself one day in the mirror and I didn't like what I saw.
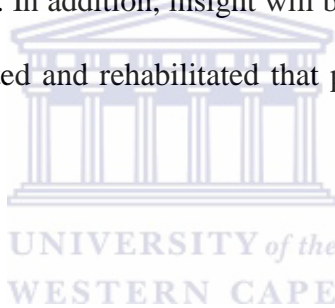
P8: Well I was just very tired of using, you know? And I realized I really need to stop using drugs because by that time I pushed away my mother, I pushed away my sister. I like stripped the house wire out of the house. I like vandalized the house man. I stole everything that was to be stole, I stole it. I did a lot of damage and shoo, I was scary. I was getting scary of myself. It's when I realized that I'm either gonna die or I'm gonna get help.

Research participants entering treatment voluntarily, acknowledged that the harm caused as a result of substance use and individual motivation contributed to them accessing help. Motivation to change was a commonly cited theme amongst this sample for entering and completing treatment, and maintaining sobriety post-treatment. Individual motivation to change has been cited as a key concept in treatment, and produces positive results (DiClemente *et al*., 1991; Carbonari & DiClemente, 2000; CSAT, 1999; Projects MATCH Research Group, 1997; Joe Simpson, & Broome, 1998 in DiClemente *et al*., 2008; Laudet, Stanick & Sands, 2009). However, motivation in itself may not be sufficient in maintaining sobriety and recovery encompasses a range of complex factors during and post-treatment.

4.3.2. In-treatment

The research participants in this study completed the outpatient substance-abuse treatment programme in the City of Cape Town and have been drug free for a number a months. In the light of the high drop-out rates in outpatient treatment centres, as well as the relapsing nature of substance abuse and SUD, participants managed to maintain abstinence indicating positive outcomes in relation to the programme. In this section of the report, an overview of the in-treatment experiences of service users will be provided and protective factors that aided compliance and ultimately completion of the programme will be identified. In addition, insight will be given into the conditions under which participants were treated and rehabilitated that posed challenges in the recovery process.

4.3.2.1. Psycho-education and social support

The City of Cape Town's outpatient substance abuse programme is characterised by an educational component, including topics, such as the biology of addiction and conditioning of the brain. Research participants expressed a new-found understanding of addiction and how the brain responds to internal and external triggers. All participants reported having no knowledge or understanding of these concepts prior to entering treatment and found this to be most useful in the initial stages of treatment.

The identification of external triggers during *Early Recovery Groups* was commonly referred to during interviews as the *three P's,* that is, people, places and things

associated with participants' history of substance use. Both treatment sites where the research study was conducted are situated in what was referred to as disadvantaged communities of Parkwood and Delft South in the Cape Flats where poverty, engendered gangsterism and a rapidly growing drug trade are structural challenges plaguing these areas. Areas marred by gang violence, drug trade and poverty contributed significantly to relapse and are considered factors that are conducive to substance abuse (Laudet, Stanick & Sands, 2009; Watt *et al.*, 2014: 220). Research participants identified the presence of drug dealers or easy access to substances in their communities as a significant external trigger.

Two out of nine participants moved out of their communities to live with extended family members during treatment in order to escape these external triggers. Even though community conditions proved challenging, participants felt that the identification of triggers and awareness of how they affected the substance-dependent brain were useful. The *Early Recovery* topics also taught participants useful cognitive behavioural techniques to deal with triggers and cravings.

The *Family Education Group* had similar benefits for family members and affected others who participated in the programme. Research participants noticed changes in the way family members responded to their recovery process. With the aid of educating families, participants reported improvement in relationships with loved ones that were frustrated during active use. This is consistent with international literature, where family participation contributed to compliance and treatment completion (Rawson & McCann, 2005). For many service users, family involvement remains a challenge. Two out of nine

research participants experienced resistance from family members to become involved in treatment, where parents felt that they do not use illicit substances and therefore should not be expected to attend treatment sessions.

The sentiment that family members should not be expected to undergo treatment is not uncommon. The perception that initiation and management of substance abuse treatment is the sole responsibility of the person using is problematic, which fails to acknowledge the adverse systemic impact on families and affected others. The damage caused in personal and social relationships cannot be overlooked and it would be unrealistic to place the responsibility of treatment on the family system. However, family education provides a space for families to understand the actions and behaviour of the service user during active substance use, and equally important, acknowledges the suffering experienced by those affected by substance abuse, as reflected in the following excerpts:

P1: And with coming to family education they could understand there's different stages. And when I was on a high like happy, they would know…no she didn't use today she's just full of endorphins.

P3: They can know what's the characteristics of addiction and they can understand when I have that bad day, you know, when I just don't feel like getting out of bed or I just don't want to speak to anybody.

P6: [A]nd it's good also my mother also knows there's something called triggers man, you see? So the more knowledge she have of my life as a recovering addict the better, better chance for me also man.

P7: Because then she realized that…uhm the way I used to act with her sometimes, why I was like that because they would explain that there. You know, being triggered and my aggression and what used to go through my mind.

The *Family Education Group* has had a profound impact on the way in which family members understood and responded to the research participants during and post-treatment. The onus is on service users to extend an invitation to family education sessions, but it should be noted that it remains the family or affected others' decision to participate in treatment. Furthermore, the target audience for family education groups consists mainly of adult members and does not include support services for minors or children of service users. Children affected by substance abuse often experience abandonment and neglect (Watt *et al*., 2014: 222) and may also need support and education to adjust to the recovered parent. This will be explored later in this chapter.

