


**Clients' Experience of Substance Abuse Recovery in a Faith-Based
Programme in the Western Cape**

By
Colleen Herman

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degree of
Masters in Nursing in the
Faculty of Nursing at Stellenbosch University*

The crest of Stellenbosch University is centered behind the text. It features a shield with various symbols, including a book and a quill, topped with a crown and a banner.

Supervisor: Dr. Eunice Seekoe

March 2013

DECLARATION

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

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ABSTRACT

The focus of the study is on clients' experiences of substance abuse recovery in a faith-based programme in the Western Cape. In describing the nature and extent of the substance abuse problem at an Imbizo on substance abuse, the speech of the Minister of Social Development, Benjamin (2006:1) stated that there are major challenges in rendering services to people who abuse substances. These challenges exist particularly with regard to prevention, rehabilitation and treatment of abusers. Baumann (1998: 238) stated that drug misuse is widespread and a growing problem in Southern Africa. This epidemic will have an increasing impact on mental and physical health. The focus of the literature review is to highlight the escalation of the problem over the last decade or so. Substance abuse is classified as a mental health illness, which could be healed in the application of various modalities of care. Little is understood and documented about the role of FBO programmes in substance abuse recovery in the Western Cape. The researcher hopes to add to the body of nursing research knowledge by conducting the study to answer the research question by understanding the experiences of clients accessing this level of care.

The objective of the study is to explore, describe and interpret clients' experiences of substance abuse recovery in a faith-based (FBO) programme in the Western Cape. An explorative, descriptive, interpretive, phenomenological, qualitative research design was chosen for this study. The population for this study comprised males and females, aged 18 years and older, who were admitted as in-patients in the 6-month residential substance abuse recovery facility, who followed the programme.

The researcher used purposive sampling to recruit 7 participants who met the inclusion and exclusion criteria, until saturation of data was reached. The primary data collection tool used was in-depth semi-

structured recorded interviews and field notes. The researcher used Nola Pender's (1996) Health Promotion model (HPM) as the conceptual framework for the study as described. The Braun and Clarke's inductive thematic analysis (2006) was used to conduct the data analysis which yielded two overarching themes, namely, the positive recovery experience and the modified future experience. Recommendations were made based on the HPM assumptions and the thematic analysis. Ethical principles were followed in conducting the study and participants were advised that they are helping researchers to answer the research questions by participating in the study.

OPSOMMING

Die studie fokus op kliënt-ervaringe van dwelmmisbruik-herstel in 'n geloof-gebaseerde programme in die Wes-Kaap. In die beskrywing van die aard en omvang van die dwelmmisbruikprobleem by 'n Imbizo op dwelmmisbruik tydens 'n toespraak van die Minister van Maatskaplike Ontwikkeling (2006:1), is verklaar dat groot uitdagings heers met betrekking tot die lewering van dienste aan persone wat dwelmmiddels misbruik. Hierdie uitdagings het veral betrekking op die voorkoming, rehabilitasie en behandeling van misbruikers. Baumann (1998: 238) verklaar dat dwelmmisbruik tans 'n wydverspreide en groeiende probleem in Suider-Afrika is. Hierdie epidemie hou 'n toenemende impak op die geestelike en fisiese gesondheid van misbruikers in. Die fokus van die literatuuroorsig is om die verhoogde effek van die probleem uit te lig wat oor die laaste dekade voorgekom het. Die misbruik van dwelmmiddels word geklassifiseer as 'n geestesgesondheidsiekte wat gebruik kan word in die toepassing van verskeie modaliteite van gesondheidsorg. Daar is tans onvoldoende inligting beskikbaar om die rol van die FBO programme in die herstel van dwelmmisbruik in die Wes-Kaap behoorlik te kan ontleed en verstaan. Die navorser beoog om met die uitvoer van die studie die navorsingsvraag te kan beantwoord en sodoende 'n meer ingeligte en in-diepte oorsig te kan vorm oor die ervaringe van kliente wat toegang het tot hierdie vlak van sorg.

Die doel van die studie is om kliënt-ervaringe van dwelmmisbruik-herstel in 'n geloof-gebaseerde (FBO) programme in die Wes-Kaap te verken, beskryf en te interpreteer. Daar is besluit op 'n ondersoekende, beskrywende, verklarende en fenomenologiese kwalitatiewe navorsingsontwerp vir die studie. Die populasie vir hierdie studie het mans en vrouens in die ouderdom van 18 jaar en ouer ingesluit wat as kliente in die 6-maande residensiële dwelmmisbruik-herstel fasiliteit se program toelating verkry het en wat deelgeneem het aan die programme.

Die navorser het gebruik gemaak van 'n doelgerigte steekproeftrekking en sodoende 7 deelnemers gewerf wat aan die insluitings en uitsluitings kriteria voldoen het. Die proses is gevolg totdat 'n versadigingvlak van die data bereik is. Die primêre data insamelingsinstrument het die gebruik van 'n in-diepte, ongestruktureerde onderhoud-metode behels, wat die neem van veldnotas en bandopnames ingesluit het. Die navorser het gebruik gemaak van die Pender se 'Health Promotion Model' (HPM) as die konseptuele raamwerk vir die studie. Die Braun en Clarke's induktiewe tema-analise (2006) is gebruik om die data analise uit te voer wat twee oorkoepelende temas ingesluit het, naamlik, die positiewe herstelervaringetema en die gewysigde toekomstige ervaringe tema. Aanbevelings is gemaak wat op die HPM aannames en die tema analise gebaseer is. Etiese beginsels is streng gevolg en deelnemers is in kennis gestel dat hul deelname aan die studie die navorser instaat sou stel om die nodige data in te samel om sodoende die navorsingsvraag van die studie te kan beantwoord.

DEDICATION

This study is dedicated firstly to Jared Zachary Herman and Adam Ezra Herman, my sons, and secondly to my parents, Peter and Charlene De Villiers. I cannot do what I do, or be who I am, without your support. Thank you for always believing in me and pushing me to greater heights. I love you.

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1. CHAPTER 1: FOUNDATION OF THE STUDY

1.1 INTRODUCTION

According to Volkow (2010: 5) drug addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. As a Registered nurse working part time in a faith-based substance abuse recovery home, I have observed the impact that the programme had on young men and women recovering from drug addiction. I will explain, through my research, the clients' experiences of recovery from substance abuse in a faith based organisation (FBO) programme. Substance abuse has a substantial and reciprocal impact upon both the individual and families because of its harmful use. Harmful use implies use that causes physical or mental damage that alters the structure of the brain if left untreated, according to Volkow (2010: 5). This has been witnessed in the FBO facility among the 363 clients who were admitted to the programme since its inception in 2007. Wright (2003: 1) quotes Prochaska *et al* (1992) by stating that reports in literature on substance abuse indicated that recovery from substance abuse is a complex multidimensional process that occurs both with and without expert assistance. Some addicts, therefore, do not require intervention, while others have specific needs which should be met to facilitate recovery from substance abuse. One such method is a Faith Based Organisation (FBO) approach. Clients' lived experiences in a recovery programme need to be explored, described and interpreted so that the programme can document how clients benefitted and prevented future relapse into substance abuse if the phenomena is understood. This chapter will look at the significance of the problem, rationale, research problem, research question, research aim, research objectives, conceptual framework, research methodology, ethical consideration, operational definitions, and duration of the study, chapter outline and the significance of the study.

1.2 SIGNIFICANCE OF THE PROBLEM

Substance abuse is a widespread and ever-increasing problem in many areas both internationally and locally. The nature of substance abuse is that it is mind altering and creates dependency by the user on an illicit drug. It is therefore classified as a mental illness according to the American Psychiatric Association's (APA) draft Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V) and classified by the international coding of diseases (ICD-10) system (2000). This mental health illness could be treated by the application of various common modalities of care, e.g., medical model, matrix model, behaviour modification model, psychotherapeutic model or a faith-based model of care. Wright (2003) quotes Prochaska (1992) stating that recovery from this multi-dimensional illness took on different forms for each client. Some clients may require one kind of intervention, while others do not. Crawford (2003) reported on a study done in Nashville and stated that traditional approaches to substance abuse treatment may be problematic among African-Americans given unfavourable views of available treatments and historical relationships with social services. Further, traditional middle-class European-American intervention and treatment models may be inconsistent with the needs of many African-American substance users. These models assume that people have the necessary resources and do not consider barriers to interventions.

For the purposes of the study, I will look at a faith-based model of substance abuse recovery and care. Although the faith-based modality of care is documented for many settings, little is understood and documented about the role of these FBO programmes in substance abuse recovery in the Western Cape. The researcher hopes to add to the body of nursing research knowledge on this modality of treatment. This study was

conducted to answer the research question, namely, what are clients' experiences of substance abuse recovery in a faith-based programme in the Western Cape?

1.3 RATIONALE

Statistics published by the United Nations Office on Drugs and Crime (UNODC) World Drug Report 2012 states that there is an increase in substance use and abuse with a focus on the Southern African region. Many factors could account for this phenomenon but one proposed by the United Nations Office on Drugs and Crime (UNODC) suggests that the local production of illicit substances in the Southern African region could be accounting for the increased use because it is cheaper to manufacture and make available illicit substances compared to importing thereof as was done historically. This sentiment is echoed in the recently announced as yet unpublished 2012 South African Census conducted by Statistics South Africa; rating Cape Town as having the highest statistics for substance abuse in the country.

Crawford (2003) states that their research has increasingly emphasized the need for programmes promoting pro-social motives (i.e., re-entry into a moral community, renewed spirituality, collective and individual self-esteem as well as establishing/re-establishing role in family) as an approach to increase service utilization among their middle to poor income clients. Clients' lived experiences in a recovery programme needed to be explored, described and interpreted so that the programme could document how clients would benefit and also prevent future relapse into substance abuse if the phenomenon is understood.

1.4 **PROBLEM STATEMENT**

Baumann, (1998: 215) states that the link between substance misuse and accidents, crime, absence from work, family breakdown, child abuse and mental and physical ill health is clear. Parry (2003:1) reported on a review conducted by the Medical Research Council (MRC) in the Western Cape between 1997 and 2004 which explains the vast nature of both alcohol and drug abuse in the Western Cape. The report states that the range of drugs abused and the burden of drug use is generally greater in the Western Cape than in other provinces. The latest South African 2012 census conducted by Statistics South Africa, still unpolished, confirms Parry's finding, 8 years later. In the last few years the influx of illicit substances entering the Western Cape rose exponentially. Myers, Fakier, & Louw. (2008: 5) list some reasons as being an increased availability of drugs due to less rigorous restrictions and lack of resources in various law enforcement institutions. This resulted in an increased amount of drugs at reduced prices and an inability of over-burdened law enforcement institutions to cope adequately with the situation, thus perpetuating the problem. The current UNODC World Drug Report, 2012, lists increased regional manufacturing as the latest trend to increase the substance use and abuse exponentially. This will be discussed in Chapter 4 of this study. NIDA (210: 28) states that getting an addicted person to stop abusing drugs is just one part of a long and complex recovery process. By the time people enter treatment, addiction has taken over their lives.

In a speech at an Imbizo on substance abuse, in 2006, the then Deputy Minister of Social Development, Minister Benjamin, stated that the far-reaching implications of substance abuse should not be underestimated. She further stated that substance abuse touches the roots of our society, for example, children and family lives, criminal behaviour, HIV and AIDS infection, poverty, unemployment and other forms of trauma, violence and

various forms of abuse, loss of productivity and in fact has an impact on every facet of South African social fabric. She highlighted the fact that it is appropriate to feel helpless in the face of this threat. Clients accessing health-care to recover from the substance abuse problem come from these relatively impoverished Western Cape communities. They enter a substance abuse recovery programme having some expectations, while simultaneously increasing the burden on the health-care system. A study done to understand the clients' experiences in a FBO programme is needed to explore, describe and interpret the present situation.

1.5 RESEARCH QUESTION

What are clients' experiences of substance abuse recovery in a FBO in the Western Cape?

1.6 RESEARCH AIM

The aim of the study is to describe the clients' experiences of substance abuse recovery in a FBO programme in the Western Cape.

1.7 RESEARCH OBJECTIVE

The objective of the study is to explore, describe and interpret clients' experiences of substance abuse recovery in a faith-based (FBO) programme in the Western Cape.

1.8 CONCEPTUALISATION

Conceptualisation involves embedding or incorporating one's research into a body of knowledge that is pertinent to the research problem, Mouton (1996: 119). Burns and Grove (2007: 534) define conceptual map as a

strategy for expressing a framework of a study that diagrammatically shows the interrelationships of concepts and statements. For the purpose of this study, I used Pender's Health Promotion Theory as the conceptual framework. The application thereof will be discussed in Chapter 4 of this study.

According to Mouton (1996: 195) conceptualisation also refers to the underlying theoretical frameworks that guide and direct the research. Braun and Clarke's Inductive Thematic analysis was used for this study. This will be discussed in Chapter 2.9.

1.9 RESEARCH METHODOLOGY

1.9.1. **Research Design**

An explorative, descriptive, interpretive, phenomenological qualitative research design was chosen for this study. Burns and Grove (2007: 63-64) states that there are two approaches to phenomenological research namely, descriptive and interpretive. Descriptive phenomenological research describes the experiences as they are lived, while interpretive phenomenological research involves collecting and analysing the data.

1.9.2. **Study Setting**

Polit and Beck (2008: 221) states that qualitative researchers usually collect their data in real-world, naturalistic settings. This study will be conducted in a faith-based (FBO) substance abuse recovery home in the Western Cape. The home houses a 28 bed male facility and a 10 bed female facility. The research setting will be discussed in more detail in Chapter 2.

1.9.3. **Population and Sampling**

The study population was identified by the inclusion and exclusion criteria listed below. Purposive sampling was used to identify the study participants. Burns and Grove (2007: 344) state that purposive sampling could also be called judgemental, non-probability or selective sampling because the researcher consciously selects certain participants, elements, events or incidents to include in the study. Polit and Beck (2008: 227) state typically phenomenological studies involve a small number of study participants, often 10 or fewer. While this method is criticized for not being scientific, Burns and Grove (2007: 345) contend that in qualitative research, this sampling method seems to be the best method to gain insight into a new area of study or to obtain in-depth understanding of a complex experience or event. Thus clearly identifying inclusion and exclusion criteria eliminates bias on the part of the researcher.

1.9.3.1. **Inclusion Criteria**

Participants were included into the study based on the following criteria: Men and women, 18 years and older, who have been registered as an in-client in the facility to be studied, until data saturation was reached.

1.9.3.2. **Exclusion Criteria**

Participants were excluded from the study based on the following criteria: Clients under the age of 18 years old and/or clients who only attended the out-

client programme and were not admitted to the in-client programme of the FBO being studied.

1.9.4. **Data Collection Tool**

Burns and Grove (2007: 78) state in qualitative studies that the interview format is more likely to be open-ended. They further state, although the researcher defines the focus of the interview, there is no fixed sequence to the questions asked, and the researcher is guided by the insights of the previous interviews and observations made. The goal of interviews is to obtain a rich source of data. Burns and Grove (2007: 79) further describe the strategies used to record information from interviews, such as writing notes during the interview, writing detailed notes immediately after the interview, and recording the interview on tape. I used recorded in-depth individual interviews as the primary data collection as well as field notes, as the methods to obtain rich data for the study.

1.9.5. **Pre-test Study**

Polit and Beck (2008: 564) define pre-test as the trial administration of a newly developed instrument in order to identify potential weaknesses. I conducted a pre-test in discussion with the staff and clients resident in the programme to gauge the relevance of the study question prior to conducting the study. This was also done to understand my own feelings and sentiments on the topic, so as to pre-identify my prejudices and minimize researcher bias. This will be discussed in conjunction with bracketing and explicating in Chapter 2.

1.9.6. **Trustworthiness**

Lincoln and Guba (1985: 316) suggest in Guba's model that trustworthiness of a qualitative research study is important to evaluating its worth. Trustworthiness involves establishing of credibility, transferability, dependability, and confirmability. This will be discussed further in Chapter 2.7 of this study.

1.9.7. **Data Collection**

Polit and Beck (2008: 227) state in phenomenological studies that the main data source typically is in-depth conversations, with researchers and informants as co-participants. Researchers help informants to describe lived experiences without leading the discussions. Data collection was done using recorded in-depth interviews and field notes. This will be discussed in Chapter 3.5.

1.9.8. **Data Analysis**

The Braun and Clarke's inductive Thematic Analysis was used to analyse the data gathered from the recorded interviews, Braun and Clarke (2006: 87). This method was borrowed from Psychology and is an example of derivation used in the study, further discussed in Chapter 2.

1.10 **ETHICAL CONSIDERATIONS**

Permission to conduct the study was obtained by the Stellenbosch University Ethics Committee. Secondly, permission to conduct the study was sought from the management of the FBO substance abuse facility and lastly from the clients. The following ethical principles were

considered: beneficence, informed consent, anonymity, justice and confidentiality.

In this study beneficence was maintained by informing all the potential clients of the potential study in a general mail to the past clients and a general meeting of the current clients. All clients therefore had an equal opportunity to participate in the study. The interested volunteers had everything explained to them again by a question-and-answer session to gain further clarity, before they consented. Interested parties were invited to participate. Signed informed consent was then obtained individually from all interested clients, informing them of the purpose of the study and the potential risks and benefits involved. Clients were also advised that participation was voluntary and that they could decline, even if they had already agreed to participate, without fear of retribution (Brink, 2000: 42). Anonymity was maintained by having the recorded interviews marked with a number only. No personal names and surnames were used for the data analysis. Beneficence involves an effort to secure the well-being of individuals. It states that one should do good, and above all do no harm. Therefore, I made every effort to protect participants from victimisation, discomfort and harm (Brink, 2000: 40). Justice was ensured when all interested and qualifying clients was offered an equal opportunity to participate in the study. Clients refusing to participate were not discriminated against in any way (Brink, 2000: 40). Confidentiality was ensured by preventing access to the study clients' information, interview notes and tapes, and the questionnaires, as well as conducting the interviews at a mutually convenient time and in a private room; thereby maintaining clients' confidentiality (Brink, 2000: 41).

1.11 OPERATIONAL CONCEPTS

Experiences

Polit and Beck (2008: 227) state essence is what makes a phenomenon what it is, and without which it would not be what it is. Phenomenologists investigate subjective phenomena in the belief that critical truths about reality are grounded in people's lived experiences. Experiences are particular instances of personally encountering or undergoing something. For the purposes of the study, experiences were defined as any event lived by the client while resident in the substance abuse recovery programme or which led to admission in the FBO programme. These could be good or bad lived experiences. Polit and Beck (2008: 227) state that the topics appropriate to phenomenology are ones that are fundamental to the life experiences of humans.

Client

Funnell, Koutoukidis and Lawrence (2008: 4) define client as person who engages the advice or services of another who is qualified to provide this service. The client is the party for which professional services are rendered. For the purposes of the study, a client was defined as an individual male or female, age 18 years or older; resident in the recovery home for the purposes of overcoming their substance abuse addiction.

Faith-based Organisation (FBO)

Kramer *et al* (2002: 7) conducted a study and concluded that there is no single generally-accepted definition of what a faith-based organization entails. They further state that for the purposes of their report, a faith-based organization is an organization that holds religious or worship services, or is affiliated with a religious denomination or house of worship. Faith-based non-profit organizations generally maintain a faith-based

mission but the services they deliver may or may not have a faith-based content and they do not necessarily restrict clients to those who adhere to that faith. For the purposes of this study, all clients in residency in the recovery home have agreed to - by signing the rules and regulations on admission - abide by the faith-based rules and regulations set out by the programme's leadership in their constitution.

Programme

A programme is a system of projects or services intended to meet a public need. NIDA (2010: 28) states the best programmes incorporate a variety of rehabilitative services into their comprehensive treatment programmes. For the purposes of this study, the substance abuse recovery programme is the structured faith-based, cognitive behaviour therapy (CBT) programme that the client agreed to abide by in order to obtain recovery from the addiction. The programme was structured in the following way: a minimum of 2 weeks orientation phase, 6 months in the residency phase and then 3 months in the reintegration phase before a client graduated from the programme.

Substance abuse

Curley (2010) reported that the American Psychiatric Association's (APA) draft Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V) has added a new category for addictive disease that would include a variety of 'substance-abuse disorders' broken down by drug type, such a 'cannabis-use disorder' and 'alcohol-use disorder'. Substance abuse is a maladaptive pattern of use of a substance that is not considered dependent. For the purposes of the study, substance abuse was defined as any illicit mind-altering drug which has the ability to cause addiction with use and abuse.

1.12 DURATION OF THE STUDY

Research proposal (first draft)	Early June 2011
Research proposal (corrections: second draft)	Sept - Nov 2011
Submission to REC for approval	Dec 2011
Approval notification obtained	07 Feb 2012
Data collection interviews	Mar- May 2012
Data Analysis and interpreting findings	Mar – Oct 2012
Meet with the Supervisor and doing corrections	Oct – Nov 2012
Final submission to Nursing Division, Stellenbosch	29 Nov 2012
Oral presentation and report dissemination	Jan – Mar 2013

1.13 CHAPTER OUTLINE

Chapter 1 discussed the Foundation of the study;

Chapter 2 discussed the Research Methodology used;

Chapter 3 discussed the Results;

Chapter 4 discussed the Conceptual Framework;

Chapter 5 discussed the Discussion, Conclusion and the Recommendations.

