


**CHALLENGES EXPERIENCED BY SERVICE USERS
DURING SUBSTANCE DEPENDENCY AFTERCARE
AND REINTEGRATION SERVICES**

by

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in the
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at
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The image shows the crest of Stellenbosch University, which is a shield with a blue and white design, topped with a red and white crest. The shield is surrounded by a red and white border. The crest is positioned behind the text of the thesis title.

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December 2019

DECLARATION

By submitting this thesis electronically, I, Emma Gibbons, declare that the entirety of the work contained within this research study is my own, original work. That I am the sole author thereof (unless to the extent explicitly otherwise stated), that reproduction and publication thereof by University of Stellenbosch will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining a qualification.

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ABSTRACT

Substance dependency has been a growing epidemic for the past century, and difficulties surrounding this disorder are not easily overcome. In this light, the recent relapse statistics being as high as 75% after a 3 to 6 month period of a recovering addict receiving formal treatment are extremely alarming. Consequently, the goal of the research study was to gain an understanding of the challenges experienced by adult service users during aftercare and reintegration services for substance dependency.

The study utilised the Biopsychosocial model as a theoretical underpinning to distinguish between the various biological, psychological, social and cultural challenges surrounding aftercare and reintegration services for recovering addicts. A qualitative research approach with some quantitative elements, along with an exploratory and descriptive research design, was followed for this study. Ethical clearance was obtained.

The empirical data that was collected was done through semi-structured interviews with a sample of 18 participants. These participants were formerly discharged from formal treatment for substance dependency and are currently service users of aftercare and reintegration services. Certain criteria for inclusion applied. Participation in this study was voluntarily and participants could withdraw from the study if they wished to. The interviews were audiotaped and transcribed by the researcher. Through the data collected and analysed, four themes with relevant sub-themes and categories emerged. The four themes identified were biological challenges, psychological challenges, social challenges and cultural challenges. The data was also verified as far as possible by ensuring credibility, transferability, dependability and conformability.

To meet the aim of the study, the researcher described the literature, policy and legislative frameworks pertaining to current substance dependency aftercare services and explored service users' lived experiences with aftercare services. By empirically investigating the research topic, the views and experiences of service users regarding their challenges during aftercare and reintegration services were explored.

Thereafter, the contextualised literature and empirical findings were reviewed, so that the researcher was able to provide relevant conclusions and recommendations. It is evident from this study that service users are experiencing several challenges during aftercare and

reintegration services. It is recommended that further research be conducted regarding these services for the dependent person as well as for the family. More research on the implementation procedures of policies and legislation during substance dependency aftercare and reintegration services is also recommended.

OPSOMMING

Middelafhanklikheid het die afgelope eeu toegeneem, en uitdagings rondom hierdie toornis is moeilik om te oorkom. Teen hierdie agtergrond, is die huidige terugval statistieke vir 'n middelafhanklike persoon wat formele behandeling ontvang het, tot so hoog soos 75% na 'n 3 tot 6 maande periode, kommerwekkend. Gevolglik, was die doel van die navorsingstudie om 'n begrip te ontwikkel oor die uitdagings ervaar deur volwasse diensverbruikers gedurende nasorg- en reïntegrasiedienste vir middelafhanklikheid.

Die studie het die Biopsigososiale model as teoretiese grondslag benut om tussen die verskeie biologiese, sielkundige, sosiale en kulturele uitdagings rondom nasorg- en reïntegrasie dienste vir herstellende verslaafdes te onderskei. 'n Kwalitatiewe benadering wat sekere kwantitatiewe aspekte bevat, met 'n eksplorerende en beskrywende aard is gevolg. Etiese klaring is verkry vir die studie.

Die empiriese data is ingesamel deur semi-gestruktureerde onderhoude te voer met 'n steekproef van 18 deelnemers. Hierdie deelnemers is ontslaan uit formele behandelingsprogramme vir middelafhanklikheid en is tans diensverbruikers van nasorg- en reïntegrasiedienste. Sekere kriteria vir insluiting het gegeld. Deelname aan die studie was vrywillig en deelnemers kon enige tyd onttrek, as hulle nie langer wou deel vorm van die studie nie. Die onderhoude is opgeneem en getranskribeer deur die navorser. Deur data opname en analise is vier temas met relevante sub-temas geïdentifiseer. Die temas was biologiese uitdagings, sielkundige uitdagings, sosiale uitdagings en kulturele uitdagings. Die data is ook geverifieer deur geloofwaardigheid, oordraagbaarheid, bevestiging en betroubaarheid sover moontlik te verseker.

Om die doel van die studie te bereik, het die navorser literatuur, beleid en wetgewing relevante rakende nasorg- en reïntegrasiedienste vir middelafhanklikheid beskryf en diensverbruikers se eie ervarings oor nasorg- en reïntegrasiedienste is geëksploreer. Deur hierdie navorsingonderwerp empiries te ondersoek, is die sienings van diensverbruikers van nasorg- en reïntegrasiedienste vir middelafhanklikheid geëksploreer.

Nadat literatuur en die empiriese bevindinge bestudeer is, kon die navorser relevante gevolgtrekkings en aanbevelings maak. Dit is duidelik uit hierdie studie dat diensverbruikers verskeie uitdaging ervaar tydens nasorg- en reïntegrasiedienste. Dit word aanbeveel dat meer

navorsing gedoen word oor nasorg- en reïntegrasiedienste vir die middelafhanklike persoon sowel as vir die betrokke gesin. Meer navorsing oor die implementering van wetgewing en beleid gedurende nasorg- en reïntegrasiedienste word ook aanbeveel.

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LIST OF ACRONYMS AND ABBREVIATIONS

AA:	Alcoholic Anonymous
AOD:	Alcohol and/or other drugs
APA:	American Psychiatric Association
BPS model:	Biopsychosocial model
DOH:	Department of Health
DSD:	Department of Social Development
ISDM:	Integrated Service Delivery Model
NA:	Narcotics Anonymous
NDMP:	National Drug Master Plan
SACENDU:	South African Community Epidemiology Network on Drug Use
SUD:	Substance Use Disorder
REC:	Research Ethical Committee
UNOCDC:	United Nations Office on Drugs and Crime

CHAPTER 1

INTRODUCTION

1.1 PRELIMINARY STUDY AND RATIONALE

Substance dependency is a growing epidemic, as difficulties surrounding the disorder are not easily overcome. It is a challenge not only in developing countries such as South Africa, but also in developed countries. In fact, as indicated in the World Drug Report (2015), 29.5 million people of the world adult population is dependent on alcohol and/or other drugs (AOD). Although many treatment services and approaches have been developed throughout the years to address this epidemic, there are still high levels of substance dependency and reoccurring relapses after being discharged from formal treatment services. Historically in South Africa during Apartheid (1948-1991), substance dependency was less prevalent and the treatment services that were available were only accessible to urban areas that were predominantly occupied by white privileged communities (Parry, Myers, Morojele, Flisher, Bhana, Donson & Plüddemann, 2004). This segregation of services had caused a lack of collaboration on substance dependency-related issues at national, provisional and local levels, as well as between the Department of Social Development (DSD) and the Department of Health (DOH), which resulted in inadequate and inaccessible services. Looking forward into the new democratic South Africa since 1994, with its fast-growing population and increasing availability of illegal substances, DSD was forced to develop a clear policy framework that prioritises service provisions for substance dependency. This included a National Drug Master Plan (NDMP, 2006-2011; 2013-2017; 2018-2022: not implemented yet), as well as the Prevention of and Treatment for Substance Abuse Act 70 of 2008.

According to the most recent statistics taken for the United Nations World Drug Report (UNSD, 2014), substance dependency statistics in South Africa show that 7.06% of the population is dependent on substances. This “[m]ak[es] one in every 14 people regular users adding up to a total of 3.74 million people” (taken as a percentage of the population as of 2013). The rise of substance dependency is associated with numerous negative outcomes such as violence, unsafe sexual behaviour, family dysfunctions, crime and gang affiliation. With these statistics and outcomes in mind, the Prevention and Treatment of Drug Abuse Act (70 of 2008), in accordance with the National Drug Master Plan (NDMP, 2006-2011; 2013-2017) and the key departments

as listed in the Act are responsible for developing plans in line with their core functions which are referred to as Mini-drug Master Plan (MDMP). These plans offer many approaches to reduce these statistics through treatment services that are offered on all levels of the Integrated Service Delivery Model (ISDM, 2006) enshrined in the White Paper for Social Welfare (1997). This model acts as a guideline for what level of services should be rendered in terms of prevention, early intervention, statutory intervention/alternative care/residential care, and reunification and aftercare.

Statutory or tertiary intervention is delivered in the form of formal treatment services, which entail services administered to users being admitted into a controlled drug-free environment for the duration of a programme, which usually involves between four and nine weeks of abstinence from AOD. According to Gossop, “[t]hese services involve treating withdrawal, mental and health deficits, interpersonal problems and unsupportive social and family environments” (2006). The South African Community Epidemiology Network on Drug Use (SACENDU, 2018) indicated that “in 2017 there were 80 registered formal treatment facilities in South Africa which had an increase in patient admissions from being only 8787 in 2016 to 10047 in the beginning of 2017.” Only a minority of these facilities are government subsidised, and had to provide services for an estimated 3.74 million substance dependent individuals of the population as mentioned above. As emphasized in the Mini-drug Master Plan (MDMP, 2014), the aftercare/reintegration level of the ISDM (2006) is to continue the care that was initially provided within the controlled setting of formal intervention treatment services. The aim of this level of service delivery is “to promote service users to regain self-reliance and optimal social functioning to ensure their reintegration into family and community life after being discharged from the secure environment of the inpatient/formal treatment facility as a successful transition” (Department of Social Development, 2006). However, there are no statistics available regarding the number of aftercare services available in South Africa.

South Africa’s legislation and policies have attempted to address the high presence of substance dependency. However, a high number of relapses are still reoccurring, the majority of these taking place in the aftercare/reintegration level of service delivery. This corresponds with the findings of Adinoff, Talmadge, Williams, Schreffler, Jackley and Krebaum (2010) who discovered that substance dependency relapses after formal treatment is evident among “75% of the service users after a 3 to 6 month period.” These scholars found that relapses occur due to re-exposure to risk factors such as community disorganisation, socio-economic deprivation

and availability of drugs, as well as intrapersonal factors such as learned behaviour (habits), culture, ethnicity and unsupportive family networks. Accordingly, the research findings of McKay (2011) emphasise the importance of aftercare involvement after receiving formal treatment for its positive attributes. These include longer days of no relapse, less re-offending and increased AOD abstinence rates. However, these outcomes are dependent on various variables of aftercare, such as “the service user’s attendance rate, intensity and frequency of participation, as well as length of aftercare” (Steven, 2015).

The most documented aftercare services available are 12-step self-help groups, which include Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). Alcoholics Anonymous is the largest support group in which up to 2 million members exist worldwide. The year 1935 was considered its birth date, making it the oldest support group structure in existence. The group follows a traditional 12 step programme to ensure long-term sobriety. Narcotics Anonymous grew out of AA, and was founded in 1953 with similar principles, although the focus term ‘alcoholics’ was replaced with ‘narcotics’ to indicate its focus on different substances (Fiorentine & Hillhouse, 2000). These aftercare support groups are the most popular in South Africa. However, these group structures were developed prior to South African democracy in 1994. Therefore, research is needed to investigate how aftercare services have been adapted to render effective continuing care services to vulnerable populations that were previously segregated due to Apartheid, whereby access to such aftercare services were limited due to transport, safety, demographic location and funds. In this light, this research study explored the relationship between substance dependency intervention (formal treatment) and aftercare/reintegration service delivery levels, as it is evident that during intervention the service users are taken out of their harsh environment and put into urban designed treatment facilities that have little consideration for the harsh realities that some of them have to return to in terms of environmental and interpersonal risk factors. With these risk factors in mind, along with the current lack of research focusing on the perspective of adult service users, it is essential to determine what challenges are experienced by them in order to attempt to reduce relapses. Thus, this study investigated the challenges experienced by services users during substance dependency aftercare and reintegration services according to the Biopsychosocial (BPS) model. The BPS model identifies the biological, social, psychological and cultural categories that make individuals vulnerable to substance dependency relapses (Smith, Fortin, Dwamena & Frankel, 2013). The problem statement, objectives and aims of the proposed research report are furthermore discussed.

1.2 PROBLEM STATEMENT

According to the Gorski model of relapse (Gorski & Miller, 1984), as depicted in the revised journal of Miller and Harris (2000), relapses of substance dependent service users after formal treatment are linked to factors such as failure to maintain coping mechanisms in trigger situations, continuous negative substance abuse thoughts, boredom due to unemployment, interpersonal problems, failure to avoid substance use environments and unsupportive family structures. These factors are argued by McKay (2011) to all be manageable and avoidable if service users are active participants within aftercare and reintegration services such as the attendance of AA and NA meetings. This corresponds with the Prevention of and Treatment for Substance Abuse Act 70 of 2008, which stipulates that the aim of aftercare and reintegration services “is the successful reintegration of a person into society, the workforce, family and community in order to promote their optimal functioning so that relapses can be prevented.” However, the reality is that a significant number of service users in aftercare still have reoccurring relapses.

In recent literature, aspects of biology, psychology, environmental setting, socio-economic circumstances and culture have all been linked to substance dependency relapses by adult service users. However, there is a lack of research in terms of how to account for these aspects during aftercare and reintegration level of service delivery (ISDM, 2006), especially for vulnerable populations that are found within South Africa (Sun, 2009). According to the Nexus research database (Nexus, 2016), in the past five years, only two studies have been conducted regarding substance dependency aftercare and reintegration services in the Social Work field. Therefore, the reoccurring incidence of relapses that happen after formal treatment and in the aftercare/reintegration level of the Integrated Service Delivery Model (2006) has raised much concern about the challenges experienced by these substance dependent service users that predispose them to relapse factors. Ultimately, the research of this thesis explored these grey areas in substance dependency policies, legislation and literatures in order that future recommendations could be made.

1.3 RESEARCH QUESTION, AIM AND OBJECTIVES

The research question for this study is: what are the challenges experienced by adult service users during substance dependency aftercare and reintegration services? The aim of this research is to develop an understanding of the challenges experienced by adult service users

during substance dependency aftercare and reintegration services. To meet this aim, the following objectives were formulated:

- 1) To describe the challenges of adult service users after they have received substance dependency formal treatment from a Biopsychosocial model.
- 2) To contextualise the available literature, policy and legislation framework of substance dependency aftercare and reintegration services for adult service users.
- 3) To empirically investigate the challenges experienced by adult service users during substance dependency aftercare and reintegration services.
- 4) To comprehend the outcome of the research in order to present conclusions and develop corresponding recommendations for future aftercare and reintegration services to strengthen relapse prevention.

1.4 THEORETICAL FRAMEWORK

The theoretical framework substantiates the theory that explains why the research problem under study exists. The theoretical point of departure for this research problem is the Biopsychosocial model (BPS) that was developed by Engel (1981) and is based on the systems theory (Adler, 2009). The BPS model attempts to group risk and protective factors according to biological, social and psychological categories that make individuals vulnerable to substance dependency relapses (Smith *et al.*, 2013). It emphasises, not only that there is an inherited and an induced biological component to addictive disorders, but also that psychological-behavioural and social-cultural factors contribute to substance dependency (Frankel, Quill & McDaniel, 2003). The complexity of these factors are connected and influence each other continuously through feedback loops (Smith *et al.* 2013). This model takes three domains of an individual into account, the first being the biology in terms of genetic predisposition, biochemical, and physical characteristics. The second considers the psychological domain, which entails the developmental, psychopathological, behavioural and personality aspects of an individual. Lastly, the social domain is focused on family systems, culture, social justice, education and socio-economic aspects (McDonagh & Reddy, 2015). However, in recent years culture has been characterised into its own domain, which is a factor that is especially relevant to South Africa because of social stigmas and stereotypes that are attached to substance dependency. Although these domains can be evaluated separately, they still influence each other interchangeably and play a role in continuous sobriety or relapse (Routledge, 2005).

The goal of the BPS model is to integrate information gathered from the different components through open-ended questions aimed at understanding the individual's needs and experiences (Smith et al. 2013). The BPS model was chosen as the theoretical framework guiding this study as it allows for a deeper understanding of the participants' challenges during substance dependency aftercare and reintegration services.

The additional theoretical point of departure for this research was the Integrated Service Delivery Model (2006), which is an integral factor in the delivery of integrated social services and works in accordance with legislation and policies of National Drug Master Plan (NDMP, 2006-2011; 2013-2017), as well as the Prevention of and Treatment for Substance Abuse Act 70 of 2008. This approach emphasised integrated systems of social services, facilities and programmes in order to promote social development, social justice and social functioning of people. Thus, this legislation and approach was utilised as a theoretical point of departure to assess how and what aftercare/reintegration level of social service delivery is available within the democratic South Africa to ensure relapse prevention of its substance dependent services users.

Therefore, with both these theoretical points of departure in mind the researcher was able to determine the realities of service user's biological, psychological, social and cultural background during substance dependency aftercare/reintegration services (ISDM, 2006) in accordance with the BPS.

1.5 CONCEPTS AND DEFINITIONS

Clarification of the following concepts is necessary to ensure a comprehensive understanding of the purpose of the proposed research project:

1.5.1 Experience

Experience can be defined as a particular instance of personally encountering or undergoing something, which in this case entails adult service users encountering aftercare and reintegration services after receiving formal treatment for substance dependency (Sarason & Sarason, 2009).

1.5.2 Adult service users

The South African Community Epidemiology of Drug Use (SACENDU, 2018) showed that 13.3% of adult South Africans met the criteria for a substance use disorder (SUD). Therefore, adult service users refer to individuals with alcohol and/or other drug (AOD) problems that have been discharged from formal treatment and are encountering services from the aftercare and reintegration level of the social service delivery (ISDM, 2006)

1.5.3 Aftercare and reintegration services

These services are a means of continuing professional support to a service user after receiving formal treatment in order to “enable the individual to maintain sobriety, personal growth and to enhance self-reliance and proper social functioning in least restrictive environment possible” (Prevention of and Treatment for Substance Abuse Act 70 of 2008). Reintegration services are aimed at reintegrating and reunifying individuals and their families once interventions outside the home environment have been completed and terminated (DSD).

1.5.4 Substance dependency

In this research project the terms ‘substance abuse’ and ‘substance dependency’ will be used to include both illegal (cocaine, cannabis, etc.) and legal (alcohol) substances. Substance dependency is the “use of a substance for a purpose not consistent with legal or medical guidelines, as in the non-medical use of prescription medications” (Encyclopaedia of Social Work, 2013). The term “substance abuse” is defined in Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM–V) as “a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) criteria, occurring within a 12-month period” (APA, 2013).

1.5.5 Relapse prevention

Relapse refers to the use of alcohol and/or drugs (AOD) after a period of abstinence, usually after receiving formal treatment (Encyclopaedia of Social Work, 2013). The reoccurrence of use can vary between slip, which is an episode of AOD use, and relapse, which is the return to uncontrolled AOD use. There are two fundamental models of relapse prevention, these being the Cenaps Model (Gorski & Miller, 1984) and Cognitive-Social Model (Donovan & Marlatt, 2005). Although these models differ in terms of the definition of readiness of the client for

relapse prevention programme, their strategies to prevent relapse are similar. Therefore, relapse prevention includes strategies such as enabling the service user to cope with high risk situations (places, things, urges) and lifestyle changes (self-care, relationships, financial planning). These strategies will be aided by support systems that should be available at aftercare services. Accordingly, aftercare and reintegration services are designed to prevent relapses.

1.5.6 Biopsychosocial model

This model is based on the perspective that “humans are inherently Biopsychosocial organisms in which the biological, psychological, and social dimensions are inextricably intertwined” (Melchert, 2007). It explains how all four domains (social, psychological, biological and cultural) combine and interact to influence each other. The researcher adopted the BPS model as a guide in this study to gain a comprehensive understanding of the experiences of adult service users during aftercare and reintegration services. It suggests that an understanding of the participants’ subjective experience is critical in developing accurate diagnoses and successful treatment options (Smith *et al.*, 2013).

1.5.7 Challenges

A challenge refers to “[a] situation of being faced with something that needs great mental or physical effort in order to be done successfully and therefore tests a person's ability” (Encyclopaedia of Social Work, 2013). In terms of this topic under study, this will be conceptualised under the domains of the Biopsychosocial model (social, psychological, biological and cultural), which are seen as factors that could test a person’s ability to either maintain sobriety or relapse during aftercare and reintegration services.

1.6 RESEARCH METHODOLOGY

In this section, the related literature was developed as a logical and theoretical framework for the research study. This section also elaborated the sample size, the methods of data collection, and the research instruments that was utilised throughout the research. Lastly, it encompassed a theoretical analysis of the body of methods and principles associated with a branch of knowledge and the outline of methods of the data analysis that was utilised.

1.6.1 Research approach

The way that the researcher chose to conduct the literature research did not solely depend on the research topic, but also on the research approach. Therefore, the qualitative approach was the most suitable for this research, as it corresponded with the objectives in terms of gaining understanding of a problem that has not been comprehensively investigated before (Bless, Higson-Smith & Sithole, 2013).

The purpose of the qualitative approach is to obtain a more meaningful record of human experiences by means of constructing detailed descriptions of their social reality (Bless *et al.* 2013). The structure of this approach is flexible and circular. Therefore, the researcher investigated the problem from the participants' view point. This was done by the researcher taking an objective frame of reference. For instance, the researcher investigated the subjective views of the service users that utilise aftercare and reintegration services for substance dependency. The qualitative approach was utilised, as it is focused on the oral and written expressions of the participants about a particular phenomenon or issue (Bless *et al.* 2013). Moreover, the researcher gathered these verbal expressions of the participants by means of semi-structured interview and participant observation in order to gain detailed descriptions of the participants' experiences about the topic. Once the researcher received a written informed consent form from the participants, the interview was recorded by a voice or tape recorder in which the researcher referred to each participant by an assigned number code so that their personal details, such as name and surname, were protected during the interview recordings (De Vos, Strydom, Fouche & Delpont, 2011). Although the research study is qualitative in nature there were also some quantitative aspects utilised, as depicted in chapter 4 in terms of the participant particulars.

Trochim (2006) refers to two "broad methods of reasoning in terms of inductive and deductive approaches". The inductive approach can be defined as moving from the specific to the general (arguments based on experience or observation are best expressed inductively), while the deductive approach begins with the general and ends with the specific (arguments based on laws, rules, or other widely accepted principles are best expressed deductively). Therefore, general inductive and deductive approaches for qualitative data analysis were utilised in order to achieve the aim of the research topic. The purposes for using a deductive approach for qualitative analysis would be to reason the literature study in order to emphasise the legislation and theory regarding aftercare/reintegration services. Conversely, the inductive approach to

qualitative analysis was utilised within the empirical study in order to highlight the participants' subjective experiences regarding the research topic (Trochim, 2006). The researcher then moved between inductive and deductive logic of reasoning in order to identify the gaps or links between theoretical knowledge, legislation and narratives of primary source participants.

1.6.2 Research design

The function of this section was to give a clear indication of the means by which the researcher hoped to reach the set aims of the research. The research design went into some detail about the methods and procedures that were utilised. Therefore, in accordance with the research aim, the research project was exploratory and descriptive. Exploratory research "is relevant to the research topic, as it is conducted to gain insight on a phenomenon that has limited knowledge or information and the purpose of the research is to develop a broader understanding about that unfamiliar situation or issue" (Bless *et al.*, 2013: 60-62).

On the other hand, descriptive research was done even if there was enough background information and knowledge available to permit a precise topic of investigation (Bless *et al.*, 2013). Although this research design was similar to exploratory research as it blended in practice, descriptive research presented a picture of the specific details by gathering information through observation in terms of viewing and recording the participants. The descriptive research design was more likely to deliver an intensive examination of the issue and its deeper meanings, therefore resulting in denser descriptions (De Vos *et al.*, 2011).

Throughout this analysis of research designs, the researcher focused on the implementation of the exploratory design with elements of the descriptive design, as the research topic had limited knowledge regarding the challenges experienced by adult service users with substance dependency aftercare and reintegration services.

1.6.3 Sample

According to De Vos *et al.* (2011), a sample is a subset of the whole population considered relevant to the investigation for the study. A sample can be depicted as a small portion of the total set of events or persons from which the selection is made for the representative. The population for this research study was represented by adult service users who received substance dependency aftercare and reintegration services in order to prevent relapse. To conduct the research at a domain that renders aftercare and reintegration services such as CAD

(Christian Action for Dependence), the researcher received proof of consent to be part of the study from the Department of Social Work at Stellenbosch University.

The sampling method that was utilised was based on the non-probability sampling because the odds of selecting particular participants are not known. The researcher therefore made particular reference to purposive sampling and snowball sampling which are sometimes used together. According to De Vos *et al.* (2011), the purposive sampling is a technique that is also referred to as judgemental sampling, as it was based entirely on the judgement of the researcher regarding the characteristics or typical attributes of the population that best serve the purpose of the research study. The research sample only consisted of 18 participants instead of the stipulated 20 participants, because as depicted in chapter 4, the researcher obtained enough information regarding substance dependency aftercare and reintegration services. The researcher obtained these participants by getting the names and contact details from the organiser of CAD in order to contact individuals that had shown interest in participating in the research project. This was done telephonically, so that the research process could be cohesively explained to each participant. CAD gave the researcher written permission to have access to the organisations service users who had participated in at least one individual or group session with the organisation (as depicted in Annexure C). This was done by the organiser and researcher contacting the various CAD support groups in order to encourage the group leaders to inform the group members about the research project. Potential participants were told that those interested in finding out more could contact the researcher directly or give CAD permission to allow the researcher to access their contact details. Additionally, the snowball sampling was utilised for identifying people that were not listed or difficult to find, an example being service users that may have relapsed (De Vos *et al.*, 2011).

In light of this, the criteria for inclusion in the sample for the study was therefore based on the following:

- Participants must have substance dependency aftercare and reintegration services available for adult service users.
- The participants should be former substance dependent individuals that are partaking in an aftercare and reintegration service programme for substance dependency after they have received formal treatment.

- Informed consent must be obtained by participants that encounter substance dependency aftercare and reintegration services in order to conduct research regarding the challenges experienced by them.
- Participants should be able to understand English or Afrikaans.
- Participants should be over 18 years old.

1.6.4 Instrument for data collection

The researcher collected data by means of interviewing, which is the predominant mode of data collection in qualitative research. This form of data collection is done by direct interchange with the participant and researcher in the aims of gathering information that they are expected to possess in relation to the research topic (De Vos *et al.*, 2011).

The researcher used a semi-structured interview guide (Annexure G) in order to gain a detailed description of the participants' experiences and views about the particular phenomenon (De Vos *et al.*, 2011). According to the research study, the semi-structured interview was beneficial to the exploratory research, as this method enabled the researcher to clarify concepts and problems. The qualitative researcher gathered data from participants through semi-structured interviews in order to identify themes which allowed the researcher to develop theories inductively (Creswell & Clark, 2007). The researcher had a set of predetermined open-ended (unstructured) and close-ended questions (structured). These questions were based on an interview schedule that guided the interview to ensure all the necessary information was gathered for the research topic (as depicted in Annexure H) (Bless *et al.*, 2013).

As soon as the researcher received ethical clearance (see Annexure A), the participants that agreed to take part in the research study had to formally sign a consent form so that the professional semi-structured interviews could commence (as depicted in Annexure D). The researcher obtained permission from the participants in order for the interviews to be recorded by tapes or videos, as it provided for a fuller record than field notes (De Vos *et al.*, 2011).

1.6.5 Data analysis

According to De Vos *et al.* (2011), data analysis begin once the data has been effectively collected and organised. Qualitative analysis aims to describe and understand the participants' 'lived experience' in order for the researcher to explore the way these participants construct

meaning to their reality. Therefore, the researcher ensured to be objective throughout data analysis of data findings by means of showing self-awareness as a practising aftercare social worker in order to ensure credibility of research outcomes.

The analysis of data also aimed to describe the range of diversity among participants' experiences by means of studying them in their natural context. The researcher therefore aimed to describe the service users' experiences by means of investigating them in their immediate environment within South Africa. The critical elements of qualitative analysis are that it must be systematic, verifiable and continuous which sought to enlighten it as a process of comparison. Therefore, by ensuring that the sampling population was of random selection, it corresponded with an established sample size of 18 participants, as the researcher was able to reach a point in the analysis of data whereby sampling more data would not have led to more information related to the research questions, which in turn meant that the research saturation was reached faster (Bless *et al.*, 2013).

Thereafter, the researcher transcribed and analysed the semi-structured interviews shortly after the interview to ensure the credibility of the research (De Vos *et al.*, 2011). The researcher utilised tables to transcribe information from interviews in order to develop and analyse the profile of participants more cohesively. This information was then divided into the identification of themes and the sub-themes in accordance with the seven-step process of constant comparative template initially developed by Lincoln and Guba (1985). These steps referred to forming codes for many of the potential themes such as nationality, race, ethnicity or hierarchy. These codes within the tables had relevant context to the research study by means of coding minority and contradictory aspects, so that patterns were established from the codes which 'payed differentials' that eventually developed into the theme or subthemes (Bless *et al.*, 2013). These tables allowed the researcher to analyse and compare findings with existing literature contained in literature review and to those of participants' primary experiences.

Lastly, member checking with participants was emphasised within qualitative research and is also known as informant feedback or respondent validation (as depicted in Annexure H). This is a technique that was done at the end of data analysis in order to assist the researcher in ensuring the credibility, transferability, and validity of the research study (De Vos *et al.*, 2011). Member checking was done by providing the transcribed interviews to two participants to ensure that these transcriptions were a true replication of the interviews. An independent coder was utilized to confirm that the data were represented by the themes, sub-themes and categories

(as seen in Annexure I). Lastly, the researcher completed a reflexivity report (Annexure J) in order to acknowledge and reflect on the research process, as well as the overall outcome.

1.6.6 Ethical clearance

The research project was conducted in an ethical manner based on mutual trust, acceptance and cooperation about the expectations between all entities involved. Research ethics is a set of fundamental rules or behavioural expectations about the correct conduct towards the participants of the research project (De Vos *et al.*, 2011). The researcher obtained informed consent (Annexure D) from all participants involved in the research project by providing the potential participants with information regarding the expected duration of their involvement and the procedures that will be followed during the project. It was essential that the participants were legally and psychologically competent to provide informed consent, whereby they had to be aware that they are liable to withdraw from the research at any time (De Vos *et al.*, 2011). The researcher had the ethical responsibility to maintain the privacy of the participants in terms of confidentiality and anonymity, which will be ensured through password protected methods for a required amount of time which will be at least 5 years. This was done by ensuring that the data collected by participants was protected by password codes on computer systems as well as through hard copies stored in a cabinet in the supervisor's office. The supervisor's office is secure, as only she has access to it, and it is situated at the CAD head office. Lastly, the researcher received ethical permission from the Social Work Department at Stellenbosch University and from the Research Ethical committee (Annexure A). This committee with reference to De Vos *et al.* (2011) reviewed the research proposal according to strict guidelines to evaluate that the project was sustainable for further research.

In accordance with the research topic, the sample population was made up of vulnerable individuals, and for this reason, the ethical clearance was classified as medium-high risk. This research status that was suggested had the potential risk of emotional or psychological discomfort if it was not dealt with in a responsible and professional manner. The data and information needed for this research topic involved intimate details of vulnerable social categories that dealt with sensitive topics in terms of substance dependency. The topic investigated is controversial and connected to social stigmas, and consequently the researcher handled the participants with professionalism. For this reason, the CAD provided opportunities for debriefing, as well as the option of counselling services at no additional cost. Lastly, the researcher had previously emphasized the importance of this research, as it explored avenues

from participants that are primary sources to information, experience and knowledge regarding the topic. This ethical clearance allowed credibility, transparency and transferability of its findings in order for beneficial recommendations and conclusions to be made in chapter 5 for future aftercare and reintegration services.

1.6.7 Presentation

The research project will be categorised into several chapters that correspond with the objectives of the research within the relevant time framework. In chapter 1, there was an introduction of the research study by including the aims and objective. Further, chapter 2 presents an explanation of the challenges experienced by adult service users during substance dependency aftercare and reintegration services from a Biopsychosocial model. In chapter 3, the academic and legislative framework for substance dependency aftercare and reintegration services are mentioned. In chapter 4, the empirical findings and study is shown and lastly, in chapter 5, the necessary conclusions and recommendations regarding the findings are made.