It was evident during interviews that both research participants and families who participated in the programme benefitted from psycho-education. Understanding substance abuse and SUD from a biological stance, provided new-found insight into how the addicted brain responds to triggers and cravings and families could identify and understand their role in recovery. Participation in the programme also assisted participants in gaining the support from their families and starting to rebuild relationships that deteriorated during active substance abuse. Research participants who felt that they had the support of family, noted that their treatment and recovery process may have suffered in the absence of such support, as described in the following statements:

P1: I don't think I would've been so successful in my recovery… in recovery you need a support structure, you know people that's around you that support what you're doing and that can be there to lift you up when you're feeling down.

P5: I believe you have to have a family. You have to have somebody that supports you who is important in your life because you cannot do it alone.

P7: I think the support, the support plays a major factor. Having loved ones around you having people that believe in you, you know? And wants to help you stay clean.

Participants expressed the importance of family support as a vital component in the treatment and recovery process, without which the treatment outcomes may have been different. This finding is consistent with local and international literature, where social-specific support was found to contribute to treatment retention and positive outcomes for service users (Laudet & White, 2010; Myers, Pasche & Adam, 2010). The concept of support may be subjective and differ amongst population groups. For this participant group, family participation and engagement in treatment, assistance with childcare, transportation to attend sessions and open communication in the household indicated a supportive family for research participants. Furthermore, family education sessions appeared to have contributed to family becoming more supportive during treatment.
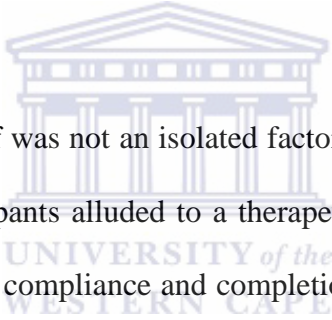
4.3.2.2. Compliance and abstinence

High drop-out rates are not a challenge unique to the City of Cape Town, but an ubiquitous theme in substance addiction both locally and internationally. A fundamental factor in recovery is that the substance user voluntarily submits himself/herself to treatment. Scholars are in consensus on the relapsing nature of substance abuse, characterised by the revolving-door concept (Laudet, Stanick & Sands, 2009; Strebel *et al*., 2013: 49). The retention of service users remains a core challenge for service providers, affected others and stakeholders in the substance abuse and treatment cycle. In view of the relapsing nature of substance abuse, it is of interest to explore those factors that pose challenges to treatment compliance, as well as the protective factors for those who comply with and complete treatment.

Research participants identified a number of protective factors that contributed to treatment compliance and completion, the most notable being an innate desire and motivation to become drug-free. Laudet (et al., 2009) found that motivation levels of service users influence compliance and overall outcomes of treatment. Five out of nine research participants had previously accessed treatment in inpatient, outpatient or both treatment modalities. Research participants noted that previous treatment episodes were not effective, as they felt pressured by loved ones to enter treatment and not necessarily because they had perceived a need for treatment. Three participants responded to the question *"What was different for you with this treatment episode?"* as follows:

P3: I think I made a decision man. I actually made a decision to want help. Ja, it's a very personal thing for me and I think with any…with most programmes man, there must be some form of willingness cause otherwise then for me it's not gonna work. If you try anything, if you don't want it, it's not gonna work.

P5: Me, my choices, my vision, my uhm…surrender. I finally surrendered this time. I didn't keep back.

P8: So I need to go, I need to be willing to do whatever is possible for my recovery. And I need to start to be honest with myself first, you know, and be honest with my higher power.

Individual motivation in itself was not an isolated factor, which contributed to treatment compliance. Research participants alluded to a therapeutic alliance with therapists as a positive variable in treatment compliance and completion. The application of the values and principles of the City's outpatient programme strengthened the therapeutic alliance between therapist and service user. The treatment programme is grounded in principles of non-judgment, professional expertise and motivational concepts as espoused in the treatment approach. Meier *et al*. (2006) found a positive link between therapeutic alliance and length of retention of service users in treatment. The positive therapeutic alliance contributed positively to the treatment experiences.

Random drug testing is a core component of the programme. Drug testing is not intended to antagonise service users but rather serves as a progress report or a point of departure for therapists in instances where service users relapse (Rawson & McCann,

2005). Participants responded positively to random drug testing and found it to have benefits for recovery. Firstly, the sense of achievement and pride were expressed with negative results and encouraged participants to maintain abstinence. Secondly, the negative test results provided the family with evidence of abstinence and re-established trust in personal relationships. Furthermore, participants who relapsed in the early stages of recovery found the motivation and non-judgmental approach of therapists as being helpful and encouraging.

The relapsing nature of substance abuse has posed challenges for service providers, service users and affected others in maintaining abstinence during and post-treatment. Laudet (et al., 2009) found that substance use during treatment and returning to communities that are conducive to substance abuse to be key factors in early drop-out in outpatient substance abuse treatment. The treatment sites identified for this study are situated in the predominantly Coloured areas of Delft and Parkwood as demarcated by erstwhile apartheid legislation. Statistically, the racial demographic of persons accessing substance abuse treatment in Cape Town, has consistently reflected Coloured males as the main beneficiaries of this service, which may be indicative of the extent of the substance abuse problem in communities in the Cape Flats (Dada *et al*., 2015: 5). These communities are plagued by crime and high rates of unemployment, poverty and limited and below par infrastructure and meaningful development opportunities (Watt *et al*., 2014: 220). Furthermore, the identified communities are affected by gang violence and a high incidence of drug-related crimes (WCG, 2015).

