THE AVAILABILITY AND ACCESSIBILITY OF AFTERCARE SERVICES FOR RECOVERING ADULT ADDICTS IN THE WESTERN CAPE

by

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Thesis presented for the degree of

MASTER OF SOCIAL WORK

in the

FACULTY OF ARTS AND SOCIAL SCIENCES

at

STELLENBOSCH UNIVERSITY

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March 2021

DECLARATION

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ABSTRACT

Globally, substance abuse is on the rise. In South Africa, however, substance abuse has reached epidemic proportions. Social workers in South Africa have been tasked to address and combat substance abuse along a continuum of care, by providing prevention, intervention, and aftercare services. In this context, this study aims to explore the availability and accessibility of aftercare services to recovering adult addicts in the Western Cape, South Africa.

The goal of the research study was to explore the availability of and accessibility to aftercare services for recovering adult addicts within South Africa with a distinct focus on the Western Cape. The purpose of the research was to investigate whether or not there were sufficient availability of services and accessibility to aftercare treatment for recovering adult addicts in order to provide them with protective factors needed to maintain sobriety.

The research study utilised and referred to the biopsychosocial model as its theoretical underpinning in analysing the needs of recovering addicts across biological, psychological, social, and cultural domains. This was also applied to see if the accessibility and availability of aftercare services met these biopsychosocial needs. The service users that was investigated were recovering adult addicts. A qualitative approach alongside purposive sampling was utilised to investigate and explore the experience of these service users in terms of their perception regarding the availability and accessibility of aftercare services once they have left treatment.

The information was collected with the use of semi-structured interviews guided by an interview schedule. The interviews were conducted along ethical-based practices by ensuring that informed consent was obtained from all 16 participants prior to the interviews being conducted. Confidentiality was respected and maintained throughout the study and debriefing services were available at all times. These participants were selected via a criteria of inclusion, namely that they were at that stage all entering the aftercare phase of treatment and had to have direct knowledge and experience about the accessibility and availability of these services in their communities. The interviews were conducted via Zoom video calls, given that face-to-face interviews were not possible due to Covid-19 and the subsequent lockdown regulations. Once the data reached saturation, the interviews were transcribed and underwent thematic analysis. The data was

categorised into themes, sub-themes, and categories. The four themes identified were the biological challenges, psychological challenges, social challenges and cultural challenges in relation to the accessibility and availability of aftercare services. The data of the study underwent a verification process ensuring the validity of the study through safeguarding the credibility, transferability, dependability, and conformability of the data obtained.

The researcher furthermore explored the relevant literature, together with the policy and legislative frameworks pertaining to the accessibility to and availability of aftercare services in South Africa. These findings were then analysed in light of the empirical investigation to gain knowledge on the lived social experiences of recovering addicts in attempting to access available aftercare services in their communities in the Western Cape. After examining the literature and empirical findings, the researcher was able to provide applicable conclusions and recommendations.

It is evident from this research study that recovering adult addicts experience numerous structural, systemic and attitudinal barriers regarding the accessibility and availability of aftercare services, especially amongst the disadvantaged communities of the Western Cape. It is recommended that a concerted effort be made by non-profit organisations as well as government departments to render and establish the availability and accessibility of aftercare services to all communities and recovering addicts in the Western Cape. It is also recommended that further research be conducted on the accessibility to and availability of aftercare services across South Africa. Finally, it is recommended that further research on the actual implementation of policies and legislative frameworks in light of aftercare treatment in South Africa, be explored.

OPSOMMING

Die misbruik van alkohol en dwelms is besig om wêreldwyd toe te neem met wydverspreide toename in Suid-Afrika. Daar word van maatskaplike werkers verwag om hierdie misbruik in die kontinuum van sorg, naamlik voorkoming-, intervensie-, en nasorgdienste aan te spreek en te beveg. Verder neem die terugvalsyfers globaal en plaaslik toe, tot so hoog soos 70 tot 90 persent, wat die toeganklikheid en beskikbaarheid van nasorgdienste noodsaak, ten einde die herstelsyfers in Suid-Afrika te verbeter.

Die doel van hierdie navorsingstudie was om die beskikbaarheid en toeganklikheid van nasorgdienste aan volwasse verslaafdes wat in die herstelproses is, binne Suid-Afrika en spesifiek in die Wes-Kaap, te verken. Die oogmerk van die navorsingstudie was om ondersoek in te stel of daar voldoende beskikbaarheid en toeganklikheid is van nasorgdienste vir volwasse verslaafdes wat in die herstelproses is, ten einde hulle toe te rus met beskermde faktore wat nodig is om soberheid te handhaaf.

Die navorsingstudie het van die Biopsigososiale model as teoretiese raamwerk gebruik gemaak met die analisering van die behoeftes van volwasse verslaafdes wat in die herstelproses is in die biologiese, sielkundige, sosiale, en kulturele domeine. Die toeganklikheid en beskikbaarheid van nasorgdienste is ook ondersoek ten opsigte van die biopsigososiale behoeftes van volwasse verslaafdes wat in die herstelproses is. ’n Kwalitatiewe benadering saam met doelbewuste steekproeftrekking is benut om die ervarings van diensverbruikers, naamlik volwasse verslaafdes aan die herstel, te ondersoek en te eksploreer in terme van hulle persepsies rakende die beskikbaarheid en toeganklikheid van nasorgdienste, nadat hulle behandeling ontvang het.

Die inligting is ingesamel deur van semi-gestruktureerde onderhoude met ’n onderhoudskedule gebruik te maak. Die onderhoude het geskied aan die hand van etiese riglyne. Daarom het al 16 deelnemers ingeligte toestemming gegee voor die onderhoude begin het, en is konfidensialiteit en respek deurgaans gehandhaaf, en was terapeutiese dienste deurentyd beskikbaar. Die deelnemers is gekies volgens sekere kriteria vir insluiting, naamlik dat hulle almal die nasorgfase van behandeling moes betree het, en dat hulle direkte kennis en ervaring oor die toeganklikheid en beskikbaarheid van hierdie dienste in hul gemeenskappe moes gehad het. Die onderhoude het

plaasgevind deur Zoom video-oproepe, aangesien onderhoude van aangesig tot aangesig nie moontlik was nie weens Covid-19 en die daaropvolgende grendeltyd nie. Nadat data versadiging bereik is, het die navorser die onderhoude getranskribeer en ’n tematiese analise gedoen. Die data is in temas, sub-temas en kategorieë verdeel. Die vier temas was biologiese uitdagings, sielkundige uitdagings, sosiale uitdagings en kulturele uitdagings ten opsigte van die toeganklikheid en beskikbaarheid van nasorgdienste. Daar is ook dataverifikasie gedoen wat die betroubaarheid van die studie verseker het in terme van geloofwaardigheid, oordraagbaarheid, betroubaarheid, en bevestiging.

Die navorser het relevante literatuur, sowel as beleid en wetgewing rakende die toeganklikheid en beskikbaarheid van nasorgdienste in Suid-Afrika verken. Hierdie bevindinge is teen die agtergrond van die empiriese ondersoek geanaliseer ten einde kennis in te win oor die werklike ervaringe van volwasse verslaafdes in die herstelproses in hul pogings om toeganklike, beskikbare nasorgdienste te bekom in hul gemeenskappe in Wes-Kaap. Die navorser het die literatuur en empiriese bevindinge bestudeer om relevante gevolgtrekkings en aanbevelings te maak.

Dit is duidelik uit hierdie navorsingstudie dat volwasse verslaafdes aan die herstel verskeie strukturele-, sistemiese- en gesindheidsstruikelblokke ervaar ten opsigte van die toeganklikheid en beskikbaarheid van nasorgdienste, veral in benadeelde gemeenskappe in die Wes-Kaap. Dit word aan beveel dat ’n gesamentlike poging van beide nie-winsgewende organisasies en staatsdepartemente aangewend moet word om nasorgdienste te lewer en te vestig wat beskikbaar en toeganklik is vir alle gemeenskappe en volwasse verslaafdes wat in die herstelproses is in die Wes-Kaap. Dit word ook aanbeveel dat meer navorsing gedoen moet word oor die daadwerklike implementering van beleid en wetgewing rakende nasorgdienste in Suid-Afrika.

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CHAPTER 1

INTRODUCTION TO THE STUDY

1.1 INTRODUCTION AND RATIONALE

Worldwide, substance abuse is on the rise and has shown no indication of deceleration. The global status report of the United Nations Office on Drugs and Crime (UNODC) of 2018 states that, opium and cocaine reached its highest levels of production and consumption ever recorded in history. Substance abuse affects roughly 275 million people worldwide. This means that 5.6% of the global population are misusing substances. Of the 275 million substance abusers 31 million abuse substances to such an extent that intervention and aftercare treatment is required. Substance abuse furthermore also contributes to the disintegration of communities and families, the spread of contagious diseases, an increase in criminal activity, poor productivity, unemployment, economic stressors, and political instability (Sindelar & Fiellin, 2014; Golestan, Abdullah, Ahmad & Anjomshoa, 2010). To combat substance abuse social workers, whether local or international are tasked with implementing prevention strategies, providing a variety of effective intervention methods, and managing aftercare services and referrals (Forrester & Harwin, 2006).

According to international studies and literature, aftercare services form an essential part in the treatment and recovery of substance abusers (Brown, Seraganian, Tremblay & Annis, 2002). Aftercare services can be described as the treatment made available to recovering addicts following an initial rehabilitation programme. This service is often necessary to assist the service user to maintaining their recovery (Patterson, 2019). Regular attendance of aftercare services following inpatient, residential, or outpatient treatment has shown a direct link to an improved, long lasting recovery and higher rates of abstinence from illicit substances (Orbon, Mercado & Balila, 2015). In the United States, regular attendance of aftercare services showed improvements in reducing the spread of contagious diseases by having clean needle clinics, as well as an overall improvement regarding societal costs within the health, economic, and criminal justice sector (Horn, Crandall, Forcehimes, French & Bogenschutz, 2017; Irwin, Jozaghi, Weir, Allen, Linday & Sherman, 2017; Sindelar & Fiellin, 2014). However, maintaining recovery of substance users, remains one the core

issues that social workers have to deal with in drug rehabilitation programmes as relapse amongst substance users can be as high as 80%. In a study conducted in China, 90% of the 170 000 people treated for substance abuse, relapsed. In the United States it was found that 50% to 90% of patients attending recovery programmes relapsed. Globally high relapse figures could be attributed to personal and other reasons, such as a lack of motivation or fear of judgement, but also to the numerous institutional barriers that service users come up against when trying to access aftercare treatment services (Gordon, 2003). These institutional barriers therefore negatively impact the recovery process of adult addicts.

Factors that influence the lack of availability and accessibility to aftercare services could be insufficient funding, barriers in terms of service providers, a lack of available services, geographical location, and a shift in policy from quality care to quantifiable benefit-cost analysis of services (Horn et al., 2017; Cumming, Troeung, Young, Kelty & Preen, 2016; Forrester & Harwin, 2006). Statistics for 2018 show that access to aftercare services for recovering adult addicts remains a global issue in that only one in six people receive such treatment (United Nations Office on Drugs and Crime, 2018).

The United Nations Office on Drugs and Crime verified in their World Drug Report of 2012 that South Africa was the regional centre for drug trafficking and the largest transportation region for illicit drugs in Africa (Lutchman, 2015; United Nations Office on Drugs and Crime, 2012). In 2013, the South African Medical Research Council stated that 11% of the South African population suffered from addiction and remained untreated (Reagon, 2013). Despite South African substance abuse statistics being inconsistent, the South African National Council on Alcoholism and Drug Dependence (SANCA, 2017) stated that drug abuse continues to escalate, especially amongst the youth. These young people often continue with drug abuse into adulthood. Furthermore, drug abuse and the provision of drugs widely contribute to violence in South Africa, especially in the Western Cape which is characterised by high levels of violence and crime, poverty, unemployment, dysfunctional communities and family bonds, the transmission of contagious diseases like HIV and TB, and premature deaths (Isobell, Kamaloodien & Savehl, 2018; Myers, Louw & Pasche, 2010; Republic of South Africa, 2007). In this regard it is also important to bear in mind the biopsychosocial nature of drug abuse as will be discussed later.

In response to the growing drug abuse in South Africa, the government formulated The Prevention of and Treatment for Substance Abuse Act 70 of 2008 . This Act aims to implement initiatives that target the reduction of supply, demand, and harm of illicit substances in South Africa (Republic of South Africa, 2008). The Act further stipulates that services must be provided for recovering adult addicts in terms of prevention, intervention, and aftercare and that services must also be provided for treatment centres and personnel in order to offer necessary, effective, and efficient treatment. To put this Act into effect, the National Drug Master Plan (NDMP) 2006-2011 and 2013-2017, was created to guide and monitor the actions of government departments to achieve the vision of a drug-free society. The NDMP was created to focus on delivering services and treatment to communities and individuals suffering from substance abuse and addiction, as stipulated in the Substance Abuse Act (Republic of South Africa, 2013-2017). However, despite these services being accessible and available in legislation, the reality South Africans face is profoundly different.

The reality in South Africa is that treatment and intervention take months to access due to limited resources, services, and the availability of social workers to assist recovering adult addicts (Lutchman, 2015). This is evident if it is considered that current intervention services and available social workers can only assist approximately 3500 people yearly in the Western Cape (Myers, Louw & Pasche, 2010). Availability and accessibility to these services and interventions are even further limited to the majority of the population who reside in isolated and poverty-stricken, disadvantaged geographical locations (Isobell, 2013; Myers, Pasche & Adam, 2010). Unfortunately, this pertinent structural issue regarding service delivery does not take into consideration aftercare services delivered by social workers which have had proven benefits for long-term recovery (Isobell, Kamaloodien & Savehl, 2018). Limited aftercare services are further hindered because of inadequately trained social workers in the field of addiction, poor referrals and follow-ups during the critical post-treatment period due to high caseloads, and poor collaboration amongst social workers and other relevant professionals (Myers, Fakier & Louw, 2009). Furthermore government-funded aftercare services are extremely limited and neglected in terms of establishment and in terms of being accessible both economically and geographically to poorer communities (Pasche, Kleintjes, Wilson, Stein & Myers, 2014). The focus has also increasingly been on private treatment centres for aftercare services however, these are inaccessible to poorer communities who are often plagued by addiction. The neglect of appropriate

aftercare services has resulted in recovering adult addicts being more likely to relapse and revert to their old behaviours, thus re-entering already limited treatment and intervention services.

From the above, it can be deduced that substance abuse is a global pandemic that social workers and other mental health professionals have been tasked to address. Although there are attempts and a growing focus on the prevention and intervention of drug abuse, aftercare services are still a consistently neglected area of concern, despite it being a critical step in the long-term recovery and support of recovering adult addicts. Globally the neglected establishment of aftercare services is further disregarded as the few services that currently exist, are largely inaccessible due to economics, geographical location, poorly trained social workers and staff, and a highly competitive admissions process (Orbon et al., 2015). These factors highlight that more focus and exploration into aftercare services in terms of availability and accessibility is required to improve service delivery and the long-term recovery of addicts.

1.2 PROBLEM STATEMENT

From the aforementioned discussion, it is clear that there is a need for improved access, availability, and quality of aftercare services for recovering adult addicts on a global scale. Apart from a lack of access and availability of aftercare services for recovering adult addicts in South Africa, there are further structural barriers hindering access to services (Ederies, 2017) such as a lack of funding for the establishment and implementation of aftercare services and a lack of adequately trained social workers in the field of addiction (Myers, Louw & Pasche, 2010; Myers, Fakier & Louw, 2009). Moreover, within the Western Cape, there are admission procedures such as that proof of residency must be provided, which in itself excludes the homeless and majority of citizens residing in informal settlements (Lutchman, 2015; Isobell, 2013). These barriers, namely access and availability of aftercare services, inevitably result in a lack of support for recovering adult addicts, thus increasing the risk of adult addicts to relapse (Isobell, Kamaloodien & Savehl, 2018). This creates a cyclical pattern of relapse and re-entry into treatment which placing further pressure on an already unmanageable workload for social workers combating substance abuse.

It can thus be concluded that aftercare services are being neglected worldwide, this despite there being a direct link to improved, long-term recovery for those struggling with substance abuse (Isobell, Kamaloodien & Savehl, 2018). It can also be concluded that there is a need for further

investigation into aftercare services in the Western Cape in terms of accessibility and availability for recovering adult addicts. Taking further steps is a necessity as substance abuse is accelerating globally, highlighting the fact that further steps must be in place to provide support and guidance to patients once they have left treatment to contribute positively to long-term recovery rates and sobriety. From the abovementioned discussion the following research question, goal, and objectives were formulated:

1.3 RESEARCH QUESTION, GOAL AND OBJECTIVES

The research question is "How available and accessible are aftercare services for recovering adult addicts in the Western Cape?"

The goal of this study is to develop an understanding of the availability and accessibility that recovering adult addicts have to aftercare services in the Western Cape.

The following objectives have been formulated to meet the goal of this study:

- To discuss the nature and scope of substance misuse, continuum of care, and relevant legislation with a specific focus on existing aftercare services provided by social workers.
- To explore the availability and accessibility of aftercare services provided by social workers for recovering adult addicts within the domain of the biopsychosocial approach.
- To empirically investigate the availability and accessibility of aftercare services for recovering adult addicts.
- To present conclusions and recommendations to relevant organisations and government bodies regarding availability and access to aftercare services for recovering adult addicts.

1.4 THEORETICAL POINTS OF DEPARTURE

The biopsychosocial approach was utilised as theoretical framework for this study. The biopsychosocial approach attributes phenomena and events to numerous origins with focus on the interaction amongst psychological, biological and sociocultural aspects (The biopsychosocial perspective, n.d.). The emphasis of this approach is to achieve positive wellbeing and functioning, whilst relieving psychological distress and symptoms amongst service users across all areas of their lives (Melchert, 2011). Furthermore, the biopsychosocial approach utilises evidence-based practices that focus on building the strengths of service users and lessening the harm of difficulties

experienced across the biopsychosocial spheres. This is achieved through understanding and treating service users as part of a system composed of supra-personal levels in a psychosocial environment, rather than solely focusing on singular, individualistic aspects and symptoms (Babalola, Noel & White, 2017). This approach goes hand in hand with the World Health Organisation's (WHO) definition of health, namely that health is 'a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity'. This is particularly important within aftercare services as there are a variety of psychosocial domains that can impact the sobriety and wellbeing of recovering adult addicts. Therefore, it is crucial that aftercare services account for and address the interactions amongst biological, psychological, and sociocultural factors of recovering adult addicts in order to render effective services that positively contribute towards improved sobriety rates.

1.5 CONCEPTS AND DEFINITIONS

1.5.1 Availability

Availability is defined as the quality of being able to be used or obtained as well as the state of freedom to do something (Oxford Living Dictionary, 2019).

1.5.2 Accessibility

Accessibility is the quality of being easily reached, entered, or used by people who have a specific need (Oxford Living Dictionary, 2019).

1.5.3 Substance abuse

Substance abuse is defined as the prolonged and excessive use of illicit substances and the unlawful usage of such substances at any given time (Republic of South Africa, 2008).

1.5.4 Substance misuse

Substance misuse is a term used interchangeably with substance abuse and refers to the continued misuse of an illicit substance that affects a person's physical, mental, and social health as well as

impacting negatively on their social circumstances and responsibilities (North West Boroughs Healthcare, 2020).*

1.5.5 Recovering adult addict

A person over the age of 18 who formerly abused or was dependent on substances and who, following assessment, received services in a treatment centre, halfway house, or community-based service (Republic of South Africa, 2008).

1.5.6 Aftercare services

Ongoing professional support to a service user after a formal treatment episode has ended in order to enable him or her to maintain sobriety or abstinence, personal growth, and to enhance self-reliance and proper social functioning (Republic of South Africa, 2008).

1.5.7 Biopsychosocial approach

The biopsychosocial approach systematically considers biological, psychological, and sociocultural factors and their complex interactions in understanding health, illness, and health-care delivery (Melchert, 2011).

1.6 RESEARCH METHODOLOGY

The research approach, research design, sample, instrument of data collection, data analysis and data verification will be briefly discussed below.

1.6.1 Research approach

A qualitative research approach with quantitative elements was utilised when investigating the availability and accessibility of aftercare services for recovering adult addicts. According to Leedy and Ormrod (2005) the qualitative approach is most suitable where the purpose of research is to describe and understand a certain phenomenon rather than to predict and explain it. Furthermore, this approach allows the researcher to gain an understanding about the phenomenon through

* The terms substance abuse and substance misuse have both been defined with the same core meaning, thus these terms will be used interchangeably throughout this paper.

interviews with participants where themes begin to present themselves. In addition, inductive reasoning is applied which incorporates these explicit observations and themes in order to extrapolate conclusions about more general phenomena (De Vos, Strydom, Fouché & Delport, 2011). This approach was utilised for the researcher's study by conducting semi-structured interviews in order to gain an understanding of the participants' viewpoints and experiences regarding the availability and accessibility of aftercare services. Once these interviews were conducted, the researcher identified themes within the data and utilised inductive reasoning in order to draw more general conclusions about said phenomena.

1.6.2 Research design

In this research study, both an exploratory and descriptive research design were used. An exploratory research design aims to advance insight by answering a 'what' question to develop a research question regarding a certain phenomenon (De Vos et al., 2011). An exploratory research design is deemed appropriate in cases where there is a lack of literature and theory in relation to a phenomenon (Ivankova, Creswell & Plano Clark, 2016). The descriptive research design differs in that it aims to answer the questions of 'how' and 'why' to conduct a more thorough investigation of a phenomenon and to understand its weighted significance (Rubin & Babbie, 2005). These two research designs were both utilised to gain an understanding of the 'what', 'how', and 'why' of accessibility and availability of aftercare services from the participants' viewpoints. From this, the researcher was able to gain insight into this phenomenon and a tentative research question was formulated.

1.6.3 Sample

The researcher used purposive sampling in which participants were selected that had the most characteristics and best represent the population that attended to the objective of the study (De Vos et al., 2011). Data saturation refers to the point where all categories have become saturated and no new data presents itself within the study (Nieuwenhuis, 2016). Data saturation was reached after 10 interviews. The researcher approached a drug and alcohol rehabilitation centre in Worcester to interview participants. This rehabilitation centre was selected because the researcher did their fourth year practical here, and because the centre treated both female and male patients from a variety of socioeconomic backgrounds, spanning widely across various Western Cape

communities. The criteria for inclusion in the sample included a purposive selection of 25 recovering adult addicts in week five, the final week, of their program at the rehabilitation centre. The purpose of selecting patients in the fifth week of their treatment plan is due to them having direct knowledge on the availability and accessibility of aftercare services in their respective communities across the Western Cape which is included in their relapse prevention programmes. However, due to complications brought on by the Covid-19 pandemic there were only a restricted numbers of patients in the rehabilitation centre. Therefore the researcher was only able to interview 16 participants. These participants were selected because they were about to enter the next phase of their treatment, namely aftercare services, and had direct knowledge about the accessibility and availability of treatment options in their immediate environments in the Western Cape. The researcher conducted all interviews with the participants after consent was obtained by Toevlug, an alcohol and drug rehabilitation centre (Annexure 3).

1.6.4 Instrument for data collection

Semi-structured face-to-face interviews with the participants were initially planned to collect data. However due to the Covid-19 pandemic, face-to-face interviews were neither appropriate nor possible and the researcher opted for video interviews via Zoom. Further details regarding these interviews will be discussed in Chapter 4. An interview schedule guided the interview process, this schedule assisted in engaging the participant in a dialogue regarding the subject matter rather than dictating specific questions and answers (De Vos et al., 2011). The semi-structured interview was appropriate as it provided flexibility for both the researcher and participant to explore certain themes identified in literature, and for the opinion and personal experience of each participant to be explored (Annexure 2).

The researcher planned to conduct a pilot study with two participants that presented similar characteristics as those mentioned in the criteria for inclusion of the central investigation (De Vos et al., 2011). Denzin and Lincoln (1994) explain that a pilot study is important as it allows the researcher to test certain questions and anticipate issues that may arise in the interview, which would then allow for amendments to be made to ensure quality interviewing during the empirical investigation. Unfortunately, because of complications regarding the Covid-19 pandemic, it was impossible to conduct a pilot study Covid-19 as access to the patients for Zoom interviews was

limited and because the number of patients present in the rehabilitation programme was limited. The researcher approached the rehabilitation centre via email to request permission for week five patients to take part in the study. However, due to the pandemic, the rehabilitation centre was closed and only outpatients were available for interviewing via video call on Zoom. For the Zoom interviews, the participants could choose if they wanted to take part in the interviewing process. The participants that agreed then contacted the researcher and individual appointments were set up. The interviews were conducted by the researcher in English and the data was obtained through audio-recordings which were then transcribed with permission of the participants. The researcher made use of a denaturalistic approach when transcribing the interviews. This means that certain components of speech, such as pauses, are removed, without influencing the meaning of what the participants said (Oliver, Serovich & Mason, 2005). Data collection took place throughout July and August of 2020 via video calls through Zoom meetings whilst the patients were at the rehabilitation centre in Worcester.

1.6.5 Data analysis

The interview process and data collection were discontinued when data saturation occurred. Data saturation occurs when all themes and categories have been identified and the information presented becomes repetitive (Niewenhuis, 2016). After data saturation occurs, the data will undergo thematic analysis in which transcripts need to be organised and reduced within a two-step coding procedure (De Vos et al., 2011). The first step refers to open coding in which the data is processed and reduced into manageable themes and categories. These themes are then identified within the data when there are recurring ideas and patterns that link the participant's beliefs. The second step is called axial coding in which the data is reanalysed in order to understand the linkages amongst the identified themes and categories. With axial coding meaning is ascribed to the categories and themes presented by the participants through applying context, intervening conditions, and consequences. In this study the data was analysed in accordance with thematic analysis and by following the two-step coding procedure. Once the data from the interviews had reached saturation, the information had undergone open coding wherein the transcribed information was organised into relevant themes and categories by identifying recurring thoughts and patterns. Once these themes and categories were identified axial coding was implemented and

the researcher could then relook and evaluate the data to ascribe connotation and context to the themes and categories identified through the interview process.

1.6.6 Data verification

Validation lies in the openness and transparency of decisions, interpretations, procedures, and instruments utilised throughout the research process (Niewenhuis, 2016). These aspects should be readily accessible and open for scrutiny in order to ensure the integrity and reliability of a qualitative study. In terms of data validity, there are four key areas of concern, namely that of credibility, transferability, dependability, and conformability (De Vos et al., 2011).

Credibility refers to how accurately the findings of the study are in comparison to reality. Credibility, furthermore, involves an accurate description and identification of the subject matter as relayed by the participant. The researcher planned to ensure this through member-checking where participants would be asked to verify if the data collected and interpretations thereof were accurate and correctly understood (Niewenhuis, 2016; De Vos et al., 2011). Unfortunately, due to Covid-19 and the nature of the outpatient program wherein contact with participants was extremely limited, the researcher was unable to document the verification process, but was able to verbally verify their accounts within the interview process.

According to De Vos (2011), transferability is considered problematic within qualitative research as it can become difficult to generalise findings to other population groups or context-specific situations. However, the researcher utilised a variety of participants from different geographical locations in the Western Cape, of differing socioeconomic backgrounds, and of different ethnic groups to achieve some level of transferability within the study.

Dependability refers to the research design and its implementation in that it should follow a logical process that is well-documented and inspected. The researcher achieved this by keeping a thorough database with records of the interviews, case study memos, as well as detailed descriptions of the analysis process and relevant interpretations.

Lastly, conformability refers to the objectivity of a study and whether the findings can be confirmed by another study. It is important for researchers to understand their own limitations and

personal bias within a study and to have an 'audit trail' in which all decisions and steps taken in the research process could be analysed by outside observers.

1.7 ETHICAL CLEARANCE

The researcher ensured that consent was obtained from the participants prior to the interview process. Informed consent requires that the participants are supplied with adequate information regarding the purpose of the study, their involvement, and how data would be gathered and utilised (De Vos et al., 2011). The participants were informed that their participation in the study were strictly voluntary and that they could withdraw from the study at any point. Throughout the study and interview process, confidentiality and anonymity were of key importance. The researcher ensured that confidentiality was maintained throughout the process by handling the content in a professional and ethical manner through password protected files saved on Microsoft OneDrive. In terms of anonymity, the researcher ensured that the study was presented in a general manner in which participants were not distinguishable, by means of assigning all participants a random number. All participants had debriefing services available to them to ensure they avoided harm and to protect their emotional wellbeing, (Annexure 4). Ethical clearance was provided by the Research Ethical Committee of the University of Stellenbosch preceding the commencement of the study (Annexure 5). The consent forms are available in Annexure 1.

1.8 LIMITATIONS OF STUDY

All studies have limitations, however, for this study, the Covid-19 pandemic caused more limitations. The limitations encountered in this research study are discussed below.

- The researcher had to work with a sample size that was smaller than anticipated with only 16 patients who could partake in the study. This was because the rehabilitation centre was closed for some time due to complications surrounding the Covid-19 pandemic. During this time only the outpatient site remained open, leaving a limited number of patients available for interviews.
- The researcher was unable to conduct the pilot study as access to participants was extremely limited due to restrictions imposed in terms of the Covid-19 pandemic.

- The researcher could not conduct face-to-face interviews with participants due to lockdown and regulations pertaining to the Covid-19 pandemic. Video calls via Zoom were implemented instead.
- The researcher focused only on the Western Cape population, thus with regards to access and availability of aftercare services, the findings of this study cannot be implemented on the rest of South Africa.
- The researcher could only interview male participants. This was because the rehabilitation centre was closed due to Covid-19 restrictions. Only the outpatient site was open, and this service was only available for men. The researcher was thus unable to interview women. Thus, a clear depiction of access and availability to aftercare services for men and women in recovery remains unclear.
- The researcher could only interview patients who visited the outpatient site as the rehabilitation centre was closed due to the Covid-19 pandemic. These were all patients that relied on government subsidised treatment. Thus, they represented persons of lower socioeconomic status only. This means that the study does not provide a clear understanding of access and availability to treatment across the socioeconomic domain in regard to aftercare services.
- The research study is qualitative which makes it impossible to quantify results and findings to the greater population and South Africa.

In this chapter the research study was described in detail to clearly depict the purpose, objective, and outcome of the study. The importance in understanding the availability and accessibility of aftercare services in the Western Cape was also highlighted. The researcher also explained how the research was conducted and the techniques that were utilised in order to collect rich data through Zoom video conferences that were held with participants. This chapter further analysed how the information would be categorised and verified in order to shed light on the accessibility and availability of aftercare services in the Western Cape. The aim of this research study was furthermore explored and investigated alongside interviews that were conducted with a biopsychosocial approach in order to fully understand addiction as a multifaceted disease. This was done in order to gain a clear understanding of aftercare services, and to distinguish if there

were available and accessible services along a biopsychosocial continuum for those in recovery. In the following chapter the continuum of care in substance abuse treatment with a special focus on after services and subsequent legislation, will be explored.

CHAPTER 2

THE CONTINUUM OF CARE AND SUBSTANCE ABUSE TREATMENT LEGISLATION WITH SPECIFIC FOCUS ON AFTERCARE SERVICES

2.1 INTRODUCTION

In this chapter the first objective of the study will be addressed. In doing so the nature and scope of substance misuse in South Africa and the continuum of care delivered by social workers to address such substance abuse will be explored. In this chapter the relevant legislative frameworks pertaining to substance misuse and appropriate treatment will also be investigated whilst focusing on aftercare services. Finally, the available aftercare services for recovering adult addicts in the Western Cape will be analysed by comparing appropriate legislature regarding access and availability to treatment to existing and applicable research concerning the genuine service user experience.

2.2 OVERVIEW OF SUBSTANCE MISUSE AND THE NEED FOR CONTINUUM OF CARE FOR SUBSTANCE ABUSE

In 2018, the United Nations Office on Drugs and Crime released a global status report which estimated that worldwide 257 million people were misusing substances (United Nations Office on Drugs and Crime, 2018). Of the 257 million people, the UNODC estimated, 31 million were suffering from a harmful drug use disorder that required professional intervention. However, with the global limited availability and accessibility of services, only one in six persons misusing substances, received treatment, and were there only four countries that provided adequate coverage of services in terms of rehabilitation centres, clean needle clinics, and opioid substitution therapy.

As mentioned in Chapter 1, global substance abuse can be linked to the breakdown of communities and family structures. However, global substance abuse can also be linked to a vast and destructive impact on the health, political, and economic sectors of a country (Irwin et al., 2017; Sindelar & Fiellin, 2014). This is evident in the United States where the social costs of drug abuse reached

700 billion dollars in 2011 in direct and indirect damages (Caulkins, Kasunic & Lee, 2014). In 2015 substance abuse killed roughly 450 000 people worldwide and sent hundreds of thousands more to emergency rooms for treatment (United Nations Office on Drugs and Crime, 2018). Substance abuse further plagues the international health sector by contributing to the spread of contagious diseases through unhygienic needle sharing practices, and the allocation of money required to treat associated medical complications of drug abuse, such as HIV and AIDS, hepatitis B and C, as well as Tuberculosis. Substance abuse often goes hand in hand with crimes. Increased crime-related costs and incarceration could lead to a loss in productivity, thus increasing damages to the economy (Horn, Crandall, Forcehimes, French & Bogenschutz, 2017).

Apart from the economic impact, considerable societal and cultural issues arise with the detriment of the addict's mental and physical wellbeing and also because of the repercussions that disseminate into the families and communities drug addicts are a part of (Golestan, et al., 2010; Sindelar & Fiellin, 2014). For instance, substance abuse has massively contributed to child neglect and abuse cases, the degeneration of families, and social functioning within communities that has led to increased crime and a significant growth in the prison population (Horn et al., 2017; Caulkins et al., 2014).

In 2012 the UNODC regarded South Africa as the regional core for drug trafficking with one of the largest transit districts for illicit drugs (United Nations Office on Drugs and Crime, 2012). According to statistics of 2018, the national average for substance abuse and dependency in South Africa affects 13,3% of the population, whilst in the Western Cape, 18,5% of the population are affected (Elias, 2018). According to the South African Police Service statistics and compared to the national average, the Western Cape has alarmingly higher substance abuse rates than any other region in South Africa. The Western Cape also has the highest rates of Foetal Alcohol Spectrum Disorders and drug-related crimes. Substance abuse has furthermore also contributed to a rise in communicable diseases in a country where HIV and AIDS are rife (United Nations Office on Drugs and Crime, 2002). According to literature a third of all HIV and AIDS cases are recorded annually because of dangerous injecting practices and because individuals are more likely to engage in risky sexual behaviours whilst abusing substances (Western Cape Government, 2016).

These factors all contribute significantly to the burden of harm in South Africa where it is clear that substance abuse negatively affects not only the health and economic sectors, but also the societal and cultural sectors, as they have to deal with high rates in crime, violence, and poverty, a loss of productivity and employment, and the disintegration of families and communities (Republic of South Africa, 2013-2017; Pasche, Kleintjes, Wilson, Stein & Myers, 2014; Peltzer, Ramlagan, Johnson & Phaswana-Mafuya, 2010). It is evident that families and communities must not only deal with substance abuse; they must also face financial pressures, address debt, deal with theft, and carry the high cost of treatment, in this way, the emotional and psychological wellbeing of all parties involved are compromised. The combined tangible and intangible damage to the South African economy due to alcoholism alone has been estimated at a minimum annual cost of R37,9 billion (Matzopoulos, Truen, Bowman & Corrigall, 2014). It is thus evident that there is a need for an integrated continuum of care system in order to combat a substance abuse crisis in South Africa and specifically in the Western Cape.

Whether international or local, in an effort to combat substance abuse, social workers are usually appointed to treat patients along a continuum of care (Forrester & Harwin, 2006). Social workers are thus appointed to implement a variety of strategies from prevention and intervention, to aftercare and reintegration, in an attempt to mitigate the devastating effects of substance abuse on individuals, families, and communities (Sindelar & Fiellin, 2014; Golestan et al., 2010). However, internationally and locally there remains a gap in treatment which could be attributed to low motivation from service users to seek and maintain treatment, an overall lack of funding and availability of treatment options, as well as the institutional barriers (Smith, Hayes & Jordan, 2019; Buck, 2011; Myers, Louw & Pasche, 2010). Internationally there are on average 1,7 beds per 100 000 people available in formal treatment centres. In South Africa one in eighteen service users will receive formal treatment, and in the Western Cape where there is an estimation of 15 000 heroin users alone, approximately 3500 individuals can be assisted yearly (WHO, 2017; Central Drug Authority, 2016). Of those who enter into and who complete formal intervention treatment, relapse rates still remain high at 70% to 90% (Orbon et al., 2015; Gordon, 2003). Consequently, it is imperative that a country plagued by substance abuse such as South Africa, should have services along a continuum of care that are provided for and delivered by trained social workers in order to combat substance abuse as this would in turn reduce societal costs and damage inflicted on the various sectors of the country (Bhana, 2007).

In this chapter the various services along the continuum of care will be explored in order to understand why these services are necessary, how they should be implemented, and the actuality of the service user's experience. Specific focus will be allocated to aftercare services as this is an often-neglected area of concern along the continuum of care, due to the fact that the majority of funds, resources, and social work personnel are usually tasked with implementing prevention, intervention and community-based strategies.

2.3 PREVENTION SERVICES

Substance abuse has detrimental and devastating effects on individuals, families, and communities making prevention services essential in attempts to provide effectual means of deterrence (Medina-Mora, 2005). Prevention services are universally understood as a service or activity that provides knowledge and awareness of the nature and scope of substance abuse, as well as increases perceptions of risk in an attempt to diminish the health and social consequences accompanying substance abuse (State of Hawaii, 2019). It is essential that prevention programmes are implemented both before and after symptoms of a substance use disorder (SUD) emerge, especially given the recurring and relapsing nature of SUDs along with making the program as impactful and effective as possible.

Primary prevention services have been categorised into universal, selective, and indicated services which act in accordance with the level of risk a service user faces in terms of using and abusing substances (Ballester, Valero, Orte & Amer, 2018; Marshall, Ruth, Sisco, Bethke, Piper, Cohen & Bachman, 2011). The United States Institute of Medicine describes universal prevention programmes as programmes that address common protective and risk factors of whole communities or population groups in a specific setting (State of Hawaii, 2019; Marshall et al., 2011). Thus, selective programmes target subgroups of the community or population who are exposed to certain factors which place them at a significantly higher risk of developing SUDs. Lastly, indicated prevention services target high-risk individuals who have either commenced with substance use, are presenting with symptoms which are suggestive of SUDs, or those who have a biological predisposition for the disorder but do not currently meet the diagnostic criteria for it. Moreover, within all three categories the core of prevention services remains the same, to reduce the supply, demand, and harm of substances on individuals, families, and communities.

Internationally and nationally prevention services focus on reducing the demand, harm, and supply of substances (Republic of South Africa, 2008; Medina-Mora, 2005). Preventing and ultimately reducing the demand and supply of substances is based on the principle that by decreasing the availability of substances it creates the opportunity to minimise exposure, as well as to limit the opportunities for substance abuse and consequent dependence on a substance while promoting health and disease prevention. Social workers are tasked with assisting and attempting to reduce the demand and harm of substances on individuals, families, and communities (National Institute on Drug Abuse, 2018b).

Demand reduction comprises certain programmes that address certain risk factors which place individuals in vulnerable positions that could lead them to experiment with, use frequently, or become dependent on substances (Medina-Mora, 2005). Furthermore, demand reduction aims to establish and promote protective factors within individuals, their environments, and their communities in order to mitigate the possibility of future SUDs (Marshall et al., 2011).

Harm reduction focuses on the health and social consequences of substance abuse with a holistic treatment approach (Medina-Mora, 2005). In the United States harm reduction comprises making clean needle clinics available that ultimately assist in the reduction of health complications such as the spread of contagious diseases, as well as providing options such as substitution treatment (Irwin et al., 2017). In South Africa, the emphasis of harm reduction is on treating service users and families in a therapeutic setting in an attempt to reduce the social, psychological, and overall health impact of substance abuse (Republic of South Africa, 2008).

Prevention services rest on a scientific model that provides a platform for identifying needs and providing effective prevention strategies in order to diminish the probability of future drug abuse within communities (Bröning, Kumpfer, Kruse, Sack, Schaunig-Busch, Ruths, Moesgen, Pflug, Klein & Thomasius, 2012). Part of this process is identifying individuals who are at risk and who are the most vulnerable to initiate substance use and consequent misuse. As a result, children and adolescents have become the main focus of prevention interventions since they have been identified as being at a critical turning point for commencing with drug abuse (Marshall et al., 2011; Nation, Crusto, Wandersman, Kumpfer, Seybolt & Davino, 2003). Thus, social workers have been given the responsibility of implementing and attaining the prevention of drug abuse, in

order to promote healthy development amongst the youth and adolescents. However, this poses a great challenge for social work practice as adolescence involves a period of transition where several biological, social, cultural, and emotional changes occur leaving the youth in a vulnerable state where they are prone to risk-taking behaviour, poor judgement, and poor decision-making skills. Furthermore, children from substance-affected families have shown a dramatically elevated risk for developing a SUD in the future which further places them as the target group for prevention efforts.