1.6.8 Limitations of the study

There were certain limitations in this study as will be mentioned below:

- In this research study, the sample size was small, consisting of only 18 participants, and for this reason the findings of the research study cannot be generalized.
- No pilot study was conducted due to the complexities of accessing such vulnerable participants.
- The research was only focused on the Western Cape, making it impossible to generalise to the entirety of South Africa.
- Some of the literature sources are outdated due to limited research available regarding the topic at hand.
- Regarding the race of the participants, it would have been ideal if all races could have been represented on an equal basis, but due to the geographical area of the organisation that was used only one black participant formed part of the sample. Due to safety reasons the researcher also could not enter communities that were seen as unsafe on her own.

- Regarding the findings, the researcher could have distinguished more between narratives displayed by female and male participants. However, the focus of the study was specifically on substance dependency aftercare and reintegration services and not on how the different genders experience challenges.

CHAPTER 2

AN OVERVIEW OF CHALLENGES THAT EXIST FOR RECOVERING SERVICE USERS/SUBSTANCE DEPENDENTS ACCORDING TO THE BIOPSYCHOSOCIAL MODEL

2.1 INTRODUCTION

This chapter seeks to respond to the second objective of this study, which is to mention the challenges that exist for recovering service users after receiving formal treatment. Its departure point is to elaborate on the identified and recognised challenges of substance dependency aftercare so that a Biopsychosocial backdrop can be created for further comparisons and research findings to be made. These challenges have been documented in the services users' recovery process, which is rendered during the aftercare and reintegration level of service delivery. According to the Integrated Service Delivery Model (ISDM, 2006), the aftercare level of services is intended to respond to these challenges, because it has been made evident that substance dependent individuals are taken out of their harsh environments and circumstances so that they can receive formal treatment that is offered in predominately urban areas. However, once these individuals have been discharged from such a controlled setting as is provided by formal treatment, they are put back into the same unchanged environments that were problematic for their substance dependency to begin with (Steven, 2015). Therefore, recovering service users experience various challenges in preventing relapses.

As emphasized by United Nations Office on Drugs and Crime (UNODC, 2016), there is no one cause for substance dependency relapse, but rather a combined net of challenges that individuals are often exposed to after receiving formal treatment. These challenges are defined as predictors for relapse, in which the more challenges individuals are exposed to, the more at-risk they will become to experiencing reoccurring relapses. Therefore, aftercare and reintegration services have the ability to foster 'protective factors,' which buffer and balance risk factors that are produced by various Biopsychosocial challenges. The incidence of reoccurring substance dependency relapses appears to be less voluntary, and "includes a combination of factors such as "uncontrollable use, fear of withdrawal symptoms, dependence, social exclusion, mental health problems and other psychosocial and environmental

circumstances” (Rassool, 2011). Within these reasons of continued dependency, there are challenges that can be identified that predispose an individual to reoccurring substance dependency relapses. These risk factors and protective factors are subject to genes, background and environment. The latter can be categorised into four domains: biological, psychological, social and cultural, which influence each other in a circular pattern (Nutt, 2012).

In this light, the theoretical point of departure for this research study will be the Biopsychosocial model (BPS) (Engel, 1981), and there is also a correlation between this BPS model and ecological perspective. These underpinnings provided a framework that attempted to group risk factors and protective factors according to biological, psychological and social categories that make individuals vulnerable to substance dependency relapses (Smith *et al.*, 2013). In this research study, these categories will be referred to as challenges, which are predictors for reoccurring relapses. The development of the Biopsychosocial model with reference to important concepts and implications to substance dependency will also be discussed in order to gain insight into challenges that exist for recovering service users after they have been discharged from formal treatment.

2.2 DEFINITION OF SUBSTANCE DEPENDENCY

Substance dependency refers to a maladaptive pattern of substance use that manifests regularly and results in negative outcomes and consequences (Swartz, de la Rey, Duncan & Townsend, 2011). There are several possible reasons that people abuse AOD, such as an attempt to relieve suffering and to experience immediate pleasure (Leach & Kranzler, 2013). There are many types of substances that an individual can become dependent on, namely: central nervous system depressants (cannabis, heroin, benzodiazepine), psychostimulants (caffeine, nicotine, amphetamines) and psychedelics (hallucinogenic, mushrooms, acid, ecstasy) (Fisher & Harrison, 2013). Substance dependency is the ongoing use of one or more of these substances regardless of the negative consequences.

There are various formal and informal treatment options for substance dependency intervention, such as inpatient treatment and outpatient treatment facilities. These facilities provide service users with the opportunity of recovery in a drug-free environment whereby they have access to professionals that will assist them with underlying Biopsychosocial issues surrounding

addiction. However, this study is focused on the aftermath of formal treatment in terms of aftercare and reintegration services according to the Integration Service Delivery Model (ISDM, 2006).

2.2.1 The consequences of substance dependency

There is a misconception regarding the severity of substance dependency in terms of the degree to which it impacts whom and what. Although abusing AOD is an act done by oneself, it does not mean the individual is the only victim. Instead, substance dependency is a multi-faceted problem that creates consequences, not only for the individual in terms of health and social status, but also the social systems surrounding that individual in terms of employers, families, children and communities (DiClemente, Schlundt & Gemmell 2004).

2.2.1.1 Social consequences of substance dependency

The social cost of substance dependency is virtually incalculable due to continuous unemployment rates, which have increased from 27.1% in the fourth quarter of 2018 to 27.6% in first quarter of 2019 (Statistics South Africa, 2019), whereas poverty rates have grown to 55.5% (Statistics South Africa, 2018). Additional social costs involve loss of productivity, indirect medical costs, property damage and social welfare payments, as well as a growing sense of frustration and helplessness amongst those affected (Laudet, 2011).

As mentioned above, South Africa is still overcoming the consequences of Apartheid, which has allowed substance dependency to further impact the society in terms of its growing correlation with criminal activity, gang activity, school dropout rates, property vandalism. This correlation has a profound impact on all levels of society, and how the history of South Africa shaped the social challenges experienced by all citizens today. Therefore, it is essential to understand that substance dependency cannot be treated in isolation from Biopsychosocial challenges that were caused by discriminatory and oppressive systems. Instead, aftercare services must focus on all aspects of society.

2.2.1.2 Economic consequences of substance dependency

Combating substance dependency has a detrimental effect on the country's economy, as illustrated by the findings of the Department of Social Development. Based on these findings it indicated that the international economic costs for substance dependency can be estimated to

be at 6.4% of the Gross Domestic Product (GDP), and approximately R136 380 million is allocated to the cause per year (DSD, 2013).

2.3 THE DEVELOPMENT OF THE BIOPSYCHOSOCIAL MODEL

The Biopsychosocial model (BPS) (Engel, 1981) expands the Biomedical view. It achieves this in terms of emphasizing that there are not only inherited and biological factors that underline substance use disorders (SUD), but also psychological-behavioural and sociocultural factors that interchange towards the overall outcome of substance dependency and reoccurring relapses. In Engel's study (1981) as well as in Smith *et al.* (2013), the Biopsychosocial model was referred to in an attempt to group risk and protective factors according to biological, social and psychological categories that make individuals vulnerable to substance dependency relapses. The interconnectedness of these factors within these categories bring the derivation of addiction into full circle.

The development of this BPS model unifies prior biological, psychological and social theories of addiction. However, this does not mean that this model collaborated all traditional theories into one version, but instead that it incorporates the strengths of these prior theories while remaining a distinct entity (Frankel, Quill & McDaniel, 2003). In particular, these prior theories refer to the systems theory and Biomedical theory, in which the BPS model emerged in response to these criticisms. In contrast to these prior theories, the BPS model is a conceptual framework that allows attention to be focused on all factors related to substance dependency. There is a correlation between the BPS model and that of the ecological perspective (Johnson & Yanca, 2010; Rosa & Tudge, 2015).

This BPS framework entails grouping risk factors under three domains of an individual, and for the purpose of this study these will be categorised as challenges. Firstly, the biological challenges refer to genetic predisposition, biochemical, and physical characteristics. Secondly, psychological challenges include an individual's developmental, psychopathological, behaviour, personality and past trauma. Lastly, social challenges are focused on the individual's family systems, culture, social justice, education and socio-economic aspects (Kaplan and Coogan, 2005). However, in recent years culture has been characterised as its own challenge, which has risk factors that are especially evident in South Africa because of social stigmas and stereotypes that are attached to substance dependency. Even though these challenges convey

various risk factors independently, they still influence each other interchangeably and play a role in continuous sobriety or reoccurring relapse (Routledge, 2005).

Lastly, the development of the BPS model supports the notion that no one superior substance dependency explanation or treatment exists, and that is why this model employs multiple components in terms of social, psychological, biological domains that form part of an individual existence. Therefore, the theoretical point of departure for this research is the BPS model, because it focuses on specific challenges that exist within society. These challenges foster risk factors that need to be addressed throughout aftercare services in an attempt to enhance the recovering service users' sobriety attainment. Thus, in order to fully comprehend the BPS model, it is essential to first elaborate on the two theories upon which it was based.

2.3.1 Biomedical model

With reference to Bernard and Krupat (1993), the Biomedical model is a school of thought that proposes substance dependency is a disease which is an affliction of the body and is separate to the social and psychological processes of the mind. This model was widely accepted and dominated the industrialised societies during the 19th and 20th centuries. It places emphasis on characterising physical substance dependence with terms such as tolerance and withdrawal. Donovan and Marlatt state that “[t]olerance occurs when the body adapts to a certain level of substance use and in order to achieve the same effects that were initially experienced by the individual, they must increase the dosage of substances” (2005). Withdrawal, on the other hand, is experienced by an individual that is going through uncomfortable physiological and psychological symptoms because substance use has been discontinued. These symptoms differ from person to person but can be any of the following: sweating, nausea, hallucinations, headaches, irritability, tremors and cravings for the substance (Sun, 2009).

Although the biological category of the Biopsychosocial model refers back to the Biomedical model, it considers the Biomedical sphere as only part of what contributes to substance dependency relapses. Therefore, the Biopsychosocial model was developed in response to the Biomedical model's shortcomings in terms of neglecting psychological and social domains that contribute to substance dependency (Engel, 1981).

2.3.2 Systems theory

The systems theory explores human behaviour as the intersection of influences with multiple interrelated systems, and was derived from von Bertalanffy (1971), who defined a system as a complex of interactive elements that together forms a unit. It assesses individual behaviour in terms of interactions with various systems, and not on personal characteristics, as behaviour is seen as the manifestation of an interactional process that has recurring patterns. Further, this theory places emphasis on circular patterns, which view an individual problem such as substance dependency as the outcome of interactions with various systems, such as families, work and communities in which there is belonging to a broader societal context (Goldenberg & Goldenberg, 2000).

The Biopsychosocial model was based on the systems theory in terms of seeing the individual as belonging to a broader set of networks that interplay with one another and ultimately influence the individual in a positive or negative way. It emerged from the systems theory in terms of adapting its notion and concepts into three categories, namely: the biological, social and psychological domains that make up an individual's behaviour. The purpose of Engel's (1981) Biopsychosocial model was to include a client's psychological and social information to diagnostic and treatment procedures, as it made medicine more scientific and humanistic (Smith *et al.*, 2013).

2.3.2.1 *Important concepts*

The following concepts are important for a comprehensive understanding of the Biopsychosocial model:

a) Risk factors

Risk factors can be defined as those factors that contribute to the initiation and continuation of substance dependency. They can be internal or external aspects of a person's life that predisposes them to initial or continuous alcohol and/or other drug abuse (AOD) (Rassool, 2011). They can include but are not limited to the following predictors: peer pressure, poor coping skills, genetic predisposition, age of initial drug use, exposed to ineffective parenting, poverty etc. These are only some factors that can put an individual at risk of continuing substance dependency. For the purpose of this research study, these risk factors will be subdivided and discussed according to the four domains of the Biopsychosocial model which

are social, psychological, biological and cultural challenges. These challenges foster risk factors and are predictors for continuous substance dependency relapses.

As emphasised by Fisher and Harrison (2013), one can combine these factors and recognise that the more risk factors an individual has, the more likely it is for them to relapse. However, the way these risk factors are experienced by individuals differ in terms of the intensity of the risk factors' impact (low, medium or high), their effect outcome (indirect or direct) and their stability (stable or dynamic condition).

b) Protective factors

In contrast, to risk factors there are protective factors, which are those characteristics that reduce risk of substance dependency and enhance optimal social functioning (Fisher & Harrison, 2013). Protective factors are aspects in an individual's social system in terms of social competence, positive attachment and supervision with parents, lack of drug availability and community solidarity which serve to 'buffer' the individual against substance dependency. In correlation with the study, aftercare and reintegration services are established to enhance service users' protective factors in order to equip them with appropriate responses to the existing Biopsychosocial challenges that predispose them to relapses.

c) Adaption

This concept emphasises that individuals have the capacity to be influenced by and influence their social and physical environments through their actions. Adaption is an important concept within the ecological perspective and is therefore a central concept for this research study, because the "most favourable fit between the person and environment is desired and achieved through the individual's ability to adapt to changing situations and circumstances" (Johnson & Yanca, 2010). This adaption promotes individual survival by continued development and functioning, which enhances environment exchanges (Gilstrap & Ziertan, 2018). Adaption is a constant process that includes actions to alter the environment, such as moving to new environments or people themselves by means of adapting to those changes made. This concept is essential to this research study because the challenges experienced by recovering service users are predictors for reoccurring relapses, and therefore whether or not the individual can adapt to these challenges will determine their long-term sobriety. The reintegration component of aftercare services refers to empowering the recovering service user to adapt to the existing environmental challenges so that relapses can be prevented.

d) Life stressors

This concept is relevant to the Biopsychosocial model, as life stressors arise from environmental and psychological stressors (Swartz *et al.*, 2011). Life stressors are stimuli that cause stress reactions produced by problems that individuals experience as above their personal and environmental resources ability to control them. These stressors include intense developmental changes or events that affect recovering service users' sobriety. Different individuals exposed to the same life stressors may have different responses and reactions in terms of reasoning, attitude and actions. A stressor represents serious damage or loss, as it is associated with a sense of being at risk which has implications for an individual's sobriety (Gilstrap & Ziertan, 2018). The implications of life stressors depend on the biological, social, psychological and cultural challenges.

2.4 PRACTICAL IMPLICATIONS

According to Hepworth and Rooney (2013), the purpose of social work “is to recognise the complexities of interactions between human beings and their environments, and the capacity of individuals both to be affected by and to alter the multiple influences upon them including Biopsychosocial factors.” The social work profession focuses on theories of human development and social systems in order to explore complex situations so that individual, organisational, social, political, economic and cultural changes can be made. Substance dependency aftercare and reintegration services that are provided by professional entities correspond with the notions of the Biopsychosocial model because the main aim according to this level of services is relapse prevention. Therefore, practical implications are never preoccupied with only the individual or only the environment, because the concern is on the reciprocal relationships between individuals and their environments in terms of the cultural, psychological and social contexts within which individuals exist.

Substance dependency aftercare and reintegration services are aimed at promoting and strengthening individual's adaptive capabilities within their unchanged environments in order to allow for more adaptive reintegration within their social, psychological and cultural spheres so that relapses can ultimately be prevented (Mittal, 2005). Therefore, aftercare services are essential for rehabilitated service users in order for them to adapt to their environments that may either foster protective or risk factors. However, as depicted in the research findings of Adinoff *et al.* (2010) as mentioned in chapter 1, three quarters of recovering service users

relapse in a short period after receiving formal treatment. There is little response and research providing an explanation for these extremely high statistics, which has raised much concern. Therefore, this research attempts to explore possible challenges that exist after a service user has been discharged from formal treatment in the hope that recommendation and conclusions can be formulated for future relapse prevention services.

2.4.1 Biological challenges

The biological component of the Biopsychosocial model includes hereditary and genetic influences that induce reoccurring relapses. People with family history of substance dependency have an increased lifetime risk of substance dependency. Biological theories on the causes of substance dependency include factors such as genetics or neurochemicals, or a combination of both. These factors inhibit an individual's ability to control consumption of AOD, and consequently abstinence is regarded as the only solution to overcoming substance dependency (Rassool, 2011).

2.4.1.1 Cravings

Cravings contribute strongly to immediate relapses, as it is a fundamental predictor of relapse which is often triggered by surrounding stimuli such as smells, sounds, the sight of AOD. In the absence of AOD, the act of returning to the same unchanged environment after being discharged from formal treatment is sometimes enough for the service user to experience cravings that can lead to a relapse. Cravings are defined as persistent thoughts and urges to indulge in the effects of AOD, with which service users often justify the idea of using for the first time after formal treatment as 'one last time'. Therefore, ongoing cravings may jeopardize the person's commitment to maintaining abstinence, as the desire for immediate gratification is overpowering. A condition often related to drug cravings in humans is their cognitive awareness of the availability of their drug of choice once they have been discharged from formal treatment. As emphasized by Wadhwa (2009) it is necessary for recovering service users to identify specific coping mechanisms for different thoughts, feelings, moods and situations.

2.4.1.2 Genetic predispositions

Research on the genetic heritability of substance dependency has been a controversial viewpoint for the fact that it isolates the concept as a single influence for substance dependency

relapses. Each recovering service user has a unique set of genetic make-up that was inherited from their biological parents. Therefore, research has been conducted by various theorists into whether this genetic make-up can predispose an individual to substance dependency. The research has suggested that genetics may determine the metabolic processes involving differential effects of alcohol and/ or other drugs (AOD) (Fisher & Harrison, 2013). In other words, an individual can be genetically predisposed to the possible process of moving from initial use of AOD to complete substance dependency. Studies conducted by Lovallo, Yechiam, Sorocco, Vincent & Collins (2006) have shown that “individuals with a family history of alcoholism are 4.5 times greater at risk of developing alcoholism in correspondence with the general population”. Additionally, twin and adoption studies have credibly verified that “genes contribute to the development of substance dependency, with heritability estimates ranging from 50 to 60% for both men and women” (Agrawal & Lynskey, 2008).

Routledge (2005) emphasised that there is a lot of research that focuses on the role that an individual’s genetics play in the development of substance dependency, but most studies confirm that genetics mostly influence how individuals experience substance dependency physiologically. Therefore, the genetic components do not mean substance dependency is inevitable, but rather that it remains a choice. This allows the recovering service users to take responsibility for their sobriety instead of blaming their family genetics. Routledge states that “[t]he strongest biological factor that leads to the development of an addiction is the physiological response the body has to substances” (2005). Therefore, genetic predisposition is a challenge for recovering service users because their genetic make-up took precedence in their movement from initial use to complete dependence.

2.4.2 Psychological challenges

The psychological component for individuals that are dependent on AOD refers to their psychological desire or urge to consume these substances in order to experience immediate feelings of pleasure or to avoid feelings of discomfort. Psychological challenges experienced after a recovering service user is discharged from formal treatment is best understood from the cognitive-behavioural orientation that emphasises “the notion that human thoughts and behaviour is driven by the conditioning and reinforcement that recovering service users experience throughout their lives” (Wallace, 2005). It is evident that addicted individuals have been conditioned and reinforced by the pleasurable effects of AOD. These dysfunctional thoughts and behaviours associated with substance dependency is the outcome of inaccurate

and unhealthy life schemas in terms of how they have associated themselves in relation to the external world. Therefore, recovering service users experience numerous psychological challenges after being discharged from formal treatment because their previous life schemas need to be altered in order to adapt to their new sobriety lifestyle. The following psychological challenges put the service user at risk of relapsing:

2.4.2.1 *Coping with emotions*

According to Bain (2004), his research indicated that the primary reason for relapsing among recovering service users is their inability to deal with their emotions and feelings. As depicted by Donovan and Marlatt's (2005) findings, negative emotions, social pressures and interpersonal conflict accounted for 72% of all the relapses. One of the effects of consuming AOD is its ability to suppress emotions because of its mood-altering qualities (psychoactive). It is often used in an attempt to escape dealing with raw emotions caused by traumatic events. However, AOD has the inability to 'numb' years of pain and trauma, and therefore once the individual is sober, they have to learn to deal with emotions that have been suppressed for numerous years. This is a challenge for many recovering service users, because they have never learnt how to cope with these emotions independently as they always depended on AOD to alter their state of mind (Nutt, 2012).

Additionally, during active addiction, individuals have made their drug of choice their main priority. In other words, the majority of these individuals have done things that they would not have done if they were in a sober state of mind, such as manipulate, lie, steal or subject themselves to prostitution in order to get money to feed their addiction. This leaves recovering individuals with feelings of regret, shame and guilt. In turn, this adds to their psychological distress once reintegrating into their unchanged environment that has continuous psychological reminders of past actions and limited access to emotional support that could help relieve these feelings (McDonagh & Reddy, 2015). This lack of emotional support is associated with feelings of loneliness, which is defined as being without "friendship or companionship" (Bain, 2004). Recovering service users are advised within formal treatment to discontinue relationships with people that are still in active addiction, which leaves the service user feeling lonely and bored during aftercare and reintegration services because the relationship they had with their drug of choice and with certain social groups have been removed from their lives. The recovering service user will then experience the negative emotional consequences due to this lack of having meaningful relationships. Therefore, if service users are not taught how to deal with emotions

properly during aftercare and reintegration the chances of them relapsing increases tremendously.

2.4.2.2 Stress management

A stressor can be defined as an event that precedes the recognition of stress, and it occurs in an individual's environment, threatening his/her state of stability and security (Swartz *et al.*, 2011). Once a stressor is being experienced due to a life event (unemployment, death, poverty), it requires a person to respond so that he/she can avoid negative stress reaction symptoms, which necessitates that he/she either adjust or adapt to the stressful situation. This process is called stress management, which the majority of recovering services users have limited abilities and skills to deal with. Stress management is a psychological challenge for recovering service users after they have received formal treatment, because they have not learnt and practised stress-coping mechanisms. A coping mechanism can be any behavioural, psychological or social action taken in response to identified stressor. If formal treatment has equipped the service user with coping skills it is often practised within the controlled environment of the treatment facility. However, once the service user is discharged, he/she is exposed to a variety of uncontrolled stressors without the comfort of a secure and controlled environment that is created by formal treatment. Therefore, aftercare services are meant to enhance recovering service users' self-efficiency in order for them to believe in their abilities to carry out the coping skills they were initially taught in formal treatment.

According to Steven (2015), there are various factors that can increase or decrease the effects of stress, such as the concept of a mediator which acts as a 'buffer' that protects a person from the unpleasant outcomes that is produced by stress. However, during active addiction, a 'buffer' would be associated with the consumption of AOD in order to cope or numb feelings of stress. Stress management is a psychological challenge for recovering service users because they lack coping skills which predispose them to the possibility of relapsing during aftercare and reintegration services (Proctor & Herschman, 2014). Therefore, aftercare services are required to enhance recovering service users' protective factors, such as coping skills in order to overcome challenges that cause relapses.

2.4.2.3 Dual diagnosis/Co-occurring disorders (COD)

The terms ‘dual diagnosis’ and ‘co-occurring disorders’ refer to a co-occurrence of substance use disorders (SUD) and other psychiatric disorders as defined in Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM–V) (APA, 2013). In other words, it is the combination of at least one substance dependent disorder and at least one independent mental disorder. According to the National Institute on Drug Abuse (NIDA, 2007), individuals with any substance use disorder (SUD) are 2.8 times more likely than individuals without SUD to be diagnosed with any mood disorder (anxiety, depression, etc.). Additional statistics that were conducted by the South African Community Epidemiology Network on Drug Use (SACENDU, 2018) stipulated that 14% of people in South Africa presented with a dual diagnosis at formal treatment admission. People that have a substance use disorder (SUD) are often misdiagnosed or have their mental health neglected because of them ‘self-medicating’ with AOD. It is often exceedingly difficult for health professionals to dual diagnose a person with SUD, since it requires assessment of an individual’s cognitive functioning while they are intoxicated the majority of the time. This makes it impossible to differentiate between substance-induced psychosis and that of an existing psychiatric disorder.

Ultimately, if service users are not properly diagnosed for existing psychiatric disorders during formal treatment, they are discharged without any diagnosis or medication, which in turn increases their vulnerability to relapsing during aftercare and reintegration services. Pasche and Myers (2012) emphasised that the first phase in addressing the shortfalls of dual-diagnosis treatment in South Africa is to determine the incidence rate of co-occurring disorders as well as treatments needs, so that an aftercare maintenance plan can be developed. This reality is an evident challenge recovering service users often encounter whilst reintegrating into their unchanged environments.

2.4.3 Social challenges

The social environment that recovering services users are subjected to after being discharged from formal treatment signifies all the conditions, circumstances and influences that impact the development and behaviour of the individual as adaptive systems. Social challenges during aftercare and reintegration services predispose the recovering service user to the possibility of experiencing a relapse. These social challenges can include values and behaviours of friends, family members, role models and colleagues that affect the learning experiences of individuals.

Sigelman and Rider (2006) define adaptation as the process of an individual adjusting to the demands that exist in any given environment. Therefore, recovering service users overcoming social challenges depends on their ability to adapt to their unchanged environments, which is the role of aftercare and reintegration level of service delivery.

2.4.3.1 Employment and educational status

The consequences of substance dependency are virtually infinite due to continuous unemployment rates, which have increased from 27.1% in the fourth quarter of 2018 to 27.6% in first quarter of 2019 (Statistics South Africa, 2019), while poverty rates have grown to 55.5% (Statistics South Africa, 2018). Keeping these statistics in mind, it is evident that the majority of the percentile consists of people with substance dependency problems. During active addiction, which is prior to the individuals receiving formal treatment, they are often engaged in criminal careers such as gang membership, theft and distributing illegal substances. Therefore, the majority of recovering service users enter aftercare services with a criminal record and no legitimate employment history, which makes them vulnerable to falling back to old habits and eventually relapsing.

According to Nutt (2012), vocational responsibilities provides a major structural factor in the establishment of an individual's routine in terms of activities, challenges, accomplishments and social networking of daily life. With reference to the South African Community Epidemiology Network on Drug Use (SACENDU, 2018), the youngest onset age for substance dependency ranges between the ages of 10 to 19 years old, which has increased by 29% in 2017. The consequence of this is that the majority of recovering service users have dropped out of school due to the preoccupation with AOD from an early age. Therefore, the recovering service user population, not only consists of people with no employment history and criminal records, but also of people that have failed to complete their secondary education. This reality is problematic for recovering service users, because there is little opportunity available for employment, and access to resources to complete secondary and tertiary education are limited. This challenge is one of the leading reasons that recovering service users lack motivation and commitment to maintain sobriety.

2.4.3.2 *Socio-economic status*

The majority of people receiving formal treatment for substance dependency originate from disadvantaged socioeconomic backgrounds, which is a risk factor for relapsing. According to Sun, “[t]hese factors can be subdivided into personal dimensions which include financial and physical stressors, and can be subdivided into social dimensions which include family and the surrounding community” (2009). People that grow up in low-income communities are four times more likely to abuse substances than those that grow up in high-income families. With reference to this statement, families and socio-economic circumstances play a major role in substance dependency relapses among service users, especially for those raised in difficult conditions such as unemployment, domestic violence, health problems and poverty. These social challenges are internalised as stressors on an individual’s life, which can onset and continue substance dependency if not dealt with in formal treatment and continued throughout aftercare.

Low socio-economic status is a social challenge, because during formal treatment, which is habitually situated in an urban regions, service users are subjected to high-class surroundings in terms of equipment and ways of living (3 meals a day, functioning sanitation systems, security, health care and etc). Social workers providing aftercare services should be sensitive to the cultural and socio-economic differences among service users, as some of them might come from backgrounds where financial stress (poverty) is experienced (McCann, Burnhams, Albertyn & Bhoola, 2011). However, usually during formal treatment, these service users are not treated according to these differences, which fails to equip them for the reality of being discharged back into their unchanged rural environment.

2.4.3.3 *Availability and accessibility to alcohol and/or other drugs (AOD)*

This social challenge links with the abovementioned headings, but because of its enormous role in contributing to reoccurring relapses, it is appropriate that it is discussed in more depth under its own heading. AOD within South Africa has grown substantially in recent years, with cannabis fore fronting the largest illicit drug intake of the substance dependency population. It is often followed by experimentation with mandrax (methaqualone), which is the second largest drug intake. South Africa is the largest abuser of mandrax in the world. In fact, SACENDU states that “[t]he street value for most illicit drugs in terms of cannabis, mandrax, tik and heroin is approximately ranging between R15,00 and R50,00” (2018). Furthermore, alcohol

dependency in South Africa is one of the largest in the world because of its deep roots in the country's Apartheid history in terms of the 'dop' system, where farm workers in the Cape received part of their wages in cheap wine. This initiated a dangerous relationship between South Africans and alcohol, which consequently lead to further socioeconomic issues such as poverty and lack of education.

The availability of drugs in a service user's environment includes ease of distribution and accessibility. This refers to the recovering service user's knowledge regarding where the drug supplies are being offered in terms of the established 'business' structure that has little resistance to transporting in and out that given community (Fisher & Harrison, 2013). The high presence of gang groups within South Africa immediately contributes to high volumes of drug availability and distribution because of it being their main source of 'business' and 'income.' The fact that every street corner could be a 'drug house' where substances are readily available has made the attempt of abstinence for recovering service users much more challenging during aftercare and reintegration services.

2.4.3.4 Support systems

Continuing care that was initially provided in formal treatment is carried onto the social delivery level of reintegration and aftercare service, which has the main purpose of maintaining sobriety and preventing relapses. Existing research has highlighted that recovering service users' attendance to aftercare services for social support decreases their relapse potential (McDonagh & Reddy, 2015). Lewis, Dana and Blevins (2011) place emphasis on social support being provided by social network members or health care professionals, stating that this has beneficial emotional or behavioural effects on service users' abstinence from AOD. There are three primary types of support during aftercare and reintegration services, namely: "informational support (advice and guidance by professionals such as social workers, doctors and psychologists), emotional support (including reassurance and encouragement), and concrete support (physical help and assistance to access available resources)" (Sarason & Sarason, 2009). The purpose of social support services is to create the perception and actuality that one is cared for and has the necessary support to ensure relapse prevention.

As support systems do not only imply support from family members, it should be considered the responsibility of the recovering service user to engage in formal support systems, which for the purpose of this study is aftercare and reintegration services. However, research conducted

by McKay (2011) indicates that the largest barrier to aftercare services is transportation, which is a fundamental problem for recovering service users. South African transportation systems have continued to fail the vulnerable populations of the country because they are unsafe and unreliable. This reality leaves many recovering service users limited in terms of accessibility to available aftercare resources, which is therefore an existing challenge for service users after being discharged from formal treatment.

2.4.3.5 Family conflict

The formulation of initial relationships is developed with biological parents or caregivers. When parents or caregivers support and nurture their children, they provide a sense of security, trust, and belonging within their own lives. Goldenberg and Goldenberg state that “[t]hese initial relationships help individuals develop interpersonal skills and provide experiences that assist them in fine-tuning their emotions and feelings” (2000). During adulthood, these individuals will be more likely to trust other people and feel secure that they will not be abandoned or rejected. Therefore, they are more likely to form positive relationship bonds throughout their lifespan.

On the other hand, children who do not experience a secure, healthy relationship in early childhood may become avoidant, resilient, or ambivalent toward their parents/caregivers. These individuals are more likely to become rebellious, which is often expressed through experimenting and becoming dependent on AOD. This may cause future resentment during service user’s recovery because of unresolved conflict with caregivers. Further, during active addiction, service users have often caused a lot of destruction within their family systems due to the consequences of their substance induced actions by engaging in theft, violence and gang affiliation (McDonagh & Reddy, 2015).

In light of this, the consequences of AOD do not only affect the individual, but also his/her family members. Nonetheless, in the majority of formal treatment facilities within South Africa, the involvement of families in the rehabilitation programme is limited. This means that the service user may have the opportunity to resolve psychological trauma, but the family does not (Donovan & Marlatt, 2005). For this reason, family conflict is a social challenge that exists for service users after receiving formal treatment, because they are reintegrated back into the same unchanged family system that includes unresolved shame, guilt and trust issues. These issues are predictors for relapses during aftercare and reintegration services.

2.4.3.6 *Interpersonal relationships*

An individual's psychological health and physical well-being depends heavily on his/her ability to form interpersonal relationships which can consist of platonic, intimate or social relations. The process of forming interpersonal relationships begins within families, moves to the formation of friendships, and may eventually lead to romantic and intimate relationships. During aftercare, the recovering addict often has a lack of sober friends and has difficulty forming new meaningful relationships. This negatively impacts his/her self-confidence, which leads to low self-esteem. The constant need for peer acceptance can lead to harmful choices, as the service user will conform to the values and norms of the group that accepts him/her (Louw & Louw, 2007).