1.14 SIGNIFICANCE OF THE STUDY

Polit and Beck (2008: 227) state that phenomenology, rooted in a philosophical tradition developed by Husserl and Heidegger, is an approach to exploring and understanding peoples' everyday life experiences. Phenomenologists assumes there is an essence and ask 'what is the essence of this phenomenon as experienced by these people, and what does it mean?' The explorative, descriptive and interpretive

nature of the study being conducted in client's experiences of substance abuse recovery in a faith-based programme in the Western Cape is important to understand, in order for the study to document the benefits of such a programme in that setting and prevent future relapse into substance abuse if the phenomenon is understood.

1.15 **CONCLUSION**

This chapter described the foundation of the study. It described research design, study setting, population and sampling, data collection tools used, pre-test study, trustworthiness, data collection methods, data analysis, ethical consideration, operational definitions, duration of the study, chapter outline, significance of the study, summary and conclusion of the study. I decided to use an explorative, descriptive, interpretive, phenomenological qualitative design answer the research question on clients' experiences of substance abuse recovery in a faith-based programme because it would address the current research problem. Polit and Beck (2008: 227) state that phenomenological text that describes the results should help the readers 'see' something in a different way that enriches their understanding of experiences. The study setting allowed me to purposively sample the participants who could provide the rich data needed to explore, describe and interpret the phenomenon being studied, thereby answering the research question.

2. CHAPTER 2: RESEARCH METHODOLOGY

2.1 INTRODUCTION

The purpose of this chapter is to describe the research methodology chosen and its justification in answering the research question. The objective of the study was to explore, describe and interpret clients' experiences of substance abuse recovery in a faith-based (FBO) programme in the Western Cape. The chapter covers the goal, objective, research design, research strategy, reasoning strategies, population criteria, sampling method, data collection tools and methods, data analysis approach, trustworthiness of the data, limitations and ethical considerations used in the study.

2.2 STUDY SETTING

Burns and Grove (2007: 352) define a natural or field setting as an uncontrolled, real-life situation or environment. They further state that conducting a study in a natural setting means that the researcher does not manipulate or change the environment for the study, as is often done in qualitative studies. This study was conducted in a faith-based (FBO) substance abuse recovery facility in the Western Cape. The facility houses a 28 bed male facility and a 10 bed female facility for men and women from all areas in the Western Cape. The facility received a Certificate of Registration of Institution Regulation 24 (3): Prevention and Treatment of Drug Dependency Act No. 20 of 1992, as a Halfway House on the 01 July 2011 from the Department of Social Development. The FBO facility operates on a 'Road map to recovery' (HARH Policy, Recovery Roadmap, 2009) which is a 0-5 step-wise approach and is shared with potential clients during the screening visit. The steps covered by the facility's policy are listed below to gain a sense of clarity of the approach used:

Step 0 is for the potential client *pre-screening* and is described as: identify you have a problem, accept you need help to recover from your problem and demonstrate help-seeking behaviour by attending a screening assessment. Step 1 is the *initial screening* interview. Clients seeking help for their substance abuse addiction at the facility were screened by the Social Auxiliary Worker. The screening assessment covered the programme's admission and orientation criteria. This process discusses the individual's substance use history, medical history, criminal and financial history. It also covers the facility's fees, inclusion and exclusion criteria as well as an orientation to the non-discriminatory, faith-based structure of the programme. Interested potential clients were then referred to the facility's registered nurse for the second component to the screening process. This was to assess a need for admission using a CAGE-AID questionnaire and a general health assessment. The CAGE questionnaire was developed for alcohol abuse and is understood as C, cut down, A, annoyed, G, guilty and E is eye-opener. The CAGE-AID was adapted for drugs screening by Brown and Rounds (1995: 135-140). According to the authors, a 2 out of 4 positive score warrants further evaluation for substance abuse recovery care. The general health assessment assesses pre-existing psychiatric, communicable illnesses and current pregnancy in female clients. The registered nurse then makes an admission recommendation or referral based on the findings. Referrals could be made to an ante-natal clinic for positive pregnancies, to a detox facility for heroin addiction, to the community psychiatric nurse to assess pre-existing mental health illness or to the local community health centre for communicable diseases.

Step 2 is the admission to the *out-client programme*. This process involved the client attending the facility Monday-Friday, 07h30 to

16h30. This process allows the out-client to be in a safe space, exercise sobriety and demonstrate compliance to care and structure. The out-client's progress to Step 3 is based on a negative multi-drug urine test, available bed space and compliance to the out-client programme. This period could extend, based on joint decisions made by the out-client, the programme manager and the family. Step 3 is the admission into the *6-month in-client residential programme*. The faith-based recovery home works on the principle of second stage recovery as highlighted by Eby and Brown (2009: 238) who define recovery phase as the second phase of substance dependency treatment. It begins when clients have detoxified and are abstaining from substance use. NIDA (2010: 26) discusses treatment withdrawal by stating when patients first stop abusing drugs; they can experience a variety of physical and emotional symptoms, including depression, anxiety and other mood disorders such as restlessness and sleeplessness. Clients, therefore, need to have a negative multi-drug test on admission before they can be admitted into this safe, dormitory style environment. The programme offered is a faith-based behaviour modification programme aimed at moving the individual client from a chaotic drugging lifestyle to safe whole space in his/ her life. On admission into the in-client programme an individual development plan (IDP) is completed. This identifies where the client is at, in each aspect of his/her life, and where the potential gaps are. The IDP is completed by a Social Worker. The clients are then placed into peer groups with a senior peer leader. These groups form their basic work and support structures. The clients share information, in order to get help and the support needed. Issues get escalated from these groups to the programme manager who will arrange for the relevant interaction according to the clients' needs. This phase of recovery is based on interactions with the Social Worker and Pastoral Counsellor who facilitate individual and family counselling, the Social Auxiliary

Worker who facilitates education sessions and support groups, Peer Leaders who assist in the day to day programme implementation, Facilitators who trains on the various components of the faith-based programme, e.g., restorative justice and skills development, Mentors who assist in reintegration and the registered nurse who oversees the mental and physical health of the clients.

Step 4 is referred to as the *reintegration period*. This is based on the period following the in-client programme. The client works with the multi-disciplinary team and writes a Reintegration Plan which is aimed at an exit strategy from the safe space back into society. This phase lasts a minimum of 3 months and is aimed at successful reintegration. It involves clients living in the programme on an as needed basis only, e.g., weekends while they find employment; random drug testing, practical support, e.g., CV writing and ongoing counselling and support offered. This phase ends when a client graduates from the programme, which could be up to one year later per individual client.

Step 5 is referred as *aftercare*. This phase is based on ongoing support, referrals to support groups being made available to clients who are struggling with managing triggers associated with long-term craving. This phase is based on the individuals' need.

The faith-based recovery home is housed in the church. In 2012, the Department of Social Development part-funded a Social Worker and a Social Auxiliary Worker while all the other staff volunteer their services because they believe they can use their skills to make a difference in their community (HARH_AGM Report, 2011). Some of the staff have previously used substances themselves, and decided to give back to the community by volunteering in the faith-based facility and therefore are willing to walk the extra mile with clients. In 2012, each individual

client paid R600.00 per month for operational expenses, but clients who could not afford this were not turned away because the church buffered the costs (HARH_AGM Report, 2011). The facility's vision is to create a safe environment for addicts to confront the root cause of their addictions and to empower them to become constructive and productive citizens (HARH Policy_Profile, 2007).

2.3 RESEARCH DESIGN

Polit and Beck (2008: 227) state that phenomenologists investigate subjective phenomena in the belief that critical truths about reality are grounded in peoples' lived experiences. Phenomenological qualitative research is done to study lived experiences and is interpretive and narrative in nature. Polit and Beck (2008: 228) further state while there are a number of variants and methodological interpretations of phenomenology, the two main schools of thought are descriptive and interpretive. An explorative, descriptive, interpretive, phenomenological qualitative research design was chosen for this study. This will be discussed in greater detail in this chapter.

2.3.1 Research Strategies

As the objective of the study was to explore, describe and interpret the clients' experiences of substance abuse recovery in a FBO programme in the Western Cape, the exploratory, descriptive, interpretive phenomenological qualitative research design was the best design to describe this phenomenon. The strategy for this study will be described in the following heading: descriptive, interpretive, phenomenology and qualitative.

Explorative

De Vos (2002: 357) states that the exploratory nature of qualitative research leads to the development of new concepts or theory. The qualitative researcher takes notes and considers alternative interpretations of the data. The importance of conveying this to the reader adds to the length of the reports.

Descriptive

Burns and Grove (1993: 30) state that the descriptive nature of the study provided the researcher a way of discovering new meanings in order to collect accurate domain phenomena to be studied. For this study, the thematic analysis allowed for the description of the clients' experiences of substance abuse recovery in a FBO from the data coded.

Interpretive

Burns and Grove (2007: 543) define interpretive codes as an organisational system developed late in the process of collecting and analysing qualitative data, as the researcher gains insight into the existing processes. For this study, I conducted the coding of all the data transcripts after reading and rereading the data. During the coding of the data, I used interpretive skills to document what the clients stated.

Phenomenology

Streubert and Carpenter (2007: 98) state that, as a research method, phenomenology is a rigorous scientific process whose purpose is to translate human experiences into language. Phenomena related to nursing can be explored and analysed by phenomenological methods that have as their goal the description

of lived experiences. This method was also selected because it would allow the researcher to answer the research question and provide an evidence base for future research. The evidence of the client's stories; and how the past and present clients experienced substance abuse recovery in a faith-based programme in the Western Cape.

Qualitative

Burns and Grove (2007: 76) describe the researcher-participant relationship in qualitative research by the nature of the relationship, which has an impact on the collection and interpretation of data. Participants are not viewed as research participants, rather, as colleagues in the research journey. They further state that in varying degrees the researcher influences the individuals being studied and in turn is influenced by them. The mere presence of the researcher may alter behaviour in the setting. This involvement, considered a source of bias in quantitative research, is thought by qualitative researchers to be a natural and necessary element of the research process. The researcher personality is a key factor in qualitative research.

I joined the FBO programme as the Nursing Service Manager in October 2008. In this role in the FBO programme I had contact with the clients on a daily basis, doing the CAGE-AID questionnaires, the general health assessments, counselling, referring and facilitating their daily health promotion needs as necessary. My nursing interaction was directed at increasing the clients' wellbeing at every multi-dimensional level. I, therefore, had an opportunity to interact with them and observe them from admission, with their families, within the group sessions, until

discharge. My health practice is based on Pender's Health Promotion model which is directed at increasing a client's level of wellbeing. The Health Promotion model describes the multi-dimensional nature of persons as they interact within their environment to pursue health. I view the clients demonstrating help-seeking behaviour as multi-dimensional beings, pursuing health. As a born again, devoted Christian, I got an opportunity to practice my faith and my passion for nursing at a multi-dimensional level with the clients in the programme.

2.3.2 Reasoning Strategies

The reasoning strategies that were used throughout this study were analysis, synthesis, inductive reasoning, inferences, derivation, bracketing and explicating in order to arrive at strategies to aid understanding of the clients' experiences of substance abuse recovery in a FBO in the Western Cape.

Analysis

Analysis involves taking a complex whole and resolving it into its parts according to De Vos and Strydom (1998: 336). Analysis was used inductively in the data analysis period to explore patterns, thoughts, concepts and phenomena generated through the data extracts coded. Analysis was used deductively in conceptualising strategies for faith-based substance abuse recovery facilities.

Synthesis

According to De Vos and Strydom (1998: 336) synthesis is the process of building up separate ideas into a connective whole. In this study, synthesis was used to build a connected whole of the patterns, thoughts, concepts and phenomena described by the clients during the data collection period. This was done to arrive at

the overarching themes used to describe their experiences of substance abuse recovery in a FBO in the Western Cape.

Inductive reasoning

Inductive reasoning is a process when the premises of an argument provide only partial support for the conclusion (Rossouw 2000: 33). For this study, the research design was descriptive, interpretive, phenomenological qualitative; which meant that the empirical data was collected inductively. More evidence was added during the discourse and deliberation and the recorded in-depth interviews, which continued until data saturation was reached. The data generated during the in-depth interviews was analysed and interpreted through inductive abstraction and generalisation as described by Braun and Clarke (2006: 83)

Inferences

Inference refers to the process whereby premises support the conclusion based on other premises (Mouton, 1996: 71). Burns and Grove (2007: 542) define inference as generalisation from a specific case to a general truth, from a part to the whole, from the concrete to the abstract, or from the known to the unknown. In this study, I used inference when concluding statements were made from the conceptualisation process and data analysis to derive the conclusions, thus from the specific to the general.

Derivation

Derivation refers to the formation of words from their original concept. Wood and Brink (1997: 243) state that derivation consists of moving a concept from one field of interest to another. They further state the main advantage of derivation is that the researcher does not have to start from scratch but uses concepts

from other fields to speed up the creative process. I read widely and became familiar with existing literature on substance abuse recovery in a FBO and then used derivation to analyse the data using the Braun and Clarke's Inductive Thematic Analysis programme, borrowed from Psychology. This was done to redefine the data concepts and formulate codes and themes to place them in a meaningful relationship in order to understand the phenomena.

Data reduction

Miles and Huberman (1994: 10) state that data reduction refers to the process of selecting, focusing, simplifying, abstracting and transforming the data that appear in written-up field notes or transcriptions. Attridge-Sterling (2001: 390) quotes (Lee and Fielding, 1996) noting while debates over the centrality of coding and the homogenization of qualitative analysis techniques continue; there is overwhelming agreement that data reduction is an important strategy for qualitative researchers. This will be discussed in context with the data analysis in Chapter 2.9.

Bracketing and Explicating

Polit and Beck (2008: 228) state that bracketing refers to the process of identifying and holding in abeyance preconceived ideas and opinions about the phenomenon under study. Bracketing is an iterative process that involves preparing, evaluating and providing systematic ongoing feedback about the effectiveness of the bracketing. Streubert and Carpenter (2007: 457) define bracketing as a methodological device of phenomenological inquiry that requires deliberate identification and suspension of all judgements or ideas about the phenomenon under investigation or what one already knows about the subject prior to and throughout the

phenomenological investigation. They further state (2007: 28) if researchers do not explicate their perceptions, they may lead informants to describe their experiences in the direction of the researcher's own beliefs about what is real or important. This could be as a result of the questions asked. Explicating of personal beliefs makes the investigator more aware of the potential judgements that may occur during data collection. They suggest that the researcher write down their beliefs on the topic before data collection, or journal their feelings during data collection. This sentiment is echoed by Polit and Beck (2008: 228) who state that phenomenological researchers often maintain a reflexive journal in their efforts to bracket. For the purpose of this study, I wrote out my feelings prior to starting the study, which allowed me to cognitively bracket my own thoughts, beliefs, feelings and perceptions about the study; thus allowing me to engage with the data from a neutral point. This is evidenced by the fact that I asked the grand tour question as described by Polit and Beck (2009: 341), and then probing questions, based on the interview guide submitted to the Stellenbosch University Ethics Committee, prior to conducting data collection. Polit and Beck (2008: 228) state that although bracketing can never be achieved totally, researchers strive to bracket out the world and any presuppositions in an effort to confront the data in pure form. I believe my data collection was therefore unpolluted by my personal beliefs in working as the Nursing Service Manager in the recovery home being studied.

2.4 POPULATION AND SAMPLING

Burns and Grove (2007: 324) state that 'population, sometimes referred to as the target population, is the entire set of individuals or elements who meet the sampling criteria. An accessible population is the portion of the target population to which the researcher has

reasonable access'. The full duration of the programme utilised by the FBO facility studied is a two week orientation phase, a six month in-client residential phase and a three month reintegration phase. For a client to move from the orientation phase to the in-client phase, they need to demonstrate help-seeking behaviour, show daily attendance commitment and use this period to eradicate the drugs in their system; as described in Chapter 2.2. They are admitted as in-clients based on a negative multi-drug urine test for all the clients and a negative pregnancy test for the female clients. Some clients find it difficult to stop drugging and therefore exit the programme at this stage. Those that are committed to recovery are then admitted as in-clients into the residential programme and then move to the next phase for reintegration back into society thereafter.

For this study, the population was defined as all the male and female clients who entered the in-client phase of the FBO programme in an FBO in the Western Cape. These clients were selected because they had common elements to meet the sampling criteria and they could answer the research question. As the Nursing Service Manager of the FBO facility, I oversee the client database. The database showed a total eligible population of 254 males and 109 females, who entered the FBO programme from its inception on the 02 May 2007 to the data collection period in May 2012. Lastly, they were an easily accessible population, because contact was maintained with many of them and the FBO over time via support groups and mentors. All eligible clients were invited to participate in the study.

Purposive sampling was used to select the clients interviewed in the study because of their knowledge, substance abuse lived experience or views of the FBO-approach to substance abuse recovery. Streubert and Carpenter (2007: 94) states that purposive sampling is

used most commonly in phenomenological inquiry because this method of sampling selects individuals for study participation based on their particular knowledge, or a phenomenon for the purpose of sharing that knowledge. Burns and Grove (2007: 344) state that purposive sampling is sometimes referred to as selective sampling, where the researcher consciously selects certain participants, elements, events or incidents to include in the study. For this study, I stated the following as the study inclusion criteria which the study population had to meet, in order to answer the research question. Men and women, 18 and older, who have been registered as an in-client in the facility to be studied, until data saturation was reached. Streubert and Carpenter (2007: 460) define saturation as repetition of data obtained during the course of a qualitative study. This signifies completion of data collection on a particular culture or phenomenon. Streubert and Carpenter (2007:95) further quote Morse (1989) who stated that saturation is a myth. She proposed that given another group of informants on the same subject at another time, new data may be revealed. To maximise the likelihood of discovering the essences of the phenomena researched, Streubert and Carpenter (1999: 21) suggest interviewing participants from a variety of backgrounds, age ranges and cultural environments. To mitigate this risk, the study inclusion criteria for the sample group was open to both men and women, 18 and older, those currently in the programme and those who have already completed the programme, irrespective of employment status. The breakdown of the varied sample group is discussed in the biographical data in Chapter 3. Clients who have not moved from the orientation phase to the in-client phase of the facility's programme were not included in the study. Of the total population that was invited, 14 expressed immediate interest in participating. The sample group consisted of the first 7 who signed consent and met the

inclusion criteria. The other 7 were personally notified of this and thanked for their interest.

2.4.1 Inclusion Criteria

For this study, I stated the following as the study inclusion criteria which the study population had to meet, in order to answer the research question. Men and women, 18 and older, who have been registered as an in-client in the facility to be studied, until data saturation was reached.

2.4.2 Exclusion Criteria

For this study, the clients who were under 18 years of age and/or only attended the out-client programme and were not admitted to the in-client programme of the FBO were excluded. This was done because the research question was specifically aimed at participants who entered the six-month residential part of the programme to answer the research question.

2.5 DATA COLLECTION TOOL

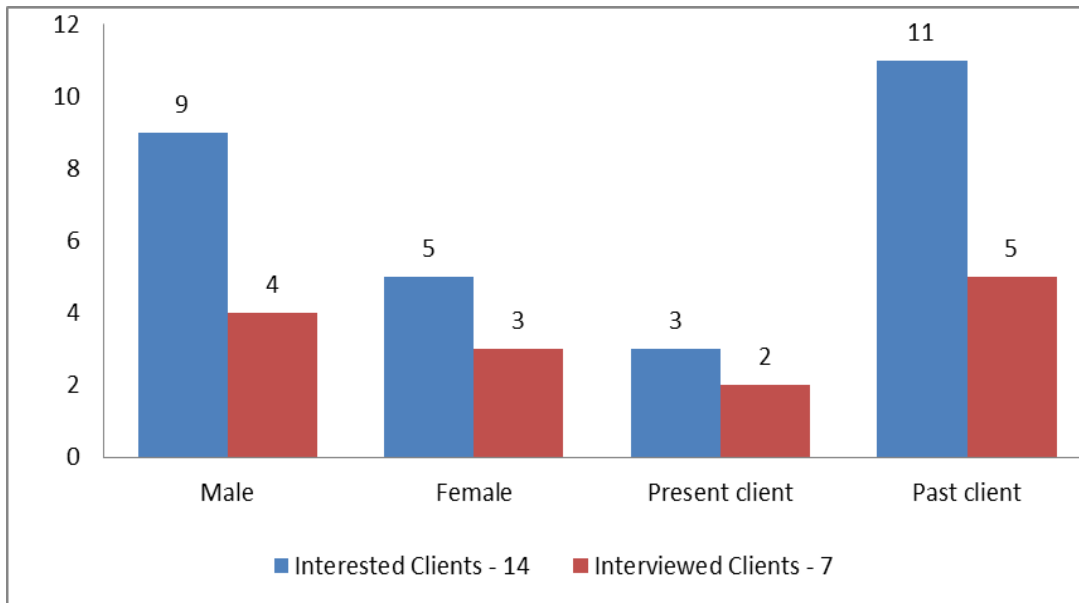
Sandelowski (2000: 338) states that data collection in qualitative descriptive studies is typically directed toward discovering the who, what, and where of events or experiences, or their basic nature and shape. Data collection techniques usually include minimally to moderately structured, open-ended individual and/or focus group interviews. Participants are encouraged to elaborate further on a particular dimension of the topic and often control the content of the interview. The interviewer's function is to encourage participants to talk freely about all the topics under discussion. For the purpose of this study, I used recorded in-depth, semi-structured individual interviews as the primary data collection method to obtain rich data, while having a broad interview guide as a reference only. According to

Lindlof and Taylor, 2002: 195, it is generally beneficial for interviewers to have an interview guide prepared, which is an informal grouping of topics and questions that the interviewer can ask in different ways for different participants. Participants were given the freedom to talk and share their opinions on their experiences of substance abuse recovery in a faith-based programme. The semi-structured interview is flexible, allowing new questions to be brought up during the interview as a result of what the interviewee says. For this study, I used the interview guide as a framework of themes to be explored. Streubert and Carpenter (2007: 95) state the interview allows entrance into another person's world and is an excellent source of data. Complete concentration and rigorous participation in the interview process improve the accuracy, trustworthiness, and authenticity of the data. This data collection method was done to gather information from the participants who met the study inclusion criteria and who gave full written informed consent for the interview and for the data recording. This research-participant relationship, in qualitative research, was useful because a measure of trust and a good rapport was established prior to the interviews being conducted; a necessary part of qualitative interviewing. Polit and Beck (2008: 406) state that field notes are important in many types of studies, not just in studies involving participant observation, because they contain a narrative account of what is happening in the field. For this study, field notes were taken during the interviews, with the client's permission, to keep track of points discussed, so as not to miss anything significant. It also allowed me to go back and clarify points not clearly understood in the interview to gain consensus.