Risk factors for adolescents engaging in substance abuse are analysed within a biopsychosocial domain as there are a variety of factors that influence their development and choices, such as community, peer groups, school, individual needs and most importantly, family structure (Bröning et al., 2012; Nation et al., 2003; Arthur & Blitz, 2000). Studies indicate that adolescents exposed to multiple risk factors have a higher occurrence and regularity of drug use and potential for future SUDs. However, protective factors are aimed at mitigating these risks and promoting healthy learning and social development of adolescents. The family structure has been identified as having the potential to be both a risk and protective factor for adolescents. Strong family cohesion, support, and communication have been identified as key protective factors in preventing delinquent behaviour in which substance abuse is a risk. As a result, the promotion of family empowerment and resilience amongst vulnerable families and adolescents have become vital in prevention initiatives.

The aforementioned is reflected in prevention services in South Africa as the focus of these initiatives has remained on preserving the family structure through providing holistic treatments with the objective of discouraging substance abuse (Lutchman, 2015). The need for prevention services amongst the youth remains high as statistics for Western Cape indicate that children and adolescents are engaging in drug abuse from an earlier age, with the average age of onset being 12 years old in 2005 (SANCA, 2017). There are also certain cultural practices in South Africa that are viewed as counteractive in prevention efforts because these practices allow adolescents to be exposed to alcohol with little adherence to age restrictions for the consumption of alcohol (Mpanza & Govender, 2017). Despite prevention services being crucial in combating substance abuse, resources, funds, and available personnel remains a core issue as the majority of personnel are

assigned to addressing intervention strategies and providing treatment for individuals already engaging in substance abuse.

2.4 INTERVENTION SERVICES

Despite prevention services being essential in attempts to reduce the demand and harm of substance use amongst individuals, families, and communities, intervention services remain critical in treating the estimated 5.6% of the global population suffering from SUDs (Smith, Hayes & Jordan, 2019; United Nations Office on Drugs and Crime, 2018). Intervention programmes, according to the UNODC, should aim towards increased pharmacotherapy and information provided to drug users in order to avoid overdoses. Intervention programmes should thus provide a continuity of care services founded on evidence-based practices, services that respect human rights, and should aim to remove the stigma associated with SUDs. Patients who remain in treatment together with prolonged active involvement in intervention services have shown improved rates of recovery and a willingness to engage in continued aftercare services to maintain their sobriety (Leslie, Milchak, Gastfriend, Herschman, Bixler, Velott & Meyer, 2015; Orbon et al., 2015). Thus, intervention services remain imperative in laying the foundation for patients' commitment to treatment programmes, positively contributing to their motivation, as well as contributing to their persistence during active recovery (Gordon, 2003).

Despite prevention services attempting to relieve substance abuse and avoid SUDs, internationally in countries like the United States as well as locally in South Africa, substance abuse remains high with no indication of deceleration (Horn et al., 2017; Fritz, 2014). Consequently, the need for effective and impactful intervention services remains imperative in combating substance abuse both internationally and locally. Intervention services take on a variety of forms from screening, brief interventions, and referral to treatment (SBIRT), to in and outpatient rehabilitation focusing on evidence-based approaches (Leslie et al., 2015; Cleaver, Nicholson, Tarr & Cleaver, 2005). Evidence-based approaches combine thoroughly researched interventions with practical experience and knowledge while considering the client's personal needs and culture to guide service delivery (Irwin et al., 2017; Social Work Policy Institute, 2010).

2.4.1 Screening, brief interventions, and referral to treatment

Screening, brief intervention, and referral to treatment (SBIRT), utilises an evidence-based approach to identify individuals at risk of developing SUDs, providing early intervention, referral services, and more specialised treatment (Horn et al., 2017; Irwin et al., 2017; Leslie et al., 2015). With SBIRT individuals are identified who present with risky levels of substance abuse in an attempt to reduce usage and risk-related behaviours, SBIRT also contributes to lessening the burden of harm and disease that is associated with substance misuse and abuse, and to facilitating access to care through referrals. In 2008 in the United States, approximately 19 million people needed alcohol abuse treatment yet only 8% were able to enter into formal rehabilitation treatment (Irwin et al., 2017). This gap in treatment led to the promotion of SBIRT in order to provide low cost early-intervention services to the population within a variety of settings outside of conventional substance abuse treatment centres.

The screening process assists in identifying persons with risky levels of substance abuse. The process can also assist in a formal diagnosis of a SUD whilst appropriate referrals are made (Leslie et al., 2015). Once screening has been conducted and a client has been identified within the low to moderate risk for developing or having a SUD, brief interventions can be implemented (Irwin et al., 2017). These brief interventions consist of a range of time-efficient and cost-effective services; from prescriptive to motivational interviewing where the goal is to decrease consumption of substances, as well as to elicit the need for change within the client. Referrals are essential in facilitating access to services in addition to establishing the appropriateness of intervention methods based on the client's needs. Referrals may lead a client to brief interventions or provide access to care that is more appropriate for serious substance dependence. In instances where the client requires aid outside the scope of brief interventions, referrals can be made to more formal and specialised services such as in- and outpatient rehabilitation.

2.4.2 In- and outpatient rehabilitation

Once clients have undergone a screening process which established that their needs surpassed the scope of brief interventions, they are often referred for more specialised treatment at outpatient rehabilitation facilities (Leslie et al., 2015). Rehabilitation centres and treatment programmes assist patients in overcoming their physiological and psychological dependence on substances with

the ultimate goal of being able to lead a substance-free life (Orbon et al., 2015; Sindelar & Fiellin, 2014). Treatment facilities strive towards this goal through providing support, counselling, and education where coping mechanisms, lifestyle changes, basic life skills, principles, and awareness are taught to empower recovering addicts. Inpatient rehabilitation centres are residential treatment programmes where clients reside within a controlled environment that provides medical and emotional support from a multidisciplinary team (Addiction Centre, 2019). Outpatient programmes provide treatment sessions that are scheduled with clients throughout the week with specific focus on counselling, education, establishing a network of support, and in some instances, pharmacotherapy.

Inpatient treatment has been associated with better outcomes, especially for those struggling with severe SUDs. This could be because of around the clock emotional and medical support, and because there are limited distractions so focus can be directed towards recovery (Addiction Centre, 2019). However, inpatient rehabilitation is disruptive to the recovering addict's personal and work environment as inpatient treatment on average lasts 30 days. Thus inpatient treatment is not considered to be feasible to the majority of addicts requiring intervention, as it comprises of a strict admissions process with extremely limited availability, as well as a high relapse rate. Outpatient treatment programmes are ideal for those with mild SUDs, it is more cost effective with further accessible services, and allows for normal daily routines to be maintained. However, recovery rates in outpatient programmes are considerably lower than inpatient rehabilitation centres with both retention and effectiveness being two significant areas of concern (Sindelar & Fiellin, 2014). Statistics demonstrate that recovery rates from both in- and outpatient facilities remain as low as 20% to 30% or even less, as illustrated in a study done in China where the relapse rate for 170 000 addicts undergoing treatment was 90% (Orbon et al., 2015).

2.4.3 Barriers to intervention services and the role of social workers

Barriers to intervention services range from psychosocial, practicality, suitability of the services delivered, and the suitability of service providers (Cumming, Troeung, Young, Kelty & Preen, 2016). Psychosocial barriers present themselves when clients have been referred to treatment but feel they are in control of their addiction and deem treatment unnecessary, or when clients generally avoid treatment due to a variety of causes, be it low motivation, fear of stigma, or denial

(Sindelar & Fiellin, 2014). Practical barriers can be attributed to a lack of funding and a resultant lack of available services and facilities, strict admissions processes, and unequal access to services based on gender as some facilities do not accommodate women. Suitability of services can range from a lack of confidence of the service user in the treatment programme, an absence of pharmacotherapy, and the refusal of the service user to accept treatment where polysubstance abuse is treated due to associated stigma. Lastly, concerning the suitability of service providers, certain institutions require service users' behaviours to be stabilised prior to admission to treatment, such as comorbidity that could pose potential barriers to access. Another service provider barrier is a shortage of qualified, trained, and competent social workers in the field of addiction, where many who have no formal training would apply an ad hoc approach to treatment (Horn et al., 2017; Orbon et al., 2015; Golestan et al., 2010).

In South Africa, intervention services for recovering adult addicts remain exceptionally limited, even more so for those in disadvantaged communities (Myers, Petersen, Kader & Parry, 2012; Myers, Fakier & Louw, 2009). This could be attributed to practical barriers such as financial restraints, poor geographic location, a severe lack of state-funded facilities, and limited access for women (Pasche et al., 2014). Furthermore, referrals in South Africa act as the entryway to treatment for recovering addicts, however, referrals require home addresses which place the homeless and those living in poverty with no formal address at a disadvantage, as they would be unable to access treatment (Horn et al., 2017; Orbon et al., 2015). The majority of treatment options and inpatient facilities for recovering addicts are private institutions with exorbitant fees. As a result, most of the population suffering from SUDs rely on state-funded and established treatment centres of which there are only a few available (Isobell, Kamaloodien & Savahl, 2018; Myers et al., 2010), for example, the De Novo Rehabilitation Centre in Kraaifontein is the only free state-subsidised inpatient treatment centre in the Western Cape, that can accommodate up to 80 adults at a given time. However, this centre has a waiting period of up to six months (Lutchman, 2015) which poses a challenge for those in desperate need of intervention as the majority of addicts lose motivation and return or continue with their previous drug using and abusing habits.

Structural barriers that diminish the quality of intervention services for recovering addicts are the use of untrained social workers who implement practices with limited evidence-based approaches whilst not being evaluated or monitored by the state (Myers et al., 2009; Pasche et al., 2014). Social

workers in South Africa receive limited training in the field of addiction and the relevant treatment of SUDs, however due to facilities and organisations that are always understaffed, inexperienced and poorly trained social workers are often relied upon to deliver services to people with SUDs.

From the aforementioned discussion, it is evident that there is a need for intervention services in providing treatment to 5.6% of the population that suffer from SUDs (United Nations Office on Drugs and Crime, 2018). These intervention services act as the foundation of support, education, and motivation for recovering addicts to seek sober habits and maintain their recovery through newly learnt skills and lifestyle principles (Orbon et al., 2015; Buck, 2011; Bijttebier, Goethals & Ansoms, 2006). Effective intervention services can empower and motivate recovering addicts to continue and maintain their recovery, these intervention services can also provide recovering addicts with the knowledge and skills of what to do when entering the new phase of treatment, namely aftercare services (Cleaver et al., 2005). However, it is evident that intervention services are plagued by a variety of biopsychosocial barriers on an international and local level that hinders active addicts attempting to receive treatment, causing higher relapse rates and a reluctance to utilise aftercare services (Gordon, 2003; Cumming et al., 2016; Horn et al., 2017).

2.4.4 Aftercare services

Social workers and mental health practitioners have focused their efforts on addressing addiction services along a continuum of care with specific focus on prevention and intervention. (Jason, Davis & Ferrari, 2007; Lash, Burden, Monteleone & Lehmann, 2004). However, despite maintaining that recovery and sobriety are both core issues in treating substance abuse, aftercare services have been a continually neglected field with minimal focus or resource allocation, especially in South Africa (Isobell et al., 2018; Orbon et al., 2015; Bhana, 2007). In South Africa, less than 30% of all inpatient service users request, utilise, or are referred to aftercare services upon completion of their programme despite it being crucial to maintain their recovery. Aftercare services remain almost non-existent in Cape Town's poorer communities and demand remains low due to a lack of access, availability, and knowledge about such services (Myers et al., 2010; Myers et al., 2009). Lastly, the lack of aftercare services and follow up with patients during the critical post-treatment period dramatically increases chances of lapses and relapse amongst recovering

adult addicts. This in turn places further strain on treatment centres as they enter the incessant cycle of relapse and re-entry into treatment.

Maintaining recovery after intensive intervention treatment remains one of the principal issues in treating SUDs on a global scale (Orbon et al., 2015; Lash et al., 2004). Numerous studies have indicated that only 20% to 30% of all those who receive treatment for SUDs are able to recover and maintain their sobriety. More specifically, an average of 80% of recovering adult addicts lapse and relapse, with studies in the United States demonstrating a 70% to 90% relapse rate following treatment at inpatient rehabilitation centres (Gordon, 2003). Relapse is when a person returns to addictive patterns of behaviour, thoughts, and chronic use of substances, whilst a lapse is a single episode of substance use after a period of abstinence (Hitzeroth & Kramer, 2010). High relapse rates not only contribute to increased substance abuse, but also increase the burden of harm on families, communities, and society. For example, a study done in Asia found that relapse rates were directly associated with increased drug-related violent crimes, depression, suicides, premature deaths and the disintegration of family structures. In South Africa, relapse rates remain as high as 70%, of which a third had already been treated for substance abuse (Ederies, 2017; Peltzer et al., 2010). Factors contributing to relapse rates in the Western Cape are predominantly linked to poverty, unemployment, communities riddled with both licit and illicit substances, and a lack of access to and availability of aftercare services.

Continued treatment and rehabilitation into aftercare services is strongly associated with improved abstinence rates and active involvement in recovery (Orbon et al., 2015; Lash et al., 2004; Gordon, 2003). Studies conducted in the USA and Asia found that almost 60% of recovering addicts attending aftercare services on a weekly basis for over a year reported improved rates of sobriety. These patients were able to abstain from substance use throughout the year whilst experiencing increased motivation and less stress within their personal lives. Aftercare services focus on empowering recovering addicts in order to increase their recovery potential and avoid re-entry into treatment (Van der Westhuizen, Alpaslan & De Jager, 2013). This is achieved through establishing support networks, providing counselling and guidance, monitoring of sober habits, as well as identifying and addressing negative patterns of behaviour or thoughts that could lead to a lapse and ultimately, relapse (Doweiko, 2009).

Despite efforts to avoid relapse amongst recovering addicts, SUDs are known to be relapsing in nature and those not actively involved in self-monitoring through a variety of aftercare services, are especially vulnerable (Gordon, 2003; Doweiko, 2009). This is why aftercare services account for the fact that lapses amongst certain recovering addicts may be intrinsic to their recovery process. Thus, it is essential that aftercare services provide the opportunity for recovering addicts to remove the stigma associated with lapses and relapses. Furthermore, aftercare services should assist recovering addicts to learn their vulnerabilities and to address them, as well as to provide support and a controlled environment that is needed in order to address a lapse or relapse, should it occur.

Aftercare services need to be rendered in a manner that suits the personal needs and development of the recovering addict (Gordon, 2003). As a result, recovering addicts should be guided by social workers in terms of which services are available to meet their personal needs, whether it is counselling, support groups, religious congregations, the knowledge of clean needle clinics, and in some instances, pharmacotherapy (Doweiko, 2009). Despite the majority of institutions and social workers that treat aftercare as an optional appendage to addiction treatment, aftercare is fundamental in assisting recovering addicts to maintain their sobriety throughout their lifetime (Orbon et al., 2015). This is achieved through empowerment, frequent monitoring, guidance, motivation, and support. A key element in recovery that aftercare services advocate towards, is creating social support networks that promote sober lifestyles and principles. These could then be used to amplify motivation and to create an open and supportive environment for recovering addicts (Jason et al., 2007). This therapeutic and supportive space allows recovering addicts to develop self-efficacy and implement it within their personal capacities and environments where high-risk situations and triggers may threaten their recovery.

2.4.5 Individual or group counselling and support groups

Individual or group counselling, as well as support groups, have been linked to improved rates of sobriety amongst recovering addicts, especially if attended regularly on a long-term basis (Orbon et al., 2015). Regular counselling sessions with a social worker establishes a trusting professional relationship in which consistent monitoring of the clients can be established to assist them in sharing concerns, triumphs, and their vulnerability to relapse (Gordon, 2003). This therapeutic

environment can assist the recovering addict in identifying personal triggers and early warning signs of relapse whilst engaging with strategies and techniques in managing them. Furthermore, counselling also establishes a therapeutic environment where recovering addicts are afforded the opportunity to confront personal distresses that have contributed to, or supported their substance use, and remain a threat to their recovery (Doweiko, 2009). New behaviours, coping strategies, lifestyle principles and open communication are addressed throughout the counselling sessions in attempts to stabilise the recovering addicts' ability to function, and encourage them to remain actively involved in aftercare services.

The most common support groups are church-based initiatives or Narcotics and Alcoholics Anonymous that follow a 12-step programme (Ederies, 2017). Globally, the purpose of these support groups remains the same, namely that they provide a safe, non-judgmental, and substance-free environment to recovering addicts. These support groups assist in teaching socialisation skills, reintegration into communities, building positive relationships, as well as establishing support networks with other recovering addicts (Western Cape Government, 2016). Additionally, support groups are relatively simple to establish and to maintain on a community level by social work professionals, non-governmental organisations, or by individuals affected by substance abuse.

One of the key issues in maintaining recovery and staying actively involved in aftercare services for recovering addicts is their motivation (Orbon et al., 2015). This is where support groups assist, as they maintain and encourage motivation amongst their members with reference to the core principle of the 12-step programme, whereby surrendering oneself to the process and accepting that there is a need to recover and receive assistance. One of the benefits of Narcotics and Alcoholics Anonymous is that all members are recovering from a SUD whilst the majority of the facilitators are peers that have found success in working with the 12-step programme (Smith, Hayes & Jordan, 2019; Western Cape Government, 2016). This method assists in achieving a sense of normality within the groups and allows other recovering addicts who have maintained their sobriety, to act as positive role models and as motivation when assisting addicts that are at the start to middle stages of their recovery. Furthermore, Narcotics and Alcoholics Anonymous has groups in up to 130 countries where meetings are open to the public with no membership fees; making it the most prevalent and economical aftercare service worldwide.

2.4.6 Needle and syringe programmes

When analysing addiction and the harm incurred from substance abuse, one of the major health risks is unsanitary needle sharing practices. Baltimore City in the United States, for example, has one of the highest overdose death rates relating to injecting practices (Irwin et al., 2017). Furthermore, 18% of those injecting narcotics are HIV positive, as well as one out five suffering from skin disease and infection. South Africa faces similar issues, with one third of all AIDS cases reported yearly that can directly be associated with unsafe injecting practices (Western Cape Government, 2016). A solution to this issue is the establishment of clean needle clinics, otherwise known as needle and syringe programmes (Avert, n.d.).

Needle and syringe programmes (NSPs) are considered a harm reduction initiative within aftercare services that provides clean needles and syringes to those who inject drugs, with the aim of reducing the transmission of blood-borne viruses like HIV and Hepatitus B and C (Irwin et al., 2017; Avert, n.d.). NSPs falls under the Cognitive-Social Learning Approach to relapse prevention, in which addiction is understood as a learnt habit and those in recovery wish to maintain a behaviour change (Ellis, Stein, Thomas & Meintjies, 2012). This behaviour change comprises of either complete abstinence or moderate use of substances in which social workers delivering aftercare services need to accommodate both approaches. NSPs are designed with the purpose of advising active drug users on safe injecting practices, how to avoid overdosing, safe discarding, and management of injecting apparatus, as well as screening and treatment of communicable diseases. Moreover, NSPs are able to motivate drug users towards safer drug use practices, total abstinence, and referrals to further drug treatment like pharmacotherapy.

2.4.7 Pharmacotherapy

Traditionally, relapse prevention efforts within aftercare services have focused solely on counselling and psychotherapy whilst the clinical aspect of addiction has been largely overlooked (Buck, 2011). Pharmacotherapy provides a solution to this issue in directly and effectively addressing the clinical dimension of addiction by strongly focusing on opioid substitution therapy (Buck, 2011; Matzopoulos et al., 2014). Opioid addictions, such as heroin use disorders, account for up to 70% of the global burden of drug-related harm and disease (Matzopoulos et al., 2014).

This can be attributed to dangerous and unhygienic injecting practices which contributes to the spread of communicable diseases (Bijttebier et al., 2006; Matzopoulos et al., 2014).

Opioid addictions are of particular concern in South Africa. Heroin, for instance, is readily available and is a plague to communities that are already under resourced with a fraught healthcare system (Matzopoulos et al., 2014). With Opioid substitution therapies the extreme withdrawal symptoms are relieved, cravings are reduced, and the effects of heroin and other opioids through receptor coverage, are blocked (Reuter & Stevens, 2015). Methadone is one of the more common pharmacotherapies utilised in treating opioid addiction and is either used for detoxification purposes or as a maintenance regime (Bijttebier et al., 2006). Methadone is highly regulated and administered under the supervision of a clinic, it has limited side effects whilst being considered one of the safest and most effective means of treating opioid addiction.

The use of pharmacotherapies has shown direct links to decreased opioid use and needle sharing, improved retention in treatment programmes, and vast improvements in drug-related burden of harm and disease (Reuter & Stevens, 2015). Methadone maintenance and other appropriate pharmacotherapies assist those suffering from an opioid addiction to focus on their treatment and recovery, whilst affording them the opportunity of a stable life (Bijttebier et al., 2006).

2.4.8 Barriers to aftercare treatment and the role of social workers

Despite the aforementioned aftercare services having proven prolonged benefits in assisting recovery, especially when utilised conjointly, there are numerous barriers to treatment which render them inaccessible, unavailable, and ineffective to populations in need. Globally, aftercare services are a neglected field in addiction care where the majority of resources, funding, and social work personnel are allocated to prevention and intervention services (Brown, Seraganian, Tremblay & Annis, 2002). Aftercare services are for instance not deemed a critical step in recovery treatment but rather promoted as an optional accessory to those having received intervention services. Within South Africa, less than 30% of all patients completing a formal intervention programme at an inpatient facility will be referred to, be made aware of, or request aftercare services (Bhana, 2007). Moreover, the general trend in South Africa is indicating that less people are utilising formal intervention services and even less so, aftercare services. This is a potential indication and reflection of the barriers to treatment experienced by recovering addicts when

attempting to utilise treatment services. The barriers to treatment along the continuum of care and specifically within aftercare, can be classified as structural, systemic, and attitudinal barriers (Cumming et al., 2016).

2.4.8.1 Structural barriers

Structural barriers within this study are understood to be barriers that impede a person's ability to access or utilise services such as geographic location, affordability, availability, and community health (Manitoba, n.d.). The geographical location of services remains a substantial barrier to aftercare treatment (Sindelar & Fiellin, 2014). The majority of services, both international and local, are located closer to city centres, resulting in those living in distant communities to be unable to access or benefit from them (Myers, Pasche & Adam, 2010). In the Western Cape, aftercare treatment, like individual or group counselling, remains substantially geographically inaccessible to disadvantaged communities, as majority of services are rendered within the city, which makes for lengthy and unaffordable commutes (Lutchman, 2015).

Individuals who are able to geographically access services, face extensive and competitive admissions processes, as well as limited affordable services (Sindelar & Fiellin, 2014). The Western Cape's addiction services are severely limited and even more so for state funded facilities (Myers et al., 2010). These limitations result in long waiting lists and admission processes wherein clients are required meet a certain criterion in order to gain entry to treatment (Lutchman, 2015). Regarding affordability of services, those unable to meet the expenses of private institutions, are forced to rely solely on state-funded services and facilities (Matzopoulos et al., 2014; Isobell, 2013). Despite pharmacotherapy making essential contributions to the recovery of clients with opioid addictions, this service remains inaccessible and unaffordable to the majority of the South African population (Matzopoulos et al., 2014).

In South Africa methadone maintenance is up to 30 times more expensive than what it would cos on average in the US and Ukraine, making methadone maintenance unattainable for those in need (Matzopoulos et al., 2014). For those able to utilise aftercare services, the structural barriers in communities remain problematic to their recovery (Ederies, 2017; Lutchman, 2015). This is evident as many disadvantaged communities in the Western Cape cite a flourishing drug trade with extreme substance abuse that hinders the recovery process. Apart from addressing individual needs

and concerns, aftercare services need to go further by way of collaboration and coordination efforts to address community needs in decreasing the supply and demand of substances in order to combat substance abuse as a whole.

2.4.8.2 Systemic barriers

Systemic barriers are programmes and policies that discriminate against, or result in certain individuals being unable to receive, access, or participate in aftercare services (Manitoba, n.d.). Globally, there is a minimal allocation of funding and resources for maintaining and establishing aftercare services (Forrester & Harwin, 2006). This may be attributed to the general negative perceptions of illicit drug users, or to uncertainty regarding the effectiveness of such programmes. However, these systemic barriers infringe on the rights and abilities of recovering addicts to access and participate in much needed maintenance services (Lutchman, 2015).

In South Africa, aftercare services are paid marginal attention, and those that are able to access these scarce services, are unlikely to receive treatment or support on an ongoing basis (Myers et al., 2010). Aftercare services in the Western Cape are insufficient and the majority of these services only attend to individual needs, while ignoring how communities suffer with thriving drug trades, violence, and severe substance abuse (Ederies, 2017). The aftercare services that are available, are not always funded or maintained by the state, this then often results in recovering addicts being left without the treatment they need in order to recover. Another issue is that people often have negative perceptions about aftercare establishments which could result in these establishments not being allowed to operate. This is illustrated in Durban where the establishment of a much-needed clean needle exchange programme was closed in 2018, claiming that needle exchange programmes posed a risk to the public if used needles were not handed in, or disposed of correctly (Herrmannsen, 2016). However, in this instance, up to 70% of the needles exchanged were in fact returned to the organisation; whilst the South African Medical Journal in 2012 showed no evidence of almost 5000 needles being returned in a diabetic patient program. This demonstrates how the negative perceptions of recovering addicts infringes on their rights and ability to access aftercare services (Forrester & Harwin, 2006).

In South Africa, a recovering addict would need referrals to be able to access aftercare services. This is a way of collecting information, but also to act as a systemic barrier (Myers et al., 2010).

A strict admissions criteria inevitably causes certain individuals to be excluded from receiving or participating in aftercare services. This is particularly true for people suffering from comorbid conditions as they are required to seek psychiatric intervention and be stabilised before being allowed to enter aftercare services for treatment. Lastly, access to aftercare for the homeless and those living in poverty remains an issue in the Western Cape as residential addresses are required before referrals to appropriate treatment can be made.

In this scenario, social workers contribute to the systemic barriers experienced by service users as they are often the leading providers of addiction services, including referrals and aftercare (Forrester & Harwin, 2006). Social workers in South Africa are furthermore inadequately trained to treat SUDs, many social workers are even unfamiliar with aftercare services such as the 12-step programme implemented in Narcotics or Alcoholics Anonymous groups (Orbon et al., 2015; Golestan et al., 2010). Likewise, social workers are plagued by high caseloads with exceptionally limited time to deliver in-depth and impactful aftercare services (Myers et al., 2009). As a result, follow-up consultations are often delivered telephonically as they are less time and resource intensive (Isobell et al., 2018). However, this method may be inappropriate for effective follow-up procedures as non-verbal signs of recovery and relapse cannot be assessed and addressed over the telephone.

2.4.8.3 Attitudinal barriers and the role of social workers

Attitudinal barriers comprise of poor perceptions, a lack of appropriate knowledge regarding aftercare services, and a limited belief in the programme benefits and competency of healthcare providers (Avert, n.d.). One of the core attitudinal barriers towards aftercare treatment is the associated stigma and personal attitudes of recovering addicts (Cumming et al., 2016). Stigma towards aftercare involves being personally embarrassed regarding addiction, the fear of being labelled or regarded as ‘mentally ill’, and concerns regarding the confidentiality and privacy of utilising such services. The stigma, fear, and embarrassment that recovering addicts place on receiving treatment and continuing for the sake of their recovery is often a major factor in those that refuse to attend or that stop attending aftercare services (Orbon et al., 2015). This stigma is further perpetuated by the media and public who lack knowledge and understanding of addiction

and who encourage a negative perception and attitude towards active or recovering addicts (Doweiko, 2009).

Apart from the associated stigma, there is generally a poor outlook on the effectiveness and quality of service programmes and health care workers that provide aftercare services (Forrester & Harwin, 2006). Factors that contribute to this disbelief is the lack of training that social workers undergo and a meagre understanding of addiction in general (Cumming et al., 2016). Moreover, inadequate referrals following intervention services, interfere with the availability of knowledge provided to recovering addicts in terms of what their options are for further treatment and support. A lack of monitoring and evaluation of service providers' performances and running of aftercare programmes contributes to poor quality service rendering and fewer recovering addicts seeking to continue their recovery process (Myers et al., 2012). This is evident in Cape Town where the utilisation of both intervention and aftercare services has declined amongst recovering addicts, from 3058 slots being utilised out of an available 3500 in 2007, to less than 2600 slots being utilised in 2009 (Myers et al., 2010).

A contributing factor to attitudinal barriers and poor perceptions towards services amongst recovering addicts in South Africa, is the lack of cultural competency amongst organisations and social workers (Mpanza & Govender, 2017). Cultural competency is critical in a diverse country like South Africa as substance use often interplays with traditional cultural practices, and the recovery must also be culturally sensitive and appropriate to those utilising it. Cultural competency requires social workers to value diversity, to respect the various cultures that exist, and to know how this diversity affects personal experience and behaviours within recovery and treatment (Campbell, 2017). However, culture in itself has proven difficult in treating substance abuse as there are certain examples of cultural practices in South Africa where alcohol serves several purposes with almost no adherence to age restrictions, and no monitoring of home-brewed or grown substances.

Consequently, it is imperative in South Africa, a country plagued by substance abuse, that services along a continuum of care are provided for, in order to combat substance abuse. This in turn reduces societal costs and damages inflicted on the various sectors of the country (Forrester & Harwin, 2006). Increased personnel training, allocation of funds, and development of resources

must be administered to aftercare services in order to assist recovering addicts in maintaining their recovery for improved long-term results.

In attempts to address substance abuse, the South African government implemented specific legislation to target the reduction in harm, supply, and demand of illicit substances (Republic of South Africa, 2008). This legislation was developed with the vision of striving towards a drug-free South Africa. The legislation falls under Act 70 of 2008, the Prevention of and Treatment for Substance Abuse, as well as the National Drug Master Plan of 2006-2011 and 2013-2017. The next section will focus on analysing and investigating whether the stipulated South African legislation accounts and provides for the availability and accessibility of aftercare services for recovering adult addicts (Isobell, Kamaloodien & Savehl, 2018).

2.5 SOUTH AFRICAN LEGISLATION ATTENDING TO ADDICTION SERVICES

Worldwide substance abuse has rapidly increased; especially in South Africa (Republic of South Africa, 2007). It is one of the leading contributors to increased crime, violence, unemployment, decreased productivity, political instability, premature death, the spread of communicable diseases, and dysfunctional community and family interactions. As a result, the South African government aimed to address and combat substance abuse through establishing legislation that provides for a wide range of services and programmes along a continuum of care that are made available to South African citizens (Republic of South Africa, 2008). The purpose of these services has been to strive towards a drug-free South Africa where resources and focus could shift to address the needs of the poor and alleviate poverty within the country. This legislation is geared towards the reduction in harm, supply, and demand of substances in South Africa, while also creating a uniform law addressing substance abuse, the harm associated with substance abuse, and relevant services. The legislation that this study focused on is Act 70 of 2008, the Prevention of and Treatment for Substance Abuse as well as the National Drug Master Plan.

Despite the South African government's efforts to develop and establish legislative frameworks to combat substance abuse, there are several key issues that obstruct their implementation, monitoring, access, and availability to the public. One of the frequent legislative issues that arise is the lack of accurate and current statistics on substance abuse in terms of supply, demand, and harm (Republic of South Africa, 2008). This creates difficulties in understanding the present-day

substance abuse trends and where resource allocation should be focused (Republic of South Africa, 2013-2017). Furthermore, there are inadequate platforms and opportunities for policy makers, civil society, and government officials to share information, developments, as well as valuable experiences within the field of substance abuse. This further impacts the effectiveness and efficiency of current legislation and available services as they may be inappropriate in relation to the needs of individuals, families, and communities that suffer from substance abuse.

Likewise, there is a severe lack of available resources allocated to substance abuse together with an inadequate capacity to address it (Republic of South Africa, 2013-2017). These key issues are worsened by the current legislative frameworks that are outdated, poorly managed, not being implemented and not being monitored. When the above issues are coupled with the fact that addiction is also not adequately treated throughout the continuum of care then the situation looks dire. It is necessary to comprehend the legislative frameworks currently in place in order to understand the rights that recovering adult addicts have in terms of availability and accessibility to aftercare services. In addition, this knowledge can be utilised with the aim of improving current legislature and services to adequately address addiction in South Africa.

2.5.1 The Prevention of and Treatment for Substance Abuse, Act 70 of 2008

The Prevention of and Treatment for Substance Abuse Act 70 of 2008 is the legislative framework developed by the South African government to address and combat substance abuse. Act 70 of 2008 stipulates that the South African government needs to implement mechanisms and programmes directed at reducing the supply, demand, and harm of substances in the country (Republic of South Africa, 2008). This entails establishing and maintaining a variety of services, from prevention, to early intervention, to formal treatment and aftercare that is accessible to those in need. The Act further calls for the establishment and registration of inpatient treatment centres and halfway houses to be available for citizens in need of treatment and rehabilitation, as well as to provide the opportunity for people with SODs to continue their recovery and skills development. The Act also called for the creation of the Central Drug Authority (CDA) in order to monitor treatment facilities and services rendered to recovering addicts and to act as a support structure to communities, in addition to implementing the National Drug Master Plan.

In terms of aftercare and reintegration services, the Prevention of and Treatment for Substance Abuse Act states that the purpose of these services must aim to successfully reintegrate recovering addicts into their societies, workplaces, communities, and families after completing formal treatment. The services rendered in aftercare must allow recovering addicts to become equipped with knowledge and skills to maintain their sobriety and treatment gains (Republic of South Africa, 2008). Aftercare services must also provide a platform in which recovering addicts are linked to further services and resources in order to maintain their sobriety and develop their wellbeing. Furthermore, the Act stipulates that the state must establish support groups that are accessible and available to all recovering addicts. These support groups need to be structured and delivered in a manner in which the recovering addict can develop self-reliance and can strive towards optimal social functioning and wellbeing. Support groups should furthermore afford recovering addicts the opportunity to interact with other service users, families, and communities and so be given the opportunity to share their sobriety experiences. The aim being that this would create a therapeutic and motivational environment in which their recovery can be maintained and supported. Aftercare services should theoretically deliver structured programmes that promote sobriety and group cohesion amongst recovering addicts, with the intent of preventing relapse. According to the Act the support groups can be created at a community level by a professional such as a social worker, a non-governmental organisation, or by persons affected by substance abuse.

In order for the aforementioned services and aftercare programmes to be implemented the South African government established the Central Drug Authority (CDA) (Republic of South Africa, 2008). The CDA is the advisory body of the Prevention of and Treatment for Substance Abuse Act and has been authorised to assist and provide support in combating substance abuse in South Africa. As a result, the CDA was tasked to develop the National Drug Master Plan of 2006-2011 and 2013-2017 (NDMP) in accordance with Act 70 of 2008. The CDA is responsible for directing, guiding, monitoring, and ensuring the implementation of the NDMP. The CDA is also required to assess and evaluate the successes and failures of the NDMP in order to make applicable amendments to promote the plan's success. It is the CDA's responsibility to review and produce a new NDMP every five years in order to ensure that services and implementation are tackling substance abuse as effectively and efficiently as possible. Furthermore, the CDA is mandated with coordinating the efforts of all governmental departments to collaborate in order to combat substance abuse at both national and provincial levels.

2.5.2 The National Drug Master Plan 2006-2011 and 2013-2017

Each of the National Drug Master Plans (NDMP) of 2006-2011 and 2013-2017 was devised by the CDA in light of the stipulations of the Prevention of and Treatment for Substance Abuse Act and to meet international requirements. The purpose of the NDMP is to coordinate efforts of various government departments in order to reduce the demand and supply of substances within South Africa as well as to reduce the harm associated with substance abuse (Republic of South Africa, 2013-2017). The NDMP's mission is to strive towards a drug-free South Africa where efforts and resources can be shifted to other areas of need within the country (Republic of South Africa, 2008). Furthermore, the NDMP is required to address the specific needs of South African communities that are plagued by substance abuse, through establishing and maintaining cost-effective interventions that empower vulnerable groups.

The NDMP is responsible to take the necessary steps to improve treatment for both active and recovering addicts through providing improved evidence-based service delivery, commissioning relevant research, and to provide a monitoring and evaluating framework of such services (Republic of South Africa, 2013-2017). The NDMP further sets out the requirements and tasks that each government department is responsible for on a national, regional, and provincial level in order to combat substance abuse as an integrated system. The CDA is required to oversee, direct, and evaluate the NDMP in order for appropriate amendments to be made whilst supplying annual feedback reports in September to the Minister of Social Development which feedback is then transferred to Parliament.

2.5.3 The National Drug Master Plan 2006-2011

In theory, the NDMP successfully contributed towards the combat of substance abuse in South Africa, however, the reality that local communities and citizens faced prove otherwise. The NDMP of 2006-2011 had several key weak areas that required attention and immediate changes. The changes that were necessary for the success of the NDMP was that the NDMP had to make a shift from a national approach to community-based approach in which the specific needs of communities were addressed (Republic of South Africa, 2006-2011). The CDA also identified the need for developing and implementing evidence-based practices in treating addiction in addition to having a monitoring and evaluating framework for such services. Lastly, the CDA indicated the

need for increased research in order to develop and predict community needs and changes in the field of addiction, together with governmental departments collaborating to address substance abuse.

The NDMP of 2006-2011 shed light on the severity of substance abuse in South Africa when the social and economic costs for the country in 2006 was 101 million rand (Republic of South Africa, 2006-2011). The NDMP further illustrated that the national approach was failing to reach the communities in need as only 58 per cent of respondents interviewed admitted that they were having a substance abuse issue, 65 per cent reported having family members abusing substances, together with as little as 40 per cent being aware of available intervention and aftercare services. These areas of concern in the 2006-2011 NDMP were said to be addressed by the CDA within the 2013-2017 amended version.

2.5.4 The National Drug Master Plan 2013-2017

The NDMP 2013-2017 approach had new specific outcomes such as aiming to reduce the biopsychosocial impact of substance abuse whilst providing South Africans with the ability and skillsets to deal with substance abuse issues in their communities (Republic of South Africa, 2013-2017). The approach allowed for the creation of recreational and diversion programmes to prevent vulnerable groups from abusing substances. The approach also allows for the development of multi-disciplinary approach with evidence-based practices to diagnose, treat, and maintain substance dependency whilst increasing funding for such services. However, despite these amendments to the NDMP, the CDA's annual feedback reports showed further failures in combating substance abuse, such as not being able to provide for individuals, families, and communities in need, and not implementing the required services stipulated in the Prevention of and Treatment of Substance Abuse Act (70 of 2008).

The main challenges that the CDA noted, was a continued lack of national data on substance abuse which was hindering evidence-based practices from being developed and implemented in treatment programmes (Republic of South Africa, 2013-2017; Central Drug Authority, 2016). Furthermore, illegal and unregistered treatment centres continue to thrive throughout South Africa, placing those in need of care in a vulnerable position for abuse and neglect. In terms of governmental departments, there was also poor collaboration and a general lack of support for the

local drug action committees combined with inadequate and insufficient reporting from the stakeholders.

These issues culminated and resulted in recovering adult addicts being unable to adequately access treatment services along the continuum of care, especially as part of aftercare services, as less than 1 in 18 persons received treatment (Central Drug Authority, 2016). The core reason for the failure of the 2013-2017 NDMP was the overall lack of resources and funding for its implementation and the fact that many South African governmental departments were largely absent in executing their roles (Republic of South Africa, 2013-2017). Thus the lack of funding and resources hampered treatment centres and programmes from being established and implemented, and also obstructed the Department of Social Development in employing enough social workers to sufficiently provide treatment to recovering addicts. This in itself has had devastating effects on communities where social workers could have assisted in reducing and alleviating the impact of social ills and problems related to substance abuse, whilst providing the necessary support to recovering addicts (Central Drug Authority, 2019).

In the light of the above it is of great concern that the Committee of the CDA continues with meetings to discuss and reform the NDMP, while not submitting any annual reports (Central Drug Authority, 2019). A lack of action and leadership in the CDA is demonstrated by the fact that the CDA Committee only addressed and discussed the CDA-annual report of 2017 in March 2019, that, to this date, no amendments had been made to the 2013-2017 NDMP, and that no revised version of the NDMP implemented in 2019 has, as yet, been provided. In terms of the governmental departments, the continued lack of implementation, communication, and reporting has resulted in the Committee neglecting its constitutional obligations and being in direct breach of the Prevention of and Treatment for Substance Abuse Act whilst also infringing on the constitutional rights of active and recovering addicts (Central Drug Authority, 2016).