Traditionally, an intimate relationship is between two people that are committed to one another and engage in sexual courtship. Healthy relationships can be beneficial to an individual's development in terms of improving communication, compromising and empathy skills. These relationships provide a valuable source of support for when a partner experiences difficult or stressful times in the duration of their relationship (Goldenberg & Goldenberg, 2000). On the other hand, unhealthy relationship can consist of emotional, financial, physical and mental abuse that impacts the well-being of an individual. An unhealthy relationship is often found in couples where at least one or both partners are engaging in alcohol and/or other drug (AOD) abuse.

Rassool (2011) mentions that romantic or intimate relationships that are involved in substance dependency are more likely to practice unsafe sex, which can lead to them contracting HIV/AIDS and/or other sexually transmitted diseases, as well as unwanted pregnancies. According to Myers, Carney and Wechsberg (2016), "a major influence of HIV risk is alcohol and other drug (AOD) use which is pressing public health concern with particularly the use of alcohol, cannabis, and methamphetamine (tik) in Cape Town, South Africa." Additionally, it is evident that substance dependent individuals are often found in co-dependent relationships, which is a behavioural condition in a relationship where one person enables another person's addiction and irresponsibility. Therefore, individuals that enter formal treatment are often engaged in such relationships, and these are still present during service users' aftercare services.

These intimate relationships are a significant social challenge for service users during aftercare services because of the unhealthy characteristics that are attached to it. Therefore, aftercare

services have to address and consider the impact of co-dependent relationships on the service user's sobriety in order to prevent relapses.

2.4.4 Cultural challenges

Culture plays a central role in forming the expectations of individuals about potential challenges that predispose them to risk factors that cause relapses. In recent years, culture has been characterised into its own domain, which is a factor that is especially evident in South Africa because of social stigmas and stereotypes that are attached to substance dependency. This is evident with South Africa having a population of approximately 57.7 million which consist of 11 official languages (Statistics South Africa, 2018). Additionally, South Africa is still overcoming the consequences of Apartheid, which occurred between 1948-1991 and entailed racial segregation that subjected all non-white people to discrimination and inequality. The non-white population is still experiencing the impact of Apartheid because of injustice and lack of resource accessibility in rural areas that was caused by racial segregation. This has left the majority of non-white communities with limited access to health care and education, which is a huge predictor to substance dependency relapses.

Within the South African context, support groups are predominately found in urban areas, making it difficult for people that live in rural areas to have appropriate and safe access to such services. Additionally, the reality of various social classes existing within South Africa plays a significant role in the formation of a support group that will benefit all scopes of the population in terms of various education, intelligence and circumstance levels (McCann *et al.*, 2011). Thus, there is a lack of support groups in rural areas of South Africa, which leaves vulnerable populations with numerous challenges that put them at risk of relapsing after receiving formal treatment for substance dependency.

2.4.4.1 Stigmatisation

Stigmatisation is a cultural challenge because it adversely affects the sobriety of recovering service users because of community members being discriminatory towards them. It can be defined as the exclusion of individuals with alcohol and/or other drug use (AOD) history from social acceptance and subjecting them to marginalisation and alienation because of the societal negative attitudes and perceptions attached to substance dependency (Routledge, 2005). This is problematic for recovering service users, because stigmatisation acts as a barrier to effective

aftercare and reintegration services. Many families of recovering service users feel ashamed about their offspring's addiction problems and want to keep it undisclosed from the rest of the community (Rassool, 2011). This often leads to families taking the recovery process into their own hands, which means that they fail to reach out for professional help, instead dealing with it internally. The fear of being ostracised from community members, as well as stigmas attached to substance dependency, have paralysed recovering service users and their families from engaging in aftercare and reintegration services, therefore, making stigmatisation a predictor to reoccurring relapses.

2.4.4.2 *Ethnicity and cultural diversity*

Norms, values, and health beliefs differ across cultures and can affect substance dependency aftercare services. For example, "some cultural groups may consider treatment invasive; others may wish to involve the extended family" (Ramaglan, Peltzer & Matseke, 2010). Treatment services need to be culturally sensitive and use the preferred language of service users and their families. However, this has been an ongoing struggle within South Africa because of the difficult task of accommodating for 11 official languages. During Apartheid, substance dependency treatment programmes were only readily available for the white population, and were based on Western health care practices. Therefore, the majority of treatment facilities were situated within the urban areas. Although South Africa is celebrating 25 years of democracy in 2019, the consequences of Apartheid have directly left the majority of rural areas with limited access to substance dependency treatment programmes as well as treatment programmes that are culturally sensitive. Therefore, cultural diversity is a reality of South Africa that can be a protective factor or risk factor for relapses during aftercare and reintegration services.

2.5 CONCLUSION

This chapter has explored the complexity of substance dependency in terms of the prevalence rates and its detrimental consequences. With these harsh statistics and realities in mind, it has raised questions as to why the frequency of reoccurring relapses is still increasing. This chapter therefore addressed and analysed the possible underlying factors that make individuals vulnerable to relapses by making reference to the Biopsychosocial (BPS) model. This point of departure has provided an in-depth exploration into the various challenges that surround and exist for recovering service users after being discharged from substance dependency formal treatment that can account for such high relapse rates. The BPS model demonstrates the

interconnectedness of challenges for recovering addicts, which brings the derivation of reoccurring relapses full cycle.

The BPS model has emphasised that individual behaviour such as substance dependency relapses depends on the service users' ability to adapt to these challenges. This will be emphasised in the following chapter, where the necessity of aftercare and reintegration services to enhance service users' protective factors in order for them to adapt to the Biopsychosocial challenges that put them at risk of relapsing will be addressed.

This chapter has therefore made it evident that there are numerous amounts of existing Biopsychosocial challenges for service users after they have been discharged from formal treatment. However, there is lack of research indicating the extent to which available literature and legislative frameworks hinders or fosters risk or protective factors for reoccurring relapses. Thus, the following chapter will explore the available literature and legislative frameworks that exist for substance dependency aftercare and reintegration services.

CHAPTER 3

THE CURRENT FRAMEWORK AND AGENDA DEVELOPED FOR SUBSTANCE DEPENDENCY AFTERCARE AND REINTEGRATION SERVICES

3.1 INTRODUCTION

The previous chapter provided insight on the complexities of substance dependency recovery so that a Biopsychosocial backdrop surrounding the topic could be created. There is a reoccurring assumption and ideology that substance dependency can be cured by means of a once off treatment procedure in the form of a rehabilitation program, and once discharged the service user is cured. However, this is unfortunately not the reality, as “recovery from addiction which is a chronic and relapse-prone disorder, is a lifelong dynamic process” (NIDA, 2016).

Therefore, this chapter will provide an overview of current substance dependency legislation and literature that was developed in response to the challenges that were identified in the previous chapter in an attempt to prevent reoccurring relapses. It specifically focuses on the new democratic South Africa, twenty-five years after the period of segregated services. With a fast-growing population and increasing availability of illegal substances, the Department of Social Development (DSD) attempted to develop a clear policy framework that prioritises service provisions for substance dependency. This included a National Drug Master Plan (NDMP, 2006-2011; 2013-2017) and the Prevention of and Treatment for Substance Abuse Act 70 of 2008. This chapter will therefore elaborate on the established substance dependency literature, policy and legislation.

Furthermore, substance dependency and reoccurring relapses have a negative impact on the achievement of social development goals and puts tremendous pressure on service delivery in developing countries such as South Africa (Cami & Farre, 2003). Reoccurring relapse is defined by Steven (2015) as the misuse of AOD after a period of abstinence, which undermines the country’s effort in addressing substance dependency. Current research emphasises that biology, psychology, culture and social challenges all contribute to substance dependency relapses in adults. However, there is little research on elaborating such factors from a service user point of view. Therefore, this chapter will discuss legislative and literature frameworks that were developed to provide guidelines for the implementation of substance dependency aftercare and

reintegration services in terms of definitions, models and approaches with the overall aim of preventing relapses.

3.2 DEFINITION OF SLIP AND RELAPSE

A slip is an episode of alcohol and/or other drug (AOD) use following a period of long-term abstinence, which can occur without returning to regular use (McIntosh & McKeganey, 2001). Conversely, a relapse is resuming or returning to uncontrolled use of AOD after a period of sobriety. As emphasised by the United Nations Office on Drugs and Crime (UNODC, 2018), there is no one cause for substance dependency relapse, but rather “a combined net of challenges that individuals are often exposed to after receiving formal treatment that are defined as predictors for relapse.” Lewis et al. (2011) further correlated with the UNODC’s findings by indicating through their research that close to 90% of substance dependent individuals relapse 1 year after receiving formal treatment because of the transformation of coming from an isolated treatment programme to being immediately reintegrated into their community of origin with unchanged challenges. Therefore, it is the responsibility of aftercare and reintegration services to be proactive and to take these existing challenges into consideration once or if a service user has experienced a slip, in order to prevent a complete relapse.

3.2.1 Three stages of relapse

According to Gorski and Miller (1984), there are warning signs to consider for an individual that could be at-risk of experiencing a slip or relapse. Relapse does not happen because of a single event, but rather follows an enmeshed process that can occur over a couple of weeks or over several months before the physical relapse of AOD use. In Melemis’ (2015) journal of relapse prevention and the five rules of recovery, Gorski and Miller’s (1984) established warning signs are represented in three stages. The first of these is the emotional stage, which is then proceeded by the mental stage, and shortly after, the physical relapse stage. These stages are essential in relapse prevention plans, because they relate to various stages that are often experienced in recovery as a result of being subjected to challenges during aftercare and reintegration services.

3.2.1.1 Emotional stage

In the emotional stage, the recovering service user is not thinking about using AOD, but is emotionally vulnerable. Further, old behaviours and patterns are returning, increasing the possibility of relapsing (Black, 2000). The warning signs during this stage can include any of the following: anger, impatience, not asking for support, decadent sleeping and eating habits, poor support group attendance as well as mood swings. Relapse prevention at the emotional stage would require the recovering addict to recognise that he/she is experiencing emotional warning signs and needs to proactively change his/her behaviour towards accepting help and support from others. The aim of aftercare and reintegration services is to be readily available and accessible to recovering addicts during this stage, as they would need to be vulnerable in a non-judgemental environment. However, if the warning signs in the emotional stage are ignored, the mental stage of relapse will proceed.

3.2.1.2 Mental stage

In the mental stage, the recovering service user is experiencing inner conflict about thinking of using AOD) and about not giving in to temptations. The individual is thinking about the benefits and consequence of using AOD in the hope of finding a solution that will allow him/her to give in to temptations. The most common thought experienced by service users is, “I can use AOD for one last time” (Melemis, 2015). The warning signs during the mental stage can include all or some of the following: fantasizing about people, places and things associated with AOD, lying or manipulating, planning your relapse around other people’s schedules, as well as socialising with old AOD using peers.

The relapse prevention plan during the mental stage would be for the service user to attend maximum amount of support groups during the week and to inform others about his/her current situation. The aim of aftercare services during this stage would be to ensure that support groups and individual counselling sessions are available for individuals and their families, so that coping skills/mechanisms can be taught and practised within a safe environment (Black, 2000).

3.2.1.3 Physical stage

Finally, if the preceding warning signs in both the emotional and mental stages are not addressed in aftercare and reintegration services, the recovering service user will progress from being in the mental stage to experiencing the physical stage of relapse, which is the return to

AOD use. Part of relapse prevention during aftercare services is rehearsing and practising these situations of opportunity to engage in AOD and then to develop healthy exit strategies (Melemis, 2015).

3.3 AFTERCARE AND REINTEGRATION SERVICES

Aftercare and reintegration services refer to the ongoing professional support of a service user after he/she has received formal treatment. Further, these services aim to enable the service user to maintain his/her sobriety and personal growth, and to enhance his/her self-reliance so that optimal social functioning can be achieved (Swartz *et al.*, 2011). In other words, aftercare and reintegration services are described as continuing the services that were initially provided in formal treatment. However, these aftercare services will not be provided within a drug-free safe, secure and controlled environment. Instead, these services are provided within the service user's immediate environment, which the majority of the time is a rural settlement. As mentioned before, a significant number of service users relapse after formal treatment. Hence, aftercare services are essential for rehabilitated service users, so that their protective factors can be enhanced in order for them to adapt to their environmental challenges that foster numerous amounts of risk factors for relapsing. The following purposes of aftercare services have the overall aim of successfully reintegrating the service user back into his/her community, family and work life.

3.4 PURPOSE OF AFTERCARE AND REINTEGRATION SERVICES

Aftercare and reintegration services are defined and designed to carry out the assumption that substance dependency rehabilitation does not end after a service user has received formal treatment, but, rather that formal treatment is seen as the initial part of long-term recovery. The aftercare and reintegration part of the Integrated Service Delivery Model has the main aim of ensuring that service users achieve optimal social functioning and obtain self-efficiency after they have received formal treatment, so that they can successfully reintegrate into their community, work life and family life (Department of Social Development, 2006). Within formal treatment, the service user receives professional strategies and counselling for sobriety in terms of working through detox, personal trauma, conflict, grievances and forgiveness. However, during formal treatment a lot of focus is put on only the recovering service user, while those affected by his/her past actions such as family members, work colleagues or concerned friends are left neglected. According to McDonagh and Reddy (2015), the

involvement of family in relapse prevention is crucial because of the emotional, mental and physical support they offer the recovering service user, which enhances his/her prevalence of long-term sobriety. On that note, aftercare and reintegration services are put in place to ensure that this support is available for the service users and their families after formal treatment, in order that they may successfully reintegrate into their social systems and relapses can be prevented. Therefore, the following headings mention some of the tasks of aftercare and reintegration services in terms of lifestyle changes that are necessary for relapse prevention.

3.4.1 Family support

Families of recovering addicts have also suffered the consequences of substance dependency in terms of emotional, physical, financial and mental burdens. In the 21st century, family systems have broken away from the traditional set ups and have become characterised by other labels such as step families, single parent families, foster families and multigenerational families. It has been conceptualised that a person with substance dependency problems has a primary relationship with his/her drug of choice, therefore impacting his/her other relationships dramatically. According to Goldenberg and Goldenberg (2000), problematic human behaviour such as substance dependency is part of complex, interactional and reoccurring patterns that take place within the family, which emphasises that problem behaviour is not the result of personal characteristics, but of interactions within social systems. As a result, communication in these families are often characterised by criticism, guilt, blame and nagging, in which they often feel powerless and project these problems onto outside entities such as neighbours or church groups (Laudet, 2011). Therefore, changes in the recovering addict's family lifestyle need to be made during aftercare and reintegration services. That is why aftercare and reintegration services have beneficial aspects in terms of relapse prevention, because this level of service delivery aims to address family dynamics by continuing family counselling after the service user has been discharged from formal treatment. Although there is a lack of statistics and data about how and to whom these services of family counselling are rendered within South Africa, it still represents the potential benefits of aftercare and reintegration services.

3.4.2 Safe environment and leisure time

Once the recovering addict has received formal treatment, he/she is discharged into an unchanged community that may either threaten or encourage his/her sobriety. During formal treatment, the substance dependent service user is safeguarded within a drug-free environment.

However, once he/she is eventually discharged from the programme, which is usually after 28 days, the recovering addict is reintegrated into his/her unchanged community that is surrounded by triggers in terms of merchants, unresolved conflicts, financial and family burdens (Fisher & Harrison, 2013). Therefore, the benefit of aftercare and reintegration services is that it offers a 'safety net' that catches the recovering addict after he/she has been discharged from formal treatment in order to alleviate boredom and dysfunctional circumstances so that reintegration is more reassuring and comforting. This is achieved through support group attendance, whereby the service user has access to positive social networks that can help relieve feelings of boredom and loneliness.

3.4.3 Self-care and self-love

In terms of aftercare and reintegration services, creating a safe and non-judgemental environment is restrictive due to dysfunctional challenges such as poverty, gang affiliations, merchants, stigmas etc. However, this level of service delivery provides the former substance dependent the necessary ongoing coping strategies to build up and maintain his/her self-efficiency, which involves the positive belief the service user has about his/her ability to resist the surrounding temptations (Fisher & Harrison, 2013). A significant number of substance dependents have low self-esteem and lack confidence in their abilities to remain sober in the face of their immediate triggers. Self-care and self-love is a relapse issue because people tend to reject the recovering addict due to past actions, appearance and hygiene, which can cause negative emotional states. Therefore, the benefit of aftercare and reintegration services is that it offers realistic advice on nutrition, recreational activities and hygiene. This benefit works in accordance with the aim of aftercare and relapse prevention being to encourage the service user to achieve self-reliance and optimal social functioning.

3.4.4 Educational and vocational guidance

There is a significant correlation between poor academic performance and alcohol and/or other drug abuse (AOD). Low education accomplishment is reported by the majority of people with substance dependency within a rehabilitation programme (Sun, 2009). Lack of education has resulted in former substance dependents with poor academic skills, exposure to violence, the inability to secure employment and daily experiences of discrimination in the vocational setting. This reality has to be addressed in aftercare and reintegration services to ensure that the service user achieves optimal social functioning. The benefit of this service delivery level is that it has

the ability to network and refer service users to relative adult learning centres for them to complete their secondary education, as well as to relative tertiary education institutes. This is a benefit because education is the gateway that empowers individuals to achieve optimal social functioning and self-reliance. However, there is little empirical evidence in South Africa to support the implementation of this potential aftercare benefit.

3.4.5 Addressing the issue of cravings

Aftercare and reintegration services are planned services that help recovering service users to adapt to everyday community life. Cravings are intense longings to abuse AOD, which can happen unexpectedly or in a response to thinking, relating, sensory or acting triggers (Mittal, 2005). These cravings can lead to self-defeating thoughts, which ultimately lead to relapses. Therefore, aftercare and reintegration services are beneficial towards the service user when dealing with cravings, because these services equip the service user to anticipate situations within his/her immediate environment that may lead to a relapse. For example, the former addict may have his/her previous merchant living in the opposite street. Therefore, during aftercare services, the service user will be reminded to avoid walking down that street and to take an alternative route (changing habits).

3.5 AFTERCARE AND REINTEGRATION SUPPORT GROUPS

According to Gorski and Miller (1984), individuals that have been discharged from formal treatment are considered to be ‘relapse prone,’ and therefore cannot recover alone or in isolation. Aftercare services “refers to ongoing support to addicted persons and their families following formal treatment in order to increase their recovery potential and thereby limiting the need for re-admission to treatment facilities” (Ramaglan *et al.*, 2010). The involvement of family is seen as critical part of social support because of the fundamental biological, spiritual, emotional and physical ties they have with the recovering service user (McDonagh & Reddy, 2015). The involvement of family is not only catered in the interest of the service user, but also for the family needs, because support groups provide them with an opportunity for healing from the emotional pain caused by the substance dependent past behaviour. The main purpose of support groups is to provide a safe and non-judgemental environment for service users to feel supported when dealing with challenges that put them at-risk of relapsing. These challenges can be anything from the social level (communication problems, lack of education,

unemployment), emotional level (self-efficiency, self-awareness, forgiveness) or physical level (appearance, health) (Smith *et al.*, 2013).

Therefore, it is also essential that there are professional support structures in place to ensure relapse prevention, which is usually in the form of self-help support groups such as Narcotics Anonymous (NA) and Alcoholics Anonymous (AA). There are several studies that have demonstrated positive outcomes of service users continuing care with aftercare and reintegration services. These outcomes are increased abstinence rates (Addaction, 2004), less reoffending (Fox, 2000) and longer delays of relapsing (Mckay, 2011). The following aftercare and reintegration services have adapted substance dependency literature and legislation as guidelines in order to provide professional services that attempt to prevent relapse and readmissions into formal treatment.

3.5.1 Alcoholics Anonymous

The most documented aftercare services available are 12-step self-help groups, which include Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). These self-help groups are run by recovering addicts and are essentially meetings for people to share their concerns, stories and accomplishments in the hope that it motivates others. Alcoholics Anonymous was established in 1935, thereby making it the oldest and largest support group whereby up to 2 million members exist worldwide (Fiorentine & Hillhouse, 2000). This self-help group was founded by Bill Wilson and Dr. Bob Smith, and follows a traditional 12 steps to ensure long-term sobriety. AA's primary aim and purpose is to maintain sobriety and to help others do the same. There is a list of steps that the AA group must follow in order to ensure relapse prevention. These are:

1. Admitting powerlessness over drugs or alcohol
2. Believing a power greater than the individual restores sanity
3. Dedicating one's life to that higher power
4. Making a moral inventory
5. Admitting the nature of one's wrongs to oneself and the higher power
6. Becoming ready to have these wrongs removed
7. Asking the higher power to remove character flaws

8. Making a list of those harmed by addiction and become willing to make amends
9. Making direct amends whenever possible, but not hurting people in an attempt to make amends
10. Continuing the personal moral inventory process
11. Praying for knowledge of the higher power's will
12. Carrying healing to others in need, such as by becoming a sponsor

3.5.2 Narcotics Anonymous

Narcotics Anonymous grew out of AA and was founded in mid-1940s by Jimmy Kinnon with similar principles and steps, although the focus term 'alcoholics' was replaced with the focus point of 'narcotics' (Fiorentine & Hillhouse, 2000). The aim of the twelve-step model is "to provide a change of lifestyle, focused on abstinence and the helping of others with alcohol or drug related problems" (Wilson, 2015). Narcotics Anonymous is fundamentally made up of NA groups, which are members that have a substance abuse disorder (SUD) who meet weekly at the same time and place with the primary purpose of carrying out motivational messages to the service users. 12 step participants find a group of people who share similar concerns and problems in the hope that they can form supportive networks. According to McCann *et al.* "[g]roups are largely independent from one another and members of NA are encouraged to choose a home group to belong to, a group they attend regularly and where they will be missed if they are absent" (2011).

3.5.3 SMART Recovery

SMART Recovery stands for Self-Management and Recovery Training, which is an alternative option for mutual-help groups that was developed by physician Joseph Gerstein in 1992. There are two primary goals to this support group, the first being to help individuals gain independence away from addictive behaviour, and the second to teach service users how to enhance and maintain motivation to remain sober by coping with triggers, urges and behaviour (Bishop, 2002). These meetings are aimed at discussing primary goals, as well as activating and analysing events using a cognitive approach. However, although it has been introduced within South Africa, there is little empirical evidence on the success or existence of this mutual-help group throughout the country's communities.

3.6 RELEVANT MODELS FOR RELAPSE PREVENTION

According to a report by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), “aftercare” is a general term used to describe any ongoing or follow-up treatment for substance dependency that occurs after an initial formal rehabilitation to ensure relapse prevention. Regardless of the setting or methods used, the goals of substance dependency aftercare remain the same, and include maintaining recovery from substance dependency, preventing relapses from occurring and lastly to achieve a life filled with rewarding relationships and a sense of purpose.

A relapse in substance dependency recovery is the return to uncontrolled use of AOD after a period of abstinence (Fisher & Harrison, 2013). When a relapse occurs, the individual receives confirmation regarding the addictive nature of the AOD. There is no singular reason for relapses to occur, but rather many integrated factors that, when combined, make individuals vulnerable to relapsing on AOD (Leach & Kranzler, 2013). This is why the Biopsychosocial model has been utilised for this study, so that the various factors surrounding an individual’s existence can be identified.

Relapse prevention, which is the main purpose of aftercare and reintegration services, refers to resolving any ambivalence that may exist in the recovering service user’s sobriety. Methods to relapse prevention include coping skills training, cognitive behavioural therapy and lifestyle modification (Ramaglan *et al.*, 2010). Coping skills training involves teaching recovering service users in the capacity to cope with everyday life stressors. On the other hand, “cognitive behavioural treatment aims to assist the rehabilitated individual through goal orientated methods that focuses on the present instead of focusing on the past which entails aftercare services empowering them with healthy new habits” (Proctor & Herschman, 2014). Lastly, lifestyle alterations involve substituting old habits with activities that are designed to help an individual’s overall coping capabilities.

The literature framework to aftercare and reintegration services provides guidelines and contextualise the purpose of these services, which is to support service users after they have received formal treatment for substance dependency in order to address their circumstantial challenges so that relapses can be prevented. These guidelines are summarised in relative practice models, which according to Weyers (2001) provides a unique way of looking at the nature of a situation and the different ways to deal with the situation. This scholar refers to the

“practice model” as a “framework” that provides an outline of concepts in understanding a situation and then forming the foundation for services directed to create social change. Therefore, the following headings are models that are based on the main purpose of aftercare and reintegration services, which is relapse prevention.

3.6.1 The Stages of Change Model

The Stages of Change Model, which is also known as the Trans-theoretical Model, was developed by Prochaska and DiClemente in the late 1970's. This model was revised in the recent work of Sussman and Ames (2001), whereby the main stages of pre-contemplation, contemplation, preparation, action, maintenance and relapse are discussed. People with substance use disorder (SUD) go through the stages in a cyclical nature, in which they can enter, exist and stagnate between stages. This model offers a client-centred method of “enhancing intrinsic motivation to change by exploring and resolving ambivalence” (Fisher & Harrison, 2013). For this reason, it is the responsibility of aftercare and reintegration services to continue to achieve the progress that began in the action stage and maintain the service user's notion of long-term sobriety.

Sussman and Ames state that “[d]uring pre-contemplation stage, the service user is often unaware that they have a problem with AOD and are caught off guard when they find out that others are concerned about their substance dependency” (2001). At this stage, the service user may not experience any AOD consequences, and once he/she does, it eventually pushes him/her towards the contemplation stage. At the contemplation stage, the service user has acknowledged that others perceive a problem, which encourages him/her to either reject or consider the possibility of change. A person can stagnate at this stage for years or can backslide into the pre-contemplation stage. However, once the person is ready for change, he/she moves towards determination stage. At this stage, options and change strategies are formulated which may include short-term experiments of ‘slowing down’ AOD use so that the experience can be evaluated. According to Prochaska and DiClemente (in Sussman & Ames, 2001), the action stage is when the process of change begins with or without help in order to overcome addiction. This stage is normally carried out within formal treatment admissions, whereby early phases of discontinuing addiction is initiated.

Additionally, the aim of the maintenance stage is continuing to achieve the progress that commenced in the action stage. In other words, it is usually the role of aftercare services to

maintain the service user's intentions made in the determination stage, as well as the changes that resulted in the action stage. For the purpose of this research, the aim of aftercare services is to maintain the service user's behaviour changes (abstinence from AOD) that were initiated during formal treatment in order to prevent relapses. Lastly, "the relapse stage acknowledges that a recovering service user may experience a slip or a relapse before maintenance is completely achieved" (Sussman & Ames, 2001). The purpose of aftercare and reintegration services is to assist the service user during their relapse stage of recovery, so that ambivalence can be resolved. A recovering service user may cycle through stages of change several times before achieving complete abstinence of AOD.

3.6.2 The Cenaps Model

The Cenaps Model for relapse prevention was developed by Terence Gorski, and was derived from the Disease Model of Addiction. It builds on the philosophy that substance dependency leads to physical, psychological and social problems. Therefore, substance dependency is viewed as a Biopsychosocial disease. This model integrates the fundamental principles of Alcoholics Anonymous in order to meet the needs of relapse-prone service users (Gorski & Miller, 1984). It provides a six-step recovery process:

1. Recognition of the need to abstain from all alcohol and other drugs.
2. Separation from people, places and things that threaten recovery, and the development of a social support network.
3. Dealing with self-defeating behaviours that prevent the client from accepting and dealing with awareness of painful feelings and thoughts.
4. Learning how to deal with feelings and emotions responsibly without having to resort to alcohol and other drugs.
5. Managing to change substance dependency thinking patterns that create self-defeating and painful feelings.
6. Identifying and changing mistaken core beliefs about the self, others and the world that encourage irrational thinking.

According to this model, the relapse process begins at step 6 and works itself upwards. Therefore, this model provides guidelines for aftercare and reintegration services to follow in order to be proactive regarding signs of possible relapses.

Fisher and Harrison (2005) made further recommendations to the process of substance dependency recovery by including the following four phases within the 12 steps: The initial phase is the assessment and commitment to become involved in service delivery, whereas the second phase is the cognitive and behavioural change. This is followed by making amends and finally, by maintaining change. Support groups such as AA and NA provide valuable support for individuals going through similar situations and are organised by recovering addicts, which has raised many concerns regarding the authenticity, reliability and accuracy of the professional assistance that oversees the recovery and relapse prevention process.

Ultimately, the Cenaps Model of relapse prevention is developed to reduce the frequency, severity and duration of relapse periods by educating service users to identify and manage high risk situations that can cause relapse after receiving formal treatment.

3.6.3 The Cognitive-Social Learning Model

The Cognitive-Social Learning Model was developed by Marlatt (Donovan & Marlatt, 2005) for substance dependency aftercare and reintegration services. In comparison to the Cenaps Model, the Cognitive-Social Learning Model for relapse prevention does not require service users to complete primary goals of treatment beforehand. The specific focus of this model is on the prevention of relapses, thereby initiating behaviour change and maintaining sobriety behaviour. This is evident within support groups such as AA and NA, because these groups provide a safe environment for recovering service users to practice new positive and sober behaviours in order for behaviour change to take place through positive social reinforcement.

According to the Cognitive-Social Learning Model, relapse prevention services focus on the identification of risk factors that make the service users vulnerable to relapses, as well as the identification of protective factors, which are characteristics such as biological and social domains that provide protection for service users during vulnerable situations (Donovan & Marlatt, 2005). Risk factors are acknowledged as contributors to relapse, and aftercare services aim to identify and address these risks. This model focuses on both the determinants and consequences of substance dependency behaviours, whereby a significant amount of focus is put on the services users' ability to cope with high risk situations (Keegan & Moss, 2008). Lastly, the Cognitive-Social Learning Model for relapse prevention acknowledges a slip to be an episode of alcohol and/or other drug use (AOD) after a period of abstinence, while relapse

is the return to uncontrolled substance dependency. Consequently, this model views the slip as a learning opportunity, and aims to assist the service user to return and maintain sobriety.

3.6.4 The matrix model

This model was developed by the Matrix Institute on Addiction (2008) in order to address substance dependency through both formal treatment and aftercare services. This model combines aspects of both the relapse prevention models that were mentioned above. Research done by National Institute on Drug Abuse (NIDA, 2007) gave preference to the Matrix Model, because this model views relapses as learning opportunities. Further, it includes the cognitive-behavioural approach,” therefore making the Relapse Prevention Therapy (RPT) the foundation of this model (Matrix Institute on Addiction, 2008). According to the Matrix Institute on Addiction (2008), “[t]he matrix model puts emphasis on four stages of recovery which is: firstly, the withdrawal stage from harmful substances which lasts between 1 and 15 days; secondly, the honeymoon stage which is characterised by feelings of overconfidence and can last between 15 and 45 days; thirdly, the wall stage which involves problems of relapse, loss of motivation and isolation that can last between 45 and 120 days; lastly, the adjustment and resolution phase is characterised by problems such as feelings of guilt, anger, lack of goals which can last between 120 and 180 days.”

As depicted by the National Institute on Drug Abuse (NIDA, 2016), most people require at least 90 days of treatment to end their drug dependency. Longer treatment periods are correlated with better outcomes, which indicates that the duration of treatment may be more important than the type of treatment. According to Fisher and Harrison (2013) since the majority of formal treatment is 21 days the recovery service users are consequently integrated back into their community in the honeymoon stage which means they experience overconfidence in their sobriety or are in denial of their addiction problem. Therefore, substance dependent service users are discharged from controlled formal treatment and reintegrated into their community without having completed the full recovery process in terms of reaching the adjustment and resolution stage. This point of view places emphasis on the importance of aftercare services to be readily available to ‘catch’ these services users after they have been discharged from formal treatment to ensure that they have the necessary professional support so that relapses can be prevented.

Thus, the matrix model provides a realistic perspective on substance dependency and relapse prevention. However, the question remains whether this model is effectively being implemented and considered throughout aftercare and reintegration services in South Africa.

3.7 LEGISLATION AND POLICY FRAMEWORK FOR AFTERCARE AND REINTEGRATION SERVICES

Prior to 1994 in South Africa, substance dependency was less prevalent and existing treatment services were only accessible to predominantly white privileged communities due to the racial segregation caused by Apartheid (1948-1991). One of the consequences of Apartheid was leaving the majority of South Africa's rural communities with limited or no access to substance dependency services in terms of formal or informal treatment (Parry *et al.*, 2004). This resulted in growing numbers of substance dependency and a lack of treatment services to resolve this epidemic, as well as the associated amount of criminal activity, gangstersism, poverty, unemployment, child headed households and increased school dropout rates.