The structural conditions created by separate development continue to impact disadvantaged communities. Research participants found the treatment process particularly challenging as the presence of drug-related triggers in communities had clinical implications for persons in recovery. The community conditions were cited as a key challenge as described by participants:

P1: But being back in the same area, without knowing how to deal with people that I used with and emotions and stuff I ended up using again. So moving out, taking me out of that situation I could stay without the drug.

P7: The merchant is still there where he was, your using friends are still using, everything is still the same its only you that's trying to change. So it is, it's actually tough…to come here, you feel safe here, you're okay but then you go back home to that surroundings and it, sometimes it was triggering.

P8: The most difficult part for me would be going home. Because if I'm here for three hours, four hours and I had to go home that's when everything is back to normal. The drug dealer's house is still there, my drug dealing….my drug friends is still around, people are still using you know, wherever I'm…maybe I have to go somewhere, people are busy using you know?

Research participants pointed out that drug use is common and the drug trade is flourishing in their communities, as evidenced by the most recent drug-related crime statistics released by the Minister of Safety, Dan Plato (WCG, 2015). The historical context of substance abuse in South Africa continues to affect disadvantaged

communities and has far-reaching consequences for those affected. These structural and invariable causal factors of substance abuse cannot be addressed in treatment and require a macro approach aimed at combating supply and demand. The resilience and motivation of the research participants is commendable in the light of the structural and spatial inequalities created by an oppressive political regime; however, these innate characteristics are not innate for the majority of persons affected by substance abuse.

4.3.3. Post-treatment

Treatment for substance abuse occurs over a specified period, generally over a number of weeks. The City of Cape Town's outpatient program runs over a 16-week period after which service users formally graduate from the programme. The process is not linear and service users who relapse during treatment are required to re-start. Furthermore, social support groups are open to members who have graduated and may schedule sessions with the therapist, as needed. The notion of treatment being a cure-all is common amongst service users, families and the general public, including the research participants in this study. However, once formal treatment concludes, a lifelong process of recovery commences. The following section will present the finding in relation to post-treatment experiences.

4.3.3.1. Aftercare

Aftercare, by definition, involves the re-integration of the service user back into the family, community and workplace following formal treatment (The Prevention of and Treatment for Substance Abuse Act, Act No 70 of 2008). The City of Cape Town's

substance abuse programme does not offer a formal aftercare service, but introduces social support during the programme and encourages attendance in the early stages of treatment. All participants were members of a spiritual self-help support group at the time of the interviews where eight out of nine participants had a sponsor who provided individual support, guidance and assistance with completing the 12-steps that forms part of the aftercare/social-support programme. The self-help group is founded on a 12-step programme of discovery, retribution, forgiveness and acceptance (Narcotics Anonymous, 1998).

Participants who had previous experience with self-help groups reported that the transition from the City's programme into post-treatment support services gave them a better understanding of the self-help concept. This improved participation in aftercare/social-support groups. The value of aftercare or self-help support groups was emphasised in all interviews as expressed by one participant:

P9: I always say treatment got me clean but the rooms of Narcotics Anonymous keeps me clean. And the reason why I say that is when we come together, there's only addicts that experience the exact same thing.

The support-group experience encompassed the sense of collective consciousness and normalisation, where members shared experiences of substance abuse, treatment and recovery. Social support groups provided a platform for participants to re-establish their lives and social connections in the absence of drug-related activities. It should be noted that aftercare and/or accessing post-treatment social support is a voluntary process,

which again requires some level of motivation on the part of the individual. Furthermore, the support group does not include therapeutic services and professional expertise, in which case participants scheduled sessions with the therapist.

4.3.3.2. Recovery

Recovery from substance abuse and SUD's is often understood as a time-bound process after which substance users are *cured* from the disease. This perception of recovery is common amongst individuals and families affected by substance abuse, as well as the general public. This belief that treatment is a cure-all contributes to the perception that treatment is ineffective, particularly in historically disadvantaged communities (Myers, Fakier & Louw, 2009: 220). Similarly, the research participants in this study initially perceived substance abuse treatment as the miracle cure to what they experienced to be a difficult period in their lives. The relapsing nature of substance abuse creates frustration with the service user, particularly for the family and affected others. Treatment for substance abuse is therefore viewed as being ineffective and those affected feel hopeless and helpless against substance abuse.

The clinical approach to substance abuse treatment and recovery in the City's outpatient programme has adopted a paradigm shift, where substance abuse or SUD is considered a lifelong disease that requires maintenance treatment to remain healthy. This realisation and understanding initially created anxiety and fear for research participants and challenged the pre-conceived ideas about substance abuse treatment and recovery, which through the process of re-education and support resulted in acceptance and

understanding. It re-enforced the concept that treatment is not a cure and the importance of taking care of one's recovery to prevent relapse.