Before conducting the interviews, I sought permission from both the Stellenbosch University Ethics Committee and the Management of the FBO facility. Once this was received, I sent a general mail to all past

clients and called a meeting of all current clients, advising them of proposed study. Figure 1, below, is a breakdown of the interested and interviewed clients according to gender and present status in the programme.

Figure 1: Interested and Interviewed participants



A total of 14 clients confirmed interest immediately, 9 males and 5 females; 3 present clients and 11 past clients. I advised them that I will call them if needed, or until the interviews yield no new data. I then set up interviews as convenient, over a period of a month. A total of 7 clients signed informed consent and were interviewed for this study; 4 males and 3 females. Thereafter I felt that no new evidence was generated through the interviews and data saturation was reached. I notified the remaining 7 and thanked them for their interest in participating in the research. In preparation for the interviews, I set up a private room with a tape recorder, water and tissues for the clients. I made the appointments at convenient times and set out to conduct the interviews. The biographical data of the clients

interviewed is discussed in Chapter 3 of the study. During the semi-structured interviews I encouraged the clients to share their experiences of recovering from substance abuse addiction in an FBO programme. The semi-structured interview is the preferred method for phenomenological qualitative studies because it gives participants the freedom to express the depth of their lived experiences, unhindered, while the researcher has an interview guide to frame the discussion in order to answer the research question. Hancock, Ockleford and Windridge (2009:16) state that the semi-structured interview includes a topic guide which is a list of topics the interviewer wishes to discuss. They further state that the guide is not a schedule of questions and should not restrict the interview, which needs to be conducted sensitively and flexibly allowing for follow-up of points of interest to either interviewer or interviewee. The clients were also encouraged to raise issues and concerns not addressed by myself. Streubert and Carpenter (2007: 94) state that the researcher should help participants describe lived experience without leading the discussion. Burns and Grove (2007: 78) state although the researcher defines the focus of the interview, there is no fixed sequence of questions.

2.6 **PRE-TEST**

As previously stated, Polit and Beck (2008: 564) define pre-test as the trial administration of a newly developed instrument in order to identify potential weaknesses. I conducted a pre-test in discussion with the staff and clients resident in the programme to gauge the relevance of the study question prior to conducting the study. A decision to proceed with the study, and fine tune the research question was based on the narrative discussions and field notes conducted during the pre-test. The pre-test also allowed me to identify my personal feelings on the phenomenon, which I explicated during my bracketing phase.

2.7 TRUSTWORTHINESS

The following four strategies were used in accordance with Lincoln and Guba's model (1985: 316-327): credibility, transferability, dependability and confirmability. I conducted recorded, in-depth individual interviews and made field notes during these sessions, with the clients' permission. Follow-up interviews were done with three clients to establish trustworthiness for the study after the initial data was collected. This allowed me to link data concepts and yield rich results.

2.7.1 Credibility

De Vos (2002: 351) states that credibility is the alternative to internal validity, in which the goal is to demonstrate that the inquiry was conducted in such a manner as to ensure that the subject was accurately identified and described. The major techniques or activities that make the findings more credible are prolonged engagement, persistent observation, member-checking, reflexivity, authority of the research and triangulation. These activities are described below:

Prolonged Engagement

Lincoln and Guba (1985: 77) state prolonged engagement is lengthy and intensive contact with the phenomena (or respondents) in the field to assess possible sources of distortion and especially to identify salencies in the situation. As the Nursing Service Manager in the programme, I had lengthy and intensive contact with clients to study the phenomenon. This allowed me to establish a rapport which was evident during the recorded interviews. Participants were made to feel comfortable and express their thoughts without fear of discrimination. Cutcliffe and

McKenna (1999: 379) suggest that the researcher should return to the participant and attempt to gain verification of the data to prove credibility. Follow-up interviews were conducted when information was unclear or consensus was needed.

Reflexibility

For this study I validated the data in real time, by confirming that I understood the answers from the clients correctly. As a registered nurse I completed my Diploma in Psychiatric Nursing. This formal training allowed me to use various interviewing techniques, e.g., probing, summarizing, paraphrasing, being non-judgemental and using open-ended questions to interview the clients. This was done to elicit the response in order to answer the research question. When consensus was not reached between the participant and me, I used the interviewing techniques to rectify my understanding in real time. This was not necessary for the scope of this study as only one interview was conducted with each participant. Taking field notes allowed me to keep track of details, to jot down points and comments made, that I needed to follow-up or clarify during the interview. Consensus on understanding was gained between the participant and me. Cutcliffe and McKenna (1999: 379) suggest that the researcher should return to the participant and attempt to gain verification of the data to prove credibility.

Triangulation

Lincoln and Guba (185: 77) state that triangulation is cross-checking of data by use of different sources, methods and, at times, different investigators. Triangulation is an important activity to improve the portability of findings and ensure that the interpretations are found to be credible. For this study, in-depth

individual interviews were conducted with participants who had experience of substance abuse recovery in a FBO in Western Cape. Field notes were taken during the interviews and, where necessary, follow-up interviews were also conducted to ensure validation of the information obtained and consensus was reached. Lastly, a co-coder was used to verify coding and thematic mapping of the transcribed information.

Member checking

Lincoln and Guba (1985: 77) state that member checks are the process of continuous, informal testing of information by soliciting reactions of respondents to the investigator's reconstruction of what he or she has been told or otherwise found out and to the constructions offered by other respondents or sources, and a terminal formal testing of the final case report with a representative sample of stakeholders. For this study a co-coder and the Supervisor were used to check if the constructions offered by myself are the constructions offered by the participants.

Authority of research

As the study researcher, I underwent previous training on research methodology and nursing. My research Supervisor is the head of Nursing at a University in South Africa, and holds a PhD. My co-coder is a qualitative research specialist and holds a Masters in Nursing. This qualified us to be an authority on this research study.

2.7.2 **Transferability**

De Vos (2002: 352) states that transferability is the alternative to external validity or generalizability in which the burden of demonstrating the applicability of one set of findings to another context rests more with the investigator who makes the transfer than with the original investigator. It therefore refers to showing that the findings have applicability in other contexts. Lincoln and Guba (1985: 77) think descriptive data is narrative developed about the context so that judgements about the degree of fit or similarity may be made by others who may wish to apply all or part of the findings elsewhere. A dense description of the study makes transferability possible. For this study, this was done by conducting recorded interviews and making field notes to ensure that the data collected was dense. A complete description of the research design, research strategy and method was done in detail, to show transparency. Also, a literature review was done to render the results trustworthy.

2.7.3 **Dependability**

De Vos (2002: 352) states that dependability is the alternative to reliability, in which the researcher attempts to account for changing conditions in the phenomenon chosen for the study, as well as changes in the design created by an increasingly refined understanding of the setting. As the nursing service manager at the facility, I have an in-depth knowledge of the research setting. This, together with the chosen phenomenological qualitative research design, was appropriate for the study. Lastly, the supervisor appointed an independent co-coder to review transcribed interviews against the data extracted until consensus

was reached. The guidance given by the co-coder and the supervisor was another method used to confirm the scientific rigour of the data collected thereby proving dependability of the data.

2.7.4 **Confirmability**

This refers to confidence in the 'truth' of the findings. Cutcliffe and McKenna (1999: 379) state that the confirmability of qualitative research is concerned with using different methods or approaches in the same study in order that one set of results confirms those of another. I confirmed the data by keeping a reliable audit trail in the form of field notes and reflexivity notes during the data collection period. Further, during the data analysis period, by rereading and verifying the data and coding by using the thematic analysis steps. This was done according to the Braun and Clarke (2006: 83) inductive data analysis method described above, which is similar to the grounded theory model. Lincoln and Guba (1985: 77) state for dependability and confirmability an external audit requiring both the establishment of an audit trail and the carrying out of an audit by a competent external, disinterested auditor is necessary. For this study, a competent, external, disinterested co-coder was appointed to establish the confirmability and dependability of the study.

The purpose of trustworthiness in qualitative research is to aim for objectivity, while it must take into account the views of the clients simultaneously. In following the above, I aimed to establish the trustworthiness of the qualitative data collected and the findings produced.

2.8 **DATA COLLECTION PROCESS**

The clients were invited to a private room where they were informed about the study by me and consent was obtained. Polit and Beck

(2009: 341) state that the researcher needs to ask a broad grand tour question. This question is the basis for the research conducted. For the purposes of this study, the clients answered the following grand tour question: 'How would you describe your substance abuse recovery experience in this FBO programme?' The interviews varied from 35 minutes to approximately one hour. I allowed clients to answer the grand tour question. When necessary, I asked the following probing questions based on responses and the study's objective, in order to guide the participant: 'Do you feel you that doing a faith-based programme benefitted you in your personal recovery journey?' 'Has the faith-based programme had an impact on your relationship with your family/ loved ones in any way? If yes, please explain how.' 'Tell me about your experiences with the other clients in the home.' 'Lastly, tell me about your experiences with the staff in the home.' All the interviews were recorded, as per the informed consent. Burns and Gove (2007: 554) define saturation of data as a phenomenon that occurs when additional sampling provides no new information or there is redundancy of previously collected data. No new knowledge emerged from the interviews, which led me to believe that data saturation was reached at this point. The 7 recorded interviews were transcribed verbatim, as per the recording, and then coded for themes that emerged from the data.

2.9 DATA ANALYSIS

An independent co-coder was purposefully selected because of her expertise in qualitative research skills and she played an important role, together with me, in data analysis. Streubert and Carpenter (2007: 98) state that Phenomenology is an integral field of inquiry to nursing, as well as Philosophy, Sociology and Psychology. The Braun and Clarke's inductive thematic analysis was used to analyse the data. This data analysis was borrowed from Psychology as discussed in

derivation, in Chapter 2.3, but it is relevant to nursing because like Psychology, nursing is directly related to human behaviour. Braun and Clarke (2006: 83) state that an inductive approach to thematic analysis means the themes identified are strongly linked to the data itself and as such it is similar to the grounded theory model of data analysis. They further state, in this approach, if the data has been collected specifically for the research, e.g., via interview or focus group, the themes identified may bear little relation to the specific questions that were asked of the clients. They would also not be driven by the researcher's theoretical interest in the area or topic. Inductive analysis is therefore a process of coding the data without trying to fit it into a pre-existing coding frame, or the researcher's analytic preconceptions. In this sense, this form of thematic analysis is data-driven. Braun and Clarke (2006: 86) further describe and outline a step-by-step approach to conducting a thematic analysis. They state that the process starts when the analyst begins to notice, and look for, patterns of meaning and issues of potential interest in the data – this was done during data collection period as suggested by the authors. The endpoint is the reporting of the content and meaning of patterns (themes) in the data. Data analysis is therefore a constant reading, re-reading, moving back and forth between the coded data that you are extracting and the data that you are producing. This process was circular as it allowed me to conduct data collection, reading, reading and going back to the clients to verify my understanding and clarify data points. In this context, coding is regarded as a helpful. Streubert and Carpenter (2007: 80) state that the phenomenological reduction begins with a suspension of beliefs, assumptions and biases about the phenomenon under investigation, as was done during explicating and bracketing, as previously discussed. Isolation of pure phenomenon is the goal of the reductive procedure. I will now briefly describe the step-by-step

approach of thematic data analysis and how I applied it to my research project, during the data collection period.

Braun and Clarke (2006: 87) describe Step 1 as the process of familiarizing yourself with the data. They further state that it is vital that you immerse yourself in the data to the extent that you are familiar with the depth and breadth of the content. Immersion usually involves 'repeated reading' of the data, and re-reading the data in an active way - searching for rich meanings, patterns and so on. It is ideal to read through the entire data set at least once before you begin your coding, as ideas and identification of possible patterns will be shaped as you read through it. To accomplish the first step of familiarizing myself with the data, I interviewed the clients and then I listened to the recorded interviews. I then appointed a colleague to transcribe all the data verbatim. I then listened to the recordings, while reading the transcripts to validate their accuracy and to familiarize myself with the data. While listening, I also made comments in the margins of the transcripts in an attempt to identify possible patterns in the data.

Braun and Clarke (2006: 88) describe Step 2 as generating the initial codes. Step 2 begins when you have read and familiarized yourself with the data, and have generated an initial list of ideas about what is in the data and what is interesting about them. This phase then involves the production of initial codes from the data. Codes identify a feature of the data (semantic content or latent) that appears interesting to the analyst, and refer to 'the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon'. Braun and Clarke (2006: 89) further state that the researcher should work systematically through the entire data set, giving full and equal attention to each data item, and identify interesting aspects in the data items that may form the basis of

repeated patterns (themes) across the data set. Elo and Kyngas (2008: 109) state if the researcher has chosen to use inductive content analysis then he/she will prepare the data then organize the qualitative data. The organization process includes open coding, creating categories and abstraction. Open coding could be likened to Braun and Clarke's Step 2. This means that headings and notes are written in the text while reading it. The written material is read through again, and as many headings as necessary are written down in the margins to describe all aspects of the content. The headings are collected from the margins onto coding sheets and categories are freely generated at this stage. For this study each transcript was listened to and read in its entirety to familiarize myself with the data and initial notes were written in the columns for each new concept.

Braun and Clarke (2006: 88) further state that coding will, to some extent; depend on whether the themes are more 'data-driven' or 'theory-driven' themes. This will depend on the data, but in the latter case, you might approach the data with specific questions in mind that you wish to code around. For the purposes of this study, I decided to use the data-driven theme analysis approach of inductive content analysis, as previously stated; therefore the themes emerged from the data extracted and initial codes generated to complete Step 2.

Braun and Clarke (2006: 89) describe Step 3 as searching for themes. Step 3 begins when all data has been initially coded and collated, and you have a long list of the different codes that you have identified across the data set. This phase, which re-focuses the analysis at the broader level of themes, rather than codes, involves sorting the different codes into potential themes, and collating all the relevant coded data extracts within the identified themes. Essentially, you are starting to analyse your codes and consider how different codes may

combine to form an overarching theme. At this point I reviewed the long list of codes for each of the clients and grouped them into candidate themes. The following 13 random candidate themes emerged: Benefits of the faith-based programme structure; impact of the programme; responding to the faith aspect of the programme; not responding to the faith aspect of the programme; relapse prevention; positive and negative family dynamics; comparison of two worlds; previous attempts at recovery; relapse; personal goals for recovery; drugging lifestyle; clients in the programme; staff in the programme and miscellaneous. Miles and Huberman (1994: 69) note that for the qualitative analyst, pattern coding has four important functions, namely: it reduces large amounts of data into smaller numbers of analytic units; it get the researcher into analysis during data collection so that later fieldwork can be more focused; it helps the researcher elaborate a cognitive map, an evolving, more integrated schema for understanding local incidents and interactions; and for multi-centre studies, it lays the groundwork for cross-case analysis by surfacing common themes and directional processes.

Braun and Clarke (2006: 89) note that this stage is when you start thinking about the relationship between codes, between themes, and between different levels of themes (e.g. main overarching themes and sub-themes within them). Some initial codes may go on to form main themes, whereas others may form sub-themes, and others still may be discarded. Elo and Kyngas (2008: 111) state after open coding, the lists of categories are grouped under higher order headings. The aim of grouping data was to reduce the number of categories by collapsing those that are similar or dissimilar into broader high order categories. They further state when formulating categories by inductive content analysis; the researcher comes to a decision, through interpretation,

as to which things to put in the same category. The impact of this on the study is in the results and discussion chapter.

Braun and Clarke (2006: 91) describe Step 4 as reviewing themes. Step 4 begins when you have devised a set of candidate themes and it involves the refinement of those themes. During this phase, it will become evident that some candidate themes are not really themes (e.g., if there is not enough data to support them, or the data is too diverse), while others might collapse into each other (e.g., two apparently separate themes might form one theme). Other themes might need to be broken down into separate themes. Data within themes should cohere together meaningfully, while there should be clear and identifiable distinctions between themes. This phase involves two levels of reviewing and refining your themes. Level one involves reviewing at the level of the coded data extracts. This means you need to read all the collated extracts for each theme, and consider whether they appear to form a coherent pattern. If your candidate themes do appear to form a coherent pattern, you then move on to the second level of this phase. If your candidate themes do not fit, you will need to consider whether the theme itself is problematic, or whether some of the data extracts within it simply do not fit there, in which case, you would rework your theme or create a new theme, finding a home for those extracts that do not currently work in an already-existing theme, or discard them from the analysis altogether. Once you are satisfied that your candidate themes adequately capture the contours of the coded data/once you have a candidate 'thematic map' you are ready to move on to level two of this phase. Level two involves a similar process, but in relation to the entire data set. At this level, you consider the validity of individual themes in relation to the data set, but also whether your candidate thematic map 'accurately' reflects the meanings evident in the data set as a whole. To some

extent, what counts as 'accurate representation' depends on your theoretical and analytical approach. However, in this phase you re-read your entire data set for two purposes. The first is, as discussed, to ascertain whether the themes 'work' in relation to the data set. The second is to code any additional data within themes that has been missed in earlier coding stages. The need for re-coding from the data set is to be expected as coding is an ongoing organic process. If the thematic map works, then you move on to the next phase.

In conducting the level one and level two of Step 4 I created a thematic map of the data by rearranging the 13 candidate themes.

Table 12: Candidate Themes categorised as an initial Thematic Map

The substance abuse-recovery continuum		
Negative substance abuse phase	Positive faith-based recovery phase	The modified future phase
Drugging lifestyle	Benefits of the Faith-based programme structure: <ul style="list-style-type: none"> • Clients in the programme • Staff in the programme 	Impact of the Faith-based programme structure: <ul style="list-style-type: none"> • Behavior modification • Family reunification • Successful social reintegration
Stigma associated with drug addiction	Responding to the faith aspect of the programme	Relapse prevention
Negative family dynamics	Positive family dynamics	
Relapse: <ul style="list-style-type: none"> • previous attempts at recovery • Not responding to the faith aspect of the programme 	Personal goals for recovery	

According to the inductive thematic analysis of the data coded for these two overarching themes, the following emerged: the first sub-theme or category, namely, positive recovery also had sub-themes. This will be discussed in detail in the results and discussion chapter. The second theme, namely modified future also had one sub-theme or category with sub-categories. Again, this will be discussed in the results and discussion chapter – see Table 2. The information obtained which did not fit into the overarching themes will be noted in the results and discussion in this Chapter as well.

Table 2: Final Thematic Map with Sub-themes and Sub-categories

Themes	Positive recovery experience				Modified future experience
Sub-themes	Structure	Support	Responding to the faith aspect of the programme	Personal goals for recovery	Impact of Faith-based programme
Sub-categories	Counselling	Family			Behaviour modification
	Application of rules and discipline	Staff			Ongoing sobriety
	Sobriety	Peers			Family reunification
	Training and skills	Church			Successful social reintegration
					Relapse prevention

Braun and Clarke (2006: 92) describe Step 5 as defining and refining themes. At this point, you then define and further refine the themes you will present for your analysis, and analyse the data within them. By ‘define and refine’, we mean identifying the ‘essence’ of what each theme is about (as well as the themes overall), and determining what aspect of the data each theme captures. For each individual theme, you need to conduct and write a detailed analysis. As well as identifying the ‘story’ that each theme tells, it is important to consider how it fits into the broader overall ‘story’ that you are telling about your data, in relation to the research question or questions, to ensure there is not too much overlap between themes. So it is necessary to consider the themes themselves, and each theme in relation to the

others. As part of the refinement, you will need to identify whether or not a theme contains any sub-themes, also called categories. Sub-themes or categories are essentially themes-within-a-theme. They can be useful for giving structure to a particularly large and complex theme, and also for demonstrating the hierarchy of meaning within the data. It is important that by the end of this phase you can clearly define what your themes are and what they are not. One test for this is to see whether you can describe the scope and content of each theme in a couple of sentences. The definition for each theme is described in the results and discussion chapter.