This segregation of services had caused a lack of collaboration on substance dependency-related issues at national, provisional and local levels, as well as between the Department of Social Development (DSD) and Department of Health (DOH), which resulted in inadequate and inaccessible services. During the post-Apartheid period, the new democratic government was pressured to address these issues by ensuring that the DSD developed a clear policy framework that prioritises service provisions for substance dependency. This included a National Drug Master Plan (NDMP, 2006-2011; 2013-2017) and the Prevention of and Treatment for Substance Abuse Act 70 of 2008 that also highlighted substance dependency as a major contributor to non-contagious diseases such as cancer, heart diseases, psychological disorders and premature death (DSD, 2013).

As mentioned above, relapses occur mostly after recovery service users are discharged from formal treatment, which according to the Integrated Service Delivery Model (ISDM, 2006) occurs during aftercare and reintegration services. Therefore, the following headings will discuss the legislation and policies that were developed to address substance dependency relapses during aftercare and reintegration services.

3.7.1 Prevention of and Treatment for Substance Abuse Act 70 of 2008

The establishment of this Act was a breakthrough for South Africa in terms of combating substance dependency in the country. Its aim is to provide mechanisms aimed at three categories, namely: “(a) demand reduction, which entails prevention and early intervention strategies in order to raise awareness as well as (b) harm reduction which involves holistic treatment of service users and their families, and mitigating the social, psychological and health impact of substance dependency and lastly, (c) supply reduction, which refers to efforts aimed at stopping the production and distribution of illicit substances and associated crimes” (Prevention and Treatment of Drug Abuse Act, 70 of 2008).

Based on the specific focus of this study being substance dependency aftercare and reintegration service, it is essential to comprehend section 30, chapter 7 of the Prevention and Treatment of Drug Dependency (Act, 70 of 2008). According to this section, “the minister must prescribe integrated aftercare and reintegration services aimed at the successful reintegration of a service user into society, the workforce and family and community life.” It clearly indicates that social welfare services have the statutory responsibility to provide aftercare and reintegration services that promote the rehabilitated discharged service user towards the achievement of housing, employment and education.

The aftercare services contemplated in subsection 30(1), chapter 7 of the Prevention and Treatment of Drug Dependency (Act 70 of 2008) must include several elements that can be summarised as the following. This subsection focuses on reintegration and aftercare services which “encourage service users to interact with other services users, their families and communities so that they can have the opportunity to share long term sobriety experiences in order to promote group cohesion which will enable services users to abstain from substance abuse” (Prevention and Treatment of Drug Abuse Act, 70 of 2008). Further, these services are based on structured programmes and must focus on successful reintegration of the service user into society, family and community life in order to prevent the recurrence of problems in the family environment of the service user that may contribute to continued substance dependency.

Additionally, according to subsection 30(2), chapter 7 of the Prevention and Treatment of Drug Dependency (Act 70 of 2008), the purpose of establishing support groups is to firstly “provide a safe and substance free group experience whereby service users can practice re-socialisation skills.” Further, it aims “to facilitate access for service users to persons in recovery or have

recovered from substance dependency who can serve as role models to service users who are in the beginning or middle stages of the recovery process.” Lastly, “it exists to encourage service users to expand their support systems with people that share similar challenges and circumstances”.

According to subsection 30(3) chapter 7 of the Prevention and Treatment of Drug Dependency (Act 70 of 2008), support groups may be established at the community level by a professional, non-governmental organisation or a group of service users or persons affected by substance dependency. This Act makes provision for the establishment of a Central Drug Authority (CDA) to provide an oversight function in the implementation of the Act in terms of strategies as well as plans. It is also responsible for the development of a National Drug Master Plan (NDMP, 2006-2011; 2013-2017; 2018-2022: not implemented yet) to develop a comprehensive approach to addressing the prevalence of substance dependency in South Africa.

Therefore, based on this legislation, it can be concluded that aftercare and reintegration services are defined as ongoing support during the recovery process to ensure relapses are prevented. However, the reality is still as mentioned before that 75% of service users relapse in a 3 to 6 month period after receiving formal treatment, regardless of what procedures or provisions are stipulated within this legislation (Adinoff *et al.*, 2010). Therefore, this study attempt to highlight this grey area by researching the existing challenges recovering service users experience after they have been discharged from formal treatment in order for recommendations and conclusions to be formulated regarding limitations in current policy and legislations.

3.7.2 National Drug Master Plan (NDMP, 2006-2011; 2013-2017)

The aim of NDMP as a policy is to provide a five-year plan in dealing with the epidemic of substance dependency in order to bring about reduction, as well as resolve related consequences by focusing on five priority areas: crime, youth, community health and welfare. The NDMP provides a vision of priorities that comprehend the composition of Central Drug Authority (CDA), local Drug Action Committees and provincial Drug Forums in terms of each sector’s responsibility and role in the reduction of substance dependency. In terms of aftercare and reintegration services, the NDMP has stipulated that the provincial forums have the responsibility to allocate members from various forums to deal specifically with the portfolio of substance dependency aftercare and reintegration services. However, the NDMP is not clear as to which service provider between government and non-government organisations (NGO’s)

should take responsibility in the establishing and rendering of aftercare services. Therefore, this uncertainty is a grey area that leaves a gap for reoccurring relapses to occur. The NDMP (2018-2022) has also not been implemented to date as indicated earlier.

The NDMP has specific outcomes within which each contain a number of resolutions which need to be combated by national and provincial departments. There is specific reference to resolution 30, that has the outcome of increasing the provision of rehabilitation and aftercare services. This will be done through a 10% increase of aftercare facilities that implements practices and protocols, as well as an increase in the treatment methodologies offered to service users in the hope of increased success rates for treatment and aftercare services as illustrated in SACENDU (2018) and Ministry of Health data Resolutions 23, 25, 28, 30. However, although a resolution has been defined to make provision for aftercare services, there is still a concern as to how, who and when these solutions will be adequately implemented.

The key specific outcomes derived from a review of the NDMP 2006 – 2011 are described in the NDMP 2013 – 2017 in terms of the basic concepts of monitoring and evaluation (Public Service Commission of South Africa, 2008). These outcomes are listed below:

1. Reduction of the Biopsychosocial and economic impact of substance dependency and related disorders on the South African population
2. Ability of all people in South Africa to deal with problems related to substance dependency within their communities.
3. Recreational facilities and diversion programmes that prevent vulnerable populations from participating in substance dependency.
4. Reduced availability of dependence-forming substances/drugs, including alcoholic drinks such as unregistered shebeens in local communities.
5. Development and implementation of multi-disciplinary and multi-modal protocols and practices for integrated diagnosis and treatment of substance dependence and co-occurring disorders and for funding such diagnosis and treatment.
6. Harmonisation and enforcement of laws and policies to facilitate effective governance of the supply chain with regard to AOD.
7. Creation of job opportunities in the field of combating substance abuse. In a national rapid participatory assessment (RPA), community respondents indicated that alcohol

and cannabis were the two main substances of abuse (Dada, Plüddemann, Parry, Bhana, Vawda, Perreira, Nel, Mncwabe, Pelsler & Weimann, 2012). These conclusions are supported by data gathered from the South African Community Epidemiology Network on Drug Use (SACENDU, 2018)

Currently, however, the South African legislative response to the growing substance dependency problem has been questionable, disintegrated and uncoordinated. This incoherent response has undermined the approach to the combat of substance dependency in terms of certain services (existing and non-existing), misusing available resources and the failure to secure others that are direly needed. Overall, there has been a lack of solitary strategic response to the substance dependency epidemic (SACENDU, 2018).

3.7.3 Integrated Service Delivery Model (ISDM)

The ISDM (2006) is one document that provides a guideline for social services within the context of social development approach so that a value chain is created for the delivery of social services (Department of Social Development, 2006). The ISDM (2006) categorically provides a framework of four levels of social service delivery, which is determined by the specific developmental needs and social challenges that are being experienced and that must be addressed. These four levels are referred to as: prevention, early intervention, statutory intervention/alternative care/residential care, and reintegration and aftercare. With specific reference to the aftercare and reintegration component, the aim of this service delivery level is to empower service users to recuperate their self-reliance and optimal social functioning within their immediate environment that may either encourage such growth or hinder it. Furthermore, this level of service delivery facilitates reintegration of recovering service users into family and community life after they have received formal treatment, so that a symbolic 'safety net' is in place to catch them after they are discharged from the controlled and safe environment that is created by formal treatment.

In order to improve social functioning and quality of life, services are rendered at different levels with a specific outcome in mind, which in aftercare services is long term sobriety. These levels are best understood and operated on a continuum line. The service provider and the service user mutually determine the service users' current social functioning, needs and challenges in order to develop an intervention strategy that will enable him/her to reach the optimum level of social functioning and self-reliance (Department of Social Development,

2006). Current legislation refers to prevention, early intervention, statutory intervention/alternative care/residential care, and reintegration and aftercare. The framework that corresponds with this study and current legislation is statutory intervention in terms of formal treatment as well as aftercare and reintegration services.

At the statutory intervention level, service users' quality of life or social functioning is compromised due to circumstances and consequences surrounding substance dependency. This could require some form of statutory intervention, or require the movement of service users to the most restrictive environment as they can no longer function sufficiently in their community. They may have to be removed from their normal place of residence, either by court order or on the recommendation of a service provider, to alternative care or placed in a residential facility, which in this study is a formal treatment facility such as a rehabilitation programme. This level of service includes protection and rehabilitation services that attempt to safeguard the well-being of service users.

Lastly, the reunification and aftercare level of service delivery has the aim of enabling recovering service users to improve self-reliance and optimal social functioning in the least restrictive environment possible. It facilitates reintegration into family and community life after separating due to service user being admitted into formal treatment.

3.8 CONCLUSION

This chapter has explored the complexity of substance dependency relapses in terms of the various relapse stages and the severity of their impact on long-term recovery. During this exploration, the various approaches to prevent substance dependency relapses with regards to literature and legislative frameworks were discussed in order to highlight the current options available within South Africa. Therefore, this chapter has focused on the available aftercare and reintegration services in terms of the integrated service delivery model (ISDM, 2006). There are various literature and legislative frameworks that correspond and provide guidelines during aftercare and reintegration services that were elucidated throughout.

In this light, this chapter has identified the various aftercare and reintegration frameworks that were developed with the main aim of preventing relapses by enhancing the service users' protective factors against various risk factors. This was done in order to determine whether the current substance dependency literature, policy and legislative frameworks have reduced or

resolved these existing challenges experienced by service users. The following chapter will therefore conduct an empirical study that will investigate the lived experiences of recovering service users with these identified challenges as a frame of reference in terms of how they are being dealt with in order to prevent relapses during aftercare services. The purpose of this exploration is to determine whether these challenges are currently being dealt with and addressed by available legislation and literature in order to prevent relapses, because it is evident that the relapse rates are still growing significantly.

Thus, the following chapter will focus on these challenges that exist for recovering service users after they have been discharged from formal treatment according to the Biopsychosocial model. This will hopefully be of significance for social workers rendering services to service users of substance dependency aftercare services, so that future recommendations can be made to address these existing challenges in an attempt to reduce relapses.

CHAPTER 4

EMPIRICAL INVESTIGATION OF THE CHALLENGES EXPERIENCED BY SERVICES USERS DURING AFTERCARE AND REINTEGRATION SERVICES

4.1 INTRODUCTION

A critical discussion of literature regarding the various challenges that exist during aftercare and reintegration services was explored in chapter 2. Building on this, a theoretical evaluation on current legislative frameworks and approaches relating to substance dependency aftercare and reintegration was explored in chapter 3. This fourth chapter will address the third objective of the study, which is to empirically investigate the challenges experienced by adult service users during substance dependency aftercare and reintegration services. This will be achieved by exploring the lived experiences of recovering service users in order to compare and analyse it with the preceding two literature and theoretical chapters. Fisher and Harrison (2013) explained that it is imperative to consider the aspects surrounding an individual's existence, as this promotes the manifold nature of the Biopsychosocial model and allows service providers to understand the challenges that are predisposing relapse factors. By extension, this enables them to implement the most effective aftercare and reintegration services. The purpose of this chapter is to empirically investigate whether available substance dependency aftercare literature and legislative frameworks address the existing challenges during aftercare services. It will provide an exploration on whether current aftercare and reintegration frameworks hinders or fosters the risk or protective factors for reoccurring relapses.

In chapter 4, the researcher has identified the themes, sub-themes and categories from the information and data that was gathered (as depicted in Annexure H). These will be discussed throughout this chapter with regards to the data collected from these recovering substance dependent service users (participants). Lastly, conclusions will be formulated based on these empirical findings, as well as certain recommendations, which will be developed in chapter 5.

4.2 RESEARCH METHODOLOGY

The research methodology is related to the research question and is composed of the goals and objectives of the study, the research approach, design, instruments utilised along with the data

analysis and lastly the data quality verification. The following headings below encompass the theoretical body of means and principles that outline methods of data analysis that will be utilised.

4.2.1 Research question

The research question that was formulated at the beginning of the research study was: What are the challenges experienced by services users during substance dependency aftercare and reintegration services? Through the gathering, analyses and interpretation of data, the research question has been answered and the researcher was able to effectively categorise the lived experiences of service users concerning their challenges during aftercare and reintegration services. This is elaborated in more depth in section B of this chapter.

4.2.2 Goals and objectives

The goal of this research study was to develop an understanding about the challenges experienced by service users during substance dependency aftercare and reintegration services within a South African context. The researcher formulated objectives in the beginning of the study so that this overall goal could be achieved. The outlined objectives provided the research with structure and enabled the research goal to be efficiently achieved. The objectives formulated are:

1. To describe the challenges of adult service users after they have received substance dependency formal treatment from a Biopsychosocial model.
2. To contextualise the available literature, policy and legislation framework of substance dependency aftercare and reintegration services for adult service users.
3. To empirically investigate the challenges experienced by adult service users during substance dependency aftercare and reintegration services in order to correlate it to the literature review.
4. To comprehend the outcome of the research in order to present conclusions and develop corresponding recommendations for future aftercare and reintegration services to ensure relapse prevention.

The first objective was achieved throughout Chapter 2 of this research study, and the second objective was addressed in Chapter 3. The third objective will be achieved in Chapter 4 and the last objective in Chapter 5, whereby conclusions and recommendations are formulated.

4.2.3 Research approach

A qualitative approach with some quantitative elements was undertaken for this research study as it corresponded with the objectives in terms of gaining understanding of a problem that has not been comprehensively investigated before. The qualitative approach allowed the researcher to obtain a more meaningful record of human experiences by means of gaining detailed information regarding the participants' lived social reality (Bless *et al.*, 2013). The utilisation of this approach allowed the participants to be as descriptive, informative and inclusive in their responses as they desired to be.

4.2.4 Research design

In accordance with the research aim, an exploratory and descriptive research design was applied. The exploratory research design allowed the researcher to gather information based on the lived experiences of participants in order to gain insight about the unfamiliar issue related to reoccurring relapses. The descriptive research design allowed for a more insightful and intensive examination of the participants so that denser descriptions could be articulated (De Vos *et al.*, 2011). The researcher therefore amalgamated elements of both research designs with specific focus on the descriptive research design, because it allowed the researcher to explore and describe the participants' lived experiences with regards to their challenges during aftercare.

4.2.5 Research instrument

The predominant mode of data collection for this research study was conducted through semi-structured interviewing, which corresponds with the framework of qualitative research. The researcher utilised a semi-structured interview guide throughout the interview process in order to capture the views, experiences, descriptions and terminology expressed by the service users (participants). The semi-structured interview schedule comprised of predetermined questions, which were open-ended in order to pre-empt further responses and detailed discussions by the participants (see Annexure F). The researcher conducted the interviews by gathering informed consent by participants to voice record them so that their discussions could be accurately transcribed, which ensured that their exact language, tone and views were gathered. The interview took approximately 50 minutes to complete, and afterwards, debriefing took 15

minutes (as shown in Annexure D and Annexure F). The interviews took place either in a professional environment of CAD organisation or in the privacy of the participants' households.

4.2.6 Data quality verification

In accordance with the eminence of the research study, the researcher ensured that data quality verification was maintained in order to ensure credibility and transparency. This was done by illustrating an accurate and precise representation of what was expressed by the participants during the interview. This accurate representation of data was obtained by transcribing the full interview with participants so that a comprehensive understanding of detailed descriptions could be documented (Claire, Craig & Sello, 2013).

Confirmability was also upheld by the researcher permitting that all findings which are obtained and presented be a representation of the overall research study. To ensure data quality verification, the researcher encouraged two of the participants to read through their transcribed interviews so that they could ensure that everything stipulated was a true reflection of what they said during the interview (see Annexure H). An independent coder as depicted in Annexure I was utilised to evaluate if the themes, sub-themes and categories correspond with the transcribed interviews (data). Lastly, the researcher also compiled a reflexivity report in order to reflect on the research process, experience and outcomes (see Annexure J).

4.3 DEVELOPMENT OF THE INTERVIEW SCHEDULE

As emphasised before, the research study was qualitative, exploratory and descriptive, which allowed the researcher to fully gather in-depth insight on the views of the participants. The researcher compiled the interview schedule by developing a set of semi-structured questions utilised to guide the interview, which was conducted through individual interviews with each participant (as illustrated in Annexure H). The researcher developed the semi-structured interview, which was based on the literature reviewed in preceding chapters in order to ensure theoretical connection and perspective. The semi-structured interview consisted of open-ended questions, which increased the likelihood of collecting accurate and in-depth responses from the participants, whereas, close-ended questions were utilised to gather identifying details of the participants (Annexure G).

Furthermore, the researcher was able to formulate themes, sub-themes and categories which were devised within the development of the interview schedule in order to guide the interview process (Creswell & Clark, 2007).

4.4 ETHICAL CONSIDERATIONS

This research study was conducted in an ethical manner that was based on mutual trust and transparency regarding the expectations for both the researcher and participants. In correlation with the criteria for inclusion consisting of participants that have directly experienced the challenges of substance dependency aftercare and reintegration, the research is considered medium/high risk. The research study being classified by the research ethical committee (REC) as medium/high risk was based on the fact that the sample population included vulnerable participants that had the potential risk of emotional and psychological discomfort if the interview was not dealt with in a professional and responsible manner (Annexure A).

In accordance with the research topic, the semi-structured interview consisted of questions that prompted for intimate details of vulnerable social categories which deal with sensitive topics of substance dependency. In order to ensure ethical viability and clearance, the researcher maintained the privacy and confidentiality of the participants. Additionally, the researcher received the consent of participants through a written agreement which was signed by both the researcher and participant (see Annexure D).

The overall ethical consensus is to ensure voluntary participation, informed consent, confidentiality, anonymity and privacy, as well as to avoid psychological, emotional or mental harm of the participant (De Vos *et al.*, 2011). These ethical considerations were all maintained by the researcher following required procedures. These included ensuring that the data collected by participants are password protected for a required amount of time, which is at least 5 years, as well as seeing to it that all information is stored in a secure cabinet in the supervisor's office. As depicted in Annexure A and C, the researcher also received permission from the organisation and institutions involved in the data collection process.

Lastly, all the data that was collected by semi-structured interviews with participants was completed and finalised by 21 June 2019. This was done to ensure it was conducted within the ethical clearance time period before it lapsed on the 4 July 2019 (as seen in Annexure A).

4.5 REFLEXIVITY

The reflexivity report was compiled by the researcher in order to show that transparency and awareness was upheld during the research study. This was done by the researcher taking an objective role during the research process by ensuring that her own views and perspectives did not influence the information presented. The reflexivity report allowed her to openly reflect on her experiences, emotions and expectations regarding the research study. As depicted in Annexure J, this report provides the researcher with a platform that separates her own views, perspectives and thoughts from that of the data collected by the participants, which in turn alleviates any potential prejudice or biased views.

4.6 SAMPLE

In accordance with this research, the researcher utilised the non-probability sampling method because the likelihood of selecting specific participants are unknown. The researcher made particular reference to purposive sampling and snowball sampling by utilising them together. The purposive sampling was used as a technique to entirely base the selection of the population off the judgement of the researcher regarding certain characteristics of participants that best suited the purpose of the research (De Vos, *et al.*, 2011).

The researcher utilised this purposive selection method because it confirmed that participants were selected based on the set criteria for inclusion to ensure that they provided adequate answers and experiences related to the research topic. The research study was conducted within the Western Cape whereby the sample size was initially 20 participants, but because of the snowball sampling method, data saturation was reached by participant number 14. However, the researcher decided to round off the sample size by participant number 18 (De Vos *et al.*, 2011). It was also a challenge to obtain 20 participants that were willing to partake in the research study. All 18 of the selected participants met the following criteria for inclusion:

- Former substance dependent individuals.
- Partaking in an aftercare services after receiving formal treatment.
- Able to understand English or Afrikaans.
- Over 18 years old.

Once the researcher received professional permission from an aftercare and reintegration organisation (Christian Action for Dependence), she then had access to the CAD support groups whereby the group leaders were contacted in order to encourage group members to participate in the research study (see Annexure C).

4.7 ANALYSIS AND INTERPRETATION OF DATA

As soon as the qualitative data was collected, the information was analysed and interpreted by the researcher. Thereafter, the researcher thoroughly transcribed each interview as it was recorded. She utilised a de-naturalistic approach to transcribing, which is the process of removing unique elements of speech such as pauses and non-verbal factors which suggest that within dialogue there are certain meanings and perceptions (Oliver, Serovich & Mason 2005). Through this process of data interpretation, the researcher was able to identify certain themes, sub-themes and categories, as well as reoccurring patterns that could be organised and presented in section B of this chapter. Lastly, this organisation of data allowed the researcher to correlate the participant findings to the existing literature and theoretical frameworks contained in the literature review in order for relevant conclusions and recommendations to be formulated (De Vos *et al.*, 2011).

4.8 RESULTS OF THE INVESTIGATION

The results of the investigation will be presented in two sections, namely Section A and Section B. Section A will provide an exploration on the identifying details of the participants, whereas Section B will elaborate and present the empirical investigation of the experiences of voluntary participants with the challenges that exist during aftercare and reintegration services. These results will be analysed in terms of themes, sub-themes and categories that have emerged through the findings.

SECTION A: IDENTIFYING DETAILS

4.8.1 Identifying particulars of participants

The collection of information regarding the participants' identifying details was obtained through a qualitative approach. However, this section requires a more measurable approach to formulate facts and uncover patterns in research. Therefore, it required the researcher to include

elements of the quantitative approach for this section. This has been done in order to attain a comprehensive summary of the numerous amounts of variables that such a sample consists of. In accordance with this research study, the identifying details of the 18 participants include the following: gender of participants, age, educational status, dependents, relationship status, residential area, race, drug of choice as well as the onset age of substance dependency.

Table 4.1: Identifying particulars of participants

Participant number:	Gender	Race	Highest Education Level	Marital Status	Number of children	Number of relapses
1	Female	Coloured	Tertiary education	Married	1	1
2	Male	Coloured	Grade 11	Single	0	1
3	Male	Coloured	Grade 9	Single	0	4
4	Male	Coloured	Tertiary education	Single	0	2
5	Female	Coloured	Matric	Single	0	Many times
6	Male	Coloured	Grade 9	Single	0	Many times
7	Male	Coloured	Tertiary education	Divorced	2	Many times
8	Female	White	Matric	In relationship	1	Many times
9	Male	White	Tertiary education	Divorced	2	2
10	Female	White	Grade 11	Married	2	4
11	Male	Coloured	Tertiary education	Single	0	3
12	Male	Coloured	Tertiary education	Married	3	Many times
13	Female	Coloured	Tertiary education	In relationship	1	1
14	Male	Black	Grade 11	In relationship	1	Many times
15	Male	Coloured	Grade 10	Single	1	4
16	Male	Coloured	Tertiary education	Married	4	Many times
17	Female	White	Tertiary education	Single	0	Many times
18	Male	Coloured	Grade 11	Single	0	3

4.8.1.1 Gender of participants

As determined in the research proposal, the voluntary participants were not limited to focus solely on one gender, but rather on both-male and female. A recent consensus study has stipulated that more than half of South Africa's population consists of females making up 51%, whereas males are at 49% (Statistics South Africa, 2018). The aftercare and reintegration services are rendered to both genders once they are discharged from formal treatment.

As depicted in the above displayed figure of the 18 participants who were interviewed, 33% were female, whereas 67% were male. With specific reference to gender particulars, there are predominately more men involved in substance dependency aftercare services, which correlates with the high statistics of men being admitted into rehabilitation facilities compared to women (SACENDU, 2018).

4.8.1.2 Race of participants

The participants were identified by their race in terms of being classified either as Black, Coloured and White. This data is illustrated in table 4.1.

In accordance with this displayed figure, 72%, which is the majority of the participants, are of Coloured descent. Conversely, 22% of the participants are White and 6% Black. These findings correspond with the SACENDU (2018) statistics that stipulate that all rehabilitation facilities show the "proportion of Black African persons in treatment is still substantially less than would be expected from the underlying population demographics."

4.8.1.3 Highest educational level of participants

This research study did not stipulate an inclusive attribute relating to the participants' education status, because the questions were developed to be straightforward so that all participants could comprehend what was being asked. The various educational levels of participants are represented in table 4.1.

According to the figure, the majority of participants have completed their matric and have obtained tertiary education qualifications. However, there is still 28% of the participants that dropped out of school in Grade 11, this being the highest educational level they have obtained. Further, 11% was held by participants that have a matric, whereas 6% of participants either

obtained a Grade 10 or Grade 9. These abovementioned findings correlate with van der Westhuizen's research (2010), which found that substance dependency among South African school children, both rural and urban, is undermining the quality of education and development of the children in the country. This finding is sobering, bearing in mind that school failure in terms of dropping out of school is a strong predictor of 'failed' developmental stages, delinquency, gang affiliation, criminal activity as well as anti-social behaviour (Webster, 2009).

4.8.1.4 Marital status of participants

The research study did not stipulate a preference regarding the participants' relationship status. The participants labelled their relationship status as either married, divorced, single or in a relationship.

As illustrated in table 4.1, the most common relationship status amongst the participants is single. This coheres with a study conducted by Bain (2004), which stipulates that lacking a significant other or companion can instil a sense of loneliness, which is one of the main contributing factors to relapsing. On the other hand, 17% of the participants are in a relationship and 22% of them are married. Accordingly, research by Sussman and Ames (2001) articulates that relationships formed during active addiction and continued through to aftercare is often characterised by co-dependency, which is a risk factor for making the recovering individual vulnerable to relapsing. Therefore, these conflicting findings will be explored in more depth in section B with reference to the theme of social challenges experienced by participants.

4.8.1.5 Number of children

This research study wanted to highlight how many dependents each recovering participant is responsible for. The figure above illustrated how many children each individual has.

The highest percentage of participants, namely 44%, do not have any dependents. The second highest percentage is 28%, which comprises participants who are responsible for at least one child. The rest of the participants were as follows: 6% have three children, 17% have two children and 6% have 4 children. It is evident that all children are raised differently and within different environments because of the increased trend in South Africa of child-headed households as well as single parent households (Routledge, 2005).

4.8.1.6 The frequency of relapses amongst participants

The researcher decided to gather specific details regarding the participants' history with relapses in order to highlight a pattern of reoccurrence.

According to table 4.1, the majority of the participants could not recall how many times they have relapsed because it happened numerous times. Further, 17% of the participants relapsed at least once in their lifetime, 11% twice, 11% three times and the remaining 17% at least four times. These results correlate with the findings of Adinoff et al. (2010), as mentioned before, that most service users relapse after being discharged from formal treatment.

As presented above, it is evident that all the participants experienced at least one relapse during their recovery process, which often occurs during aftercare and reintegration services. Therefore, the relapse stage acknowledges that a recovering service user may experience a slip or a relapse before the maintenance stage of changed behaviour is achieved during aftercare and reintegration services (Sussman & Ames, 2001). Section B will further discuss the findings of this study, which highlights the aftercare challenges that increase the participants' risk of relapsing.

4.8.1.7 Age range of participants

This research study clearly stipulated within the criteria for inclusion that the participants had to be above 18 years old. Therefore, the age data was collected concerning individuals older than 18 years old within intervals of 4 years from the youngest participant to the oldest. Figure 4.1 is an illustration of age ranges between the 18 participants.

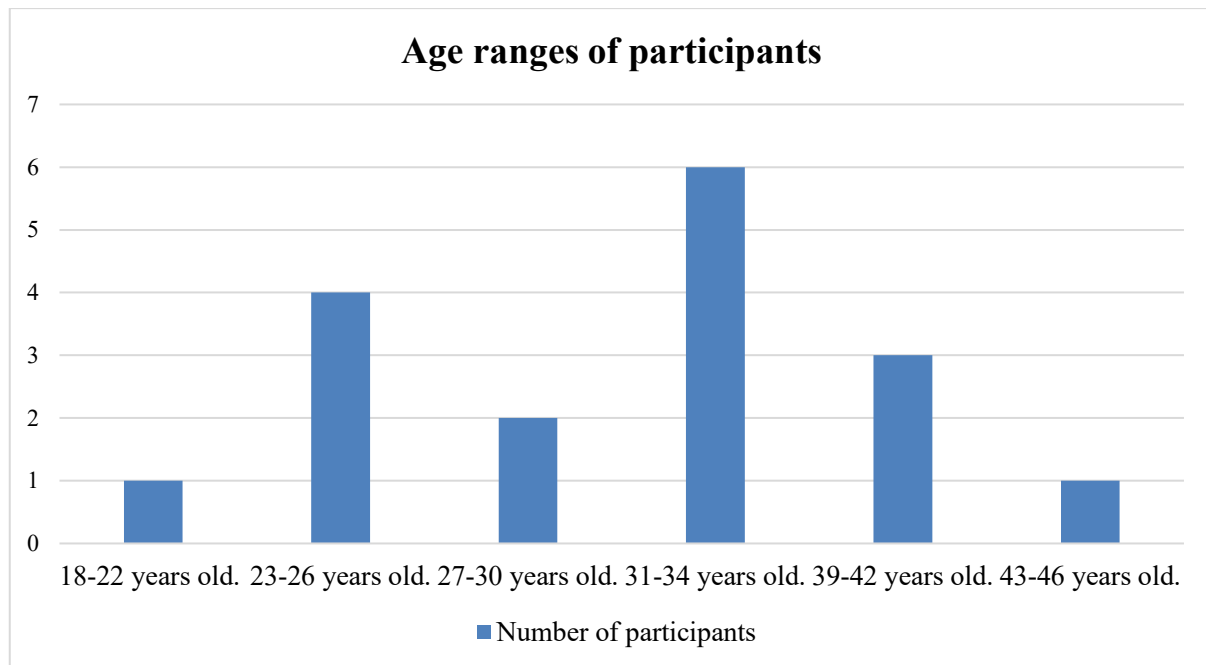


Figure 4.1: Age range of participants

The average age range of participants was between the ages of 31 and 34 years, making it 33% out of the 18 participants. The youngest participant that was interviewed was 21 years, while the oldest was 45 years. In summary, 22% were between the age range of 23 to 26 years, 11% between 27 to 30 years, 17% between 35 to 38 years and finally 6% 39 to 42 years, 43 to 46 years and 18 to 22 years. There is lack of research regarding the age statistics of people involved in aftercare and reintegration services. Researchers such as Fisher and Harrison (2013) and Lewis et al. (2011) did articulate that the lack of statistics may be due to the anonymity of support groups such as Alcoholic Anonymous (AA) and Narcotic Anonymous (NA).

4.8.1.8 Drug of choice

The participants' drug of choice is significant to this research topic, because it indicates a prevalence rate within a given population. In accordance with this research study, the drug of choice will include both illegal substances such as cocaine, tik (methamphetamine) and heroin and legal substances such as alcohol and cannabis (which was decriminalised in 2018) (SACENDU, 2018). Substance dependency is the "use of a legal or illegal substance for a purpose not consistent with permitted or medical guidelines, as in the non-medical use of prescription medications" (Encyclopaedia of Social Work, 2013). Research recorded by Plüddeman, Parry, Bhana, Dada & Fourie (2010) indicates that between 32% and 45% of substance-users prefer more than one substance of choice. Therefore, for the purpose of this

study, the participants were allowed to give more than one answer due to the fact that there is a proliferation of dangerous cocktails which are emerging in the country, which include a mix of substances. This will be supported by figure 4.2.