Addiction scholars have adopted the recovery approach, with a shift from pathology-focused care to optimal well-being (McLellan *et al*., 2005; Laudet, 2011). Optimal wellbeing includes abstinence and improvements in health, social functioning and the socio-economic status in recovery. The research participants in this study placed greater emphasis on abstinence and their primary goal in treatment was to become and remain drug-free. A secondary objective for accessing treatment was to restore and rebuild family relationships that suffered during active use, which challenges Laudet and White's (2010) findings where employment and education were listed as key secondary priorities for service users accessing outpatient treatment. The unmet social service needs were also cited as key individual-level factors for early drop-out. It can be argued that while both groups prioritised abstinence as the primary goal of treatment, the level of motivation and the value placed on social relationships resulted in better outcomes for the research participants in this study.

The quality of life indicators, i.e. social relationships, employment status, health status have improved for participants. However, these indicators improved gradually during the course of treatment, aftercare and overall recovery and with the number of drug-free months also increasing. In essence, treatment in combination with social support and abstinence produced positive outcomes for the participant group under investigation, but did present challenges for research participants particularly in terms of gender and parenting.

The City of Cape Town's outpatient substance abuse programme's admission profile in terms of gender is consistent with national statistics, where males are more likely to access treatment (Dada *et al*., 2015: 5). Five women participated in this study and described the challenges experienced by women in accessing treatment. The female participants alluded to the gender roles ascribed to women and the stigma associated with substance abuse amongst women, specifically those who have children, which is consistent with international literature in developing countries (Elbreder *et al*., 2009: 353; Guerrero *et al*., 2014: 2).

All mothers amongst the research participants had assistance from family members in childcare during treatment, which had an immense impact on the treatment process. In the initial stages of treatment, participants experienced withdrawal, which involves unbearable physical and emotional symptoms, which limits the parent to perform childcare and parental duties. Furthermore, the transition from a mother who uses drugs to a mother who is drug-free presented parenting challenges in addition to the guilt and shame of having neglected their children during active use. Children of persons who use drugs often experience neglect and abandonment while parents abuse substances (Watt *et al*., 2014: 222); an aspect of recovery that exacerbates feelings of guilt and shame. Research participants described parenting post-treatment as follow:

P5: In your active addiction you're not that mother you're supposed to be and you don't learn the tools that you're supposed to. So now you come out of active addiction and you still got that mentality.

But I still got problems with her [daughter]. She doesn't listen to me because she knew I was an addict. She knew I was never…you know I always say I was physically there but mentally and emotionally I wasn't there.

I never hit her, but I would shout and swear and things like that. Today she doesn't listen to me. It's hard, it's hard. I've tried everything. My sponsor got so agitated with me already because she manipulates. Like I feel I have to give her because I wasn't there before.

P9: And having to go back it was a big, big transition for me and for him, having to have his mother now back again. So it was a huge, huge step for me you know, having to step in again and taking control…as being a mother, being responsible for him and sometimes I get frustrated. And now being clean and sober, having to tap in that motherhood again, it was a bit difficult for me, you know, but I'm getting there and I also learn a lot in terms of what I can do better now and what my mistakes was then.

The female parents particularly reported challenges in adjusting back into their maternal role of mothers for children of all ages. One male participant in the participants group is a father to a seven-year-old and acknowledged that he did not prioritise spending time with his son. However, the socialisation of women as mothers and gender roles ascribed to women in society continues to affect women in treatment (Ramaglan, Peltzer & Matseke, 2010: 43; Elbreder *et al*., 2009: 353; Guerrero *et al*., 2014: 2) and provides insight into the discrepancy in treatment-seeking behaviour in respect of gender. Furthermore, childcare issues may contribute to early drop-out for women in treatment.
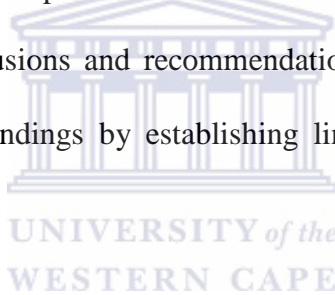
Two research participants' children are teenagers and were aware of their substance abuse history. Furthermore, they had been exposed to behaviours associated with substance abuse and had to adjust to the drug-free parent as well. Children of the research participants did not participate in the programme, as these sessions were developed and tailored to suit an adult audience. One participant's child had experimented with cannabis and participants who had children experienced anxiety and fear that their children would develop substance- abuse problems, a fear that is justified.

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CHAPTER FIVE: CONCLUDING PERSPECTIVES: OUTPATIENT SUBSTANCE-ABUSE TREATMENT IN THE CITY OF CAPE TOWN

5.1. Introduction

This study aimed to explore the experiences of service users who had completed an outpatient substance abuse treatment programme offered by the City of Cape Town's Health Directorate. Nine semi-structured, in-depth interviews with five female and four male research participants were conducted. In Chapter 4, the research findings were thematically presented. This chapter concludes the research report with a discussion of the research findings, conclusions and recommendations. The discussion aims to add coherence to the research findings by establishing links between the main and sub-themes.

5.2. Discussion

Chapter four presented the research findings in three chronological categories, that is, pre-, during, and post-treatment. The following discussion section will be organised in accordance with these categories. Furthermore, it will present a discussion of the sub-themes, which emerged during the semi-structured interviews.