Braun and Clarke (2006: 93) describe Step 6 as producing the report. They further state that Step 6 begins when you have a set of fully worked out themes, and involves the final analysis and write-up of the report. The task of the write-up of a thematic analysis, whether it is for publication or for a research assignment or dissertation, is to tell the complicated story of your data in a way which convinces the reader of the merit and validity of your analysis. It is important that the analysis (the write-up of it, including data extracts) provides a concise, coherent, logical, non-repetitive and interesting account of the story the data tell within and across themes. Your write-up must provide sufficient evidence of the themes within the data i.e., enough data extracts to demonstrate the prevalence of the theme. Choose particularly vivid examples, or extracts which capture the essence of the point you are demonstrating, without unnecessary complexity. The extract should be easily identifiable as an example of the issue. However, your write-up needs to do more than just provide data. Extracts need to be embedded within an analytic narrative that compellingly illustrates the story you are telling about your data, and your analytic narrative needs to go beyond description of the data, and

make an argument in relation to your research question. This will be described through the results and discussion chapter of this study.

2.10 **SUMMARY**

This chapter covered the research methodology of the study. I specifically looked at the study setting, the phenomenological qualitative research design used to understand the lived experiences of the phenomenon, the research strategies and research reasoning strategies, population and sampling, data collection tools used, pre-tests conducted, a discussion on trustworthiness, the data collection process and data analysis. Using the step-by-step guide in Braun and Clarke's inductive thematic analysis I was able to analyse the rich data obtained from the participants in the study.

CHAPTER 3: RESULTS

2.11 INTRODUCTION

Qualitative data consists of words and observations and not numbers as in the case of quantitative analysis. Sandelowski (2000: 337) states that qualitative descriptive designs are typically an eclectic but reasonable and well-considered combination of sampling, and data collection, analysis, and representational techniques. As with all data, analysis and interpretation are required to bring order and understanding. This requires creativity, discipline and a systematic approach. There is no single or best way. Qualitative researchers search through the data from the coding, categories and sub-categories and decide which story to tell. Sandelowski (1998: 376) who stated that critical first step qualitative researchers must take as they contemplate the write-up is to determine its central point, or story line. Qualitative researchers must choose which story, of the many stories available to them in a data set, to tell in a given article or book chapter.

In conducting the Braun and Clarke's inductive thematic data analysis, as described in Chapter 2, the story that I would like to tell in this chapter is of clients' lived experiences of substance abuse recovery in a faith-based programme in the Western Cape. As previously reported, the two overarching themes are the positive recovery experience and the modified future experience. A third theme called the negative substance abuse experience emerged from the data. A decision was made not to include it as a theme, because it speaks to the participants' experiences prior to admission into the residential faith-based recovery programme which was not answering the study's research question. A high-level discussion of that theme will be discussed later in this chapter. Each of the overarching themes has

sub-themes and sub-categories; which build the theme. This will be discussed in this chapter. Braun and Clarke (2008: 93) state that the task of the write-up of a thematic analysis is to tell the complicated story of the data in a way which convinces the reader of the merit and validity of the analysis. It is important that the write up, which includes data extracts, provides a concise, coherent, logical, non-repetitive and interesting account of the story the data tell, within and across the themes. Data extracts were embedded in the chapter as compelling illustrations of the analysed data.

2.12 PRESENTING THE FINDINGS

2.12.1 Biographical Data

As previously stated, Streubert (1999: 21) suggests interviewing participants from a variety of backgrounds, age ranges and cultural environments is essential to maximise the likelihood of discovering the essences of the phenomena researched and thereby data saturation. The biographical data of the varied group of clients interviewed for this study are representative of the phenomena. It is listed as follows:

- Total sample group interviewed: 7;
- Gender: 4 males and 3 females were interviewed;
- Client status in the programme: 2 were present clients and 5 were past clients with 1 of the past clients now volunteering in the programme.
- Employment status: 2 males were employed, 1 male was unemployed, 1 male was working a volunteer in the programme, 2 females were still in the programme and 1 female was unemployed.
- Parental status: 2 of the females were parents and 1 was not. 2 of the males were parents and 2 were not.

- Mean age: 26 years was the mean age for the males and 29 years was the mean age for the females.

2.12.2 Themes and Sub-Themes/ Categories

Listed below is each theme, categories and sub-theme that were identified through the thematic data analysis process:

Theme 1: Positive Recovery Experience

- Structure
 - Counselling
 - Application of rules and discipline
 - Sobriety
 - Training and Skills
- Support
 - Family
 - Staff
 - Peers
 - Church
- Responding to the faith aspect of the programme
- Personal goals for recovery

Theme 2: Modified Future Experience

- Impact of faith-based programme
- Behaviour modification
- Ongoing sobriety
- Family reunification
- Successful social reintegration
- Relapse prevention

As previously stated in Chapter 2, Braun and Clarke (2006: 92) describe Step 5 as defining and refining themes. They further state by 'define and refine', we mean identifying the 'essence' of

what each theme is about (as well as the themes overall), and determining what aspect of the data each theme captures.

Theme 1: Positive Recovery Experience:

In defining and refining the positive recovery experience, it is important to note that the clients reported the prior drugging lifestyle as being chaotic and resulting in dire consequences for themselves, their families and their communities. These chaotic experiences associated with substance use and abuse led to admission into the substance abuse recovery home being researched. These negative experiences prior to admission, were directly compared with the positive experiences in the faith-based programmes because of the direct contrast of these two worlds, as described by clients during the in-depth interviews. This sense of normality, as described through the data, was previously stripped away by continued substance use and abuse. The positive recovery experience allowed them to develop a sense of identity, and feel 'normal' again, as quoted in the data extract below.

***Participant 6:** The structure here is completely different like things that you would never ever had, like with the drugs. Like when you are into drugs, your self-esteem, your whole self, you give yourself to the outside world. You forget about your values what you were taught and principles but coming now here they give it back to you again. It makes you feel like a normal person again, because the things that was like abnormal was normal for you in your drugging. But now being clean and sober, it is like okay... so now when you do something normal it is like a big thing for you, because you didn't see it as normal.*

Participant 7: *Because I have seen it, I have experienced, how drugs take you to the bitter end and takes you to the gutters and the very people who does it with you, their lives goes on and here you are stuck in this rut and you can't get out of it. And your family starts turning their backs on you and you just live this lonely, lonely, lonely life, which wasn't cool at all. You are very lonely, because it only lasts for a few hours. It only lasts, for example, they come fetch you on a Friday evening, so Friday you have got money and then Saturday or Sunday morning you don't even have a cigarette to smoke and you were the entertainer, you were just entertaining. Flashing and entertaining everyone. And then I discovered, look at these people man that has kept on to Christ, they have kept on to Jesus and they are prospering and they are going forward in life and I saw how that scripture Jeremiah 29 verse 11 is coming to pass in their lives. And I thought this is what I want and I came and I said 'Lord I surrender everything to you. Every single thing I give to you. I know it is going to be hard, but I am willing and I am prepared to take this journey.' So I committed, I recommitted my life and ever since then I haven't looked back and I haven't smoked drugs again.*

Sub-theme 1: Structure

For the purposes of the study, the sub-theme structure was defined as any activity or point that framed the programme, process or the participant's day in the faith-based facility. This is highlighted by the following data extracts.

Participant 6: *My day, this is interesting. We wake up 6:00am and then we wash 7:00am till 8:00am and then till 8:15am we have devotion where the girls sit in a circle and we sing, praise and worship and then like one would lead the chorus and then another*

one, everyone has a chance every day. Then you bring the Word across, maybe like saying what God laid upon your heart and you encouraging one another. And then after that we would have house chores, things you have never done you will learn. You do your chores and then you have your breakfast and then after that you still do chores. Then by 9:45am we leave to go to church, because then we have sessions up till about 12:00pm. Then at 12:00pm we come back home, 12:30pm we have prayer and share until 13:00pm. 13:00pm we have lunch and then chores after that, like if you are working in the kitchen you need to wash up and 14:00pm we play games and interact with one another, at 15:00pm till 17:00pm we have sessions, and then after session we have supper. And then after that we do chores, like the bathrooms, you close the windows; you mop the floors, just to see that your chores are done properly. Then from that we just have quiet time, and then 19:30pm to 21:00pm we again have devotion and that is like praise and worship. Oh and we have peers-group, like where the peer-leader... and that is so awesome, because someone is in charge of you, they are just leading you, overseeing. And especially when you had a life like me, that you don't want people to tell you, now unfortunately you have to have someone to tell you, it is like making you humble to the next person. So then the peer-leader will write down, like what are going to say today, like example 'Colleen, how was your day today?' And then in that book you write your emotions and what you experienced throughout the day. At 21:30pm, then you can go put your pyjamas on and then 22:00pm it is lights out.

The other benefit of structure in a substance abuse recovery programme is that it became a barometer to measure compliance or non-compliance against. This is also essential in unlearning

untoward negative behaviour and relearning societal accepted behaviour which was addressed in the facility's Step 3 in its programme.

Sub-category 1: Counselling

For the study, the data points for the counselling sub-category were defined as the one-on-one or family interventions aimed at assisting the participant to get to the root cause of their addiction and working through the challenges that led to it.

***Participant 5:** Well you see, we are taught that we need to use the six months and address the issues that made us turn to drugs. And I would say, fortunately for me, I did use the six months wisely I didn't just come there and sit around and think okay I am just going to do this for the six months and then I am going to be clean and everything is going to be fine. What I did was, in every session when we had to speak about what we were going through or what we went through, I would speak about it, because I remember doing the trauma debriefing and what I have dealt with in that trauma debriefing was the death of my father. This is what created the void in the first place and I was given the space to identify it and deal with it.*

Sub-category 2: Application of rules and discipline

For the purposes of the study, the application of rules and discipline sub-category was defined as all data coding related to rules, discipline and guidance given in the in-client programme, aimed at modifying the participants' behaviour. The data extracts below are evidence of this:

Participant 1: *The two months went okay and then the four months I got disciplined in the home, but the discipline for me was what brought me through that I am still standing here today, because if it wasn't for discipline, the things you learn from the home.*

Participant 6: *Well discipline for me at home, was like first my mother will take my phone away from me and think that will help or maybe ground me, you know that when you are still a teenager, but discipline left my life like after Grade 10. I had no discipline, like I said I don't want people to tell me, I will do what I want to do. Even if my mommy, she tells me to do this then I will do it halfway and my way. And coming here, it is mighty and it is powerful, because you just need to submit. And if you don't submit you are making your own life difficult, so that's really where discipline comes in and especially the home criteria. Especially during the day, if you swear or have bad behaviour, if you lie or steal, you get disciplined for it. Well there discipline is different, like with me I got disciplined several times like you'll have to write out a whole Proverb. And they give you a discipline that suits you, a Bible verse that will speak to you and help you in a certain area where you are lacking. Because one of the main problems in my life with which I was struggling with, and especially with having disrespect towards my mommy, was my tongue. And James 3 – the taming of the tongue, it spoke to me, really. At the beginning stage I really never took note of it, but I was like okay this is like whatever I must write out 40 times, so now I am writing, but coming in the half of it and I am reading like... okay. I use to go to church and then I am like 'Hallelujah, Hallelujah' and then when I come out of church and I'll swear 'Hey, your mother's this or that', but now here it is teaching me that you can't want to praise God and want to be by*

your fellow men or whatever, like you can't want to act like a teacher, but you are not practising what you are teaching. So it spoke to me and really man it is just but God. Yes, it is giving you discipline. It is like self-control. If you are going to be out-of-hand, then they are going to discipline you again. So if you are not on a balance, then they work with you in that area.

Sub-category 3: Sobriety

For the purposes of this study, the sub-category sobriety was defined as the reporting of cessation of using all illicit substances and/or any substances which in the view of the faith-based context is viewed as an entry level substance and therefore defiling the body, e.g., cigarettes.

Participant 3: *From when I was little, eleven year old girl, I had a relationship with God. And although I was smoking that joint, I know that one day Jesus is going to make a way for me to come sober and here I am. I am not even smoking a cigarette for two weeks, since I am here. Because like, the cigarette addiction is broken, finally; I am grateful for that. If it wasn't for this programme I will still be a cigarette smoker because I smoked every day since age 11 and I am 28 now. Oh my word, I feel, I don't know how to explain it. It is a great feeling, knowing that you are clean, especially cause I really never thought that I would go without a cigarette, and here I can stand and say... in the morning like we would go to church and the sessions there are people in the road that smoke cigarettes and that smell alone just makes me nauseous. I can't even handle it. So for me, being clean is a big thing.*

Participant 6: *So then they told me I can't smoke, I can't do anything, that was a big shock to me because as we came here, I bought me two boxes of cigarettes and I had my last smoke still in front of the church and I just had to give it. It was very difficult but I did it and like I am happy for it now.*

Sub-category 4: Training and skills

For the purposes of this study the sub-category training and skills was defined as any data coding referring to up-skilling, training or educational development. This is evidenced by the following data extracts reported by the participants.

Participant 1: *That is how it was in the home and I applied it outside. Getting up and making up your bed, I never used to do that. And in the home, your bed needs to be made up and before you brush your teeth your bed needs to be pulled straight. My mommy use to wash our clothes and I never used to wash; now I do my own washing and you learn a lot in the home.*

Participant 3: *Because in one particular lesson they speak about your IQ (intelligence), EQ (emotions) and your SQ (spiritual); and I thought wow! I have an EQ and the SQ is stronger but the EQ also, and the IQ... I don't know where my IQ is... but for me to find out and learn about the SQ was such a liberating experience. Now I don't have to self-condemn about the way I am. Because I saw it there, it is a study now. And then I know, I am perfectly normal.*

Participant 4: *But basically you make you your decision based on a long time; it is not something you look for just now. It is amazing how it changes you now; because, if I had to go to a non-faith-*

based-programme I would never have been busy with my matric or my learner's licence which I got here.

Participant 5: *Okay, when I became use to the whole team, then we went to different life skills programmes; we had Bible study, life skills etc.*

These life-skills are aimed at behaviour-modification and improved decision-making. This not only impacts your future, but your present thinking as well.

Sub-theme 2: Support

For the purposes of this study, the sub-theme support was defined as any individual or group who reportedly came alongside the participant in the substance-recovery journey. This sub-theme has the sub-categories of family, staff, peers and the church.

Sub-category 1: Family

Family support is a sub-category of the support sub-theme. For the purposes of this study, family support was defined as any data coded relating to support offered to the participant by their family, as it related to the positive recovery experience. The data extracts below are evidence of this.

Participant 1: *And then I lived by my aunty and before I came in I cried and I never use to stay away from the house and I was always at home. But, you get used to it and as time goes on you start seeing your family and that is the best thing. When the first two weeks is finished and you start to see your family it is like the best feeling ever. And your family see how well you are looking when they come visit the first time...Ja. You can model and look in*

the mirror ten times before you see them and you get this 'lekka' feeling in your stomach. And you don't even want to eat before you see them and things and it is nice and you spend time. And it is even better if you have a family that is serving God, because you can speak to them and spend time with them and say that you are sorry for what you did.

Participant 4: *But to come back to my family – they trust me again and they accepted me with open arms. They are excited for me. They are excited for the things I am about to accomplish. And they support me 100%. And 'ja', they have my back, which weren't the case in the beginning, because I was way weird.*

Sub-category 2: Staff

Staff support is a sub-category of the sub-theme support. For the purposes of this theme, the term staff referred to the Pastors, Nursing Service Manager, Social Workers, Social Auxiliary workers, Facilitators, Mentors and residential volunteer staff who supported the participant in healing. The following data extracts are evidence of this.

Participant 7: *Wow, I can go on and on about talking about the staff, because seriously, people that offer up time to make an impact in people's lives that has gone wayward. That to me was like a wow moment, they don't get paid for what they do, but yet they want to see you bettering your life. I was exposed to prison ministry, I use to go with on call to prison ministry and I used to think that people like myself and like you who would land up behind bars and I journeyed with in a part of my life and it made me feel like a person again. Even the staff at the home, the pastors offered up their time and the rest of the people offering up their*

time, coming along side us, and just journeying through this journey with us. That has impacted me greatly and my experiences with them have been good. They have been there in time where you have been at your lowest of lows. And they have been there in times where you are excited and happy, they celebrate with you.

Participant 2: *The privilege of having that access to the Bible 24/7 is amazing. So, when you go out of your six months here, you can lack nothing. Because the Bible, it gives you wisdom, it gives you direction of life, it gives you everything that you need, it even builds you stronger, than when someone else needs advise you can give them, but not of your own knowledge. Because if you are going to give them of your own knowledge, it is going to be... You did not have knowledge when you came in here; you just had a drug perception of life.*

Participant 3: *What has also played a major role, I have great mentors and I think that plays a major part in your recovery. Is having mentors, not only that has been on drugs, but people that has not used drugs, that has sober judgement that can give you sound advice and they can guide you along the way. Mentors play an important role, I am talking about Christian mentors that have been serving Christ for years and that you can really look up to. So that has also played a major role in my recovery as compared to the last time.*

Participants also reported that the staff offered support by walking a journey with them from the worst to the best parts of their life through their faith.

Sub-category 3: Peers

For the purposes of the study, peer support was defined as the support offered to participants by their peers who were also admitted into the faith-based 6-month in-client programme. The following data extracts are evident of the theme.

Participant 5: *So you go and you tell that person, how you doing? And then you speak about your children, maybe and you tell them you must hold on. Because that is the experience I had one day, sitting in the room with one of the girls. I told her that 'You shouldn't give up, because your child needs you to be in this place, so that you can get better for his sake and for you to be together as a family.' And she came to me later on in that day and she told me 'I needed to hear that, because I was thinking of leaving.' And that is another experience. Other experiences that I had was when, you know when you feel disappointed. When people decide to give up in the middle and you have walked alongside them, you have encouraged them and maybe they have even slept in the same room as you. You know what they are going through and where they come from and their experiences and then you feel let down, because now it is like, not, I am going to say you have wasted your time in talking to them and encouraging them and telling them that God loves them. And he is so proud of what they are doing and still they decide to leave. It is because you become... it is not just a client, it is your sister. You are living in the same house for six months and you start developing a bond and ties. There are ties, not blood ties, but there are ties and a sense of family in the house. So you feel like this is your sister and now it is almost like your sister is running away to go and elope with her boyfriend, that nobody wants her to have anything to do with.*

Participant 1: *I saw guys praising God and worshipping and really that made me come back. I saw brotherly love and things that I never had, I mean I had a brother, but we use to use together and here was brotherly love and people that I could relate to.*

Participant 2: *I got a real close relationship with the guys that were in my programme, we are like really tight and we have got this pact. When I was in the programme I was also taught that things that you mustn't break down on each other, you mustn't be the stumbling block for each other. So in order to get rid of that we needed to become one. So when we become one, things that we go through here we don't take to leadership. We deal with it here and in order for that we are gonna become close because in that way we are showing each other brotherly love. If I don't feel strong, of if I am weak today, you can lift me up. So with the clients that were in the programme with me, we have got this tight relationship and also with the support group we are the ones that are actually keeping strong. Because we know, when we were in the home, we had this love there. Not even leadership could take on, cause we stand together and whatever we believe or we go through we are gonna deal with now and we are gonna put it beside us. Because we first need to make right here in Jerusalem, before we can go anywhere. And in order for us to make right here, we need to have this bond where even <named people> come, they are not going to break this relationship. Because I know people are put in place to do certain things but if there is a connection in place and we could deal with something in here then we can deal with anything. And that is the connection we have. If I have a problem, I can phone <name>, <name> can phone me or I can phone <name>, even though he is in Joburg.*

Sub-category 4: Church

For the purposes of this study, the sub-category church support in the support sub-theme is defined as all the data points relating to the support offered by the church housing the substance abuse recovery home in the Western Cape. The following data extracts are evidence of this, as reported by the participants.

Participant 2: *If you know of somebody is in a place, if I know that my brother is in a place where there is love and a lot of people have much respect for a church. Even if you are in the gangsterism world, when you come to a point where you say 'This is my life and I am giving my life to God.' They respect that and they don't go against that because they know you are taking a step of faith.*

Participant 5: *I definitely think it is a result of a faith-based-programme that we've had; because it is not only in the house it is in the church as well. There are people that, even strangers that can come up to you and make you feel that you are part of one big family and I had experiences with that. In the home, we had corporate prayer on a Wednesday, and my first Wednesday, that was basically my first whole day in the home as well, and one of the sisters came up to me and she said to me 'I need to pray for you' and I said 'Okay'. She said 'You don't understand, I had a dream about you. And God showed me your face and I have to pray for you' and it is so funny because now, three years down the line, this lady and I we still have that bond. We still have that connection. And it is because we have developed a bond as a family through prayer even though we were strangers in the beginning.*

Participant 1: *But the only way you are going to make it is to have Christ in your heart and you go regularly to church and you involve yourself and help when you are here. I mean, there are guys that also accept Christ and also fall back, because they kept themselves away from the church. But the guys that don't give their hearts to Christ are more likely to fall – 99% chance, which is my opinion; that is my opinion. The church forms a community that support you not to fall when you are in the world.*

Sub-theme 3: Responding to the faith aspect of the programme

The sub-theme, responding to the faith aspect of the programme, is deeply entrenched in every aspect of the positive recovery experience, because participants link faith to healing in their contexts. For the purposes of the study, it is defined as any aspects of faith as reported by the participants.