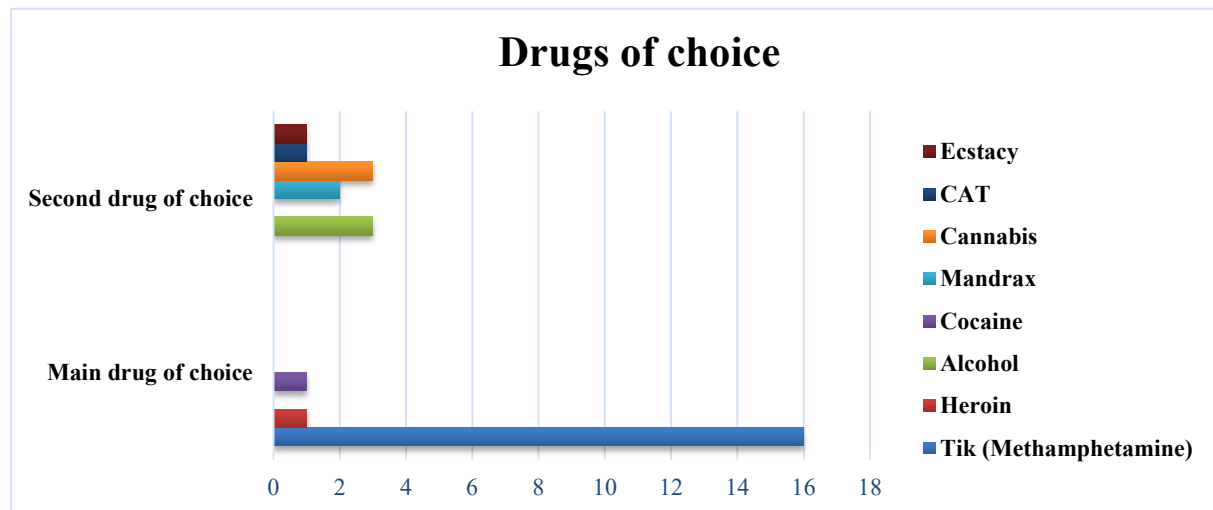


Figure 4.2: Drug of choice

As illustrated in figure 4.2, the highest percentage was 89%, which comprised participants that stipulated that their main drug of choice was tik. This corresponds with statistics from South Africa's Medical Research Council (MRC), which "show[s] that 46% of patients seeking drug treatment in Cape Town from January to June last year were tik users, compared to 0,7% four years earlier." Additionally, Parry *et al.* (2004) find that in Cape Town, "methamphetamine, or more commonly known as 'tik', has affected more than 70% of patients under the age of 20 thereby indicating that methamphetamine is their primary substance of choice." Of the remaining two participants, 6% indicated heroin as his main drug of choice, and the other participant representing 6% identified cocaine as his main drug of choice.

Additionally, within context of this identifying detail, it was often found that participants mentioned a second drug of choice that they would utilise during their active addiction. As depicted in figure 4.2, the participants could mention more than one answer with regards to their secondary drug of choice. According to these findings, the majority of participants also utilised alcohol, as exactly 17% engaged in alcohol dependency alongside their main drug of choice. Coming up second to alcohol dependency was the abuse of cannabis, which 11% of the participants indulging in it alongside their main drug of choice. Further, 11% of the participants utilised mandrax in conjunction with their main addiction. This corresponds with SACENDU (2018) findings which indicates that "mandrax" (methaqualone) is the second most commonly

used illegal drug whereas cannabis abuse is the most frequently utilised. Mandrax is frequently smoked with cannabis, a combination referred to as ‘white pipe.’ The remaining 11% of participants either utilised ecstasy or CAT with their main drug of choice.

4.8.1.9 Age of substance dependency onset

This researcher wanted to know the age of substance dependency onset in order to detect a possible pattern amongst participants. Therefore, the onset age data was collected within intervals of 2 years from the youngest age to the oldest. Figure 4.3 is an illustration of the range of onset ages between the 18 participants.

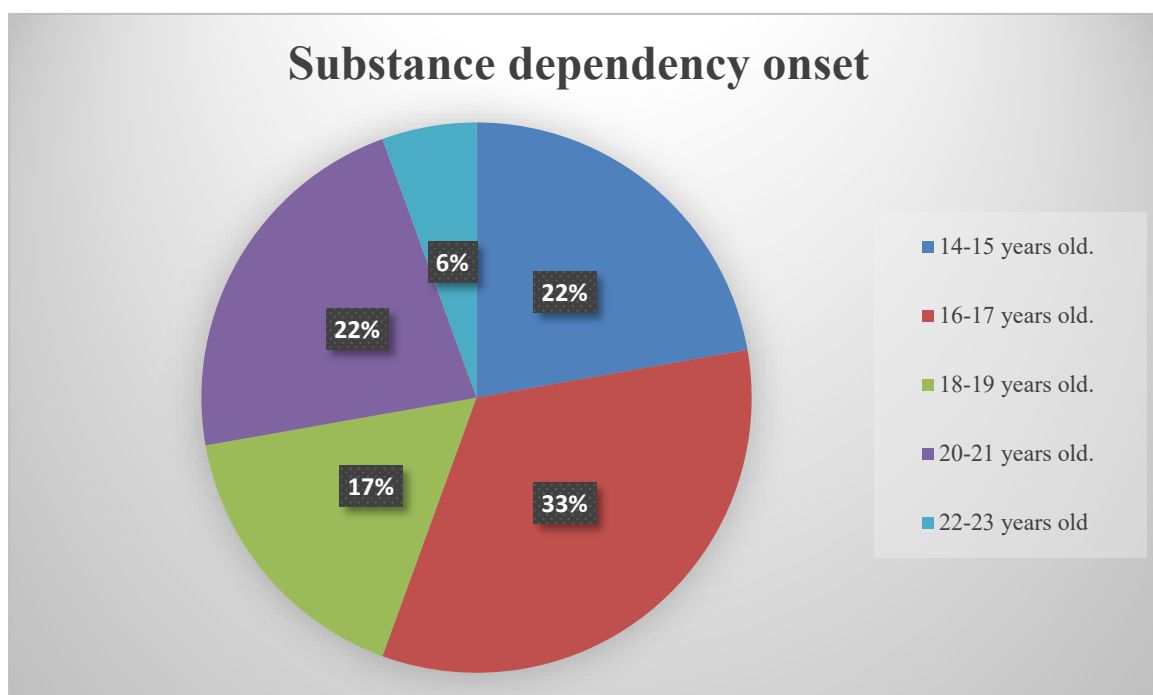


Figure 4.3: Age of substance dependency onset

The abovementioned outcomes indicated that 33% of the 18 participants were dependent on substances between the ages of 16 and 17. The youngest age of substance dependency onset was between 14 and 15, which was represented by 22% of the participants. Additionally, 17% of participants became dependent on substances between the ages of 18 and 19, whereas 33% became dependent on AOD between the ages of 20 and 21. Lastly, the oldest age group to become dependent on AOD was between the ages of 22-23, which was represented by 6% of the participants.

The results displayed in figure 4.3 corresponds with the latest findings of UNODC (2018), which exhibits that the average age of drug dependency in South Africa is 12 years and declining, and that late adolescence (15–17 years) is a critical risk period for the transition from the experimentation phase to complete substance dependency. With reference to Erik Erikson's (1902-1994) Psychosocial Developmental Theory, adolescence is a time of identity formation in which the adolescent should have time for experimentation and rejection of certain roles or identities. At each stage, there is a crisis or task that the adolescent needs to resolve whereby the successful completion of each developmental task results in a sense of capability and a healthy development. Accordingly, failure to complete these tasks leads to feelings of inadequacy and insufficiency. The period of adolescence is therefore seen as the time in which one can first experience identity diffusion, which will lead to experimentation and ultimate identity formation often based on the external approval of others. It is when this happens that adolescents may begin to involve themselves in high risk behaviour such as substance abuse in order to gain acceptance (Laudet, Savage & Mahmood, 2002). This theoretical underpinning can be correlated with figure 4.3, which highlights that the majority of participants initiated their substance dependency during adolescence.

4.8.1.10 Demographics of participants

The purpose of this identifying detail was to grasp the socio-economic backgrounds of people engaging in aftercare services. Therefore, the data that was collected was arranged according to repeating patterns with regards to shared residential areas between participants. Figure 4.4 illustrates the demographics of participants.

Demographics of participants (Residential areas)	Number of participants
Kuilsriver (KR)	4
Somerset West (SW)	2
Stellenbosch (SB)	1
Blouberg (BB)	1
Bellville (BV)	4
Paarl (PL)	1
Durbanville (DV)	1
Goodwood (GW)	4



Figure 4.4: Demographics of participants

As illustrated in the figure, the researcher attempted to find voluntary participants in both rural and urban areas, so that a more in-depth and diverse understanding of aftercare challenges could be gathered. The distribution of areas included: low-, middle- and high-income communities within the Cape Town region. Although only 18 participants were interviewed, this could also potentially indicate a wider spectrum of needs, as different communities will have different levels of accessibility to certain resources and aftercare services.

Based on figure 4.4, it was interpreted that 22% of the participants reside in Kuilsriver, 22% in Bellville and 22% in Goodwood, whereas 11% reside in Somerset West. The remaining 24% all stay in different areas, meaning that Stellenbosch, Paarl, Blouberg, Durbanville and each include 6% of the participants. The following section B will further evaluate the role of the environment in the participants' substance dependency recovery.

4.8.1.11 Frequency of completed admissions into formal treatment:

The researcher decided to gather specific details regarding the participants' patterns during their recovery process in order to gain an in-depth understanding of their lived experiences. Figure 4.5 illustrates the amount of formal treatments completed by participants prior to entering aftercare services.

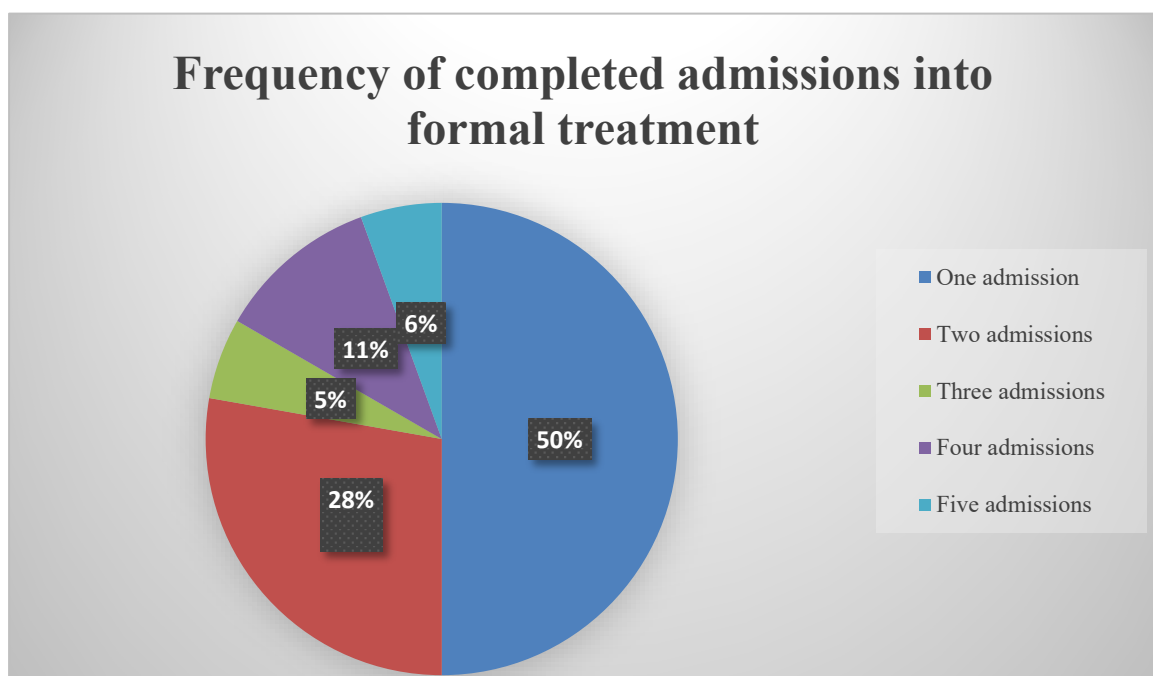


Figure 4.5: Frequency of completed admissions into formal treatment by participants

The graph illustrates that half of the 18 participants were admitted and completed at least one formal treatment programme within their lifespan. More than a quarter (28%) of the participants completed two treatment programmes. Additionally, 5% finished their treatment programme within their third admission, 11% completed formal treatment four times, and the remaining 6% completed five treatment programmes

In the most recent South African Community Epidemiology of Drug Use (SACENDU, 2018), it was evident that the first half of 2017 experienced an increase in the number of persons admitted for treatment, from 8787 admission in 2016 to 10047 in 2017 across 80 registered centres. However, there is no available data that indicates the amount of people being readmitted into formal treatment centres. Therefore, figure 4.5 provides the data of a small sample of participants, and indicates that under 50% of them have been admitted into formal treatment more than once.

4.8.1.12 Participants length of sobriety

During the data collection each participant was asked to stipulate how long they have been sober for up until the interview date. Therefore, each participant's response would differ because of the various time periods that the interviews took place. The researcher attempted to find a wide range of participants in terms of their length of sobriety, so that certain trends could be highlighted as applied throughout the recovery process.

Table 4.2: Participants' length of sobriety

Participants:	Length of sobriety
1.	1 month
2.	5 months and 2 weeks
3.	6 months and 17 days
4.	1 year
5.	1 month
6.	5 months
7.	9 months
8.	9 months
9.	7 months
10.	3 years
11.	2 years
12.	8 years and 8 months
13.	1 month
14.	3 months
15.	1 year and 3 months
16.	6 years
17.	1 year
18.	2 months

In accordance with this table, 5 of the participants (28%) were as early as 1 to 3 months into their sobriety and 4 participants (22%) were as long as 8 years into their sobriety. This diverse range of sobriety periods allowed the data to determine whether aftercare challenges that existed almost a decade ago are still being experienced in recent years. Additionally, the findings of this research can detect any significant patterns over the recovery process over a long period of time amongst a variety of participants that only share one common variable, which is being a recovering addict (Laudet et al., 2002).

Furthermore, 3 (17%) of the participants were sober for 4 to 6 months when the interview was being conducted, and 3 (17%) were sober for 7 to 9 months. Lastly, 2 (11%) of the participants were 10 to 12 months sober and 1 (5%) participant was 13 to 15 months sober. According to the Matrix model for aftercare services (as depicted in chapter 3), the majority of the participants are in the wall stage of the recovery process, which can last between 45 and 120

days. During this time period, participants are often in the aftercare level of the Integrated Service Delivery Model (ISDM, 2006), which focuses on sobriety motivation and relapse prevention.

4.8.1.13 Information about participants' aftercare and reintegration

The research proposal clearly stipulated that participants must be involved in aftercare and reintegration services after they are discharged from formal treatment. This inclusive criterion guaranteed that the collected data would have in-depth information and experience regarding existing challenges that are either being hindered or fostered during aftercare and reintegration services. As illustrated in table 4.3, the close-ended responses have been about their current aftercare programme that is documented in the table.

Table 4.3: Participants aftercare and reintegration services

Closed-ended responses (Yes/No)	Aftercare available in immediate community	Knowledge of aftercare literature or legislation
Yes	11	7
No	7	11

As depicted by table 4.3, participants were asked closed-ended questions so that a direct answer of yes or no could be captured within the data collection. In terms of having knowledge or information regarding aftercare literature or legislation, up to 61% of the participants had no theoretical knowledge about the services they were receiving. Conversely, 39% of participants had some form of aftercare knowledge in terms of the 12-step programme that forms part of Narcotics Anonymous (NA) or Alcoholic Anonymous (AA). However, they lacked knowledge regarding aftercare legislation or policies.

Additionally, 61% of participants stated that there are aftercare services available in their community, whereas 39% did not have accessible or available aftercare services in their immediate community. This corresponds with the studies conducted by Pasche and Myers (2012) that show South Africa's undeniable lack of accessible and affordable substance dependency aftercare services in every community.

SECTION B: EMPIRICAL INVESTIGATION

The previous section was able to comprehensively present the identifying details and information about the participants so that a background foundation could be formulated while proceeding to Section B. In this section, the data collected from the participants during the empirical study have been classified by the researcher into themes, sub-themes and categories (as depicted in table 4.4), with the Biopsychosocial model being the frame of reference (Engel, 1981). The themes of this study have made reference to the Biopsychosocial model in order for the identified existing challenges to be classified in each of the following four domains: biological, psychological, social and cultural. These themes derived certain sub-themes that term existing challenges within each section of the model. Lastly, the data collected by participants has been captured and grouped into categories based on their experience with and viewpoints of these identified existing challenges. These challenges that exist during aftercare and reintegration services are predisposing relapse factors.

The empirical investigation was set in place to answer the research question, this being: what are the challenges experienced during aftercare and reintegration services? As illustrated in chapter 3, aftercare services are developed to address these identified challenges, summarised in chapter 2, for the overall aim of relapse prevention. Therefore, the data collected from service users will determine whether their aftercare services have hindered or fostered their experiences with these existing challenges.

Table 4.4: Themes, sub-themes and categories identified in this research study

Theme	Sub-theme	Categories
Theme 1: Biological challenges	Sub-theme 1.1: Patterns of addiction	a) Parents' addiction patterns b) Extended family patterns
	Sub-theme 1.2: Cravings	a) Stimulus b) Lack of coping mechanism
	Sub-theme 1.3: Biological well-being	a) Weight gain
Theme 2: Psychological challenges	Sub-theme 2.1: Dealing with emotions	a) Negative emotions b) Aggression c) Untrustworthiness d) Inconsistency of coping skills
	Sub-theme 2.2: Cause of previous relapses	a) Unemployment b) Reservations c) Lack of support group attendance d) Protective factors
	Sub-theme 2.3: Dual Diagnosis or co-occurring disorders	
	Sub-theme 2.4: Sexual trauma	
Theme 3: Social challenges	Sub-theme 3.1: Family systems	a) Lack of family involvement b) Unresolved conflict c) Support for families
	Sub-theme 3.2: Availability and accessibility of AOD	
	Sub-theme 3.3: Interpersonal relationships	a) Peer and social pressure b) Intimate relationships c) Sex drive
	Sub-theme 3.4: Socio-economic status	a) Unemployment b) Educational status
	Sub-theme 3.5: Criminal record	
	Sub-theme 3.6: Housing	
Theme 4: Cultural challenges	Sub-theme 4.1: Barriers to aftercare and reintegration services	a) Transport b) Safety
	Sub-theme 4.2: Stereotyping and stigmatising	
	Sub-theme 4.3: Lack of knowledge and awareness by community members	

4.8.2 Theme 1: Biological challenges

The biological aspect of the Biopsychosocial model (Engel, 1981) takes into consideration all the biological and inherited aspects that underline substance dependency relapses. This theme draws on the Biomedical model in terms of the notion that there are biological factors that contribute to substance dependency (Benard & Krupat, 1993). However, unlike the Biomedical model, the Biopsychosocial model does not limit its school of thought to this one biological aspect. Instead, it integrates it with various components that surround the existence of an individual (psychological, social and cultural). Therefore, this theme will refer to genetic predispositions, biochemical and physical challenges that expose recovering substance dependents to various predisposing relapse factors during aftercare and reintegration services. It emerged from various studies, as demonstrated in chapter 2, that the following biological factors are challenges that put participants at-risk for relapsing: family hereditary addiction patterns, physical cravings, general health, biological needs and wellbeing.

4.8.2.1 *Sub-theme 1.1: Patterns of addiction*

Patterns of addiction refers to the cyclical nature of substance use disorders (SUDs) within an individual's life-span and family. The patterns of addiction are an existing biological challenge for the service users because it refers to the genetic heritability of substance dependency, which has been a much-debated topic over the years because it isolates the concept as a single predictor for substance dependency relapse. However, in accordance with this study it is one of the many aspects that contribute to substance dependency relapses, as depicted in the following narrative:

“There is a family pattern of alcohol abuse from my grandparents that I know of which is on my mother's side, and my dad was also an abuser of alcohol, as well as some of my uncle and aunties.” (Par 7)

This notion has been supported by twin and adoption studies that have credibly verified that “genes contribute to the development of substance dependency, with heritability estimates ranging from 50 to 60% for both men and women” (Agrawal & Lynskey, 2008). The following categories were developed based on the narratives provided by the participants to detect if biological challenges are still being experienced during aftercare and reintegration services.

a) Parental addiction patterns

Each recovering service user has a unique set of genetic make-up that was inherited from their biological parents. This genetic make-up can either hinder or foster the development of substance use disorders (SUDs). The vulnerabilities to substance use disorders (SUDs) that are “under genetic control are usually discussed as risk factors in developing drug dependency, but they also have a relationship to relapse” (Donovan & Marlatt, 2005). Through the data obtained by participants, majority of them experienced the genetic pattern of addiction. This is illustrated in the following narratives:

“Uhm, yes my mom is an alcoholic, and my middle brother who also lives with my mom, so they enabling each other and it took me to be in recovery to actually see from the outside because there is always wine in the house.” (Par 8)

“... there is a pattern, as my mom was a pill popper at one stage, what I mean it was prescription drugs and my father is an active alcoholic. My father once went for help but he still drinks and gets the shakes if he doesn't drink alcohol. I went to the same rehab my dad first went to.” (Par 18)

Linking the above-mentioned narrative with the theoretical underpinnings, the findings show that genetic predispositions is still a significant challenge for the majority of service users during aftercare and reintegration services. There is a clear pattern of addiction within families that make recovering substance dependents vulnerable to experiencing relapses. For some of the participants, their family members are still in active addiction, which increases their risk factors even more with regards to relapsing because of the general acceptance and availability of AOD. This corresponds with the research studies of Lovallo (2006), which found that individuals with a family history of alcoholism is at 4.5 times greater at risk of developing alcoholism than the general population.

b) Extended family patterns

Extended family members can refer to any family member that extends from the nuclear family, such as cousins, uncles and aunts. Although the likelihood of being predisposed to SUDs is higher when linked to direct bloodline of parents, research has indicated that there is still a connectional pattern between substance dependents and extended family members. Extended families are especially relevant to this study because it is based on a South African perspective.

Within South Africa, there are existing challenges in terms of having single-parent household, blended families, homes headed by grandparents or child headed households. Each of these family structures have an impact on the reoccurring patterns of addiction. Studies conducted by Donovan & Marlatt (2005) have shown that substance dependents usually have extended family members that are either in active addiction or in recovery. The following narratives are based on the participants' experience with extended family addiction patterns:

“My father used to drink alcohol now and then but my mother didn't drink at all, but I know my uncles were alcoholics.” (Par 9)

“Yes there is quite a few family members on my mom's side using still, and a couple of alcoholics.” (Par 11)

“Yes, I don't have brother or sisters, but my cousin, my two cousins, the one is drinking alcohol and the other one is smoking tik. He was the one that learned me how to smoke a cigarette because it starts from there. He was like a big brother to me and is now staying in Northern Cape.” (Par 14)

Based on these narratives, it is evident that addiction patterns are still a challenge, not only within immediate family structures, but also extended ones. Most of the participants stipulated that they have family members (grandparents, cousins or uncles) that are either in active addiction or in recovery. The lack of positive support from family members has been a challenge for participants to maintain sobriety. These existing patterns are often hard to break because of the cyclical nature that it represents.

4.8.2.2 Sub-theme 1.2: Cravings

Substance dependency cravings are intense urges or temptations to indulge in the effects of AODs that is often triggered by surrounding stimuli such as smells, sounds or objects. Cravings have been found to be a strong predictor of relapses during aftercare and reintegration. These urges have been identified as a challenge during aftercare because ongoing cravings may hinder an individual's commitment to sobriety, as the desire and availability of AOD is overpowering (Donovon & Marlatt, 2005). This is a biological challenge, because it involves an individual's mental reaction to a thing or event that evokes a specific functional reaction in an organ or tissue. This is illustrated by the following narrative:

“I had a craving last night, there was actually uhm a taste in my mouth and I have to just learn to switch my brain off. You know just deal with it for a couple of seconds then immediately just change my thought pattern because it can come instinctively.”

(Par 1)

This narrative indicates the link between cravings and the functional reaction of an individual's organ or tissue such as taste sensations. Therefore, the following categories were established based on the participants' experience with the biological challenge of cravings during their aftercare services.

a) Stimulus

A stimulus is a thing that arouses activity or energy in someone or something. In substance dependency aftercare, the absence of AODs and returning to an unchanged environment after formal treatment is sometimes enough for the service user to experience cravings that often lead to relapses. Stimulus that exists for service users during aftercare services is often linked to people, places and things associated with previous AOD use (Fisher & Harrison, 2013). The following narratives are based on the participants' experience with stimulus that lead to cravings during aftercare and reintegration:

“Absolutely, the using dreams I would wake up feeling disappointed in myself because

I thought I relapsed and then when I fully wake up you realise that you still sober and that motivates you for the rest of the day. Cravings absolutely I would be sitting somewhere or driving somewhere and I would just get that chemical taste which kind of drives you up the wall. I would deal with this by telling my sponsor and by attending meetings”

(Par 8)

“I have still a few vivid dreams about using. It was a few months ago that I was using and it was in my subconscious that made me realise I always have to be alert that I am still an addict.”

(Par 12)

Based on these responses it is evident that majority of service users are still experiencing cravings during aftercare and reintegration. Many participants mentioned that they experience a chemical taste in their mouth or have using dreams which trigger cravings. These experiences are supported by Bernheim, and Rangel's (2004) research on “Addiction and cue-triggered

decision processes,” which suggests that recovering addicts desire or crave alcohol or other drugs (AOD) that can be triggered by exposure to environmental cues associated with a patient’s prior use. As illustrated in the identifying details of participants, the length of sobriety among the participant range between short and long term. Therefore, it is apparent that cravings are an ongoing and reoccurring challenge for recovering substance dependents.

b) Lack of coping mechanisms

This category strongly relates to the previous category, whereby it was made evident that recovering addicts are susceptible to experiencing cravings during their aftercare. It is therefore essential and advisable for recovering service users to identify specific coping mechanisms for different thoughts, feelings, moods and situations that are derived from continuous cravings (Wadhwa, 2009). This category was formed by asking the participants about their coping mechanisms towards dealing with cravings. The following are retorts from participants:

“I feel I want to go and smoke but then I realise why I am here and why did I get sober and if I relapse I wasted everyone’s time that helped me.” (Par 2)

“I deal with it by sleeping or sometimes I eat, for instance my father likes sweets and stuff like that, as we were told in hospital if you crave something keep something sweet nearby.” (Par 5)

“I go and praise to God and mostly I go to meetings.” (Par 9)

“... I deal with it by sitting down and read my daily Bible and eat or just walk around.” (Par 14)

It was made evident by analysing the narratives of participants there were only a few that utilised theoretical or adequate coping mechanisms in terms of going to support groups or contacting NA or AA sponsors. However, the remaining sum of participants lacked coping mechanisms and independently formed coping mechanisms that are not supported by theoretical models or approaches. Instead, the majority of participants utilised insignificant means of dealing with cravings (eating, walking around) in the hope that the intense urges and desires would disappear. These viewpoints correspond with the increased risk statistics of substance dependency relapses, in which Van der Westhuizen (2010) found that it could be resolved by developing coping skills and life skills such as assertiveness, decision-making and problem-solving during their aftercare services in order to deal with these cravings. However,

it is apparent that there is a lack of coping skills which make cravings an ongoing challenge for service users during aftercare and reintegration services.

4.8.2.3 Sub-theme 1.3: Biological well-being

A person's well-being and needs has been referred to as an existing challenge for service users in recovery. If the well-being of recovering addicts are neglected, it increases their risk of relapsing. This sub-theme allowed for the prevalent category of weight gain to be emerged amongst the participants' narratives.

a) Weight gain

Body image refers to the perception that an individual has about their physical self and the feelings and thoughts surrounding that perception. Sun (2009) stated that individuals that perceive themselves as overweight tend to disjoint their sense of well-being. The majority of participants mentioned that their negative body image was directly linked to their perception of their weight gain in recovery. This is depicted in the following narratives:

“I have gained a lot of weight because I was on uppers and now I don't have anything to drive me, which has been very hard on me, as I picked up 20kgs” (Par 8)

“Not really, but I struggled with weight gain which made me feel insecure, but I have accepted it and starting to gym.” (Par 10)

“Uhm, a pick up a little bit of weight gain and I am unfit.” (Par 15)

Weight gain has been mentioned by the majority of the participants as a defiant biological challenge, because during active addiction they were at their skinniest. AOD misused by individuals often suppressed their appetite, which leads to extreme weight loss, whereas during recovery their appetite resurfaces and the idea of following a balanced diet is something that was never a priority for them (Sun, 2009).

4.8.3 Theme 2: Psychological challenges

Routledge (2005) articulated that developmental, cognitive, personality, psychiatric disorders and past trauma are all factors that play a role in the psychological relapses of service users during aftercare services. The psychological aspect of the Biopsychosocial model (Engel, 1981)

refers to the existing mental and psychological challenges that have been identified and subdivided into sub-themes. The participants were then asked about these challenges which provoked personal experiences and viewpoints that have been classified into categories. As depicted in the research proposal the criteria of inclusion stipulated that participants had to be currently receiving aftercare services. This criterion allowed for participants to be asked about their experience with existing psychological challenges and how it has been dealt with in order to prevent relapses during aftercare and reintegration services.