2.6 CONCLUSION

From the discussions in this chapter it is clear that globally, aftercare is a largely neglected field as most of the focus is placed on prevention and intervention services (Irwin et al., 2017; Lutchman, 2015). Recovering adult addicts in South Africa lack available and accessible options for aftercare treatment and support necessary to maintain their sobriety and for them to remain

actively motivated in their recovery. Most of the services are also either unaffordable or geographically inaccessible to majority of the population that suffer from addiction (Pasche et al., 2014). Furthermore, communities under siege from substance abuse are not receiving the assistance they need to move towards a drug-free South Africa, which would in turn contribute to improved sobriety rates whilst simultaneously preventing further engagement with substance abuse (Forrester & Harwin, 2006). Within South Africa, despite the creation and implementation of the Prevention of and Treatment for Substance Abuse Act 70 of 2008, the CDA and other governmental departments are neglecting their responsibilities and duties in light of the NDMP (Central Drug Authority, 2019; Republic of South Africa, 2013-2017). This neglect has resulted in active and recovering addicts being unable to access treatment, it has also resulted in general treatment options being scarce and ineffective, thus infringing on active and recovering addicts' basic constitutional rights. Aftercare services are even more difficult to access due to a lack of availability as the few resources and funding allocated to substance abuse in South Africa are channelled towards prevention and inpatient intervention (Gordon, 2003). This perpetuates the cycle of re-entry into treatment and the further rescinding of communities and the country as a whole (Isobell et al., 2018; Jason et al., 2007). The importance of aftercare services cannot be overlooked as addiction needs to be treated on a continuum of care, addressing biopsychosocial elements rather than specified, singular parts (Buck, 2011). In the next chapter the biopsychosocial domain of addiction and aftercare services will be explored and investigated in order to further understand its necessity and role in addiction treatment.

CHAPTER 3

THE ACCESSIBILITY AND AVAILABILITY OF AFTERCARE SERVICES WITHIN A BIOPSYCHOSOCIAL APPROACH

3.1 INTRODUCTION

This chapter will address the second objective of the study, namely, to understand addiction in the light of the biopsychosocial approach and its relevance in aftercare services. Additionally, the development of the biopsychosocial approach from conception to its current form and how this is utilised within social work service rendering will be investigated. Moreover, this chapter will explore why this approach is applicable and fundamental in treating addiction within a social work framework, together with how it can be used in conjunction to other critical frameworks. The research will explore the importance of this approach in a South African context through analysing biological, psychological, social, and cultural determinants that are linked to uniquely South African experiences, needs, and problems in the field of addiction. Finally the availability and accessibility of aftercare services in South Africa that meet the needs of recovering addicts within a biopsychosocial domain will be explored.

3.2 OVERVIEW OF THE BIOPSYCHOSOCIAL APPROACH

The biopsychosocial model was formulated in 1977 by Doctor George Engel. The biopsychosocial approach suggest that thoughts, behaviours, and emotions have the potential to influence an individual's biological functioning (Engel, 1977). This approach was one of the first to indicate that biological, psychological, and social factors affect mental health. Engel introduced this model as a more dualistic and interactional approach to health and illness where biological factors and the psyche could not be separated in treatment when attempting to understand the total human experience and related suffering (Melchert, 2011).

In contrast to the customary biomedical approach at the time, Engel argued that the role lifestyles played amongst individuals of society could no longer be ignored especially when entering the

twenty-first century (Babalola, Noel & White, 2017). Engel's argument for the biopsychosocial approach contrasted with the traditionally accepted biomedical model in which illness and its associated treatment strictly remained within a medical realm. The biomedical model has been critical in advancing medicine by finding direct cures to disease and illness, together with preventative measures through formulating vaccinations. The biomedical model rested on the standard that if an illness or disease could not be objectively assessed and treated at a cellular level, it could be disregarded and devalued. Engel, however, asserted that the biomedical approach limited treatment options with regards to patient health as, "a biochemical alteration does not translate directly into an illness" as well as the inverse in which, "illnesses or forms of suffering that constitute health problems, including, at times, biochemical correlates" (Borrel-Carrió, Suchman & Epstein, 2004: 577). Additionally, Engel criticised the excessively narrow approach to health that the biomedical model undertook and the impact it had on the clinician's ability to treat patients when regarding them as objects and simultaneously ignoring the realities of subjective experience, "unlike inanimate subjects of scientific scrutiny, patients are profoundly influenced by the way in which they are studied, and the scientists engaged in the study are influenced by their subjects".

Engel argued that this approach both dehumanised medicine and disempowered patients through disregarding the very human aspect of illness and suffering (Borrel-Carrió et al., 2004; Melchert, 2011). Engel advocated for the biopsychosocial model to transcend further than a scientific practice and be accepted as an ideology in which medicine and psychosocial aspects are combined to extend the approach towards disease and illness in clinical practice, thus humanising treatment and placing it within context. The biopsychosocial approach introduced a shift from a medical approach to a more holistic one wherein the patient can begin to wholly understand their health, gaining self-awareness and empowerment (Black & Hoeft, 2015). This approach further assists clinicians in broadening their understanding of how systems self-organise, which in turn provides a representative framework for treatment plans. This approach also safeguards treatment plans from implementing unrealistic expectancies that a patient can be aware of and control all aspects and contributors to their illness, be it mental or physical, and mitigate all outside influences thus producing more impactful practices.

In modern day and especially in the field of social work, the biopsychosocial approach has become crucial in assisting clients to reach a state of positive health (Melchert, 2011). This approach has become holistic wherein the biological, psychological, social, and cultural influences of an individual's life can be assessed and analysed in terms of their influence on client development and their overall functioning (Babalola et al., 2017). Particularly in the field of mental health, the biopsychosocial approach places the individual in a system comprising of 'sub-personal levels' and 'supra-personal levels' (Shea, Boldt, Bang, Yeung, Heyes & Frith, 2014). The 'sub-personal levels' relate to the physical and the specific genetics that each person comprise of, while the 'supra-personal levels' refer to the psychosocial dimensions. This approach has thus become important as it assists social workers in providing treatment and aid that promote positive health for clients while also focusing on alleviating their psychological distress.

This approach further puts mental health in context for social workers and clients as it provides a full understanding of a disorder in terms of its etiology and phenomenology. In doing so, apart from a diagnoses, clients are given the tools to understand their mental disorder and to gain comfort in the knowledge that there is research and relief methods in place and that there are others with similar diagnoses, thus alleviating associated stigmas (Melchert, 2011). Within this approach social workers utilise evidence-based strategies in which strength building and asset identification form the core foundations in addressing the problems and needs of client systems together with decreasing the negative impact these issues produce across the biopsychosocial spheres (Babalola et al., 2017). When social workers advocate for clients to achieve positive health it is important to understand that positive health goes further than the absence of disease. Positive health is defined by the World Health Organisation as "a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity" (WHO, 2013: 7).

The benefits of the biopsychosocial approach lie in being able to address multiple issues at a singular time, focusing on strength building, as well as it being a-theoretical in nature, which allows for the approach to be used in conjunction with other approaches, such as the harm reduction or disease model (Borrel-Carrió et al., 2004; Engel, 1977). This is particularly important for social workers providing treatment in the field of addiction as addiction itself is considered a multifaceted disease (Van Wormer & Davis, 2013). This is evident in the biological,

psychological, and social dimensions of addiction that are attributed to its causation and relevant consequences.

The biological dimension of addiction looks at how hereditary factors impact chemical use, as well as the physical consequences of extended and prolonged usage (Van Wormer & Davis, 2013; Washton & Zweben, 2006). Literature has begun to explore the concept of addiction to be a complex disease of the brain based on deficits in the functioning of the prefrontal cortex that control the executive functioning in a person. This would for example, explaining an addict's compromised ability to stop using and abusing substances (Johnson, 2004). Another example can be seen where there is an endorphin deficiency which predisposes an individual to certain addictive characteristics prior to any substance usage.

The psychological dimension of addiction embodies the line of thinking that leads to substance use. This thought process is often characterised by depression and anxiety which in turn leads to irrational and nonsensical decision making irrelevant of the consequences (Van Wormer & Davis, 2013). Leshner (2006) went on to describe the psychological aspect as the 'essence of addiction' in which uncontrollable and compulsive craving, seeking, and using behaviours develop, despite any social and physical consequences to the user and those around them.

The social dimension explores the 'where' in terms of the people, places, and things that impact addictive activities. This 'where' component analyses the peer and family groups involved and affected by the addict's behaviour and acknowledges how social class and economic privilege impact addiction (Van Wormer & Davis, 2013). The spiritual component of addiction reflects on the addict's purpose and meaning in life together with the concept of interconnectedness where recovery focuses on positive forgiveness and healing rather than negative punishment (Neff & MacMaster, 2005). In the rest of this chapter the dimensions of the biopsychosocial approach will be explored and investigated, while the way the biopsychosocial approach impacts aftercare services for recovering addicts will be analysed.

3.3 BIOLOGICAL DIMENSION

The biological dimension of the biopsychosocial approach has an immense impact on mental health, illness, and addiction. The biological aspects comprise a variety of factors, such as genetic makeup including hereditary characteristics, hormones, toxins, physical trauma to the brain and body, and nutrition, to name a few (Van Wormer & Davis, 2013). As individuals age, their environment transforms on micro-, meso- and macro-levels, but so too does the brain and its function. Within these changes it is important to note that hereditary characteristics and genetic makeup of individuals will intermingle in conjunction with their environments and that this could have profound effects on a person's mental health (Pycroft & Bartollas, 2014; Pycroft, 2010). Consequently, to truly understand mental health and wellbeing in order to develop appropriate treatments, it is necessary to consider all biopsychosocial factors and how they affect an individual. When attempting to provide treatment for addiction, the importance of understanding these biopsychosocial factors and their interactions are demonstrated. Thus, for social workers to address aftercare treatment they must have a crucial understanding of how these biopsychosocial dimensions intermingle and affect the recovering addict in order to understand how each element plays a role in driving addictive behaviours and thought processes. Furthermore, social workers need to understand how, and account for, biological factors that influence addiction and recovery. Such an understanding of biological factors in addiction has been made possible by research and scientific advances, and through documenting brain changes during both active addiction and recovery (Van Wormer & Davis, 2013). culturally only are social workers equipped with knowledge on the impact that biological factors have on the recovering addict, but also how to understand and utilise pharmacotherapy within treatment programmes.

3.3.1 Hereditary components

Before a treatment program can be established for active or recovering addicts, it is important for social workers to understand the genetic features and history of the individual in treatment. According to biological factors, certain individuals are predisposed to certain addictive characteristics which increase their likelihood of developing a SUD (Van Wormer & Davis, 2013). When analysing family histories, research has shown that individuals with a family history of

substance abuse through the generations have an increased chance of developing a SUD together with having the predisposed characteristics (Schuckit, 2009).

According to Schuckit (2009) individuals suffering with a SUD have a 40% to 60% range that is affected by genes with the remaining percentage relating to their environment. The environmental factors discussed refer to social aspects like peer pressure or stress experienced. The genetic characteristics can be attributed to certain hormone deficiencies, for example an endorphin deficiency in which case individuals are at risk of developing an addictive disorder prior to engaging in any substance use or abuse (Johnson, 2004). Johnson (2004) demonstrated the role of serotonin in the addiction process where a decreased amount has been linked to depression, anxiety, poor impulse control, together with behaviours associated with intoxicated conditions.

Adding to the findings of Johnson (2004), Schuckit (2009) reports that gene formations and genetic factors in personality traits can be identified that render certain individuals vulnerable to developing SUDs through characteristics associated with impulsivity, sensation-seeking behaviours, impaired judgment in decision making, and not being able to learn from previous blunders. Schuckit (2009) continues that, apart from gene formations, certain variations of genes impact the enzymes that metabolise alcohol, which, in some individuals increase their sensitivity to alcohol thereby lowering their risk of alcohol use disorders (AUDs), as opposed to others where a low responsiveness is created. These individuals with a lowered responsiveness towards alcohol, and who have a certain set of gene formations with associated behaviours, are predisposed to developing an AUD. Moreover, these gene formations, personality factors, hormone deficiencies, and hereditary components assist in explaining and understanding the relentless cravings and triggers that many recovering addicts face (Johnson, 2004).

3.3.2 Cravings and triggers

Experimentation, use, and abuse of substances can result in benign to severe consequences in terms of how it affects the brain and biological functioning of an individual. For social workers to gain clarity on how and why recovering addicts experience cravings, compulsions, and urges to use and abuse substances, it is important to understand how their brain functioning has been affected through this process.

All cravings, triggers, and compulsions are rooted in the biochemistry of the brain (Van Wormer & Davis, 2013). These cravings, triggers, and compulsions can be attributed to the prolonged use of substances and could include changes in brain function and structure. Begley (2001) explores this phenomenon by explaining how cocaine blocks the removal of dopamine from the synapses resulting in the accumulation of neurotransmitters that ultimately leads to feelings of euphoria or a 'high'. Repeated activation of these neurotransmitters enhances pleasurable feelings, but also leads to the adaptation of the brain cells, causing substances to lose their potency or effect. The result of prolonged activation and adaptation is called tolerance. By becoming more tolerant, the substance user would then increase the quantities of a substance in order to achieve the same level of euphoria or 'high' (Begley, 2001). According to Johnson (2004), the adaptation of the brain functioning, and structure would specifically affect two areas of the recovering addict, namely, a loss of motivation, and the storing of emotional memories and responses to the high. Volkow (2010) examines how these changes of the brain result in cravings, triggers, and compulsions that the recovering addict experience, and explains that the initial use of a substance, be it drugs or alcohol, is a voluntary experience, however, once neurochemical changes of the brain have transpired due to prolonged use of substances, the need and compulsion experienced by recovering addicts to return to substance use is an involuntary process. Researchers have postulated that addiction is comparable to not only a disease of the mind but to a brain injury due to exposure to self-administered toxins over a prolonged period of time.

Cravings can be overwhelming and preoccupy the mind of a recovering addict. It is important to note the severity and complexity of these cravings because the recovering addict's brain has undergone neuronal damage and has experienced a dopamine deficiency which would result in that person's inability to experience pleasure normally (Van Wormer & Davis, 2013; Johnson, 2004). In understanding the biological component of cravings and urges, social workers are better equipped to recognize the overwhelming experience recovering addicts are faced with, as well as being able to adjust aftercare services to be more impactful and appropriate for those in recovery.

When treating addiction, social workers form part of a multidisciplinary team that requires social workers to have baseline knowledge of how substances affect the recovering addict. It is furthermore expected that everyone involved in treating addiction must be cognisant of the physiology of chemical addiction in order to truly have a comprehensive understanding of the

formation of psychological and social dimensions of addiction (Van Wormer & Davis, 2013). Without this knowledge, social workers would not be able to provide a comprehensive treatment plan for those in recovery and could very well be ignorant to the severity of symptoms and biological processes that the recovering addict experiences. This would help social workers understand that triggers, cravings, and compulsions experienced by those in recovery go further than psychological symptoms and social circumstances, but rather form part of an involuntary process in the brain. By being knowledgeable social workers would have greater understanding and empathy for the struggles of the recovering addict and would be equipped to develop a recovery plan that takes into consideration the relentlessness and depth of the cravings and triggers the recovering addict experience. This biological knowledge about the struggle and internal battle of recovery, can also be utilised in strengthening and empowering the client system through eliminating the concepts of failure, laziness, and weakness that is largely associated with substance use and relapse. Likewise, having knowledge about the biochemical aspects of cravings, highlights why it is so important to include pharmacotherapy in active and recovery treatment as part of a maintenance regime. This will now be discussed in detail.

3.3.3 Biological-based aftercare treatment

3.3.3.1 Pharmacotherapy

Pharmacotherapy or opioid substitution therapy (OST) is a biological-based intervention and aftercare service that helps restore normal functioning of the recovering addict's brain (Van Wormer & Davis, 2013). This intervention does not look to discount the importance of psychological and social components in treatment, pharmacotherapy is to be used alongside other treatments. Volkow (2010) explains the need for pharmacotherapy in addiction treatment and aftercare services with an example of an individual suffering from schizophrenia, "just as individuals with schizophrenia require medical treatments to normalize their behaviour, we need to contemplate similar treatments for those whose brain states have been altered artificially through drugs". Knapp (1997) confers with Volkow (2010) that therapeutic interventions and aftercare services will remain redundant as long as the 'brain is screaming for booze'. Pharmacotherapy is the solution to this fixation experienced by several recovering addicts and affords them the opportunity to be more responsive to therapeutic treatment provided by social workers.

In South Africa, pharmacotherapy is largely inaccessible and unaffordable to the average person in recovery. This is because pharmacotherapy is up to 30 times more expensive in South Africa than in countries like the United States and Ukraine (Matzopoulos et al., 2014). Furthermore, South African legislation, (The Prevention of and Treatment for Substance Abuse Act) does not address pharmacotherapy, its importance or its relevancy, neither does it mention the potential access that active and recovering addicts should have to this service (Republic of South Africa, 2008). However, the Prevention of and Treatment for Substance Abuse Act does call for "effective, efficient, relevant, prompt and sustainable services" and for equipping individuals with "additional tools to maintain their treatment gains, sobriety and avoid relapse" whilst also stating that services must be made available in the forms of "medical interventions that address the physiological and psychiatric needs of the service user" (Republic of South Africa, 2008). In accordance with this legislation pharmacotherapy could and should be advocated for as it is a medical intervention that would equip active and recovering addicts with the tools they require to move towards abstinence or maintain their sobriety (Republic of South Africa, 2013-2017). Pharmacotherapy is also an effective, efficient, and relevant service that directly addresses the neuronal damage sustained by the recovering addict's brain due to excessive substance use (O'Malley & Kosten, 2006). Pharmacotherapy has further been endorsed and advocated for as an intervention strategy by the World Health Organisation (WHO). For example, the WHO endorses Opioid Substitution Therapy (OST) amongst active and recovering addicts and calls for 40% of those users (active and in recovery) to receive treatment in order for OST to make an impact. The WHO further requires that those receiving OST should be tested for HIV and receive subsequent counselling and antiretroviral therapy (World Health Organisation, United Nations Office on Drugs and Crime, UNAIDS, 2009). Pharmacotherapy as a treatment, is a biochemical intervention designed to assist individuals to recover more swiftly from substance usage, manage their cravings, and maintain their sobriety (Van Wormer & Davis, 2013). Additionally, this medical intervention assists social workers to deliver impactful therapeutic services and work towards positive behaviour change within the recovering addict who should then no longer be consumed by biological-based cravings, making them more responsive to treatment.

In South Africa treatment has continued to rely on abstinence-based inpatient and outpatient residential treatment facilities that have continuously resulted in poor recovery rates based on maintained sobriety (Scheibe, Shelly, Gerardy, Von Homeyer, Schneider, Padayachee, Naidoo,

Mtshweni, Matau, Hausler & Marks, 2020). In 2011, Stikland Hospital in Cape Town offered the first OST treatment plan but required patients to fund their own medications. Two years later Groote Schuur Hospital in Cape Town offered similar self-funded services and treatment for recovering drug addicts, but because of the costs involved OST treatments remained financially inaccessible to most. In 2013, the Department of Social Development funded the first government provided OST project at Sultan Bahu Rehabilitation Centre in Mitchell's Plain, Cape Town (Michie, Hoosain, Macharia & Weich, 2017). This program treated 168 heroin addicted individuals over a period of two years and saw major improvements in programme retention and enhanced sobriety rates. The success of OST treatments is illustrated in the numbers, as the retention rate in standard care is 44.1%, whereas the retention rate of people in the OST programme, is 65.7%. These statistics demonstrate the need to improve government planning models to include pharmacotherapy in treatment and to expand on government-funded OST projects.

3.3.3.2 Needle and syringe programmes

Needle and syringe programmes (NSPs) are crucial services meant to mitigate the physiological harm caused by illicit substances injected into active or recovering addicts (Derrick & Clark, 2013). NSPs are biological interventions and aftercare services that assist in reducing the spread of disease like Hepatitis B and C and that form part of HIV prevention programmes amongst active and recovering addicts. According to the World Health Organisation (WHO) there is a major need to increase access to sterile injecting equipment in order to prevent the spread of disease, but to also incorporate other therapeutic interventions in order to support behaviour change in the active and recovering addict (WHO, 2004). As a result, NSPs play an important role in providing another biological-based intervention which can be used alongside therapeutic interventions delivered by social workers to benefit the recovering addict and guide changes in both behaviour and thought processes. NSPs afford active and recovering addicts the opportunity to inject safely together with receiving treatment from a social worker advocating for safe drug use practices, moving towards abstinence or moderate use concepts, in addition to referrals to applicable intervention treatments if needed (Lesley, 2019).

In 2018 statistics showed that there were 17 103 injecting drug users across South Africa (Van Dyk, 2018). If these drug users were to partake in unsafe injecting practices due to a lack of available clean needles and no access to NSPs, the injecting population is at serious risk of contracting diseases. Injecting drug users are 40% more likely to contract HIV and Hepatitis B and C than the general population (Van Dyk, 2018). Needle and syringe programmes are endorsed by the World Health Organisation and calls for an annual 300 needles per person that can be combined with supplying OST therapy, and where those who have tested positive for HIV, could be treated and monitored (WHO, 2019). However, the reality in South Africa is that only 7316 people across the country were able to access the NSP programmes in 2018 before (Van Dyk, 2018). The 2018-statistics conveyed less than 4% coverage in terms of OST across the country together with an average of only 76 clean needles distributed per person per year to those able to access the programmes (Avert, n.d.). Lastly, only 24% of the people within this programme across the country were tested for HIV, and of those tested an average of 33% were diagnosed with HIV. Researchers concluded that in order to meet the WHO standards with regards to both HIV epidemic control measures and meeting the objective to reach South African citizens injecting drugs, clean needle distributions must double in numbers, OST therapy must expand ten-fold, and access to HIV testing and treatment must increase five-fold. From the above it is evident that NSPs are imperative in combating the spread of communicable diseases through unsafe injecting practices across South Africa (Derrick & Clark, 2013). In reality NSPs go further than providing clean needles, because through these programmes people who need antiretroviral treatment, or provisions for OST therapy, or referrals to social workers and appropriate health care workers for further interventions and aftercare services are often identified.

3.4 PSYCHOLOGICAL DIMENSION

The psychological aspect of addiction refers to the maladaptive behaviours, thoughts, and feelings associated with substance abuse. Maladaptive behaviours and thought processes are understood as those that constrain or depress an individual's functioning and overall contentment in life (National Institute on Drug Abuse, 2018a; Wallace, 2005). The psychological dimension of addiction allows for social workers to gain clarity on why active and recovering addicts engage in substance use or relapse. The psychopathological model looks at addiction as a mental illness in which dysfunctional thoughts and beliefs create similar dysfunctional behaviours that ultimately lead to

relapse. Zimmerman and Coryell (1989) found that between 43% and 77% of people with SUDs or AODs suffered from co-occurring personality disorders. Certain personality characteristics have been identified in contributing to addictive disorders and associated behaviours. These comprised of difficulties in emotional regulation, poor impulse control, and an inability to confront or account for obvious personal dilemmas (National Institute on Drug Abuse, 2018b). According to Wallace (2005), one of the core challenges experienced by recovering addicts is the battle between reinforced and conditioned maladaptive behaviours through prolonged substance usage, and altering these behaviours, thoughts, and feelings upon exiting treatment. This battle can extend throughout the recovering addict's life coupled with further psychological challenges like the ability to manage stress and emotions, together with treatment of and coping with co-occurring mental disorders.

3.4.1 Stress and emotional management

Stressors have proven to be one of the main obstacles in maintaining sobriety for recovering addicts. This is evident as recovering addicts are especially sensitive to emotional stressors whilst lacking general coping mechanisms to handle such stressors (Proctor & Herschman, 2014). Often recovering addicts have become accustomed to utilising substances as a buffer and relief to psychological distress. Thus stress management and coping mechanisms form a large part of the intervention of drug treatment programmes. The goal of stress management is to aid those in recovery by providing various coping tools to equip them to handle stressful situations and triggers whilst regulating their emotions in a positive manner, rather than resorting to defence mechanisms which is usually in the form of substance use (Reuter & Stevens, 2015; Swartz, De la Rey, Duncan, Townsend & O'Neil, 2011). The self-medication theory explores the link between stress management and substance use and analyses the potential impact of stress management and substance use on relapse amongst those in recovery (Hartney, 2019). The self-medication theory suggests that substances are used and abused amongst active and recovering addicts as a coping tool or defence mechanism when faced with stressors and that this happens due to the absence of acceptable solutions, or a shortage of coping skills, or a lack of meaningful relationships to act as a buffer and management tool. Swartz et al. (2011) explain stressors as occurrences that infer stress in an individual's environment which threatens their stability and safety. Stressors can be related to any life event such as unemployment, poverty, traumas, or death, as well as general

psychological distress which calls for a stress response in order to avoid negative symptom reactions. Examples of stress responses and symptoms are irritability, anxiety, emotional distress, aggression, and drug or alcohol cravings. Coping mechanisms are required to adequately address stressors and can take the form of behavioural, psychological, or social actions. Often drug and alcohol treatment programmes address and practice stress management and coping skill techniques within a controlled environment (Proctor & Herschman, 2014). However, upon leaving treatment and entering aftercare, recovering addicts return to potentially unstable environments with numerous stressors and triggers which may render the coping strategies they learnt at treatment facilities ineffective. This is where the importance of continued aftercare services becomes evident as aftercare services would be able to provide recovering addicts with the necessary guidance and support to positively navigate uncontrolled and everchanging stressors. The more control recovering addicts have over their emotions and reactions to life and environmental stressors, the more self-efficacy is developed and experienced assisting them in controlling these situations rather than resorting to old defence-mechanisms, and ultimately, relapse (Hartney, 2019; Reuter & Stevens, 2015).

3.4.2 Dual diagnosis and co-morbidity within addiction

Dual diagnosis or co-occurring disorders refers to an individual experiencing one or more substance-related disorders together with one or more psychiatric disorders (Substance Abuse and Mental Health Services Administration, 2010). The National Institute on Drug Abuse (2020) has demonstrated that up to half of all individuals experiencing substance use disorders will experience a co-occurring mental disorder and vice versa. Data indicates that people with SUDs are highly likely to have co-occurring anxiety, mental, or personality disorders. Furthermore, the South African Community Epidemiology Network on Drug Use (SACENDU) stated in 2018 that up to 14% of those entering formal addiction treatment had presented with a dual diagnosis. However, it is important to note that despite the prevalence of comorbidity between substance use disorders and mental disorders, it does not mean that one caused the other (National Institute on Drug Abuse, 2020). According to Santucci (2012) there are three main areas that play a role in dual diagnosis in addiction. The first is a common genetic predisposition and risk factors that contribute to the development of both SUDs and mental illness. The second being that mental illness can lead to drug use and addiction, and the third point refers to how substance use and addiction can lead to

the development of mental illness. Santucci (2012) hypothesises that people ranging from severe to subclinical mental disorders resort to drug use as a form of self-medication and coping strategy. However, whilst substance usage can temporarily subdue symptoms of a mental disorder, symptoms are often exacerbated and worsened over a prolonged period of time. This can be illustrated with cocaine abuse which has been seen to worsen and advance the symptoms of bipolar disorder in patients. Substance usage that precedes the symptomology of a mental disorder can arouse an underlying condition through altering the structures in the brain that may have initially disrupted the mental illness (National Institute on Drug Abuse, 2020). This has been seen quite prevalently amongst mood disorders like anxiety and schizophrenia. Individuals suffering with co-occurring disorders in addiction are particularly vulnerable to relapse with poorer treatment adherence in comparison to those without a dual diagnosis (South African Medical Research Council, 2018). An integrated treatment approach is crucial in order to render impactful services. Integrated treatment approaches involve stress management, establishing coping mechanisms, cognitive behavioural therapies, as well as providing motivation, support, and focus on functional recovery.

3.4.3 Psychologically-based aftercare treatment

3.4.3.1 Cognitive behavioural therapies

Cognitive behavioural therapy (CBT) is a combination of two approaches in which “talk therapy” is utilised to build a relationship between the individual in recovery and the social worker providing aftercare treatment (Vertava Health Editorial Team, 2020). This alliance and therapy promote healing and knowledge of healthy behaviours. CBTs assist to actively engage recovering addicts in their aftercare treatment plan. It provides positive encouragement in recovering addicts to avoid substance use, in addition to confronting maladaptive behaviours, thoughts, and feelings that drive their addiction (National Institute on Drug Abuse, 2018a). CBT focuses on identifying and removing self-sabotaging thoughts and attitudes that ultimately influence behaviour, thus assisting in empowering the recovering addict through increasing their self-efficacy, as well as improving their knowledge of self which allows them to make more mindful decisions supporting their sobriety. Every individual in recovery experiences unique life stressors and circumstances that have led to their substance abuse and subsequent addiction. Thus, by identifying and

addressing personal triggers and self-destructive behaviours, new positive behaviours, thoughts, and feelings can be developed that not only increase wellbeing but also contribute to sober living habits and general life skills. However, guidance from a social worker remains important because, if the cognitive behavioural developments result in dysfunctional behaviours, thoughts, and feelings, a person in recovery will experience harm to their sobriety, health, and overall wellbeing. CBT is useful in aftercare services as social workers can easily adjust treatment and recovery goals while taking the up-to-date life circumstances of the recovering addict, into consideration (National Institute on Drug Abuse, 2018a). This is important in keeping aftercare services relevant and impactful for those in recovery and to assist in navigating their everchanging environments outside of formal treatment. CBT can be utilised alone or in conjunction with other therapeutic approaches, as well as in line with pharmacotherapy if needed. CBT has also shown positive outcomes in treating individuals suffering with comorbid conditions who require multiple, integrated approaches frequently utilised in South Africa (Vertava Health Editorial Team, 2020).

3.4.3.2 Motivational interviewing

Motivational interviewing (MI) aims at directing an individual away from indecision regarding their addiction and towards making positive changes to previously destructive behaviour (Patterson, 2018). The core of MI is assisting recovering addicts to find motivation to make constructive decisions regarding their sobriety whilst achieving recognised goals (Hardey, Thomas, Stein & Kelley, 2019). It has been found that motivation is a core issue in maintaining sobriety for many recovering addicts. MI rests on the principle that each person suffering from addiction has some level of knowledge about the negative consequences of their abuse. From this, it is important to understand that each person in recovery is experiencing a different stage of readiness and willingness to stop or reduce their usage, as well as changing the patterns of their addictive behaviours. Social workers facilitate change from the ambivalence stage, to the action stage, and lastly to the maintenance stage of recovery. Through their guidance, motivation can be monitored, and could clients become more aware of their thoughts, feelings, behaviours, and subsequent triggers to actively make daily choices that contribute to their sobriety. MI is important in aftercare as the focus is placed on the recovering addict who must establish their own goals and who will be held accountable in achieving them. MI is also a useful tool in aftercare services as

social workers are required to establish strong bonds with those in recovery in a short amount of time, thus making it a time efficient and effective service.

3.5 SOCIOCULTURAL DIMENSION

The psychological aspect of addiction focuses on the individual and their specific behaviours, thoughts, and feelings whereas the sociocultural dimension reflects on the behaviour of larger groups (Horvath, Misra, Epner & Cooper, 2020). Sociocultural dimension thus refers to analysing the behaviours and interactions amongst societies, families, and cultures in order to understand their impact on the recovering addict. Sociocultural dimensions are crucial to address within aftercare services as they establish the quality of life the recovering addict is able to maintain, they also provide several repercussions for relapse if not addressed (Daley, 2013). The social dimensions focus on looking at people, places, and things that may act as buffers or triggers for those in recovery. These dimensions reflect on the relationships in the recovering addict's life and seeks to resolve relationship or familial problems, foster supportive networks together with recognising, and avoiding contact with high-risk situations (Lewis, Dana & Blevins, 2011). Regarding the cultural dimension, it is important to note that culture refers to the shared values, beliefs, attitudes, and practices of certain groups or organisations which influence and guide behaviour and social interactions (Merriam Webster, 2020). It is important to note the influence that culture holds as well as its interaction with social dimensions of addiction, especially within a South African context where there are a multitude of cultures, traditions, and languages amongst the population.

3.5.1 People, places, and things

The social dimension in recovery focuses on investigating triggers in relation to "people, places and things" (Fisher & Harrison, 2013; Tagliareni, 2020). Triggers refer to social, environmental, and emotional stimuli that remind recovering addicts of previous substance use. These stimuli can trigger urges and cravings that increase the likelihood for those in recovery to return to substance use and ultimately, relapse (Patterson, 2020). In terms of people, this refers to any significant person involved in the recovering addict's life that evokes strong emotional responses. It is not necessarily individuals who have directly engaged or contributed to the use of substances, it can even refer to familial or spousal relationships. In terms of places, this refers to high-risk areas that

are associated with previous substance use. Walking, driving, or traveling through these areas can result in memories of past substance use being triggered. It is also important for those in recovery to notice whether they are purposefully exposing themselves to these locations in order to test the boundary of their sobriety, as this may be an indication of an impending relapse and the need for immediate aftercare (Tagliareni, 2020). 'Things', this can be a tricky area to pinpoint in treatment as this can refer to certain music, food, television, time of the day, or drug paraphernalia that can result in a trigger. It refers to any object within a recovering addict's everyday life that may cause a trigger and subsequent cravings. Once a recovering addict can identify these triggers, it is important for them to work alongside social workers to learn positive strategies and coping mechanisms in order to minimise the effect of these various triggers (Fisher & Harrison, 2013). A large part of these coping mechanisms is improving upon personal relationships and fostering supportive social networks.

3.5.2 Cultural impact and stigmatisation

In terms of culture, it is important to note and understand how certain historical events can continue to impact a certain group or population. This is often reflected in a generational transmission of culture amongst families (Horvath et al., 2020). In the South African context, it is significant to recognise family histories of oppression and the associated feelings of distress, anger, loss, anguish, mistrust, and hopelessness. Grandparents and parents who were directly affected by Apartheid and experienced such oppression, discrimination, and racial inequality may communicate and transfer the emotional trauma to their children (Rassool, 2011). Their children then become adults who share similar emotional trauma and associated feelings as their elders. This trauma continues through the generations and they regard the world as a dangerous place wherein opportunities remain unequal, which exacerbate feelings of despair and hopelessness. In South Africa, the geographical separation of the population that largely remains together with services that are mostly inaccessible to those in rural areas, enforce these generational feelings and experiences of oppression, discrimination, and inequality (McCann, Burnhams, Albertyn & Bhoola, 2011). It is important to understand the cultural influences and their contribution to addiction amongst the South African population. Understandably during treatment, social workers are unable to change these cultural influences and should treat them with respect. However, social

workers can look to work alongside cultural influences and potentially reframe then as elements of new-found empowerment and motivation.

Stigmatisation of substance use and addiction is another factor in which culture plays a role. In many cultures, addiction is deeply scrutinised and faces cynicism from the community. This makes accessing treatment for those in recovery very difficult (Rassool, 2011; Routledge, 2005). In certain South African cultures addiction is seen as an embarrassment and humiliation for the family and as a result the family will either reject or hide the recovering addict's addiction from the community (Horvath et al., 2020). These cultural forces and attitudes marginalise and alienate recovering addicts from their communities. The isolation, stigma, and feelings of guilt, shame, and loneliness have devastating effects on recovery and maintaining sobriety, they also act as a barrier for recovering addicts to access treatment. For a recovering addict to access treatment and aftercare would be a direct confession of addiction which could then lead to the associated stigma and marginalisation to ensue. This is why cultural stigma has become a predictor for relapse amongst recovering addicts.

3.5.3 Sociocultural-based aftercare treatment

3.5.3.1 Family counselling

SUDs and addiction are strongly linked to dysfunctional families and problematic relationships. Addiction not only affects the recovering addict but creates serious challenges, stressors, and concerns for the family and individuals involved in the recovering addicts' life (Daley, 2013; Donovan & Marlatt, 2005). Moreover, these stressors are mostly represented through the emotional burden that the family experiences, such as feelings of anxiety, depression, despair, embarrassment, and guilt. There are also economic burdens due to costs associated with the addict's drug use, treatment, loss of employment, as well as potential reliance on the family for funding. Families furthermore face instability where abuse, violence, and neglect may be present, especially when children are involved (Goldenberg & Goldenberg, 2000). This is why family counselling and related aftercare treatment become important so as to mend damaged relationships. There are services that assist those in recovery together with their families, as well as services that directly assist the family members affected by the recovering addicts' substance use (Kaufman & Yoshioka, 2004). Family counselling requires family members to become actively involved in the

healing process through attending counselling sessions in order to address issues of the past and focus on the recovery process of the family as a whole going forward. Family counselling can be extremely therapeutic for those in recovery because it helps for healing to start, and because family members can becoming active contributing members in the sobriety of the recovering addicts by engaging in discussions about triggers, cravings, and how to recognise warning signs of a relapse (Daley, 2013; Szapocznik, Hervis & Schwartz, 2003). Families are then also afforded the opportunity to voice their trauma and experiences surrounding the recovering addict's addiction, to learn to examine their own behaviour, and to learn positive and healthy coping mechanisms. Family counselling can take place in a therapeutic environment or it can take place in family-orientated support groups.

However, family counselling in South Africa as a formal intervention service within treatment facilities or as an aftercare service, remains restricted. Because of this, it often happens that the recovering addict finds personal healing and receives treatment for their addiction and associated traumas whilst the family remains untreated (Daley, 2013; Donovan & Marlatt, 2005). Subsequently, the associated stressors, concerns, and consequences that initially brought the addition on, just continues, together with unresolved emotional trauma in the form of mistrust, anxiety, anger and shame. These then become an issue when recovering addicts attempt to reintegrate into their families, significant relationships, and communities because those systems remained unchanged. When the family has not been involved in counselling, the chance of relapse for the recovering addict increases. This is attributed to any progress that the recovering addict may have made during their intervention and associated aftercare remains unrecognised and compromised by the family's unresolved psychosocial trauma which can then result in loss of motivation and feelings of hopelessness for the recovering addict − often the emotional triggers that initiated the addicts substance use.

3.5.3.2 Support groups

Research has shown that those in recovery who regularly attend aftercare services in the form of support groups, increase their sobriety rate in comparison to those who do not attend aftercare services (Orbon et al., 2015). This could be because of the social support that those in recovery receives which increases their motivation and adherence to their recovery goals (Gordon, 2003).

Social support services take on three forms, namely that of emotional, informational, and concrete support (Corcoran & Roberts, 2015; Sarason & Sarason, 2009). Emotional support refers to the important relationships in the recovering addict's life, including that of their social worker or recovery support group, who shows empathy, compassion, and genuine interest in the wellbeing and sobriety of the recovering addict. Informational support refers to interactions with social workers or other healthcare professionals who provide guidance and advice, and who provides or points to useful information that pertains to recovery, motivation, and goal achievement. Lastly, concrete support involves being referred to aftercare services that are not only available but are also accessible to those in recovery. This linkage of services remains crucial in the aftercare process in order to address any needs or concerns that arise and to assist those in recovery in maintaining their sobriety.

In South Africa, however, access to and availability of support services or any aftercare services remain limited, due to the multitude of structural barriers that those in recovery face. Geographic location, transportation, affordability, availability, and poor community health are some of the major structural barriers encountered in South Africa (Pasche, Kleintjes, Wilson, Stein & Myers, 2014; Myers, Petersen, Kader & Parry, 2012). Support groups in the form of Alcoholics Anonymous and Narcotics Anonymous are present throughout the country but remain geographically limited to poorer, more isolated rural communities (Ederies, 2017). These barriers not only impede the access that recovering addicts have to the few services that are available, but further create an extremely difficult and tense environment to maintain sobriety. Communities are riddled with crime, violence, illicit substances, unemployment, and poverty of which none contribute to successful recovery.