Participant 4: *I was on drugs for about eight years and so on and off – I was clean for about four months and then I went back to old friends, but I think to stay clean or to recover you need to be strong enough and to make decisions, or how can I put it, if you are being influenced easily by people then you are going to lose. Ja, like peer pressure and like any kind. Ja. And not just that, fitting in, you feel like you want to be there because you are scared of rejection at home. So because you are scared of the rejection you go for the acceptance on the corner, there where they are smoking weed and all that. It is like, they don't invite people and they don't chase people away you can just come. Yes. Acceptance is 'mos' nice because I am being accepted by this gang and I am going to show them what I am capable of. I am going to prove to them that*

I am that guy that would want to see me as. Okay I was on drugs ne, and then I thought 'No man, I am not moving forward in life'. I went to Hope Again and I made an appointment so that they can see me and so it was basically my decision to get clean and I did it for me. So I didn't need to prove myself to no one. Yes, there were many other options, but I knew man, there is something there. At another place I will still smoke and when I come out I will still smoke again. But with this faith-based, it is like life changing. You make a new commitment, you make new friends, you can elevate to the next level, you are just moving forward in life; because if it is not faith-based then they treat you with legal drugs, so that don't work. That will never work. No drugs needed, just the pure gospel. I needed that to stay clean this time.

Participant 5: *And then from the very onset from my coming into the home and knowing it was a faith-based-programme, my first experience that I had was that God started waking me up early in the morning. But I wasn't aware that it was God actually waking me up, until I went to the house-mother and I explained to her that I kept waking up at the same time every morning. And I felt the need or urge to go and read my Bible. Because, I wouldn't say forced, but we were told to, you know it was recommended that we spend a lot of time with our Bibles. Because that is, basically the Bible is your best friend when you come into the programme, so I would get up at about 4:00am and then spend time with The Word. And by that time, I haven't developed a technique to say, you know when you start praying, because I wasn't exposed to all of that prior.*

Participant 5: *The love of God, the love that God has for me and we were obviously taught about His grace and His mercy. And*

because I was developing a relationship with Him, he was filling as I was dealing with the issues, that cause me the pain and the hurt, which has caused me to turn to drugs. I was able to fill it with His love. So I could feel myself being restored again, because of the joy that I felt for serving the Lord.

Participant 2: *The privilege of having that access to the Bible 24/7 is amazing. So, when you go out of your six months here, you can lack nothing. Because the Bible, it gives you wisdom, it gives you direction of life, it gives you everything that you need, it even builds you stronger, than when someone else needs advice you can give them, but not of your own knowledge; because if you are going to give them of your own knowledge, it is going to be false. You did not have knowledge when you came in here; you just had a drug perception of life.*

Sub-theme 4: Personal goals for recovery

For the purposes of this study, the sub-theme personal goals for recovery is defined as any data point coded where participants directly related their personal reasons for entering into the programme and recovering. This is evidenced by the following data extracts reported by the participants.

Participant 2: *Once you become threatened by your family and your parents, it is like you are doing it for them. But if you are coming in and you made up your mind and you are focused on what God has in store for you and where you are going from here then you are going to change because you become tired of changing for your mother. You become tired of changing for your father. You are going to come out of it eventually, I changed my*

life because of you and I can't anymore. When you do it for yourself, the six months is over enough.

Participant 5: *You remember when I was in the programme I came and my children was placed in a children's home and they had to wait for me. So I had no relationship with them and because I was starting to build new relationships with them, that is also motivating me to come through the programme and be able to stick to what I've got. It still motivates me to stay clean. It is one of my very key aspects as to why I make it through each day, because some days it is not easy. But, I mean, I look at my daughter, I look at my son and they are happy. They are both serving God with me and it is reason enough to go on every day.*

Theme 2: Modified Future Experience:

The second overarching theme which emerged from the data was that of the modified future experience. Participants reported this as an important experience in doing a 6-month residential faith based programme; because their broken lives are now made whole. This healing or wholeness is a daily walk but the long-term benefits are to the individual, the family and the community as a whole. This theme had sub-themes which emerged from the data.

Participant 2: *And I need to do it according to the Bible. You don't want that and yet you want to point fingers at other people. So, I told them that when you come to that point when you want to achieve, don't look at other people's faults. Look at what God has done in my life. I don't need to tell you what God has done with my life, cause you know where I am coming from. You know what I gave up. I don't need to tell you a lot of things but don't judge your*

brother for how he has fell. Because God still has greater things in store for you. But yet, you need to get up and come forward.

Participant 7: *Day by day, and I am not going to think of three months or six months or a year. I am going to take it, day by day.' If I got through today, praise God I got through. Tomorrow's challenges are going to be different than yesterday's challenges. So that is kind of like what has kept me motivated.*

Sub-theme 1: Impact of the Faith-based programme

For the sake of the study, the sub-theme, impact of the faith-based programme was defined as any data evidence to link the benefits or impact of the faith-based programme on clients' modified future experiences. The following are examples of the data extracts reported by participants.

Participant 7: *I will go up for prayer, when they will call for prayer in front, I will go up and I would think that you then said come up for prayer and then you will be delivered but I didn't know that it needs to start with me. I need to like forgive this person, I need to let go and all of those things. And I went through my six months and I learnt a lot in the faith-based-home. I learnt that through prayer you can really move mountains and I've seen how it has worked in my life even though I still had this anger and this stuff within me, I still started praying and I started reading my Bible and I started doing the practices that I was taught in the home. I started doing it and it became a lifestyle.*

Participant 4: *Yes, there were many other options, but I knew man. There is something here. At another place I will still smoke and when I come out I will still smoke again. But with this faith-*

based, it is like life changing. You make a new commitment, you make new friends, you can elevate to the next level, you are just moving forward in life.

Participant 2: *And also, my brother was in the home and the state that my brother was in before he came into the home and what he was like five months later. It was just an amazing experience to see that somebody that was like down and out and this person has this happiness and this love and in the beginning he did not have that. And for me, with seeing that alone I already wanted to change my life*

Sub-theme 2: Behaviour Modification

For the purposes of this study, the sub-theme behaviour modification is embedded in the theme the modified future experience. It is defined as any data that points to evidence modified behaviour as reported in the participants' interviews.

Participant 5: *Look the whole process of healing didn't take place in the six months. The six months took care of what was needed to be taken care of so that I can become more stable in my life. But what I am saying is that as the years passed on I went from day-to-day, the bond that I had there, where the rift was the bond became stronger. When I came out I started addressing issues that like where I have caused hurt, I needed to go and ask for forgiveness. So that I knew that some of the forgiveness process took a bit longer than the others because obviously that needed to be worked on, because I have hurt some people deeply because of drugging. But over time it got restored and now there is nobody that I haven't gone to ask for restitution. Restitution has taken place.*

Participant 6: *Oh yes. Prior to coming in to the home, I was rough, I was a at that point where it was described to me that I was one of those people that you can't tell me anything. But I have learnt that you have to submit and humble yourself and that there is only one Great Authority and that is God and nobody else.*

Sub-theme 3: Ongoing Sobriety

For the purpose of this study, the sub-theme ongoing sobriety is embedded in the modified future experience theme. It is defined as any data coded from the interviews discussing sobriety when the participant completed the 6-month programme. The following data extracts are examples of participants' reports of ongoing sobriety.

Participant 2: *I tell some friends, look at me, I am still standing and here you are smoking a cigarette and such. I don't even crave for that cigarette, because I have God. I have, what you want, but you don't want to take it. You want what I have, but yet you are not ready to take that step of faith. And you are not ready to step into what God has for you. So what, you are going to suffer and I mean all of us we wanted God's presence over us but we didn't want to take that step of faith, we didn't want to relive a life where – I need to serve God, I need to do things in God's way, not my way. I am sober almost... January I was two years so say two years and a bit. Ja, two years, two months.*

Participant 1: *I am standing for almost three years now. I was naughty, inside the home, I did smoke a cigarette but because I got disciplined, that is why I say I say that discipline helped me a lot. I would have been smoking today, if I haven't been disciplined. And*

since I came out of the home, I am out now for two years, I haven't touched a cigarette. No alcohol. No drugs. So I am clean of a cigarette two and a half years and of drugs three years.

Participant 4: *For me, I choose to be around people who will build me and make positive impact in to my life, so I don't hang around people that uses or smoke or whatever the case may be. Even my family members, it is just 'Hello', 'Bye-bye', 'Is jy oraait?' and 'Okay'. I have been there and I have done that. I can 'mos' not make the same mistake over and over again.*

Participant 5: *Sober for three years and counting. To God be the glory.*

Sub-theme: Family Reunification

Family reunification is a sub-theme for the modified future theme. This defined as any data texts on the reunification of the client in the programme and the family as evidenced by the data extracts reported by participants.

Participant 7: *The relationship with my parents is, it is not where I want it to be, but it is not where it used to be. But I can say, praise God, because it is a 100 fold better than what it was. I have that mother-son relationship that I did have, because through your drugging you say things to your mother and your mother say things to you. You exchange harsh words with each other and she used to say things like 'You are nothing of Me.' and all those things and it use to hurt but in turn I also said things to her. Like now you realise that how precious a mother is to you and I am a big mommy's boy. There is just something, a mother's touch and a mother's love, a hug from a mother just does something to you as*

a boy, as a man. It just does, even if you are a grown married man and your mom just hugs you, it just does something special to you. So my relationship with my mom and all my other family members has been restored, we have an open relationship, they are very proud of where I am at. They keep on telling me, when I speak to my aunts, that they are so proud of me or my mom says she is so proud of me. And I say, it is not me, I am not doing this on my own strength and all glory goes back to God.

Participant 4: *Yes, in the beginning they didn't trust me, because I was on drugs and I was a criminal and I was... you name it. But since I have been through the programme, I came to know Christ and I have a relationship with Christ now. So now obviously I need to be a testimony for other young people my age, but to come back to my family – they trust me again and they accepted me with open arms. They are excited for me. They are excited for the things I am about to accomplish. And they support me 100%. And 'ja', they have my back. This weren't the case in the beginning, because I was way weird.*

Sub-theme 5: Successful Social Reintegration

Successful social reintegration is a sub-theme of the modified future theme. For the purpose of this study, this sub-theme is defined as data coded as evidence of successfully reintegrating back into to society. The following data extract is a rich text of one of the participants' accounts of this.

Participant 5: *You know what happened a couple of weeks ago, I was faced with a telephone call from a police detective telling me that a case of mine of 2006, there was still a warrant of arrest out for me. And I went to see him and he had a photograph of me in a*

file and I looked at him and I told him 'This is not me, that person I buried a long time ago' and that is what Jesus can do. Because that person's eyes was standing dead in her head. It just didn't resemble me at all, I said to him 'That's not me.' He said 'No, I can see.' And the funny thing is that he read my posts on Facebook and he said to me 'I can see, on Facebook a different person.' I said 'Yes, I have changed my life around, 360°.' And that is what the whole aim was. Because I remember the day that I told my mom 'I can't do this anymore.' And there are many people that always tell me about how I was. And many people I meet in the street, I recommend this programme to them. I tell them, because I say 'You know what? You need Jesus in your life. Rehabs don't work. Because they don't work with the core issue as to why you would use drugs.' I said 'You know what? We all have reasons for why we do things. But at the end of the day it is a deep rooted issue that lies within you and that is why you turn to drugs.' And we were taught drugs are not the issue, it is just a way out of helping to release, basically it blocks out. But you know what? When you are sober the problem is still there, but because of Christ I am a changed person today, working and a mom to my children who was given back to me. My family is restored because of GOD and Hope Again programme.

Sub-theme 6: Relapse Prevention

Relapse prevention is a sub-theme of the modified future experience theme. This is defined as any data points made by participants in interviews depicting relapse prevention. NIDA (2010: 27) states that science has taught us that stress cues linked to drug experience are the most common triggers for relapse. The following data extracts supports this theme.

Participant 7: *I know that speaking through it like speaking through my craving, cravings are something that will get better but it is not going to leave you. It is still going to come up in your subconscious and things like that, because there are going to be certain things that are going to trigger you through your journey, through your life. So speaking about it, immediately if I crave I would speak about it or I would drink a glass of water or eat something sweet because I like eating.*

Participant 2: *Ja, as long as you stay connected. I believe the home is my foundation. Here is where I laid my foundation and from here I am going to build my life now. As long as I stay connected I have people in my life which can pray with me and this church and friends community has helped me prevent relapse, but still I have a choice and I choose Christ.*

Participant 4: *If you stay connected to the people who rehabilitated you, you will never go back to using drugs; never ever, unless you have hidden agendas. Unless you distance yourself; unless you disconnect, then you won't have the support.*

A high-level discussion about the negative substance abuse experience

From the data, participants reported their chaotic lifestyle associated with substance abuse, because it is an illicit substance, therefore punishable by law. Some of the reported incidents were theft, breakdown in significant relationships, lack of trust from family and friends, doing poorly scholastically or in their careers, to mention just a few incidents. Using Braun and Clarke's inductive thematic analysis (2006), these incidents were coded as a negative substance abuse experience.

Participant 1: *drugging was nice, but it had many bad consequences, e.g., stealing to support my habit, I stole from family, friends, anyone. I used my mother's car to drive a drug merchant around, so that he could support me with drugs and I lied to my mother. I even stole from my granny after pension day, which is how bad I was.*

Participant 7: *I was absconding from work and all those stories that I conjured up, it was crazy. So my grandfather was very sick at this time and I would always use that as an excuse at work, because it was like the best one ever, so my manager can't tell me I can't leave now. So I got to the point where I started using at work. And I was a 100% agent; I always got compliments from guests and stuff like that. And when my qualities in my calls start dropping, management called me and I was coming in late for work and just am never-minded. Just not bothering or worrying. I started smoking joints during my lunch time and that is how bad it became. I became so dependent on this drug.*

In discussion with the appointed co-coder, a decision was made not to add the negative substance abuse experience as a theme in this study, because it related to the participants' lives prior to admission into the programme. This life, prior to the faith-based substance abuse recovery programme, albeit important to understand where the participants started their healing journey from, did not answer the research question of experiences in the faith-based substance abuse recovery programme in the Western Cape, therefore it was not added to the final study results.

2.13 **SUMMARY**

This chapter discussed the biographical data, the results of the two overarching themes, sub-themes, sub-categories and gave relevant data extracts to support the results obtained for these from the study. Lastly, the chapter covered a high level discussion on a theme that emerged from the data, but was not used for this study because it did not answer the research question.

3. CHAPTER 4: CONCEPTUALISATION

3.1 INTRODUCTION

The conceptualisation chapter discusses the conceptual framework of the study, the review and presentation of the literature. This will be done accordingly; by reviewing substance abuse, experiences, recovery, faith-based programmes, the role of the nurse in substance abuse recovery, the role of faith in nursing, community care in recovery, the conceptual framework and assumptions of the conceptual framework.

3.2 REVIEWING AND PRESENTING THE LITERATURE

Substance addiction is a mental health illness which affects the individual, family and society. The South African Nursing Council (2001/5) Reg. 2598, Chapter 2 (0) states that the facilitation of the attainment of optimum health for the individual, the family, groups and the community in the execution of the nursing regimen, which is important to the execution of duties of the registered nurse. The nurse in the substance abuse recovery facilities has role to play in the attainment of health and prevention of illness. A review of the literature below and the conceptual framework listed below aims to understand the phenomenon of the clients' experience of substance abuse recovery in a faith-based programme in the Western Cape.

Guiding principles and policies on Substance Abuse:

The following is a discussion on guiding principles and policies on substance abuse, both internationally and nationally.

The American Psychiatric Association (APA) and the International Coding of Diseases (ICD-10):

The American Psychiatric Association's (APA: 2000) Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-IV-TR) International Coding of Diseases (ICD-10) are two diagnostic tools used for diagnosing illnesses. They define substance dependence by three or more of the following criteria, occurring in a twelve month period as: "A maladaptive pattern of substance use evidenced by three or more of the following occurring in the same 12-month period. Usually leads to a clinically significant impairment or distress.

- 1) Tolerance, as shown by either of the following:
 - a. A need for obviously increased amounts of the substance to achieve intoxication or the wanted effect.
 - b. Obviously decreased effect with ongoing use of the same amount of the substance.
- 2) Withdrawal, as shown by either of the following:
 - a. The characteristic withdrawal syndrome for the substance.
 - b. The same (or similar) substance is taken to relieve or avoid withdrawal symptoms.
- 3) The substance is often taken in bigger amounts or over longer periods than was intended.
- 4) There is a history of persistent wish or unsuccessful effort to reduce or control the use of the substance.
- 5) A great deal of time is spent in activities necessary to get, use or to recover from the substance and its effects.
- 6) Important social, occupational or recreational activities are given up or reduced because of substance use.
- 7) The substance use is continued despite knowledge of having persistent or recurrent physical or psychological problems related to its use.

With this definition in mind, recovering from substance dependence requires a multi-faceted approach because the illness does not only affect all aspects of the individual user, but those of the family, society and province as a whole. The phenomenon of this illness was reviewed in the Health Promotion model (HPM) conceptual framework proposed by Nola J Pender (1982; revised, 1996). The HPM describes the multi-dimensional nature of persons as they interact within their environment to pursue health. The Health Promotion model notes that each person has unique personal characteristics and experiences that affect subsequent help seeking actions. The results and discussion are presented using the main themes, sub-themes and sub-categories as the framework and then drilled down to the interpretation of these.

United Nations Office on Drugs and Crime (UNODC):

In comparing the 2010 and 2012 World Drug Report presented by the United Nations Office on Drugs and Crime (UNODC), one notices that more illicit substances are making their way onto the streets, because the economics of supply and demand make it more affordable to produce the drugs locally, rather than to import. In 2010, Costa (2010: 20) reported that the World Drug Report states that the overall number of drug users appears to have increased over the last decade from 180 to some 210 million people. In 2012, the main findings of the UNODC's World Drug Report reveal the following global and Southern African regional statistics:

Global report: Drug Use: Around 230 million people, or 5% percent of the world's adult population (aged 15 to 64 years), are estimated to have used an illicit drug at least once in 2010, amounting to approximately one out of every 20 people. This is an increase of 20 million people reported in 2010. Drug-Related Deaths: Heroin, cocaine, and other drugs continue to kill around 200,000 people a

year. Cannabis: Cannabis remained the world's most widely used illicit substance, with between 119 million and 224 million estimated users worldwide and many countries presently considering its legalisation. ATS: The use and global seizures of amphetamine-type stimulants (ATS), the second most widely used drugs worldwide, remained largely stable. Cocaine: The estimated number of annual cocaine users in 2010 ranged from 13.3 million to 19.7 million, or around 0.3 to 0.4 percent of the global population aged 15 to 64. Opioid/Opium: Opium production has rebounded to previous high levels in Afghanistan, the world's biggest opium producer. Global opium production amounted to 7,000 tons in 2011, up from the low levels of 2010, when plant diseases wiped out almost half the crop yields and triggered steep price rises in Afghanistan. Heroin: A shortage of heroin in some countries seemed to be giving rise to crude and highly dangerous codeine-based replacements, such as desormorphine, also known as 'krokodil'. The injected substance is known to pose serious health problems, even with limited use. Prescription Drugs: In many countries, non-medical use of prescription drugs is more prevalent than the use of illicit substances (other than cannabis). While overall illicit drug use has been much higher among males than females, the non-medical use of tranquillizers and sedatives has reached higher levels among women (as demonstrated by available data from South America, Central America, and Europe).

Southern African regional report: A perceived increase in the use of both cannabis (namely in the form of herb rather than resin) and cocaine was observed in the region. The estimated prevalence of the use of opioids and amphetamine-type stimulants (ATS) in all African sub-regions remained comparable to the global average. However, a shift in the production of ATS has taken place, having previously been imported into the countries of Southern Africa; it is more

recently being produced locally in South Africa. South Africa is continuing to emerge as a transit hub for cocaine shipments originating from South America as well as heroin shipments originating from Afghanistan and Pakistan, both destined for Europe. The consequence of this has been increased exposure of the region to the distribution and use of both illicit substances.

Department of Social Development, South Africa:

Substance abuse facilities and programmes are presently registered by the South African Department of Social Development under the following Act: Prevention and Treatment of Drug Dependency Act: No. 20 of 1992. Many changes to this Act have been made and the facilities are awaiting the promulgation of the following Act and regulations in 2012: No. 70 of 2008: Prevention of and Treatment for Substance Abuse Act, 2008. The Act will cover the following: Interventions to combat substance abuse, strategies and principles for demand and harm reduction, prevention and early intervention services, community-based services, in-patient and out-patient services, aftercare and reintegration services, admission, transfer and referral to treatment centre, disciplinary intervention and appeal procedure, central drug authority and supporting structures. The faith-based substance abuse recovery organization being studied in is covered by this legislation for the work done with clients in the Western Cape and surrounding areas.

Experiences

Dentlinger, L. (2008). Spotlight falls on drug and alcohol rehabilitation facilities. *The Cape Argus*, 06 April 2008 reports that treatment for substance abuse, particularly the use of Tik (methamphetamine), is on the increase and a number of centres have opened their doors over the past two years. The evidence of this was shown in the rates of

relapse from clients completing these programmes. The article further quoted Dr. Stephen Kimani, the Substance Abuse Commission representative as stating that it was important to accredit facilities to set professional standards and assure the public access to quality treatment. Access to quality treatment seems to be the missing ingredient for many addicts because quality treatment was a scarce resource, and even more so the access to it. Understanding the lived experiences of clients accessing recovery programmes is an important lesson for leaders in the fight against substance abuse.