4.8.3.1 Sub-theme 2.1: Dealing with emotions

Dealing with emotions in depressive and stressful situations is the primary reason or trigger for relapsing because of recovering addict's inability to properly deal with their psychological well-being. This comes after years of consuming AODs, which has suppressed and numbed feelings (Bain, 2004). Therefore, aftercare services are developed according to the six-step recovery process of the Cenaps Model (Gorski & Miller, 1984) which is summarised in chapter 3. With specific reference to addressing psychological challenges, step 4 of the recovery process is about "the service user learning how to deal with feelings and emotions responsibly without having to resort to AOD." As depicted in the following narrative, individuals experience various emotions during aftercare services:

"Uhm, I think when everyone feels sadness, anger and happy and when you are recovering you will feel sad at one point because it is normal human emotions and when you do feel sad I think the first thing people jump to is the substance because they not used to handling it like everyone else." (Par 17)

During aftercare and reintegration services, many of the service users are faced with unresolved emotions that were caused by trauma, regrets or past mistakes. Recovering service users have to deal with various situations that provoke the following emotions during aftercare services, as collected and summarised in the following categories.

a) Negative emotions

Negative emotions can include many feelings, but the ones that were constantly repeated amongst the participants were sadness, loneliness, guilt, shame or regret. For numerous years, recovering addicts were oblivious to feeling or dealing with emotions because of the suppressing of the AOD. Therefore, negative emotions are a psychological challenge for service users

because they have no prior coping skills or mechanisms that buffer them against relapse prevention (Miller & Harris, 2000). The following statements are based on the participants' experience of dealing with stressful and depressive situations that provoked certain negative emotions:

“All the time I feel depressed I feel I can't take it anymore and that I can take a knife or a blade and just cut myself, is there any way God can get me out of this situation? I feel like this every day, even at work small problems an example such as having an argument with my boss or my colleague would activate that stress feelings of my addiction and I would get in an emotional state” (Par 2)

“I was one of the wealthiest guys in Bloemfontein and then sometimes looking at what I had and what I have now makes me depressed ...” (Par 9)

“I had to let go of a lot of friends and family included with this walk of sobriety, and sometimes it does get lonely because you can't always rely on talking to colleagues. Me and another volunteer at the rehab used to use together and we have come a long way over the years but there are certain things I can't share with him” (Par 11)

The available literature of psychological risk factors echoes these experiences of the participants by highlighting numerous amounts of negative emotions that are activated during aftercare. It has also been made evident that the majority of participants experience certain emotions but do not have reliable or established emotional support, even though they attend aftercare services. Instead, most of the participants experience a sense of loneliness and isolation when having to deal with their emotions. These narratives correspond with the findings of Bain (2004) that reiterates lack of emotional support is associated with feelings of loneliness because many individuals in recovery have to remove themselves from previous social groups that are comprised of active addicts.

b) Aggression

This category strongly relates to the previous category as anger is seen as a negative emotion, however, only some of the participants experienced aggression during their recovery process. Aggression is often the result of suppressed emotions that were caused by a traumatic and painful event that has not been dealt with. Therefore, it is manifested in the form of anger (Routledge, 2005). This is a psychological challenge because it has been made evident that unpredictable

anger outburst make individuals vulnerable to relapsing. The following statements are participants' descriptions of the aggression they have experienced, and how this psychological challenge has been dealt with to prevent relapses:

“I was dealing with my issue that I wasn't ready to deal with, which ultimately causes me to have the anger in which the anger in turn cause you to use so much. When I was in Hesketh King it was the first time I dealt with it in 12 years, which ultimately led me to my anxiety uhm my emotional instability, so to speak, and only when I dealt with it did things get better for me and now I actually became stronger.” (Par 4)

“Yes, I experience anger, depression and defiantly anxiety.” (Par 7)

“Just the anger and irritation I still struggle with. I am married now and even the kids can irritate me and I don't want to be like that, but it just happens because I am short tempered. I think I have issues from the past that I didn't properly deal with yet and that irritates me.” (Par 12)

In correlation with the abovementioned narratives, some of the participants still experience aggression during aftercare, which is after they received formal treatment. These findings are supported by the notion that aggressive behaviour is the root cause of many psychological problems and paves the way for delinquency, interpersonal conflict, and, most importantly, reoccurring relapses (National Institute on Drug Abuse, 2016). Therefore, participants are still experiencing aggressive behaviour, probably because they are not properly dealing with psychological problems during aftercare.

c) Untrustworthiness

Lack of trust within the familial system is a psychological challenge, as it provokes emotional uncertainty, whereas a recovering addict feeling untrusted often leads to substance dependency relapses. As depicted in Donovan and Marlatt's (2005) research, “negative emotions, interpersonal conflict and pressures accounted for 72% of all relapses.” A family's lack of trust in the recovering service user's sobriety is often caused by the constant lies, criminal activities, manipulation and immoral actions that the former addict subjected the family and themselves to during active addiction. Mistrusting the service user's ability to remain sober refers to others'

lack of confidence in them. This feeling of being untrustworthy was a common emotional situation experienced among the participants, as illustrated in the following narratives:

“I think it’s because they lack support, uhm their families don’t understand what they are dealing with or how difficult it is to, uhm and some of us are not strong enough to say no.” (Par 5)

“... there was a lot of trust issues because of my addiction.” (Par 8)

The thing that stresses me the most that my parents don’t believe that I am clean and trying to change so they accuse me of stuff I didn’t do.” (Par 13)

“When things don’t come right and when I am accused of something that I didn’t do but I learnt to deal with it by staying calm because it will get better in the future. My family is also putting pressure on me to get money, job and for my girlfriend wanting things such a marriage but I am not strong enough to deal with all these pressures.” (Par 14)

“Also people not trusting you even if you felt you earned but you learn you still have a long way to go.” (Par 15)

The above stated narratives fall in line with the literature discussed, as the majority of service users still experience trust issues during aftercare due to lack of understanding and knowledge by others regarding addiction recovery and relapse prevention. Additionally, mistrusting the recovering addict tends to lead people such as family members to question or constantly interrogate his/her movements, which causes him/her to feel isolated and overwhelmed, and, by extension, vulnerable to relapsing (Bain, 2004). It has been made evident that unresolved family issues have a direct impact on the service user’s psychological well-being, which increases his/her risk of relapsing during aftercare and reintegration services.

d) Inconsistency of coping skills

Coping skills to deal with distressing and high-risk situations, such as those expressed in the abovementioned categories, is essential to relapse prevention during aftercare services. A coping skill can be any behavioural, psychological or social action taken in response to an identified stressor or trigger, such as these distressing situations which have already been found within sub-theme 1.2 to be cravings. These skills are meant to act as a buffer that protects the

service user against unfavourable situations or events (Proctor & Herschman, 2014). During active addiction, a ‘buffer’ is often associated with the AOD’s intoxication in order to numb or cope with unpleasant feelings. Therefore, formal treatment facilitates equip the service users with coping skills to ensure sobriety and relapse prevention. Accordingly, subsection 30(2), chapter 7 of the Prevention and Treatment of Drug Dependency (Act, 70 of 2008) states that the purpose of establishing aftercare support groups is to provide a safe and substance-free group experience whereby service users can practice re-socialisation and coping skills. These statements elaborate the variety of knowledge and skills of different participants in order for them to deal with distressing situations:

“I will avoid people, places and things where I used to use drugs and alcohol.”(Par 3)

“Smoking cigarettes is one of them and breathing exercises that I am trying to do now.” (Par 6)

“I remove myself from the situation and sometimes would watch movies.” (Par 13)

“... I still haven’t dealt with any of it as I am numb to everything so I don’t really deal with it so there is a certain level of bottling up because I am not ready to talk about it.” (Par 15)

As illustrated in the above stated narratives, there is not a consistent coping skill or mechanism that is known or utilised by a group of people. Instead, there is a lack of effective coping strategies among aftercare service users. Accordingly, Nutt (2012) finds that people who avoid dealing with stressful or high-risk situations in recovery are susceptible to relapsing because of associating AOD use memories to that of stress relievers.

4.8.3.2 Sub-theme 2.2: Cause of previous relapses

Substance dependency relapses were initially defined in the research proposal as the use of AOD after a period of abstinence, which occurs usually after receiving formal treatment (Encyclopaedia of Social Work, 2013). Numerous amounts of research have been conducted to find out the underlying causation factors for relapses. The majority of researchers conclude that there is no single cause for experiencing relapses, but rather an amalgamation of factors that causes relapses. This study adapted the Biopsychosocial model so that all these domains surrounding an individual’s existence could be studied. For the purpose of this study, the cause

of relapses is a psychological challenge, because there are recognised risk factors that affect their mental motivation of sobriety. The psychological and mental challenge of relapsing has been highlighted by the following narrative:

“... I realised if you don’t know where you have been and where you are and where you are going, if you don’t stand for anything you will fall for anything. Therefore, you must be grounded and have realistic goals and vision for you it is not going to work.” (Par 12)

According to the Cognitive-Social Learning Model (Donovan & Marlatt, 2005), substance dependency aftercare and reintegration services focus on these risk factors and identify protective factors that buffer service users against vulnerable challenges. Therefore, the most common causes of relapses that were experienced or understood by the participants during aftercare services are divided in the following categories.

a) Unemployment

“In South Africa the unemployment rate has increased from 27.1% in the fourth quarter of 2018 to 27.6% in first quarter of 2019” (Statistics South Africa, 2019). This is an epidemic for many people in South Africa, because as identified in previous chapters, the poverty rate has grown to be at 55.5%. During active addiction, many individuals are often engaged in criminal activity as a source of income which consequently led to criminal records, drop-out rates and no legitimate employment history. With regards to unemployment, the majority of participants indicated this as a predisposing factor for relapsing as depicted in their statements below:

“The stress is put on you to get a job ...” (Par 14)

“Boredom and unemployment, defiantly those two are the killers. Also, people not trusting you even if you felt you earned, but you learn you still have a long way to go.” (Par 15)

Unemployment is also listed by Wadhwa (2009) as one of the challenges that predispose recovering individuals to relapses. Related to this is the fact that most of the recovering service users did not complete their high school studies because of them dropping out of school, which increases their chances of relapsing. Similarly, as mentioned in the narratives above, boredom becomes another consequence when facing limited opportunities of employment.

b) Reservations

The notion of reservations is based on the literature developed by the self-help groups Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). Reservations are psychological thought patterns that are seen as stumbling blocks in long-term recovery, and if not dealt with can lead to relapses. These thought patterns are associated with specific events which would push you to utilise AOD again, such as your wedding day, death of a loved one or not reaching goals in a certain time period. Some of the participants encountered this as a psychological challenge during aftercare services, which put them at risk of relapsing, as depicted in the following statements:

“People that have reservation, is basically when you have this type of idea or scenario where you would use. For example, if your mom would passed away ... you would think to yourself I won’t be able to handle this so if it does happen you plan ahead and say you will then start using again.” (Par 6)

“Reservations, if this happens I will relapse. For example, if my mother dies tomorrow, I will relapse and that is a reservation. If I have to lose my job or lose my house, I will definitely relapse that is all reservations. Addicts grants themselves the right to use again.” (Par 9)

It was notable that some participants were able to provide personal examples of their reservations which put them at risk of relapsing during aftercare. The abovementioned narratives can be strongly related to the term ambivalence, which is the individual’s uncertainty in their ability to remain sober, and is addressed in the aftercare services of the 12-step programme in terms of AA and NA (Ramaglan *et al.*, 2010).

c) Lack of support group attendance

The purpose of aftercare support groups is to provide “ongoing support to addicted persons and their families following formal treatment in order to increase their recovery potential, and thereby limiting the need for re-admission to treatment facilities” (Ramaglan *et al.*, 2010). This is to ensure a safe and non-judgemental environment for service users to feel supported when dealing with challenges that put them at-risk of relapsing. As depicted by the identifying details of participants, all of them have relapsed at least once in their past, whereas the majority of

them indicated that it was due to them not attending support groups after receiving formal treatment. Adinoff, Talmadge, Williams, Schreffler, Jackley and Krebaum (2010) declared that lack of support group attendance by recovering addicts is one of the most frequent cited reasons for relapses. The findings correlate with the following experiences of participants:

“The four times that I relapsed one week after coming out of rehab was because I didn’t do aftercare and support groups, and I was still seeing my old friends that I used drugs with.” (Par 3)

“Instead of attending support groups you isolate yourself and try and deal with it by yourself and that is why people like me have relapsed in the past.” (Par 17)

Linking the narratives with the theoretical underpinnings it is evident that making the psychological decision to not attend support groups puts the individual at risk for relapsing because it leaves space for vulnerability. Once a recovering addict has received formal treatment in a controlled, isolated and safe environment they are discharged into their unchanged, uncontrolled and threatening environment. Therefore, support groups act as a vehicle to transport the literature and knowledge of relapse prevention to the recovering service user’s recovery process. Without the structural support of self-help groups, it has been made evident that participants are left to their own devices.

d) Protective factors

This category directly links with those mentioned above, because the participants were asked to elaborate on how they dealt with these identified predisposing relapse factors during their most recent recovery process. For the purpose of this study, this refers to protective factors. Aftercare and reintegration services are developed to identify recovering service users’ risk factors that predispose them to relapses, as well as to identify protective factors that can provide them with protection during these vulnerable challenges (Donovan & Marlatt, 2005). The majority of the participants dealt with the risk factors by attending support groups and ultimately avoiding people, places and things.

“I will avoid people, places and things where I used to use drugs and alcohol.” (Par 3)

“The sad thing is if I had to come out of treatment and go back to Brackenfell, work in the same environment which I was a manager at a very big restaurant, I would have relapsed. Also, if I had my dealer’s number on my phone that would also be easy to relapse. The unfortunate thing is you can’t see old using friends which I had to cut off ... I dealt with it by avoiding negative people, places and things.” (Par 8)

“Yes, this is what makes the 12-step programme so unique if you really follow all the suggestions and you do your step work and answer your questions. This programme will show reservations before you knew you had them. So, in other words, I would write those down and work on it.” (Par 9)

Now I take my aftercare seriously and attend as many support groups as I can.” (Par 18)

In comparison with the previous categories, this category emphasises the protective factors that ‘buffer’ the service users against relapses. The majority of participants emphasised the importance of changing old behavioural patterns that are associated with people, places and things which correlates with the school thought related to the maintenance stage of the Change Model (Sussman & Ames, 2001). The abovementioned statements also correlate with aftercare policy and legislation in terms of subsection 30(2), chapter 7 of the Prevention and Treatment of Drug Dependency (Act, 70 of 2008), which stipulates that “the purpose of establishing support groups is to firstly provide a safe and substance free group experience whereby service users can practice re-socialisation skills.”

4.8.3.3 Sub-theme 2.3: Dual diagnosis or co-occurring disorders

The term ‘dual diagnosis’ and ‘co-occurring disorders’ means a co-occurrence of substance use disorders (SUD) and other psychiatric disorders as defined in Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM–V) (APA, 2013). According to the National Institute on Drug Abuse (NIDA, 2007), “individuals with any substance use disorder (SUD) are 2.8 times more likely than individuals without SUD to be diagnosed with any mood disorder” (anxiety, depression, etc.) this closely correlates with sub-theme 2.1 in terms of dealing with emotions. Additional statistics that was conducted by South African Community Epidemiology Network on Drug Use (SACENDU, 2018) stipulated that 14% of people in South Africa presented with a dual diagnosis at formal treatment admission. People that have a substance use

disorder (SUD) are often misdiagnosed or have their mental health neglected because of them ‘self-medicating’ with AOD.

The National Drug Master Plan (NDMP, 2006-2011; 2013-2017), as depicted in the literature review, developed specific outcomes derived from a review of the NDMP 2006 – 2011. These are described in the NDMP 2013 – 2017 in terms of the basic concepts of monitoring and evaluation (Public Service Commission of South Africa, 2008). The outcome number 5 refers to the “development and implementation of multi-disciplinary and multi-modal protocols and practices for integrated diagnosis and treatment of substance dependence and co-occurring disorders and for funding such diagnosis and treatment.” With these aftercare policies in mind, this sub-theme was created to determine to what extent the participants experienced their psychological wellbeing being addressed during aftercare. Half of the participants have not been assessed, or have not had access to psychological services in order to be potentially diagnosed, as depicted in the following narratives:

“No I haven’t ... I haven’t been concerned as I feel I am stable enough. However, there is just other stuff such as my biggest concern I wasn’t born normal like other people. I was a bit deformed. You can’t see it immediately, but people have made fun of me every day.” (Par 2)

“No, I have not been assessed.” (Par 6)

“No.” (Par 13)

This correlates with the findings of Swann (2010) which highlight that the lack of psychological treatment and diagnosis of recovering service users have a direct impact on reoccurring relapses because of them self-medicating with AOD in an attempt to resolve psychiatric symptoms. Regardless of the increasing dual-diagnosis statistics, psychological treatment is still being neglected during aftercare, which creates a challenge for service users to remain sober. However, the other half of the participants have been assessed by mental health professionals and have been diagnosed with the following psychiatric disorders:

“Yes, I have been diagnosed with borderline personality.” (Par 5)

“Yes, when I was diagnosed with severe depression, ja, I was mainly put on anti-depressants.” (Par 4)

“... Okay, well I am on antidepressant medication, like double the normal dosage, and I feel that’s how I deal with it ...” (Par 17)

These narratives correlate with McCrady, Ladd and Hallgren (2012), who estimate that between “19-34% of individuals with mood disorders has a comorbid substance use disorder.” Swann (2010) states that there is a lack of information regarding co-occurring disorders, and for this reason he explains that there is a necessity for further dual-diagnosis studies. Whereby, future studies should make further reference to intervention and treatment of co-occurring disorders on a much larger scale.

4.8.3.4 Sub-theme 2.4: Sexual trauma

Sexual trauma as a psychological stressor refers to stimuli that cause stress reactions produced by a problem or trauma that individuals experience that are beyond their personal resources to control (Swartz *et al.*, 2011). This is often the reason individuals become dependent on illicit substance as an attempt to cope with the damage or loss caused by the stressor (Germain & Gitterman, 1980). During data collection, participants were asked to describe any other psychological challenges, and a quarter of the participants expressed sexual trauma as still being problematic to their sobriety. These psychological stressors are seen as a challenge in a service user’s aftercare, because if not dealt with correctly in formal treatment (intervention), it increases the likelihood of relapses.

Sexual trauma is a psychological challenge that is classified as an intense life stressor that contributes to reoccurring relapses if not dealt with properly. This trauma refers to being a victim of sexual abuse, which includes any form of sexual violence including rape, child molestation, incest, and similar forms of non-consensual sexual contact (Frazier, 2003). There is a significant amount of research that finds a strong association between sexual abuse history and that of AOD misuse by individuals. These are the statements of participants that have been victims of sexual trauma and are still feeling the consequences of such an ordeal:

“Uhm, well overcoming the emotional pain that was caused when I was gang raped as a teenager has been very traumatic, because I only properly dealt with it in rehab, because in the past I felt so little of myself so I started experimenting with drugs and alcohol to numb the pain.” (Par 1)

“... I am also still working through the trauma of when I was raped when I was 19 years old.” (Par 13)

“I was molested and I was raped, but there wasn’t place for me to go until I went to rehab, which was one of my core issues, which I feel it is very important that the aftercare gets reports about these core issues so it can be further dealt with in aftercare, because why must I tell someone again that I was raped and I have already worked on it? Now I can talk about it openly because I work through it.” (Par 16)

The abovementioned experiences correlate with the American Psychiatric Association (2013) that found that survivors of sexual trauma are at high risk of posttraumatic stress disorder (PTSD). It states that “[t]he Diagnostic and Statistical Manual of Mental Disorders (DSM-V), defined PTSD as the exposure to a traumatic event that invokes intense fear, helplessness, or horror and a range of symptoms, such as reoccurring recollections or dreams of the event, persistent avoidance of all things associated with the trauma, numbing and lack of responsiveness” (APA, 2013). Myers *et al.* elaborate that “[s]ubstance use also increases young women’s risk of further exposure to physical and sexual trauma, and consequently HIV, as substance use often places women in high-risk environments for assault and because it often exacerbates conflict in relationships” (2016). Since the participants’ predisposition to trauma appeared to have prevalence, it could explain why they felt easily overwhelmed by emotions and considered stimulants as a means of coping with psychological stressors (Frazier, 2003; McMahon, 2001). Therefore, if not acknowledged and further dealt with during aftercare services, it has the potential to put service users at risk of relapsing.

4.8.4 Theme 3: Social challenges

The social aspect of the Biopsychosocial model (Engel, 1981) takes into consideration all the social, environmental and interpersonal factors that contribute to substance dependency relapses. The social sphere surrounding a recovering addict is often uncontrollable. Therefore, it requires the adaptation process whereby the individual’s sobriety depends on his/her ability to adjust to the demands or influences that exist in any given environment. For the purpose of this study, these influences are referred to as social challenges, which are predisposing relapse factors that exist in the recovering service user’s environment. Sigelman and Rider (2006), articulate that although the recovering service users have attempted to change their addictive

behaviour patterns within a structured treatment facility, once they are discharged, they are reintegrated into the same unchanged environment. Consequently, the purpose of aftercare services is to ensure the transition period is beneficial to the service users' adjustment to sobriety, so that relapses can be prevented (Laudet, 2011). Therefore, the following sub-themes were developed based on the existing social challenges that predispose individuals to relapses. As depicted in the research proposal, the criteria of inclusion stipulated that participants had to be receiving aftercare services. This criterion allowed for participants to be asked about their experience with existing social challenges in order to gain empirical evidence on whether aftercare services have dealt or addressed with it in order to prevent relapses. These are the following social challenges experienced during aftercare and reintegration services:

4.8.4.1 Sub-theme 3.1: Family systems

In the 21st century, a family system has moved away from the traditional structure and has become characterised as step families, single parent households, foster families or child headed families. During active addiction, the families of recovering addicts have also suffered the consequences of substance dependency in terms of emotional, physical, financial and mental burdens. Additionally, the family has a significant influence on the recovery process of addicts, because they provide a supportive structure, and statistics found that majority of individuals are reintegrated within their family homes (Laudet, 2011). This can be found and supported by the following participant's narrative:

“My family, because they were very over protective, and I didn't control anything on my own even with my health they sorted it out. They were very supportive even though they kicked me out on the street which was my rock bottom and made me want to get help at a rehab.” (Par 16)

According to Goldenberg and Goldenberg (2000), “problematic human behaviour such as substance dependency is part of a complex, interactional and reoccurring patterns that take place within the family, which emphasises that problem behaviour is not the result of personal characteristics but is a result of interactions within social systems.” Therefore, family systems are a social challenge during aftercare because of the following predisposing relapse factors that are based on the participants experiences.

a) Lack of family involvement

The lack of family involvement in a service users' recovery process has been a reported problem for many people in substance dependency aftercare and reintegration services. The recovery rate for service users are also much higher when family members are actively involved in the treatment process (Donovan & Marlatt, 2005). However, certain legislation and policies have been developed to address the problem, with specific reference to subsection 30(1), in chapter 7 of the Prevention and Treatment of Drug Dependency (Act 70 of 2008). This act focuses on successful reintegration of the service user into society, family and community life in order to prevent the recurrence of problems in his/her family environment that may contribute to continued substance dependency. The majority of the participants still experience lack of family involvement in their aftercare programme in terms of counselling and support groups, as depicted in the following statements:

“... my family doesn't participate in my recovery at this stage.” (Par 7)

“No, because they don't believe I will stay sober.” (Par 13)

“Uhm, well the options are there but they are choosing not to, and my mom has breast cancer right now, so everything she is going through right now it is difficult for her to take part of my recovery.” (Par 18)

These narratives link with available literature as described by Routeledge (2005), which states that the lack of family involvement increases the probability of services users relapsing because there is no emotional support received from family members, which in turn creates the perception and actuality that one is not cared for. The nature of support groups is to provide families with the opportunity to heal from the pain caused by the recovering substance dependent's past behaviour.

b) Unresolved conflict

An individual's wellbeing depends significantly on his/her ability to form healthy interpersonal relationships. However, during active addiction, the service user has caused a lot of destruction within the family system in terms of stealing, lying and manipulating in order to maintain his/her addiction habits. During active addiction the his/her primary relationship was with his/her drug of choice, therefore impacting other relationships radically. As a result, communication and interactions within the family system is often associated with blame, guilt,

anger and shame (Laudet, 2011). It is evident that recovering addicts are admitted into formal treatment to overcome these consequences that they have caused. However, it often neglects the necessary healing of family members who are not, as illustrated in the abovementioned category, involved in the service user's aftercare programme, which results in the social challenge of unresolved conflict within the household. This is evidential in the following narratives:

“Household issues like, uhm, with my mother there is a lot of arguing going on and she never finds herself to be wrong even though people in the house know she is wrong, but you don't want to tell her because firstly she is your mother and second of all, if you do tell her it will just make things worse.” (Par 6)

“No-one (laughs), and they need it because they don't know how to deal with addiction and they always remind me about what I did wrong in the past and that causes arguments.” (Par 17)

Approximately half of the participants expressed their challenges with unresolved conflict within their families. This may directly be the result of the previous category in terms of limited involvement by families in the structural platform that aftercare provides in order to resolve conflict and unproductive communication, which in turn prevents relapses. Lewis et al. (2011) recognise that it is common for family members to either withdraw from the service user, or increase conflict in an effort to motivate or force him/her to maintain sobriety, but this has been proven to have the opposite effect.

c) Support for families

Support for families during the service user's aftercare and reintegration level of service delivery can consist of informational support (advice and guidance by professionals), emotional support (encouragement) and concrete support (physical help and assistance) (Sarason & Sarason, 2009). Although it has been made evident by various authors, such as McDonagh and Reddy (2015), that most formal treatment facilities include at least one family counselling session, there is still a limited amount of research and knowledge regarding support services for families during aftercare services. The majority of participants experienced this lack of support for families as a social challenge during aftercare services, because while they are practising and maintaining behaviour changes, their family members are not progressing. This is evident in the narratives below:

“No, they are not being supported.” (Par 2)

“No, because my sister and her husband, who is a pastor, they offer each other support.” (Par 9)

“No, but they did attend the family programme at the rehab I was in.” (Par 14)

These findings are supported by the theoretical underpinnings of self-help groups such as Alcoholic Anonymous (AA) and Narcotics Anonymous (NA), which make up the most prevalent aftercare support groups in the world and only consist of members that are recovering addicts (Fiorentine & Hillhouse, 2000). The exclusion of family members in such support groups has a direct effect on the recovering addict, because it is often found that the family healing process weighs heavy on the service user’s sobriety. Therefore, family members should be provided an opportunity to heal separately from the recovering addicts. As supported with literature from Wadhwa (2009), a family system is influenced by internal (stress, employment, housing) and external (political, economic and social) changes, whereas a recovering addict becoming sober is an internal change in which a family system must adapt to in order to regain balance. This balance is therefore threatened, because based on the abovementioned narratives and categories, families are not involved and supported in aftercare services. The assumption can be made that maybe the lack of family involvement in the service user’s aftercare process is due to the lack of available support systems for family members.

4.8.4.2 *Sub-theme 3.2: Availability and accessibility of alcohol and/or other drugs (AOD)*

The increased presence of AOD within any given environment has a direct impact on the people that reside in that community, and especially for those in substance dependency recovery, as it can also be linked to both sub-theme 1.2, which is cravings, and sub-theme 2.2, which is past relapses. It has been reiterated throughout this study that the inclusion criterion of participants was restricted to individuals that have received formal treatment and are currently aftercare and reintegration service users. Based on these requirements, it is clear that recovering service users were initially admitted into a drug-free and controlled environment created by a treatment facility, and thereafter readmitted into their residing unchanged and unfavourable environment. The National Drug Master Plan (NDMP, 2006-2011; 2013-2017; 2018-2022) responded to this national crisis by developing specific outcomes derived from a review of the NDMP 2006 –

2011, and implemented in the NDMP 2013 – 2017 in terms of outcome 4, which is “reduced availability of dependence-forming substances/drugs, including alcoholic drinks such as unregistered shebeens in local communities.” Therefore, the participants were asked to describe their experiences with the social challenge of having accessibility and availability to AOD during aftercare services, as can be seen in the narratives below:

“Very easy to get hold of drugs and alcohol in my community.” (Par 3)

“Easy, it is behind me, two blocks and then two streets away from me.” (Par 12)

“Just next door, down the street, around the corner.” (Par 16)

“I have four dealers on speed dial that drop off in front of your door, that would carry it in a little Mac Donald’s bag like quick and efficient even outside your work.” (Par 17)

It is notable to indicate that these narratives were taken from participants that reside in various demographic locations in terms of low to high class areas, as illustrated in the identifying details of participants. All of the participants expressed the effortless, availability and accessibility of AOD during aftercare and reintegration services. This corresponds with the research of Bain (2004) that listed the availability of AOD as being one of the biggest challenges for recovering addicts because it is associated with reoccurring relapses.

4.8.4.3 Sub-theme 3.3: Interpersonal relationships

Interpersonal relationships are social relations, connections, or associations between two or more people. They vary in different levels of intimacy and sharing, implying the discovery or establishment of common ground or interest (Encyclopaedia of Social Work, 2013). These interpersonal relationships are formed throughout an individual’s life span in terms of kinship relations, friendship and social groups, as well as intimate and romantic relations. The existence of interpersonal challenges during aftercare services can be seen in the following narrative:

“Relationships, uhm I am able to establish a relationship, but I am not able to stay in it at the end of the day due to fear that I have of being hurt once again.” (Par 4)

Positive interpersonal relationships provide the actual and perceived benefits of social support, which is highly related to long-term abstinence rates across several addictive behaviours (Nutt,

2012). In comparison, negative interpersonal relationships impact an individual's ability to achieve optimal social functioning, as well as reaching their full potential in their recovery process. Unfortunately, various studies have indicated that interpersonal relationships that are present in a substance dependent's recovery are usually characterised by the latter, because they are often developed and maintained during AOD misuse (Donovon & Marlatt, 2005). For this reason, interpersonal relationships can be classified as a social challenge during aftercare and reintegration services because of the following predisposing relapse factors and categories.

a) Peer and social pressure

A sense of belonging is seen as a basic human need according to Abraham Maslow's theory on the hierarchy of needs for motivation and personality (Maslow, 2000). It is an essential part of human development and is often created through social acceptance, connections, recognition as well as to be valued by a certain group of people. In the search for this sense of belonging, an individual has the potential to get involved and pressured by negative social and peer groups, which has a detrimental effect on his/her development. Negative social groups are often associated with activities such as AOD abuse, risky sexual behaviour, illegal activities and criminal or gang affiliations (Louw & Louw, 2007). Peer pressure is defined as the pressure or desire to partake in such activities in order to feel a sense of belonging and acceptance by a certain social group. Various studies found that substance dependent individuals usually belong to such negative social groups in order to normalise the severity of their addiction problem. Once the recovering service user is discharged from formal treatment, he/she is generally still exposed to peer pressure from his/her previous social groups in order to encourage relapsing (Bain, 2004). This is evident by the following peer pressure challenges experienced by most of the participants:

"... even asked at a family braai when can I start drinking again in which I had to explain to her that I can't ever drink alcohol again ..." (Par 8)

"Old friends I had to stop contacting them and visiting them after I got out of rehab." (Par 12)

"The only problem I still have is that the people I used to use and smoke with, they still consider us as friends ..." (Par 15)

“People thinking addicts can drink alcohol if their main addiction was drugs.” (Par 16)

It emerged from the abovementioned narratives that the majority of people are still being subjected to significant amount of peer and social pressure to engage in AOD behaviours. These participants have directly and indirectly experienced peer pressure during aftercare, which correlated with the available literature by Ward, Van der Merwe and Dawnes (2012) that suggested direct peer pressure consists of peers trying to convince a person to use AOD again, or indirectly through modelling by utilising AOD in the presence of the recovering service user. Peer pressure is a predisposing relapse factor because it approves, encourages and normalises AOD relapses.

b) Intimate relationships

Recovering addicts that are in intimate relationships during aftercare and reintegration services are often in co-dependent or unhealthy relationships. This is based on the notion that the relationship is usually formed during the service user’s active addiction period and continued throughout formal treatment and on to aftercare services. As illustrated in the identifying details, more than half of the participants are involved in romantic or intimate relationships during their aftercare services. According to Prochaska and Diclemente’s (in Sussman & Ames, 2001) stages of change model, the action stage is affiliated with behaviour changes by recovering addicts that happen in order to overcome addiction which normally occurs within formal treatment. Therefore, the maintenance stage occurs once the service user is discharged into aftercare services, whereby these behaviour and socialisation changes must be practised within safe environment. According to subsection 30(2), chapter 7 of the Prevention and Treatment of Drug Dependency (Act, 70 of 2008), the purpose of establishing support groups is primarily to provide a safe and substance free group experience through which service users can practice re-socialisation skills. However, existing patterns within intimate relationships are built around the substance use disorder, and it is often found to be a challenge for partners to adjust to the recovering service user’s behaviour changes. Therefore, substance dependency recovery is affected by intimate relationships, as it may either maintain behaviour changes or provoke past behavioural habits associated with substance dependency. These challenging social experiences that occur in intimate relationships are evident in the following narratives:

“In the past, I used to use relationships as an excuse to relapse.” (Par 11)

“In the beginning, I had two girlfriends after I got out of rehab, and it was very toxic because she drank and smoked a lot which almost cost me my sobriety. It was up and down, it was very toxic and when I think now, I think I was only with her to be with her physically.” (Par 12)

“It has been the most difficult thing, because I am never doing anything right and I don’t feel good enough. My girlfriend and I always fight about everything I do or don’t do.” (Par 14)

“My last intimate relationship was very unhealthy because it was based on getting high on drugs.” (Par 18)

Based on these narratives, most of the participants did not experience their intimate relationships as beneficial to their recovery process, but rather as predisposing relapse factors. These participants experienced more conflict than supportive exchanges within their intimate relationships. Wadhwa’s (2009) research supports these findings by emphasizing that unresolved conflict can set off old SUD behaviour patterns in service users, which is characterised as an instantaneous coping and defensive mechanisms to respond to their partners’ grievances. Marinchak and Morgan (2012) suggest that “counselling conducted with individuals that are involved in committed relationships are more effective when behavioural couple therapy was used as opposed to individual behaviour therapy.” This can be seen based on these narratives. However, there is a lack of empirical evidence about the available professional services for intimate or romantic partners of substance dependent individuals during the intervention and aftercare level of service delivery (Department of Social Development, 2006). The assumption can therefore be made that the high prevalence of participants experiencing intimate relationships as negative could be due to the lack of designated couple or partner interventions that resolve unresolved conflict in a controlled setting.

c) Sex drive

As linked with the abovementioned category, a relationship between two people that abuse AOD are often involved in unsafe sex which increases their vulnerability to HIV/AIDS, sexually transmitted diseases as well as unwanted pregnancies (Myers *et al.*, 2016). This has been highlighted in the South African Statistics (2019) which indicates that “between 19 - 56% of the individuals that attended HIV clinics presented with a co-occurring psychiatric disorder

such as substance use disorder.” The majority of the participants, as illustrated in the identifying details, have an intimate partner during aftercare and reintegration services, in which some expressed challenges with their sexual drive. Sex drive refers to urge or desire to have sex, and several studies have found many recovering addicts experience low sex drive after receiving formal treatment compared to their once active libido during their AOD abuse. This correlated with some of the participants who experienced low sex drive since abstaining from AOD. The drug of choice for all of these participants was tik (methamphetamine), which is known to heighten libido and enhance sexual pleasure, and is also linked with high risk sexual behaviours (Sun, 2009). This can be supported by the following narratives:

“Biological sex was very difficult for me to cope with my sexual life, because you know when you on drugs you go for long and then all of a sudden you without this substance then you in a relationship, but then you go two minutes and then you done, so everything changes. I was very open about my sexuality and I had a very good partner that supported me in that structures. I even went to the doctor who said give it time and then we have a look at it again. It was a very big adjustment for me.” (Par 16)

“... My sexual drive and urges have defiantly decreased now that I am sober, which has been something I needed to get use to ...” (Par 17)

These narratives highlight how intimate relationships have been a social challenge for some of the participants because of their low sex drive that is associated with AOD abstinence. Linking these findings with the theoretical underpinnings of Goldenberg & Goldenberg (2008) shows that an individual suffering from low sex drive often has feelings of inadequacy, low self-esteem and insecurities, which directly predisposes the service users to relapse because of their positive association with high sex drive and AOD abuse.