3.5.3.3 Cultural recovery

Cultural recovery is a majorly overlooked area within addiction treatment. Cultural recovery will either take place during intensive intervention or during the aftercare stage. Cultural recovery involves reclaiming the client's ethnic identity together with rebuilding their sociocultural support network within their families and communities and regaining their social role in their community (Horvath et al., 2020). Recovering addicts who are unable to recover culturally are at risk of relapse. Family involvement within culture is an important aspect and therefore family counselling

becomes an important aspect within cultural recovery (Daley, 2013; Szelemko et al., 2006). Immediate and extended family are seen as significant in numerous cultures across the globe and therefore need to be involved with intervention and aftercare services. Substance abuse is seen as shameful, embarrassing, and a family humiliation inflicted by the recovering addict, thus, it is important to mend these relationships so that those in recovery are able to fully reintegrate into their family and community roles. Regarding the community, social work efforts in treatment should parallel the community cultural values in aftercare treatment so as to deliver a meaningful services to those in recovery. This in turn will assist the recovering addict to re-establish their place within the community and to focus on achievable goals to reintegrate and find acceptance in their community. The importance of cultural recovery is demonstrated in the Alkali Lake community in British Columbia where intervention and aftercare services focused on re-establishing the community's traditions and cultural values where alcoholism was not tolerated. This cultural recovery efforts saw alcoholism in the Alkali Lake community go from a rate of 90% down to 5% over the course of 10 years. In this case the chief of this native American village stated that, "the community is the treatment centre" (Szelemko et al., 2006). This line of thinking could be applied and should be reflected in the culturally diverse South Africa where community and tradition are held sacred. The importance of cultural recovery in South African communities can be understood through the isiZulu saying "Umuntu ngumuntu ngabantu" which directly translates to "a person is a person through other people" (Stangen Insurance, 2018). This reflects the deeply held importance of community and unity throughout various cultures in South Africa.

However, culturally appropriate aftercare services are not always a reality in South Africa. In fact, very few support groups in South Africa cater to education levels, socioeconomic circumstances, language, and culture (McCann et al., 2011; Ramaglan, Peltzer & Matseke, 2010). There is also a lack of support groups within rural areas, and those that are present may not take cultural recovery into consideration. Ideally, apart from being culturally sensitive, treatment services need to be delivered in the preferred language of those accessing the services, however this remains extremely challenging given that South Africa has 11 official languages (Rassool, 2011). Furthermore addiction treatment in South Africa remains an issue as treatments were, since the Apartheid era, based on westernised concepts catering to the white population in urban areas (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009). Thus, the majority of treatment facilities and aftercare services remain westernised and mostly available in urban areas, leaving those in rural

communities often without access to services. Furthermore, if services are available and accessible in rural areas, they fail to recognise the importance of cultural recovery and thus, remain inadequate. Regardless, it is important to realise that cultural diversity and sensitivity in treatment can act as a protective buffer or can result in a risk factor for relapse amongst those in recovery.

3.6 CONCLUSION

From the above it is evident that addiction can be classified as a complex, multifaceted disease in which more than one approach is necessary for successful intervention and continued care. Addiction is influenced by biological, psychological, social, and cultural factors, all of which contribute not only to its causation but also to relapse amongst those in recovery. This is why the biopsychosocial approach is imperative to use whilst rendering services along a continuum of care and especially with aftercare services. Aftercare services need to account for the biopsychosocial elements of addiction as recovering addicts often return to relatively unstable and unpredictable environments. Within these environments, those in recovery need to focus on the biological, psychological, social, and cultural aspects of recovery as they will face numerous triggers and hardships related to them. Thus, by utilising a biopsychosocial approach, social workers can assist those in recovery by developing achievable goals for recovering addicts, by motivating and empowering clients, and by starting the healing process across the biopsychosocial dimensions. Furthermore, the biopsychosocial approach assists in the development and utilisation of impactful, effective, and relevant services for those in recovery. It sheds light on the importance of supportive networks, family reunification, community reintegration, and cultural recovery to assist recovering addicts to maintain sobriety and for family and communities to begin the healing process. In South Africa, the biopsychosocial approach is imperative given our diverse nation with 11 official languages and a multitude of cultures. Thus, aftercare services need to remain culturally sensitive and incorporate our various traditions, belief systems, and values into treatment rather than focus solely on westernised models. Yet, in South Africa it is evident that culturally appropriate services remain limited and that the variety of services remain scarce. Evidence further shows that services in rural areas are limited because they are mostly unavailable but also because they are geographically, financially, and culturally inaccessible.

CHAPTER 4

EMPIRICAL INVESTIGATION OF THE AVAILABILITY AND ACCESSIBILITY OF AFTERCARE SERVICES FOR RECOVERING ADDICTS IN THE WESTERN CAPE

4.1 INTRODUCTION

In this chapter the third objective of the study will be addressed by empirically investigating the availability and accessibility of aftercare services for recovering adult addicts in the Western Cape. This investigation will explore the direct experiences of recovering adult addicts in accessing services, as well as the availability of services that meet their unique requirements and needs for successful aftercare. These experiences and accounts of the recovering adult addicts will be analysed and compared with the two previous literature chapters in order to identify inconsistencies in accessibility and availability of services and to assess whether legislative frameworks regarding aftercare services are being implemented. With this assessment conclusions regarding the appropriateness of accessibility and availability of aftercare services for recovering addicts can be made, and in turn, the effect that accessibility and availability has in terms of fostering or hindering relapse amongst those in recovery. In this chapter the researcher will identify themes, sub-themes, and categories from the data obtained through the interviews conducted with the participants. Once this data has been formulated, analysed, and discussed, conclusions and recommendations will be formulated in Chapter 5.

SECTION A:

4.2 RESEARCH METHODOLOGY

The research methodology encompasses the research question while also utilising certain procedures in identifying the goals and objectives of the study for the processing and analysing of the relevant data in light of the topic. The research methodology provides a critical evaluation of the data through an extensive verification process (De Vos et al., 2011). The headings below

elucidate and outline the theoretical body of work regarding the data collection and analysis method utilised throughout this study.

4.2.1 Research question

The research question formulated for this research study was: "How available and accessible are aftercare services for recovering adult addicts in the Western Cape?" as mentioned in Chapter 1. The research question was investigated whereby data was collected, analysed, and interpreted. Through this explorative process and these empirical findings, the research question was answered. The researcher was able to categorise the lived experiences and social realities of recovering adults addicts regarding the accessibility and availability of aftercare services within the Western Cape. These findings are elaborated upon in section B of this chapter.

4.2.2 Goals and objectives

The goal of this research study as indicated in Chapter 1 was to develop an understanding of the availability and accessibility recovering adult addicts have in terms of aftercare services within the Western Cape. The outline objectives were formulated to set concrete steps to achieve the goal of the study (De Vos et al., 2011). The objectives formulated were:

1. To discuss the nature and scope of substance misuse, continuum of care, and relevant legislation with specific focus on existing aftercare services provided by social workers.
2. To explore the availability of and accessibility to aftercare services provided by social workers for recovering adult addicts within the domain of the biopsychosocial approach.
3. To empirically investigate the availability of and accessibility to aftercare services for recovering adult addicts in the Western Cape.
4. To present conclusions and recommendations to relevant organisations and government bodies regarding the availability of and accessibility to aftercare services for recovering adult addicts in the Western Cape.

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

4.2.3 Research approach

A qualitative research approach with some quantitative elements was utilised in this study as indicated in Chapter 1 in order to describe and explore the needs and problems surrounding the accessibility and availability of aftercare services for recovering adult addicts in the Western Cape. The qualitative approach in this research study afforded the researcher an opportunity to account for and record meaningful human experiences in light of the research topic (De Vos et al., 2011). This was achieved by the researcher who obtained detailed information from participants, and who developed an understanding of the meaning participants ascribe to the problem at hand, with the purpose of comprehending and describing the participants lived social realities and experiences. The qualitative research approach remained largely unstructured which provided flexibility within the research process that resulted in participants being able to freely express themselves through descriptive and informative accounts of their lived experiences (Kumar, 2005).

4.2.4 Research design

Both an exploratory and descriptive research design was utilised in this research study. An exploratory research design allows for further examination of topics where information may be limited. It also answers the question of 'what' when investigating certain phenomena (De Vos et al., 2011). An exploratory research design was employed in order to gain insight and further information regarding 'what' aftercare services for recovering adult addicts within the Western Cape are available and accessible. A descriptive research design focuses on the 'how' and 'why' when looking at the specific details of a situation or phenomenon (De Vos et al., 2011; Rubin & Babbie, 2005). The descriptive research design provides a more in-depth examination of aftercare services whilst ascribing deeper meaning towards this phenomenon in light of the lived experiences of recovering adult addicts in terms of availability of and accessibility to aftercare services in the Western Cape. These exploratory and descriptive research designs were utilised in order to describe and explore the needs and challenges recovering adult addicts face in regard to availability and accessibility of aftercare services from their personal viewpoints and lived experiences.

4.2.5 Research instrument

A semi-structured interview was utilised in the collection of data for the research study. This type of interview was utilised to accurately detail the personal beliefs, lived social experiences, perceptions, and specific terminology communicated by participants in regard to the availability of and accessibility to aftercare services in the Western Cape. The semi-structured interview followed an interview schedule with pre-determined questions that guided the interview process rather than dictating it and demanding specific answers to specific questions (De Vos et al., 2011). These pre-determined questions remained open-ended to allow flexibility for the researcher and participants. This provided participants the freedom to be the experts of their lived realities which prompted further responses and detailed discussions (Annexure 2). Informed consent was first obtained from the participants before interviews took place. These consents granted permission for voice recordings of the interviews to take place, as well as for the discussions to be accurately transcribed in order to capture their personal viewpoints, beliefs, and social experiences (Annexure 1). The researcher made use of the denaturalistic approach, this means that certain elements of speech, such as pauses, are removed, without influencing the meaning of what the participant said (Oliver, Serovich & Mason, 2005). The interviews took approximately 40 minutes with 15 minutes allocated for debriefing. The interviews were initially planned to take place at the rehabilitation facility in Worcester but due to the Covid-19 pandemic, this was not possible. However, the Worcester gatekeeper organization assisted the researcher to obtain the sample and the signed consent forms, and to set up Zoom meetings with prospective participants. For the safety of the researcher and participants involved, all interviews were thus conducted online via Zoom video calls.

4.2.6 Data quality verification

Data quality verification refers to the mechanisms that are used throughout the research process to ensure the quality, transparency, and validity of the captured data. Data quality verification furthermore involves maintaining credibility, transferability, dependability, and conformability within the data collection and analysis process (Morse, Barrett, Mayan, Olson & Spiers, 2002). The researcher managed to maintain data quality verification by accurately transcribing interviews that were held with participants. These interviews and subsequent transcriptions produced a precise

representation and documentation of the participants' personal beliefs and lived experiences with regards to access and availability of aftercare services in the Western Cape. In this way an in-depth understanding was achieved.

Conformability and credibility involve establishing the findings of the research study to be objective and accurate (De Vos et al., 2011; Lincoln & Guba, 1999). The researcher achieved data quality verification through establishing conformability and credibility by transcribing the interviews, documenting the information and findings, and then having two of the participants read the transcriptions and confirm its accuracy and validity (Annexure 6). Data quality verification was further achieved by sourcing an independent coder to evaluate the themes, sub-themes, and categories and how accurately they correspond with the transcriptions (Annexure 7). Lastly, the researcher composed a reflexivity report in order to deliberate on personal experiences, thoughts, the research process as a whole, and the outcome of the research study (Annexure 8).

4.3 DEVELOPMENT OF THE INTERVIEW SCHEDULE

Because of the qualitative nature of this research study, the researcher was afforded more flexibility in formulating a semi-structured interview schedule for the interview process (Neuman, 2006; De Vos et al., 2011). This interview schedule allowed for an in-depth understanding of the participants' personal viewpoints, beliefs, and lived social experiences regarding the availability and accessibility of aftercare services to be documented and captured. The semi-structured interview consisted of open-ended questions that guided the interview process rather than dictating a specific answer and direction which allowed for rich data to be collected from participants. Closed questions were only used to obtain identifying details (Annexures 2 and 6) (De Vos et al., 2011; Neuman, 2006). The semi-structured interviews were formulated by incorporating appropriate knowledge and information from the previous literature chapters. This was done in order to analyse the relationship between literature and the lived social realities of the participants with regards to the research topic, as well as allowing for themes, sub-themes, and categories to be contextualised.

4.4 ETHICAL CONSIDERATIONS

Ethics were maintained throughout the study through mutual trust, approval, collaboration, and transparency between the researcher and the participants (De Vos et al., 2011). The participants were selected via an inclusive criteria. As they were all recovering adult addicts entering the aftercare phase of their treatment programmes, they had direct knowledge and experience about the accessibility to and availability of aftercare services in the Western Cape. The Research Ethics Committee (REC) classified this study as medium risk due to the vulnerable nature of the participants and because the research had a potential risk of causing emotional and psychological discomfort and distress if interviews were not handled professionally, ethically, and responsibly (Annexure 5).

The semi-structured interview consisted of questions that precipitated personal and sensitive details regarding the history, needs, and problems that participants faced in accessing available aftercare services to manage their substance use disorders and subsequent addiction. In order to ensure that the interviews remained ethically viable and in line with the conditions set out by the REC, the researcher ensured that participants were interviewed with caution, that the researcher adhered to the interview guideline, and that the confidentiality of the participants was maintained (De Vos et al., 2011). The researcher obtained permission from the rehabilitation centre to conduct interviews with participants involved in their intervention programmes (Annexure 3). Prior to the commencement of all interviews, the informed consent form was read and explained, together with the concepts of confidentiality and voluntary participation, to the participants, with debriefing services available if needed, after which they signed this form in agreement (Annexures 1 and 4).

Throughout the interview process the researcher was mindful to ensure certain ethical practices such as maintaining voluntary participation, informed consent, confidentiality, and actively practicing avoidance of harm be it emotional or psychological with debriefing services if needed (De Vos et al., 2011; Grinnell & Unrau, 2008). This meant that the researcher upheld the strict confidentiality guidelines by guaranteeing that all recordings of interviews would be password protected through Microsoft OneDrive for a minimum of five years, after which the recordings would be destroyed. All interviews and data collection were completed within the time parameters

set out by the REC, and all interviews were concluded by 7 October 2020 which was well within the ethical clearance period that expires on 12 February 2021 (Annexure 5).

4.5 REFLEXIVITY

The reflexivity report (Annexure 8) was written by the researcher in order demonstrate the level of self-awareness and transparency throughout the research process. The purpose of this report is to ensure that the researcher's personal viewpoints and opinions on the subject matter did not interfere or influence the research and outcome, and that the researcher remained objective throughout the process. The reflexivity report afforded the researcher the opportunity to contemplate and acknowledge her own emotions and experiences regarding the research topic, and to reflect on her conjecture regarding the research process and findings. Through the personal analysis in the reflexivity report the researcher was able to disconnect from her own personal frame of reference and any presumptuous thoughts that may have influenced the data obtained from participants, which in turn assisted in maintaining an unbiased standpoint throughout the research process and analysis of the data (Yates, 2004).

4.6 SAMPLE

The researcher utilised purposive sampling for the research study. Purposive sampling relies on the discretion of the researcher in terms of selecting participants with characteristics that best fit the purpose of the research study (Grinnell & Unrau, 2008). By utilising purposive sampling, the researcher was able to ensure that the participants were well suited to the research topic through having direct and personal experiences concerning the accessibility to and availability of aftercare services in the Western Cape. Furthermore, the researcher was able to meet the elected criteria of inclusion. The research study was conducted in the Western Cape with a planned sample size of 20 participants. However, due to the Covid-19 pandemic, only 16 participants could be interviewed. Data saturation was reached after 10 interviews as no new data was presented and because the relevant categories had become saturated (Nieuwenhuis, 2016). In order to strengthen the findings, whilst implementing an additional step in verifying the data, the researcher continued with interviews until all the participants (16) were interviewed.

To be included in the study, a participant had to be:

- a recovering adult with a former substance or alcohol use disorder;
- entering their final week of treatment in a rehabilitation centre, transitioning to aftercare services;
- able to communicate in English or Afrikaans; and
- over the age of 18 years.

The researcher approached an in- and outpatient rehabilitation organisation via email and received permission from the management of the organisation to conduct face-to-face interviews (Annexure 3). However, because of safety precautions due to the Covid-19 pandemic, no face-to-face interviews were allowed. For consent, the participants were approached via a social worker in the rehabilitation organisation and those interested in partaking in the research study were emailed informed consent forms. Willing participants then signed the informed consent forms, which were scanned by the social worker, and sent back to the researcher before any interviews could take place (Annexure 1).

The REC also prohibited face-to-face interviews during the lockdown period. The interviews were also planned to take place during April and May of 2020, but due to the lockdown regulations the researcher could only conduct the online Zoom interviews during August, September and October of 2020 once the rehabilitation organisation had reopened.

4.7 ANALYSIS AND INTERPRETATION OF DATA

Once the qualitative data was collected, the researcher managed and reduced the data. Managing the data involved precisely transcribing the interviews as they were recorded. The researcher then reduced and interpreted the data which involved identifying predominant themes, sub-themes, and categories that emerged, as well as recognising reoccurring patterns in relation to the accessibility to and availability of aftercare services in the Western Cape (Grinnell & Unrau, 2005). These themes, sub-themes, and categories were documented and presented in section B of this chapter where the researcher correlated the findings with pre-existing theoretical frameworks and literature found in the literature review (De Vos et al., 2011). This enabled the researcher to formulate and establish relevant conclusions and recommendations.

4.8 RESULTS OF THE INVESTIGATION

The findings of the investigation are presented in Sections B and C. Section B comprised of the identifying details of the participants whilst Section C encapsulated the empirical findings from the investigation with regards to the accessibility to and availability of aftercare services for recovering adult addicts in the Western Cape. The results were analysed and evaluated in terms of the emergent themes, sub-themes, and categories from the empirical findings.

SECTION B: IDENTIFYING DETAILS

4.8.1 Identifying particulars of participants

The researcher utilised a qualitative approach to collect the data for this research study. However, in order to have an inclusive overview of the participants and variables in this study, the researcher included quantitative aspects in this section. These quantitative elements demonstrate themselves in the form of identifying details of the 16 participants, which included gender, ethnicity, age of onset for substance experimentation and chronic use, and phase of treatment the participants are currently in.

4.8.1.1 Gender of participants

As mentioned in the research proposal, the research study was available to both male and female participants. However, due to Covid-19 and the inpatient rehabilitation organisation remaining closed, participants were sourced from the outpatient site where those receiving treatment were male. According to a consensus conducted by SACENDU in June 2019, 68.1% of individuals seeking treatment for a SUD accessed outpatient treatment facilities (SACENDU, 2019). Of those accessing treatment, 73% were male whereas and 27% were women (Sindelar & Fiellin, 2014). At the rehabilitation facility where the study took place, only men were enrolled in the outpatient programme, thus only men took part in the research study.

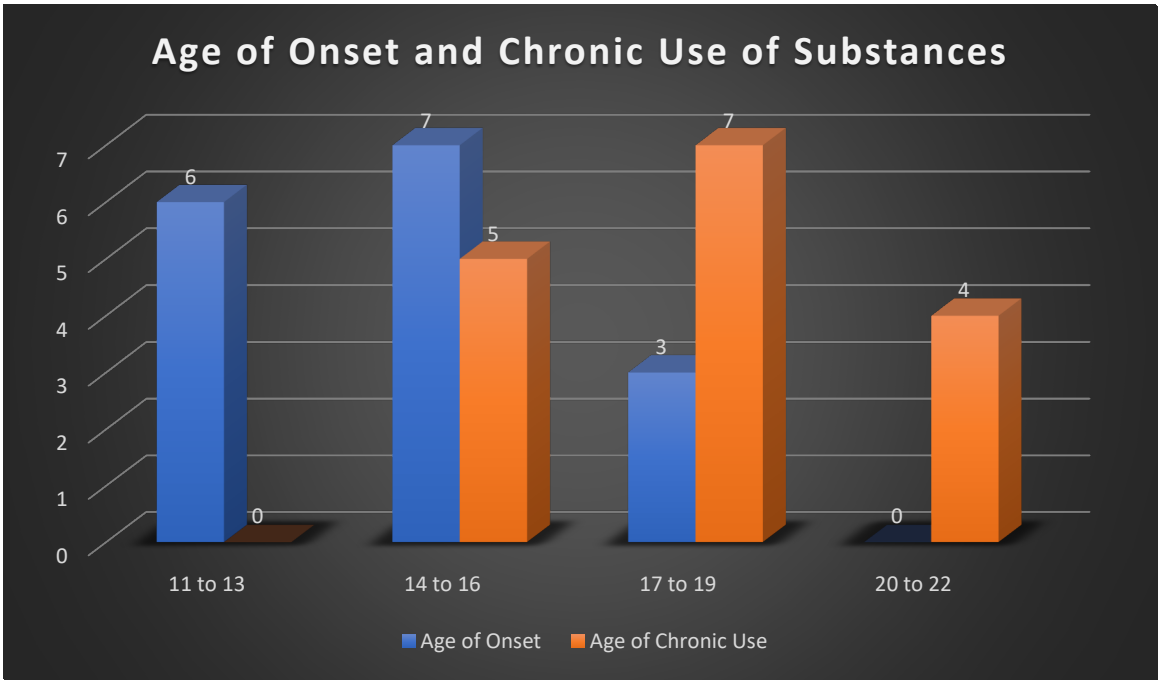
4.8.1.2 Ethnicity of participants

All the participants of this study were of Coloured ethnicity. This identifying detail correlates to the SACENDU statistics of 2019 where 69.8% of those accessing addiction treatment at a formal

rehabilitation organisation were of Coloured descent, 17.9% were Black African, 11.7% White and 0.6% Indian (SACENDU, 2019; South African Medical Research Council, 2018). These statistics reflect the 2018 and 2019 findings of SACENDU namely, that the proportion of individuals classified as Black African ethnicity seeking treatment for SUDs have remained consistently low in the Western Cape, while those of Coloured ethnicity remained the highest percentage of the population accessing addiction treatment services.

4.8.1.3 Age of onset for substance use and subsequent chronic use

It is important to know the age of onset for substance use and subsequent chronic use in order to establish patterns amongst the participants with regards to their SUDs. The age of onset and chronic use were documented through intervals of two, in two separate columns, starting from the youngest age ranging to the oldest. From the participants' data it was found that the average age of onset for drug experimentation and use were ages 13 and 15, with subsequent chronic use beginning most frequently from ages 15 to 17, as displayed in Figure 4.1 below.



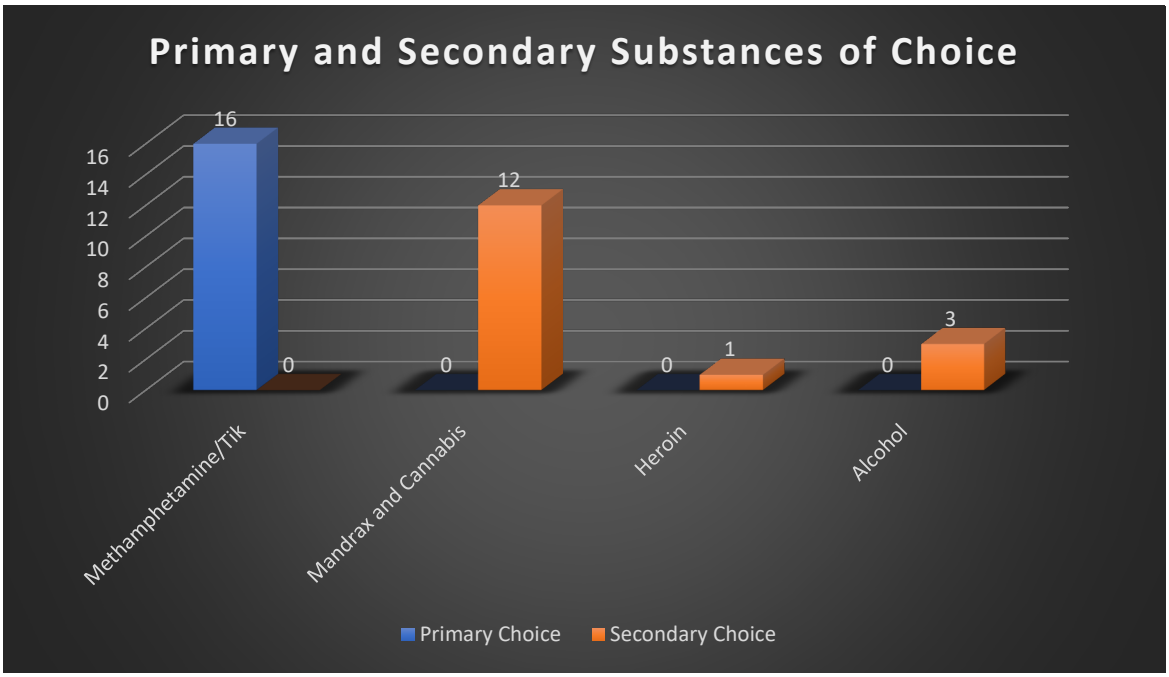
N=16

Figure 4.1: Age of onset and chronic use of substances

Figure 4.1 demonstrates that 6 (37.5%) of the 16 participants began using substances between the ages of 11 and 13. Just under a half of the participants, 7 (43.75%) began using illicit substances from 14 to 16 years of age, whereas only a few, namely 3 (18.75%) participants between the ages of 17 and 19 started using illicit substances. None of the participants began experimenting with substance use after the age of 19. In terms of when chronic use was noted amongst participants, none began prior to 13 years of age. However, 5 (31.25%) participants engaged in chronic use from the ages of 14 to16, 7 (43.75%) participants from 17 to 19 and 4 (25%), of the participants from the ages of 20 to 22. These findings correlate to 2014 statistics published by the South African Government, namely that the average age of onset for engagement in drug and alcohol use for children and adolescents, was 12 years old (Fritz, 2014). In 2018 this figure was further confirmed by the UNODC, namely that the average age for onset of substance use was 12 years and younger (United Nations Office on Drugs and Crime, 2018). Lastly, the UNODC in 2018 declared ages 15 to 17 as being a critical period in the transition from experimentation to chronic use and succeeding addiction to substances, this is reflected in Figure 4.1 which indicates the average age of chronic use and dependency to be from 17 to 19, closely followed by those aged between 14 and16 years of age.

4.8.1.4 Primary and secondary substance of choice

The researcher included the participants' preferred illicit and licit substances for use as this information provides important statistics and correlations within the population regarding SUDs. Illicit substances refer to illegal substances such as Mandrax and Methamphetamine (MA) or 'tik'; whereas licit substances refer to those that are legalised and decriminalised, such as alcohol and cannabis (South African Medical Research Council, 2018). During the interviews, the participants made it clear that all 16 of them engaged in polysubstance usage (use of more than one substance). The findings indicated in Figure 4.2 below demonstrate the participants' primary substance of choice as well as their secondary substance of choice.



N=16

Figure 4.2: Primary and secondary choice of substances

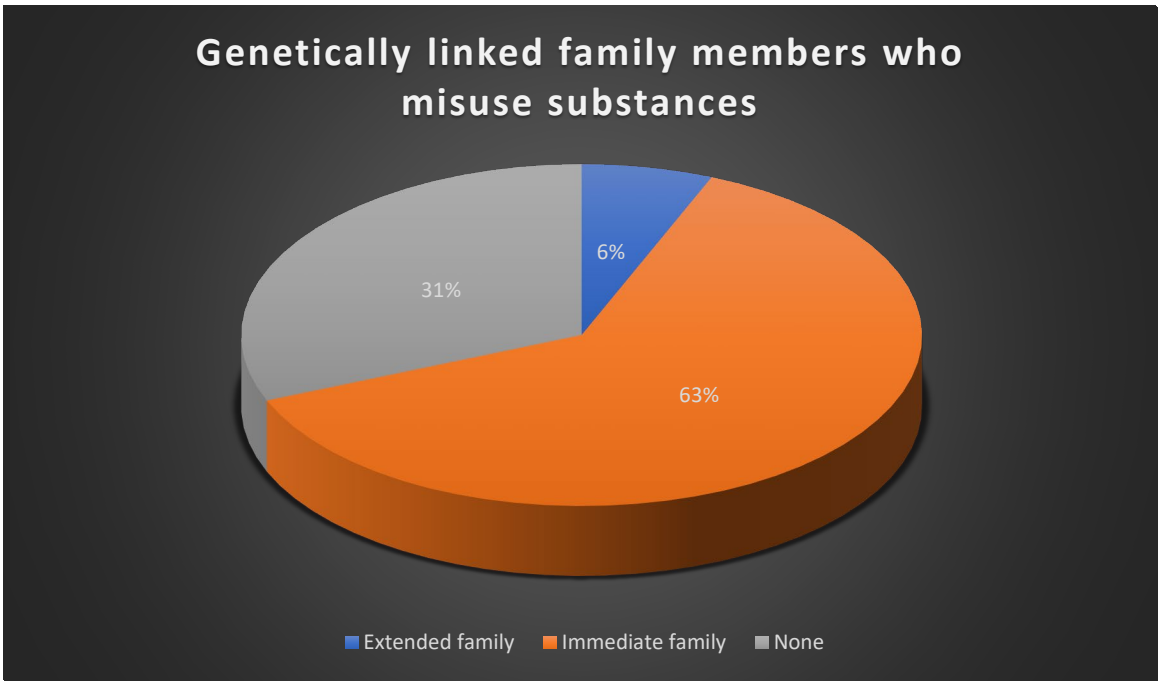
Figure 4.2 above illustrates the prevalence of MA use in the Western Cape where all 16 (100%) participants indicated MA as their preferred choice. This finding is supported by statistics released by SACENDU in 2019 illustrating that 77% of MA users in the Western Cape were Coloured and 67% of MA users were male (SACENDU, 2019). Figure 4.2 furthermore demonstrates the popularity of polysubstance usage amongst substance users in the Western Cape as all 16 participants indicated secondary and even tertiary drugs and alcohol of choice. Mandrax in conjunction with cannabis was found to be the second most popular choice for 12 of the 16 participants, whereas 3 of the participants indicated their second most popular choice to be alcohol and lastly, 1 participant indicated that heroin was their second choice. In 2018, SACENDU stated that 56% of those who abused substances in the Western Cape, engaged in polysubstance use, where more than one substance is abused. Furthermore, according to 2018 statistics, Mandrax was found to be a common secondary drug of choice in the Western Cape often used in conjunction with cannabis (South African Medical Research Council, 2018).

4.8.1.5 Phase of treatment

All (16) participants were at such a stage of their treatment programmes at an outpatient rehabilitation facility that they were ready to enter the final phase of treatment namely, aftercare. Aftercare services are defined as ongoing support provided to an individual after formal treatment was rendered in order to assist in maintaining their sobriety and enhancing proper social functioning (Republic of South Africa, 2008).

4.8.1.6 Genetic predisposition to SUDs

It is important for social workers to understand the influence that genetics play in SUDs in rendering impactful and effective addiction treatments and aftercare services. There is a 40% to 60% chance that an individual, who has a genetic predisposition to addiction, will develop addictive characteristics. The rest would be left to environmental factors (Schukit, 2009). Immediate family in this context refers to mother, father, and siblings whilst extended family refers to cousins, uncles, aunts, and grandparents, all of whom are blood relatives as illustrated in Figure 4.3 below.



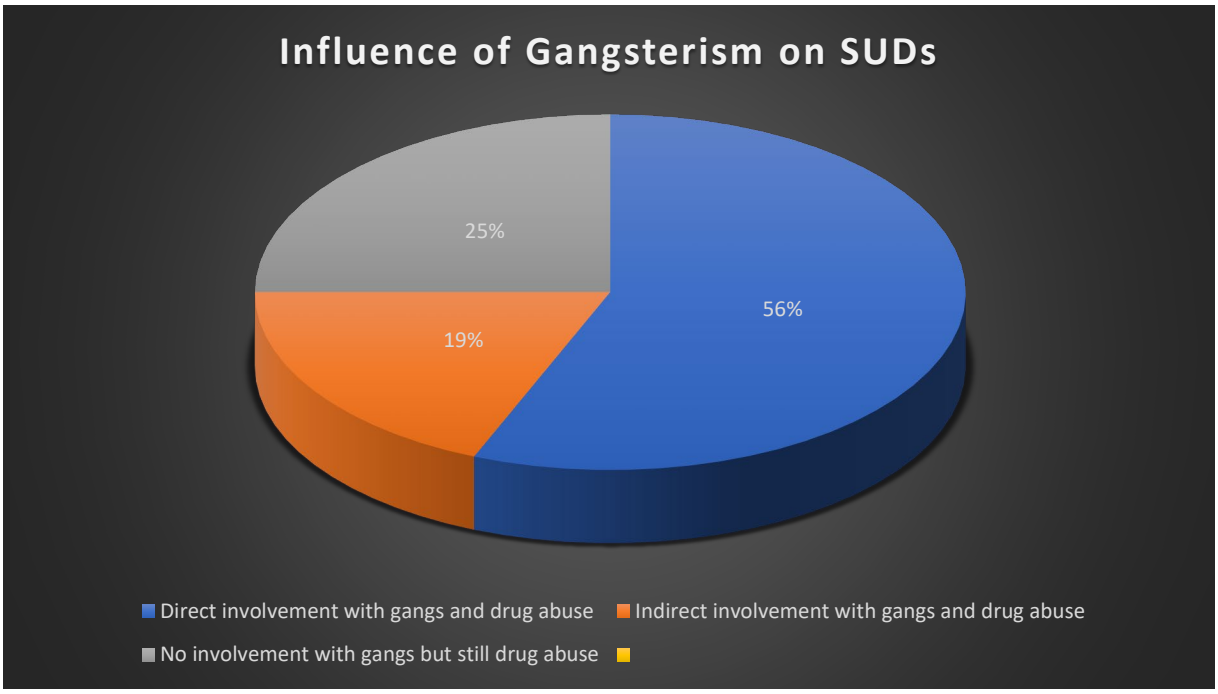
N=16

Figure 4.3: Genetically linked family members who misuse substances

Figure 4.3 illustrates that 11 (63%), of the participants had immediate family members who abused substances. This comprised of mothers, fathers, brothers, and sisters who had a history of SUDs. One (6%) of the participants had extended genetic family who suffered with a SUD. Five (31%) of the participants had no genetic links to immediate or extended family members with SUDs. The above findings correlate with Schukit (2009) and Johnson (2004) who found that a family history of SUDs account for a genetic predisposition of developing a SUD by up to 60% amongst those currently diagnosed and struggling with a SUD.

4.8.1.7 Influence of gangsterism in development of SUDs

Gangsterism continues to plague the Western Cape and contributes significantly to the abuse of substances and development of SUDs amongst the population. A variety of reasons have been attributed to adolescents and young adults engaging in gangsterism and subsequent drug abuse, ranging from poverty, dysfunctional families, communities still left disrupted from the remnants of Apartheid, high unemployment rates, peer pressure, insufficient education, and an overall lack of positive guidance, support, and opportunities for the youth (Lundberg, 2016; Peltzer et al., 2010). When participants were interviewed by the researcher, a resilient theme of gangsterism or gang culture was evident as many admitted to either being directly involved and affiliated to gangsterism and drug abuse, or having their community plagued by it where drugs are filtered into the community.



N=16

Figure 4.4: The influence of gangsterism on SUDs

Figure 4.4 above illustrates that 9 (56%) of the participants were directly affiliated and involved in gangsterism and subsequent drug abuse, and that 3 (19%) participants were not affiliated or involved in a gang but that gangsterism still controlled their community and brought an influx of substances. Lastly, 4 (25%) of the participants indicated that they had not been involved with a gang nor was gangsterism impacting their communities or bringing an influx of substances. The majority of the findings correlate to information provided by the Western Cape Government (2019) in which gangsterism was directly linked to extreme violence, school dropouts, and substance abuse across the Western Cape communities.

SECTION C: EMPIRICAL INVESTIGATION

The data collected from participants through the semi-structured interviews during the empirical investigation have been documented and classified into themes, sub-themes, and categories by the researcher. The themes of this research study encapsulated the biopsychosocial approach and were broken down into biological, psychological, social, and cultural challenges that recovering adult addicts experience when accessing available aftercare services in the Western Cape. The themes

in the four domains of the biopsychosocial approach were then organised into sub-themes that characterised known, existing challenges that were relevant within each of those domains. From the sub-themes, categories were formulated in light of the lived social experiences participants expressed in terms of accessibility to and availability of aftercare services throughout the biopsychosocial domains in the Western Cape. The aforementioned themes, sub-themes, and categories were summarised and are presented below in Table 4.1. The empirical investigation answered the research question of the study in terms of the availability and accessibility that adult recovering addicts have to aftercare services in the Western Cape. For this section, the abbreviation "P" will be utilised for "participant", in other words P1 will refer to participant 1.

Table 4.1: Themes, sub-themes, and categories identified in this research study

Theme	Sub-theme	Category
Theme 1: Biological challenges for recovering adult addicts in relation to aftercare services	***Sub-theme 1.1:*** Genetic Predisposition to addiction	**a)** Immediate family **b)** Extended family
	Sub-theme 1.2: Cravings	**a)** Biochemical reaction to stimuli **b)** Pharmacotherapy
	Sub-theme 1.3: Health	**a)** Difference in health pre-and-post active use **b)** Sports groups
Theme 2: Psychological challenges for recovering adult addicts in relation to aftercare services	***Sub-theme 2.1:*** Emotional management	**a)** Aggression **b)** Depression **c)** Defence mechanisms **d)** Coping mechanisms
	Sub-theme 2.2: Triggers	**a)** People **b)** Places **c)** Things
	Sub-theme 2.3: Availability and accessibility of psychological-based aftercare services	**a)** Support groups **b)** Social worker/therapist
Theme 3: Social challenges for recovering adult addicts in relation to aftercare services	***Sub-theme 3.1:*** Interpersonal relationships	**a)** Peer groups **b)** Intimate partners **c)** Family members
	Sub-theme 3.2: Availability and accessibility of alcohol and drugs in the community	

Theme	Sub-theme	Category
	Sub-theme 3.3: Availability and accessibility to social support structures	**a)** Church **b)** Rehabilitation centre aftercare services **c)** Sports groups
Theme 4: Cultural challenges for recovering adult addicts in relation to aftercare services	***Sub-theme 4.1:*** Community standpoint	**a)** Stigma **b)** Poverty and unemployment **c)** Absent parents
	Sub-theme 4.2: Gangsterism	**a)** Involvement/affiliation with gangs **b)** Community impact **c)** Effect on aftercare service rendering
	Sub-theme 4.3: Accessibility and availability of aftercare services in the community	**a)** Geographically **b)** Financially **c)** Variety

4.8.2 Theme 1: Biological challenges for recovering adult addicts in relation to aftercare services

The biopsychosocial model, as explained in Chapter 3, was one of the first models to acknowledge that behaviours, thoughts, and emotions could have an impact on a person's biological functioning (Engel, 1977). Chapter 3 described the need and ability to understand the multitude of intermingling factors that contribute to the development of addiction through demonstrating the role that biological, psychological, and socio-cultural elements play in conjunction with one another and their impact on the individual (Melchert, 2011). The biological component of the biopsychosocial approach in addiction analyses the role of genetic predispositions in the development of SUDs or AUDs, and the impact on physical health due to chronic or prolonged use of substances. The biological component further investigates how the aforementioned results of prolonged chronic use impact the individual's recovery with addiction in terms of unrelenting cravings, consequential hormonal changes, and imbalances in the brain, together with how these factors influence relapse rates (Pycroft & Bartollas, 2014; Van Wormer & Davis, 2013). In theme 1 the biological component of addiction together with the relevant access and availability of aftercare services that cater to those in recovery in the Western Cape is analysed. These biological

components are the genetic history of the participants, the impact of addiction on their physical health, the impact of biologically driven cravings, and the appropriate access to and availability of services to address these needs in aftercare services.