5.2.1. Pre-treatment

In this study, the age of onset of substance experimentation was predominantly during adolescence, which is consistent with local literature (Flisher *et al*., 2003; Ramaglan, Peltzer & Matseke, 2010; Carstens & Eigelaar-Meets, 2014). Even though participants

experimented with substances in early adolescence, participant's accessed treatment in adulthood, at which point symptoms of dependence were present and observed by affected others. Participants reported having used substances for an extended period of time before entering treatment.

In this study it is very noteworthy that family members did not recognise substance use until participants displayed behavioural or physical changes as a result of substance use. Research participants alluded to parents having suspected their substance use and being in denial. However, this does not explain the way parents responded initially. Firstly, the lack of early intervention could be ascribed to poor substance education and symptom identification on the part of parents and significant others. Secondly, the stigma associated with substance abuse cannot be overstated; where families recognised the signs of use with the hope that it would "go away" if left unattended. The stigma associated with substance abuse, coupled with the negative beliefs of treatment, create barriers to service access and utilisation and nullifies the positive impact of early intervention (Myers, Fakier & Louw, 2009: 221).

The perception that public services are inefficient is common and fuelled the anxiety of accessing treatment services. Furthermore, the family may want to preserve their standing in the community and not be associated with the problem of substance abuse. The reluctance to admit and accept the problem may be fuelled by the widely accepted notion that treatment should cure SUD, lacking a comprehensive understanding of recovery as an on-going lifelong process.

A critical gap in the substance abuse field is the lack of interventions aimed at persons with an existing substance abuse problem who had not accessed treatment or wish to enter treatment. The amount of time that lapses between the onset of substance use and entering treatment poses significant challenges to persons who use substances, affected others and society at large. Research participants noted that this was also a period where life domains deteriorated, particularly social relationships and connections. It can be argued that a delay in treatment exacerbated the damage inflicted on different life domains. Social support remains critical during treatment and recovery, but it appears to be the life domain that is mostly affected during active use.

Prevention, awareness and early intervention strategies have been widely implemented across the City and the need thereof has been clearly articulated in key substance abuse policies and legislation; however, the stigma associated with substance abuse remains a challenge for those affected and continues to create barriers to treatment utilisation in the early stages of substance abuse and SUD. The City of Cape Town's Alcohol and other Drugs Strategy (COCT, 2014a) highlights the importance of a holistic approach to addressing substance abuse. However, the impact and effectiveness of prevention requires further exploration.

The City of Cape Town's programme is tailored to adult service users and participants in this study entered the programme after having used substances for five years or more. In view of the age of admission to treatment facilities for the over-20 years age group in all treatment facilities in the Western Cape in recent years, and the reported incidence of substance abuse amongst adolescents (Flisher *et al*., 2003: 61-62; Van Heerden *et al*.,

2009: 365; Ramaglan, Peltzer & Matseke, 2010: 44; Carstens & Eigelaar-Meets, 2014), it is evident that treatment interventions need to be intensified and tailored for minors requiring specialist treatment.

The majority of participants entered treatment and expressed an innate motivation to become drug-free. However, it should be noted that treatment entry occurred when the life domains of participants had deteriorated, also referred to as hitting rock bottom. This indicates that treatment entry was a means to an end (Laudet, Stanick & Sands, 2009), either to appease the family or because life had become unmanageable. Treatment for substance abuse is a voluntary process, unless court mandated, and therefor the decision to access and complete treatment remains the prerogative of the individual.

This poses challenges to families and communities affected by substance abuse and raises important questions, such as how does one motivate an individual who abuses substances to access treatment? Is the notion of hitting rock bottom the only catalyst for treatment-seeking behaviour? If so, should families and affected others wait for the individual to cause enough damage in order for them to realise that they have a problem? There is no simple answer to the questions raised; however, it is clear that individual motivation and readiness to access treatment services contributed to the positive outcomes amongst the participants in this study.

5.2.2. In-treatment

Psycho-education was consistently referred to in interviews as an integral aspect of treatment. Participants along with their family members who participated in the programme found the sessions on the biology of addiction enlightening and these concepts explained behaviour during active addiction. The family component is strongly recommended by participants; however, families who hold the belief that addiction is an individual responsibility do not necessarily agree that they should be active participants in treatment. Families stand to gain insightful information and support from the education group, which re-enforces social support and ultimately improved outcomes for service users (Myers, Pasche & Adam 2010).

Family involvement in treatment remains a key challenge experienced by service users and service providers (Strebel *et al*., 2013: 45) and attempts to address the issue needs to be intensified to create opportunities for families to actively participate in treatment. The NDMP (DSD, 2013) and the City's Alcohol and other Drug Strategy (2014a) articulate the need for a comprehensive treatment approach, but fail to clearly define the role of and to secure the buy-in of affected others in treatment. Additionally, the family group mainly comprises family members and/or affected others of individuals in treatment, and not necessarily the general public who may similarly benefit from psycho-education.

The level of motivation of research participants and family support was individual-level factors that contributed to the retention and completion of the programme. The service-level factors identified by participants included strong therapeutic alliances with

therapists, the psycho-educational component of the programme, drug testing, and the introduction of social support during the treatment process. The research participants who entered treatment as a result of pressure from the family ascribed their success in complying with the programme to the motivational concepts employed by the clinical staff, that is, while the innate motivation to change was lacking at treatment entry, they became motivated while in the programme. Treatment retention and completion were therefore affected by a combined number of variables such individual motivation, external pressure, therapeutic alliance, programme components and family support. It is unclear which of these variables were more or less effective in retaining participants and it should be noted that these were contributory factors which aided the process.