4.8.4.4 Sub-theme 3.4: Socio-economic status

The social and economic background surrounding the recovering addict’s immediate environment plays a role in their relapse prevention. Throughout various research studies, it has been made clear that individuals who have been raised in low-income communities are four times more likely to abuse AOD than to those who have grown up in high-income families. This is a social challenge for service users during aftercare services, because they are discharged

from formal treatment facilities which are predominately in urban areas, and discharged to their unchanged environments which are normally in rural settlements (Florentine & Hillhouse, 2000). This research study made sure to include participants from various demographics (low, middle and high income), so that socio-economic challenges between various socio-economic backgrounds could be gathered and illustrated. However, regardless of the income bracket of individuals, all families and households of recovering addicts suffered financial burden due to substance dependency consequences (Bain 2004). This can be highlighted in the following narrative:

“My family is also putting pressure on me to get money, job and for my girlfriend wanting things such a marriage but I am not strong enough to deal with all these pressures.” (Par 14)

Therefore, socio-economic status is a social challenge during aftercare services because of the following predisposing relapse factors based on the participants’ experiences:

a) Unemployment

Unemployment was also brought up as a psychological challenge under the sub-theme of causes of relapses. This shows how various social and psychological aspects of an individual can intertwine. The category was emerged as a social challenge because it is one of the most frequent high-risk situations precluding to reoccurring relapses (McCann *et al.*, 2011). It has been previously highlighted that the current unemployment rate is a growing epidemic within South Africa, whereby statistics grew from being 27.1% in the fourth quarter of 2018 to 27.6% in first quarter of 2019 (Statistics South Africa, 2019). These statistics are consistent with the fact that the majority of the percentile consists of people with substance dependency problems. Accordingly, section 30, chapter 7 of the Prevention and Treatment of Drug Dependency (Act 70 of 2008) stipulates that “the minister must prescribe integrated aftercare and reintegration services aimed at the successful reintegration of a service user into society, the workforce and family and community life.” This section clearly indicates that social welfare services have the statutory responsibility to provide aftercare and reintegration services that promote the rehabilitated discharged service user towards the achievement of housing, employment and education. However, the majority of the participants are unemployed and are experiencing it as a predisposing relapse factor, as is stated in the narratives below:

“Unemployed with no opportunities.” (Par 4)

“Unemployed and currently hoping to get a job as a policeman again.” (Par 11)

“... I feel stressed and depressed about work because I am unemployed, and my parents are putting pressure on me.” (Par 13)

“No opportunities and I really need a job for my family.” (Par 14)

“Currently unemployed. Even though I have tried to hand out my CV, people tend to not trust recovering addicts.” (Par 15)

These narratives correlate with the current crisis within South Africa and has a direct impact on reoccurring substance dependency relapses. This deprives the recovering addict of his/her ability to experience the benefits of being sober, which includes the development of his/her productivity, sustainable income, accomplishments and social networking of daily life (Nutt, 2012). As depicted by the poverty statistics being as high as 55% (Statistics SA, 2018), families are putting pressure on their children to get employed, which directly impacts the recovering addict, who the majority of the time was not employed throughout his/her AOD abuse, and is now feeling the burdens and consequences during aftercare. As supported by the findings of Rassool (2011), socio-economically disadvantaged households can place individuals at risk for AOD relapses, because these environments may involve stressful living conditions, social disorganisation, few social opportunities for individuals, and instability.

b) Educational status

This category directly links with the predisposing relapse factor of unemployment. Yet, it is seen as a separate and significant challenge that is present within the recovering addicts aftercare programme. According to the South African Community Epidemiology Network on Drug Use (SACENDU, 2018), the youngest onset age for substance dependency is ranging between the ages of 10 to 19 years old, which has increased by 29% since 2017. This directly influences the fluctuation of school drop-out rates due to the preoccupation with alcohol and/or other drugs (AOD) from an early age. These statistics correlate with the participants' identifying details, because at least half of them dropped out school. Therefore, most of the participants experienced their educational status as being a challenge during their aftercare services, as demonstrated below:

“I was never offered, but I would like to empower myself to finish my school and get my matric, so that I can be the best person I can be.” (Par 12)

“I would like to finish my grade 12 and do my welding course.” (Par 14)

“I am not in a position to finance myself, even though I want to finish my matric and maybe study further.” (Par 15)

These findings correlate with the work of Sun (2009), which shows that a lack of educational status held by recovering addicts has resulted in them having poor problem-solving skills and employment security, as well as limited access to opportunities such as further tertiary education. Recovering addicts are already part of a vulnerable population. However, the fact that they also having limited educational achievements increases their risk of relapsing.

4.8.4.5 Sub-theme 3.5: Criminal records

Criminality can be defined as the unlawful or prohibited behaviours that individuals partake in. It has been found that there is a strong correlation between substance dependency and criminal activities such as theft, gang afflictions or drug possessions (Nutt, 2012). This is therefore an existing social challenge for recovering addicts that are attempting to successfully reintegrate into their communities. As mentioned below, the majority of the participants have criminal records and experienced it as a predisposing relapse factor during aftercare services:

“Yes. For possession of drugs, but it has already been dealt with and is currently on my criminal record, but I want to get it removed after a couple of years.” (Par 3)

“I do have a criminal record.” (Par 7)

“Yes. I have a criminal record for theft three years ago.” (Par 13)

“No. More unresolved cases, as they have been resolved. But I do have a criminal record for possession and for intent to do harm or assault, which I got convicted for, and have a 5 year suspended sentence which I have three years to go.” (Par 15)

Criminal records act as barriers to recovering addicts’ prospects of re-entering society and achieving optimal social functioning. The narratives fall in line with the literature discussed by Fisher and Harrison (2013), which depicts that the majority of addicts were involved in theft, illegal distribution of drugs or possession, which was a source of income in order to maintain their addiction. This resulted in their obtaining criminal records, which has a direct impact on

the service users' self-efficiency to remain sober in the face of finding employment and to obtaining educational achievements with a criminal record.

4.8.4.6 Sub-theme 3.6: Housing

Once a recovering addict is discharged from formal treatment, it is evident that he/she is reintegrated into his/her original environment, which is most likely his/her family household. During data collection, the participants were asked to describe any other social challenges that they may have experienced during aftercare services, in which some expressed housing difficulties. Studies have emphasised this challenge by showing that individuals completing formal treatment who are homeless or returning to AOD environments are more susceptible to relapsing than individuals living in sober environments (Braucht, Reichardt, Geissler & Bormann, 1995; Chandrika, 2015). These findings also indicate that housing assistance such as 'halfway houses' or 'sober living house' are associated with long-term recovery. These establishments are AOD-free for individuals attempting to establish or maintain sobriety. Therefore, section 30, chapter 7 of the Prevention and Treatment of Drug Dependency (Act, 70 of 2008) addressed and stipulated that social welfare services have the statutory responsibility to provide aftercare and reintegration services that promote the rehabilitated discharged service user towards the achievement of housing, employment and education. However, as depicted below, some of the participants' narratives have voiced that their housing circumstances are a social challenge for them during aftercare services:

“The biggest challenge was finding accommodation after I was discharged from rehab, because my family didn't want me to live with them because they didn't trust me, and I was scared to move in with my mom because of unresolved conflict between us, and I was scared I would relapse. When looking for cheap accommodation or halfway houses, there wasn't anything, or they were private meaning to expensive.” (Par 15)

“... they kicked me out on the street, which was my rock bottom and made me want to get help at a rehab.” (Par 16)

“Also, it has been difficult for me to return home after rehab, because there was a lot of trust broken with my family and my drug dealer lived close to me, so it made it very hard for me to come from a rehab where I was protected and then to return as a different person to the same unchanged environment and social problems such as family conflict.” (Par 17)

Although substance dependency aftercare policy and legislations have been developed to promote the service users towards housing solutions after receiving formal treatment, there are still services users that are experiencing their housing as a social challenge during their aftercare services. These narratives correspond with the findings of Chandrika (2015), who reiterated the lack of available research regarding the establishment, existence and implementation of ‘halfway or sober living households’ within developing countries such as South Africa.

4.8.5 Theme 4: Cultural challenges

The cultural aspect of the Biopsychosocial model (Engel, 1981) was developed in more recent years due to the impact various cultural backgrounds has on an individual’s existence and development. Diversity, ethnicity and social justice are all factors that need to be considered when focusing on the cultural level of an individual’s functioning (Kaplan & Coogan, 2005). This is specifically relevant in South Africa that consists of 11 official languages in a population of approximately 57.7 million people (Statistics South Africa, 2018). These cultural differences have made the people of South Africa particularly vulnerable to discrimination and inequality, especially since the period of Apartheid (1948-1991). The division of resources, facilities and opportunities between the non-white and white people during this time period has impacted people in the 21st century. Current communities that contain a majority of non-white people have little access to available health care, education, employment and other opportunities. Therefore, these cultural aspects have an even worse impact on those in recovery and that are in need of continuing care services offered by aftercare and reintegration entities. Bearing this in mind, the participants consist of individuals of various cultural and racial backgrounds, so that a versatile perspective could be comprehended. The following sub-themes are based on the existing cultural challenges in which certain categories were thereafter derived from the general experiences of participants with the following predisposing risk factors.

4.8.5.1 Sub-theme 4.1: Barriers to aftercare and reintegration services

The comparison between the accessibility to services and resources within a formal treatment facility to that of accessibility to services during aftercare and reintegration is significant. It has been reiterated that formal treatment usually occurs at in-patient facilities, which comprises of service users being removed from their immediate environment and admitted into an intervention facility whereby services and resources are easily accessible to support their immediate needs and problems (Rassool, 2011). Aftercare and reintegration services are provided once the service user is discharged from formal treatment, and are out-patient based, which is less focused, controlled and not readily available. Instead it requires more accountability and effort by recovering addicts to participate in such aftercare services. This is where certain barriers were found regarding the accessibility and availability of aftercare and reintegration services. These barriers can be highlighted within the following narrative:

“... it is difficult to go to support groups because of your safety, and I don’t have transport to the groups, which makes it difficult to always attend.” (Par 13)

Accordingly, Florentine and Hillhouse (2000) found that lack of aftercare involvement by recovering addicts is one of the main contributing factors to reoccurring relapses. Therefore, barriers to aftercare services is a cultural challenge that is experienced by the participants because of the following predisposing relapse factors.

a) Transport

Aftercare and reintegration services are designed to continue professional services that were initially provided in formal treatment in order to ensure relapse prevention. The services include “ongoing support to addicted persons and their families following formal treatment in order to increase their recovery potential and thereby limiting the need for re-admission to treatment facilities” (Ramaglan *et al.*, 2010). The aftercare services are delivered in the form of individual or family counselling, self-help and support groups. This was addressed in the National Drug Master Plan (NDMP, 2006-2011; 2013-2017) by developing specific outcomes from a review of the NDMP 2006 – 2011, and implemented in the NDMP 2013 – 2017 in terms of outcome 2, which is the “ability of all people in South Africa to deal with problems related to substance dependency within their communities.” Therefore, the participants were asked to describe their experiences with this cultural challenge of having accessibility and availability to aftercare services within their communities, as is reflected in the narratives below:

“Transport is difficult to get to the support groups ...” (Par 2)

“No nearby support group, and the community doesn’t get together to support addicts, as well as transport issues towards meetings and support groups.” (Par 6)

“Transport to get access to support groups.” (Par 7)

“... the transport aspect of it and uhm, ja, it is a lot of effort me.” (Par 17)

The majority of participants experienced transport as being a barrier towards the accessibility of aftercare services. With reference to these narratives, it can also be assumed that aftercare services are not available in the service user’s immediate community and environment, but instead requires transport to attend aftercare services. Challenges in aftercare accessibility because of transport difficulties has a direct impact on the service users’ attendance and participation rates, which predisposes them to relapses. As described by Laudet (2011), lack of aftercare attendance by recovering addicts decreases their encounters of emotional, physical and mental support, which usually serves as protective factors.

b) Safety

In line with the above-mentioned category, half of the participants experienced their safety to be a cultural challenge in terms of accessing aftercare and reintegration services. This category directly links to transport because utilising public transport or walking to aftercare services within various communities is dangerous. In South Africa, public transport includes train services, mini-bus (taxi) services and bus services. However, statistics show that public transport is one of the highest modes of transport involved in violence, accidents and fatality (Statistics South Africa, 2019). Additionally, the majority of support groups occur in the late evenings after work hours, which means less public transport is available, and walking in the dark is extremely dangerous. South Africa in 2017/18, estimated the incidences of crime on individuals to be over 1.6 million, which is an increase of 5% from the previous year. Therefore, as seen below, safety is a cultural challenge that some of the following participants have experienced:

“Transport and safety to access support groups.” (Par 4)

“Transport and facilities and, we could say, safety.” (Par 12)

“Transport, and it is very dangerous to walk around at night because people steal even from their own people in the community.” (Par 14)

These narratives correspond with the existing statistics that estimate that 79% of South Africans feel safe walking alone in their communities during the day, which is a decrease of 6,7% from last year, whereas only 32% feel safe walking alone in their communities at night (Statistics South Africa, 2018). Safety and lack of transport has increased the challenge of accessing aftercare and reintegration services for recovering service users. These barriers have further limited the already challenging conditions that are involved in receiving aftercare and reintegration services in order to prevent relapses.

4.8.5.2 *Sub-theme 4.2: Stereotyping and stigmatising*

Culture is defined as the customary beliefs, social forms, and material traits of a racial, religious, or social group. It was previously mentioned that South Africa has 11 official languages that are practised by various cultures. By extension, there are various cultures within South African communities that differ, not only in form of communication, but also in their values, norms, customs, religion and traditions (Room, 2005). Each existing community usually has a dominant culture, which can be seen especially in South Africa due to previous racial separation of communities during Apartheid. Therefore, participants experienced the views of communities as a cultural challenge, because AOD abuse is generally frowned upon and seen as unacceptable by society. It is also often associated with the stereotypical behaviour of criminal activity, as well as gang affiliation, which makes community members anxious and uncomfortable. Stigmatisation can be defined as the exclusion of substance dependent individuals from social acceptance and subjecting them to societal negative attitudes and stereotypes attached to addiction (Routledge, 2005). The majority of the participants expressed that they experienced stigmatisation within their cultural and community groups, as depicted below:

“Being labelled as an addict makes it difficult, which is why I am reluctant to disclose that status to just anybody, unless I actually trust them. Just I think being generally seen as an addict you are being frowned upon as the scum of society ... no good.” (Par 7)

“It has become normal, and people look down at you when they find out that you are an addict. They see you as nothing and look down at you.” (Par 13)

“The community won’t treat you different because they know you as the drug addict, and they don’t know you as the rehabilitated person, so just coming back into the community is kind of a challenge because you have to kind of prove yourself, which is something I don’t like to do.” (Par 15)

“The general acceptance of drugs and coming back to an unchanged environment such as places I used drugs, friends living close to me that I used drugs with and family problems because they don’t understand what addiction is.” (Par 17)

As described by Fisher and Harrison (2013), social stigma has a negative impact on recovering addicts due to its potential to lead them to relapses. This challenge directly impacts the client’s self-efficiency, which can be defined as belief in one’s ability to maintain sobriety in the face of difficulties. Additionally, many families of recovering addicts are aware of these existing stereotypes and stigmas in their community, so they try to keep the addiction problem a secret from their church, community and social groups in an attempt to avoid judgement. Room (2005) also finds that this cultural challenge caused by the community members “usually projects negative traits onto former addicts, such as them being untrustworthy, manipulative, lazy, and lead an idle life.” This further causes a barrier to substance dependents in terms of accessing and receiving aftercare services. Recovering addicts then use the negative stigma excuse to justify their actions to relapse, stating that this is due to discrimination by their environment and community.

4.8.5.3 Sub-theme 4.3: Lack of knowledge and awareness by community members

During the data collection of other cultural challenges, it was revealed by participants that the lack of knowledge regarding the recovery process for AOD abuse by community members is a predisposing relapse factor. Just over three million South Africans remain illiterate, according to Statistics South Africa (2018), which can be defined as “the inability to read and write in at least one language.” Further, various cultures in South Africa have different beliefs and customs regarding substance use disorders (SUD). These act as cultural barriers towards AOD recovery, which in turn increases the recovering addicts’ chances of relapsing. In comparison to Western approaches, traditional African treatment may be more likely to attribute SUD to a spiritual or

social cause rather than a physiological or scientific cause (Global Health Action [GHA], 2014). Lack of SUD knowledge and awareness by community members have subjected some of participants to this as a cultural challenge, as is illustrated by the following narratives:

“There is a lot, but people not taking responsibility because they still want to be babied and think the lack of other people’s understanding of addiction and how to handle people in recovery. Awareness and lack of knowledge ... because they still think when they come out of rehab he is saved and is fixed. People thinking addicts can drink alcohol if their main addiction was drugs.” (Par 16)

“The understanding and people thinking you going to rehab or an institution and they think you come out fixed, and they don’t understand addiction such as your primary addiction is heroin they think it is okay for you to use anything else. They don’t understand addiction is addiction, so it doesn’t matter if it is substances or activities.” (Par 18)

Communities that have limited knowledge about substance dependency recovery often lack skills or methods in terms of knowing how to deal with recovering addicts appropriately. These narratives are linked with studies conducted by Omu and Reynolds (2012) that emphasise that different cultural groups have vastly different perceptions of the causes of health problems, and these perceptions influence their health seeking behaviour and treatment. Therefore, misconceptions regarding AOD abuse have been created by community members because of cultural differences, and has often led to mistreatments of substance use disorders (SUD) because it is conceived by some cultural groups that addiction is completely curable.

4.9 CONCLUSION

Relapse is a formidable challenge in substance dependency aftercare and reintegration services, because service users are engaging in behaviour change while being confronted with various predisposing factors regarding the maladaptive behaviours they are attempting to modify. This chapter displayed the empirical findings derived from the exploratory and descriptive research study. Throughout this chapter, the challenges experienced by services users during aftercare and reintegration services were investigated. This was achieved by means of examining the service users’ views and experiences with the identified existing challenges during aftercare (as depicted in chapter 2). A total of 18 participants were interviewed with purposive sampling,

and the interview schedule acted as a guideline to direct the data collection by integrating the literature that was reviewed in both chapter 2 and chapter 3. Thereafter, the data that was collected was analysed and interpreted in order to classify them into themes, sub-themes and categories. The overall findings related to the Biopsychosocial challenges that were highlighted in the empirical study and will be incorporated in chapter 5, where recommendations and conclusions will be formulated.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The purpose of this research study was to investigate the challenges experienced by recovering service users during aftercare and reintegration services. The previous chapter illustrated the empirical investigation and the findings of this research conducted. In chapter 5, the researcher will achieve the final objective of the research study, which is to present the conclusions regarding the aftercare challenges that are experienced by service users, and to provide recommendations related to relapse prevention by making reference to current policy, legislative and theoretical frameworks. The conclusive statements prospectively emphasise the shortfalls in the current aftercare services by addressing identified challenges. This is done so that recommendations can be formulated regarding the possible solutions in order to enhance aftercare services with the aim of reducing and preventing further relapses.

The aim of these recommendations is to identify possible ways to improve current aftercare services and reduce the amount of challenges experienced by service users. In this chapter, the researcher will examine the research findings according to identifying particulars, as well as the Biopsychosocial model (themes) in order to conclude what was found based on the exploratory and descriptive information derived from participants. To conclude whether current aftercare and reintegration policies, legislation and theoretical frameworks are either hindering or fostering relapse prevention. Lastly, recommendations will be derived from these conclusions so that future aftercare service can be enhanced to prevent reoccurring relapses.

5.2 CONCLUSIONS AND RECOMMENDATIONS

The following section will comprise of conclusions and recommendations that were derived from the previous chapters in terms of the relative literature and empirical findings. This section will contextualise the conclusions and recommendations according to the following headings: identifying particulars, biological challenges (theme 1), psychological challenges (theme 2), social challenges (theme 3) and cultural challenges (theme 4). Furthermore, the recommendations for the study will be derived from the conclusive statements in order to provide guidelines for future aftercare and reintegration services so that relapses can be reduced

and prevented. The recommendations will be based entirely on the key themes emerging from this research, and will be supported by the literature review.

5.2.1 Research goals and objectives

The goal of this research study was to explore the challenges experienced by service users during substance dependency aftercare and reintegration services in the Western Cape.

The following research objectives enabled the researcher to achieve the research goal:

- Objective 1: To describe the challenges of adult service users after they have received substance dependency formal treatment from a Biopsychosocial model.

The first objective was achieved in Chapter 2, whereby substance use disorders (SUD) were contextualised in terms of its definitions and consequences, as well as the various challenges that are experienced by recovering addicts as predisposing relapse factors. The biological, psychological, social and cultural challenges influencing an individual's recovery process was discussed in-depth, as the study was guided by the BPS model. Literature on the development and relevance of the BPS model as the theoretical point of departure was elaborated throughout Chapter 2. Factors unique to South Africa, for example its political history that impacts the recovery of individuals, although limited, were also provided throughout the literature review (see Chapter 2).

- Objective 2: To contextualise the available literature, policy and legislation framework of substance dependency aftercare and reintegration services for adult service users.

The second objective of this research study was achieved in chapter 3, by identifying the available theoretical and literature frameworks that were developed for aftercare and reintegration services in order to prevent relapses. Additionally, the process of relapsing was discussed in depth in order to highlight the complexities of relapse prevention. Throughout chapter 3, the policies and legislation that were developed in order to address these complexities and challenges as identified in chapter 2 were contextualised. This second objective was achieved in chapter 3 by identifying all theories, legislations and policies that are specifically relevant, not solely to the treatment of substance dependency (intervention), but also the developed frameworks relevant to aftercare and reintegration services.

- Objective 3: To empirically investigate the challenges experienced by adult service users during substance dependency aftercare and reintegration services in order to correlate it to the literature review.

The third objective was reached in chapter 4 by means of empirically investigating the descriptive and exploratory data obtained by the participants so that the overall research question could be answered. The research findings were divided into themes, sub-themes and categories, which were linked to existing literature so that a comprehensive understanding of the participants' experiences could be developed. The challenges experienced during aftercare services by service users were derived from the Biopsychosocial model (Chapter 2) and probed within the interview schedule.

- Objective 4: To comprehend the outcome of the research in order to present conclusions and develop corresponding recommendations for future aftercare and reintegration services to ensure relapse prevention.

The final objective is achieved in chapter 5 by means of taking the factual information that was derived from the empirical investigation in chapter 4 in order to make conclusions based on the results obtained concerning the challenges experienced by service users during aftercare services in comparison with the fundamental frameworks of chapter 3. Once conclusions have been formulated, corresponding recommendations will be made in an attempt to address aftercare shortfalls so that future aftercare and reintegration services can be enhanced. The achievement of the goal and objectives ultimately allowed the researcher to answer the following research question:

What are the challenges experienced by service users during substance dependency aftercare and reintegration services in Western Cape?

The key findings that in essence answer the research question are depicted in the following conclusions and recommendations.

5.2.2 Identifying particulars

The participants who took part in this study were diverse in terms of their age, race, background and developmental life phase. This allowed a variety of responses to be derived from the prescribed questions that were posed to the participants. All the participants have been

discharged from formal addiction treatment facilities and are currently receiving aftercare and reintegration services. Based on these identifying details, as well as their experience during aftercare services, the participants were fully equipped to provide valuable insight into their challenges experienced during their aftercare services that predispose them to relapsing.

It can be concluded that:

- In terms of gender, more or less a third of the participants were female and the rest were male.
- The majority of the participants were between the ages of 31 and 34 years when they were interviewed. The youngest was 21 and the oldest 45.
- Most of the participants were of Coloured descent, less than a quarter of them were White and only one participant was Black.
- The educational level of participants was divided, with participants either being school drop-outs or having a matric certificate with a tertiary qualification.
- The majority of the participants were single, and the remaining participants had a partner (married or in a relationship).
- More than half of the participants had one or more children.
- The main drug of choice for the majority of the participants was tik (Methamphetamine), and, if applicable, the second drug of choice was either cannabis, mandrax or alcohol.
- The majority of the participants were dependent on AOD in their adolescent years, which is between the ages of 16 and 17.
- Most of the participants do not come from the same community. Instead, they are distributed between various rural and urban areas in the Cape Town Region.
- All of the participants have been admitted into one or more rehabilitation centres, which indicates that a majority of the participants have relapsed at least once in their past.
- The length of sobriety amongst participants range between one month and almost 9 years.
- More than half of the participants have access to aftercare services, but have no knowledge of aftercare literature, policies or legislation.

It is recommended that:

- Further research should be conducted at a larger scale in terms of including more participants from regions all over the country, so that knowledge and understanding can be gathered from a wider spectrum.
- The sample of participants should be more racially and culturally balanced so that a variety of perspectives and experiences can be gathered.

5.2.3 Theme 1: Biological challenges

The biological aspect of the Biopsychosocial model explored the challenges associated with the service users' inherited genetic predispositions and biochemical elements that are predisposing relapse factors during aftercare and reintegration services. Through the identified literature and views of participants, the following factors are recognised as biological challenges: patterns of addiction, cravings and biological well-being.

a) Patterns of addiction, it can be concluded that:

- In accordance with the empirical findings it can be concluded that genetic predisposition is still a biological challenge for most recovering addicts during aftercare and reintegration services due to some family members still being in active addiction.
- In accordance with the empirical findings, it can be concluded that addiction has a cyclical nature within family systems, as there is a high prevalence of recovering addicts having one or more family members with a history of addiction.
- Recovering addicts have a higher chance of relapsing if they have family members that are still in active addiction, whereas recovering addicts that have no family history of addiction are less vulnerable to relapsing.
- Patterns of addiction are not limited to the immediate family system, but also includes the negative influences of extended family members.

It is recommended that:

- With reference to the literature and findings, aftercare and reintegration services could be made available to family members in order to educate them about the heritability nature of addiction to ensure relapse prevention.
- Aftercare services request the involvement of family members in the recovering addicts programme.

b) Cravings, it can be concluded that:

- Urges and cravings are a common biological challenge for recovering addicts during aftercare and reintegration services due to the continuous mental reactions to specific stimuli.
- Stimuli that are often experienced by recovering addicts and may include AOD using dreams, past AOD using places and even taste sensations.
- Although recovering addicts are attending aftercare services, they still do not have sufficient coping mechanisms to deal with cravings. Instead, they indulge in cross addiction by eating, or distract themselves by walking around and watching movies.
- Regardless of the length of sobriety amongst recovering addicts, cravings are still a biological challenge experienced by service users during aftercare services.

It can be recommended that:

- Aftercare and reintegration services provide service users with applicable coping mechanisms in order to deal with cravings.
- In accordance with the literature and findings, aftercare services apply elements of SMART (Self-management and Recovery Training), which is an alternative option for self-help groups. One of its primary goals is to teach service users to cope with urges, triggers and behaviours by means of coping mechanisms such as stress management.
- Aftercare professionals should educate service users about cross-addiction so that it can be prevented.

c) Biological well-being, it can be concluded that:

- During active addiction individuals had a suppressed appetite which led to extreme weight loss, whereas during aftercare services their appetite resurfaced to cause weight gain, which is experienced as a biological challenge.
- Recovering addicts associate being at their skinniest with AOD abuse.

It can be recommended that:

- Aftercare and reintegration services should include positive lifestyle factors, such as exercise and healthy eating habits, as part of recovery.
- Individuals and family members should be educated on both the positive and negative effects of lifestyle choices (hygiene, nutrition), and on the impact of lifestyle choices on long-term recovery.
- A multi-disciplinary team is integrated within the aftercare and reintegration programme in terms of including nutritional and fitness professionals.

5.2.4 Theme 2: Psychological challenges

The psychological component of the BPS model refers to the existing developmental, cognitive, behavioural, traumatic and psychiatric factors that predispose individuals to relapsing after they have received formal treatment. It has been made evident that during active addiction individuals have been conditioned by the pleasurable effects of AOD, which lead to them developing negative life schemes. Therefore, these negative life schemes need to be altered and maintained during aftercare and reintegration services in order to ensure sobriety. This has been found to be a significant psychological challenge. Through the identified literature and empirical findings, the following predisposing relapse factors are recognised as psychological challenges: dealing with emotions, cause of previous relapses, dual-diagnosis and sexual trauma.

a) Dealing with emotions, it can be concluded that:

- Recovering addicts are unequipped to deal with their emotions and past experiences because they utilised AOD during their active addiction as a way of self-medicating to achieve an instant state of happiness in an attempt to avoid negative emotions.

- Many service users feel overwhelmed with emotions and past experiences and tend to resort to coping skills that are detrimental (avoidance and denial).
- In accordance with the empirical findings, there is a lack of emotional support for recovering addicts during aftercare services, which makes them feel a sense of loneliness and isolation when dealing with emotions.
- Aftercare service users are still experiencing aggression as a result of being discharged from formal treatment because they are not dealing with their emotions properly.
- Feeling untrustworthy is a predisposing relapse factor that is caused by the recovering addict's family constantly questioning him/her and affecting his/her sobriety motivation during the aftercare programme.
- Families usually do not trust the recovering addicts' sobriety process due to their past lies and manipulation, which has been found to be detrimental to the development of service users' self-efficiency in terms of dealing with emotions.

It can be recommended that:

- Life skills should be taught during formal treatment as well as aftercare services, especially considering that dealing with emotions was highlighted as a significant psychological challenge that predisposes recovering addicts to relapsing.
- In accordance with the Cenaps Model six step recovery process, the aftercare and reintegration services should reintegrate "Step 3 which is skills related to dealing with self-defeating behaviours that prevent the client from accepting and dealing with awareness of painful feelings and thoughts." Further, these services should refocus step 4, which is learning how to deal with feelings and emotions responsibly without having to resort to alcohol and other drugs. Lastly, step 5 should be re-established, which involves managing to change substance dependency thinking patterns that create self-defeating and painful feelings.
- Aftercare services should provide emotional support in terms of reassurance and encouragement that should be offered by professionals, sponsors or support group members.

b) Cause of previous relapses, it can be concluded that:

- Most recovering addicts have relapsed at least once during their past aftercare and reintegration programmes.
- Unemployment is a fundamental risk factor that is associated with reoccurring relapses.
- The notion of reservations was commonly experienced amongst service users as a psychological challenge, which entailed them either consciously or subconsciously reserving a relapse date for a certain situation or circumstance such as the death of a parent.
- The psychological decision to not attend support groups is a predisposing relapse factor, because the main purpose and benefits of aftercare services is relapse prevention and to resolve any ambivalence.
- In accordance with the findings, without structural support of self-help groups, recovering addicts are left to their own devices in dealing with challenges, which increases their likelihood of relapsing.

It can be recommended that:

- According to relevant literature and empirical findings, aftercare services encourage support group attendance to ensure service users' protective factors are developed and new behavioural patterns are practiced. As illustrated in subsection 30(2), chapter 7 of the Prevention and Treatment of Drug Dependency (Act 70 of 2008), "the purpose of establishing aftercare support groups is to firstly provide a safe and substance free group experience whereby service users can practice re-socialisation and coping skills."
- Aftercare services correspond further with section 30, chapter 7 of the Prevention and Treatment of Drug Dependency (Act 70 of 2008), that prescribes integrated aftercare and reintegration services aimed at "the successful reintegration of a service user into society, the workforce and family and community life." This section clearly indicates that social welfare services have the statutory responsibility to provide aftercare and reintegration services that promote the rehabilitated

discharged service user towards the achievement of employment in order to prevent relapses.