4.8.2.1 Sub-theme 1.1: Genetic predisposition to addiction

Certain individuals have genetic predispositions to developing a SUD or AUD prior to any use of substances where addictive characteristics present themselves through hormone deficiencies (Johnson, 2004). Genetic hormone deficiencies, such as a serotonin deficiency, predispose individuals to developing an addiction disorder through presenting characteristics of depression, anxiety, and limited impulse control. Individuals with a family history of SUDs or AUDs are predisposed to an addiction disorder by 40 to 60 percent with the remainder being associated with environmental influences (Schukit, 2009). The influence of genetic predispositions to the development of a SUD or AUD are presented in the following narrative:

> *"My dad who doesn't stay too far from where I am now, he's the only one I can think of that's, that's you know, a real alcoholic. I think I get that addictive nature from my father's side because he's been drinking for quite some time before I was born." (P1)*

It is interesting to note that the participant was able to analyse their family history with substance abuse and see the generational patterns of abuse through their own addiction. The viewpoint of the participant was supported by the findings of both Schukit (2009) and Johnson (2004) who state that family histories of addiction disorders are found to produce genetic predispositions in the form of gene formations. As discussed in Chapter 3, these gene formations contribute to addictive personality characteristics such as sensation seeking behaviour, impulsivity, and impaired judgment together with some being predisposed to a lower responsiveness to alcohol and drugs (Schukit, 2009). Two categories identified under this sub-theme are presented below.

a) Immediate family

Gene formations and genetic makeups are inherited from an individual's biological parents. When there is a history of addiction disorders in the immediate biological family, certain genes and gene mutations can be inherited that predispose individuals to developing a SUD or AUD (Schukit, 2009). Genetic mutations can alter the functioning and structure of the brain which then influences

the manner in which individuals respond to substances. These responses are represented in both addictive personality traits, such as compromised temperamental characteristics and executive dysfunctions (Louisiana Addiction Recovery, 2019; Johnson, 2004). Lastly, the aldehyde dehydrogenase gene impacts the manner in which alcohol is metabolised in the body which can act as a protective factor against AUDs with increased sensitivity, but also as a risk factor when the response is low. From the data collected, it was evident that the majority of the participants had an immediate biological family history of substance use disorders. This is reflected in the following narratives:

> *"Only two members of my family that use and still use drugs and that is my sister and cousin, she is as you can say an alcoholic, she believes she has to drink and can't have two or three." (P4)*

> *"Me and my brother had always used together, and look, my dad smoked Mandrax by the house with friends so by 15 I saw this and started trying it." (P6)*

> *"Mandrax, you see ma'am, I had seen my dad drinking and then smoking it, and it had had an effect on me man, I then had also done it." (P8)*

Linking the aforementioned narratives with the theoretical underpinnings in Chapter 3, the findings demonstrate that there is a strong correlation between genetic inheritance and predispositions to addiction disorders. This is evident amongst the findings as the majority of participants mentioned at least one of their parents, together with a biological sibling, were presenting with a SUD or an AUD. It is evident that genetic history plays a significant role in the development of an addiction disorder in both the inherited gene formations as well as the predisposed characteristics of impulsivity, poor emotional regulation, and sensation seeking behaviours to name a few. It is compelling to note that participants 8 and 6 both mentioned the influence and impact of seeing a biological parent abuse substances in their presence, and how this was one of the leading factors in the initiation of their own substance misuse. At the time of the research, the majority of the participants' immediate family were still in active addiction and misusing substances, which, apart from increased environmental pressure and availability of substances, further act as a risk factor for the adult recovering addicts to relapse. These results correspond with the research studies of Van Wormer and Davis (2013) and that of the Louisiana Addiction Recovery (2019) that found

where individuals with an immediate biological family link to addiction disorders are four to eight times more likely to develop a SUD or an AUD than those genetically unrelated to relatives with similar drug or alcohol related issues.

b) Extended family

Extended family refers to the members outside of the family nucleus (the parents and siblings), such as cousins, aunts, uncles, and grandparents. As explained in Chapter 3, although a genetic history of substance abuse amongst the immediate family predisposes individuals up to 60 percent to developing a SUD or AUD, the remaining 40 percent is attributed to environmental factors (Schukit, 2009; Johnson, 2004). Environmental factors within the family unit include extended family members misusing substances and how this impacts and influences the development of SUDs and AUDs amongst other family members (Louisiana Addiction Recovery, 2019). In 2017, South African statistics revealed that 36 percent of all households comprised of extended family members. In 2019 statistics found that in the Western Cape, 25 percent of the population resided with extended family members and 50 percent with just the family nucleus (Statistics South Africa, 2019; Statistics South Africa, 2017). The demonstrated close-knit dynamics of the household compositions in South African communities amongst immediate and extended family members contribute significantly to the environmental risk factors in the development of a SUD or an AUD amongst family members. The following narratives are the participants' lived experiences regarding substance abuse amongst extended family, and the subsequent impact on the development of their SUDs:

> *"My cousin is the guy who gave me my first abuse of drugs and he's basically the guy that presented it to me you know, he is still taking drugs." (P4)*

> *"Yes, yes! My uncle used Mandrax and I was still a little child and then he offered it to me coming into the house, he stayed the weekends." (P16)*

The above narratives demonstrate that extended family members with SUDs and AUDs pose as significant environmental risk factors in the development of an addiction disorder amongst family members, rather than only the immediate family who are genetically linked. It is interesting to note that the extended family members of participants 16 and 4, played a significant role in the

development of their SUDs, where these extended family members had introduced and provided them with substances at a young age. Most of the participants stipulated that they had both immediate and extended family members that abused substances, and both had significant roles in both their experimentation with substances and subsequent addictions.

4.8.2.2 Sub-theme 1.2: Cravings

As explained in Chapter 3, cravings are rooted in biochemical reactions of the brain. The chronic and sustained use of substances causes substantial changes in the functioning and structure of the brain, which in turn results in intense, unremitting cravings (Van Wormer & Davis, 2013). Volkow (2010) went on to explain that within the experimentation stage of substance use, the experience and choices individuals make are all voluntary. However, once substance use has proceeded from the experimentation phase into chronic use and dependency wherein neurochemical damage is incurred in the brain, the use and subsequent compulsion to use substances, becomes involuntary. The above information is demonstrated through the following narrative:

> *"When I have cravings I kind of feel down, I think, I think maybe it is a chemical that is released in my mind telling me that I am on the road to recovery, but sometimes I think I am not too strong. I don't understand why I feel it but maybe because I stopped using, and just my mind with past experiences just trying to rewind it." (P1)*

This narrative demonstrates the intensity of cravings and the unrelenting biochemical urge to abuse substances despite the individual being sober. It is noteworthy that participant 1 could acknowledge the intense drive and compulsions of cravings being attributed to something more primal and biological than simply accrediting it to using drugs again and relapsing. The following categories were formulated based on the biochemical stimuli and ensuing cravings amongst recovering addicts and subsequent aftercare services that cater to biological needs.

a) Biochemical reaction to stimuli

Stimuli in addiction often refers to the people, places, or things that trigger a reaction or craving within the recovering addict. Many of these triggers or stimuli are involuntary biochemical reactions in the brain resulting from the damage incurred from the extended chronic use of substances (Van Wormer & Davis, 2013). Even when individuals are sober, these stimuli can result

in unrelenting and overwhelming cravings which often contribute to relapse. It is important to note the significance of biochemical reactions to stimuli amongst those in recovery, as cravings are not only psychological indicators or social contexts, but actual involuntary chemical processes of the brain (Volkow, 2010). The following narratives illustrate the participant's experiences and challenges in unrelenting cravings during their recovery and aftercare:

> *"Cravings yes, whenever my stomach starts to get pain, my head starts feeling pain, I would get angry and emotional and want to use again. My hands were always shaking, and I needed to use otherwise I would shout and throw stuff." (P4)*

> *"When the cravings come, it is about five or six minutes, but I must just hold on when I get these cravings because they do pass. They come every day and you must just keep your mind busy; it helps." (P12)*

> *"When we talk about the old days, I am getting a tik craving, I am very irritated and don't have much patience, I just want my one thing and I don't think anyone must be around me when I get a craving." (P15)*

The aforementioned narratives demonstrate the severity and remitting nature of cravings throughout the recovering addicts' recovery process. Many of the participants experienced cravings when in the presence of stimuli, such as a certain time of the day, or hearing, or thinking about substance use. These participants even had bodily reactions such as shaking or stomach pain. Furthermore, these narratives demonstrated the urge and need to use substances from a biological standpoint in which aggression, irritation, and bodily shakes would ensue when triggered by stimuli and successive cravings. These experiences are supported by studies conducted by Volkow (2010), Johnson (2004), and Van Wormer and Davis (2013) who described the complexity of cravings from an involuntary biochemical process in relation to certain environmental stimuli. Furthermore, these theorists noted the overwhelming aspect of biochemical cravings due to neuronal damage, in that it completely preoccupies the mind of those in recovery and drives them into compulsions to use, and ultimately to relapse.

b) Pharmacotherapy

As discussed in Chapters 2 and 3, pharmacotherapy is both a biologically-based intervention and an aftercare service for individuals in recovery from an addiction disorder. Pharmacotherapy assists in restoring the normal neuronal and hormonal functioning of the brain amongst those in recovery (Van Wormer & Davis, 2013). Pharmacotherapy is an essential aftercare service as it assists in alleviating the distress and fixations experienced by recovering addicts on a biochemical level, and in gaining some level of control over cravings (Volkow, 2010). Pharmacotherapy also assists those in recovery from a biological standpoint and provides the opportunity for individuals to be more responsive and present when accessing or receiving therapeutic, social, or cultural aftercare treatment options, often provided by social workers. However, as was discussed in Chapter 2 and 3, access and availability to pharmacotherapy in South Africa is met with severe structural barriers. These barriers include the general lack of availability of pharmacotherapy options across South Africa and the Western Cape specifically, and the inaccessibility due to pharmacotherapy aftercare treatment that is up to thirty times more expensive than in countries like the United Kingdom or Ukraine (Matzopoulos et al., 2014). As discussed in Chapter 2, both Stikland and Groote Schuur Hospitals in Cape Town offer self-funded pharmacotherapy services which makes such services mostly inaccessible to the poorer communities (Scheibe et al., 2020). In 2013 the Department of Social Development funded the first government aided pharmacotherapy treatment for 168 patients at the Sultan Bahu Rehabilitation Centre in Mitchell's Plain, Cape Town. The following narratives demonstrate the knowledge that participants had on what pharmacotherapy was, the availability of such services, and if they felt this was a service that would have assisted their recovery in aftercare:

> *"No, don't know what it is but I tried very hard on my own to make the right choices to change my life, I would get on my knees and pray for help, but the cravings were a bit serious and I didn't make the right choices. I think it would have made it easier." (P12)*

> *"I don't know of it, of course it would have helped! That craving allowed me to use daily, I would use daily because, I would say if I didn't have cravings, I would have stopped a long time by now." (P16)*

> *"I don't know what that is, but I don't think it's possible, believe me I tried. If you don't change your own ways you will still do the things that you were doing and that medicine, no, maybe it is powerful and addictive." (P4)*

> *"No, I don't know what that is, I never knew about it. There were many times I tried to be sober, but it hung on money. Money is my biggest trigger. As long as I didn't have money I wouldn't use, so I don't think that pill or medicine would have helped." (P2)*

The above narratives demonstrate the barriers that recovering addicts experience because they are unable to access pharmacotherapy treatment options, and because they are not aware or have knowledge that these treatment options are available or even exist. None of the participants had ever heard or known about pharmacotherapy, even after the service and what it entails was explained to them. This situation illustrates the barrier to treatment that exist in South Africa and is confirmed by Bhana (2007), who states that less than 30 percent of all patients completing an intervention programme are informed of relevant aftercare services.

The participants' narratives demonstrated mixed reviews as to whether or not this aftercare treatment would assist them in their recovery and sobriety. It is interesting to note that half of the participants felt that pharmacotherapy would have assisted them greatly in handling their unrelenting and overwhelming cravings that led to subsequent relapses, while the other half felt that the solution resided with themselves, their choices and actions, and that pharmacotherapy would not have assisted them. These experiences are reflected in a study of Reuter and Stevens (2015) who documented the importance of pharmacotherapy in specifically treating opioid use where improvements were noted in treatment retention and decreased relapse rates. Yet, despite emerging findings demonstrating that Naltrexone, a form of pharmacotherapy, may assist in treating MA in the future, there is still no approved form of pharmacotherapy to treat it (University of California, 2015). Pharmacotherapy is mainly targeted towards opioid dependencies and thus, may not be an appropriate treatment option to all individuals in recovery whose substance of choice may differ to opioids, especially with regards to the aforementioned participants whose substance of choice was MA.

4.8.2.3 Sub-theme 1.3: Physical Health

In Chapter 2 the impact that substance abuse has on an individual's physical health was discussed. According to WHO statistics for 2015, 450 000 people died from substance misuse with thousands more requiring emergency medical attention (Caulkins et al., 2014). In South Africa, substance abuse has led to an increase in the spread of communicable diseases, risky sexual behaviours, Foetal Alcohol Spectrum Disorder, and an overall increased burden of harm on the health sector of the country (Western Cape Government, 2016; Elias, 2018). This sub-theme explored how participants' active addiction and substance abuse impacted their physical health and which services the participants wanted to access to maintain their health during their aftercare period.

> *"It affected my health in a major way, loss of breath, you know I can still feel it in my lungs when I do some exercise. My body is still healing." (P1)*

This narrative demonstrates the negative impact that substance abuse and addiction have on the physical health of the individual. The following categories were formulated based on the impact of substance abuse on the participants physical health together with what available aftercare services were accessible to maintain their health in sobriety.

a) Difference in health pre- and post-active use

Abuse of substances has consistently resulted in serious physical harm and poor health amongst those in active addiction. In South Africa, one third of all HIV/AIDs cases results from substance abuse and associated risky sexual behaviours and unhygienic needle sharing practices (United Nations Office on Drugs and Crime, 2002). Furthermore, people who abuse substances have consistently reported lung and heart disease, mental health conditions, and weight and memory loss, to name a few (National Institute on Drug Abuse, 2020). The following narratives demonstrate the impact that substance abuse has had on participants' health, pre- and post-active addiction:

> *"I couldn't move or run a lot, I was tired and would be so out of breath and also, I'd struggle to breathe in, it made me very sick. Loss of memory loss as well. Like, when I was using, I couldn't remember stuff as well as now, my brain began to struggle, but now I've put on weight again." (P2)*

> *"It effected my health, two months ago I was taking medication I was getting TB, you see my right lung was finished with the Tik because the Tik was eating it. I lost a lot of weight. I'm a lot better now and I can breathe properly now, I couldn't run or pull heavy stuff, but I can do it now, I feel better now." (P15)*

> *"I started to lose weight and then uh, lots of memory loss. I've gained some weight again, but I wouldn't say my memory is a lot more because I still can't remember some things, I struggle to remember stuff still." (P16)*

These narratives demonstrate the impact that chronic substance abuse has on physical health. Most of the participants experienced weight loss, fatigue, difficulty breathing, and memory loss as the most common symptoms. It is interesting to note how the participants expressed that since maintaining sobriety their health has improved vastly, however, for participant 16, memory impairment still remained an issue. These experiences are reflected by the National Institute on Drug Abuse (2020) who stated that individuals abusing substances often had multiple health issues with the most common being lung and heart disease, mental health disturbances, as well as strokes or cancer.

b) Sports groups

Physical exercise has many known and established health benefits. Research increasingly demonstrates a want amongst recovering addicts to engage more or remain active throughout their sobriety (Neale, Bloor & McKeganey, 2007). Coalter (2007) confirms the positive gains from recovering addicts who remained involved in physical activities that directly improved their physiological health and wellbeing through increased feelings of belonging and inclusivity. The following narratives demonstrate the want and need of the participants to be included and to access sport teams as part of their aftercare regime:

> *"There are some soccer fields by where I stay with a bunch of young guys, but there is nothing planned but maybe we can do something like that, do something a bit positive." (P6)*

> *"When I am done with the programme, I want to see if there are any sports groups like rugby I can join, soccer, something to keep me busy." (P12)*

From the aforementioned narratives it is evident that physical activity and sports remain an important factor in each of the participants recovery processes. The majority of the participants wanted to return to a sports group in their communities or establish one in order to keep them busy and motivated in their sobriety. These viewpoints expressed by the participants are evident in studies conducted by Coalter (2007) who advocates for sports groups being utilised in conjunction with formal addiction treatments and therapies as an aftercare tool. Landale and Roderick (2014) support these findings through exploring the notion of 'natural recovery' according to which sobriety can be sustained without formal treatment facilities and services, but rather through developing meaningful, purposeful activities and social support networks in the direct communities of those in recovery, which are often seen replicated in sports teams and groups.

4.8.3 Theme 2: Psychological challenges for recovering adult addicts in relation to aftercare services

The biopsychosocial model as explained in Chapter 3, was one of the first models to advocate for the inclusion of psychological and social elements in medicine (Engel, 1977). The aim of the biopsychosocial model was to shift treatment from a medical approach towards a holistic one which not only assisted in humanising treatment, but also placed it within the context of each person's lived social realities and environments (Black & Hoeft, 2015; Melchert, 2011). The psychological component of the biopsychosocial approach within addiction refers to the mindset, emotional state, and decisions that was made, that lead to substance misuse. Furthermore, theorists like Leshner (2006) described the psychological element of addiction as the 'essence' that further gives clarity on the unremitting cravings, substance using behaviours, and emotional instability which often leads to irrational decision-making regardless of the outcome and consequent relapse (National Institute on Drug Abuse, 2018a; Van Wormer & Davis, 2013). In theme 2 the psychological component of addiction together with the accessibility and availability of appropriate psychologically-based aftercare services in the Western Cape is analysed. The psychological components that will be analysed are emotional management, triggers, and the availability and accessibility of aftercare services.

4.8.3.1 Sub-theme 2.1: Emotional management

Chapter 3 revealed that poor emotional management of stressors remains one of the core challenges for recovering addicts in maintaining their sobriety and avoiding relapse (Proctor & Herschman, 2014). Recovering addicts are particularly sensitive towards emotional stressors and generally lack the appropriate coping strategies to address them. These emotional sensitivities are often seen during active addiction where substances are used as a defence mechanism and buffer in mitigating any psychological distress. This is illustrated in the narrative below.

> *"Your emotions will take over, your stress will take your mindset, the way you were thinking, the way you were talking, people who you approach and that is the thing that will be the biggest problem." (P1)*

It is compelling to see that participant 1 was able to reflect on how people, places, and things could form the risk factors in maintaining his sobriety, as well as the impact that poor emotional regulation can have on a potential relapse. The experience of participant 1 was supported by the National Institute on Drug Abuse (NIDA) (2020) in America that found emotional instability and sensitivities towards stress to be particularly common amongst MA users. These studies showed that the structural and functional damage to the brain mostly affect emotional regulation and memory. This is applicable to all of the participants interviewed who disclosed that MA or 'tik' was their primary substance of choice. The elements contributing to poor emotional management and regulation are described in the following four categories.

a) Aggression

As explained in Chapter 3, long-term chronic use and abuse of substances lead to both short-term and long-term brain damage. This damage often presents itself through the development of mood and anxiety disorders, of which aggression is common (National Institute on Drug Abuse, 2019). Due to these consequences of prolonged substance abuse, recovering addicts are prone to being increasingly sensitive towards emotional stressors. When recovering addicts stress emotionally, their stress responses take over and mostly present themselves as aggression, cravings, and irritability (Proctor & Herschman, 2014). The following narratives demonstrate the impact that

chronic use of MAs has in relation to the development of aggressive responses amongst recovering addicts:

> *"That temper, that temper will make or break you. If you don't have control you will go do the same things, you can hurt someone, you can end up in a bad space, and you will have a big problem." (P1)*

> *"Anger, I have a very big anger issue. You know I get angry very quickly, and that is the thing of the past that made me go and do drugs." (P4)*

> *"I have anger management issues. I get angry quickly. I need to learn how to handle it and not get so angry, to think before you speak to someone." (P12)*

The aforementioned narratives demonstrate the impact that chronic abuse of MA has on the development of an emotionally aggressive state of mind, with the majority of participants stating that they struggle with aggression. These narratives also demonstrate the importance of emotional regulation amongst those in recovery, as aggressive outbursts and emotions could lead to illogical and nonsensical decision-making that ultimately contributes towards a relapse. It is significant that participants 1, 4 and 12 were able to admit to having severe aggression issues as well as to acknowledge the role that aggression has played in previous relapses and could potentially play in future relapses if left unresolved. These findings were supported by theorists Steven (2015) and Hartney (2019) who stipulated that the more emotional control recovering addicts have over general life stressors, the more self-efficacy they will develop, and in turn would resort to protective factors like healthy coping mechanisms rather than risk factors such as defence mechanisms and stress responses.

b) Depression

Apart from developing aggressive tendencies, chronic MA users also tend to develop depression. Such depression could be attributed to the damage that long-term chronic use incurs on the brain, causing MA users to struggle to develop and experience pleasurable feelings when not using the drug (National Institute on Drug Abuse, 2019). This inability to experience pleasure normally is attributed to the neuronal damage causing subsequent dopamine deficiencies (Van Wormer & Davis, 2013). Depression together with symptoms like anxiety, confusion, and insomnia has also

been documented as a known withdrawal symptom amongst MA users. The following narratives portray the participants' experiences with depression in their recovery:

> *"I've made the wrong choices and I now am chronically depressed." (P3)*

> *"Also, the negative feelings are a trigger or bad feelings. I try to think positive things, but it isn't easy, and life is never easy, but it can make your way through healing a lot harder." (P4)*

> *"When everything in my life felt dark and heavy, it is now starting to feel lighter." (P2)*

The aforementioned narratives demonstrate how some of the participants have struggled with feelings of depression or negativity in their recovery. These experiences corroborate with the findings of Johnson (2004) and Van Wormer and Davis (2013) who documented the impact and results of prolonged substance use in the development of mood disorders and stress responses of which the most common were anxiety, aggression, and depression. It is interesting to note how participant 2 mentioned that things were "starting" to feel lighter. As was indicated in theme 1 of this chapter, chronic substance abuse has biological implications on the recovering addict and can in some instances, cause damage to the brain. Poor emotional regulation like depression are symptoms of the aforementioned damage sustained to the brain and for some of those in recovery, these symptoms can improve as the brain heals, thus possibly explaining why this participant felt 'lighter' since remaining sober.

c) Defence mechanisms

Chapters 2 and 3 explained the role of defence mechanisms amongst active and recovering addicts in light of emotional or environmental distress. Defence mechanisms present themselves as a buffer against emotional distress when healthy coping mechanisms are absent (Proctor & Herschman, 2014). In addiction defence mechanisms often refer to the negative behaviours and choices that active users make in the presence of emotional or environmental stressors, often resorting to substance use to mitigate the negative emotional impact of said stressors (Hartney, 2019; Swartz et al., 2011). The following narratives express how participants have responded to emotional or environmental stressors prior to receiving addiction treatment:

"In the beginning it was very hard for me, I didn't know how to handle my problems at the end of the day, and I would use." (P2)

"When I have an argument or don't get my way then I will take my money and go use." (P4)

"Whenever people argue and stuff, I get out and I go to the drugs and I use just to forget about it." (P9)

The aforementioned narratives demonstrate that substance abuse was the defence mechanism that the majority of the participants resorted to when confronted with emotional or environmental stressors. Some of the participants did not how to deal with their problems whilst others did not know how to effectively deal with conflict or arguments. In accordance with these narratives, Swartz et al. (2011) and Hartney (2019) express how substances are often abused and utilised as a defence mechanism when there is a lack of knowledge regarding acceptable solutions, coping skills, or meaningful relationships to act as a positive buffer to emotional distress.

d) Coping mechanisms

Closely related to the category of defence mechanisms, is that of coping mechanisms. Chapter 3 described coping mechanisms as behavioural, psychological, or social actions taken to positively address and handle stressors (Proctor & Herschman, 2014). Coping mechanisms are one of the core areas developed in addiction treatment within a controlled environment in an attempt to equip recovering addicts with the tools to navigate and effectively handle stressors in their own environments. Knowing healthy coping mechanisms provide recovering addicts with the opportunity to develop their self-efficacy which could assist them in handling and controlling their own emotions when met with stressful scenarios. The following narratives display the coping mechanisms that participants plan on utilising when they leave the treatment organisation and return to their own environments:

"I started praying and asking God for help with my cravings and problems. Any time I have cravings now I go to praise and worship and then write down what I am feeling. I need to occupy my mind, either talking about it or colouring in, all of these had really helped me." (P2)

"I learnt some tools to be maybe distract my mind from it, drink water, pray and just delaying it man. Telling myself not today and then each new day the same thing over and over." (P16)

"I speak to someone or I go and exercise, doing my own thing there at the gym and talk to someone." (P3)

The aforementioned narratives depict the most common coping strategies that participants plan on utilising when returning to their environments. Coping mechanisms utilised by most of the participants varied from praying, keeping a journal, drinking water, learning new coping skills, exercising, or speaking to someone. Proctor and Herschman (2014) echo these narratives by describing how important it is for recovering addicts to learn healthy coping skills in formal rehabilitation organisations in light of stressors. However, they also express concern that these coping skills are learnt and practiced in controlled environments which may present differently in the uncontrolled home environments of those in recovery. Thus, Proctor and Herschman (2014) call for the need and urgency of continued aftercare services in order to assist recovering addicts in navigating and coping in their turbulent and everchanging environments. This is particularly relevant in a South African context where the majority of the participants would be returning to environments plagued by poverty, gangsterism, violence, and extensive substance abuse and where continued guidance, support, and aftercare services from social workers remain crucial in maintaining their sobriety.

4.8.3.2 Sub-theme 2.2: Triggers

Chapter 3 referred to triggers as emotional, environmental, or social stimuli that bring about memories of prior substance use in recovering addicts (Patterson, 2020; Tagliareni, 2020). These triggers often induce cravings and compulsions to use amongst recovering addicts, which in turn increase the possibility of a relapse. Triggers in an addiction setting more often refer to people, places, and things that recovering addicts wish to avoid for relapse purposes. Moreover, it is important that social workers in intervention and aftercare treatment are able to assist recovering addicts in not only identifying their triggers, but in developing effective coping mechanisms in response to them (Fisher & Harrison, 2013). The following narrative depicts how this participant experienced triggers.

"Triggers for me, the fact that the places I used to hang out by and the people I hung out with there, and the drug houses where we would smoke drugs and use in the garage." (P8)

Identifying triggers such as mentioned in the above narrative in terms of people, places, and things is crucial in aftercare treatment for recovering addicts as this will help in improving self-awareness and in learning to foster positive coping mechanisms (Fisher & Harrison, 2013). Through achieving positive coping mechanisms, the impact and effect of triggers can be reduced and can assist recovering addicts in fostering positive social support networks and relationships to strengthen their mindset and sobriety. Three categories were identified under this sub-theme, namely people, places, and things.

a) People

As discussed in Chapters 2 and 3, a common trigger amongst recovering addicts are the people associated with their past. Moreover, 'people' refer to any significant individual involved in the recovering addict's life that prompts a strong emotional response that leads to thoughts or urges of substance use (Patterson, 2020; Tagliareni, 2020). These individuals do not only need to be directly associated with substance use but can be in any significant relationship such as a spouse or family member that rouse an emotional response. The following narratives express the 'people' that the participants deem triggering in terms of cravings and intrusive thoughts surrounding substance use:

"I need to avoid people who are using, because they are the people who put all the negativity to you, and I saw it first-hand. When you are still walking with the same friends it is a turning point in your life to still turn back and use, it is very hard to stay sober. Actually, all my friends are using so when I go out, I won't have any friends." (P12)

"I have a lot of friends who are using so, I learnt that I need to be calm and not go back to the same friends. The thing is that friends was one of the reasons I had relapsed, for the choices I had made." (P6)

"Me and my friends were in and out of jail and gangs, making the wrong choices. When I leave the programme, I need to choose better friends to make sure I make better choices when things get dark." (P8)

From the above narratives it is evident that the majority of the participants had friends in their environments with whom they abused substances, and who remain major triggers. The general findings of the participants were that they needed to avoid these friends or completely sever ties with them in order to maintain their sobriety and avoid being triggered with succeeding cravings. These findings were substantiated by Dyer's (2020) research. Dyer posits that recovering addicts need to re-evaluate their lives and choices, including the people they spent time with or abused substances with. Dyer (2020) continues how important it is for recovering addicts to make decisions that support and protect their sobriety but that these decisions often involve ending relationships with individuals who pose a threat or risk to their recovery.

b) Places

The environment in which recovering addicts reside can be a powerful trigger and risk factor to their sobriety. Often within their communities and environments there are specific high-risk areas that are associated or directly linked to previous substance use (Patterson, 2020; Tagliareni, 2020). As mentioned in Chapter 3, walking, driving, or any form of travel through these high-risk areas can trigger certain memories in recovering addicts in relation to previous addictive behaviours and substance abuse which may then result in subsequent cravings. An indicator of a possible impending relapse is when recovering addicts begin to purposefully subject themselves to areas associated with their prior substance abuse to test the boundaries of their sobriety and willpower. The following narratives demonstrate the established 'places' in the participants environments that act as triggers:

> *"My main problem is that I am staying next to a merchant, a drug dealer. That is going to be a big problem for me because every time I must walk by his house, you know, it's going to trigger me. All of the places I would use and drink, like the taverns, I must stay away from the taverns that is a big trigger." (P3)*

> *"There are many places I need to avoid where I know that they are using stuff, where they are selling stuff." (P5)*

The aforementioned narratives demonstrate that the majority of the participants had specific places within their communities that presented as triggers and risk factors to their sobriety. The findings

and narratives demonstrate that the most common trigger places in the communities were local drugs houses and common meeting places for using and selling of substances. The general consensus among the participants in light of this trigger was that they would attempt to find alternative routes for travel but for many, their communities were too small to avoid these places and would rely on willpower and coping skills to mitigate the effects. These findings were encapsulated by Tagliareni (2020) who stated that high-risk areas within recovering addicts' communities render them vulnerable to environmental triggers and subsequent cravings which can ultimately contribute towards a relapse.

c) Things

Chapter 3 described triggers in the form of 'things' as being difficult to identify as it relates to anything outside of 'people' and 'places' that causes a strong emotional response with thoughts of previous substance use amongst recovering addicts (Patterson, 2020; Tagliareni, 2020). This can refer to anything from dreams, foods, music, or drug paraphernalia. The following narratives give light to the various 'things' known as common triggers among participants:

> *"I have been getting Tik nightmares, I call them Tik nightmares I don't know what they are. The worst thing is that dreams can seem very real, and then I start smoking in my dreams and I feel the high." (P1)*

> *"Money was the biggest trigger at the end of the day. If I didn't have money, I would smoke dagga and when I had some more money, I'd use it and smoke Mandrax and tik." (P2)*

> *"I only get these dreams about these things, you know, that I am smoking and doing the drugs in my dreams and it is something I must get rid of because having the thoughts in your mind can trigger you when you go outside." (P4)*

The above narratives demonstrate the most common triggers in relation to 'things' amongst the participants. The majority of the participants referred to money and 'tik dreams' as being their main triggers. It is significant to note that 'tik dreams' experienced by the participants involve having incredibly vivid dreams of smoking MA and experiencing the euphoria of the high so when they wake up, their cravings would continue. These findings were reflected by studies conducted

by Milios (2016) that found that dreaming about former substance use were common amongst recovering addicts, especially amongst those who were completely abstinent.

4.8.3.3 Sub-theme 2.3: Availability and accessibility of psychological-based aftercare services

Chapter 2 investigated the importance of psychologically-based aftercare services, such as individual or group counselling as ways of relapse prevention. Statistics have shown that recovering addicts who are actively and regularly involved in a support group, or who are receiving individual therapy, have improved rates of sobriety than those who do not (Orbon et al., 2015). Therefore, it is fundamental that psychologically-based aftercare services are not only accessible and available to recovering addicts in their communities but that they are also linked to these services after treatment. South Africa and specifically the Western Cape, have a multitude of barriers in terms of availability and accessibility of psychologically-based aftercare services amongst their communities. These barriers are geographical and financial limitations for the poorer communities to access services, as well as poverty, crime, and violence which renders aftercare services ineffective in such triggering and unstable climates (Pasche et al., 2014; Myers et al., 2012). The following narratives portray the challenges participants experience regarding the availability and accessibility of aftercare services.

> *"It's a bit difficult in my area so we use the church as a support group, my family are my support group. There is an N/A meeting in the next town that maybe my family can take me." (P12)*

> *"No there are no support groups and no aftercare in my area." (P6)*

A general lack of available and accessible psychological-based aftercare services remains a pertinent issue in the Western Cape, as displayed in the narratives. Psychologically-based aftercare services, such as support groups or individual counselling with a social worker, remains largely inaccessible in the Western Cape. This can be attributed to poorer communities that remain geographically isolated with the majority of aftercare services that are far-removed within the city and that calls for lengthy and uneconomical commutes (Lutchman, 2015; Myers et al., 2010). Two categories were identified under this sub-them, namely support groups and social workers.

a) Support groups

Support groups or group counselling aim to provide a non-judgmental, safe space for recovering addicts. These support groups are most commonly found in church-based programmes or follow Narcotics and Alcoholics Anonymous with the 12-step programme (Ederies, 2017). Chapter 2 described support groups as assisting recovering addicts in fostering supportive networks and relationships with other individuals in recovery. These support group sessions are therapeutically based and is where recovering addicts share their experiences and concerns, and learn new social skills, and coping mechanisms. Support groups are typically established and run by social work professionals, non-governmental organisations, or individuals affected by substance abuse (Western Cape Government, 2016). Research has continually demonstrated the importance of attending support groups during aftercare programmes for recovering addicts due to their strong links with social support and motivation to adhere to recovery goals (Orbon et al., 2015; Gordon, 2003). Despite the known benefits of support groups in maintaining sobriety amongst recovering addicts', structural barriers continue hinder accessibility and availability of such aftercare services across South Africa. The following narratives demonstrate the accessibility and availability that participants have to support groups in their communities:

> *"Every now and then I hear about it, there are many support groups in Cape Town but in Worcester there is a lack of support groups. In the past I did relapse because there was no structure of support groups you see. You hear about them now and when you go there, there are none." (P11)*

> *"No when I am done with the programme, I am going to try come back to the programme here, there are no services by me, it is far to walk to the next town, to Tsitsikamma for services." (P14)*

> *"I heard of some support group but it's not in the area, it's in the other area you see. But here there is no support group I must go to the next area or the next town." (P15)*

The aforementioned narratives depict the continued structural barriers that many of the participants face when wanting to access support groups in their communities. Most of the participants did not have support groups in their immediate environment and had to travel to different towns to receive

treatment. This in itself was an issue amongst many of the participants as they had to find someone to transport them to support groups, while some stated that the support groups did not exist upon their arrival. These findings are echoed by Myers et al., (2010) who describe structural barriers to support group services that remain an issue, such as communities being geographical distanced from services which render them inaccessible, together with affordability, and availability.

b) Social worker or therapist

In Chapter 2 the importance of continued emotional support amongst recovering addicts in their aftercare regime is discussed. This support is often provided through the therapeutic relationship with their professional social worker. Such individual counselling provides emotional support and also helps recovering addicts to maintain their sobriety by regularly assessing their wellbeing and by demonstrating empathy and compassion. Individual counselling also provides continued support and guidance when these recovering addicts integrate back into their communities (Corcoran & Roberts, 2015; Sarason & Sarason, 2009). Thus, individual counselling sessions allow those in recovery to be consistently monitored and to immediately address any vulnerabilities to relapse (Gordon, 2003). In South Africa, however, the majority of social work personnel are allocated and dedicated to rendering prevention and intervention services, whilst individual counselling for aftercare services are often neglected and unavailable due to shortage of staff and time (Brown et al., 2002). The following narratives demonstrate the participants' need and want to access available social work therapeutic aftercare services:

> *"Yes, I would like to see a social worker, it keeps you sober and away from the wrong things." (P14)*

> *"I'll got back to the rehab for aftercare when I am done with my programme, I would like to carry on with the social worker." (P3)*

The aforementioned narratives demonstrate that the participants would want to access aftercare services with a social worker in a therapeutic environment. The majority of the participants conferred that they would want to utilise a social worker in their aftercare but were unaware that this was an option. These findings are reflected by Bhana (2007) who demonstrates that in South

Africa, less than 30 percent of recovering addicts that enter the aftercare phase after formal treatment, will be referred to, made aware of, or request aftercare services.

4.8.4 Theme 3: Social challenges for recovering adult addicts in relation to aftercare services

The social aspect of the biopsychosocial approach examines the behaviours and interactions amongst larger groups that may have an influence on the individual (Horvath et al., 2020). Chapter 3 described the social element of this approach in addiction as gaining an understanding of how the behaviours and collaborations amongst families and communities may interact with, and affect, the recovering addicts' journey with maintaining their sobriety (Daley, 2013). The social element of the biopsychosocial approach assists social workers and recovering addicts in determining the quality of life that can be expected when the recovering addicts return and reintegrate back into their communities. Thus, the recovering addicts can prepare coping mechanisms for themselves to address certain risk factors and triggers in their communities, such as unemployment, poverty, poor familial relationships or substances that remain easily accessible. Through the establishment of specific risk factors, certain coping strategies can be implemented in advance, thus attempting to mitigate the impact of triggers on the recovering addict, all in an effort to act as a buffer to potential relapses. The following narrative illustrates how goals can be utilised as coping strategies in order to prevent relapse.

> *"It is difficult to be here because if you are not busy, with nothing to do, there is a gap for relapse. You need to achieve your goals, figure out your goals and learn to see yourself somewhere in life. This community and the people in it need a lot more support." (P15)*

This narrative illustrates the importance of knowing high-risk situations and triggers in the community and of establishing coping mechanisms and appropriate aftercare services in maintaining sobriety. These coping strategies and buffers to high-risk situations often present themselves as strengthening significant relationships whether familial or otherwise, through establishing support networks in the community, and by providing linkages to appropriate aftercare support services (Lewis et al., 2011). In the next section the social components of addiction will be analysed. These are the impact of interpersonal relationships, the accessibility to and availability

of substances within communities, and the accessibility and availability that recovering addicts have to social support services in the Western Cape.

4.8.4.1 Sub-theme 3.1: Interpersonal relationships

In Chapter 3 the role of dysfunctional families and significant relationships in the development of SUDs amongst recovering addicts, was discussed. Dysfunctional families and problematic relationships were documented as one of the strongest risk factors to the development of an addiction disorder (Daley, 2013; Donovan & Marlatt, 2005). It is important to note the impact that addiction has, not only on the recovering addict, but on their families and other meaningful relationships. The people involved in the recovering addict's life often face immense stressors, such as emotional stressors (anxiety or depression), financial burdens, and instability where violence and abuse were present (Goldenberg & Goldenberg, 2000). Therefore, it is important for families to be included in the healing and recovery process, in order for the recovering addict to effectively reintegrate into these relationships after treatment. Interpersonal relationships in the recovering addict's life can either act as a buffer or risk factor to relapse. The following narrative explains a recovering addicts' experience of friends and family.