The experience of women in treatment was a key theme that emerged from the data, particularly female service users who were also parents. These participants alluded to the stigma associated with being female drug users, compared to their male counterparts. Female parents experienced feelings of shame and guilt for neglecting their children during active substance use and experienced difficulty in adjusting to their new role as being drug-free mothers. Women participants contend with external factors, such as stigma, but also internal emotional factors during treatment and post-treatment. Even though families were supportive in their childcare duties while participants attended treatment, being a mother and primary caregiver presented emotional and practical challenges in their new drug-free parenting role.
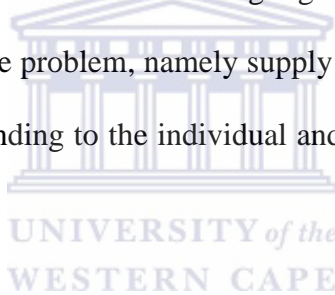
5.2.3. Post-treatment

Aftercare was most commonly cited by research participants as an important factor in maintaining sobriety post-treatment. The City's outpatient programme does not offer an aftercare service as defined by the Act, but introduced social support as an aftercare concept in a 12-step programme. The 12-step programme assisted participants in re-socialisation and integration into their communities and engendered a sense of fellowship amongst service users. The positive outcomes reported indicated that the 12-step programme successfully reintegrated participants and assisted with building new drug-free networks; however, the programme was not equipped to address therapeutic and social-specific needs of service users upon exiting formal treatment.

Seven participants were employed at the time of the interviews, but experienced a number of challenges in the work place. Two participants reported non-disclosure of their recovery to their employers due to the fear of being discriminated against. The one participant who disclosed his drug history to his immediate supervisor had difficulty in engagement with colleagues and stressful situations. Participants employed as EPWP workers in the outpatient programme reported significant improvements in workplace re-socialisation and feelings of purpose and being of service to others in their outreach activities. Sheltered employment for participants exiting the outpatient substance abuse programme within a supportive environment produced positive outcomes.

Even though research participants completed treatment and maintained sobriety, the structural challenges within their communities posed challenges in the process of

recovery. Participants cited the flourishing drug trade and being surrounded by substance abuse in their communities as key factors that impacted on their recovery process. Clinically, the treatment programme equipped the participants with tools and techniques to mitigate the risk of relapse.

The aftercare 12-step programme further assisted with re-integrating back into their communities and building positive relationships and networks. However, treatment in itself cannot change and therefore address the community conditions present in historically disadvantaged communities. In the light of the fact that substance abuse and SUD are relapsing in nature, these conditions highlight the need for coordinated efforts to address the substance abuse problem, namely supply and demand reduction initiatives that are coordinated in responding to the individual and community needs in combating the substance abuse problem.

5.3. Conclusions

This study explored the experiences of service users who had completed an outpatient substance abuse treatment programme in the City of Cape Town's Health Directorate. Substance abuse has created a burden at all levels of society, particularly affecting individuals, families and communities. In addition, substance abuse has posed challenges to public health and safety and is not limited to those directly affected. Interventions aimed at combating substance abuse are organised on three levels as prescribed in the Act; that is, reducing the supply of, demand for and harm caused by substance abuse. This study is underpinned by the harm reduction concept but

highlighted that the phenomenon requires a holistic approach involving coordination in these intervention domains.

Substance-abuse legislation and policy articulate the need for coordinated interventions, but in the City, this has not come to fruition (COCT, 2014a). The eradication of the substance abuse problem cannot be addressed by a single government department. Defining the roles and responsibilities in key legislative and policy directives is required to improve the coordination and holistic response to the substance abuse problem.

The City's outpatient substance abuse treatment programme has effectively reduced harm and improved quality of life for the participants in this study. All participants reported abstinence at the time of interviews and improved social relationships. Even though work re-socialisation presented challenges, seven out of nine participants were employed at the time of interviews. All participants were members of a 12-step programme and benefited from ongoing support upon exiting the programme. The successful treatment of participants was ascribed to individual-level, as well as service-level factors, which aided the treatment and recovery process.

Treatment and recovery from substance abuse remains a complex issue, particularly in view of the relapsing nature of the phenomenon (Laudet, Stanick & Sands, 2009; Strebel *et al.*, 2013: 49). The study highlighted the need for targeted evidence-based awareness initiatives to address the stigmatisation of and discrimination against substance abuse and the negative beliefs about treatment. Drug-related education should remain a priority, particularly in high risk areas to promote early entry into treatment programmes
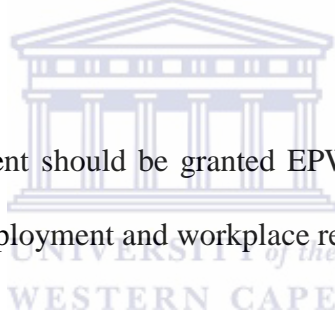
and to encourage re-entry in instances of relapse. The availability and accessibility of substances within communities continues to pose challenges for persons in recovery. These triggers not only pose risks to persons in recovery, but also threaten public safety.