Recovery

Baumann (1998: 217) outlines the general principles of the management of the substance misuse by categorising it into four groups; namely, identifying the problem; motivating the person to change – treatment cannot begin until the substance abuser is ready to take action; thirdly, rehabilitation or treatment phase, which involves detoxifying if necessary to achieve control of abstinence and the management of associated medical, psychological and social problems; and lastly the follow-up and relapse-prevention phase. Costa, (2010: 2) reports that the United Nations Office on Drugs and Crime (UNODC) noted that drug dependence is a preventable and treatable disease. The most effective way to treat drug dependence is by the use of a multi-disciplinary team. The UNODC called for health to be the centrepiece of drug control by stating that drug addiction is a treatable health condition, not a life sentence. Drug addicts should be sent to treatment, not to jail and drug treatment should be part of mainstream healthcare. The time had come for universal access to drug treatment. In a workshop booklet issued by the Cape Town Drug Counselling Centre (2009: 3) they state that there are different stages of drug and alcohol use; namely experimentation (initial use of a substance); abuse and addiction. Some clients may require in-patient

and some may require out-patient treatment to recover from the disease, but, according to Eby and Brown (200: 238) recovery continues indefinitely. Eby and Brown (2009: 239) state that the aim of recovery services are aimed at maintaining sobriety (abstinence), developing coping skills, making a plan for relapse prevention and living life with all its responsibilities, joys and frustrations. Benjamin (2006: 1) states that the reintegration of patients back into their families and communities is a vital phase in the recovery of drug patients. This phase is often neglected and contributes to patients relapsing and falling into their old habits of drug abuse. Eby and Brown (2009: 238) list the kinds of treatment options available to clients in the recovery phase as pharmacotherapy; medications used in this phase are aimed at relapse prevention. The second option is cognitive-behaviour therapy (CBT); clients are helped to alter behaviour and thinking with behaviours associated with addiction. NIDA (2010: 28) states that CBT seeks to help patients recognize, avoid and cope with the situations that are most likely to abuse drugs. The third option is support groups, e.g., Alcoholics Anonymous or Narcotics Anonymous groups. NIDA (2010: 28) states that group therapy helps patients face their drug abuse realistically, come to terms with its harmful consequences and boost their motivation to stay drug free. Patients learn effective ways to solve their emotional and interpersonal problems without resorting to drugs.

Faith based programme

Erasmus, J and Mans, G (2004:37) conducted a study for the Unit for Religion and Development Research at the Stellenbosch University and conducted a Transformation Research Project on the Cape Flats in 2003-2004. One of the conclusions that they arrived at was that the area tells a story of poverty, crime and drugs but that the church has contact with virtually every household in the community. Christian

drug rehabilitation facilities are prominent entities in the rehabilitation scenario, internationally. They believe that they are amongst the many rehabilitation modalities that aid an addict to get rid of drug dependency, with the use of faith as their rehabilitation method. These Christian drug rehabilitation facilities provide effective programmes based on the concept of faith that assists the addicts towards the path of recovery. McCoy *et al* (2004: 1) reported on a study conducted with staff working at the faith-based substance abuse rehabilitation home. They suggested that although containing comprehensive secular components, the core activities are strongly rooted in a Christian belief system that informs their understanding of addiction and recovery and drives the treatment format. These governing conceptions, that addiction stems from attempts to fill a spiritual void through substance use and that recovery happens through salvation and a long-term relationship with God, provide an explicit, theory-driven model upon which they base their core treatment activities.

Crawford (2003) reported on a study conducted on faith-based substance abuse treatment services for African-American substance abusers at risk for HIV. The faith-based programme for African American substance users utilized a culturally relevant framework for services that sought to be inclusive and non-coercive, and was based on Motivational Enhancement Theory. The study employed a non-experimental design to determine the programme's effectiveness in reducing drug-related harm and demonstrated significant reduction in substance use.

The role of the nurse in substance abuse recovery

Neeraja (2008: 64) states that the role and functions of the nurse in psychiatric nursing are in three domains, namely, direct care, communication and management. Understanding and empathy from

nurses working in the mental health arena reinforces a positive psychological balance for patients. Conveying an understanding is important because it provides patients with a sense of importance. Wright (2003: 1) states that recovery from substance abuse is a phenomenon that is of importance to nursing. Nurses are trained in developing a therapeutic relationship with patients and then creating a therapeutic milieu for families and care givers to assist the clients on their journey to health. Attributes encouraged are understanding and empathy, individuality, providing support, being there/being available, being 'genuine', promoting equality, demonstrating respect, demonstrating clear boundaries, and demonstrating self-awareness. Nurses are always concerned with a client as an individual, in his family and then in society at large. The cost of delivery of evidence-based treatment is less than the detrimental social and developmental problems caused to a society by untreated drug dependence.

Sales (2006: 4) noted that substance abuse is a major social problem and concern for counselling and nursing staff. Given this, a need exists to implement strategies to insure that all counsellors have expertise in this area. The following conclusions regarding counselling individuals with substance abuse problems have been highlighted by them, namely, counsel and empower individuals with substance abuse problems versus treat the substance abuse problem. Secondly, establish the same open, collaborative, therapeutic relationship in counselling individuals with substance abuse problems as they do with other client populations. This ability is viewed as a prerequisite to successful outcome in any counselling setting. Thirdly, focus the counselling relationship on addressing the client's presenting problems directly and identifying client need for change. Next, articulate and implement counselling intervention strategies perceived as appropriate by both the counsellor and the client. Lastly, know

community resources and procedures for referral to be able to insure access to effective and appropriate support services for client, e.g., NA/ AA. The purpose of the study would, therefore, be to understand the clients' experiences of substance abuse recovery in a FBO setting in the Western Cape scenario.

The role of faith in nursing

Eby and Brown (2009: 368) define religion as an organised system of beliefs concerning the cause, nature and purpose of the universe. Even though the religions of the world offer various interpretations of this, most individuals seek a personal understanding of their existence at some point in their lives. Eby and Brown (2009: 368) quote Andrew and Boyle (2003) who define spirituality as each individual's personal effort to find purpose and meaning in life. Faith brings hope to the hopeless. Eby and Brown (2009: 369) quote Dunn and Horgas (2000) reporting on a study that 96% of elderly Americans use prayer to cope with stress, and prayer is the most frequently reported alternative treatment modality used. Eby and Brown (2009: 369) quote Meisenhelder and Chandler (2000) stating research shows that praying can positively affect not only anxiety, but also blood pressure, the course of heart attacks and migraine headaches. Eby and Brown (2009: 368) define prayer as a communication with a divine being.

The role of the nurse in faith based substance abuse recovery settings would firstly be health promotion and secondly to look at the mental illness from the perspective of a spiritual crisis. Spiritual interventions, along with psychosocial interventions, emphasize the importance of engagement, however, spiritual interventions focus more on caring and 'being with' the person during their time of crisis, rather than intervening and trying and 'fix' the problem. Spiritual interventions tend to be based on qualitative research and share some similarities with

the humanistic approach to psychotherapy. Eby and Brown (2009: 368) quote Hicks (1999) stating the focus of health care has become increasingly holistic, which has brought back a renewed attention to spirituality. Eby and Brown (2009: 368) state that even people who do not have religious beliefs have a spiritual dimension. Insightful nursing requires nurses to know themselves and their own values. Nurses do not need to be fully aware of the meaning of life, but they do need to be aware of their own spiritual direction. Holistic care is possible when nurses can recognise and address the spiritual needs of their clients. Eby and Brown (2009: 368) quote Hemmila (2002) stating despite the time crunch found in providing care of the client, nurses need to make time to nurture the spiritual needs of their clients; just being 'mindfully present' with clients during any nursing activity can be a spiritual experience. This connection between a client's spiritual beliefs and positive outcomes of his/her physical condition has been recognised by the Joint Commission on Accreditation of Healthcare Organisations (JCAHO) and is now included in its performance standards used when surveying healthcare institutions. The Joint Commission now requires that spiritual assessments be included with the overall client assessment in the healthcare facility to determine how spirituality affects the client's care, treatment and services (Joint Commission, 2005)

Community care in recovery

The UNODC issued a discussion paper on treating drug dependence through health care and not punishment. Arria (2010: 3) quotes (Chandler *et al.*, 2009, Dackis and O'Brien, 2005, McLellan *et al.*, 2000) and notes that drug dependence is a health disorder (a disease) that arises from the exposure to drugs in persons with these pre-existing psycho-biological vulnerabilities. Such an understanding of drug dependence suggests that punishment is not the appropriate

response to persons who are dependent on drugs. Indeed, imprisonment can be counterproductive to recovery in vulnerable individuals who have already been 'punished' by the adverse experiences of their childhood and adolescence, and who may already be neurologically and psychologically vulnerable. The poor are more at risk of committing a crime and being imprisoned than people that dispose of sufficient income and live in a more privileged environment. With a criminal record, access to employment is restricted and, because of time served in prison, valuable lifetime is lost which further decreases the chance of leading a sustainable life. Arria (2010: 3) further states that incarceration in prison and confinement in compulsory drug treatment centres often worsens the already problematic lives of drug users and drug dependent individuals, particularly the youngest and most vulnerable (Jurgens and Betteridge, 2005). Exposure to the prison environment facilitates affiliation with older criminals and criminal gangs and organizations. It also increases stigma and helps to form a criminal identity. It often increases social exclusion, worsens health conditions and reduces social skills. Alternatives to incarceration within the community (outpatient or residential therapeutic setting), such as psychosocially supported pharmacological treatment for opiate dependence, can be more effective than imprisonment in reducing drug-related offences.

The following plan of action on drug demand reduction was listed at the UNODC, Commission on Narcotics (2009: 22) Mainstreaming community involvement and participation; to ensure, to the extent possible, that measures are mainstreamed in the provision of public and private health, education and social services (such as family, housing and employment services). To involve all stakeholders at the community level (including the target populations, their families, community members, employers and local organizations) in the

planning, delivery, monitoring and evaluation of drug demand reduction measures. To involve communication media in supporting ongoing drug prevention programmes through well-targeted campaigns. To promote collaboration between governmental and non-governmental organizations and other members of civil society in the establishment of drug demand reduction measures at the local level.

Conceptual Framework

The researcher used Pender's Theory of health promotion as the conceptual framework for the study. Polit and Beck (2004: 121) state that the Health Promotion model (HPM) proposed by Nola J Pender (1982; revised, 1996) focuses on explaining health-promoting behaviours using a wellness orientation. According to the model, health-promotion entails activities directed toward developing resources that maintain or enhance a person's wellbeing. Polit and Beck (2004: 121) further state that the HPM encompasses a decision-making and an action phase. In the decision-making phase the model emphasizes seven cognitive/perceptual factors that compose motivational mechanisms for acquiring and maintaining health-promoting behaviours and five modifying factors that indirectly influence patterns of health behaviour. In the action phase, barriers and cues to action trigger activity in health-promoting behaviour. The HPM was designed to be a complementary counterpart to models of health protection. It defines health as a positive dynamic state not merely the absence of disease. Health promotion is directed at increasing a client's level of wellbeing. The Health Promotion model describes the multidimensional nature of persons as they interact within their environment to pursue health. The model focuses on following three areas: Individual characteristics and experiences;

Behaviour-specific cognitions and affect and lastly, Behavioural outcomes; noted in the framework below.

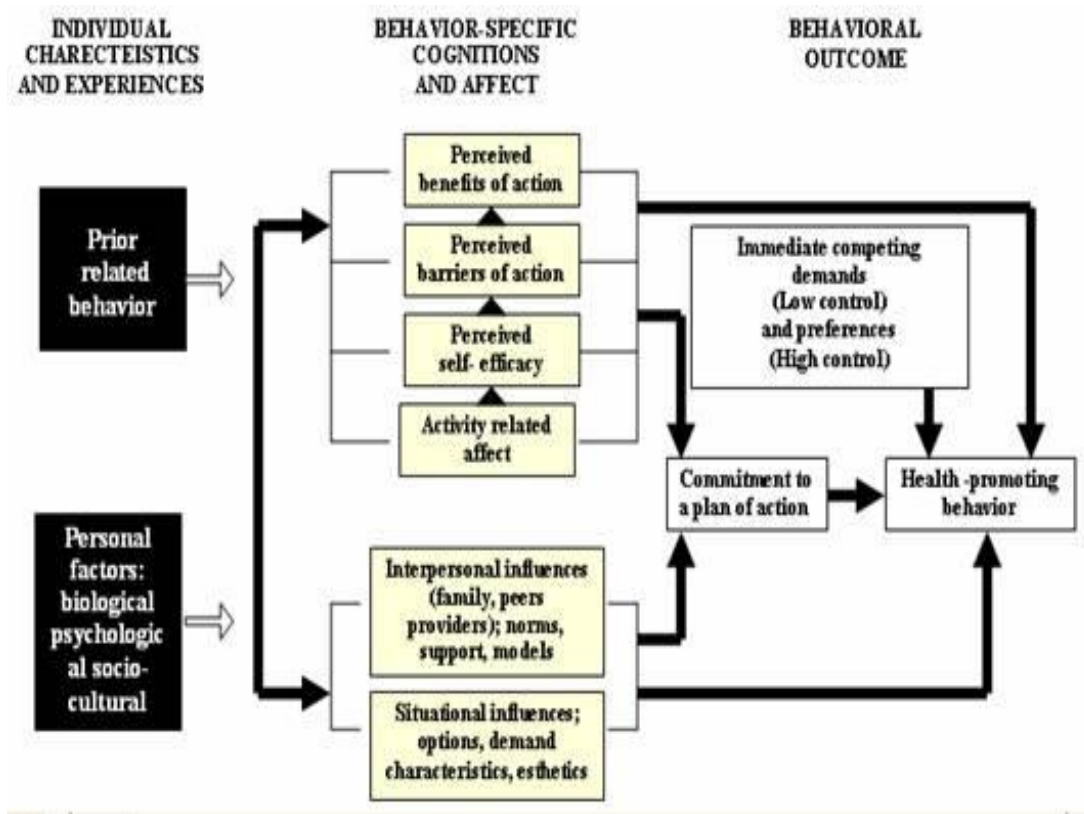


Figure 2: Pender's Health Promotion Model

ASSUMPTIONS AND APPLICATION OF THE HEALTH PROMOTION MODEL

In applying the HPM model in a faith-based substance abuse recovery programme, the health professionals firstly needed to understand the HPM assumptions and secondly decide on the most applicable way to meet the client's need using this model. The management decided on a cognitive-behaviour modification therapeutic (CBT) and a support group approach to healing was adopted. The HPM is based on the following assumptions, which reflect both nursing and behavioural science perspectives and its application as the conceptual framework for the programme and the study:

Table 3: HPM Assumptions and Faith-based programme applications

HPM Assumptions	Faith-based Programme Application
<p>Individuals seek to actively regulate their own behaviour.</p>	<p>Help-seeking behaviour needs to be demonstrated by individuals accessing the programme;</p> <p>Individuals agree to abide by the CBT approach implemented in the programme.</p>
<p>Individuals in all their biopsychosocial complexity interact with the environment, progressively transforming the environment and being transformed over time.</p>	<p>Individuals contract to washout from substance use prior to admission into the programme;</p> <p>Individuals contract to abstain from substances while in the programme;</p> <p>Individuals agree to abide by the faith-based rules and regulations implemented in the faith-based programme, thus being transformed from the untoward negative substance abuse lifestyle to a positive recovery and then a modified future lifestyle.</p>
<p>Health professionals constitute a part of the interpersonal environment, which exerts influence on persons throughout their lifespan.</p>	<p>Health professionals in the programme outline and implement the CBT programme to clients.</p> <p>Health professionals conduct ongoing counselling and nursing care in the programme and support groups after the residential component is completed. This is done in an effort to facilitate relapse prevention.</p>
<p>Self-initiated reconfiguration of person-environment interactive</p>	<p>Individuals initiate changes to effect reconfiguration of person-environment interaction during reintegration. This allows for</p>

patterns is essential to behaviour change.	behaviour modification, social reintegration and relapse prevention.
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3.3 CONCEPTUALISATION

Dentlinger (2008) reported on the spotlight falling on drug and alcohol rehabilitation facilities. *The Cape Argus*, 06 April 2008 reported that the increased abuse of methamphetamine commonly known as 'TIK', and misuse has been flooding communities, especially communities on the Cape Flats area of the Western Cape. Benjamin (2006: 1) stated that substance abuse has thus become a threat to the future of our society and it necessitates our urgent attention. Pludderman *et al* (2006: 1) stated that, in Cape Town, the most common primary substance abuse admissions reported by the 27 specialist treatment centres participating in their monitoring and trends project, were methamphetamine, alcohol and heroin with 81% admissions. Based on the experience of international research, the economic costs of the abuse of alcohol and drugs to the province are likely to well exceed R1 billion per year. Benjamin (2006:1) further stated that for many years we heard that the drugs that cause negative health and social consequences were heroin and cannabis.

Nurses who specialize in community mental health work with individuals in community residential settings will often emphasize work on mental health promotion. These mental health nurses also work in rehabilitation settings where people are recovering from a crisis episode and where the aim is social inclusion and a return to living independently in society. The Pender's HPM allows nurses to interact with the multi-dimensional levels of clients in these residential care settings to move them through the phases of understanding their individual characteristics and experiences, working with their behaviour-specific cognitions and affect to achieve the behavioural outcomes needed, being a modified recovery experience as discussed

in Chapter 3. As the prevalence of substance dependence increases, more research is being conducted in the area of substance abuse recovery, but it is noted that not much has been documented in the area of faith-based programmes in the Western Cape.

3.4 **SUMMARY**

In this chapter, I reviewed the current literature by reviewing substance abuse, experiences, recovery, faith-based programmes, and the role of the nurse in substance abuse recovery, the role of faith in nursing, community care in recovery, the conceptual framework and assumptions of the conceptual framework.

3.5 **CONCLUSION**

A review of the literature revealed that substance dependence, as a mental health illness, is on the increase with the poorer communities being mostly affected. This impacts every facet of communities. Rehabilitation of dependants is paramount to any health care service rendered, but this could be done in different ways, because not all drug users need the same recovery model. One such model is a residential substance abuse recovery home. This is only one way of assisting the user because help is focused on modifying the behaviour. One way of implementing this approach is Pender's Health Promotion model which was used as a conceptual framework for the study. This allowed participants to share their lived experiences in light of substance abuse recovery in the faith-based programme. Exploring, describing and interpreting clients' lived experiences in light of the literature reviewed and the conceptual framework allowed the researcher to make recommendations in the next chapter of the study.

4. CHAPTER 5: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

During the discussion, conclusion and recommendations chapter, I will discuss my findings from the study, the limitations of the study, draw study conclusions and make recommendations based on the results.

4.2 DISCUSSION

In conducting the phenomenological study to answer the research question, I used the reasoning strategies of analysis, synthesis, inferences, inductive reasoning, data reduction, derivation, bracketing and explicating to conduct the step by step thematic analysis proposed by Braun and Clarke (2006). The following themes, sub-themes and sub-categories which emerged from this analytical process below will now be discussed.

Theme 1: Positive Recovery Experience

Many categories and sub-themes emerged from this overarching theme, highlighting the positive recovery experiences for clients. They are discussed as sub-themes and sub-categories below.

Subtheme 1: Structure

Structure was highlighted as an important aspect of the positive recovery experience. This is so because of the direct contrast to the unstructured lifestyle experienced with substance abuse, prior to

entering the in-client faith-based substance abuse recovery programme. Structure is essentially introduced by following a dedicated routine of daily activities from the morning until the evening. Following a structured routine daily becomes a frame of reference for clients which allows neural pathways to develop in the brain. This is discussed in Pender's HPM. The set of variables for behavioural specific knowledge and affect have important motivational significance. These variables can be modified through nursing actions. Health promoting behaviour is the desired behavioural outcome and is the end point in the HPM. This adjusted behaviour becomes a pattern or a reference point for clients after they exit the 6-months residential in-client programme.

Sub-category 1: Counselling

Counselling was reported as a sub-category of structure because it occurred in the in-client programme. It was an important part of healing from hurt for any individual. The FBO used the SONAR approach in counselling, which refers to s = summarising, o = open-ended questions, n = non-judgemental environment created, a = affirming and r = reflective listening. This method is documented in the CTDCC Training Manual (2009: 4). Neeraja (2008: 68) states that communication is the basic element of human interaction which allows people to establish, maintain and improve contacts with others. Nurses should be aware of both verbal and non-verbal type of communication. Participants reported the counselling as a positive recovery experience for them in the faith-based programme because they were taught how to identify the root cause of the drugging and deal with the void that caused it, to move into the future whole in this process. NIDA (2010: 28) states that treatment counsellors should select from a menu of services for meeting the individual medical,

psychological, social, vocational and legal needs of the patients to foster their recovery from addiction.