> *"I know that I am going to have to go back to my community, I need to face my life there and the problems I made. I will face old friends and I will ask that they respect my choices and won't try to misguide me. I need to rebuild with my cousins and family who were always there for me, my family will play a big role in my sobriety." (P2)*

Negative interpersonal relationships stop the recovering addict from reaching ideal social functioning and can consequently contribute towards a relapse (Donovan & Marlatt, 2005). However, when interpersonal relationships remain positive, recovering addicts often rely on these individuals for support and guidance through their recovery process. It is interesting that these findings are reflected in the narrative wherein the old friendships of the participant will stand as a risk factor to his sobriety given that they also abuse substances, whilst his family will stand as a buffer and support structure, despite there being emotional damage that needs to be repaired. Three categories were developed under this sub-theme, namely peer groups, intimate partners, and family members.

a) Peer groups

Peer groups and friendships remain an important risk and protective factor amongst recovering addicts. Often friends have fallen under the category of negative interpersonal relationships wherein substance abuse was a common thread. However, friends can also foster positive relationships in which sober habits and support are prominent features (Donovan & Marlatt, 2005). Basic human nature calls for the need and want to belong to certain groups, even if this involves fostering negative peer groups and friendships (Louw & Louw, 2007). The impact of peer groups as a risk or protective factor is demonstrated through the following narratives:

> *"My friends are gang bangers, they use me, and I do not feel like I am being loved, it's false. Because I know that real friends don't give each other drugs, they would rather give support. I can't say I've been supported by them, before, I thought they loved me and that they were my only family." (P1)*

> *"I only have one friend, a very close friend, a best friend. I was usually doing my thing with him and we were both smoking drugs. At the moment he is still using drugs, but I must stay away from him, I've made my choice and he understands." (P3)*

The aforementioned narratives demonstrate that most of the participants had peer groups in their communities wherein substance abuse was the common link. It is interesting to note that participant one and three could identify their peer groups as a negative influence as well as a risk factor to their sobriety. This was evident as participant one was able to reflect on the toxic nature of his friendships together with the common link of substance abuse and pondered on the true meaning of friendship in terms of healthy support and love. These narratives correlate with findings of Louw and Louw (2007) who described negative peer groups as having often been accompanied by risky behaviours such as substance use, criminal activity, or sexual misbehaviours, all of which remain detrimental to a recovering addicts' sobriety. These negative peer groups are often found to be linked to substance abuse and continue to remain a risk factor for recovering addicts after treatment.

b) Intimate partners

Intimate partners refer to spouses or dating partners of recovering addicts, both in the present and the past (Patterson, 2020). SUDs have been strongly associated with unhealthy intimate relationships. These relationships are important risk factors when recovering addicts attempt to reintegrate back into their families (Daley, 2013; Donovan & Marlatt, 2005). If unhealthy intimate partner relationships remain unchanged throughout the recovering addicts' treatment and recovery, it increases the chances of relapse during the reintegration and aftercare phase. This can be attributed to the progress made in treatment remaining unrecognised and compromised by previous unresolved trauma in the relationship. This unresolved trauma amongst intimate partners can present itself in the resurfacing of previously dysfunctional communication patterns and behaviours which can lead to emotional triggers such as a loss of motivation and feelings of hopelessness in the recovering addict. Thus, it is important for those in recovery to ensure that their intimate partner relationships are maintained and that they function in a healthy, positive space, and that they can act as support structures. The following narratives demonstrate the challenges but also the importance of intimate partners in the participants' lives:

> *"Lots of times when I'm in an argument with my girlfriend, after the argument I was stressed and would want to use. The arguing with my girlfriend is a trigger but we haven't been arguing that much since I've been in the programme, I want to rely on her, she's all I have." (P16)*

> *"My girlfriend, we have a child together, but her parents did not want to accept me because of my wrong choices and the drugs, but this is my last chance they are giving me. I have a short temper with her, but I want to make it work" (P12)*

The aforementioned narratives demonstrate that intimate partner relationships remain important support factors in the lives of participants. These participants were able to recognise risk factors in their relationships and could even mark arguments with their partners as emotional triggers. Despite these identified triggers and possible contributing factors to a relapse, these participants wanted to pursue their relationships and rely on them for support. It is interesting to note that participant 12 mentioned his partner's parents and their lack of trust in his actions, which demonstrates the impact that unresolved trauma and substance abuse can have on family. These

findings are echoed by Donovan and Marlatt (2005) as well as Daley (2013) who found that unresolved trauma amongst intimate partners and family members due to the recovering addicts prior substance use, can act as a risk factor to relapse. This is because the recovering addict may heal and improve in their communication, behaviour, and dealing with past traumas, whereas the family at home remains unchanged.

c) Family members

Family members either play a significant role in the support of recovering addicts or in their relapse. SUDs are strongly associated with dysfunctional family dynamics and genetic predispositions, as was discussed in this chapter as well as in Chapter 3 (Donovan & Marlatt, 2005). It is important that families should enter their own process of healing in order to resolve past traumas associated with the recovering addicts' active addiction (Daley, 2013). This allows for the family to express their trauma and concern whilst learning new tools in communication and coping mechanisms. The purpose of this is for the family to prepare and accommodate the recovering addict's reintegration into the family without having to address traumas associated with the addict's previous substance abuse. The following narratives depict the family involvement with the participants as support structures in their aftercare regime:

> *"I am still in contact with my brother, he tells me I must keep strong. I look up to him, he's been clean for a year and a half and it's a lifestyle now. I want to do the same thing and he supports me." (P3)*

> *"My aunt is sober and that is where I am going to go stay after this programme, she is going to be my mentor and show me the path I need to walk." (P5)*

> *"At the moment, my family is very supportive since I've been in the programme, even though I did the wrong things, and did the wrong things in the house like stealing and smoking, I broke their trust but they're still here." (P8)*

The aforementioned narratives demonstrate the importance of family involvement as support structures in the lives of the participants. The majority of the participants named family members as their primary source of support when entering the aftercare phase of their treatment. It is noteworthy in the account of participant 8, that despite damaging the family relationship through

breaking their trust during his active addiction, the family remains supportive of his treatment and aftercare. These findings are confirmed by Arthur and Blitz (2000) who noted the importance of having a strong family cohesion and sense of communication as a protective factor against relapse amongst recovering addicts. Furthermore, the comment of participant 8 with regards to his family that remained supportive despite his substance abuse, is echoed by Bröning et al. (2012), who stated that family empowerment and resilience have remained vital in the prevention of substance abuse and relapse.

4.8.4.2 Sub-theme 3.2: Accessibility and availability of alcohol and drugs in the community

As discussed in Chapter 2, substance abuse rates in South Africa remain extremely high with the South African Medical Research Council that stated as far back as 2013, that 11 percent of the population suffered with some form of untreated addiction disorder (Reagon, 2013). Substance abuse in the Western Cape have been linked to increased crime, unemployment, dysfunctional communities and families, together with increased transmission of communicable diseases (Isobell et al., 2018). Furthermore, the thriving drug trade in communities across the Western Cape provides serious implications for the sustained sobriety of recovering addicts. As discussed in sub-themes 1.2 and 2.2, cravings and triggers, the availability of substances, and the ease of accessibility remain significant risk factors and predisposing factors for relapse for those in recovery in their communities. It is also clear that when recovering addicts learn coping mechanisms to address cravings and triggers while attending rehabilitation centres, these teachings are rendered in controlled environments (Addiction Centre, 2019). Thus, when recovering addicts return to their communities they are faced with uncontrolled environments, triggers, and direct access to substances in their communities, wherein the coping mechanisms they were taught may be rendered ineffective. The following narratives encapsulate the challenges recovering addicts face when entering the aftercare phase of their treatment in terms of the availability and accessibility of substances in their communities:

> *"There are a lot of ways to get drugs, the drug houses. There are three drug houses all around that you can smoke at but about two or three more drug houses where you can also get alcohol. They are all nearby." (P12)*

"No, it's not easy to get drugs here, it's a one and a half hour walk to find drugs in the next town. Alcohol is the most used in the town." (P14).

"It is very easy to get drugs and I was part of a gang. So, I would go to their house where they are operating, selling drugs and I was one of the guys keeping the drugs where I was staying. So, it is very easy to get drugs there." (P15)

"It is very easy: they just opened another shebeen in my community." (P16)

The aforementioned narratives demonstrated that for the majority of the participants, drugs, and alcohol were easily accessible in their communities, most commonly through drug houses, shebeens, and gangs. It is interesting to observe that for participant 14, who resided in a more rural area of the Western Cape, drugs were not easily available or accessible, but alcohol was. However, it is worth noting that despite the hour and a half trek to find substances, the participant would regularly commit to this commute in order to sustain his addiction. The aforementioned issues were encapsulated in the South African Government's response to the accessibility and availability of illicit substances in communities, through establishing the NDMP of 2013-2017 in which the target for demand reduction involved clamping down on the illegal sale of substances and alcohol in local shebeens and drug houses (Republic of South Africa, 2016-2017). Despite these efforts, the aforementioned narratives demonstrate that drug trade is flourishing in the local communities across the Western Cape through both the establishment of illegal drug houses and shebeens, coupled with the influence of gangs in the trading of illicit substances.

4.8.4.3 Sub-theme 3.3: Accessibility and availability to social support structures

Social support structures remain crucial in the lives of recovering addicts in maintaining their sobriety (Orbon et al., 2015; Gordon, 2003). The importance of support structures has been discussed in Chapter 3 and sub-theme 2.3. As previously mentioned, support groups have shown consistent linkages to improved sobriety rates when attended on a long-term basis as well as with assisting recovering addicts in fostering social support networks in their communities. These social support networks assist in guiding recovering addicts and maintaining their motivation in adherence to their treatment goals. Yet, in South Africa, aftercare social support services are not easily accessible, as they rely heavily on referrals as the gateway to accessing available treatment

options and because referrals are often met with systemic and structural barriers (Myers et al., 2010). As discussed in sub-theme 2.3, access to and availability of social support groups to the recovering adult addict is often met with structural barriers, such as financial issues and geographic locations (Pasche et al., 2014). These structural barriers are often also combined with systemic barriers, such as recovering addicts not being referred to appropriate, available social support services when accessing their aftercare phase of treatment. Referrals as a systemic barrier could result in recovering addicts having limited knowledge on appropriate support and treatment options in their aftercare phase, which in itself acts as a risk factor for relapse. The following three categories were developed for this sub-theme, namely, Church, rehabilitation centre aftercare services, and sport groups, which are presented below.

a) Church

One of the most common forms of social support in aftercare services remains church-based initiatives. Church-based groups provide a safe, non-judgmental environment for recovering addicts and are often easily established amongst community networks. For many recovering addicts', religion is a significant factor in their lives and is often utilised to maintain their sobriety and to reintegrate into their communities (Ederies, 2017). Research demonstrated that religion and spirituality amongst religious recovering addicts can act as a protective buffer in stress inducing settings (Miller & Thoresen, 2003). Furthermore, studies have demonstrated that spiritual activities, or attendance of church-based groups, have often elaborated on the themes of hope, strength, and finding purpose in life, all of which act as protective buffers for those in recovery. The following narratives demonstrate the importance of church-based social support groups in the participants' aftercare regimes:

> *"I was raised that I must go to church every Sunday, so I am very familiar with churches. When I leave the programme, I want to join the church again and take part in their activities. It will help my focus and help to keep me busy." (P2)*

> *"There are churches here, but they fall, then they rise again and fall. I need to decide on where I am going to church because I don't want to go to a place that is going to fall in three months, and then starts in six months again. It will affect me and my Christianity, I want to go where I feel welcome and fit in." (P4)*

"Jesus needs to be the centre. I must go to church and be part of the community. I need their support, there is one on the farm at least, I just didn't go because I was using." (P7)

The aforementioned narratives describe the importance of religion and church-based groups in the recovery of participants. Most of the participants expressed that they want to utilise church-based groups as part of their support structures. Most of the participants also mentioned that they had stopped attending church due to their substance abuse. It is interesting to note that participants 2 and 7 described church-based social services as being critical in their recovery in terms of support, reintegrating back into their communities, and helping them to maintain focus on their goals and sobriety. These findings are supported by Morjaria and Orford (2002) who describe church-based groups in aftercare as an important social support service for recovering addicts where support is rendered towards sober living and where recovering addicts occupy their time with church-based activities, together with the church promoting social values encouraging living a substance-free life. However, it is important to note that, although church-based support groups can act as protective factors, they can also act as a risk factor if not managed correctly. This is evident from participant 4's account where the churches in his community were unreliable and constantly changing and where he experienced being potentially stigmatised. Participant 4 described how these elements acted as a risk factor to his sobriety and Christianity together with him wanting to find a religious-based group where he would not be exposed to stigmatisation for his previous substance use but rather be accepted without judgment. Fisher and Harrison (2013) conferred with this narrative in that social stigma, even in religious-based settings, can be a risk factor to relapse amongst recovering addicts as it directly impacts their self-efficacy and can lead to feelings of shame and hopelessness.

b) Rehabilitation centre aftercare services

Rehabilitation organisations provide controlled environments wherein patients are rendered medical, psychological, and emotional support in recovery. Although most rehabilitation organisations are known for rendering inpatient or outpatient intervention services, many provide social support services for those entering their aftercare phase of treatment (Addiction Centre, 2019). These support services are rendered as individual counselling with a social worker, or as support groups, as mentioned in sub-theme 2.3. However, in South Africa, rehabilitation

organisations are generally understaffed, and would the available social workers usually be assigned to render prevention and intervention services (Brown et al., 2002). Consequently, individual therapy with a social worker during the aftercare phase of treatment at a rehabilitation organisation remains severely limited and largely unavailable for those in recovery. However, the majority of the rehabilitation organisations provide aftercare support groups for recovering addicts wanting to attend, although this option may not always be geographically accessible to recovering addicts living across the Western Cape. The following narratives represent the want and need for participants to access after services from their former rehabilitation organisation:

> *"I need to be close to the rehab so that I can feature back into the community and get some support from the brothers and the pastor at the rehab." (P1)*

> *"I know three support groups at the rehab, at the moment I have one here at the rehab, I got one by the church here and another I'm busy with now, but not when I go home." (P3)*

> *"At the moment I am still at the rehab programme but after this I will go back, there is support here and a ministry where they can guide you, they have walked the path with me, it makes it easier." (P8)*

The aforementioned narratives depict the importance of participants being able to utilise their former rehabilitation organisation as a source of support for aftercare services and guidance in their recovery. It is interesting to note that participants 8 and 1 wanted to utilise the rehabilitation organisation as an aftercare service where the social work personnel had been directly involved in their intervention phase. Moreover, these participants wanted to remain in contact with the other recovering addicts from their programme as there seems to be a sense of belonging, familiarity, and comfort amongst them. Lastly, it is interesting to note that participant 3, despite having to travel, wanted to utilise the rehabilitation organisation as he was certain of the aftercare services rendered there, whereas it seems that there was no available or accessible form of support structure or group in his community. These narratives further demonstrate the importance of rehabilitation organisations rendering direct aftercare services to recovering addicts as well as ensuring that appropriate referrals to services are made so that those in recovery are able to access aftercare services based in their communities (Myers et al., 2010).

c) Sports groups

Sub-theme 1.3, elaborated on the importance of sports groups in the recovery process of recovering addicts. As discussed in sub-theme 1.3, sports groups are not only important from a health point of view, but also serves as an important factor as a social support structure for recovering addicts. Sports groups have been documented in improving the health and emotional wellbeing of those in recovery through promoting elements of inclusivity, purpose, and a sense of belonging (Coalter, 2007). Sports groups also assist those in recovery in reintegrating into the community, becoming directly involved in community activities, whilst promoting a heathy, sober lifestyle. The following narratives demonstrate the importance of sports groups as a social support structure in the recovery process of the participants:

> *"When I'm done with my programme; I'm going back to the soccer team. I am going to play soccer and my friends there are very supportive because they don't use substances, all of them are clean. I left the team because of my addiction." (P3)*

> *"Basically, I will be playing sports, I am a rugby player, so ja, it is my motivation to go back into sports and be a famous rugby player." (P11)*

These narratives verify the findings in sub-theme 1.3 where the majority of the participants described sports as being an important factor in their recovery and confirmed that they would want to utilise sports teams in their communities as an aftercare service. It is interesting to note that participant 3 described how sport played an important part in his life prior to his active addiction, and that he would want to return to the sport group, now that he is in sobriety. Furthermore, participant 3 described the sports team as a support structure in which his fellow teammates led sober lifestyles and would provide encouragement for him to remain sober. Participant 11 described sports groups as a positive factor in his sobriety as he was motivated to develop his identity as a rugby player in the community. These findings are supported by Coalter (2007) who examined the identities that recovering addicts undertook during their active addiction and how these identities change and develop through sobriety. Coalter (2007) went on to explain how sporting groups facilitate this change in the identity of recovering addicts through providing the means in which to transform through the routine activity of sports, the social controls involved in

the team dynamics, and the increased personal efficacy to attend the group and remain motivated in doing so.

4.8.5 Theme 4: Cultural challenges for recovering adult addicts in relation to aftercare services

The cultural dimension of the biopsychosocial approach is often interlinked with the social dimension in that both examine the behaviours of larger groups (Horvath et al., 2020). Moreover, the cultural dimension examines the behaviours and relations among families, communities, and societies as a whole. As discussed in Chapter 3, culture refers to the values, beliefs, and practices that are shared in a specific group that influences and guides the group's interactions and actions. An important aspect of culture is noting how historical events continue to impact specific groups or parts of the population which in turn could result in the generational transmission of culture amongst communities and families. In South Africa, culture remains an important aspect of community and family life and is demonstrated through the multitude of languages, traditions, and cultures across the country. Furthermore, it is important to note how historical events such as Apartheid led to the oppression, discrimination, and racial inequality and segregation amongst the South African population. The remnants and impact of Apartheid continue to affect families and communities with the emotional trauma of grandparents and parents being inherited through the generations. Resounding elements of Apartheid are still evident in South Africa where the geographical separation amongst the population and unequal access to critical services in rural areas are some of the most evident residual effects (McCann et al., 2011). Within addiction treatment in South Africa, culture needs to be understood, respected, and utilised as an empowerment tool by social workers rendering services. Thus, as mentioned in Chapter 3, the concept of cultural recovery is central in rendering addiction services in a South African context. Cultural recovery involves assisting the recovering addict in reclaiming their ethnic identity and re-establishing their sociocultural support network amongst their families and communities. If recovering addicts are unable to recover culturally within their aftercare phase, they are at risk of being alienated from their own sense of self, their families, and their communities, which would then pose as a risk factor to relapse (Szelemko et al., 2006).

4.8.5.1 Sub-theme 4.1: Community standpoint

As discussed in Chapter 3, part of cultural recovery involves rebuilding the recovering addict's sociocultural support network and regaining their cultural identity. The purpose of this action is to establish the addict's role in the community and family, which in turn helps with the reintegration and support when the addict enters his aftercare phase of treatment (Horvath et al., 2020). Cultural recovery and reintegration into the community can play an important role for recovering addicts in regaining their identities, their purpose, and finding acceptance in their communities (Szelemko et al., 2006). Social work aftercare services should parallel the community cultural values in order to ensure that the aftercare services rendered are appropriate and meaningful to both the recovering addict and their community. This will assist the recovering addict to navigate their aftercare phase of treatment and find guidance in re-establishing themselves in their community and culture. Three categories, namely stigma, poverty and unemployment, and absent parents, were developed under this sub-theme in light of community aspects of addiction and are presented below.

a) Stigma

Stigmatisation towards the use and abuse of substances in cultures across communities and amongst families remain a risk factor to recovering addicts. In Chapter 3 the extent to which substance abuse and associated SUDs are culturally scrutinised in communities across South Africa is examined. Addiction is often interpreted as shameful, embarrassing, and a humiliation of the family unit in the community. This can result in the family rejecting those in recovery or keeping their addiction a secret from the community (Rassool, 2011; Routledge, 2005). The impact of this stigmatisation and scrutiny can foster feelings of guilt, worthlessness, and hopelessness amongst recovering addicts, whilst simultaneously alienating them from their own families and communities. This in turn acts as a serious risk factor for relapse amongst recovering addicts together with an attitudinal barrier to accessing treatment as the utilisation of aftercare services would be a direct admission and link to addiction thus exposing the addict to subsequent stigmatisation and alienation. The following narratives express the participants experiences of stigmatisation or lack thereof in their communities:

"I wish that I had more understanding growing up because my mother and them loved me very much, but they were only loving inside of the house, and when we were outside, they had been embarrassed and didn't understand me." (P2)

"When you come from a poor community, and see rich people, you always think oh that guy is rich, he has such a good life so what's the point? You never think about how far you can go in life. You always think that you can never reach that point and that these people are always above me. I don't want my child to ever feel that." (P4)

The aforementioned narratives demonstrate how most of the participants had experienced some form of stigmatisation from their childhoods onwards, as well as the resounding effects stigmatisation has had on them developing SUDs. It is interesting to note that feelings of hopelessness, worthlessness, and isolation were commonly expressed by participants 2 and 4. The participants' experiences and emotions associated with stigmatisation are echoed by the findings of Horvath et al. (2020) and Routledge (2005) who mention that the consequences of stigma are feelings of loneliness, isolation, guilt, and shame which in turn act as serious risk factors to recovering addicts in their community.

b) Poverty and unemployment

Chapter 3 evaluated the impact of poverty and unemployment in the development of SUDs together with how these elements act as a risk factors to relapse amongst recovering addicts. Major structural barriers like geographic positioning, affordability, and availability impact the access that recovering addicts have to aftercare services (Pasche et al., 2014; Myers et al., 2012). The majority of aftercare services in the Western Cape are rendered in the city leaving those in the more rural areas unable to access critical aftercare treatment with lengthy and expensive commutes being unattainable and unaffordable. Furthermore, poor community health is a major contributing factor to relapse amongst recovering addicts who return to poverty-stricken areas where unemployment, crime and violence, and accessibility to substances are rife (Ederies, 2017). The following narratives depict the challenges associated with poverty and unemployment in the participants communities:

"Most of the people in my community that I know are on drugs. I would say that it's boredom because there is nothing to do for our wealth or personal finances. There are no jobs, there is nothing they can do so they are on drugs." (P3)

"The people here are used to that thing of selling drugs and alcohol to children. Everyone in the community is used to it. It goes from generation to generation how they use and sell here." (P5)

"There is a lack of jobs where most of the people are not working. Most of these people have become comfortable and when there is no income; they start their own business. These businesses are selling beer, weed, cigarettes and other drugs. There is also a lack of education so they can't get proper jobs." (P15)

The aforementioned narratives depict how the majority of the participants have residing poverty and unemployment in their communities which has driven community members to not only use, but also sell drugs and alcohol to gain an income. It is significant to note that participant 15 mentioned how the unequal access to a proper education amongst the community members has resulted in unemployment and subsequent poverty. This is important in understanding how poverty can be transferred through generations where there is unequal access to basic services like education. It is interesting that participant 5 also commented on the generational patterns of poverty and ensuing substance abuse. This participant described how the abuse and selling of substances in his community has become the norm and part of the community culture where it has been passed down through the generations as a survival tactic and means to provide an income. This account corroborates with the findings of Horvath et al. (2020) who describe how the trauma of Apartheid was passed down through the generations, resulting in the newer generations of children and young adults experiencing similar emotional trauma and associated feelings of their elders. This echoes the experience of participant 15 who resides in one of the previously segregated areas under Apartheid that still remains largely separated from other communities and where unemployment and poverty have endured, with limited access to equal opportunities. It is noteworthy how the culture of drug use and abuse has developed through the generations in these isolated and disadvantaged communities and have passed down to the youth as a means of survival, whilst the pervasive cycle of poverty continues.

c) Absent parents

It is important to note what impact parents have on children, whether this involves parents who abuse substances, or parents who are absent. For children who have a parent that abuses substances, the chances of them developing a SUD are significantly higher (Solis, Shadur, Burns & Hussong, 2012). Furthermore, the family environment plays an important role as a risk or protective factor to children developing SUDs later in life. Important risk factors to note are family environments that are coupled with family-related stressors, marital issues, parental conflicts, and households where parents are absent, all resulting in environmental instability. The following narratives demonstrate the challenges and impact of absent parents in the development of SUDs amongst the participants:

> *"My father was just using. I needed a father figure in my life. At the moment I think my mother did the best that she could do but I still disobeyed her because I thought that I didn't have a father so what was the point. You start following your own thing." (P1)*

> *"I didn't have a father figure in my life, and I had gone looking for that father person in gangs and drugs." (P2)*

> *"The mothers and the fathers need more job creations so things can get better. They must come and stand up as mothers and fathers for their children so they can lead their children and teach them how to grow up with the values of life. The mothers and the fathers need to be the role models otherwise these children will keep making the wrong choices." (P15)*

These narratives depict the importance of the roles that parents play in children's lives and how they influence the development of SUDs. Participants 1 and 2 mentioned being directly affected by not having a 'father figure' in their lives, causing them to have feelings of ambivalence and worthlessness. Furthermore, it is interesting to note the level of importance that the participants placed on having a father figure in their lives where, despite their mothers being actively involved, they still turned to drugs and gang involvement in order to compensate for their fathers being absent. These narratives resonate with Routledge (2005) who stipulate that a lack of family involvement in the recovering addict's life can increase the chances of relapse due to decreased emotional support and as such absence could echo feelings of worthlessness and the perception of

being unloved and uncared for. It is thought-provoking how participant 15 called for the need for parents to 'stand up' as mothers and fathers and pursue an active role their children's lives in order to guide them towards healthy and positive decisions. This further reiterates the negative impact of absent parents in communities across the Western Cape which leaves children vulnerable to substance abuse and gang recruitment.

4.8.5.2 Sub-theme 4.2: Gangsterism

Gangsterism is a pervasive issue in South Africa and particularly in the Western Cape with historical roots that demonstrate the social and economically fractured province (Bowers Du Toit, 2016). Crime, violence, and drug abuse are common aspects of gangsterism in the Western Cape and these actions have dramatically increased over the years. The National Annual Crime Statistics in 2018 found that 83 percent of all gang related murders originated in the Western Cape, and that 808 gang related murders out of 973 in the country took place in the Western Cape (Western Cape Government, 2019). Communities plagued by gangsterism in the Western Cape are strongly associated with poverty, unemployment, and poor education rates. Involvement and affiliation to gangsterism in the Western Cape has also become prominent in the poorer communities due to the overwhelming presence of gangs, the role of absent parents, living in poverty-stricken conditions, and being attracted by the support rendered in terms of finances, munition, and illicit substances to name a few. One participant noted the following regarding gangsterism:

> *"The people are scared to speak against the drug problem here. And a lot of the police here are involved with the drug dealers and gangsters so they can't do much or be used, the gang leaders have huge control over the community." (P2)*

The aforementioned narrative encapsulates the severity of gangsterism in communities across the Western Cape. Communities and families are held hostage by the violence, crime, an influx of drugs, and the control that gangs have in the Western Cape. It is concerning to note that this participant also mentioned the involvement of police in supporting gangsterism as this renders communities even more vulnerable with limited options for support and reliable safety. Kinnes (2000) conferred that the feeling of powerlessness amongst communities in light of gangsterism has been compounded by similar accounts of direct police involvement in gangsterism which has rendered communities even more vulnerable and mistrustful of the very systems that were put in

place to protect them. The following three categories were developed in light of gangsterism in the Western Cape and its subsequent role in the development of SUDs amongst communities, namely involvement or affiliation with gangs, community impact, and the effect on the rendering of aftercare services.

a) Involvement or affiliation with gangs

Despite the known risks of being affiliated to gangs of increased crime, violence, drug abuse, and subsequent imprisonment, many adults and adolescents in the Western Cape are still being recruited by gangs. There are a variety of factors that predispose individuals to being drawn to gangsterism, especially among the poorer communities of the Western Cape. The most common predisposing factors are poverty, drug abuse, unemployment, poor education, substitute families in instances where there are absent parents, or direct familial involvement in gangs (Western Cape Government, 2019). Additionally, concepts such as the 'theory of cultural transmission' from the field of criminology, state that the younger generations are more likely to be targeted by gangs whereby the families and communities remain chaotic and unstable, thus rendering the youth vulnerable to manipulation and exploitation (Daniels & Adams, 2010). The following narratives represent how and why some of the participants were involved and affiliated with gangs and drugs in their communities:

> *"I really needed a father, so I went out on the streets and I didn't have brothers either. So, I went to the streets and found myself some brothers. These things get stuck in your head and I was too naïve to think about my future." (P1)*

> *"I just followed the route as a kid, I followed what I thought was right and followed my uncle into the gang." (P11)*

> *"I didn't want to work, and I liked the way the drugs made me feel. My family kicked me out and I felt that they didn't love me, so I went to the gangs to find a family. They would come to me with a gun against my head. They would give me some money or something to smoke and I would do what they want, that's just the way it was." (P12)*

> *"The people in the community had received a lot of support and understanding from the gangs, they go to houses where they have nothing and provide for the people." (P2)*

The aforementioned narratives demonstrate how most of the participants had been recruited into gangsterism. Most of the participants had mentioned not having a 'father figure' or feeling unloved or rejected by their families so they turned to gangs in order to find a sense of belonging and love. It is also interesting to note how participant 2 had mentioned the support that gangs gave to his community in terms of providing resources for struggling families and community members living in poverty. This narrative is reflected in the theoretical literature of Bowers Du Toit (2016) who investigated how poverty factored into gang involvement. Bowers Du Toit (2016) found that in communities rife with poverty and unemployment, families and community members are overwhelmed and defenseless as they continue struggling to access basic services and resources to survive, thus establishing an opportunistic space for gangs to provide these much-needed resources and recruit new members in exchange.

b) Community impact

As mentioned in the previous theme, communities plagued by poverty, poor education, and unemployment render the community and its members vulnerable to exploitation from gangs. The gangs have notoriously used methods of providing support and economic resources to the community as a tool to gain entry and control of a population who have limited to no other options for support and relief from their circumstances (Bowers Du Toit, 2016). This was made evident in a study of the community of Lavender Hill in the Western Cape where unemployment and poverty had destructive and crippling effects on the families and children of the community, which led to gangs maintaining economic power and control over the members of this community (Bower, 2005). These gangs furthermore incite violence and are associated with increased criminal activities in the community whilst supplying a steady influx of illicit substances into the community, all that foster a breeding ground for the development of SUDs amongst members of the community. The following narratives address the community impact of gangsterism and illicit substances from the participants experiences:

> *"There are so many mothers and fathers using drugs and using their children's welfare money for their own needs. Most of the people using drugs are unemployed, they don't even have a job, but they are using drugs. But why they can maintain this habit is because the government is supporting them, and they can stay and be funded by the gang." (P1)*

"Most of the people and families are using drugs, the drugs have become a tradition in those families. The gangs use it as well, the tik, they see people who are weak and give it to them to make them strong." (P9)

"People join a gang to be something. At home, the people and children are struggling, they don't have the things that other children have, and they feel pain, they're demotivated to go to school, or they go and have nothing in their stomachs." (P11)

The aforementioned narratives encapsulate some of the community circumstances that have created the appropriate climate for gangsterism to flourish. Moreover, these communities are all commonly linked with factors of poverty, unemployment, and children lacking guidance, opportunities, or basic resources. It is interesting to note that participant 9 mentioned that drug abuse was already rife amongst families in his community together with becoming a 'tradition' across the generations. Furthermore, participant 9 confirmed this drug abuse has made his community vulnerable to gangsterism in that the gangs target 'people who are weak' and exploit their circumstances, whether it is being poor or the abuse of substances, in order to gain control. Furthermore, participant 11 accounts how poverty has severely impacted both the physical and mental wellbeing of adults and children in his community where gangsterism is viewed as an opportunity for a better life. This narrative is reflected in the study conducted by Bower (2005) according to whom poverty rendered the community of Lavender Hill vulnerable and ultimately resulted in gangs taking over this community with economic power and control over its residents. It is evident that the aforementioned exploitation of poverty and unemployment has become a common tactic for gangs across communities in the Western Cape to not only recruit new members but to hold community's hostage.

c) Effect on aftercare service rendering

Gangsterism has been documented to hold communities under siege through social and economic power. According to Wood and Alleyne (2010) there are two forms of power that gangs utilise in order to remain in control of vulnerable groups, namely that of 'coercive power' and 'power to pay and delegate status and rank to its members'. 'Coercive power' involves using physical violence, fear, and threats to maintain control, whilst the 'power to pay and delegate status and rank to its members' involves utilising economic and social control over the members and those

targeted for recruitment in which all decisions and actions are dictated by those in power, or the leaders of the gang. The social power and oppression that gangs maintain over communities results in the vulnerable community members submitting to the feelings of hopelessness and powerlessness and in the end, engaging in compliance with what is dictated by the gang, be it criminal activities or engagement in substance abuse. The power of gangs across Western Cape communities has resulted in the economic, political, and social climate being dictated by those gangs. This in turn can impede the accessibility and ability of recovering addicts to access aftercare treatment options in their communities if such services are viewed as being a threat to the political and economic ecosystem created by the gangs. The following narratives reflect the challenges of accessing or establishing aftercare treatment in communities plagued by gangsterism:

> *"They will easily give you 100 Rand to go buy yourself some bread and electricity in exchange for favours, but these community centres also give you a bowl of soup, but people misuse it. It is the people that come from the background of gangsterism, even the children that go to these centres to only use the benefits." (P1)*

> *"The guys in the gang selling the drugs don't like to see people like us making changes, getting healthy. They see they can't control us with it, and they come with guns and drugs and try to make us take them. They come for you; they will always make a plan to get you back." (P15)*

> *"If you open any kind of centre for adults or children, the gangs find a way to make it a negative place. So, something like that would help but not really because the gangs will find a way to make it a negative space. They take one or two gang members to go with to these places, even if it is children in the gang." (P16)*

The aforementioned narratives depict the extent to which gangsterism holds power and control over these communities and to what degree gangsterism impedes on the rights of recovering addicts to access critical aftercare services. It is interesting to note that participant 1 recounted that there are community centres that distribute food or render aftercare services, but that these services are taken advantage of, in conjunction to the money offered by gangs in exchange for services and recruitment. Participants 15 and 16 shared similar experiences whereby the gangs felt threatened by recovering addicts re-entering the communities as sober individuals as this interfere with their

ability to maintain control of them. It was also stated that aftercare services are being infiltrated by gang members to ensure that community members do not utilise these services so as to remain in control of the community and activities within it. These narratives confirm what is reflected in the theoretical work of Daniels and Adams (2010), namely that gangs control the activities within the communities from a political, economic, and social standpoint. This also coincides with Ederies (2017) who called for the importance of community health in mitigating relapse amongst impoverished communities. From the above it is evident that aftercare services cannot be rendered or established effectively in disadvantaged communities across the Western Cape until gangsterism and community health is addressed and improved so that recovering addicts would be able to safely access aftercare services without putting their lives at risk in doing so.

4.8.5.3 Sub-theme 4.3: Accessibility and availability of aftercare services in the community

As discussed in Chapter 2, it has been proved that aftercare services have direct links to increased rates of sobriety through long term attendance. However, in South Africa, aftercare services receive nominal efforts and resource provision as the majority of social work personnel, finances, and resources are allocated to prevention and intervention services (Bhana, 2007). It is thus important that the few aftercare services that are available should be accessible in terms of geographical location, affordability, availability, and variety (Isobell et al., 2018). However, in South Africa, a multitude of barriers are experienced by recovering addicts when wanting to utilise aftercare services such as attitudinal, structural, and systemic barriers (Myers et al., 2014). The following three categories of accessibility and availability, namely geographical, financial, and a variety, were developed through analysing factors of accessibility and availability of aftercare services in communities.

a) Geographically

Aftercare services should be geographically accessible to recovering addicts from within their communities in order for them to effectively utilise these services. In South Africa, however, geographic location remains a structural barrier amongst recovering addicts wanting to access aftercare treatment (Sindelar & Fiellin, 2014). This can be because the majority of services are rendered near the city centre, making it very difficult for the communities of the more rural and distant areas to access aftercare treatment options. This is made more difficult as rural communities

would have to make lengthy commutes to aftercare centres, which would be largely unaffordable to the disadvantaged communities in the Western Cape, thus limiting and compromising their right to access aftercare treatment services (Myers et al., 2010). The following narratives express the participants' experiences concerning the availability of geographically accessible aftercare services:

> *"There is one support group that I know of that I want to attend, but it is only in one part of the community where there are gangs. Some of the community won't even know that there is a support group here because maybe that particular area is run by a specific gang and you can't get there." (P2)*

> *"Transport is an issue; I can take a taxi, but it becomes too expensive. Money and transportation are a problem, I don't have anyone who can help me." (P4)*

> *"Transport isn't an issue; I have my own car." (P6)*

> *"Transport I can do it no problem; I will hike and hitchhike. There might be good people who will give me a lift, but it can be dangerous." (P7)*

These narratives demonstrate that geographical access and transport to aftercare services remain difficult for most of the participants, except for those who have their own vehicle. It is interesting to note that participant 2 explained that there was a support group in his area, which he could not geographically access due to it being in an opposing gang's territory. This participant made it clear that community members were not allowed access to certain parts of the area depending on which gang resided over that territory, making this aftercare service inaccessible. As mentioned in sub-theme 4.2, an event like this demonstrates why it is of significant importance to address community health and gangsterism in the Western Cape in order for recovering addicts to access aftercare treatment. It is also interesting to note that participant 7 described the potential 'hitch-hiking' to get to support groups and whilst acknowledging that this can be dangerous to do so, he feels that transport is not an issue for him. This is significant as it shows that he is willing to place himself in potentially dangerous situations in order to access aftercare treatment to maintain his sobriety.

b) Financially

For many of the Western Cape communities another structural barrier to treatment is financially accessible aftercare treatment options. The Western Cape's government-funded intervention addiction services remain severely limited, and even more so with aftercare options. Services often have extensive admission processes with lengthy waiting times to obtain entry to treatment. However, for those unable to financially access private treatment, the abovementioned state funded facilities remain their only option. The following narratives express the financial accessibility and availability that the participants have to aftercare services:

> *"Finances won't be an issue; I am going to be working and my father's finances are good. My father will help me in many ways, financing and supporting me." (P11)*

> *"I don't have a job or money so finances are an issue for me. I don't want to be dependent on my parents, the whole time I was using drugs I was dependent on them, I want to stand on my own two feet." (P9)*

> *"Yes, finances are an issue." (P5)*

The abovementioned narratives indicate how some of the participants would struggle to financially afford aftercare services, while a few felt that finances would not be a problem. The participants who felt that finances would not be an issue, planned on utilising their parents or friends for financial assistance and were not able to afford services on their own. The majority of the participants did not want to borrow money nor could they afford the taxi fees to access treatment in neighbouring communities. The aforementioned narratives demonstrate that finances are a structural barrier to recovering addicts accessing appropriate aftercare treatment.

c) Variety

As discussed in Chapter 3 and throughout this chapter, a variety of aftercare services are required to meet the needs of recovering addicts on a biopsychosocial level. This calls for aftercare services that include biologically-based elements like sports groups for physical health, and community development, and reintegration (Coalter, 2007) as well as psychologically-based aftercare services where recovering addicts can navigate their home environments, triggers, and emotional stressors

whilst working closely with social workers or therapists in addressing their addiction (Daley, 2013). These services should also have social services in which counselling and support can be rendered in a group setting and assist recovering addicts to integrate back into their communities (Gordon, 2003). Lastly, there should be culturally appropriate aftercare services to aid in cultural recovery (Szelemko et al., 2006). The following narratives express the views of the participants in terms of their experience of accessible and available aftercare services across a biopsychosocial domain:

> *"There is only one N/A group in the whole of Worcester. Other people from other communities can't get to where the N/A meeting is, I don't think that there are enough support groups here or people who come out to support us." (P2)*

> *"I will say that there should be more kinds of options because sometimes you go to groups and you also need to relax and to be there, to do some exercise and take your mind off of it. Not just sitting down in class and you hear about all this stuff, it becomes a lot." (P15)*

The above narratives depict the importance of aftercare services across a biopsychosocial domain. Participant 2 expressed that there was only one support group in his area that was largely inaccessible to the majority of the community, and that there was not enough individualised support in the form of social workers that could render aftercare services and therapeutic sessions. This narrative is reiterated by Gordon (2003) and Brown et al. (2002) who are of the opinion that therapeutic sessions with social workers were important in aftercare in order to monitor recovering addicts and their progress, while supporting and assisting them to navigate their goals in often unstable communities. Nevertheless, the reality in South Africa and the Western Cape is that there are not enough social workers to render aftercare services and thus, support groups are relied upon to provide the majority of aftercare services. It is important to note the viewpoint of participant 15 who stated that there were not enough variety of aftercare services. Participant 15 expressed the want and need to have informal services that focused on enjoyment of life and relaxation, combined with therapy and support groups. The purpose as described by the participant, is that support groups can become overwhelming, and although addressing their addiction and ensuring their goals are on track, support groups can diminish the quality of life and that for purposes of recovering aspects like sports or safe, positive group activities, are needed.

4.9 CONCLUSION

Aftercare services are crucial in the maintenance of sobriety amongst recovering addicts. Aftercare treatment needs to provide aftercare services that cater for recovering addicts across a biopsychosocial domain. The importance of such a biopsychosocial approach is that it provides services that cater to a wide range of needs and address the complex nature of addiction amongst recovering addicts. From the aforementioned themes it is evident that each domain of the biopsychosocial approach holds a significant role in the recovery process of addiction. Not only must these services be made available to those in recovery they must also be accessible to recovering addicts in order for aftercare services to be effective and impactful. In this chapter an empirical investigation was conducted into the accessibility and availability of aftercare services amongst recovering addicts across a biopsychosocial domain in the Western Cape. These findings were extrapolated from the data by utilising both an exploratory and descriptive research design. The findings of this research study investigated the viewpoints and lived social realities of the challenges experienced by recovering addicts in entering their aftercare phase of treatment in the Western Cape (as discussed in Chapter 2). An aggregate of 16 participants were chosen through purposive sampling and interviewed in accordance with a semi-structured interview schedule. The data was collected and reviewed in light of the theoretical underpinnings encapsulated throughout Chapters 2 and 3 of this research study. Once the data was obtained it was classified into themes, sub-themes and categories. The conclusions and recommendations of the study will be presented in Chapter 5.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The empirical investigation and the findings derived from the research was expounded in Chapter 4. In Chapter 5 the conclusions and recommendations regarding the accessibility and availability of aftercare services for recovering adult addicts in the Western Cape is presented, thus achieving the final objective of the study. The conclusions of this study refer to the challenges and downfall of aftercare services in terms of both accessibility and availability across a biopsychosocial domain for recovering adult addicts, while considering policy and legislative frameworks as well as theoretical underpinnings. Recommendations will be formulated in light of the conclusions in order to provide solutions to hopefully improve aftercare service rendering to recovering adult addicts in the Western Cape. The recommendations will attempt to improve access and availability to services and also to ultimately aim for an improvement in the rates for relapse. In this Chapter 5, it was important to assess whether the current aftercare service policy and legislation are being implemented across the Western Cape and whether or not these services are truly accessible to recovering adult addicts, while noting if their needs are being met across a biopsychosocial domain.

5.2 CONCLUSIONS AND RECOMMENDATIONS

The conclusions and recommendations of this section were derived from the previous chapters of the research study which analysed relevant literature in light of the empirical findings. This section will investigate the conclusions and recommendations that will confer with the following, namely, identifying particulars, theme 1 (biological aftercare services), theme 2 (psychological aftercare services), theme 3 (social aftercare services), and theme 4 (cultural aftercare services). The recommendations in this chapter are based on the identified themes of Chapter 4 with the associated literature and the empirical findings relating to the identified themes. The recommendations will go on to provide suggestions in terms of how to integrate aftercare services

and render them available and accessible to recovering adult addicts across the Western Cape in light of their biopsychosocial needs and challenges.