- Aftercare and reintegration services should help the service users identify the reasons for their past relapses to ensure that it is addressed and dealt with, so that future relapses can be prevented.
- A relapse prevention contract be formulated between the aftercare professional and service user.

c) Dual diagnosis or co-occurring disorders (COD), it can be concluded that:

- Self-medicating with AOD is often utilised by service users during their active addiction in order to deal with underlying mood or mental disorders.
- During aftercare and reintegration services, many recovering addicts have never been assessed by a mental health professional and are often left undiagnosed, which predisposes them to self-medicate with AOD again, which causes a relapse.
- Depression is the most common diagnosis for people in substance dependency aftercare and reintegration services.
- The divide between psychiatric services provided and guided by the Department of Health and the provision of substance abuse treatment provided and guided by the Department of Social Development has caused a gap, which individuals with a dual-diagnosis fall through on a continual basis.
- The National Drug Master Plan (NDMP, 2006-2011; 2013-2017), as depicted in the literature review, developed specific outcomes derived from a review of the NDMP 2006 – 2011 described in the NDMP 2013 – 2017 in terms of the basic concepts of monitoring and evaluation (Public Service Commission of South Africa, 2008). With reference to outcome number 5, which is the “development and implementation of multi-disciplinary and multi-modal protocols and practices for integrated diagnosis and treatment of substance dependence and co-occurring disorders and for funding such diagnosis and treatment,” the empirical findings suggest that this outcome is not currently being achieved during aftercare services.

It can be recommended that:

- Aftercare and reintegration services must follow the Drug Master Plan in terms of developing and implementing practices for integrated psychological diagnosis so that relapses can be prevented.
- Mental health professionals are made available and accessible to recovering addicts during aftercare and reintegration services.
- Aftercare and reintegration services must educate the service users about dual-diagnosis, as it will allow individuals to understand themselves better and empowers them to manage their diagnosis and aspects related to their diagnosis more effectively.
- The Department of Health and the Department of Social Development form a working relationship that ensures that appropriate services are established to bridge this gap during intervention and aftercare services.

d) Sexual trauma, it can be concluded that:

- There is a high number of recovering addicts have a history of sexual trauma in terms of abuse, molestation or rape.
- Sexual trauma is not limited to women, but has also been experienced by men, as shown in the empirical findings.
- Sexual trauma is an intense life stressor that contributes to reoccurring relapses if not dealt with effectively in formal treatment as well as aftercare services.
- Many individuals abused AOD as an attempt to cope with the damage and loss caused by sexual trauma.
- In accordance with literature and empirical findings, survivors of sexual trauma such as some recovering addicts, are at high risk of posttraumatic stress disorder (PTSD).

It can be recommended that:

- Aftercare services should network and correspond with the service users' previous formal treatment facilities in order to have access to their personal files that depict

a history of sexual trauma, so that it can be acknowledged and addressed during aftercare services in order to prevent future relapses.

- Formal treatment facilities should ensure that coping skills are taught to individuals as soon as they are admitted into the programme, and to ensure opportunities where coping skills (stress or anger management) can be modelled and practiced when they are discharged into aftercare and reintegration services.

5.2.5 Theme 3: Social challenges

The social component of the BPS model refers to environmental interchanges that threaten the individual's sobriety. Through literature and empirical findings, the following predisposing relapse factors are recognised as social challenges: family systems, availability of AOD, interpersonal relationships, socio-economic status, criminal records and housing. It has been made evident that social challenges predispose service users with the most relapse factors out of the BPS model. The literature and empirical findings concluded the following aspects whereby corresponding recommendations were formulated.

a) Family systems, it can be concluded that:

- The sobriety success rate of individuals is higher when family members are actively involved in their treatment and aftercare programme.
- Most recovering addicts are reintegrated into their family households once they are discharged from formal treatment.
- In accordance with the empirical findings, there is a lack of family involvement in the recovering addicts' aftercare and reintegration programme, which predisposes them to relapsing.
- Most of the service users are experiencing conflict between family members due to unresolved issues, whereby communication transitions are associated with blame, guilt and shame.
- There is limited support for family members during aftercare services, as Alcoholic Anonymous and Narcotic Anonymous (support groups) are only available to the recovering addict.

It can be recommended that:

- Aftercare and reintegration services should ensure further “harm reduction with regards to providing a more holistic treatment of service users and their families, and mitigating the social, psychological and health impact of substance dependency” (Prevention and Treatment of Drug Abuse Act, 70 of 2008).
- In accordance with literature and empirical findings, aftercare services facilities should include more family counselling sessions or support groups in order to provide a platform for healthy communication patterns to be practiced and maintained.
- During aftercare services, unresolved conflict between family members and recovering addicts must be addressed in order to prevent relapses.
- Families should be requested to be involved in aftercare services in order to establish support structures.

b) Availability and accessibility of alcohol and/or other drugs (AOD), it can be concluded that:

- AOD are easily available and accessible in both rural and urban communities in South Africa.
- In accordance with the National Drug Master Plan (NDMP, 2006-2011; 2013-2017), the “reduced availability of dependence-forming substances/drugs, including alcoholic drinks such as unregistered shebeens in local communities” still needs to be achieved, because service users still experience the social challenge of having accessibility and availability to AOD during aftercare services.

It can be recommended that:

- Aftercare and reintegration services re-examine and re-establish their services to achieve outcome 4 of the National Drug Master Plan (NDMP, 2013-2017) in order to prevent relapses.
- In accordance with the empirical findings, service users should be taught and allowed to practice various coping skills during aftercare services in order to effectively deal with the triggers associated with the availability of AOD.

c) Interpersonal relationships, it can be concluded that:

- Interpersonal relationships formed during active addiction are often developed and maintained based on AOD abuse.
- Negative interpersonal relationships during aftercare services impacts the recovering addict's ability to achieve optimal social functioning, which prompts for reoccurring relapses.
- During aftercare and reintegration services, individuals experience the challenge of peer pressure from old AOD using friends, which affects their behaviour and motivation regarding sobriety.
- Recovering addicts can easily succumb to peer pressure during aftercare services in an attempt for them to receive approval from peers and to feel a sense of belonging.
- The intimate relationships of aftercare service users that were formed during active addiction are often characterised as co-dependent and unhealthy.
- Individuals experience low sex-drive as a social challenge during aftercare services due to the absence of AOD, which has the potential to cause them to relapse in order to regain heightened libido.

It can be recommended that:

- In accordance with the empirical findings and literature, aftercare counselling services should provide couple counselling sessions for individuals involved in intimate relationships.
- Aftercare services provide coping skills and mechanisms to services users in order to effectively deal and cope with peer pressure.
- Step 2 of the Cenaps Model six step recovery process should be more integrated and emphasised during aftercare services in terms of the “separation from people, places and things that threaten recovery, and the development of a social support network that is offered in support groups.”
- Life skills be implemented into aftercare programmes in terms of healthy sex expectations and healthy relationship characteristics.

- Recovering addicts should be educated on the characteristics of being in a co-dependent relationship and how it effects their sobriety during aftercare services.

d) Socio-economic status, it can be concluded that:

- Regardless of economic status (low, middle or high income), all families have experienced and suffered financial burden due to substance dependency.
- Poverty is linked to high substance dependency relapse rates, as well as criminal behaviour as a source of income.
- Unemployment is currently 27.6% in South Africa, and a large component of this statistic consists of recovering addicts.
- There seems to be a link between not completing secondary education (High school) and being unemployed.
- Lack of education status held by recovering addicts during aftercare services have resulted in them having poor problem-solving skills, little employment security and limited access to opportunities such as tertiary education.

It can be recommended that:

- In accordance with the empirical findings and literature, aftercare services should empower and equip service users with the necessary skills to develop Curriculum Vitae's, as well as direct them to facilities whereby they have the opportunity to finish their secondary education level (matric).
- Substance dependency aftercare policy and legislation develop outcomes and solutions that specifically address and provide educational opportunities for service users so that they can be empowered to maintain sobriety.

e) Criminal records, it can be concluded that:

- There is a distinct link between individuals in aftercare and criminal records that were obtained during active addiction.
- The majority of criminal records were obtained during the service users' active addiction and was related to unlawful activities such as gangsterism, illegal possession of substances, theft or violence.

- The empirical investigation found that individuals with criminal records during aftercare services are more restricted in accessing employment.
- In accordance with literature, criminal records are a social challenge for service users, as it creates a barrier for individuals to successfully reintegrate into society, which predisposes them to relapsing.

It can be recommended that:

- Recovering addicts be educated about the option of legally applying for the expungement of certain criminal records to which aftercare services can provide access through links with government legal aid and assistance.
- Aftercare professionals should educate services users on how to disclose their criminal records in future job interviews by means of role playing.

f) Housing it can be concluded that:

- With reference to the empirical findings and literature, there is limited alternative options regarding housing for recovering addicts once they are discharged from formal treatment. Therefore, most of them are reintegrated into their family households.
- There is limited research and evidence regarding halfway houses and sober living establishments in South Africa.
- Recovering addicts found that housing was a social challenge because they did not have access to stable household or environments, which predisposes them to relapsing.
- Although section 30, chapter 7 of the Prevention and Treatment of Drug Dependency (Act 70 of 2008) addressed and stipulated that social welfare services have the statutory responsibility to provide aftercare and reintegration services “that promote the rehabilitated discharged service user towards the achievement of housing,” it has been made evident by empirical findings that there is not any clear guidelines on how the service user can achieve housing during their aftercare programme.

It can be recommended that:

- Further research be conducted regarding the benefits of halfway and sober living houses in South Africa.
- In accordance with the empirical findings and literature, certain aftercare policies and legislation should make provisions for alternative housing options for recovering addicts during their aftercare programme.

5.2.6 Theme 4: Cultural challenges

With reference to the relative literature and empirical findings, the cultural aspect of the Biopsychosocial model found the cultural challenges associated with the service users' recovery to be: barriers to aftercare services, stereotyping, stigmatising and lack of knowledge by community members. These are all predisposing relapse factors that are experienced during aftercare and reintegration services. It has been made evident that cultural challenges are specifically relevant to South Africa due to the diverse nature of the various cultural factors that interplay within the population. The literature and empirical findings concluded the following aspects whereby corresponding recommendations were formulated.

a) Barriers to aftercare and reintegration services, it can be concluded that:

- Aftercare services are provided in less structured settings compared to formal treatment.
- Recovering addicts have limited access to aftercare and reintegration services in their immediate environment and community, and often have to travel to necessary support structures.
- In accordance with empirical findings and literature, transport to aftercare services is a challenge for recovering addicts due to poor public transport in South Africa.
- There is a direct link with lack of aftercare services in immediate communities and attendance rates in aftercare.
- The majority of self-help and support groups occur in the evening, which has been experienced by recovering addicts as a challenge due to their safety, as crime on individuals increased to be over 1.6 million in 2017/2018 (Statistics South Africa, 2018)

- Although the National Drug Master Plan (NDMP, 2013-2017) developed outcome 2, which is the “ability of all people in South Africa to deal with problems related to substance dependency within their communities,” it has been made evident by empirical findings that some communities in South Africa do not have available aftercare services, which makes recovering addicts vulnerable to relapsing.

It can be recommended that:

- Aftercare and reintegration services be available in every community to ensure that recovering addicts do not have to travel outside their community for support services.
- In accordance with the National Drug Master Plan, aftercare services must make more provisions for recovering individuals living in vulnerable communities.
- In light of the empirical findings, that the aftercare services focus on a holistic approach.

b) Stereotyping and stigmatizing, it can be concluded that:

- South Africa has many different cultures that differ not only in language, but also in values, norms, traditions and customs regarding substance dependency aftercare.
- Based on the empirical findings and literature, recovering addicts are often subjected to negative societal attitudes and perceptions attached to addiction, which makes it a challenge for them reintegrate into their community successfully.
- As can be derived from the empirical findings, lack of involvement by individual and family members in aftercare services is caused by the fear of being stigmatised and judged by the community for having addiction problems.
- Recovering addicts do not receive support from community members once they are discharged from formal treatment.
- With reference to literature, recovering addicts being stigmatized by community members increases their sense of loneliness, since it resembles rejection, which predisposes them to relapsing.

It can be recommended that:

- Aftercare and reintegration services need to educate community members about addiction in terms of its effects, treatment and recovery in a holistic approach.
- Referral social service professionals should aim to address cultural challenges in terms of stigmatisation and stereotyping in the community through macro interventions.

c) Lack of knowledge and awareness by community members, it can be concluded that:

- Traditional African treatment to substance dependency is often associated with a social or spiritual cause rather than a physiological cause.
- Just over 3 million people in South Africa remain illiterate (Statistics South Africa, 2018).
- In accordance with the empirical studies and literature, community members have limited skills and knowledge about the addiction recovery process.
- Many community members believe that once recovering addicts have completed their formal treatment they are cured and do not need aftercare.
- A lack of support by the community increases the recovering addicts' likelihood of relapsing.

It can be recommended that:

- Psycho-education should be expanded to families and communities during aftercare services in order to address possible stigma, and to allow for more reassuring support structures to be developed for these recovering individuals.
- Based on the empirical findings and literature, aftercare services should be adapted to be more culturally sensitive and inclusive across all communities in South Africa.

5.3 CONCLUSIVE RECOMMENDATIONS FOR FUTURE STUDIES

Based on the findings of this study, various recommendations for future studies can be made:

- Further research should be conducted on a larger scale throughout South Africa and not limited to Western Cape.
- After a certain period of time, research should be conducted to determine whether the National Drug Master Plan has achieved its specific outcomes for aftercare and reintegration services.
- Research should be done to determine whether the relapse rates have increased or decreased.
- There is a need for research regarding the factors that hinder family involvement in aftercare services so that it can be addressed, and in turn increase recovery rates of substance dependents.
- Future research should be done on the implementation procedures of policies and legislation attaining to aftercare and reintegration services.

5.4 CONCLUSION

This chapter achieved the final objective of the research study, which was to present the challenges experienced by service users during substance dependency aftercare and reintegration services so that relative recommendations could be provided to service providers as well as policy and legislation developers. Through this research study, it has been made evident that, although substance dependency aftercare policies and legislations were developed to address relapse risk factors, the empirical findings suggest otherwise. Instead, service users are experiencing challenges on all spectrums during their aftercare and reintegration services according to the BPS model. It can be concluded that these identified challenges and high relapse rates are the result of the failed implementations of policy and legislative aftercare frameworks.

Ultimately, the aim of these recommendations was to offer input that would enhance future aftercare and reintegration services available to recovering addicts so that relapses can be prevented. This chapter made reference to empirical findings and theoretical underpinnings to ensure valid conclusions and recommendations. It is evident from the research study that

service users are still experiencing challenges during aftercare services, regardless of the provisions being made in the current aftercare literature, policies and legislations.

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ANNEXURE A: RESEARCH ETHICS COMMITTEE APPROVAL LETTER



NOTICE OF APPROVAL

REC Humanities New Application Form

5 July 2018

Project number: 6761

Project Title: Challenges experienced by service users during substance dependency aftercare and reintegration services.

Dear Miss Emma Gibbons

Your REC Humanities New Application Form submitted on 21 June 2018 was reviewed and approved by the REC: Humanities.

Please note the following for your approved submission:

Ethics approval period:

Protocol approval date (Humanities)	Protocol expiration date (Humanities)
5 July 2018	4 July 2019

GENERAL COMMENTS:

Please take note of the General Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

If the researcher deviates in any way from the proposal approved by the REC: Humanities, the researcher must notify the REC of these changes.

Please use your SU project number (6761) on any documents or correspondence with the REC concerning your project.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

FOR CONTINUATION OF PROJECTS AFTER REC APPROVAL PERIOD

Please note that a progress report should be submitted to the Research Ethics Committee: Humanities before the approval period has expired if a continuation of ethics approval is required. The Committee will then consider the continuation of the project for a further year (if necessary)

Included Documents:

Document Type	File Name	Date	Version
Data collection tool	1Themes for interview schedule and protocol	09/05/2018	2
Informed Consent Form	SU HUMANITIES Consent form template_Written 1	12/06/2018	3
Proof of permission	CAD letter head	12/06/2018	3
Research Protocol Proposal	EMMA GIBBONS, Updated Research Proposal, 8 JUNE 2018 (1)	12/06/2018	3
Default	letter of response	21/06/2018	2

If you have any questions or need further help, please contact the REC office at cgraham@sun.ac.za.

Sincerely,

Clarissa Graham

REC Coordinator: Research Ethics Committee: Human Research (Humanities)

ANNEXURE B: RESEARCH BUDGET

The following costs will be incurred during the research process:

Item	Estimated Cost
Masters' tuition fees: Year 1 (2018)	R 32477.00
Masters' tuition fees: Year 2 (2019)	R 9566.00
Transport and fuel cost for interviewing service users	R 4500.00
Transport and fuel cost for supervision sessions with supervisor in Stellenbosch	R 2500.00
Administration: telephonic and internet accessibility, photocopying and capturing of data	R 2500.00
Editing of thesis	R4710,00
Printing, copying and compiling of final document	R 1500.00
TOTAL	R57 753.00

The researcher independently paid for the studies at Stellenbosch University. The participants for the study were not expected to contribute towards any of the costs, nor did they receive any financial incentives for participating in the research study.

ANNEXURE C: LETTER OF APPROVAL FROM INSTITUTION



CHRISTELIKE AFHANKLIKHEIDSDIENS
(Wes- en Suid-Kaap)
(Registrasiennr 059-212)

25 Digtebij Street
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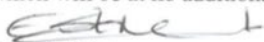
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8 June 2018

To whom it may concern

I, Estie de Wet the organiser of CAD (Christian Action for Dependence) have acknowledged the research request from Emma Gibbons (student number: 18624715). CAD is an organisation (NPO number: 059-211) that provides aftercare and relapse prevention services to client systems that are affected by substance dependency in the vulnerable populations of South Africa. The organisation is aware that the research topic is “the challenges experienced by adult service users with substance dependency aftercare and reintegration services”. Therefore, CAD gives permission to Emma Gibbons to conduct research with the organisations client systems. The researcher will obtain these participants by getting the names and contact details from the organiser of CAD in order to contact the participants that have shown interest in participating in the research project, this will be done telephonically so that the research process can be cohesively explained to each participant. CAD has given permission to Ms Gibbons to have access to the organisations service users whom have participated in at least one individual or group session with the organisation. This will be done by the organiser and researcher contacting the various CAD support groups in order to encourage the group leaders to inform the group members about the research project and for those that are interested in finding out more can contact the researcher directly or they can give CAD permission to allow the researcher to access their contact details.

The CAD will ensure the clients information that has been gathered from the interviews will be confidential by means of password protected computer systems as well as hard copies will be kept in locked cabinets within the head office of CAD. Lastly, CAD will also provide opportunities for debriefing after each interview as well as additional counselling if the participant needs extra support which will be at no additional cost.


Estie de Wet

CAD Social Worker/Organiser

Reg no:10-41047

CHRISTELIKE AFHANKLIKHEIDSDIENS
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ANNEXURE D: CONSENT FORM FOR PARTICIPANTS

STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH

You are invited to take part in a study conducted by Emma Gibbons from the social work department at Stellenbosch University. You were approached as a possible participant because research needs to be conducted regarding the challenges experienced by adult service users during substance dependency aftercare and reintegration services.

1. PURPOSE OF THE STUDY

The purpose of this research study is to investigate the challenges experienced by former substance dependent service users after they received formal treatment and are reintegrated into their communities. This study will investigate the exact challenges that you as services users experience during aftercare and reintegration services available in South Africa. The majority of relapses occur once a substance dependent service user has been discharged from formal treatment. Therefore, this research will investigate the reasons for this, and how it can be addressed in aftercare services.

2. WHAT WILL BE ASKED OF ME?

If you agree to take part in this study, you will be asked to participate in a semi-structured interview, which will consist of predetermined questions regarding your personal experiences during substance dependency aftercare and reintegration services after you have been discharged from formal treatment. This interview will be recorded via a voice or tape recorder, in which your private information, such as your name, will be protected. The researcher will never refer to your name or surname. Instead, she will acknowledge you by a code that she has assigned to you, such as participant 1, 2 or 3. The length of time for participation will be 10 minutes of explaining the purpose of the study, 50 minutes for the semi-structured interview and 15 minutes for debriefing after the interview. Further, additional counselling is offered by the CAD if you feel that you need the extra support, for no additional cost. Therefore, a total of 75 minutes will be needed from you as a participant, and the interview will either be conducted at the CAD office, or at your house in a private space where you feel the most comfortable.

3. POSSIBLE RISKS AND DISCOMFORTS

The research that is suggested has the potential risk of emotional or psychological discomfort if not dealt with in a responsible and professional manner. The data and information needed for this research topic involves intimate details of vulnerable social categories, and it deals with sensitive topics in terms of substance dependency such as relapses. This topic investigated is controversial and connected to social stigmas. Thus the researcher will handle you with professionalism, and the CAD will provide opportunities for debriefing and additional counselling if you need it, at no additional cost.

4. POSSIBLE BENEFITS TO PARTICIPANTS AND/OR TO THE SOCIETY

This research will not benefit any participant directly. However, this research topic has been developed in order to investigate experiences from primary service users such as yourself that encounter aftercare and reintegration services. There is minimal or lack of research regarding this topic. Therefore, this research gives vulnerable populations an opportunity for their voices to be heard about social services they have experienced. For this reason, your participation in such a study will indirectly benefit your community and society as a whole, because hopefully this research can address the shortcomings of government social services available for substance dependent populations.

5. PAYMENT FOR PARTICIPATION

As a participant you will not receive payment for taking part in the study, because the researcher will independently arrange the interview session to best suit you in terms of conducting the interview within your own home if you do not have the resources to come to the CAD offices.

6. PROTECTION OF YOUR INFORMATION, CONFIDENTIALITY AND IDENTITY

Any information you share with me during this study and that could possibly identify you as a participant will be protected. This will be done by the researcher taking ethical responsibility to maintain your privacy as a participant in terms of confidentiality and anonymity, which will be ensured through password protected methods for a required amount of time, which is at least 5 years. This will be done by ensuring that the data collected in terms of voice recordings or written statements is protected by password/assigned code names on computer systems, as well as hard copies which will be stored in a cabinet in my supervisor's office. This office is lock protected at the CAD head office, and the only person that has access is the CAD supervisor. Your personal information, such as name, surname and address will remain anonymous.

7. PARTICIPATION AND WITHDRAWAL

You may choose whether to be in this study or not. If you agree to take part, you may withdraw at any time without consequence. You may also refuse to answer any questions you do not want to answer and still remain in the study. The researcher may withdraw you from this study if you have not personally experienced substance dependency formal treatment and reintegration/aftercare services, and if you are not legally and psychologically competent to provide informed consent.

8. RESEARCHERS' CONTACT INFORMATION

If you have any questions or concerns about this study, please feel free to contact Emma Gibbons at 0828991883 and/or the supervisor Ilze Slabbert at 0218082075.

9. RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research participant, contact

Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

DECLARATION OF CONSENT BY THE PARTICIPANT

As the participant I confirm that:

- I have read the above information and it is written in a language that I am comfortable with.
- I have had a chance to ask questions and all my questions have been answered.
- All issues related to privacy, and the confidentiality and use of the information I provide, have been explained.

By signing below, I _____ (*name of participant*) agree to take part in this research study, as conducted by _____ (*name of principal investigator*).

Signature of Participant

Date

DECLARATION BY THE PRINCIPAL INVESTIGATOR

As the **principal investigator**, I hereby declare that the information contained in this document has been thoroughly explained to the participant. I also declare that the participant has been encouraged (and has been given ample time) to ask any questions. In addition, I would like to select the following option:

	The conversation with the participant was conducted in a language in which the participant is fluent.
	The conversation with the participant was conducted with the assistance of a translator (who has signed a non-disclosure agreement), and this “Consent Form” is available to the participant in a language in which the participant is fluent.

Signature of Principal Investigator

Date

ANNEXURE E: INFORMATION SHEET ON RESEARCH



UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

UNIVERSITY OF STELLENBOSCH

DEPARTMENT OF SOCIAL WORK

RESEARCHER: Emma Gibbons

DISSERTATION: Masters' in Social Work

RESEARCH TOPIC: Challenges experienced by service users during substance dependency aftercare and reintegration services.

DATE OF INTERVIEW INTENDED: _____

PLACE OF INTERVIEW: _____

NATURE OF INTERVIEW:

The interview between the researcher and interviewee will be conducted face-to-face, and will be approximately 75 minutes in duration. The semi-structured questions that are asked will be open-ended and comprehensive, consisting of a few questions per interview schedule. This interview will be recorded via a voice or tape recorder in which the participants' private information, such as their name, will be protected. The researcher will never refer to their name or surname. Instead, a code will be assigned to them, such as participant 1, 2 or 3. The length of time for participation will be 10 minutes of explaining the purpose of the study, 50 minutes for the semi-structured interview and 15 minutes for debriefing after the interview. Additional counselling will also be made available by the CAD if they feel that they need the extra support, for no additional cost. Therefore, a total of 75 minutes will be needed from the participants, and the interview will either be conducted at the CAD office, or at their house in a private space where they feel the most comfortable.

CRITERIA IN ORDER TO PARTAKE IN STUDY:

- Substance dependency aftercare and reintegration services available for adult service users.
- The participants should be former substance dependent individuals that are partaking in an aftercare and reintegration service programme for substance dependency after they have received formal treatment.
- Informed consent to be obtained by participants that encounter substance dependency aftercare and reintegration services in order to conduct research regarding the challenges experienced by them.
- Participants should be able to understand English or Afrikaans.
- Participants should be over 18 years old.

SUMMARY OF RESEARCH OBJECTIVE:

The goal of this research study is to gain the experiences of service users on the challenges experienced during aftercare and reintegration services within the context of South Africa. The focal research question, as formulated by the researcher is:

What are the challenges experienced by adult service users during substance dependency aftercare and reintegration services?

ANNEXURE F: INTERVIEW QUESTIONNAIRE

UNIVERSITY OF STELLENBOSCH

DEPARTMENT OF SOCIAL WORK

Title: Challenges experienced by service users during substance dependency aftercare and reintegration services

Researcher: Emma Jade Gibbons

Number _ _ _

1. IDENTIFYING PARTICULARS OF PARTICIPANT

1.1 What is biographic profile of participants

Gender	
Age	
Race	
Highest education level	
Marital status	
Number of children	
Drug of choice	
Age of substance dependency onset	
What area do you live in?	

2. INTERVENTION AND AFTERCARE SERVICES

How many admissions into formal treatment and how many of those have you formally completed?

Are aftercare and reintegration services available and accessible in your community? If so, what services? (support groups, professionals, etc.)

3. BIOPSYCHOSOCIAL CHALLENGES EXPERIENCED DURING AFTERCARE AND REINTEGRATION

3.1 Are the following biological challenges experienced, and if so, how are they dealt with in order to prevent relapses during aftercare and reintegration services?

- a) Is there a pattern of addiction in your family? If so, how has it impacted your recovery?
- b) How do you deal with cravings?
- c) What other biological challenges do your experience during aftercare and reintegration services? (i.e. weight gain)

3.2 Are the following psychological challenges experienced, and if so, how are they dealt with in order to prevent relapses during aftercare and reintegration services?

- a) Are there any situations where you feel greatly stressed or depressed? (i.e. emotions)
- b) According to your knowledge, what are the main causes or risk factors for relapses?
- c) How have you experienced the abovementioned risk factors? If so, how have you dealt with them?
- d) Have you been diagnosed with a psychological disorder? If so, how does it affect your recovery process? (i.e. dual diagnosis)
- e) What other psychological challenges do you experience during aftercare and reintegration services? (i.e. sexual trauma)

3.3 Are the following social challenges experienced, and if so, how are they dealt with in order to prevent relapses during aftercare and reintegration services?

- a) Do you feel that your family is being supported during aftercare? If so, by who?
- b) What is the availability and accessibility of alcohol and/or other drugs in your community?
- c) What has been your experience with interpersonal relationships during aftercare?
- d) Have you had job opportunities? (i.e. employed or unemployed, economic status)
- e) Do you have a criminal record or any unresolved legal matters? If so, how is it being dealt with?
- f) What other social challenges do you experience during aftercare and reintegration services? (i.e. housing)

3.4 Are the following cultural challenges experienced, and if so, how are they dealt with in order to prevent relapses during aftercare and reintegration services?

- a) Are there any challenges in your community that make it difficult to effectively utilise/access aftercare services? (i.e. barriers)
- b) How does your community/culture view substance use/misuse? (i.e. stigma, stereotyping)
- c) What other cultural challenges do you experience during aftercare and reintegration services? (i.e. lack of knowledge or awareness)

ANNEXURE G: MEMBER VERIFICATION FORM



UNIVERSITY OF STELLENBOSCH
DEPARTMENT OF SOCIAL WORK

MEMBER VERIFICATION FORM

Participant number: _____

I, hereby declare that I have read the transcribed interview completed for this research study:

(Please tick where you feel appropriate)

YES	
NO	

I, hereby, declare, that I am in agreement with the transcribed content of the interview:

(Please tick where you feel appropriate)

YES	
NO	

Signature (participant): _____

ANNEXURE H: INDEPENDENT CODE THEME VERIFICATION

INDEPENDENT CODE THEME VERIFICATION FORM

I hereby declare that I have read the transcribed interview completed for this research study and I am in agreement with the themes, sub-themes and categories derived from this:

(Please tick where you feel appropriate)

YES	
NO	

Theme	Sub-theme	Categories
Theme 1: Biological challenges	Sub-theme 1.1: Patterns of addiction	c) Parents' addiction patterns d) Extended family patterns
	Sub-theme 1.2: Cravings	c) Stimulus d) Lack of coping mechanisms
	Sub-theme 1.3: Biological wellbeing	b) Weight gain
Theme 2: Psychological challenges	Sub-theme 2.1: Dealing with emotions	e) Negative emotions f) Aggression g) Untrustworthiness h) Inconsistency of coping skills
	Sub-theme 2.2: Cause of previous relapses	e) Unemployment f) Reservations g) Lack of support group attendance h) Protective factors
	Sub-theme 2.3: Dual Diagnosis or co-occurring disorders	
	Sub-theme 2.4: Sexual trauma	
Theme 3: Social challenges	Sub-theme 3.1: Family systems	d) Lack of family involvement e) Unresolved conflict f) Support for families
	Sub-theme 3.2: Availability and accessibility of AOD	
	Sub-theme 3.3:	d) Peer and social pressure e) Intimate relationships f) Sex drive

Theme	Sub-theme	Categories
	Interpersonal relationships	
	Sub-theme 3.4: Socio-economic status	c) Unemployment d) Education status
	Sub-theme 3.5: Criminal record	
	Sub-theme 3.6: Housing	
Theme 4: Cultural challenges	Sub-theme 4.1: Barriers to aftercare and reintegration services	c) Transport d) Safety
	Sub-theme 4.2: Stereotyping and stigmatising	
	Sub-theme 4.3: Lack of knowledge and awareness by community members	

ANNEXURE I: REFLEXIVITY REPORT

I feel that it was necessary for me to complete this reflexivity report so that I could debrief myself in terms of reflecting on my thoughts and feelings regarding this research process. I was fortunate enough to have my research proposal be declared as medium/high risk, which allowed me to ask raw and in-depth questions. However, it was also an emotional experience to hear the personal realities of others with regards to their challenges combating their substance use disorder.

I am fortunate enough to come from a privileged household in terms of having access to various educational opportunities, as well as a structured and secure family system. There is no one in my immediate family that struggles with addiction. In fact, when I started studying social work in 2014, I struggled to have sympathy and understanding for people with addiction problems because I thought it was their own choice. Little did I know that when I was placed in Toevlug rehabilitation centre in my final year (2017), all my naïve thoughts would change to having complete compassion for such a vulnerable population. It was made clear to me that no one chooses addiction, and that it is rather the result of various factors. This is what led me to utilise the Biopsychosocial model for my research study. This model allowed me to address the complex nature of substance dependency recovery. Substance dependency has been an epidemic for years, and it is fuelled by unemployment, poverty and past trauma. With substance dependency relapses being as high as 75% in 3 to 6 months period after receiving formal treatment, I felt that it was necessary for me to understand what challenges are experienced by recovering addicts that predispose them to be subjected to such a high percentage. I was determined to interview the primary sources, which are the recovering addicts, and not the service providers, who merely have secondary experiences with substance dependency recovery.

It was essential to this research study that the voices of such a vulnerable population be heard, so that their lived realities with addiction and recovery could be brought to light in the hope that a difference could be made in social services. I have always enjoyed a challenge, and that is why I decided to focus my masters' research project on predisposing relapse factors.