Sub-category 2: Application of rules and discipline

The application of rules and discipline is a sub-category of structure because it occurs in the in-client programme and it provides the framework for the clients in the programme. It would ordinarily not be linked to a positive experience, but what emerged from the data analysis was that clients viewed this in a positive light because it cemented the structure needed following the chaotic lifestyle accompanied by drugging. The FBO facility has a 17 page rule book which is shared with each client on admission into the programme and throughout the client's stay. The method of discipline is a corrective, non-punitive method of discipline to correct unacceptable behaviour. The process proved to be useful with many participants reporting that they would not have completed the programme if they did not have the discipline associated with the structure in the programme.

Sub-category 3: Sobriety

The sub-category sobriety is embedded in the sub-theme structure because it was part of the expectations of the in-client in the faith-based facility as is further embedded in the participants' positive recovery experience. The faith-based facility being researched stated in its profile that it believed in and practiced absolute sobriety from every substance because certain substances are triggers for clients to crave and then relapse into more dangerous substances. They believe that each client has the ability to exercise complete cessation of substance, illicit and entry level; because their bodies are the temple of God. This principle is shared at the initial screening visit with clients and families. Clients who choose to continue using will not be admitted into the residential 6-month in-client programme. Upon

interviewing the participants, this was viewed as a positive recovery experience. The data extracts described that this was not only possible, but also necessary to prevent relapsing in the participants interviewed.

Sub-category 4: Training and Skills

The sub-category training and skills is embedded in the structure sub-theme because it was part of the in-client programme offered to participants. Some participants reported to have smoked from age 11, while many reported to have dropped out of school and not gained any skills, even basic ones. The faith-based programme offers vocational and life-skills as part of the programme. Learning new skills and doing training in the 6-months faith-based programme proved to be a positive recovery experience because participants had a tool to use when they exited the in-client programme. Some of the skills reported in the data were working in a gardening project, doing their High School exams, obtaining their learners' or drivers' licences and life skills. Participants reported that this, inevitably, improved their self-confidence and self-esteem and restored their hope for the future.

Sub-theme 2: Support

From the data that emerged, each participant reported support offered as a positive recovery experience. Support was a sub-theme embedded in the overarching theme of a positive recovery experience. Support reportedly was offered in various degrees and from various role-players, but all resulting in the participant feeling that they had someone in their corner to walk a journey with them. This is an important aspect in healing from a solitary illness, which they felt they had brought on themselves, so could not expect. The discussion will be done per sub-category.

Sub-category 1: Family

Family support is a sub-category of the support sub-theme. The data that emerged on family dynamics implies that it played a huge role in the substance abuse-recovery continuum because participants reported it both in a negative and a positive light. In some cases, participants reported that their past substance abuse habit alienated them from their families, which resulted in the families adopting a mistrusting or 'wait and see' approach to their recovery. This left them feeling abandoned and understanding the consequences of the hurt that they caused. The opposite of this was also true; when many participants stated that the support they gained from their family was invaluable and afforded them an opportunity to make amends where necessary. Restitution is an important part of healing damaged family relationships, because the participant feels empowered to take ownership for past errors and the future hope. Participants reported that the family support given made the difference to them healing holistically and being accepted, which is important to successful social reintegration and family reunification as they are all interlinked.

Sub-category 2: Staff

Staff support is a sub-category of the support sub-theme. As described in Chapter 2, two staff categories receive part funding from the Department of Social Development and the other staff all volunteers. The data noted that some of the staff have used substances in the past and are now giving back to the community by volunteering in a faith-based substance abuse recovery facility. Participants reported that the support received from staff equated to a positive recovery experience because some of the staff had lived through the same experiences which meant they could identify with their clients' struggles. Participants reported that staff treated them in a non-judgemental way by not seeing them as addicts, but rather as

people. Staff members were also willing to invest in their lives, and this, for many, was unexpected but related directly to a positive recovery experience.

Sub-category 3: Peers

Peer support is a sub-category of the support sub-theme. This was communicated as a positive recovery experience by participants largely because the common lived experiences bound clients in a programme together. The clients are put in peer groups with a peer group leader as described in Chapter 2. Participants reported that information is shared and hearts are exposed to the feelings of peers in the group that families may not have been privy to in the past. Peer members also agree to hold each other accountable for their conduct and for growing. Peer groups also agree to 'have each other's back' as reported by the data extracts. These shared experiences of healing together in a programme also gave clients the sense of brotherhood and sisterhood, because they could relate to each other's illness and healing. Participants also reported that sharing a new found faith together bound them to each other, because they learnt skills together, e.g., prayer.

Sub-category 4: Church

The support offered by the church is a sub-category of the support category, which emerged as a positive recovery experience. As the recovery home is situated in the church building, described in Chapter 2, the participants related the support offered by the church and the church community as being non-judgemental with a genuine interest in seeing them improve. This was often related as a contrast from their previous drugging world, where people turned their backs on them as a consequence of choices made. Participants also connected the church support to learning faith skills in the faith-based recovery

setting and preventing relapse because the church forms a community of support. The one other positive experience of church is that it is respected by everyone, even their previous gangster associates. This, therefore, became the only way for some clients to escape that lifestyle, thus making it a positive recovery experience for social reintegration as well as we notice a linking in the themes.

Sub-theme 3: Responding to the faith aspect of the programme

Responding to the faith aspect of the programme is a sub-theme embedded in the overarching positive recovery theme. Participants reported this sub-theme emerging from the data as a positive recovery experience because they believe that there was an initial void created by various life experiences which led them onto the drugging path. This void needed to be filled and only faith in Jesus Christ as their saviour and redeemer could replace the hurt, loneliness, rejection and low self-esteem. The faith-based programme teaches clients aspects of faith like prayer, reading the bible and developing a relationship with Jesus Christ, which would carry them through every crisis or challenge even when they exit the in-client programme. Participants reported that these faith aspects taught became a powerful relapse prevention strategy and they empowered them to share with other clients still struggling, thus giving back to the community as well.

Sub-theme 4: Personal goals for recovery

The 'personal goals for recovery' is a sub-theme of the overarching positive recovery theme. Step 0 of the faith-based programme, discussed in Chapter 2, states that potential clients needed to demonstrate help-seeking behaviour to recover. This initial step is the first step to recovering from a behaviour-based mental health illness. All the participants interviewed expressed that they took this initial step because they had personal goals for recovering from their substance

use and abuse lifestyle. These personal goals kept them motivated and driven to carry on which is the desired outcome of the Health Promotion model of nursing. This sub-theme was therefore directly linked to a positive recovery experience.

Theme 2: Modified Future Experience

A modified future experience is the goal of all substance abuse recovery programmes. This is the desired outcome of the intervention and is measurable. This overarching theme will be explained using various sub-themes.

Sub-theme 1: Impact of faith-based programme

The 'impact of the faith-based programme' is a sub-theme of the modified future experience theme. Participants reported, through the recorded interviews, that the faith-based programme had an impact on their modified future experience. Participants reported that the impact of faith on their lives not only made them want to be better people, but also equipped them with the skills achieve this. This was evident in their interaction with their families, employers and peers.

Sub-theme 2: Behaviour modification

The faith-based programme is based on behaviour modification. This has also emerged as a sub-theme in the overarching modified experience theme. NIDA (2010: 27) states that behavioural treatments help engage people in drug abuse treatment, modifying their attitudes and the behaviours related to drug abuse and increasing their life skills to handle stressful circumstances and environmental cues that may trigger intense craving for drugs and prompt another cycle of compulsive abuse. Participants reported that their chaotic, untoward drugging behaviour was modified in the safe space created by the faith-based programme. One client reported that

the 6 month faith-based programme gave her the foundation needed to become stable and allowed her to close the rift that was created by drugging; thus modifying her behaviour. This resulted in restitution for wrongs done and restoration of damaged relationships, again, a modified future experience because this was opposite to what happened in the past. Behaviour modification is ensured in the programme in various ways, e.g. rules and regulations based on faith-based principles.

Sub-theme 3: Ongoing sobriety

The sub-theme ongoing sobriety was reported by all the participants as the modified future sought after the faith-based recovery programme. The faith-based facility researched believes in absolute sobriety from all substances, even the gateway substances, e.g. cigarettes. Clients admitted into the programme are aware of this and must agree to complete cessation. Clients who are unable or unwilling to comply exit the programme prematurely. Ongoing sobriety therefore became the evidence that families witness of the modified future experience. This was also reported as the one thing that participants longed for after years of using, because of the negative effects of drugging both physically and psychologically. Ongoing sobriety is the measurement of successful recovery for programmes and could be tested by negative multi-drug tests. Participants also reported that choice is an important component of sobriety.

Sub-theme 4: Family reunification

Family reunification is a sub-theme for the modified future theme. The impact on family reunification has been reported in the data as a positive experience because it resulted in restored relationships and improved family dynamics. Hopeful families were rewarded for their investment in the participants' lives after the years of heartache and

pain caused by drugging. The faith-based facility promotes family reunification and has individual and family counselling sessions to unpack issues and drill down to the root cause of the problems identified. This is also accompanied by various programmes like Restorative Justice and a 'Face-off' programme aimed at restitution. The facility also has monthly sessions where families are invited to the programme and educated about substance abuse and its effects on the client. This is done because they believe that knowledge empowers one to make the necessary adjustments in preparation for the client's home coming.

Sub-theme 5: Successful social reintegration

Successful social reintegration is a sub-theme of the modified future theme. Society is affected by substance addiction, as evidenced by the literature discussed in Chapter 4. Participants reported successfully reintegrating into employment, churches and friendship groups after the completion of the 6-month in-client programme; as was evidenced by people trusting them again. This allowed them to be constructive, productive citizens of their communities once more. They reported being pleased about that, rather than being the menace that were previously. Successful reintegration is a programmatic goal which is linked to the HPM as a desired behaviour outcome.

Sub-theme 6: Relapse prevention

Relapse prevention is a sub-theme of the modified future experience theme. This is the goal of any long term substance abuse recovery intervention, irrespective of the modality of care. Participants reported that, while cravings are real, choice plays a big role in their decision to relapse or to stay sober. Undergoing a faith-based substance abuse recovery experience caused each of them to learn to identify the root cause of the addiction, learn skills to cope and the faith to endure

when the challenges or cravings come. The other aspect of relapse prevention reported by the participants was staying connected to the programme for ongoing support and calling on their peers in the support group. Trigger Management plans form part of the Reintegration Plan when clients exit the residential programme. This is done in conjunction with the clients' families, employers or loved ones. The programme also appoints a mentor who walks alongside the client and plays a supportive role as an accountability partner in the reintegration and aftercare periods. Clients are encouraged to reach out for help when they experience a trigger.

While the themes were two separate themes, it should be noted that links between themes and sub-themes exist and cannot be easily separated. The themes moved on a continuum from the positive recovery experience to the modified future experience. The modified future experience could be likened to the desired outcome of the Health Promotion model. Polit and Beck (2006) state that health promoting behaviours should result in improved health, enhanced functional ability and better quality of life at all stages of development. The final behavioural demand is also influenced by the immediate competing demand and preferences, which can derail any intended health promoting actions. Participants reported the immediate competing demands were issues like cravings, unresolved anger, bitterness and resentment. These demands could cloud their judgement or result in a relapse, which is contrary to health promotion if not managed. The reported examples of the preferences were again yielding to cravings because the enjoyment of the high of substance use. The HPM therefore, is focused on an unlearning of the untoward behaviours and a relearning of the desired behaviours, which would result in a positive outcome thus preventing relapse.

4.3 **LIMITATIONS OF THE STUDY**

The limitations of the study are that I am a full-time employee and a Masters student, thus time constraints needed to be managed carefully to ensure that the study timelines were met and the study objectives were reached. Also, my work at the FBO facility is daily, although part time. This proved to be a limitation to the amount of time I could spend with the clients, conducting health promotion at the multi-dimensional level needed to facilitate movement from illness to health, as per Pender's Health Promotion model. Participants could only see me after hours and weekends; this proved to be limiting. A third limitation was that of financial constraints because I did not receive a bursary. The last limitation is that of logistical challenges identified between my supervisor and myself. I am based in the Western Cape and my supervisor is based in the Eastern Cape. We both work full-time and have extensive travel commitments. This proved to be challenging at the best of times.

4.4 **CONCLUSIONS**

The objective of the study was to explore, describe and interpret clients' experiences of substance abuse recovery in a faith-based (FBO) programme in the Western Cape. The vast problem of substance abuse and its negative impact on individuals, families and societies in the Western Cape was discussed in Chapter 4. Substance abusers access health care at various stages of the illness because the neurological effect of the substances affects each individual in a different way. The Health Promotion model notes that each person has unique personal characteristics and experiences that affect subsequent actions and healing, this underpinned the care rendered to clients in the FBO-facility studied for this research project.

An explorative, descriptive, interpretive phenomenological qualitative design was the best way to capture the lived experiences of clients accessing a faith-based programme for substance abuse recovery. The step-by-step inductive thematic approach used to analyse the data proved to be a useful way of exploring and describing the research question, because the data 'told the story'. Using data reduction, two specific themes emerged, namely the positive recovery experience and the modified future experience. These were explored, described and interpreted in detail through the sub-themes and sub-categories and the examples to highlight each by the use of the data extracts and synthesis of coded information. Aspects of the thematic data analysis results emerging stated that participants experienced a renewed sense of hope, following the completion of the programme. Furthermore, they reported that this was as a result of the positive recovery experience identified by the use of structure in the programme which encompassed counselling as well as the application of rules and discipline. Sobriety training and skills were also obtained. They also reported that they were supported by family, the staff, their peers and the church. They reported that they benefited from responding to the faith aspect of the programme and by developing personal goals for recovery. Aspects of the data reported depicted a modified future experience. For this clients reported a positive impact of the faith-based programme, behaviour modification, ongoing sobriety, family reunification, successful social reintegration and relapse prevention. Findings suggest that this mode of nursing care delivery is able to demonstrate measurable positive outcomes for the targeted populations, while being cost effective.

4.5 **RECOMMENDATIONS**

A review of the literature discussed in Chapter 4 states that substance abuse is on the increase in the Southern African region and

specifically in the Western Cape. Young men and women exposed to the drugs, from an early age, struggle to heal and need support. The healing modalities are varied. One such modality, the faith-based recovery option, was explored, described and interpreted in this study by means of inferences. The Health Promotion model notes that each person has unique personal characteristics and experiences that affect subsequent actions. The set of variables for behavioural specific knowledge and affect have important motivational significance. This study has concluded that these variables can be modified through nursing actions in the setting where the client is presently. As previously stated, health promoting behaviours should result in improved health, enhanced functional ability and better quality of life at all stages of development. The following recommendations are made based on the HPM Assumptions table in Chapter 4 and implications for policy for faith-based substance abuse recovery facilities were noted, when necessary.

Recommendation 1 is based on the HPM assumption 1; namely, Individuals seek to actively regulate their own behaviour.

- If a faith-based, HPM approach is used, then it is recommended that potential clients demonstrate help-seeking behaviour by attending the facility for the initial screening, with or without the caregivers. Caregivers, families or loved ones cannot do this for them, because the first step to healing it to regulate their own behaviour and reinstate structure. This recommendation is based on theme 1, sub-theme; structure as evidenced by the results discussed.
- Potential clients agree to abide by the faith-based, HPM approach implemented in the programme. This includes being accountable for their acts and omissions and being disciplined or corrected if not. This can be done by signing the rules document and by contracting with the peer group members. This recommendation is based on the theme 1,

sub-theme; application of rules and regulations. The application of rules and regulations allows the nurse to assist the individuals to regulate their own behaviour by giving a framework in which to demonstrate acceptable behaviour.

Implications for Policy:

- Help-seeking behaviour principle to be documented in organisational policies even if the potential client is committed by the Justice system.
- Policies to clearly describe the disciplinary procedures in line with the reasons for them, in order to regulate behaviour. The aim of the discipline should be corrective and not punitive in nature. If possible, allow the peer groups to give input in the discipline to be given as this teaches the client a sense of accountability for actions and responsibility for decisions made.

Recommendation 2 is based on the HPM assumption 2; namely, Individuals in all their biopsychosocial complexity interact with the environment, progressively transforming the environment and being transformed over time.

- Individuals contract to substance abuse cessation prior to admission into the programme. This recommendation is based on theme 1, sub-theme: sobriety.
- Individuals contract to substance abuse cessation while in the programme and after programme, or to get help if this is not possible. This recommendation is based on theme 2, sub-theme: ongoing sobriety.
- Individuals agree to abide by the programme rules and regulations instituted thus being transformed from the untoward negative substance abuse lifestyle to a positive recovery and then a modified future lifestyle. This recommendation is based on theme 2, sub-theme: behaviour modification.

Implications for Policy:

- Policies should clearly depict what is termed as 'Indicators as measurements of success'. This will allow clients the opportunity to gain small successes, which will motivate them to achieve large successes, e.g., ongoing sobriety, family reunification or social reintegration.
- Policies depicting compulsory education sessions for the client and the family, to promote transformation in the home environment as well.

Recommendation 3 is based on the HPM assumption 3; namely, Health professionals constitute a part of the interpersonal environment, which exerts influence on persons throughout their lifespan

- Health professionals in the programme outline and implement the HPM programme for clients in an unbiased fashion. A faith-based component to be made mandatory in all programmes as faith impacts healing. This recommendation is made on theme 1, sub-category: counselling and theme 2, sub-theme: impact of faith-based programme.
- Health professionals to develop individual needs-based care plans for the clients, to enhance recovery and prevent relapse. If programmes are based on individual needs, the client is more likely to abide. One-size-does-not-fit-all approach to be adopted in dispensing health-care. This recommendation is based on theme 1, sub-theme: personal goals for recovery.
- Clients are supported by health professionals to identify perceived barriers which could deter healing and sobriety. This is documented in an individualized Risk Assessment Risk Mitigation Plan; in conjunction with the client.

- Clients are supported by Health Professionals to describe perceived individual benefits to enhance healing opportunities, based on their individual risk assessment.
- Health professionals' conduct ongoing counselling and nursing care in the programme and support groups after the residential component is completed. This is done in an effort to facilitate relapse prevention. This recommendation is based on theme 2, sub-theme: relapse prevention.

Implications for Policy:

- Individualised Development Plan (IDP) to be amended to include: Individualised Risk Assessment and Risk Mitigation components and implemented according to the client's needs.
- Recommend that policies include a mandatory faith-component to recovery; this is essential in dealing with the holistic being.

Recommendation 4 is based on the HPM assumption 4; namely, Self-initiated reconfiguration of person-environment interactive patterns is essential to behaviour change.

- Recommends that clients initiate progressive, small, lasting changes to effect reconfiguration of person-environment interaction during reintegration. All relevant parties are consulted in this process. This allows for behaviour modification, family reunification, ongoing sobriety, successful social reintegration and relapse prevention. An example of this is to develop a robust exit strategy with each client, e.g., going home weekly but living in residence on weekends for the first month; post the residential phase of care. This recommendation is based on the theme 2, the modified future experience.

Implications for Policy:

- Trigger Management Plans to be consultative and shared with all relevant parties, in order to keep client accountable for acts and omissions and assist with relapse prevention and make it more possible for the client to successfully reintegrate into society.

NIDA (2010: 28) states that because addiction can affect so many aspects of a person's life, treatment must address the needs of the whole person in order to be successful. Through this discussion of the results and the recommendations made, one understands that the application of Pender's Health Promotion model (1996) in substance abuse recovery programme resulted in improved health, enhanced functionality and a better quality of life for the participants. Health promotion is, therefore, recommended as the outcome for all faith-based substance abuse recovery programmes. The case for faith-based recovery programmes has been made and the hope is that more of these facilities are registered under the new Act 70 of 2008 because they are economically sound interventions. The current facility only has accommodation for up to 28 males and 10 females; future facilities could be focused on the adolescent user, as this is a gap in the current programme. Faith-based organisations, e.g. the church, propose that they are in the communities addressing their needs from the cradle to the grave; this would imply that they already have a footprint in communities. A further recommendation is therefore made that the various government departments, e.g. health, education and social development join forces with their expertise and knowledge to address the growing need for placing similar facilities in the communities at risk. These organisations offer addicts and families a cost-effective, outcomes-based alternative to mainstream treatment facilities which our communities cannot afford. Lastly, using derivation as a reasoning strategy, the use of Braun and Clarke's inductive thematic analysis method, borrowed from Psychology, to code and analyse

the data for this phenomenological study proved very useful. A suggestion that future research in qualitative nursing explore using this method as well is made.

4.6 **CONCLUSION**

Funnell, Koutoukidis and Lawrence (2008: 4) quotes the ICN's definition of nursing as encompassing autonomous and collaborative care of individuals of all ages, families, groups and communities sick or well and in all settings. Nursing includes the promotion of health, prevention of illness and the care of the ill, disabled and dying people. Advocacy, promotion of a safe environment, research and participating in shaping health policy and in patient and health systems management and education are all key nursing roles. The vast problem of substance abuse and its negative impact on individuals, families and societies in the Western Cape is well documented. Uys and Middleton (2010: 46) state that the health promotion approach fits well into the primary health care approach which has the total development of communities as its target. It is a multi-sectoral approach and involves all sectors of the public service in fulfilling the basic needs of the population. Substance abusers access health care at various stages of the illness because the neurological effect of the substances affects each individual in a different way. The mental health care spectrum is vast, ranging from out-client to residency services. Further to this, some services offer medical treatment, while others offer a faith-based modality to recovery and wellness. Uys and Middleton (2010: 151) state the principle of caring for the psychiatric patient in the least restrictive environment possible, is enshrined in the mental health legislation of many countries. Baumann (1998: 238) states that the causes are complex and interacting and that there therefore can be no simple solution to the problem. Success can be

achieved if individual treatments are employed and economic interventions are made with the emphasis on prevention strategies.