5.2.1 Research goals and objectives

The goal of this research study was to develop an understanding of the availability and accessibility recovering adult addicts have to aftercare services in the Western Cape.

The research objectives allowed for the research goal of the study to be achieved.

- Objective 1: To discuss the nature and scope of substance misuse, continuum of care, and relevant legislation with specific focus on existing aftercare services provided by social workers.

The first objective was achieved in Chapter 2. Substance misuse was defined and explored in terms of its prevalence and severity on a global and local scale. In terms of the continuum of care, Chapter 2 presented an in-depth discussion on the treatment phases of addiction starting from prevention, to intervention, and lastly addressing reintegration and aftercare treatment. Chapter 2 also investigated the challenges regarding these phases of treatment wherein access and availability together with numerous barriers to treatment, remained a pivotal issue in South Africa and the Western Cape. Lastly, the correlation between legislation in terms of the rights of recovering addicts in accessing available aftercare services together with the reality of aftercare service delivery in the Western Cape was investigated.

- Objective 2: To explore the availability and accessibility of aftercare services provided by social workers for recovering adult addicts within the domain of the biopsychosocial approach.

The second objective of the research study was attained in Chapter 3. This chapter went on to discuss the biopsychosocial (BPS) approach as a literature framework that guides aftercare service rendering in addiction treatment. Chapter 3 furthermore explored how the BPS approach was developed and the importance of its integration into addiction services when considering addiction as a complex, multifaceted disease. This approach was utilised as a theoretical point of departure when analysing aftercare services of recovering adult addicts in the Western Cape. Furthermore,

the challenges and barriers to accessing aftercare treatment across the biopsychosocial domains were investigated.

- Objective 3: To empirically investigate the availability and accessibility of aftercare services for recovering adult addicts.

The third objective of the research study was achieved in Chapter 4. The data obtained from the semi-structured interviews conducted with participants in order to answer the research question was empirically investigated in Chapter 4. The research findings were then divided into themes, sub-themes, and categories which were analysed in light of existing literature. The analyses were then applied to develop a comprehensive understanding of the lived social realities and experiences of recovering adult addicts and the associated challenges in the accessibility to and availability of aftercare services in the Western Cape.

- Objective 4: To present conclusions and recommendations to relevant organisations and government bodies regarding availability and access to aftercare services for recovering adult addicts.

The final objective of the research study was accomplished in Chapter 5. This was achieved through analysing the findings from the empirical investigation in Chapter 4 in order to formulate conclusions and relevant recommendations in light of the accessibility and availability recovering adult addicts have to aftercare services in the Western Cape in light of the theoretical framework discussed in Chapter 3. The recommendations attempt to provide realistic and achievable solutions to improve the availability and accessibility of aftercare services along a biopsychosocial range to cater to the needs of recovering addicts in the Western Cape, and South Africa. The purpose of this is to not only improve current service rendering but to also afford recovering addicts the opportunity to access more treatment options that cater to their diverse needs in a South African context. The attainment of the research goal and objectives afforded the researcher the ability to answer the research question of:

“How available and accessible are aftercare services for recovering adult addicts in the Western Cape?”

The conclusions and recommendations that ultimately answer this research question are explored throughout this Chapter 5.

5.2.2 Identifying particulars

The researcher of this study originally aimed to interview both women and men, however, due to Covid-19 and the subsequent closure of rehabilitation organisations across South Africa, only men from an outpatient site were accessible for interviews under lockdown regulations. These participants were from various communities across the Western Cape, with the majority residing in disadvantaged communities. This allowed for rich data to be obtained in terms of the realities experienced by recovering adult addicts when accessing available aftercare services in the Western Cape. All of the participants were entering the aftercare phase of their treatment after receiving formal treatment from a rehabilitation organisation. Based on the identifying details, the participants were ideal candidates to provide accounts and knowledge on the lived social realities that recovering adult addicts experience in attempts to access aftercare services in the Western Cape in order to maintain their sobriety.

- **It can be concluded that:**

  - All the participants were male, in terms of gender.
  - All the participants were of a Coloured ethnicity.
  - The majority of the participants' age of onset for substance use was in their adolescent years, between 14 to 16 years of age.
  - The majority of the participants began chronically using substances in their late adolescent and young adult years, between 17 and 19 years of age.
  - All the participants chose MA (tik) as their primary drug and the secondary substance of choice for the majority of the participants were Mandrax and cannabis.
  - All the participants were at the end of their outpatient rehabilitation programme, entering into the aftercare phase of treatment.
  - Most of the participants had a genetic family history of substance abuse and associated SUDs.

- More than half of the participants had direct involvement and affiliation to gangs, with one quarter having indirect involvement, and the last quarter not being involved or having knowledge of gangs in their environment.

➢ **It can be recommended that:**

- Further research should be conducted that is inclusive of recovering female addicts in the Western Cape to have a more in-depth and accurate understanding of the accessibility and availability of aftercare services in the Western Cape.
- The sample of the participants should be racially equal to gain a clear understanding of the needs of the various racial groups and cultures among recovering adult addicts across the Western Cape.
- Forthcoming research should be conducted on a larger scale to assess the accessibility to and availability of aftercare services for recovering adult addicts across South Africa in order to obtain a broader range of knowledge and data concerning aftercare services in the country.

5.2.3 Theme 1: Biological challenges for recovering adult addicts in relation to aftercare services

The biological dimension of the BPS approach analysed the challenges that biological functioning and genetic histories play in the development of SUDs. Furthermore, this aspect of the BPS approach examined the challenges surrounding the availability and accessibility of biologically-based aftercare services. Through the recognised literature and viewpoints of the participants, the following aspects are recognised as challenges to the availability and accessibility of biologically-based aftercare services, namely genetic predisposition to addiction, cravings, and health.

a) Genetic predisposition to addiction − it can be concluded that:

- Genetic predispositions to the development of SUDs still remain a biological challenge for recovering addicts where addictive traits and genes are inherited from biological parents who are, or were, active substance abusers.

- Recovering adult addicts that enter aftercare services have an increased chance of relapse if their immediate or extended family members are still in active addiction.
- The impact of family histories with addiction are not limited to the immediate family nucleus but extend to the negative influence that extended family members transfer to recovering adult addicts in their aftercare phase of treatment.

➢ **It can be recommended that:**

- Aftercare services should provide further knowledge and education to the immediate and extended family members, as well as the recovering addict, regarding the heritability of addictive genes and characteristics that perpetuates the cycle of addiction across generations.
- Aftercare services should aim to educate immediate and extended family members about the role that active substance use among families play in the development of SUDs, together with the knowledge of how such active use among families increases relapse rates amongst recovering addicts.
- Aftercare services should advocate towards the encouragement of familial involvement in the recovering adult addict's programme in order to promote holistic healing for the entire family unit.

b) Cravings − it can be concluded that:

- Cravings are rooted in biochemical reactions of the brain and remain a biological challenge for recovering addicts during aftercare because of their unrelenting and overwhelming nature.
- Biochemical stimuli are uncontrollable, physiological, and chemical processes of the brain that often induce cravings amongst recovering addicts when exposed to auditory, visual, or olfactory stimuli associated with previous substance abuse.
- Biochemical stimuli and cravings remain a biological challenge for recovering addicts during the aftercare phase of treatment, as cravings and triggers ensue, regardless of the duration of sobriety.

- Recovering addicts do not have sufficient coping mechanisms to biochemical stimuli and cravings which pose as a significant risk factor to relapse.
- Pharmacotherapy presents an effective aftercare service to cravings and biochemical stimuli amongst recovering addicts who have a history of opioid dependency, by eliminating cravings and withdrawal symptoms.
- Accessibility and availability to pharmacotherapy is extremely limited, despite literature demonstrating the importance of pharmacotherapy as an aftercare service and that pharmacotherapy contributes to improved sobriety rates. There are currently only two hospitals in the Western Cape rendering pharmacotherapy as a self-funded service and one rehabilitation organisation offering it as a government-funded aftercare service.
- Pharmacotherapy remains largely unavailable, unaffordable, and inaccessible as an aftercare service to the majority of recovering addicts across the Western Cape.
- Government-funded pharmacotherapy programmes will improve sobriety rates amongst opioid-dependent recovering addicts, which in turn will assist to reduce the demand and harm of illicit substances in the Western Cape.

➢ **It can be recommended that:**

- Aftercare services should provide recovering adult addicts with effective and applicable coping mechanisms in order to manage the unrelenting and intense nature of biochemical cravings.
- Pharmacotherapy should be made more available and should be financially and geographically accessible across the Western Cape to recovering addicts with a prior opioid addiction.
- Government-funded pharmacotherapy aftercare services should be more available and should be financially accessible and available to opioid-dependent recovering addicts.
- Pharmacotherapy should be rendered as an effective government service and should be utilised as a tool to reduce harm, demand, and supply of illicit substances in South Africa, providing the means towards establishing a drug-free society.

c) Health − it can be concluded that:

- Chronic substance abuse of active addicts causes a decrease in physical health with weight loss, fatigue, memory loss, and breathing complications. However, upon maintaining sobriety, the physical health of recovering adult addicts improves vastly with weight gain and improved energy levels, although memory loss may still persist and could remain a biological challenge.
- The use of needles remains a pertinent health concern in the Western Cape where unhygienic needle sharing practices contribute significantly to the spread of contagious diseases, although in this study it should be noted that none of the participants engaged in needle injecting practices.
- Access to needle and syringe programmes across South Africa are severely limited for active and recovering addicts, which increases the burden of harm on the country as the lack of treatment options indirectly promotes unhygienic needle sharing practices.
- Sports groups provide recovering addicts with healthy, positive activities to occupy their time and to improve physical and mental wellbeing through establishing support networks, fostering feelings of inclusivity, and promoting a sober lifestyle that act as protective factors to relapse.
- Sports groups ease reintegration into communities for recovering adult addicts through direct engagement in positive activities with fellow community members and through fostering new relationships with sober individuals.
- Sports groups are not always accessible or available as established aftercare services amongst communities in the Western Cape for recovering adult addicts.

➢ **It can be recommended that:**

- Aftercare services should incorporate positive lifestyle changes and activities that improve the physical and mental health of recovering addicts, such as establishing sports groups in local communities across the Western Cape.

- Aftercare services should include availability of and access to formal sports groups that could be established for recovering adult addicts in their communities, as these groups will provide recovering addicts with protective factors and because sports groups could be an inexpensive service and could thus be financially accessible.
- Social workers should educate recovering addicts on the positive and negative aspects of lifestyle choices by analysing the role that nutrition, hygiene, exercise, and overall physical health plays in fostering or preventing a relapse.

5.2.4 Theme 2: Psychological challenges for recovering adult addicts in relation to aftercare services

The psychological dimension of the BPS approach refers to cognitive factors, emotional states, decisions, and associated behaviours that either act to mitigate or predispose recovering addicts to relapse in their aftercare phase of treatment. The psychological component of the BPS approach is furthermore considered to be the core of addiction that helps explain why triggers and cravings are so unrelenting, how and why substance using behaviours present themselves, and how emotional instability can lead to irrational decision-making, regardless of consequences, and ultimately relapse. Through the identified literature and empirical findings, the following factors pose challenges to psychological-based aftercare services to recovering adult addicts in the Western Cape, namely, emotional management, triggers, accessibility and availability of psychological-based aftercare services.

a) Emotional management − it can be concluded that:

- Poor emotional management remains one of the significant challenges for recovering addicts in maintaining their sobriety.
- The development of mood and anxiety disorders are a common consequence of prolonged, chronic use of substances, and the subsequent damage to the brain amongst recovering addicts.
- Aggression and depression are common mood instabilities experienced by recovering addicts, even during sobriety, which pose as a risk factor to relapse.

- Recovering addicts are ill-equipped to deal with their emotions and various life stressors with positive coping mechanisms which results in substances or alcohol being utilised as a defence mechanism to reduce emotional distress.
- Coping mechanisms learnt during formal intervention treatment in a controlled environment are often rendered ineffective for recovering addicts when they return to their communities where there are a variety of uncontrolled variables.
- There is a lack of available and accessible emotional support aftercare services for recovering adult addicts in many of the disadvantaged communities in the Western Cape.
- Accessibility and availability to social workers for therapeutic sessions remain severely limited to recovering adult addicts in the Western Cape due to organisations that are understaffed, and because addiction services are focused on prevention and intervention services.

➢ **It can be recommended that:**

- Recovering addicts should be trained and educated by social workers to utilise positive coping mechanisms and life skills during the aftercare phase of their treatment without resorting to old defence mechanisms of substance abuse.
- Recovering addicts should have continued availability and accessibility to social workers or other relevant mental health professionals in their aftercare regime in order to receive guidance when navigating sobriety in their uncontrollable and often unstable home environments.
- Recovering addicts should have access to mental health professionals in order to manage their mood and anxiety disorders as a protective factor against relapse.
- More aftercare support groups should be established and rendered accessible and available to recovering addicts in disadvantaged communities across the Western Cape.

b) Triggers − it can be concluded that:

- Triggers refer to the people, places, and things associated with previous substance abuse which can induce cravings amongst recovering addicts and act as psychological challenges in maintaining sobriety.
- Common triggers amongst recovering addicts are family and friends with whom they abused substances, access to substances in their communities, and the overwhelming dreams of past substance abuse.
- Common coping mechanisms to triggers are avoidance or removal of old friends, finding alternative travel routes in order to avoid certain places, and drinking water.
- Recovering addicts do not have sufficient means of support to cope with triggers in their environments as many rely on willpower alone when confronted by triggers and subsequent cravings.
- Insufficient coping mechanisms and a lack of support to recovering addicts cause triggers to contribute to increased relapse rates.
- Disadvantaged and impoverished communities all act as risk factors to relapse for recovering addicts as they are riddled with a multitude of triggers, such as the availability of illicit substances and alcohol, and high rates of unemployment and crime.

➢ **It can be recommended that:**

- Aftercare services should provide recovering addicts with ongoing support and education on coping mechanisms in order for them to manage the triggers in their communities.
- Community health must be addressed and improved in disadvantaged communities across the Western Cape in order to reduce the supply, demand, and harm of substances which in turn will improve sobriety rates amongst recovering addicts.

c) Availability and accessibility of psychological-based aftercare services − it can be concluded that:

- Prolonged attendance to support groups during the aftercare phase of treatment improves sobriety rates amongst recovering addicts.
- Numerous structural and systemic barriers impede the constitutional rights of recovering addicts accessing aftercare services such as geographical and financial inaccessibility.
- Support groups and Narcotics Anonymous/Alcoholics Anonymous remain the most common form of aftercare service in Western Cape.
- There is limited to no accessibility and availability to support groups, Narcotics Anonymous/Alcoholics Anonymous amongst disadvantaged communities in the Western Cape.
- Very little social work personnel are allocated to rendering aftercare services in the Western Cape.
- The majority of recovering addicts do not have accessibility or availability to individual therapeutic services with a social worker or mental health professional in their aftercare regime.
- Therapeutic services with a social worker or other mental health professional is mostly accessible and available through self-funded, private institutions which remains financially inaccessible to recovering addicts residing in impoverished, disadvantaged communities.

➢ **It can be recommended that:**

- Structural and systemic barriers to accessing aftercare services need to be revised and addressed by the government and implemented by the Department of Social Development (CDA) within the National Drug Master Plan (NDMP).
- Support groups, which are easy to establish and are financially viable and cost effective, should be implemented across communities in the Western Cape in order to render ongoing support services that are accessible to recovering addicts in their communities.

- Support groups should be established in the communities of recovering addicts to eliminate geographical and financial barriers and to render these services accessible and available to those in need.
- More social workers need to be employed and allocated to render aftercare services to build on the momentous gains that formal intervention treatment achieves and to ultimately improve and prolong sobriety rates amongst recovering addicts.
- The CDA needs to ensure that psychologically-based aftercare services are truly accessible and available to all recovering addicts across the entire Western Cape province and not only have services accessible and available in the city centre.

5.2.5 Theme 3: Social challenges for recovering adult addicts in relation to aftercare services

The social dimension of the BPS approach studies the behaviour and interactions among larger groups that impact on the functioning of an individual. In terms of the social aspect, the challenges that recovering addicts face when returning to their communities are also analysed while considering how the environment and people in it may impact the recovering addicts' sobriety. Furthermore, it is important that aftercare services cater to and address the social needs of recovering addicts which in turn assists in reintegration into their communities and families. Through literature and the study's empirical findings, the following aspects were identified as challenges to the accessibility and availability of socially-based aftercare services amongst recovering addicts in the Western Cape, namely interpersonal relationships, availability and accessibility of substances in the community, and the availability and accessibility of social support structures.

a) Interpersonal relationships − it can be concluded that:

- Dysfunctional interpersonal relationships remain a substantial risk factor in the development of SUDs and also in recurring relapses amongst recovering addicts while compromising the development of optimal social functioning.

- Direct family support and involvement in the aftercare process is a protective factor that increases sobriety rates of recovering addicts in relation to those without such intimate support structures.
- Families and intimate partners remain the foremost support network for recovering addicts in the Western Cape.
- Family members, peers, and intimate partners incur emotional, physical, and financial trauma in relation to the recovering addicts' period of active addiction which can create tense and combative home environments if left unresolved.
- Families and intimate partners receive limited support or aftercare services in order to resolve their own trauma surrounding recovering addicts' active addiction.
- Negative peer associations remain a significant risk factor to relapse amongst recovering addicts due to potential exposure to substances and as triggers associated with previous substance abuse.
- There are limited aftercare services or social support structures to assist recovering addicts in navigating their previously dysfunctional relationships which can lead to emotional distress, dysfunctional social behaviours, and potential relapse.

➢ **It can be recommended that:**

- Aftercare services should provide support groups and family counselling to the families of recovering addicts in order to assist in the healing of trauma associated with the recovering addict's active addiction, to learn new coping mechanisms, communication skills, as well as identifying signs of a relapse.
- Couples counselling should be rendered as an aftercare service in which concepts of communication, co-dependency, and boundaries are established in order to foster healthy, supportive and intimate relationships.
- Support groups and therapy with a social worker or other mental health professional should be rendered to recovering addicts as an aftercare service in order to provide support and guidance in navigating previously dysfunctional relationships that are emotionally distressing. It is important for recovering addicts to have the adequate aftercare services to

handle this distress as it can result in previous defence mechanisms resurfacing and eventually, a relapse.

- Access to family support services in aftercare treatment amongst communities across the Western Cape is a constitutional right, as the Prevention and Treatment of Drug Abuse Act 70 of 2008 stipulates that holistic treatment options need to be provided to the recovering addict, and their families in order to mitigate the harm of illicit substances. Thus, the CDA and relevant government personnel need to revise their service plans and ensure that families in need are receiving support services in their communities.

b) Availability and accessibility of alcohol and drugs in the community − it can be concluded that:

- Alcohol and illicit substances are easily accessible in communities across the Western Cape.
- Poverty and unemployment in disadvantaged communities create a thriving environment for using and selling illicit substances and alcohol as a means of survival.
- Inadequate education in disadvantaged communities perpetuates the cycle of unemployment and poverty in communities in the Western Cape.
- The illicit drug and alcohol trade in drug houses and shebeens continue to thrive in communities in the Western Cape, particularly in impoverished areas.
- Although the NDMP (2006-2011; 2013-2017) called for a reduction in the availability of licit and illicit substances in communities across South Africa in order to reduce the supply, demand, and harm of substances, this has not been achieved.

➢ **It can be recommended that:**

- Education, employment opportunities, and basic life skills training need to be created and rendered in disadvantaged and impoverished communities to empower the population, break the poverty cycle, and afford opportunities other than trading in illicit drug and alcohol.

- The CDA needs to increase efforts to ensure that relevant stakeholders, such as the South African Police Service, make active efforts to deter the supply, harm, and demand of the illicit drug and alcohol trade through drug houses and unregistered shebeens in communities in the Western Cape.

c) Availability and accessibility to social support structures − it can be concluded that:

- Church-based initiatives and support groups remain the most common and accessible form of aftercare services for recovering addicts in the Western Cape.
- Church groups and support groups are not always available or accessible in the disadvantaged communities in the Western Cape.
- Inclusion of religion and spirituality remains an important factor of recovery for recovering addicts.
- Church-based groups and initiatives can act as protective factors to relapse when promoting a sober lifestyle and themes of hope, strength, and purpose.
- Rehabilitation organisations generally offer support groups at the facility as part of the aftercare programme however, it is not always accessible to recovering addicts in terms of geographical location and finances associated with travel.
- Sports groups remain an important social support structure where healthy, sober lifestyles are promoted, a sense of acceptance and integration into the community is achieved, and where there is potential to foster new supportive networks in the recovering addicts' community.

➢ **It can be recommended that:**

- Church and support groups are cost effective and easy to establish in communities. Thus, a concentrated effort by the government and the CDA should look to render these services available and accessible in all communities in the Western Cape in order to reduce the harm of substance abuse and increase protective factors for improved sobriety rates amongst recovering addicts.

- Sports groups are a cost effective yet underutilised aftercare service. Sport groups should be established in communities in order to promote healthy lifestyles and leisure activities for recovering addicts and community members and because sports groups could establish support networks for those in recovery.

5.2.6 Theme 4: Cultural challenges for recovering adult addicts in relation to aftercare services

The cultural aspect of the BPS approach is closely related to the social aspect where behaviours and associations amongst families and communities are examined. The cultural aspect includes the values, belief systems, and practices of groups of people and acknowledges the importance of such factors in the recovering addict's life. The cultural aspect of the BPS approach is particularly important in South Africa where there are a multitude of languages and cultures that form an integral part of South African communities. This approach also promotes cultural recovery amongst recovering addicts to assist them to re-establish their sociocultural support structures, to re-integrate into the community, and to rediscover their sense of self. Cultural recovery as well as community values of the recovering addict can act as risk or protective factors to relapse. Literature and empirical findings established that the following factors are challenges to culturally-based aftercare services to recovering adult addicts in the Western Cape, namely the community standpoint, gangsterism, and the accessibility and availability of aftercare services in the community.

a) Community standpoint − it can be concluded that:

- South Africa has a multitude of varying cultures with differing values, beliefs, customs, and norms, who interpret and utilise aftercare addiction treatment in differing respects.
- Many recovering addicts face scrutiny and stigmatisation for their history of substance abuse when reintegrating into their communities.
- Stigmatisation of recovering addicts creates challenges in reintegration and re-establishing themselves in their communities. Stigmatisation also acts as a risk factor to relapse as it gives rise to associated feelings of isolation, rejection, and the emotional distress incurred from this alienation.

- Stigmatisation is not experienced by recovering addicts from poverty-stricken communities where substance abuse has become the social norm. However, easily accessible and normalised use of substances can act as a major trigger to relapse.
- Family and church groups remain the strongest form of support for recovering addicts in the community.
- Poverty and unemployment are directly linked to the increased development of SUDs, together with increased rates of relapse amongst recovering addicts.
- Trading in illicit drugs and alcohol has become a common way of income creation amongst impoverished communities in the Western Cape.
- Children or adolescents with an absent parent have increased chances of engaging in substance abuse and developing an addiction disorder.
- Absent fathers are a significant predisposing factor to the development of SUDs amongst recovering addicts.

➢ **It can be recommended that:**

- Aftercare services should include the upliftment and empowerment of recovering addicts in learning both basic life skills and the ability to create a Curriculum Vita (CV) in order to promote active engagement in knowing and finding employment opportunities.
- Aftercare services should include a holistic approach to community education schemes on addiction and recovery, as well as the importance of community support and risk factors of stigmatisation on recovering addicts.
- Aftercare services should work in conjunction with prevention services in educating communities, schools, and parents on the impact of absent parents in the development of SUDs.
- Aftercare services should advocate for the increased emotional support to parents and children, as well as promote the establishment of mentoring programmes for children in the Western Cape.

b) Gangsterism − it can be concluded that:

- It is evident that the overwhelming control and influence of gangsterism across the Western Cape has led to the development of a gang culture in most of the disadvantaged communities.
- The majority of the recovering addicts had either been recruited into gangs as children due to an absent father figure, or because gangs are seen as a means of income when living in poverty.
- Gangs continue to increase the supply of illicit substances in disadvantaged communities as both a source of economic power and means to control the population.
- Substances are utilised as tools of power and coercion amongst gangs where vulnerable populations, such as active and recovering addicts, are exploited and recruited into gangsterism and associated criminal activity.
- Gangs pose a significant risk factor and challenge to recovering addicts in maintaining sobriety where attempts to access aftercare treatment can place their lives and families in danger. This can be attributed to gangs interpreting sobriety and aftercare services as an interference and obstruction of their economic and social control of communities.
- Gangs provide impoverished and disadvantaged communities with a means of financial support and resources in exchange for services in the Western Cape.
- Accusations of police involvement in criminal gang activities render communities, families, and recovering addicts vulnerable, unsupported, and powerless to gangsterism in the Western Cape.

➢ **It can be recommended that:**

- An increased concentrated effort and collaboration amongst the relevant stakeholders, such as the government, SAPs, and local security companies, need to be implemented in combating gangsterism in the Western Cape.

- Recovering addicts who aim to access aftercare services must be protected by the relevant authorities to safeguard accessibility and availability from gang involvement and associated violent crime.
- Empowerment projects to create employment and uplift community members should remain essential in deterring recovering addicts and individuals from being recruited by gangs.
- Community health and gangsterism must be addressed by the government to protect vulnerable populations while actively combating the supply, demand, and harm of substances across the Western Cape in order to create community environments conducive to the recovery of addicts.
- An internal governmental investigation needs to be conducted amongst the South African Police force in order to ensure the safety and protection of communities across the Western Cape through the elimination of corrupt officials.

c) Accessibility and availability of aftercare services in the community − it can be concluded that:

- Aftercare services are not geographically available or accessible to many disadvantaged communities in the Western Cape where substance abuse is rife.
- Privately rendered aftercare services are financially not accessible to recovering addicts from impoverished areas, and the majority of government-funded services that are located in the city centre are geographically not accessible and would mean that those in the rural areas had to make unaffordable and lengthy commutes into the city.
- The variety of aftercare services available to recovering addicts remains limited and largely Westernised with a common form of support groups that do not account for culturally appropriate services to recovering addicts in the Western Cape.

➢ **It can be recommended that:**

- Aftercare services need to be geographically and financially accessible to recovering addicts in disadvantaged communities in the Western Cape.

- Aftercare services need to be established in the more rural communities in order to ensure that their constitutional rights to access of aftercare services are not infringed upon.
- A larger variety of cost-effective aftercare services should be established in order to cater to the biopsychosocial needs of recovering addicts.
- Aftercare services need to incorporate cultural values and norms, as well as potentially utilise traditional community healers, in order to render aftercare services that are applicable to a South African population.

5.3 CONCLUSIVE RECOMMENDATIONS FOR FUTURE STUDIES

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

- Further research on the accessibility and availability of aftercare services should be conducted on a larger scale throughout South Africa.
- Research regarding the accessibility of addiction services for women in South Africa should be explored.
- There is a need for further research regarding the accessibility and availability of addiction services for adolescents in the Western Cape.
- Research regarding the role of sports as a potential aftercare treatment should be explored.
- Research should be conducted on whether the NDMP has achieved its specified aims for aftercare services in the Western Cape and in South Africa, and if not, why not.
- There is a need for research on the importance of cultural inclusion in addiction treatment together with the role that traditional healers can play in recovery amongst communities in South Africa.
- There is a need for further research regarding the severity of gangsterism and its role in the supply, demand, and harm of substances in communities across the Western Cape.
- Further research should be conducted on the implementation practices of government policies and legislation regarding the accessibility and availability of aftercare services in South Africa.

5.4 CONCLUSIONS

Chapter 5 went on to achieve the final objective of the research study, which was to provide an investigation and exploration of the accessibility and availability of aftercare services that recovering adult addicts have in the Western Cape. The purpose of the objective was furthermore, to provide conclusions and relevant recommendations to rehabilitation organisations, service providers, and the developers and implementors of aftercare treatment policy and legislation.

This study brought to light the lived social experiences of recovering addicts attempting to access aftercare treatment in the Western Cape, especially those from disadvantaged and impoverished communities. This study also demonstrated that, even though policy and legislation established the accessibility and referral to aftercare services is a constitutional right of recovering addicts, and even though aftercare services are needed to assist in reintegration across all biopsychosocial domains, and even though support services must be rendered to assist recovering addicts to maintain their sobriety and develop their wellbeing, the empirical findings demonstrated that this is not the case. Instead, the recovering addicts that were interviewed, found it challenging to locate available aftercare services in their communities and surrounding areas, and could not access any services across a biopsychosocial domain as these are almost non-existent in disadvantaged communities. These services were not only unavailable to the disadvantaged, poorer communities wherein substance abuse was rife, but the majority of available services in the city centre remained financially and geographically inaccessible. Lastly, it became evident that the majority of aftercare services rested in support groups, which is a Westernised concept that is culturally inappropriate in a South African context and that renders the service largely ineffective to a majority of the recovering addicts in the Western Cape.

It can be concluded that these identified challenges in the availability and accessibility of aftercare services not only infringe on the constitutional rights of recovering addicts, but further alienate and segregate recovering addicts in disadvantaged communities from critical support services due a failure to implement policy and legislative frameworks pertaining to addiction and aftercare treatment. These failures consequently resulted in the increased development of SUDs and relapse rates across communities in the Western Cape that further contributes to the demand, supply, and harm of substances in the country as a whole.

The recommendations in this chapter ultimately contributed knowledge and feasible suggestions that could improve and enhance future service delivery and the establishment of aftercare services along a biopsychosocial domain to recovering adult addicts in the Western Cape. These aftercare services will directly benefit the disadvantaged communities of the Western Cape and the recovering addicts who reside in them, these aftercare services will also improve a focused effort on safeguarding and increasing sobriety rates. This chapter further utilised and referred to the empirical findings and the theoretical underpinnings to ensure that valid and accurate conclusions and recommendations were made. Finally, this research study demonstrated that the majority of recovering adult addicts residing in disadvantaged and impoverished communities do not have adequate availability of and accessibility to aftercare services to meet their biopsychosocial needs in the Western Cape, despite aftercare policy and legislation stating otherwise.

REFERENCE LIST

'Accessibility' 2019, in *English Oxford Living Dictionary.* Oxford University Press [Online]. Available: https://en.oxforddictionaries.com/defintion/accessibility [2019, March 19].

'Availability' 2019, in *English Oxford Living Dictionary.* Oxford University Press [Online]. Available: https://en.oxforddictionaries.com/defintion/availability [2019, March 19].

Addiction Centre.com, 2019. *Inpatient Rehab* [Online]. Available: https://www.addictioncentre.com [2019, August 6].

Arthur, M. & Blitz, C. 2000. Bridging the gap between science and practice in drug abuse prevention through needs assessment and strategic community planning. *Social Development Research Group, University of Washington,* 28(3):241-255.

Avert.org, 2019. *Global information and education on HIV and AIDS: Needle and Syringe Programmes (NSPS) for HIV Prevention* [Online]. Available: https://www.avert.org/professionals/hiv-programming/prevention/needle-syringe-programmes [2019, August 20].

Babalola, E., Noel, P. & White, R. 2017. The biopsychosocial approach and global mental health: synergies and opportunities. *Indian Journal of Social Psychiatry,* 33(9):291-296.

Ballester, L., Valero, M., Orte, C. & Amer, J. 2018. An analysis of family dynamics: a selective substance abuse prevention programme for adolescents. *European Journal of Social Work,* 23(1):93-105.

Begley, S. 2001. How it all starts in your brain. *Newsweek*, 137(7):40-42.

Bhana, A. 2007. *Costing of the Prevention and Treatment of Substance Abuse Bill*. Human Sciences Research Council. Pretoria: Social Development.

Bijttebier, P., Goethals, E. & Ansoms, S. 2006. Parental drinking as a risk factor for children's maladjustment: the mediating role of family environment. *Psychology of Addictive Behaviours,* 20(2):126-130.

Black, J. & Hoeft, F. 2015. Utilizing biopsychosocial and strengths-based approaches within the field of child health: what we know and where we can grow. *New Directions for Child and Adolescent Development,* 147: 13-20.

Borrel-Carrió, F., Suchman, A. & Epstein, R. 2004. The biopsychosocial model 25 years later: Principles, practice, and scientific inquiry. *Annals of Family Medicine,* 2(6):576-582.

Bowers Du Toit, N.F. 2014. Gangsterism on the Cape Flats: A challenge to engage the powers. *Theological Studies*, 70(3):1-7.

Bowers, N.F. 2005. *Development as transformation: The local church in Lavender Hill as agent of change in a Post Carnegie II context*. University of Stellenbosch.

Bröning, S., Kumpfer, K., Kruse, K., Sack, P., Schaunig-Busch, I., Ruths, S., Moesgen, D., Pflug, E., Klein, M. & Thomasius, R. 2012. Selective prevention programmes for children from substance-affected families: A comprehensive systematic review. *Substance Abuse Treatment, Prevention, and Policy,* 7:23.

Brown, T., Seraganian, P., Tremblay, J. & Annis, H. 2002. Matching substance abuse aftercare treatments to client characteristics. *Addictive Behaviours,* 27:585-604.

Buck, J. 2011. The looming expansion and transformation of public substance abuse treatment under the Affordable Care Act. *Substance abuse & Mental health,* 30(8):1402-1410.

Campbell, V. 2017. Connecting people in need with care: structural and systematic barriers to mental health care for communities of color. Unpublished paper delivered at the 18th Canadian Collaborative Mental Health Care Conference. Ottawa: Ontario.

Caulkins, P.J., Kasunic, A. & Lee, M. 2014. Societal burden of substance abuse. *International Public Health Journal,* 6(3):269-282.

Central Drug Authority. 2016. *2014-2015 Annual Report.* South Africa: Department of Social Development.

Central Drug Authority. 2019. *2016-2017 Annual Report, structure and governance, Department of Social Development Quarter 2 & 3 performance.* South Africa: Department of Social Development.

Cleaver, H., Nicholson, D., Tarr, S. & Cleaver, D. 2005. *Child protection, domestic violence and parental substance misuse: Family experiences and effective practice.* Royal Holloway: University of London.

Coalter, F. 2007. *A wider role for sport: Who's keeping score?* London: Routledge.

Coovadia, H., Jewkes, R., Barron, P., Sanders, D. & McIntyre, D. 2009. The health and health systems of South Africa: historical roots of current public health challenges. *The Lancet,* 374(9692):817-834.

Corcoran, K. & Roberts, A. 2015. *Social Workers' desk reference*. 3rd edition. United States: Oxford University Press.

'Culture' 2020, in Merriam Webster's Dictionary, Merriam-Webster, Springfield, Massachusetts, [Online]. Available: https://www.merriam-webster.com/dictionary/culture [2020, May 1].

Cumming, C., Troeung, L., Young, J., Kelty, E. & Preen, D. 2016. Barriers to accessing methamphetamine treatment: a systematic review and meta-analysis. *Drug and Alcohol Dependence,* 168:263-273.

Daley, D. 2013. Family and social aspects of substance use disorders and treatment. *Journal of Food and Drug Analysis,* 21(4):73-76.

Daniels, D. & Adams, Q. 2010. Breaking with township gangsterism: the struggle for place and voice. *African Studies Quarterly*, 11(4):45-57.

Denzin, N.K. & Lincoln, Y.S. 1994. *Handbook of qualitative research.* Thousand Oaks, CA: SAGE.

Derrick, S. & Clark, N. 2013. Need for needle and syringe programmes in Africa. *African Journal of Drug & Alcohol Studies,* 12(2):136-143.

De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. 2011. *Research at grass roots: For the social sciences and human service professions*. 4th edition. Pretoria: Van Schaik.

Donovan, D.M. & Marlatt, G.A. 2005. *Assessment of addictive behaviours*. 2nd edition. New York: Guilford Press.

Doweiko, H. 2009. *Concepts of chemical dependency*. 7th edition. United States: Brooks/Cole, Cengage Learning.

Dyer, T. 2020. *Cutting Ties with Addicts When in Recovery* [Online]. Available: https://www.drugrehab.com/recovery/triggers/addict-friends-while-in-recovery/ [2020, October 14].

Ederies, C. 2017. A qualitative study of the experiences of outpatient substance abuse treatment in the City of Cape Town: a service user's perspective. Unpublished thesis. Western Cape: University of the Western Cape.

Elias, S. 2018. Rehabilitated substance abusers' experience of aftercare following completion of inpatient treatment. Unpublished thesis. Western Cape: University of the Western Cape.

Ellis, G.F.R., Stein, D.J., Thomas, K.G.F. & Meintjies, E.M. (eds) 2012. *Substance use and abuse in South Africa: insights from brain and behavioural sciences.* Cape Town: UCT Press.

Engel, G.L. 1977. The need for a new medical model: a challenge for biomedicine. *Science,* 196(4286):129-136.

Fisher, G.L. & Harrison, T.C. 2013. *Substance abuse: Information for school counselors, social workers, therapists and, counselors.* 5th edition. Upper Saddle River, NJ: Pearson Education.

Forrester, D. & Harwin, J. 2006. Parental substance misuse and child care social work: findings from the first stage of a study of 100 families. *Child and Family Social Work,* 11(4): 325-335.

Fritz, A. 2014. Speech delivered by MEC of Social Development at the UWC community engagement substance abuse graduation ceremony [Online]. Available: https://www.gov.za/speech-delivered-mec-social-development-mr-albert-fritz-uwc-community-engagement-substance-abuse [2019, February 17].

Goldenberg, H. & Goldenberg, I. 2008. *Family therapy: An overview*. 7th edition. Belmont, CA: Thomson Brooks/Cole.

Golestan, S., Abdullah, H., Ahmad, N. & Anjomshoa, A. 2010. Environmental factors influencing relapse behaviour among adolescent opiate users in Kerman. *Global Journal of Human Social Science,* 10(4):71-75.

Gordon, S. 2003. *Relapse and recovery: behavioural strategies for change.* Pennsylvania: Caron Foundation.

Grinnell, Jr. R.M. & Unrau, Y.A. 2005. *Social work research and evaluation: qualitative and quantitative approaches.* 7th edition. New York: Oxford University Press.

Hardey, S., Thomas, S., Stein, S. & Kelley, R. 2019. *Motivational Interviewing in Addiction Treatment* [Online]. Available: https://americanaddictioncentres.org/therapy-treatment/motivational-interviewing [2020, May 28].

Hartney, E. 2019. *The Self Medication Theory of Addiction* [Online]. Available: https://www.verywellmind.com/the-self-medication-theory-of-addiction-21933 [2020, May 13].

Herrmannsen, K. 2016. *Distributing clean needles to curb the spread of HIV* [Online]. Available: https://health-e.org.za/2016/04/21/drugs-clean-needles-try-curb-spread-hiv/ [2019, August 7].

Hitzeroth, V. & Kramer, L. 2010. *The end of addiction: A comprehensive South African guide.* Cape Town: Human & Rousseau.

Horn, B.P., Crandall, C., Forcehimes, A., French, M.T. & Bogenschutz, M. 2017. Benefit-cost analysis of SBIRT interventions for substance using patients in emergency departments. *Journal of Substance Abuse Treatment,* 76:6-11.

Horvath, A.T., Misra, K., Epner, A.K. & Cooper, G.M. 2020. *Socio-cultural forces that lead to drug addiction* [Online]. Available: https://www.cascadementalhealth.org/poc/view_doc.php?type=doc&id=48340&cn=1408 [2020, May 19].

Irwin, A., Jozaghi, E., Weir, B., Allen, S., Lindsay, A. & Sherman, S. 2017. Mitigating the heroin crisis in Baltimore, MD, USA: a cost-benefit analysis of a hypothetical supervised injection facility. *Harm Reduction Journal,* 14:29.

Isobell, D., Kamaloodien, K. & Savahl, S. 2018. Addiction treatment providers' perceptions of publicly funded treatment services in the Western Cape, South Africa. *Journal of Psychology in Africa,* 28(1): 77-80.

Isobell, D. 2013. Referring agents' perceptions of access barriers to inpatient substance abuse treatment centres in the Western Cape. Unpublished master's thesis. Western Cape: University of the Western Cape.

Ivankova, N.V., Creswell, J.W. & Plano Clark, L.V. 2016. Foundations and approaches to mixed methods research: Exploratory sequential mixed methods design. In Maree, K (eds). *First steps in research.* 2nd edition. Pretoria: Van Schaik.

Jason, L.A., Davis, M. & Ferrari, J.R. 2007. The need for substance abuse after-care: Longitudinal analysis of Oxford House. *Addictive Behaviours,* 32(4):803-818.