Women who use drugs contend with gender-specific challenges, compared to their male counterparts. The stigma associated with substance abuse towards women highlights the fact that gendered socialisation and stereotypes create barriers to treatment. Furthermore, women with children are required to prioritise the need for treatment against childcare duties and parenting pressures. The women in this study had support and assistance from family members in childcare duties; however, the small sample size in this study precluded the exploration of the experiences of women without such support. The City's Alcohol and Other Drugs Strategy (2014a) proposes that childcare be incorporated in treatment programmes; but the practical implications require some consideration. In addition, children of persons in treatment may benefit from child-friendly interventions aimed at preparing the child for the drug-free parent.

5.4. Recommendations

The findings in this study have highlighted the gap that exists in the field of substance abuse treatment research and in particular, a lack of research into the effectiveness of outpatient treatment in the South African context. In the light of the findings and the scope of the study, the following recommendations for the development of substance-abuse services and future study are submitted.

1. Treatment services must be tailored for adolescents and be responsive to the needs of children whose parents are receiving treatment.

2. Awareness and prevention activities and interventions should address the prejudice and stigma associated with substance addiction and treatment, particularly for female service users.

3. Structured aftercare programmes should be introduced to address therapeutic and social-specific needs of service users.

4. A holistic approach to substance abuse as defined in policy and legislation must be operationalised.

5. Individuals in treatment should be granted EPWP employment opportunities to promote sheltered employment and workplace re-socialization.

The participants in this study started experimenting with substances during adolescence. The need for treatment for minors is evident in the light of the age of onset and the number of youth presenting to (private, state-subsidised) treatment facilities. Participants and their children reported challenges in adjusting to being drug-free parents. Services geared towards children could aid the transition in parenting roles for both service users and their children. Furthermore, these services could mitigate the challenges experienced in relation to childcare issues and provide a comprehensive service to the family system.

The experiences of women are laced with gender stereotypes, particularly women with children. Female parents in this study contended with feelings of guilt and shame for

neglecting their children during active substance use. The City's outpatient programme has initiated services for women in a group format to address gender-specific challenges; however, traditional gender roles and prejudice remain present in communities.

All participants in this study were members of a 12-step programme, which offers social support during and post-treatment. The programme has been effective in reintegration and building drug-free social networks; however, the social-support groups do not offer professional therapeutic services to service users. A structured aftercare programme may benefit service users upon exiting the programme to address these needs and augment the social support groups.

The legislative and policy guidelines make provision for a coordinated and holistic response to the substance abuse problem. One of the core challenges identified in the City's erstwhile alcohol and other drug policy was the lack of coordination. The roles and responsibilities of government departments and other stakeholders need to be clearly defined to enforce the holistic approach to addressing the substance abuse problem at all levels and should be aimed at removing the structural and non-structural conditions, particularly in historically disadvantaged communities.

Seven participants in this study dropped out of school as a result of substance use during adolescence, resulting in limited skills, training and work experience. Those participants who entered employment in the City's outpatient programme under the Expanded Public Works Programme appeared to have re-adjusted to the work environment better than those in the open labour market. One of the challenges experienced was disclosure for

fear of being discriminated against. EPWP opportunities could provide an incentive to treatment completion and generate an income and also contribute to gaining useful work experience and transitioning back into the workplace following formal treatment.

Recommendations for further study

The small sample size presented limitations in this study. Furthermore, the research participants in this study were linked to the programme at the time of interviews as either temporary employees or attending groups in the programme. Recommendations for further study therefore are as follows:

- Large scale longitudinal studies should be conducted with this target group to explore the long-term impact of treatment.

- Comparative qualitative investigations should be completed into service users who had dropped out of treatment and/or terminated relationships with the programme upon treatment completion.

- Further examination into the experiences of family members to inform interventions aimed at improving family involvement in treatment should be explored.

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APPENDICES

Appendix I: The City of Cape Town's outpatient substance abuse treatment programme components.

Appendix II: Participant Consent Form

Appendix III: Interview Schedule

APPENDIX I

Components of the City of Cape Town's outpatient substance abuse treatment programme.

Individual Counselling: Individual counseling sessions occur between therapist and service user, and are an essential aspect of establishing rapport and the therapeutic alliance (Rawson & McCann, 2005). Individual sessions serve as a means of measuring progress and may include conjoint sessions with significant others - essentially this aspect of programme is designed to provide continuity, address individual concerns and aims to retain service users.

Early Recovery Skills Groups: The Early Recovery Skills Groups are implemented in the initial phase of treatment. These groups are designed to teach service users cognitive behavioural techniques and provide tools to assist with reducing cravings, classical conditioned cravings, the need to quit using substances and importance of connecting with support services to aid the recovery process (Rawson & McCann, 2005). Service users who relapse during or post-treatment are encouraged to return to the Early Recovery Skills groups.

Relapse Prevention Groups: Relapse prevention Groups are presented throughout the 16-week programme at the beginning and end of each week and is a central component of the programme. SUD is relapsing in nature, as aptly described by Rawson & McCann (2005) "[m]ost patients who have attempted recovery will agree that stopping using is not that difficult; it is *staying stopped* that makes the difference". The Groups comprise 32 relapse prevention topics and sessions are structured around topics. Service users are

encouraged to relate topics to their own experiences of recovery and the group is centred on a strong educational component.