The aim of the study was to use an explorative, descriptive, interpretive, phenomenological, qualitative, research design, while guided by ethical principles, to interview clients to answer the research question. Braun's inductive thematic data analysis (2006) of this study led to an understanding of clients' experiences of substance abuse recovery in a faith-based programme in the Western Cape. The results concluded that clients recovering from substance abuse in a faith-based programme greatly benefitted from such a model of nursing care. In gaining an understanding of their experiences, future programmes can be tailored to promote mental health, thus improving the quality of the client's life and secondly, preventing relapsing into substance abuse; thereby fulfilling their societal obligations of becoming constructive and productive citizens in RSA. I hope that this research project adds to the body of nursing knowledge for similar faith-based recovery facilities by using this research design, conceptual framework and data analysis approach which outlined the positive recovery – modified future continuum experienced by our clients.

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6. APPENDICES

- 6.1 APPENDIX A: Ethical Approval - University Of Stellenbosch**
- 6.2 APPENDIX B: Correspondence with the organisation**
- 6.3 APPENDIX C: Consent Form**
- 6.4 APPENDIX D: Interview Guide**
- 6.5 APPENDIX E: Co-Coder's Report**
- 6.6 APPENDIX F: Figures used**
- 6.7 APPENDIX G: Tables used**



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21 October 2011

MAILED

Ms C Herman
Department of Nursing
2nd Floor
Teaching Building
Faculty of Health Sciences
7500

Dear Ms Herman

Clients' experiences of substance abuse recovery in a Faith-Based Organization in the Western Cape

ETHICS REFERENCE NO: N11/09/297

RE : MODIFICATIONS REQUIRED

At a review panel of the Health Research Ethics Committee your application for the approval and registration of the abovementioned project was considered.

In principle the Committee is in agreement with the project, but requested that you should attend to the following matters before the project could be finally approved:

1. Inadequate description is provided of the direct observation procedure - when/ where/ how long, etc. Please correct.
2. With regards to the Patient Information leaflet and Information Consent documents:
 - 2.1 Add the words "Consent form" to the heading.
 - 2.2 Add a paragraph describing research to be done in line with the declaration of Helsinki etc - see www.sun.ac.za/rds (under application package, and participant informed consent form.
 - 2.3 Nothing is mentioned about the direct observation procedure - it should be described in detail.
 - 2.4 Add a space for witness signature.

On receipt of the additional information/corrected document(s) the application will be reconsidered. Please HIGHLIGHT or use the TRACK CHANGES function to indicate ALL the corrections/amendments clearly in order to allow rapid scrutiny and appraisal.

Please note that the application for the approval and registration of this project would be cancelled automatically if no feedback is received from you within 6 (six) months of the date of this letter.
Please quote the Ethics Project Number on all correspondence henceforth.

26 October 2011 09:20

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Verbind tot Optimale Gesondheid · Committed to Optimal Health
Afdeling Navorsingsontwikkeling en -steun · Division of Research Development and Support

Posbus/PO Box 19063 · Tygerberg 7505 · Suid-Afrika/South Africa
Tel.: +27 21 938 9075 · Faks/Fax: +27 21 931 3352



Yours faithfully

MRS MERTRUDE DAVIDS

RESEARCH DEVELOPMENT AND SUPPORT

Tel: 021 938 9207 / E-mail: mertrude@sun.ac.za

Fax: 021 931 3352

26 October 2011 09:20

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Fakulteit Gesondheidswetenskappe · Faculty of Health Sciences



Verbind tot Optimale Gesondheid · Committed to Optimal Health
Afdeling Navorsingsontwikkeling en -steun · Division of Research Development and Support

Posbus/PO Box 19063 · Tygerberg 7505 · Suid-Afrika/South Africa
Tel.: +27 21 938 9075 · Faks/Fax: +27 21 931 3352



07 February 2012

MAILED

Ms C Herman
Department of Nursing
2nd Floor
Teaching Building
Faculty of Health Sciences
7500

Dear Ms Herman

Clients' experiences of substance abuse recovery in a Faith-Based Organization in the Western Cape

ETHICS REFERENCE NO: N11/09/297

RE : APPROVED

It is a pleasure to inform you that a review panel of the Health Research Ethics Committee has approved the above-mentioned project on 30 January 2012, including the ethical aspects involved, for a period of one year from this date.

This project is therefore now registered and you can proceed with the work. Please quote the above-mentioned project number in ALL future correspondence. You may start with the project. Notwithstanding this approval, the Committee can request that work on this project be halted temporarily in anticipation of more information that they might deem necessary.

Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit.

Translations of the consent document in the languages applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Please note that for research at primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Hélène Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

07 February 2012 11:11

Page 1 of 2



Approval Date: 30 January 2012

Expiry Date: 30 January 2013

Yours faithfully

MRS MERTRUDE DAVIDS

RESEARCH DEVELOPMENT AND SUPPORT

Tel: 021 938 9207 / E-mail: mertrude@sun.ac.za

Fax: 021 931 3352

07 February 2012 11:11

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hermancolleen@gmail.com

084 645 9008

25 November 2010

Mr. Lucien Brink

Director

Hope Again Recovery Home

As you are aware, I am currently a Masters student at the Stellenbosch University, and am in the process of conducting a research project for the completion of my studies. The focus of my proposed subject is '*What are clients' experiences about substance abuse recovery in a Faith Based programme in the Western Cape?*'

I understand that this information needs to be treated with care and respect. With this understanding, and in terms of University policy, in conducting this research I am bound to following a stringent Code of Professional Ethics. My plan is to inform all the clients about the study and grant each one an opportunity to participate. Those who agree would sign an informed consent form explaining that the data will be collected through conducting interviews with them. Confidentiality will be maintained at every level of the study. All information gathered during these interviews will be for the purposes of answering the research question.

This research will, it is hoped, build onto previous work on substance abuse treatment services in South Africa, and add insight and understanding into evidence-based knowledge of Faith Based Organisations and the roles they have played and might play in the future in treating Substance Abuse Disorders. I would like to find out more about the problem in this area and the work that you are doing in this regard.

I await your response.

Kind regards



Sr. Colleen Herman



HOPE AGAIN RECOVERY HOME

Director of the Board: Reverend A.A. Schilder

P. O. Box 787, Westridge, Mitchell's Plain, 7802

Physical Address: C/o Ajax & Artemis Roads, Woodlands, Mitchell's Plain

Tel: 021-371 73 23 Fax: 086 659 3824

Email: secretary@mounthope.co.za

NPO: 020-514

30 November 2010

Sr. Colleen Herman
email: hermancolleen@gmail.com

RE: **PERMISSION TO CONDUCT MASTER'S RESEARCH:**

Dear Sr. Colleen Herman

Your letter dated the 25th November 2010 refers.

Please note the following:

- ✓ We appreciate you agreeing to conduct your research under strict ethical principles with our clients, after you have received Ethics approval.
- ✓ Please inform liaise directly with the Programme Manager for access to the clients.
- ✓ We would also like to be informed of the outcome, when available.

On behalf of Hope Again Recovery Home, we recognise the importance of such a study and we would like to grant you permission to conduct your Masters in Nursing research at our facility.

Yours in recovery!

A handwritten signature in black ink, appearing to read 'MR LUCIEN BRINK'.

MR LUCIEN BRINK
DIRECTOR: MEN'S AND LADIES HOME

Clients experiences of substance abuse recovery in a Faith-Based programme in the Western Cape

Study Id number: _____

PARTICIPANT INFORMATION SHEET AND INFORMED CONSENT FORM

Project title: Client's experiences of substance abuse recovery in a Faith-Based Organisation in the Western Cape

Name of researcher: Sr. Colleen Herman

Institution: Stellenbosch University

Contact: 084 645 9008

Email: hermancolleen@gmail.com

Description of research project

This interview is part of a Masters in Nursing research project with supervision provided by: Dr. Eunice Seekoe in conjunction with Stellenbosch University. The purpose of this research project is to understand the client' experiences of substance abuse recovery in a Faith-Based programme in the Western Cape. This will achieved through an interview and direct observation techniques. **This study has been approved by the Health Research Ethics Committee at Stellenbosch University and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki and South African Guidelines for Good Clinical Practice.** A copy of these guidelines is also available on request, for your perusal.

Sr. Colleen Herman, a Masters in Nursing research student at Stellenbosch University will conduct the interview at a mutually agreed time for approximately 45 - 60 minutes. The interview will be recorded with your permission and the tape will be used to transcribe the full interview at a later stage. The tape and transcript will be kept secure by the researcher. Access will only be permitted to the researcher, her supervisor and the Regulatory Ethics Committee. The transcript will be analysed for the purposes of this research project and may be used in subsequent research publications. Anonymity is guaranteed.

The transcribed material will be preserved as a permanent resource for use in research and publication and may be used for verification, comparative research, re-analysis or secondary analysis or for teaching purposes. The researcher will ask to be notified in advance and given copies of any publications arising from the use of this research and will ask to be acknowledged as the source of the data.

Why is this research being done?

The aim of the study is to describe the clients' experiences of substance abuse recovery in a FBO in the Western Cape; in order to improve the mental health of clients addicted to drugs; thereby preventing relapse and improving quality of life.

How many people will take part in this research project?

Approximately 6 – 10 participants will be interviewed; or until sufficient data is achieved.

What will happen if I take part in this research project?

- You will take part in an interview with the researcher. The discussion will be aimed at answering the research question.
- Your name will be omitted or you will be given a pseudo/ false name to disguise your identity.
- With your permission, a tape recording will be made so that the researcher can use the information in the interview to type it up after the interview.
- All interviews will take place at the recovery home; in a private room.

Can I stop being in the research project?

Yes. You can withdraw from the study at any time. In the event that you decide to withdraw consent, this will be confirmed in writing and any wishes for data collected to be destroyed will be fulfilled.

Are there any risks in taking part in this research project?

Clients experiences of substance abuse recovery in a Faith-Based programme in the Western Cape

There are no physical risks to you as a result of the study; but in the event that you feel uncomfortable to continue the interview you may request to stop.

Are there any benefits in taking part in this research project?

There are no monetary or direct payments to you as a result of participating in the study. However, you are helping researchers understand clients' experiences being in a faith-based substance abuse recovery programme in the Western Cape, thereby increasing knowledge on this topic.

Will information about me be kept private?

All information pertaining to you will be kept private. Demographics as a group may be written up, but you will in no way be identified.

What are my rights if I take part in this research project?

Taking part in this study is your choice. You may volunteer to participate or you may withdraw your permission if you choose to.

Who can answer my questions about the research project?

I understand that if I have any concerns or difficulties, or if I wish to speak with someone else about any aspect of my participation in this project, I can contact:

- **Researcher: Colleen Herman:**
Email: hermancolleen@gmail.com
Work phone: (021) 860 2300
Cell: 084 645 9008

- **My Supervisor: Dr. Eunice Seekoe**
Stellenbosch University appointed supervisor
Email: eseekoe@gmail.com
Cell: 082 979 1763

- **Programme Supervisor: Dr. Ethelwynne Stellenberg**
Stellenbosch University
Email: elstel@sun.ac.za
Tel: 021 938 9036

- **Stellenbosch University Research Ethics Department**

Tel: +27 21 938 9677

Fax: +27 21 931 3352

Postal address:

PO Box 19063
Tygerberg
7505
Cape Town
South Africa

Physical address:

Francie van Zijl Drive
Parow
7500
Cape Town
South Africa

INFORMED CONSENT FORM

I have been given information about the research project and the way in which my contribution to the project will be used and I agree to participate in this research project. I understand that:

- The nature of my participation is in the form of an interview.
- At the time of the interview my permission will be sought to record and later to transcribe the interview.
- My participation is entirely voluntary and I understand that I can withdraw my consent at any time.

Please tick if agreed:

I give my permission for the information I am about to give to be used for research purposes (including research publications and reports) with strict preservation of anonymity.

Participant name :

Participant Signature: Date:

Witness Signature; Date:

Researcher (signature) Date:

Appendix D: Interview Guide

Study Objective:

To explore and describe the clients' experiences of substance abuse in a faith-based organisation (FBO) in the Western Cape.

As per the informed consent, the interview will be approximately one hour. I will ask the following question to answer the research question: *How would you describe your substance abuse recovery experience in this FBO?*

I will allow the participant to answer the question. If necessary, I will ask probing questions based on responses but I will keep in mind that the probing questions will be based on the study objective.

1. Do you feel you that doing a *faith-based* programme benefitted you in your personal recovery journey?
2. Has the faith-based programme impacted your relationship with your family/ loved ones in any way? If yes, please explain how.
3. Tell me about your experiences with the *other clients* in the home.
4. Tell me about your experiences with the *staff* in the home.

DEPARTMENT OF NURSING SCIENCES

P.O. Box 1054

East London 5200

Tel: +27 (043) 7047582 | Fax: +27 (043) 7047591

e-mail: ambatha@ufh.ac.za



AN INDEPENDANT CODING UNDERTAKEN ON Ms Colleen Herman's work

PROVIDER OF SUCH SERVICE: Mrs AN Mbatha

WORK DONE:

Reading of the methodology chapter to understand the appropriateness of the problem statement, the objectives, questions, the design and the technique used to collect and analyse data in relation to the title at hand.

Transcripts of individual cases were read

Analysis of the individual and all the cases was examined and commented on

I also looked at how the researcher came up with the identification of themes, categories and sub categories as well as sub-sub categories.

Comments were made on themes identified by the researcher and their relevant categories and sub-categories. Assistance on re-organising the above appropriately to tally with the study's design and objectives was done

Sitting and discussing the work with the student to ascertain understanding of how various subcategories, categories fitted to various themes were done. Ultimately all comments were discussed with both the researcher and her supervisor

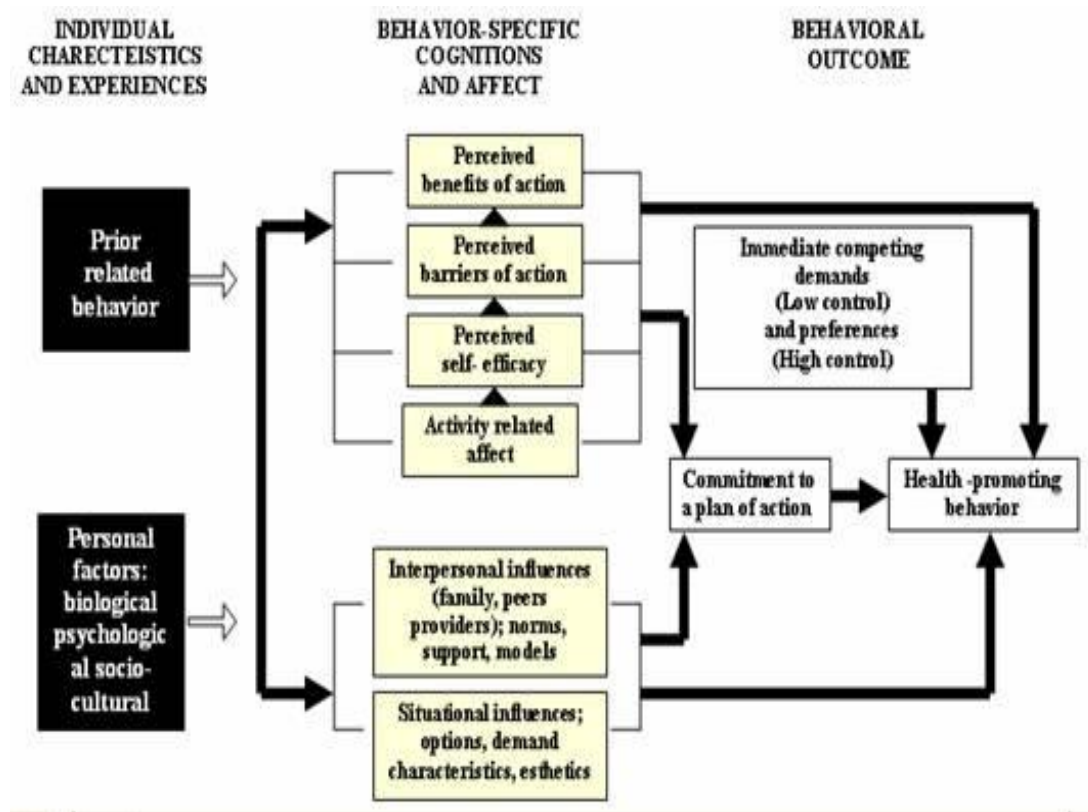
Although some books and some authorities indicate that the design used by this particular student is not recommendable to a student in Masters Level, this particular one was advised to go ahead with this design. The reasons were that she used basic concepts that fit the jargon appropriate for phenomenology. Furthermore the technique and the manner in which she analysed her data is appropriate for the design of her choice. The manner in which she has presented her themes, categories and sub-categories is the one on which the supervisor, the student and co-coder reached the consensus on

Report written by AN Mbatha

Date: 27th November 2012

Appendix F: Figures used

Figure 1: Pender's Health Promotion Model



Appendix G: Tables used

Table1: Interested and Interviewed participants

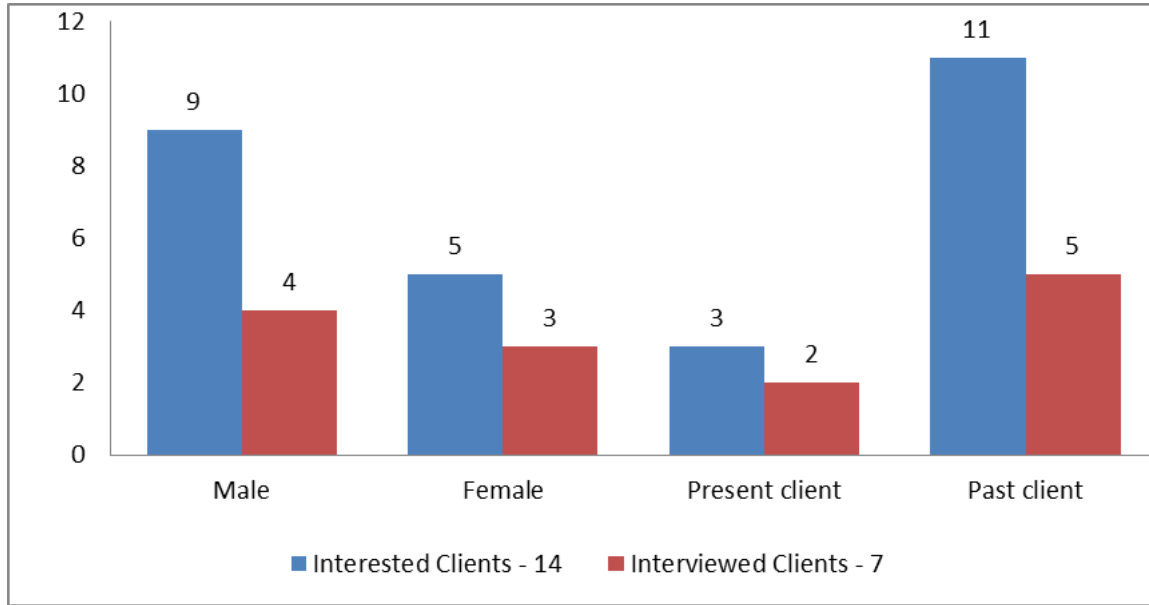


Table 2: Final Thematic Map with Sub-themes and Sub-categories

Themes	Positive recovery experience				Modified future experience
Sub-themes	Structure	Support	Responding to the faith aspect of the programme	Personal goals for recovery	Impact of Faith-based programme
Sub-categories	Counselling	Family			Behaviour modification
	Application of rules and discipline	Staff			Ongoing sobriety
	Sobriety	Peers			Family reunification
	Training and skills	Church			Successful social reintegration
					Relapse prevention

Appendix G: Tables used**Table 3: HPM Assumptions and Faith-based programme applications**

HPM Assumptions	Faith-based Programme Application
Individuals seek to actively regulate their own behavior.	<p>Help-seeking behaviour needs to be demonstrated by individuals accessing the programme;</p> <p>Individuals agree to abide by the CBT approach implemented in the programme.</p>
Individuals in all their biopsychosocial complexity interact with the environment, progressively transforming the environment and being transformed over time.	<p>Individuals contract to washout from substance use prior to admission into the programme;</p> <p>Individuals contract to abstain from substances while in the programme;</p> <p>Individuals agree to abide by the faith-based rules and regulations implemented in the faith-based programme, thus being transformed from the untoward negative substance abuse lifestyle to a positive recovery and then a modified future lifestyle.</p>
Health professionals constitute a part of the interpersonal environment, which exerts influence on persons throughout their lifespan.	<p>Health professionals in the programme outlines and implements the CBT programme to clients.</p> <p>Health professionals' conducts ongoing counselling and nursing care in the programme and support groups after the residential component is completed. This is done in an effort to facilitate relapse prevention.</p>
Self-initiated reconfiguration of person-environment interactive patterns is essential to behavior change.	Individuals initiate changes to effect reconfiguration of person-environment interaction during reintegration. This allows for behaviour modification, social reintegration and relapse prevention.