Johnson, H.C. 2004. *Psyche and synapse expanding worlds: The role of neurobiology in emotions, behaviour, thinking, and addiction for non-scientists,* 2nd edition. Greenfield, MA: Deerfield Valley.

Kaufman, E. & Yoshioka, M.R.M. 2004. *Substance Abuse Treatment and Family Therapy*. Treatment Improvement Protocol (TIP) Series, No. 39. Rockville, MD: U.S. Dept. of Health and Human Services.

Kinnes, I. 2000. From urban street gangs to criminal empires: the changing face of gangs in the Western Cape. Monograph No 48, European Union.

Knapp, C. 1997. *Drinking: A love story.* New York: Delta.

Kumar, R. 2005. *Research methodology: a step-by-step guide for beginners.* 2nd edition. London: SAGE.

Lash, S.J., Burden, J.L., Monteleone, B.R. & Lehmann, L.P. 2004. Social reinforcement of substance abuse treatment aftercare participation: Impact on outcome. *Addictive Behaviours,* 29(2):337-342.

Landale, S. & Roderick, M. 2014. Recovery from addiction and the potential role of sport: Using a life-course theory to study change. *International review for the sociology of sport,* 49(3):468-484.

Leedy, P.D. & Ormrod, J.E. 2005. *Practical research: planning and design.* 7th edition. New York: Pearson Merrill Prentice Hall.

Leshner, A. I. 2006. *The addiction recovery guide: Your internet guide to drug and alcohol addiction recovery*. [Online]. Available: http://www.addictionrecoveryguide.com [2020, February 15].

Lesley Odendal. 2019. *Low harm reduction coverage for people who inject drugs in South Africa* [Online]. Available: https://www.aidsmap.com/news/jul-2019/low-harm-reduction-coverage-people-who-inject-drugs-south-africa [2020, April, 10].

Leslie, D., Milchak, W., Gastfriend, D.R., Herschman, P.L., Bixler, E., Velott, D.L. & Meyer, R. 2015. Effects of injectable extended-release naltrexone for opioid dependence on residential rehabilitation outcomes and early follow-up. *The American Journal on Addictions,* 24(3): 265-270.

Lewis, J.A., Dana, R.Q. & Blevins, G.A. 2011. *Substance abuse counselling*. 4th edition. Belmont: Brooks/Cole Cengage Learning.

Lincoln, Y. & Guba E. 1999. Establishing trustworthiness. In Bryman, A. & Burgess, R.G. (Eds), *Qualitative Research Vol III.* London: SAGE.

Louisiana Addiction Recovery. 2019. *Can a parent's addiction be passed down to their children?* [Online]. Available: https://www.qrslouisiana.org/can-a-parents-addiction-be-passed-down-to-their-children.html [2020, October 6].

Louw, D. & Louw, A. 2007. *Child and adolescent development*. Bloemfontein: University of the Free State.

Lundberg, K. 2016. Environmental risk factors. Audio extract. Utah Addiction Centre, University of Utah. Available: http://learn.genetics.utah.edu/content/addiction/environment/.

Lutchman, S. 2015. Insufficient access to substance abuse treatment centres for illicit drug users and its potential effect on a foetus: A breach of the right to access health care services. *Law Democracy & Development,* 19:66-77.

Manitoba*: The accessibility for Manitobans Act* [Online]. [n.d]. Available: http://www.accessibilitymb.ca/types-of-barriers.html [2019, August 20].

Marshall, J.W., Ruth, B.J., Sisco, S., Bethke, C., Piper, T.M., Cohen, M. & Bachman, S. 2011. Social work interest in prevention: A content analysis of the professional literature. *Social Work*, 56(3):201-211.

Matzopoulos, R., Truen, S., Bowman, B. & Corrigall, J. 2013. The cost of harmful alcohol use in South Africa. *South African Medical Journal,* 104(2):127-132.

McCann, M., Burnhams, N.H., Albertyn, C. & Bhoola, U. 2011. *Alcohol, drugs and employment*. 2nd edition. Claremont: Juta & Company Ltd.

McKay, J. 2001. Effectiveness of continuing care interventions for substance abusers: Implications for the study of long-term treatment effects. *Evaluation Review*, 25(2):211-232.

Medina-Mora, M.E. 2005. Prevention of substance abuse: a brief overview. *World Psychiatry,* 4(1):25-30.

Melchert, T.P. 2011. *Foundations of professional psychology: The end of theoretical orientations and the emergence of the biopsychosocial approach.* USA: Elsevier: 147-166.

Melemis, S.M. 2015. Relapse prevention and the five rules of recovery. *The Yale Journal of Biology and Medicine*, 88(3):325-332.

Michie, G., Hoosain, S., Macharia, M. & Weich, L. 2017. Report on the first government-funded opioid substitution programme for heroin users in the Western Cape Province, South Africa. *South African Medical Journal,* 107(6):539-542.

Milios, R. 2016. *Dreams in Recovery: "Using" and Relapse Dreams - What do they mean?* [Online]. Available: https://www.recovery.org/pro/articles/dreams-in-recovery-using-and-relapse-dreams-what-do-they-mean/ [2020, October 15].

Miller, W.R. & Thoresen, C.E. 2003. Spirituality, religion and health. An emerging research filed. *American Psychology,* 58(1):24-35.

Morjaria, A. & Orford, J, 2002. The role of religion and spirituality in recovery from drink problems: A qualitative study of Alcoholics Anonymous members and South Asian men. *Addiction Research and Theory,* 10:225-256.

Morse, J.M., Barrett, M., Mayan, M., Olson K. & Spiers, J. 2002. Verification Strategies for Establishing Reliability and Validity in Qualitative Research. *International Journal of Qualitative Methods,* 1(2):13-22.

Mpanza, D. & Govender, P. 2017. Rural realities in service provision for substance abuse: a qualitative study in uMkhanyakude district, KwaZulu-Natal, South Africa. *South African Family Practice,* 59(3):110-115.

Myers, B., Fakier, N. & Louw, J. 2009. Stigma, treatment beliefs, and substance abuse treatment use in historically disadvantaged communities. *African Journal of Psychology,* 12(3):218-222.

Myers, B.J., Louw, J. & Pasche, S. C. 2010. Inequitable access to substance abuse treatment services in Cape Town, South Africa. *Substance Abuse Treatment, Prevention, and Policy*, 5:28.

Myers, B., Pasche, S. & Adam, M. 2010. Correlates of substance abuse treatment completion among disadvantaged communities in Cape Town, South Africa. *Substance Abuse Treatment, Prevention, and Policy,* 5:3.

Myers, B., Petersen, Z., Kader, R. & Parry, C. 2012. Moving beyond access: towards a quality-orientated substance abuse treatment system in South Africa. *South African Medical Journal,* 102(8):667-668.

Nation, M., Crusto, C.A., Wandersman, A., Kumpfer, K., Seybolt, D., Morrissey-Kane, E. & Davino, K.M. 2003. What works in prevention. Principles of effective prevention programs. *The American Psychologist*, 58(6-7):449-456.

National Institute on Drug Abuse. 2018a. *Cognitive-Behavioural Therapy (Alcohol, Marijuana, Cocaine, Methamphetamine, Nicotine)*. [Online]. Available: https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioural, [2020, April 28].

National Institute on Drug Abuse. 2018b. *Preventing drug misuse and addiction: the best strategy - Advancing Addiction Science* [Online]. Available: https://www.drugabuse.gov/publications/drugs-brains-behaviour-science-addiction/preventing-drug-misuse-addiction-best-strategy [2019, June 25].

National Institute on Drug Abuse. 2019. What are the long-term effects of methamphetamine use? [Online]. Available: https://www.drugabuse.gov/publications/research-reports/methamphetamine/what-are-long-term-effects-methamphetamine-misuse [2020, October 12].

National Institute on Drug Abuse. 2020. *Common Comorbidities with Substance Use Disorders*. [Online]. Available: https://www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders/part-2-co-occurring-substance-use-disorder-physical-comorbidities [2020, April 26].

Neale, J., Bloor, M. & McKeganey, N. 2007. How do heroin users spend their spare time? *Drugs: Education, Prevention and Policy*, 14:231-246.

Neff, J.A. & MacMaster, S.A. 2005. Spiritual mechanisms underlying substance abuse behavioural change in faith-based substance abuse treatment. *Journal of Social Work Practice in the Addictions,* 5(3):33-54.

Neuman, W. L. 2003. *Social research methods: qualitative and quantitative approaches.* 6th edition. Boston: Pearson Education Inc.

North West Boroughs Healthcare, NHS Foundation Trust. 2020. *Health and Wellbeing, substance misuse.* [Online]. Available: http://www.nwbh.nhs.uk/substance-misuse [2020, January 15].

Nieuwenhuis, J. 2016. Qualitative research designs and data-gathering techniques: Sampling in qualitative research. In K. Maree (ed). *First steps in research.* 2nd edition. Pretoria: Van Schaik.

Odendal, L. 2019. Low harm reduction coverage for people who inject drugs in South Africa [Online]. Available: https://www.aidsmap.com/news/jul-2019/low-harm-reduction-coverage-people-who-inject-drugs-south-africa [2020, April, 10].

Oliver, D., Serovich, J. & Mason, T. 2005. Constraints and opportunities with interview transcription: towards reflection in qualitative research. *Social Forces,* 84(2):1273-1289.

O'Malley, S. & Kosten, T. 2006. Rethinking Substance Abuse: What the science shows, and what we should do about it. In W. Miller & K. Carroll (eds.). *Pharmacotherapy of Addictive Disorders.* New York: The Guilford Press. 240-255.

Orbon, M., Mercado, J. & Balila, J. 2015. Effects of forgiveness therapy on recovery among residents of drug rehabilitation centres. *Procedia Social Behavioural Sciences,* 165:12-20.

Pasche, S., Kleintjes, S., Wilson, D., Stein, D. & Myers, B. 2014. Improving addiction care in South Africa: Development and challenges to implementing training in addictions care at the University of Cape Town. *International Journal of Mental Health Addiction,* 13(3):322-332.

Patterson, E. 2018. *Motivational Interviewing* [Online]. Available: https://drugabuse.com/treatment-therapy/motivational-interviewing/ [2020, May 27].

Patterson, E. 2019. *The importance of finding drug rehab aftercare programmes* [Online]. Available: https://www.rehabs.com/addiction/aftercare-programmes-drug-recovery/ [2019, September, 26].

Patterson, E. 2020. *The impact of People, Places and Things in recovery processes* [Online]. Available: https//www.rehabs.com/impact-people-places-things-addiction/ [2020, April 1].

Peltzer, K., Ramlagan, S., Johnson, B.D. & Phaswana-Mafuya, N. 2010. Illicit drug use and treatment in South Africa: a review. *Substance Use & Misuse*, 45(13):2221-2243.

Probst, B. 2015. The eye regards itself: benefits and challenges of reflexivity in qualitative social work research. *Social Work Research,* 39:37-48. doi: 10. 1093/SWR/SVU028.

Proctor, S.L. & Herschman, P.L. 2014. The continuing care model of substance use treatment: What works, and when is "enough", "enough?". *Psychiatry Journal,* (3):692423 [Online]. Available: *https://www.hindawi.com/journals/psychiatry/2014/692423/* doi:10.1155/2014/692423.

Pycroft, A. 2010. *Understanding and Working with Substance Misusers.* London: Sage.

Pycroft, A. & Bartollas, C. 2014. *Applying Complexity Theory: Whole Systems Approaches in Criminal Justice and Social Work.* Bristol: Policy Press.

Ramaglan, S., Peltzer, K. & Matseke, G. 2010. Epidemiology of drug abuse treatment in South Africa. *South African Journal of Psychiatry*, 16(2):40-49.

Rassool, G.H. 2011. *Understanding addiction behaviours: Theoretical and clinical practice in health and social care.* Hampshire: Palgrave Macmillan.

Reagon, T. 2013. *South African Addiction Problem,* [Online]. https://christiandrugsupport.wordpress.com [2019, February 18].

Republic of South Africa. 2007. *A report on the 1st Biennial Substance Abuse Summit.* South Africa: Department of Social Development.

Republic of South Africa. 2008. *The Prevention of and Treatment for Substance Abuse Act 70 of 2008.* Pretoria: Government Printer.

Republic of South Africa. 2006-2011. National Drug Master Plan. Republic of South Africa: The Department of Social Development.

Republic of South Africa. 2013-2017. *National Drug Master Plan.* Republic of South Africa: The Department of Social Development.

Reuter, P. & Stevens, A. 2015. Assessing UK drug policy from a crime control perspective. *Criminology and Criminal Justice,* 8(4):461-482.

Routledge, L. 2005. Substance abuse and psychological well-being of South African adolescents in an urban context. Unpublished masters' dissertation. Pretoria: University of Pretoria.

Rubin, A. & Babbie, E. 2005. *Research methods for social work.* 5th edition. Australia: Thomson Brooks/Cole.

Ruokonen-Engler, M. & Siouti, I. 2016. Biographical entanglements, self-reflexivity, and transnational knowledge production. *Qualitative Inquiry,* 22(9):745-752. doi: 10. 1177/1077800416658071.

Santucci, K. 2012. Psychiatric disease and drug abuse. *Current Opinion in Pediatrics,* 24(2):233-237.

Sarason, I.G. & Sarason, B. R. 2009. Social support: Mapping the construct. *Journal of Social and Personal Relationships,* 26(1):113-120.

Scheibe, A., Shelly, S., Gerardy, T., von Homeyer, Z., Schneider, A., Padayachee, K., Naidoo, S.B., Mtshweni, K., Matau, A., Hausler, H. & Marks, M. 2020. Six-month retention and changes in quality of life and substance use from a low-threshold methadone maintenance therapy programme in Durban, South Africa. *Addiction Science & Clinical Practice,* 15:1-11.

Schuckit, M. 2009. Alcohol-use disorders. *The Lancet*, 373(9662):492-501.

Shea, N., Boldt, A., Bang, D., Yeung, N., Heyes, C. & Frith, C.D. 2014. Supra-personal cognitive control and metacognition. *Trends in Cognitive Science,* 18(4):186-193.

Setlalentoa, B., Pisa, P., Thekiso, G., Ryke, E. & Loots, Du T. 2010. The social aspects of alcohol misuse/abuse in South Africa. *South African Journal Clinical Nutrition,* 23(3).

Sindelar, J.L. & Fiellin, D.A. 2014. Innovations in treatment for drug abuse: solutions to a public health problem. *Annual Review of Public Health,* 22:249-272.

Smith, J.A., Hayes, N.D. & Jordan, S.S. 2019. Systemic integration of IFS therapy and 12-step facilitation for substance use: A theoretical discussion. *Alcohol Treatment Quarterly,* 37(1):60-74.

Social Work Policy Institute. 2010. Evidence-based practice. *Partnerships to promote evidence-based practice* [Online]. Available: http://www.socialworkpolicy.org/research/evidence-based-practice-2.html [2019, June 20].

Solis, J.M., Shadur, J.M., Burns, A.R. & Hussong, A.M. 2012. Understanding the diverse needs of children whose parents abuse substances. *Curr Drug Abuse Rev,* 5(2):135-147.

South African Medical Research Council (SAMRC). *2018. South African Community Epidemiology Network on Drug Use*. [Online]. Available: http://www.mrc.ac.za/intramural-research-units/ATOD-sacendu [2019, June 8].

South African Medical Research Council (SAMRC). *2019*. *South African Community Epidemiology Network on Drug Use*. [Online]. Available: https://www.samrc.ac.za/sites/default/files/attachments/2019-10 16/SACENDUBriefPhase45.pdf [2020, October 7].

South African National Council on Alcoholism and Drug Dependence. 2017. *Trends and Statistics,* [Online]. https://www.sancanational.info [2019, February 28].

Stangen Insurance. 2018. Umuntu ngumuntu ngabantu- I am because you are. 2018. [Stangen Blog]. Available: https://www.wiseaboutlife.co.za/2018/11/19/umuntu-ngumuntu-ngabantu-i-am-because-you-are/ [2020, May 10].

Statistics South Africa. 2017. *General Household Survey 2016.* [Online]. Available: http://www.statssa.gov.za/publications/P0318/P03182017.pdf [2020, October 8].

Statistics South Africa. 2019. *General Household Survey 2018*. [Online]. Available: http://www.statssa.gov.za/publications/P0318/P03182018.pdf [2020, October 8].

State of Hawaii. 2019. *Alcohol and drug prevention, Department of Health* [Online]. Available: https://health.hawaii.gov/substance-abuse/prevention-treatment/prevention/prevention-strategy/ [2019, June 26].

Steven, M. 2015. Relapse prevention and the five rules of recovery. *Yale Journal of Biology and Medicine*, 88(3):325-332.

Substance Abuse and Mental Health Services Administration (SAMHSA). 2010. *Substance Abuse Treatment for Persons with Co-Occurring Disorders.* [Online]. Available: https://www.samhsa.gov/search_results?k=Substance+Abuse+Treatment+for+Persons+With+CoOccurring+Disorders&facet=default_collection+OR+collection%3ASAMHSA_Store+OR+collection%3Adata+OR+collection%3Ablog+OR+collection%3Arecoverymonth.

Swartz, L., De la Rey, C., Duncan, N., Townsend, L. & O'Neil, V. 2011. *Psychology: An introduction*. Cape Town: Oxford University Press.

Szapocznik, J., Hervis, O. & Schwartz, S. 2003. *Therapy Manuals for Drug Addiction Brief Strategic Family Therapy for Adolescent Drug Abuse*. Bethesda, MD: National Institute on Drug Abuse (NIDA).

Szelemko, W.J., Wood, J.W. & Thurman, P.J. 2006. Native Americans and alcohol: past, present, and future. *The Journal of General Psychology,* 133(4):435-451.

Tagliareni, S. 2020. *Relapse Triggers* [Online]. Available: https://www.drugrehab.com/recovery/triggers/ [2020, May 10].

The biopsychosocial perspective. (n.d.) In CliffsNotes.com [Online]. Available: https://www.cliffsnotes.com/study-guides/psychology/development-psychology/introduction-to-developmental-psychology/the-biopsychosocial-perspective [2019, March 05].

United Nations Office on Drugs and Crime (UNODC). 2002. *Country profile on drugs and crime. Regional Office for Southern Africa.* [Online]. Available: https://www.unodc.org/documents/southafrica/sa_drug.pdf [2019, June 19].

United Nations Office on Drugs and Crime (UNODC). 2012. *World Drug Report. Executive summary, conclusions and policy implications.* [Online]. Available: https://www.unodc.org/documents/data-andanalysis/WDR2012/WDR_2012_web_small.pdf [2019, February 24].

United Nations. 2016. *International Narcotics Control Board: Progress in ensuring adequate access to internationally controlled substances for medical and scientific purposes*. (E/INCB.2018/Supp.1) . [Online]. Available: https://www.incb.org/incb/en/publications/annual-reports/annual-report-supplement-2018.html [2019, February 25].

United Nations Office on Drugs and Crime. (UNODC) 2018. *World Drug Report 2018. Executive summary, conclusions and policy implications,* [Online]. Available: https://www.unodc.org/wdr2018 [2019, February 20].

University of California. 2015. Potentially effective treatment for methamphetamine addiction identified. Science Daily, Available: https://www.sciencedaily.com/releases/2015/05/150519132758.htm [2020, October 15].

Van der Westhuizen, M., Alpaslan, A.H. & de Jager, M. 2013. Aftercare to chemically addicted adolescents: An exploration of their needs. *Health SA Gesondheid*, 18(1):1-11.

Van Dyk, J. 2018. *Durban cuts city's only needle exchange programme* [Online]. Available: https://bhekisisa.org/health-news-south-africa/2018-05-30-00-durban-cuts-citys-only-needle-exchange-programme/ [2020, March 20].

Van Wormer, K. & Davis, D. 2013. *Addiction treatment, A strengths perspective.* 3rd edition. Brooks/Cole, Cengage Learning.

Vertava Health Editorial Team, 2020. *Using Cognitive Behavioural Therapy (CBT) in Addiction Treatment* [Online]. Available: https://www.addictioncampuses.com/addiction-treatment/cognitive-behavorial-therapy/ [2020, April 28].

Volkow, N. D. 2010. *Drugs, brains, and behavior: The science of addiction.* [Online] National Institute on Drug Abuse (NIDA) Available: https://www.drugabuse.gov/sites/default/files/soa.

Wallace, B. 2005. *Making Mandated Addiction Treatment Work.* United Kingdom: Rowman & Littlefield.

Washton, A.M. & Zweben, J.E. 2006. *Lifestyle theory: past, present and future*. Nova Science Publications: New York.

Western Cape Government. 2016. *General Substance Abuse Booklet*. Cape Town: The Department of Social Development.

Western Cape Government. 2019. *Gangsterism in the Western Cape*. Cape Town: The Department of Social Development. [Online] Available: https://www.westerncape.gov.za/general-publication/gangsterism-western-cape-0.

Wood, J. & Alleyne, E. 2010. Street gang theory and research: Where are we now and where do we go from here? *Aggression and Violent Behavior*, 15:100-111. http://dx.doi.org/10.1016/j.avb.2009.08.005.

World Health Organization. 2004. *Effectiveness of sterile needles and syringe programming in reducing HIV.AIDs among injecting drug users.* [Online]. Available: https://apps.who.int/iris/bitstream/handle/10665/43107/9241591641.pdf;jsessionid=FEC6C19EA9A0D1E5D319B174042794D6?sequence=1 [2020, April 26].

World Health Organization, United Nations Office on Drugs and Crime & UNAIDS. 2009. *WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users,* [Online]. Available: https://www.unaids.org/sites/default/files/sub_landing/idu_target_setting_guide_en.pdf [2020, February 10].

World Health Organization. 2013. *Mental Health Action Plan* 2013-2020. Geneva: WHO Press.

World Health Organization. 2017. *World Drug Report*. [Online]. Available: https://www.unodc.org/wdr2017/index.html [2019, February 26].

World Health Organization. 2019. *Measures of harm reduction service provision for people who inject drugs* [Online]. Available: https://www.who.int/bulletin/volumes/97/9/18-224089/en/ [2020, March 22].

Yates, S.J. 2004. *Doing social science research.* London: SAGE.

Zimmerman, M. & Coryell, W. 1989. DSM-III Personality Disorder Diagnoses in a Nonpatient Sample. Demographic Correlates and Comorbidity. *Arch Gen Psychiatry,* 46(8):682-9.

ANNEXURE 1

INFORMED CONSENT FORMS

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

You are invited to take part in a study conducted by Danyschka Jacobs, from the Department of Social Work at Stellenbosch University. You were approached as a possible participant because you will have direct knowledge, opinions, views and needs in regards to aftercare services for recovering addicts in the Western Cape.

1. PURPOSE OF THE STUDY

The purpose of this study is to explore and investigate the availability and accessibility of aftercare services for recovering addicts in the Western Cape. Furthermore, this study aims to understand the knowledge that recovering addicts have in terms of aftercare services as well as their needs in this regard. This study will explore which services are available across the Western Cape together with which services need to be made more accessible and, in some communities, established for recovering addicts. This study aims to demonstrate the necessity of aftercare services in healthy and active recovery for recovering addicts. A variety of aftercare services should be available and accessible as well as the knowledge of such services being made known to recovering addicts in the Western Cape in order to provide the necessary continued support and assistance throughout their recovery.

2. WHAT WILL BE ASKED OF ME?

If you agree to take part in this study, you will be asked to partake in an interview which will be conducted by the researcher which will be recorded and transcribed for research purposes. This interview will last for a maximum of one hour with no further participation required. It will take place in a private office space in a non-judgmental environment where you will have privacy to share your personal viewpoints regarding recovery and aftercare services. The researcher will ask questions related to your experience with sobriety and your journey in recovery. The researcher will ask questions that explore aftercare services, your knowledge or lack thereof of such services, your opinion on the necessity of aftercare services as well as your needs in terms of beneficial aftercare services.

3. POSSIBLE RISKS AND DISCOMFORTS

There is the potential for emotional discomfort when discussing your sobriety and aftercare services in your area, there will be debriefing services available though, if you should need this.

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

Benefits of the study would include having your voice heard regarding your recovery needs as well as the potential needs of your community in terms of aftercare services. To directly increase your knowledge on aftercare services in terms of the types of services that exist, services available in your community and exploring the following steps in your journey with sobriety. To increase your own knowledge and confidence in planning how to maintain your

sobriety through established aftercare services. Preparing you for leaving treatment equipped with knowledge on various aftercare services that may assist in continued support with your sobriety.

5. PAYMENT FOR PARTICIPATION

There will be no payment for participation in this study, it is a completely voluntary participation which will incur no costs to the participants.

6. PROTECTION OF YOUR INFORMATION, CONFIDENTIALITY AND IDENTITY

Confidentiality and anonymity will be maintained at all times through ensuring interviews, transcripts and findings will be generalised so your identity together with the organisation are protected and there are no identifiable features shared. Any critique made by the participant regarding the availability and accessibility of aftercare services received at other rehabilitation centres disclosed in the interview will not in any way affect the participant negatively in terms of the services they will receive at those centres in the future, as no names of any centres or participants will be reported. The only person privy to this content is the researcher's supervisor Dr. Ilze Slabbert. Any information shared will be further protected by utilising Microsoft OneDrive to secure electronic data obtained in interviews. OneDrive has multiple security features to protect sensitive information. All hard copy data will be stored at the University of Stellenbosch where it is locked and protected at all times and will remain here for a minimum of 5 years before being destroyed.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you agree to take part in this study, you may withdraw at any time without any consequence. You may also refuse to answer any questions you don't want to answer and still remain in the study. The researcher may withdraw you from this study if there are evident signs of emotional distress, aggression or intoxication.

8. RESEARCHERS' CONTACT INFORMATION

If you have any questions or concerns about this study, please feel free to contact Danyschka Jacobs at 19477600@sun.ac.za, and/or the supervisor Dr. Ilze Slabbert at **islabbert@sun.ac.za.**

9. RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research participant, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

DECLARATION OF CONSENT BY THE PARTICIPANT

As the participant I confirm that:

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

By signing below, I _____ agree to take part in this research study, as conducted by Danyschka Jacobs.

_____..... _____

Signature of Participant **Date**

DECLARATION BY THE PRINCIPAL INVESTIGATOR

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

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

_____ _____

Signature of Principal Investigator **Date**

ANNEXURE 2

THEMES FOR THE INTERVIEW SCHEDULE

- **Theme 1:** Biological challenges for recovering adult addicts in reference to aftercare services (Genetics, cravings, health benefits and consequences)

  Do you have any family members that abuse substances?

  If so, are any family members receiving aftercare services or medical treatment?

  When/ what age did you first experiment with substances and subsequently abuse them?

  Do you experience cravings?

  How do you react to cravings?

  How has the abuse of substances affected your health?

  How has your health changed since becoming sober?

  Do you have access to any pharmacotherapy options?

  If so or if not, how do you think this will assist or impact your sobriety? (Negative/positive)

- **Theme 2:** Psychological challenges for recovering adult addicts in reference to aftercare services (Coping techniques, triggers, stress management)

  What are your main triggers?

  How do you respond to triggers?

  What are your main coping mechanisms to triggers?

  Which scenarios/situations induce stress for you?

  How do you plan on addressing this once leaving treatment?

  Do you have access to a mental health professional/therapy or support groups/ church groups after treatment?

  If so or if not, how do you think this will assist or impact your sobriety? (negative and positive)

- **Theme 3:** Social challenges for recovering adult addicts in reference to aftercare services (Family, friends, social support, socioeconomic factors, geographic location)

  Do you have family or friends that abuse substances?

How does this effect you?

Do you have family/friends that are sober?

Do you have any family or friends that are supportive?

What other support structures do you have or rely on?

What are the support options are available for you to access once leaving treatment?

What support structures would you like to have or be able to access after treatment?

Are there people, places or things you want to avoid for relapse purposes?

How do you intend to manage these people, places or things?

Are there support groups or services in your area?

Are drugs or alcohol easily accessible in your area?

What do you think would assist your community and the people within it? (e.g. afterschool programs, recreational centers, support group options, sports groups etc.)

- **Theme 4:** Cultural challenges for recovering adult addicts in reference to aftercare services (community dynamics, cultural and societal norms, stereotypes and stigma, beliefs, rituals)

  What are your views on substance abuse?

  How does your community view it?

  How does your culture play a role in it (e.g. social drinking norms, rituals etc.)?

  How does this impact your sobriety? (e.g. are there challenges or positives in this regard)

  Are there any factors that make it difficult to stay in your community?

  Do you think aftercare services are important to your sobriety and why/how?

  Which aftercare services do you want to make use of?

  What aftercare services are available in your community?

  Would you make use of any of these services, if not, why?

  Are you able to access services that are not directly within your community?

  If so, how? If not, why?

  Are they accessible financially, geographically, culturally, variety and frequency?

ANNEXURE 3

LETTER OF PERMISSION FROM ORGANISATION

To whom it may concern

Regarding: Me. Danyschka Jacobs Student number: 19477600

Toevlug Centre for Alcohol and Drug Dependence is an NPO (110-891) registered with the Department of Health and Department of Social Development. Toevlug focusses on the prevention, treatment and aftercare of substance dependence. Toevlug has a 5 week adult and youth inpatient program in Worcester as well as an 8 week community based program for adults and youth in Worcester, Rawsonville, Beaufort West and Ceres area.

Toevlug rehabilitation centre received a research request from me. Jacobs for her Masters in Social Work. Me. Jacobs was also placed at Toevlug for her 4th year Social Work Practical during 2018 and is known to Toevlug's organisational practices. Her current research will focus on the appropriateness and accessibility of aftercare services for recovery addicts. Interviews will be held with the week 5 adult inpatients at Worcester.

Toevlug hereby gives permission to me. Jacobs to conduct her Masters research at Toevlug. Toevlug will make an appropriate time available on our week 5 patients program for me. Jacobs to conduct interviews with our adult week 5 inpatients. All patients will be participating voluntarily in the research and all will sign written consent in order for me. Jacobs to access their confidential patient files. Toevlug's multi-disciplinary team will provide access to debriefing for all participants if needed.

Nelia van Deventer
Head of Social Work Department
023 342 1162

ANNEXURE 4

LETTER OF DEBRIEFING SERVICES

Elmari
HOFFMAN-VAN ROOYEN
PRIVAAT MAATSKAPLIKE WERKER
T 074 888 4088
M 084 549 9152
F 086 638 4443
E oltheraplst@gmail.com

DETAILED
MEDICAL AID CLAIM
INVOICE

Practice Number: 0020974

26 November 2019

To whom it may concern

Master's degree student: Danyschka Jacobs

Topic: The availability and accessibility of aftercare services for recovering adult addicts in the Western Cape

I hereby confirm that I will be available to offer any debriefing services for participants taking part in abovementioned study.

Kind regards

Elmari Hoffman- Van Rooyen

ANNEXURE 5

CONSENT LETTER FROM REC

UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

NOTICE OF APPROVAL

REC: Social, Behavioural and Education Research (SBER) - Initial Application Form

12 May 2020

Project number: 11739

Project Title: The availability and accessibility of aftercare services for recovering adult addicts in the Western Cape

Dear Ms Danyschka Jacobs

Your response to stipulations submitted on 30 March 2020 was reviewed and approved by the REC: Social, Behavioural and Education Research (REC: SBE).

Please note below expiration date of this approved submission:

Ethics approval period:

Protocol approval date (Humanities)	Protocol expiration date (Humanities)
13 February 2020	12 February 2021

GENERAL COMMENTS:

1. SUSPENSION OF PHYSICAL CONTACT RESEARCH ACTIVITIES AT SU

There is a **postponement of all physical contact research activities at Stellenbosch University,** apart from research that can be conducted remotely/online and requires no human contact, and research in those areas specifically acknowledged as essential services by the South African government under the presidential regulations related to COVID-19 (e.g. clinical studies).

Remote (desktop-based/online) research activities, online analyses of existing data, and the writing up of research results are strongly encouraged in all SU research environments.

Please read the REC notice for suspension of physical contact research during the COVID-19 pandemic: http://www.sun.ac.za/english/research-innovation/Research-Development/sbecovid-19

If you are required to amend your research methods due to this suspension, please submit an amendment to the REC: SBE as soon as possible. The instructions on how to submit an amendment to the REC can be found on this webpage: [instructions], or you can contact the REC Helpdesk for instructions on how to submit an amendment: applyethics@sun.ac.za.

INVESTIGATOR RESPONSIBILITIES

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

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

Please use your SU project number (11739) on any documents or correspondence with the REC concerning your project.

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

CONTINUATION OF PROJECTS AFTER REC APPROVAL PERIOD

You are required to submit a progress report to the REC: SBE before the approval period has expired if a continuation of ethics approval is required. The Committee will then consider the continuation of the project for a further year (if necessary).

Once you have completed your research, you are required to submit a final report to the REC: SBE for review.

Included Documents:

Document Type	File Name	Date	Version
Data collection tool	Interview Schedule	01/10/2019	2
Proof of permission	Permission Toevlug	01/10/2019	1
Default	DESC form, D Jacobs	01/10/2019	1
Letter of support_counselling	scan	15/01/2020	1
Default	REC	17/01/2020	1
Research Protocol/Proposal	Proposal	17/01/2020	2
Informed Consent Form	Annexure 1	30/03/2020	3
Default	REC response letter	30/03/2020	2

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

Sincerely,

Clarissa Graham

REC Coordinator: Research Ethics Committee: Social, Behavioral and Education Research

National Health Research Ethics Committee (NHREC) registration number: REC-050411-032.
The Research Ethics Committee: Social, Behavioural and Education Research complies with the SA National Health Act No.61 2003 as it pertains to health research. In addition, this committee abides by the ethical norms and principles for research established by the Declaration of Helsinki (2013) and the Department of Health Guidelines for Ethical Research: Principles Structures and Processes (2nd Ed.) 2015. Annually a number of projects may be selected randomly for an external audit.

Principal Investigator Responsibilities

Protection of Human Research Participants

As soon as Research Ethics Committee approval is confirmed by the REC, the principal investigator (PI) is responsible for the following:

Conducting the Research: The PI is responsible for making sure that the research is conducted according to the REC-approved research protocol. The PI is jointly responsible for the conduct of co-investigators and any research staff involved with this research. The PI must ensure that the research is conducted according to the recognised standards of their research field/discipline and according to the principles and standards of ethical research and responsible research conduct.

Participant Enrolment: The PI may not recruit or enrol participants unless the protocol for recruitment is approved by the REC. Recruitment and data collection activities must cease after the expiration date of REC approval. All recruitment materials must be approved by the REC prior to their use.

Informed Consent: The PI is responsible for obtaining and documenting affirmative informed consent using **only** the REC-approved consent documents/process, and for ensuring that no participants are involved in research prior to obtaining their affirmative informed consent. The PI must give all participants copies of the signed informed consent documents, where required. The PI must keep the originals in a secured, REC-approved location for at least five (5) years after the research is complete.

Continuing Review: The REC must review and approve all REC-approved research proposals at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period.** Prior to the date on which the REC approval of the research expires, **it is the PI's responsibility to submit the progress report in a timely fashion to ensure a lapse in REC approval does not occur.** Once REC approval of your research lapses, all research activities must cease, and contact must be made with the REC immediately.

Amendments and Changes: Any planned changes to any aspect of the research (such as research design, procedures, participant population, informed consent document, instruments, surveys or recruiting material, etc.), must be submitted to the REC for review and approval before implementation. Amendments may not be initiated without first obtaining written REC approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

Adverse or Unanticipated Events: Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research-related injuries, occurring at this institution or at other performance sites must be reported to the REC within **five (5) days** of discovery of the incident. The PI must also report any instances of serious or continuing problems, or non-compliance with the RECs requirements for protecting human research participants.

Research Record Keeping: The PI must keep the following research-related records, at a minimum, in a secure location for a minimum of five years: the REC approved research proposal and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence and approvals from the REC.

Provision of Counselling or emergency support: When a dedicated counsellor or a psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.

Final reports: When the research is completed (no further participant enrolment, interactions or interventions), the PI must submit a Final Report to the REC to close the study.

On-Site Evaluations, Inspections, or Audits: If the researcher is notified that the research will be reviewed or audited by the sponsor or any other external agency or any internal group, the PI must inform the REC immediately of the impending audit/evaluation.

ANNEXURE 6

MEMBER VERIFICATION FORM

UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

UNIVERSITY OF STELLENBOSCH
DEPARTMENT OF SOCIAL WORK

MEMBER VERIFICATION FORM

Participant number: _____

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

(Please tick where you feel appropriate)

YES	
NO	

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

(Please tick where you feel appropriate)

YES	
NO	

Signature (participant): _____

ANNEXURE 7:

INDEPENDENT CODE THEME VERIFICATION

INDEPENDENT CODER THEME VERIFICATION FORM

I hereby declare that I have read the transcribed interviews completed for this research study on the availability and accessibility of aftercare services for recovering adult addicts in the Western Cape, and I am in agreement with the themes, sub-themes and categories derived from this:

(Please tick where you feel appropriate)

YES	
NO	

ANNEXURE 8

REFLEXIVITY REPORT

According to Probst (2015), reflexivity involves gaining self-awareness and acknowledging your own viewpoints, assumptions, biases and projection of thoughts and feelings. It is important to explore and understand reflexivity within the narrative of the research study as it assists in reflecting on one's standpoint and personal entanglement in the research process. The following 6 questions were developed by Ruokonen-Engler and Siouti (2016) in order for the researcher to analyse their own reflexivity in light of the research study.

1. What personal experience do I have with my research topic?

Throughout my bachelor's degree in Social Work I was continuously confronted with the impact of addiction in the Western Cape in my practical education. I was confronted with a variety of settings ranging from old-age homes, homeless shelters, to an adolescent and adult in-patient rehabilitation organisation wherein substance abuse was the common thread. Upon graduating and entering the field as a qualified Social Worker, I continued to be confronted with the challenge of addiction amongst adolescents and adults. However, what was more noteworthy was the evident lack of availability and accessibility that majority of the individuals I encountered had to not only intervention services but even more so with aftercare services.

2. How did I come to study the specific topic in the field?

Throughout my studies and professional career, I have been met with individuals suffering with addiction disorders and remaining desperate for some kind of assistance to reach sobriety. When conducting my final year practical at a drug and alcohol rehabilitation organisation for both adolescent males and adults, it became evident that there was minimal guidance and follow up for aftercare services for recovering addicts as majority of the social work personnel were allocated strictly to prevention and intervention services. However, it was a common occurrence to see those in entering their aftercare phase of treatment relapse and admit themselves back into the intervention programs. When these service users were interviewed, the relapses were often attributed to overwhelming triggers and cravings, a lack of support, poor community health, together with inaccessible and unavailable aftercare services. Thus, it became evident that there was a treatment gap in addiction services and in order to assist recovering addicts in maintaining their sobriety, it was necessary to investigate the availability and accessibility of aftercare services in the Western Cape.

3. What is my relationship to the topic being investigated?

I have a passion in field of addiction and I am consistently confronted by this aspect in my practical education in studies, and my working environment as a social worker and mediator. In the future, I would like to formally enter the field of addiction through rendering addiction services and assist in implementing improved strategies to not only increase the protective factors for sobriety amongst recovering addicts, but to reduce the harm of substances on the country.

4. How did I gain access to the field?

I gained access to participants by utilising my professional networks. I remained in close contact with the social workers at the rehabilitation organisation where I completed my final year of practical education. They were familiar with me and my work ethic, together with being able to assist me in light of the Covid19 pandemic wherein rehabilitation organisations were subsequently closed. They assisted me in gaining access to participants in their outpatient sites when the reopening of rehabilitation organisations was permitted in accordance with the lockdown regulations.

5. How does my own position (age, gender, class, ethnicity, economic status, etc.) influence interaction in the field and the data collection process?

Being a social worker with a history of working with the participant group, it assisted in the participants feeling comfortable and willing to participate in the interview. However, being a young, white, economically middle-class female, I think brought some apprehension amongst the participants in terms of establishing trust and questioning my ability to relate to their experiences and lived realities as people of colour, struggling with addiction in disadvantaged communities. However, throughout the interviews trust was established as well as respecting the participants as the experts in their own lives and being open to being educated on their lived social realties and struggles in accessing available aftercare services. This allowed for open and honest interviews to take place wherein rich data was obtained.

6. What is my interpretation perspective?

Whilst conducting the interviews I actively tried to remain objective through engaging in active listening and resisting sharing my own personal observations and opinions. However, when handling the data and research narratives I realised that I did have a subjective perspective, as I found myself agreeing with the narratives whilst also experiencing frustration on their behalves given the lack of accessibility and availability they have to aftercare services. In order to rectify this and ensure the data remains as objective as possible and valid, I made a purposeful effort to conduct member checking with the participants in order to guarantee that I was remaining impartial in my analysis and presentation of the data obtained.