Family education: Family support and involvement are important programme components and involve a strong educational focus. Family education is presented in a 12-week series with service users and families and would occur in a group setting. The educational topics focus on the biology of addiction, conditioning and addiction, the medical risks associated with substance abuse to the organs, and addiction and how it affects the family and the social support structure. The educational topics are presented with the use of presentations and videos, as well as panels and discussions. Family sessions form an important aspect of the programme and promote treatment adherence and completion (Rawson & McCann, 2005)

12-Step Meetings: The 12-step meetings are held one night per week for current and graduated service users. The goal of these gatherings is to introduce the 12-step concept to service users in a supportive and space to encourage ongoing attendance of social support groups outside of the programme. The services user is prepared and sensitized to the 12-step concept to enable a smooth transition to accessing social support groups in the community (Rawson & McCann, 2005).

Urine/Breath Tests: Urine testing is done randomly on a weekly basis. This aspect of the programme is not intended to be punitive, but is rather encouraged as a departure point for discussion where relapse or substance use had not been disclosed. Furthermore,

urine testing may indicate the progress made by service users and ensuring goals are achieved (Rawson & McCann, 2005).

Relapse Analysis: Unexpected or repeated relapse is analysed with the use an exercise designed to assist the service user in the identification and unpacking of the causes of relapse. Relapse analyses occur during individual sessions and may involve a family member and aims to explore precipitating conditions resulting in relapse. This exercise seeks to mitigate these risks and prevent relapse in future (Rawson & McCann, 2005).

Social Support: Service users enter the Social Support Group in the last month of treatment, following the family education groups. The group is less structured and encourages service users to make new connections with drug free social interactions and activities. The needs of the group members direct the narrative and may include relapse prevention or re-integrating back into society and maintaining a healthy lifestyle (Rawson & McCann, 2005). Social support extends beyond graduating from the programme. Service users are encouraged to access self-help services such as Alcoholics Anonymous or Narcotics Anonymous to aid the recovery process that may long exceed to time limitations of formal treatment.

Guiding principles: The guiding principles of the out-patient substance abuse programme are described by Rawson and McCann (2005):

- The therapist - service-user relationship is based on collaboration and partnership
- Structure and expectations are explicitly emphasized
- Psycho-education

- Cognitive-behavioural techniques introduced and practically applied

- Positive reinforcement

- Family education including the process of recovery

- Exposure to self-help concepts and promoting participation

- Urine testing to monitor drug use

APPENDIX II

Consent Form

RESEARCH TITLE: A qualitative study of the experiences of out-patient substance abuse treatment in the City of Cape Town, between 2010-2015: a service user's perspective

I have read the information presented in the information letter about a study being conducted by **Carla Ederies** towards the Masters Programme at the School of Government (SOG) at the University of the Western Cape. This study has been described to me in a language that I understand and I freely and voluntary agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and was informed that I may withdraw my consent at any time by advising the student researcher. With full knowledge of all foregoing, I agree to participate in this study.

Participant Name : _____

Participant Signature : _____

Date : _____

Place : _____

Student Researcher : Carla Ederies

Student Researcher Signature : _____

Student Number : 2534730

Mobile Number : +2778 5370055

Email : carlaederies@gmail.com

I am accountable to my supervisor : Professor J.J. Williams

School of Government (SOG)

Telephone : +27 21 959 3807

Fax : +27 21 959 3849

Email : jjwiliams@uwc.ac.za

Interview schedule: The experiences of out-patient substance abuse treatment in the City of Cape Town, between 2010-2015: a service user's perspective.

Introduction

Thank you for agreeing to participate in this study. This study seeks to explore the experiences of service users who had been exposed to out-patient substance abuse treatment provided by the City of Cape Town. This study furthermore aims to identify those variables and potential challenges experienced by service users during treatment, which impact on service users' recovery. Exploring the effectiveness of substance abuse treatment is fundamental in light of the significant social and economic consequences thereof. The efforts to address the problem require empirical research activities to explore the effectiveness of the out-patient treatment programmes as a means of intervention from the service users' perspective. Your participation in this study will assist in identifying the strengths and weaknesses of the service to contribute to improving out-patient substance abuse treatment.

I would like to ask you some questions about your experiences in the out-patient substance abuse treatment programme. Firstly, I will ask background questions about your age, employment status, marital status and level of education. The second part of the interview will involve questions regarding your experiences with substance use and how you entered the programme. Lastly, I will ask questions about your experiences in the programme and how it impacted on your life after completing treatment. The interview will take about an hour long.

Background information:

1. How old are you?
2. What is your marital status?
3. What is your employment status? If unemployed, when last were you employed?
4. What is your highest level of education?
5. Who do you live with?
6. Do you have dependents?

History of substance use:

7. When did you first use substances and how did this come about?
8. Which substances did you use at first and have you used any other substances since the onset?
9. How did your loved ones come to learn about your substance use?
10. At which point did you realize that you have limited control over using, if at all?
11. How did substance use impact on your life?

Experience of the out-patient substance abuse programme:

12. How did you become aware of the programme and how did you decide to enter the programme?
13. What did you think about substance abuse treatment before entering the programme?
14. How did you experience the programme compared to what you thought before entering?
15. What was beneficial to you about the programme?
16. As a person in recovery, what was the most difficult part of the out-patient programme?
17. If you could change anything about the programme, what would it be?
18. How has your life changed after receiving treatment, if at all?